Public Document Pack

RUSHMOOR BOROUGH COUNCIL

POLICY AND PROJECT ADVISORY BOARD

To be held at the Council Offices, Farnborough on
Tuesday, 25th July, 2023 at 7.00 pm

To:

Cllr Marina Munro (Chairman)
Cllr Jessica Auton (Vice-Chairman)

Cllr A. Allen
Cllr Jib Belbase
Cllr Michael Hope
Cllr Peace Essien Igodifo
Cllr T.W. Mitchell
Cllr M.J. Roberts
Cllr Calum Stewart
Cllr Becky Williams
Cllr G. Williams

Standing Deputies:
Cllr Gaynor Austin
Cllr P.J. Cullum
Cllr Halleh Koohestani
Cllr Jacqui Vosper

Enquiries regarding this agenda should be referred to the Administrator, Adele Taylor, Democracy Team, Tel. (01252) 398831, Email. adele.taylor@rushmoor.gov.uk.

A G E N D A

1. **MINUTES –** (Pages 1 - 2)

   To confirm the Minutes of the Meeting held on 27th June, 2023 (copy attached).

2. **ADDRESSING INEQUALITIES - MENTAL HEALTH AND WELLBEING –** (Pages 3 - 124)

   There is increasing evidence that the overall mental health and wellbeing of communities continues to worsen post covid and that people from disadvantaged backgrounds are the most affected. Data from Hampshire Public Health indicates that approaching 1 in 7 people have depression and over 21% report a high anxiety score in Hampshire. The Policy and Project Advisory Board have agreed to undertake some focused work to understand the current situation in the Borough and existing and planned provision for Mental Health services available for residents. The Board will explore current activity supporting mental wellbeing and the prevention of mental illness.

   The Board will also consider whether the Council signing the Prevention Concordat for Better Mental Health would be beneficial Prevention Concordat for Better Mental Health - GOV.UK. A briefing note providing some background on the Concordat is attached.

   It is anticipated that this work will run over 2-3 sessions with this initial session providing a number of inputs to provide Members with detail on mental health and wellbeing support and prevention that is available from the NHS, County Council and projects contained within Rushmoor's Supporting Communities Strategy. There will also be an introduction to the Concordat and the arguments supporting an increased focus on prevention. Following these presentations, Board Members will be asked to discuss what they have heard and identify areas where they would like to focus at the next session(s).

   Once the Board have concluded their review and consideration of the data and evidence they will consider implications and proposed changes for the Council's Supporting Communities Strategy as a result.

   Links to documents to support the first session include:

   Hampshire Mental Wellbeing Strategy and Suicide Prevention Plan - PowerPoint Presentation (hants.gov.uk) (copy attached).

   Creating Healthier Communities Strategy - Frimley ICS Strategy - March 2023 (frimleyhealthandcare.org.uk) (copy attached) and Frimley ICS NHS Joint Forward Plan Joint Forward Plan (frimleyhealthandcare.org.uk) (for Mental Health Services see p24) (an extract from the Forward Plan is attached and the full copy can be found via the link).

   Rushmoor Supporting Communities Strategy – Supporting Communities Strategy – Update - 2023 (copy attached) and an appendix on achievements and current actions (copy attached).

3. **WORK PLAN –** (Pages 125 - 130)

To discuss the Policy and Project Advisory Board Work Plan (copy attached).

MEETING REPRESENTATION

Members of the public may ask to speak at the meeting on any of the items on the agenda by writing to the Panel Administrator at the Council Offices, Farnborough by 5.00 pm two working days prior to the meeting.

Applications for items to be considered for the next meeting must be received in writing to the Panel Administrator fifteen working days prior to the meeting.

This page is intentionally left blank

POLICY AND PROJECT ADVISORY BOARD

Meeting held on Tuesday, 27th June, 2023 at the Council Offices, Farnborough at 7.00 pm.

Voting Members

Cllr Marina Munro (Chairman)
Cllr Jessica Auton (Vice-Chairman)

Cllr A. Allen
Cllr Jib Belbase
Cllr Michael Hope
Cllr Peace Essien Igodifo
Cllr T.W. Mitchell
Cllr M.J. Roberts
Cllr Calum Stewart
Cllr Becky Williams
Cllr G. Williams

1. **APPOINTMENT OF VICE-CHAIRMAN**

RESOLVED: That Cllr Jessica Auton be appointed as Vice-Chairman for the 2023/24 Municipal Year.

2. **MINUTES**

The minutes of the meeting held on 15th March 2023 were agreed as a correct record.

3. **APPOINTMENTS 2023/24**

(1) Progress Group

RESOLVED: That the following members be appointed to serve on the Policy and Project Advisory Board Progress Group for the 2023/24 Municipal Year:

PPAB Chairman	Cllr Marina Munro
PPAB Vice-Chairman	Cllr Jessica Auton
Conservative Group	Cllr Michael Hope Cllr Calum Stewart
Labour Group	Cllr M.J. Roberts Cllr Gareth Williams
Liberal Democrat Group	Cllr Thomas Mitchell

(2) Transformation Task and Finish Group

RESOLVED: That the following members be appointed to serve on the Transformation Task and Finish Group for the 2023/24 Municipal Year:

PPAB Chairman	Cllr Marina Munro
Cabinet Member with responsibility for Customer Experience, Digital and Transformation	Cllr J.B. Canty
Conservative Group	Cllr Ade Adeola Cllr Peace Essien-Igodifo
Labour Group	Cllr Abe Allen Cllr Jules Crossley
Liberal Democrat Group	Cllr Thomas Mitchell

(3) Elections Group

RESOLVED: That the following members be appointed to serve on the Elections Group for the 2023/24 Municipal Year:

PPAB Vice-Chairman	Cllr Jess Auton
Cabinet Member with responsibility for Electoral Issues	Cllr Sue Carter
Chairman of Corporate Governance, Audit and Standards Committee	Cllr P.J. Cullum
Conservative Group	Cllr Calum Stewart
Labour Group	Cllr K. Dibble Cllr Becky Williams
Liberal Democrat Group	Cllr Craig Card

4. **WORK PLAN**

The Board noted the current Work Plan.

It was noted that the Progress Group meeting would take place on 5th July, 2023 at 5.30pm on Teams.

The meeting closed at 7.17 pm.

CLLR MARINA MUNRO (CHAIRMAN)

About the Prevention Concordat

The Prevention Concordat for Better Mental Health Programme is a national agreement published by Public Health England in 2017 to mobilise an evidence-based, preventative approach to mental health problems.

The Concordat was designed so that all stakeholders (such as local authorities, NHS organisations, voluntary sector organisations, employers and educational organisations) could sign up to it.

Signatories have a shared commitment to work together as a whole system to prevent mental health problems and promote good mental health.

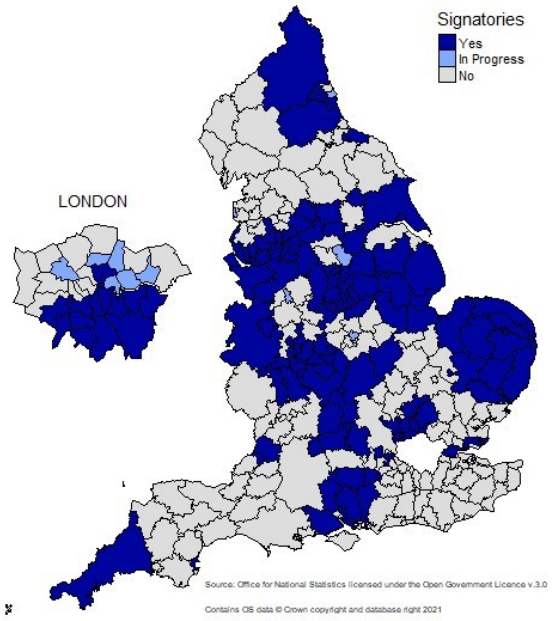
Commitment to the reduction of mental health inequalities is achieved by taking action to address the following factors:

- **Protective factors** – maternal and infant mental health, early years support, family and parenting support, connecting with others and forming good relationships, good education, stable, secure, good quality and affordable housing, good quality work, a healthy standard of living, accessible safe and green outdoor space, arts and cultural activities, community cohesion
- **Risk factors** – poverty, discrimination, socio-economic inequalities, child neglect and abuse, unemployment, poor quality work, debt, drug and alcohol misuse, homelessness, loneliness, violence, discrimination

Signatories

Signatories include a variety of organisations, including health and care organisations, professional bodies, local authorities, government departments, and voluntary organisations.

So far, 46 local authorities, including 4 districts (Bassetlaw District Council, Castle Point Borough and Rochford District, Gedling Borough Council, and Rushcliffe Borough Council), and 14 local health partnerships have signed up to the Concordat. Hampshire County Council is one of the 60 signatories.



How to become a signatory

Those who wish to sign up are currently offered 'commitment level', a pledge to take action over a minimum of 12 months.

To be recognised as a Prevention Concordat signatory, we need to agree to the consensus statement and produce an action plan addressing the 5 domain framework:

1. **Understanding local needs and assets**
   For example,
   - Are we undertaking or planning a **mental health needs assessment** that takes prevention of mental-ill health and promotion of wellbeing into account?
   - How will that take account of Covid19's disproportionate impact on different groups?

2. **Working together**
   For example,
   - Are we **collaborating with other organisations** (e.g. local employers, voluntary sector, other public sector - e.g. NHS/local authorities, emergency services) and **working collaboratively within our organisation**?
   - Are we working with **a diverse range of communities** (eg: Black Asian and minority ethnic groups, LGBT plus, those with long-term health conditions/disability), including those with lived experience of mental ill-health?

3. **Taking action for prevention and promotion, including reducing health inequalities**
   For example,
   - Are we planning on delivering both **universal interventions** and **targeted interventions**?
   - Are we taking action on the **social determinants of mental health** (employment, education, housing/homelessness, poverty, debt, etc)?
   - What steps are we taking to address the **social and economic disadvantages** that underlie mental health inequalities?
   - What steps are we taking to **address discrimination, racism and exclusion** faced by particular local communities?
   - How are we addressing **mental health stigma**?

4. **Defining success and measuring outcomes**
   For example,
   - What is the **impact** we are looking to measure?
   - What are our **agreed outcomes** and how will they be monitored?

5. **Leadership and direction**
   For example,
   - Do we have a **Mental Health Champion**?
   - Is there a **stated commitment and support from 'the top level'** of the organisation?

Once the application form is submitted to the Office for Health Improvement and Disparities (OHID), the Prevention Concordat assessment panel will review the application and provide feedback within 6 weeks.

Appendix I – Consensus Statement

Prevention Concordat signatories agree the following:

"Strengthening protective factors and reducing risk factors sit at the heart of our commitment to promoting good mental health. COVID-19 has highlighted long-standing social and economic inequalities. There is evidence that protective and risk factors for mental health are unequally distributed across the country, in our communities and for those with existing mental health conditions.

"We are committed to reducing mental health inequalities by taking action to address the following factors:

- Protective factors – maternal and infant mental health, early years support, family and parenting support, connecting with others and forming good relationships, good education, stable, secure, good quality and affordable housing, good quality work, a healthy standard of living, accessible safe and green outdoor space, arts and cultural activities, community cohesion
- Risk factors – poverty, discrimination, socio-economic inequalities, child neglect and abuse, unemployment, poor quality work, debt, drug and alcohol misuse, homelessness, loneliness, violence, discrimination

"This is an opportunity to build back better to create a fairer society, working with our voluntary and community partners, the health and social care sector, emergency services, local and national stakeholders. Signing the concordat means becoming part of a community of practice committed to taking evidence based preventive and promotional action to support the mental health of the whole population, those at greater risk of poor mental health, and those receiving treatment.

"Keeping people mentally well is as important as providing early help, and many interventions will also result in social and economic benefits, even in the short term.

"As signatories, we will work as a whole system and across organisational boundaries. We commit to supporting place-based population mental health through co-ordination of partnerships at ICS, local authority and neighbourhood levels. We will do this using needs assessment in partnership with local stakeholders, communities, people with lived experience and carers, all of whom know what matters most. As system leaders, we will also use employment and procurement levers to improve population mental health and wellbeing.

"We believe that the transformation of mental health services set out in the NHS Long Term Plan will be supported through strong prevention and early intervention, as we know that evidence-based prevention and promotion interventions reduce demand on the mental health system and support recovery. The inter-relationship between good mental and physical health should also inform the delivery of physical health improvement.

"We will encourage local and national stakeholders to invest in promoting mental wellbeing, preventing mental health conditions and preventing suicide. This will reduce demand for services and create savings not just for the NHS and social care, but also for employers, education providers, emergency services and justice systems.

"We will lead by example, taking action based on the best evidence. Where there is promising evidence, we are committed to building on this and to evaluating its efficacy. We will share our good practice and promote learning. We will regularly review and refresh our prevention approach and our action plan, giving an annual account of progress."

This page is intentionally left blank

Hampshire Mental Wellbeing Strategy and Suicide Prevention Plan

Hampshire County Council

Hampshire Health and Wellbeing Board

What is mental wellbeing?

Everyone has mental wellbeing and everyone has a right to positive mental wellbeing

Mental wellbeing includes both our feelings, such as contentment and enjoyment, our ability to function well in our lives and to engage with the world. It could be summarised as living in a way that is good for ourselves and for others.

“A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.”

Focus is not on mental health services, but on the actions required to support people before they require services or reach crisis point.

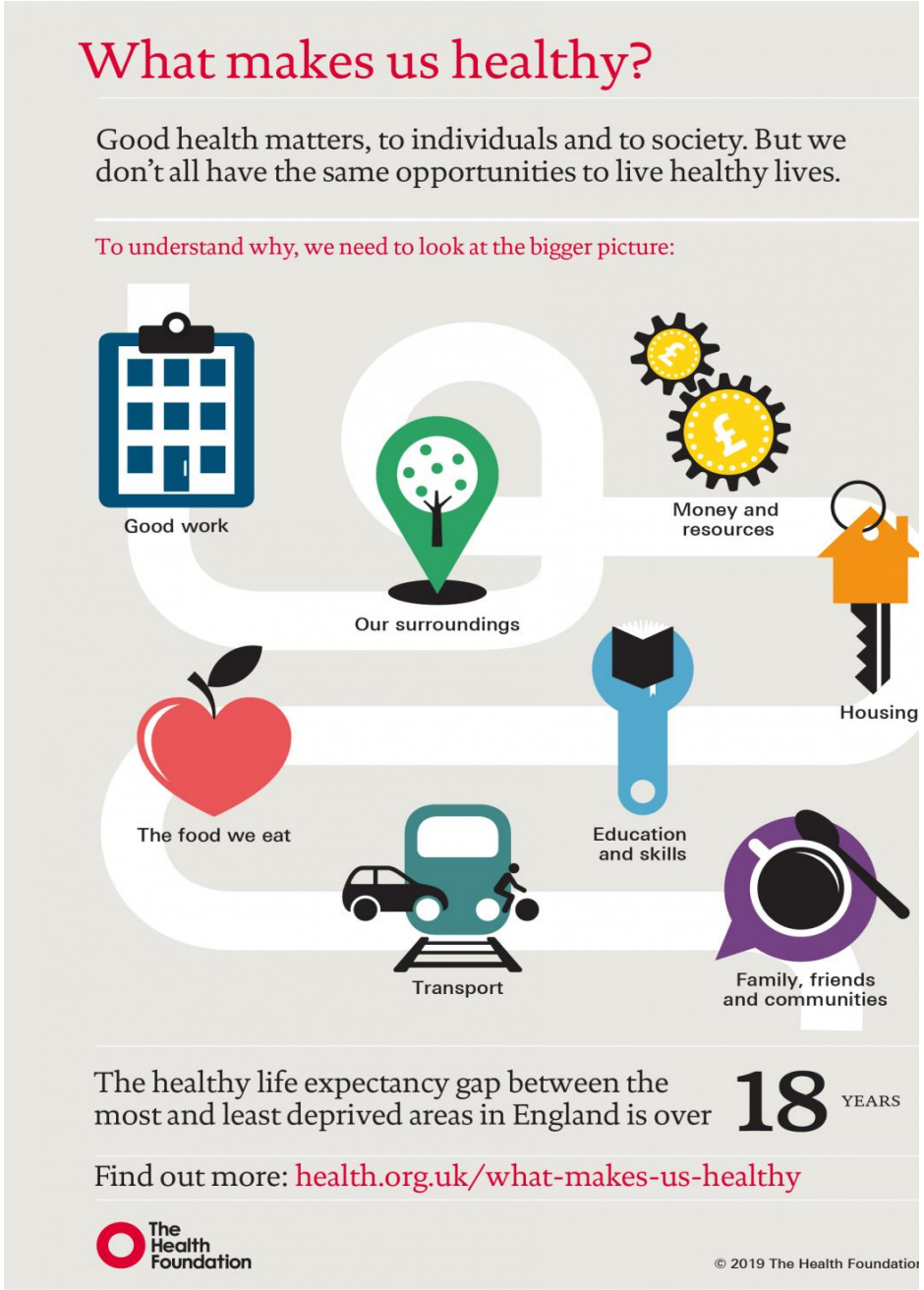
Why is it important?

Preventing mental ill health, promoting positive mental wellbeing and reducing death by suicide irrespective of anyone's circumstances.

Coordinated action required to support people before they require services or reach crisis point

Suicide prevention is a key responsibility of local government

- Inequalities exist in mental wellbeing; some groups more likely to have poor mental wellbeing
- Inequalities also affect mental wellbeing; more likely to have poor mental wellbeing if some of the building blocks are not in place: stable jobs, good pay, quality housing and good education



Almost
1 in 5 people aged 16-64 years has a common mental health disorder[2]

Approximately
350,000 people in Hampshire
experience a mental health problem of some kind each year

Women are roughly
1.5 times more likely
to suffer from a mental health disorder[2]

Nationally, in 2020 to 2021
64% of people
starting alcohol treatment reported a mental health need[9]

1 in 10 people
in Hampshire accessing alcohol treatment services are also accessing mental health services, suggesting unmet need[10]

42% of adult carers
aged 65+ years have as much social contact as they would like

The Hampshire suicide rate per 100,000 is
13.6 for men and **4.5 for women,**
this is lower than the England average[5]

Being employed is a protective factor
for mental wellbeing. Havant has a greater percentage of people unemployed (5%) than the rest of England

8.6% of Hampshire's population
reported a low happiness score[6]

Less than 40%
of people in Hampshire who are in contact with secondary mental health services live in stable and appropriate accommodation

Almost
1 in 7 people in Hampshire has depression[4]

In 2021 to 2022 there were
3,075 emergency hospital admissions
for self harm[3] but this is the tip of the iceberg a lot of self-harm does not end up in hospital

Nearly
4 in 10 veterans
report having a mental health disorder[8]

Nationally half of
people in problem debt
are experiencing a mental health problem[11]

21.3% of people
report a high anxiety score[6]

Nationally 1 in 4 people
will experience a mental health problem of some kind each year[1]

Nationally in 2018, 14-19 year olds who identify as part of the LGBTQ+ community were over
2.5 times more likely
to have a mental disorder[7]

2023-2028

Hampshire Mental Wellbeing Strategy

Mental Wellbeing Hampshire

All partners have come together and agreed this shared vision for Hampshire.

1

The people of Hampshire will be encouraged and supported to achieve the best mental health and wellbeing they can by partners that are committed, skilled and able to respond in times of need.

2

The people of Hampshire, will be enabled to maintain positive mental health and wellbeing, irrespective of their circumstances, understanding that some individuals and groups may need extra support to achieve this.

3

The people of Hampshire will know that organisations are committed to working in partnership with each other and with local people to implement integrated approaches to mental wellbeing, promotion, support and care and improve wider factors that can help or hinder mental wellbeing.

Priority outcomes

We have high aspirations for the people of Hampshire but also recognise that many steps need to take place to make our aspirations a reality. We want to show the commitment and the steps that are needed to ensure we are always working towards our end goal of improving the mental wellbeing of our local people.

The actions are categorised as '**now**' and '**next**.' This demonstrates the commitment by all partners to ensure focused action is taken at the right time and that a clear direction has been mapped out for the next five years.

The Hampshire Improving Mental Health and Wellbeing Board will regularly reassess progress to ensure we move into the '**next**' actions in a timely manner. This highlights the dynamic nature of this strategy and that priorities need to be able to flex, as do organisations, in response to local circumstances and needs.

1

System wide focus on prevention

Hampshire people will be able to draw on the support mechanisms in place enabling them to maintain positive wellbeing and prevent mental ill health happening through early intervention

2

Wider determinants of health

The people of Hampshire will be supported to improve mental wellbeing through other areas of their lives – housing, income, employment, transport, access to green space and physical activity, and social aspects

3

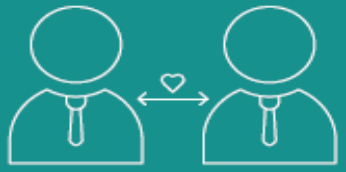
Lessen the stigma

The people of Hampshire will be able to talk about their mental health and wellbeing with the same openness as their physical health without fear of prejudice or discrimination

4

Capacity and capability across the workforce

The people of Hampshire will benefit from a competent and confident workforce with the knowledge, skills, empathy and capacity to support them with their mental health and wellbeing



5

Suicide prevention

The people of Hampshire will be aware that suicide prevention is everybody's business

6

Higher risk groups

The people of Hampshire who are at a higher risk of poorer mental wellbeing will be supported in ways that are proven to make a positive difference and suit their needs

Hampshire Improving Mental Wellbeing Board
Key achievements

- Established multi-agency sub-groups
  - Money and Mental Health Partnership
  - Communications group – joint insights and campaigns
  - Suicide Prevention Forum
- Increasing capacity / capability of front-line staff
  - Connect 5; Money & Mental Health; Suicide Prevention training
- Launched Chat About - improving wellbeing and social connection in the community.
- Mental Wellbeing Hampshire website – for professionals and the public
- **Forward view:** focus on impact of wider determinants – money and mental health, access to open space

Hampshire Suicide Prevention Plan

The Hampshire Suicide Prevention Forum has identified the following areas as priorities for local action in Hampshire:

1. Increase awareness and understanding of the economic and social risk factors for suicidality.
2. Tailor approaches to suicide prevention for particular groups.
3. Reduce access of means to suicide by promoting suicide safer communities.
4. Ensure appropriate and sensitive communications of suicide and suicidality across all sectors in Hampshire.
5. Provide the ‘right support’ at the ‘right time’ for those individuals and communities affected by a suspected suicide death.
6. Equip people with the knowledge and skills necessary to support children and young people who self-harm.
7. Improve research, data collection and monitoring.

Guiding Principles

To achieve our vision of making suicide prevention everybody's business, we have identified 5 guiding principles that will underpin all actions. These principles compliment those outlined within the Hampshire Mental Wellbeing Strategy.

1. **Living experiences:** Actions will be co-designed and developed alongside Hampshire Voices: A collective of people with living experiences of suicide.

2. **Adopt a lifecourse approach:** Consider how all ages and key transitions are managed and supported by actions.

3. **System Ownership:** Partners recognise their roles and responsibilities in implementing actions identified within this plan; working closely with other suicide prevention forum members.

4. **Data-led decision making:** Actions must make best use of available insight, intelligence and evidence to maximise effectiveness.

5. **Language:** All partners and actions promote appropriate and de-stigmatising language when discussing suicide and suicidality.

Our progress so far…

Established a Local Real Time Surveillance System to strengthen our ability to respond to suspected suicides in a timely manner.

Commissioned Amparo Suicide Bereavement Support Service. Amparo provide practical & emotional support for anyone (all ages) recently or historically affected by suicide.

Supported Hampshire Voices: A Collective of People with Living Experience of Suicide. Voices work collaboratively with organisations across Hampshire to offer guidance, advice and signposting on suicide-related action.

Rolled-Out Primary Care Suicide Prevention Training on suicide awareness and suicide intervention to increase knowledge and confidence of primary care staff across Hampshire.

Supported Suicide Prevention and Postvention in Schools and Colleges through the development of a postvention protocol, self-harm support for professionals training, and managing suicidality in students; educational psychology supervision and training pilot.

Workforce Development of frontline staff and volunteers across Hampshire through Suicide First Aid Training; Suicide Prevention Safeguarding webinar, and the Collaborative Assessment and Management of Suicidality Training for clinicians.

Area for Action	Key Actions for 2023/24
1. Economic and social risk factors for suicidality.	Deliver Money and Mental Health Training to frontline staff and volunteers.
	Improve signposting to financial education resources for education settings
	Deliver appropriate workforce suicide prevention and intervention development training
2. Tailor approaches to suicide prevention for particular groups.	Expand the Collaborative Assessment & Management of Suicidality training to frontline staff from services that work with residents experiencing multiple vulnerabilities.
	Use the 2023 Hampshire Suicide Audit to identify future cohorts to focus on; include development of a joint action plan between domestic abuse and suicide prevention.
	Promote awareness and access to training and support to community led men's health groups.
	Embed suicide awareness and mental health crisis management into the co-occurring conditions workforce training. Suicide prevention pathway is included in the co-occurring conditions joint working protocol.
3. Reducing access to means.	Host a task & finish group with rail partners to understand the roles and current actions being taken.
4. Appropriate and sensitive communication.	Deliver Suicide First Aid Training; Promote Primary Care Training; Expand the Education Suicidality Pilot
	Commission a Media Consultancy Service to identify support needed to promote responsible reporting of suicide across sectors.
5. Timely support for those affected by a suspected suicide.	Commission a Media Consultancy Service to develop a communications postvention response toolkit to support local settings.
	Refresh existing postvention protocol & promote new postvention protocol.
	Continue to promote and signpost to Amparo Bereavement Support Service.
	Develop Real time surveillance system and response plan
6. Self-harm prevention and management in young people.	Provide suicide and self-harm prevention and management training/supervision for education staff through the educational psychology pilot and Solent Mind self-harm support service. Continue to promote HiES e-training and other free, quality assured training offers.
	Through Hampshire Safeguarding Partnership, embed self-harm prevention into the refresh of the children and young people self-harm pathway.
7. Insight & Intelligence.	Conduct regular suicide audits for Hampshire and disseminate findings to inform decision-making.
	Develop Real time surveillance system to ensure data and intelilgence drives our actions
	Continue to support and co-develop actions with Hampshire Voices. Support recruitment and promotion of Hampshire Voices.

Voices

People with Living Experience of Suicide

Hampshire County Council

Voices: People with Living Experience of Suicide

Voices is a collective of People with Living Experience of Suicide. We believe our shared knowledge is fundamental in steering decision-making on suicide prevention and bereavement support. We work collaboratively with organisations across Hampshire, Portsmouth, Southampton and the Isle of Wight to offer strong guidance, advice and signposting on suicide-related action.

What you can do to support this work

Champion positive mental wellbeing through your work

- Encourage conversations about mental wellbeing: access free training sue.cochrane2@hants.gov.uk
- Consider the language used around mental wellbeing and suicide prevention
- Consider how mental wellbeing can be improved through your communities: Join Chat About
- Promote 5 ways to wellbeing: 5 steps to mental wellbeing - NHS (www.nhs.uk)
- Consider working with Voices: People with Living Experience of Suicide

This page is intentionally left blank

Frimley Health and Care

Creating healthier communities with everyone

Creating Healthier Communities Strategy Refresh

March 2023

Frimley Health and Care Integrated Care System

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

Contents

Creating healthier communities with everyone

Using this document

This document is interactive. Throughout the strategy there are a number of links to external websites, resources, videos and further information which you can access if reading on a digital device.

Wherever you see this symbol, you will find an interactive link that will provide further context and information.

You can also use the contents page to navigate around the strategy. If you are reading a printed copy and wish to access any of the digital content, please **contact** the Frimley ICS team to find out how: frimleyicb.public@nhs.net

Foreword

After a century of rising living standards, life expectancy and real incomes, our population is now facing a set of challenges which have not been experienced for many decades. For many of our residents, however, the COVID-19 pandemic which hit at the start of this decade, painfully exposed some of the inequalities which have been present for generations. The last three years have highlighted some of the main inequities which are major contributors to deprivation, variation in health outcomes and lived experience of residents of our geography.

In the months leading up to the unforeseeable onset of the pandemic, public sector leads in the Frimley Health and Care ICS geography had started the process of identifying these disparities and putting plans in place to address them. The Frimley ICS Strategy, *Creating Healthier Communities*, which was published in the Autumn of 2019, recognised these challenges and partners agreed on two core objectives; firstly to **reduce health inequalities** and secondly to **increase healthy life expectancy**.

The onset of the global pandemic significantly underlined the importance of these areas of focus. Never before in the modern day, had the lives and liberties of our residents been so restricted, and subsequently disadvantaged, in such a short period of time. Almost three years later, even with COVID-19 causing less of a daily impact, this offers little in the way of comfort to our residents; the economic shock resulting from this period and the subsequent cost of living crisis indicates an extremely difficult period ahead for all of us. As we enter 2023, we know that our residents rightly expect better access to health and care services, shorter waiting times for treatments and a better physical environment from which these services are delivered.

This context demonstrates the importance of this refreshed strategy, which sets out our collective ambitions as a partnership over the years ahead. Readers will note that the mission remains largely unchanged from three years ago, but much of the approach will be new, reflecting a fresh urgency and focus on the significant number of people in our population who experience an unacceptable degree of variation in their quality of life and health outcomes.

Undoubtedly, the world will continue to change rapidly over the years ahead and our strategic purpose and intent will need to adapt accordingly. This strategy therefore is a response to the ‘here and now’ of the challenges in front of us and is likely to evolve. Our aim is to ensure that the new Integrated Care Partnership can capitalise on the dynamic brief with which it has been established and create the collective sense of purpose which will be needed to deliver both the priorities set out in this document and the as yet unknown difficulties which will continue to emerge.

Despite the unprecedented challenges which lie ahead of us, we remain optimistic for the strength of our partnership and the huge impact which can be made for our population by working together. On this basis, as leaders of public sector bodies from the breadth of the Frimley geography, we commend and support this refreshed strategy to our residents.

Click here to learn more about the membership of the Integrated Care Board

Executive Summary

Our Objectives

We remain committed to delivering the two overarching objectives which were defined by the 2019 Frimley ICS strategy; *Creating Healthier Communities*. Our partnership focus will continue to be defined by delivering improvements against the following two headline measures:

(1) **Reducing Health Inequalities** for all of our residents who experience unwarranted variation in their **outcomes** or **experience**

(2) Increasing **Healthy Life Expectancy** for our whole population, ensuring an improvement not just in length of life but in the quality of those years as well.

Our Strategic Ambitions

The Strategic Ambitions which were established in 2019 are retained with new areas of focus and energy against a refreshed set of priorities which better reflect the challenges of 2023 and beyond.

- **Starting Well**
- **Living Well** (previously Focus on Wellbeing)
- **People, Places & Communities** (previously Community Deal)
- **Our People**
- **Leadership and Cultures**
- **Outstanding Use of Resources**

Each of our Strategic Ambitions will focus on a discrete number of headline priorities in the 3-5 years ahead, which are likely to be some of the most challenging that the health and care system has ever faced. You can read more about these, and the other areas of work for each ambition, in the dedicated sections of this strategy document between pages 13 and 35.

Our Headline Commitments in this Strategy

Starting Well
- Addressing health inequalities through a focused approach to meeting the needs of vulnerable children who experience deprivation and poverty
- Initiatives to improve the lives of babies and Children in the first 1001 days through to primary school.
- Supporting and strengthening partnerships around health visiting and school nursing, working in partnership between the NHS, Local Authorities and Public Health to make improvements in these vital roles.

Living Well
- A renewed focus on cardiovascular disease and its causes which contribute to hundreds of avoidable deaths annually
- Working with partners across Places and Public Health to help our population maintain Healthy Weights
- Helping people in our population to quit smoking by supporting them with advice and alternatives

People, Places & Communities
- A clear approach to engaging with our population at place and system levels
- Ensuring all of our diverse populations are represented with the creation of an ICS inclusivity framework
- Exploring citizen leadership and creating opportunities to develop decision making in our communities

Our People
- Creating a joint workforce model for health and care to give our people fulfilling and varied career opportunities
- Widening access to employment and keeping the people we have by ensuring we provide great places to work
- Strengthening partnership working and new models of care for our staff, residents and their communities

Leadership and Cultures
- Deliver our system equality, diversity and inclusion ambitions
- Use our leadership networks to accelerate the spread and adoption of system change
- Nurturing a shared learning culture to create the space to stimulate radical thinking, meaningful collaboration and bold action to tackle inequalities

Outstanding Use of Resources
- Reduce the need for acute and specialist services through investment in preventative and wellbeing interventions
- Optimise medication use and adopt digital innovation to deliver greater value for our population
- Make best use of our estates, community assets and anchor institutions by sharing capacity across our partnership working system wide on reducing our carbon footprint

About the Frimley Geography and System Partnership

The organisations involved in planning and providing public services locally, are working together with the community to shape future improvements.

Frimley Health and Care brings together Local Authorities, NHS organisations and the Voluntary Sector together with a clear shared ambition to work in partnership with local people, communities and staff to improve the health and wellbeing of individuals, and to use our collective resources more effectively.

The system has a diverse population of over 800,000 people in a broad geography which spans East Berkshire from Bracknell to Slough, North East Hampshire, Farnham and Surrey Heath.

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

As a result, considerable progress has been made promoting health and wellbeing, improving care and services, and making services more efficient. We have brought people together to integrate services and work across organisational boundaries, regardless of the system and organisational architecture which regularly changes around us.

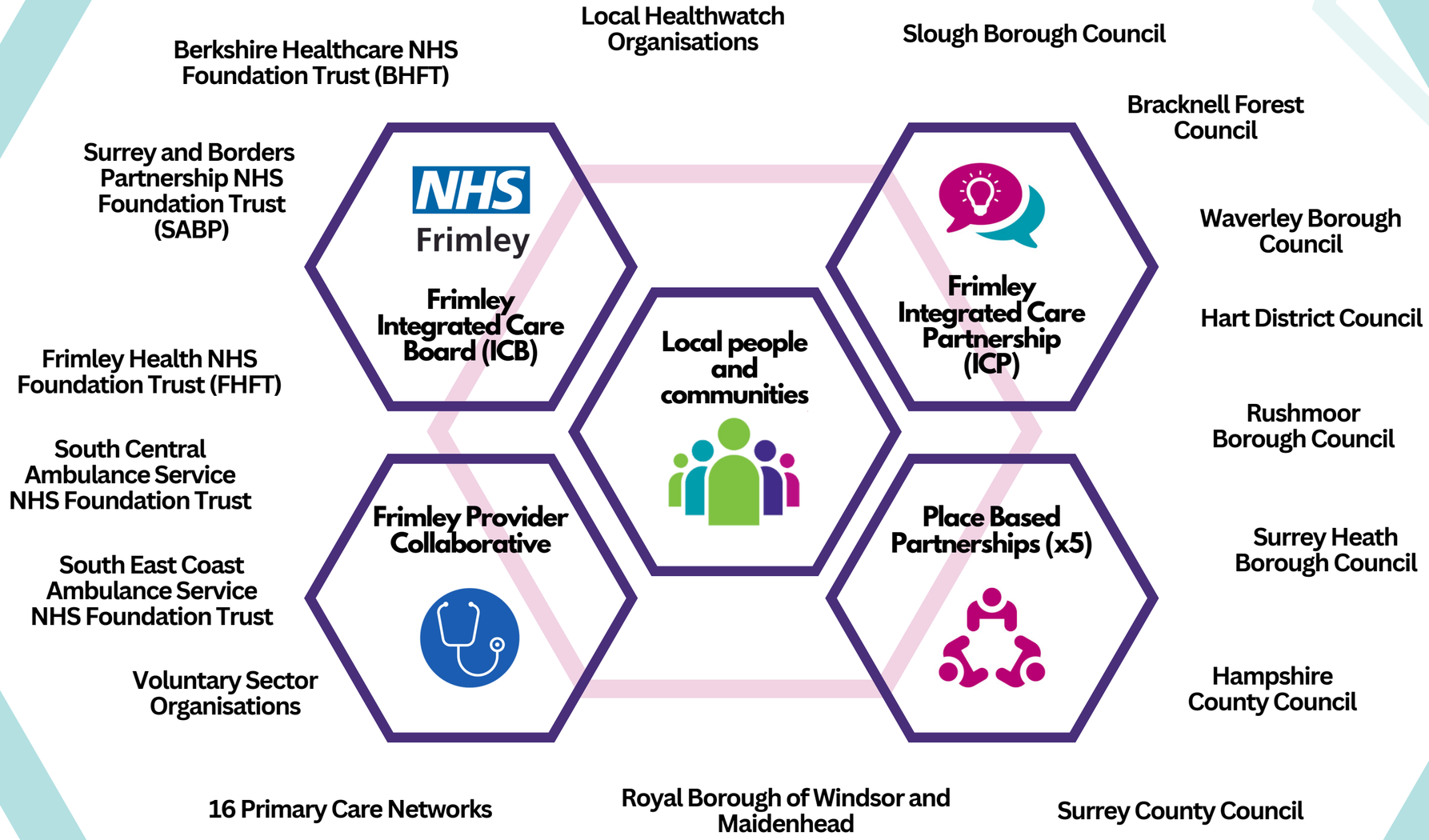
Given the challenges of the period since the last strategy was produced in 2019, the partnership has come together to create this newly revised and refreshed strategy. This new strategy builds on that work and describes the shared ambitions and priorities which will be delivered, and which will make the most difference to individual people's health and wellbeing.

Approximately 800,000 people live across five Places that make up Frimley Integrated Care System

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

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

Frimley Health and Care Integrated Care System (ICS)



Click here to learn more about our Partners

Creating Healthier Communities – The Frimley ICS Strategy

"Creating Healthier Communities" was published in 2019 as the first Frimley Health and Care ICS Strategy. The strategy was designed following significant co-production between partner organisations, the third sector, our workforce, patients and the public.

The strategy was heavily informed by the data and insight available from the Connected Care platform and led to the formation of six Strategic Ambitions which have comprised the programme architecture for strategy delivery between 2019 and 2022.

Click here to read more about the 'Creating Healthier Communities' strategy published in 2019

Our Integrated Care Partnership (ICP)

The Frimley Integrated Care Partnership, established in July 2022 is a joint committee between Local Authorities in the Frimley ICS geography and the NHS Frimley Integrated Care Board. At its core is an ICP Assembly, bringing together clinical and professional leaders of public sector, voluntary sector and charitable organisations which have an interest in improving the health and wellbeing of over 800,000 people who reside in the Frimley ICS geography. The ICP provides a platform for a broad range of stakeholders who are committed to making this ambition a reality.

Building on our engagement with our partners, we have established the Frimley ICP to have a strategic role, considering what arrangements work best in our local area by creating a dedicated forum to enhance relationships between leaders across the health and care system.

The agreed remit for the ICP is to:

- Consider and set the strategic intent of the partnership; act as final approver of the ICS Strategy, including the proposed programmes of work, outcomes and intended benefits
- Act as an objective 'guardian' of the ICS vision and values, putting the populations needs and the successful operation of the ICS ahead of any sector or organisation specific areas of focus.
- Provide a forum for consideration of wider determinants of health and health inequalities, taking fullest advantage of the opportunities arising to hear the views and perspectives of the broadest range of local stakeholders and democratic representatives.

The assembly will ensure a voice for those who speak on behalf of their communities and bring a very new approach to the design of our strategy. The Assembly met for the first time in September 2022 and again in November 2022, primarily to progress the consideration and production of this refreshed strategy document.

Partnership engagement

On Tuesday 22nd November, the second Frimley ICP Assembly took place at South Hill Park Arts Centre in Bracknell. The event brought together over 50 members of the ICP, representing local Health, Care, Local Authority, Healthwatch and Voluntary Sector organisations from across the Frimley Geography. Through a face to face facilitated workshop, Assembly Members from across the ICS met together to:

- **Understand the journey so far on the development of the ICS strategy**
- **Explore what has changed since the co-production of the strategy in 2019**
- **Enable ICP Assembly members to co-design the key areas of focus for our ICS strategy refresh**

The feedback gathered during this session and from other stakeholders who weren't able to join on the day, has been used to support and shape the development of this strategy refresh.




Collective feedback

- The language, messages and engagement of the strategy need to be translated into something our population wants to embrace. We must **hear the voice of our population** to support co design of solutions
- The strategy must be **inclusive of all partners** to provide transparency and collective opportunity across the system
- Improved understanding of the current landscape and assets is important so we can make connections and **understand multiple partner perspectives**
- Stronger working with the **voluntary sector** is imperative
- The future is uncertain - we must be **open and honest about the reality we face** - both in terms of challenging economic situation and increased demand on services

Raise the aspirations of our children and young people
Hear the children and young person's voice
Support the next generation - quality of life post 16
Greater working synergy with education

Starting Well

What does living well mean to our adults and older population?
This cohort often has the greatest health needs - how do we better engage?
Feels very disease focussed - should this be more about wider determinants?
Dual aim for this ambition - Living healthily and living well

Living Well

We need a VCSE Alliance to support these conversations
Understand the unique aspects of community assets, needs and priorities
Stronger links with Secondary Care to support community needs when discharged
Stronger links with Local Authority and Primary Care Networks (PCNs)

People, Places and Communities

What can we do to support a wider staff network including voluntary sector?
How can we tackle the temporary staffing problem as a system & across system?
How can we consider incentives to live and work in Frimley?
We need a shared narrative across partners

Our People

Values must reflect our 'collective' organisation
Exposure to more people. We need the reach out to learn how we can change culture
How is value demonstrated and who is best placed to express this?
Improved visibility of what's happening across the system?

Leadership and culture

How far can and should we share money and resources?
Co-design of joint investment models
Promotion of economic growth, shared goals and objectives
How do we have an honest conversation with the public?

Outstanding use of resources

Frimley population insights

Population 800,000

Increasing by 6.4% by 2036 - about 47,000 people - with the largest increases in the over 60's and 13-18 age group

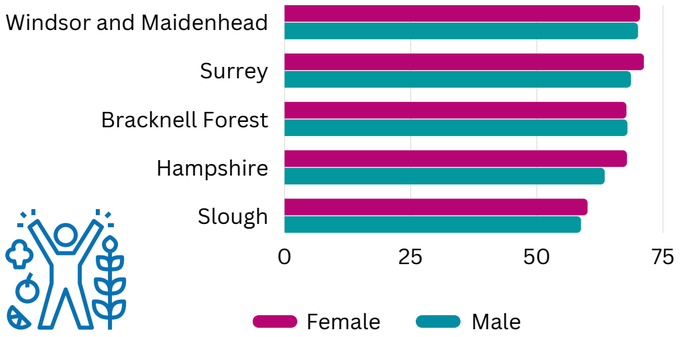
People that live in recognised areas of deprivation will often have poorer outcomes and on average will have a lower healthy life expectancy. Most of our population don't live in areas of deprivation. All areas contain pockets of deprivation, but they can be less visible due to nearby affluence. In Slough there are many more people living in deprivation.

Over 30% of the population are in the 10% least deprived in society

Around 3% of the population live in the most deprived areas of England

	Male	Female
Life expectancy	81	84
Healthy life expectancy	66.8	67.4

Healthy life expectancy at birth



About the population across our 5 places

	% from BAME ethnicity groups	% living in deprivation (IMD deciles 1-4)	% over 65	% in households of 5+ people
Bracknell Forest	11%	4%	14%	26%
North East Hampshire and Farnham	11%	13%	17%	28%
Royal Borough of Windsor and Maidenhead	16%	5%	17%	32%
Slough	61%	61%	9%	52%
Surrey Heath	12%	7%	18%	28%
Whole population	23%	19%	15%	34%

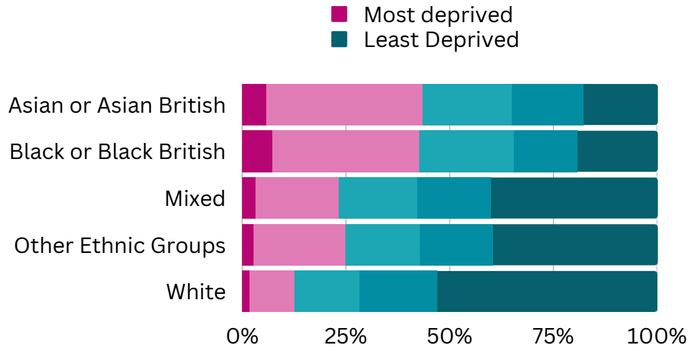
Bracknell Forest ⬡ North East Hampshire and Farnham ⬡ Royal Borough of Windsor and Maidenhead ⬡ Slough ⬡ Surrey Heath

CONNECTED CARE

Frimley population insights: wider determinants of health

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

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



56k residents are at risk of **fuel poverty**

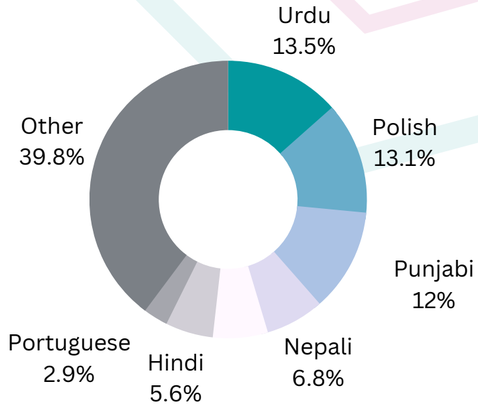
These patients are living in deprived areas and poorly insulated homes

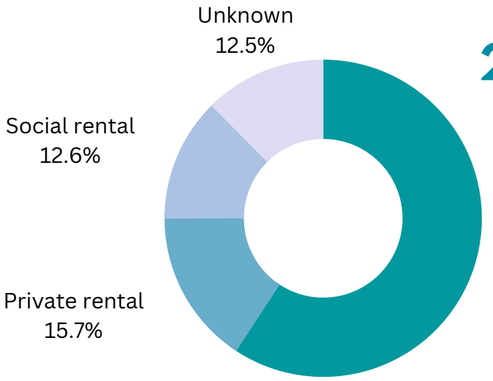
1.4% (700) have significant health issues
17.1% (9,500) have moderate health issues
76.5% (43,000) are generally healthy

There are 122 different spoken languages in our population

98,000 residents in our ICS do not have English as their main spoken language, the most common are **Urdu**, **Polish** and **Punjabi**.

Language barriers can impact a persons' ability to access and navigate health and care services





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

10.6% of the population are smokers

7.5% medium to high alcohol consumption

In areas of deprivation we see a higher prevalence of smoking and obesity (but lower alcohol consumption). Non-white ethnicities tend to have lower alcohol consumption and are less likely to smoke (or have COPD). Smoking and alcohol rates are based on what is reported in GP records.

5.8% of the population have a BMI over 35

Frimley population insights: deprivation, ethnicity and disease prevalence

CONNECTED CARE

There is a strong association for **Diabetes, COPD, Heart failure** and many other conditions with deprivation. We also see lower prevalence rates for Cancer and Atrial Fibrillation which could reflect under-diagnosis.

On average, we see many conditions are between 1.5-2.5 times more common in deprived areas versus affluent areas after adjusting for age and sex of the populations

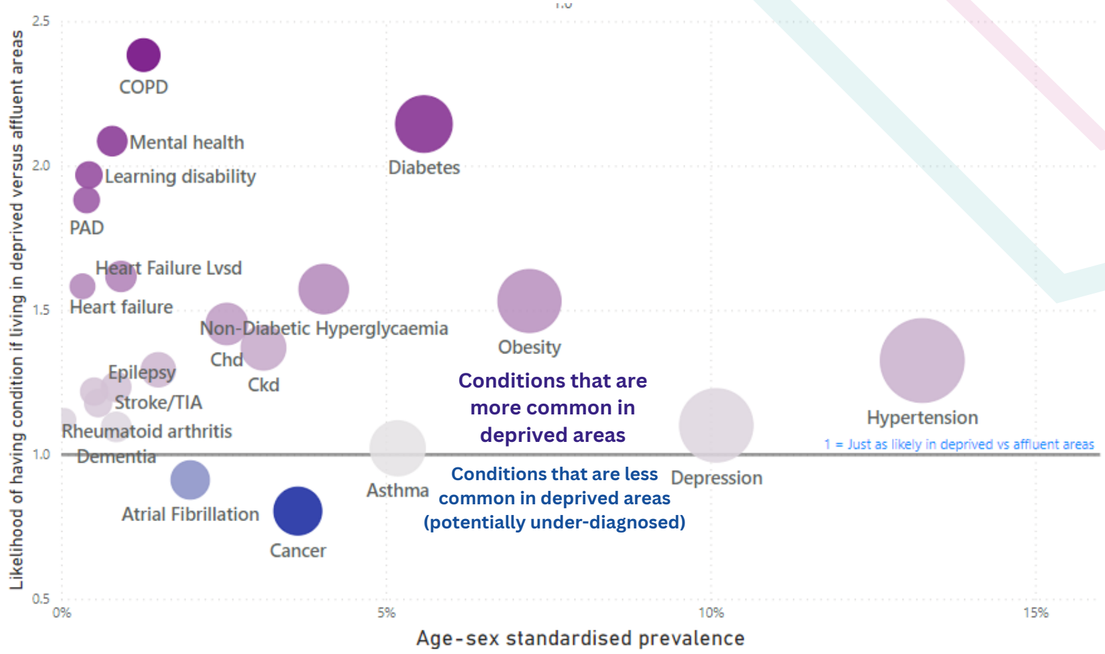
When looking at **ethnicity data** we notice the following:

- Asian / Asian British notably higher for Diabetes, Non Diabetic Hyperglycemia and Coronary Heart Disease (CHD), lower for depression, COPD and Atrial Fibrillation
- Black / Black British notably higher for Diabetes, Hypertension, Chronic Kidney Disease(CKD) and Obesity, lower for COPD, Depression and Atrial Fibrillation

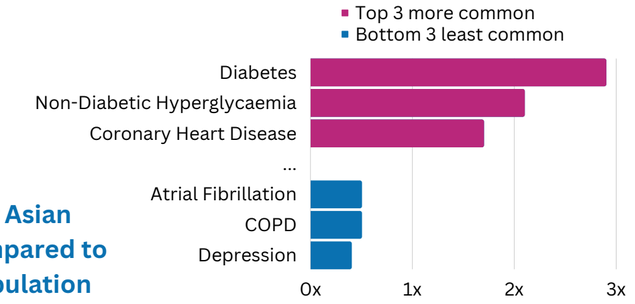
Slough compared to other parts of the system is **younger, higher % BAME, more densely populated** and **multigenerational households** and **more deprived.**

Adjusting for age and sex, **Slough has significantly higher prevalence of a wide range of conditions and risk factors.** There are strong associations between deprivation, ethnicity and prevalence of conditions such as diabetes and hypertension.

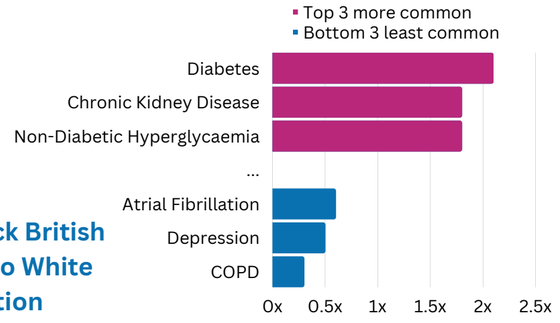
Increased prevalence of chronic diseases lead to **health inequalities** as well as disproportionate risk of impact from community transmitted conditions such as Covid-19.



Asian or Asian British compared to White population



Black or Black British compared to White population



Frimley population insights: cancer, diabetes, hypertension

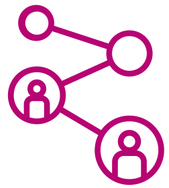
Those in the most deprived population have a lower percentage of **cancer referrals** made from all sources including National Screening programs and GPs, compared to the least deprived population (quintile 5). A greater percentage of diagnosed cancers are referred from Consultants or AE departments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

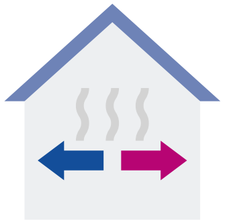
For certain care processes such as **cervical screening**, achievement is lower within the 20% most deprived population, which could suggest more effort is needed to reach these communities. For care processes such as **BMI and blood pressure reviews**, there is greater achievement in the more deprived population.

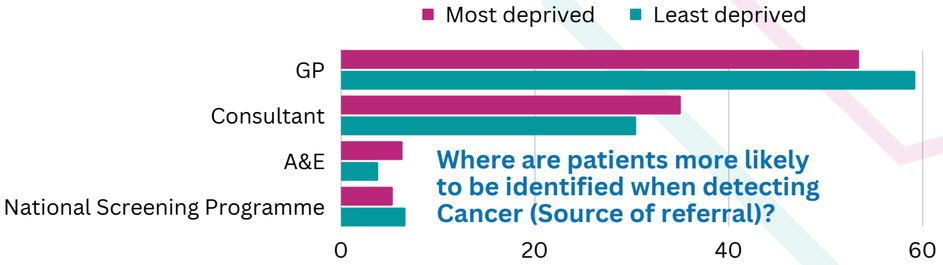
Control of **Diabetes**, however, in the Core 20 population deteriorated the most during the first year of the pandemic. The proportion of patients with **HBA1C** <=58 fell from 61.2% in Nov 2019 to 57.4% in Nov 2020. It is now improving but still below pre-pandemic levels.

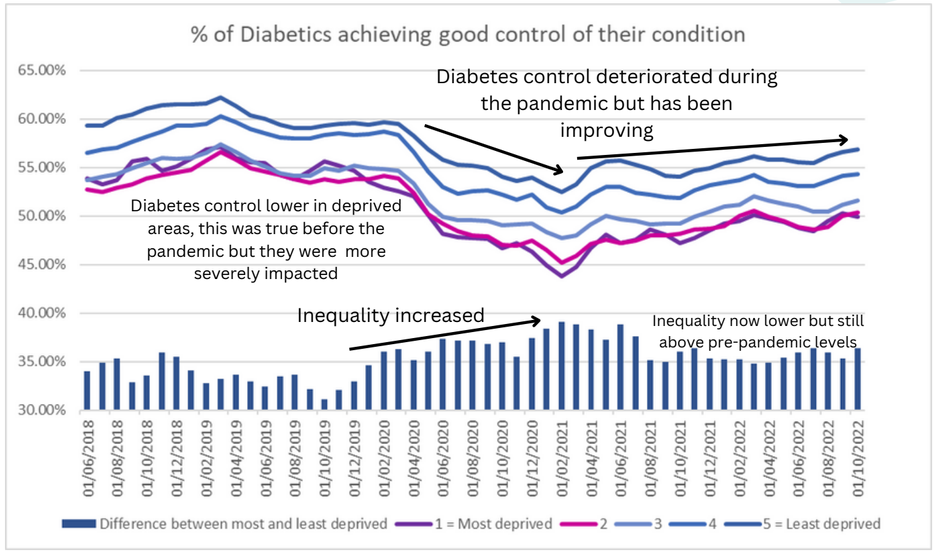
This deterioration was not seen as strongly in the least deprived population, and we now have a larger variation in control of diabetes compared to pre-pandemic.

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









Trend in proportion of patients with a recorded HBA1C with a value <=58

Throughout the Summer of 2022 a **Blood Pressure Bus** visited various sites across the system. Trained professionals were able to offer testing in local community settings. They also offered advice, began treatment as required and entered test results directly into digital patient records – checks included: Pulse, BMI and Smoking applying 'Make Every Contact Count' principles.

The bus visited 16 locations across Frimley and reached over 1200 people

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

Strategic ambition one:

Starting Well

The purpose of **Starting Well** is to work towards **improving outcomes** for children, young people and families. The plan is to work closely with communities across our population by engaging effectively with community groups, voluntary sector organisations and families. Our aim is to better understand the driving factors behind differing health outcomes and particularly barriers to opportunity and healthier choices, and improve **equity** across Frimley, taking a **co-produced, asset-based** approach to make a positive impact.

Our stakeholder events highlighted a number of areas of focus, particularly the pre-conception and early years and our agreed priorities are **vulnerable children and families** and **childhood obesity.**

By promoting the **habits of a healthy family** we aim to maximise the many opportunities that health, education and care professionals have to interact with families and **influence behaviour** including diet, oral health, supporting breast feeding and reducing smoking, particularly smoking in pregnancy.

We want to **build on the existing resources** that families and children have available, reducing confusion by having a ‘single front door’ and developing an accessible suite of tools, translated and available for all of our families.

We want to **work with places** which understand their population and can build on existing local initiatives so that we can improve outcomes for children, young people and families across Frimley.

Starting Well

Achievements

The **Equity Plan** is a key foundation for Starting Well. The detailed analysis of population and workforce highlighted differences relating to ethnicity and deprivation, for example that women in Slough are half as likely to be taking folic acid during pregnancy as women in Bracknell. Our workforce who are from Black, Asian and minority ethnic backgrounds are less likely to be represented in higher paying roles and over-represented at more junior positions. We worked collaboratively with our Maternity Voices Partnership holding focus groups with local women in Slough and Rushmoor to co-produce the Equity Plan and we are now starting to implement this by:

- promoting cultural awareness, ally-ship and being an active bystander
- planning a series of communication & engagement events for women and families in Slough
- Reviewing and improving resources and use of translators to ensure all women and families can access care

Building on the successful **Innovation Fund** programme we developed a Children, Young People and Families innovation fund with community groups and voluntary sector organisations who work with children and young people. This provided an opportunity to share insight, support and learning with this cohort of community groups and a networking forum.
The 17 projects which were funded included:

- Chalvey Action, Food and Fun family events
- Thames Hospice family days for bereaved children and families
- Projects creating green spaces, wildflower and vegetable gardens

The development of the **Frimley Healthier Together** website has created a single front door for digital resources for both families and professionals, coupled with the Maternity Website we have a comprehensive library of information verbally translatable through ‘Recite Me’. In addition successful campaigns and resources have included:

- Ready for Pregnancy and Parenthood -started in Frimley and expanded across the South East. Physical translated resources developed and shared through community venues
- Solihull parenting modules, translated in a variety of languages - with over 2000 registered learners
- Maternity personalised care app launched in October 22 has over 1200 downloads. Enabling personal decision making and signposting to wider resources

The focus on **Healthy Behaviours** has included:

- Development of a Frimley wide **‘Healthy Weight’** group bringing together place leads to share their initiatives and map existing assets. Healthy weight was a core priority for Starting Well. National Child Measurement Programme data has demonstrated high levels of over-weight and obesity particularly for children living in Slough and Rushmoor.
- We are delivering **‘This Mum Moves’** training across our 5 Health Visiting and our maternity teams and bringing together a focus on Gestational Diabetes within Maternity.
- Our continued **Smoke-free pregnancy collaborative** initiatives have resulted in the lowest smoking in pregnancy rates in the South-East. We work closely with the specialist stop smoking services and are implementing a new offer for women in line with the Long Term Plan

During COVID we know that women often felt isolated after pregnancy, and we continue to work across Public Health, Health Visiting and Midwifery teams and closely with our Maternity Voices Partnership and are developing antenatal and peer support for families on the areas which worry them, such as breast feeding support.

The **Frimley Maternity Plan app** was co-produced with local midwives, women, and the Maternity Voices Partnership, and is being used by women who are pregnant and receiving their maternity care from Frimley Health.

1148 downloads in the first 4 weeks after launch

The app supports personalised care and support plans and is a space to help record what matters to the user, plan their pregnancy, explore pregnancy choices, access useful links and resources and plan ahead for discussion with their care team.

Starting Well

Priorities

The development of the new ICS Children and Young People (CYP) portfolio transformation plan marked a clear **call to action**. As the ICS looks forward, we are raising the importance of our work to improve the health and wellbeing of children and young people.

There is a clear case for greater and faster transformation of CYP care and services:

- A quarter of our population are CYP
- We know that there is variation in the care of CYP and their outcomes that we must tackle
- The pandemic has widened existing health inequalities and worsened the health of our CYP, particularly their mental health
- The cost-of-living crisis is affecting low-income households and puts the health of children at greater risk
- The health and care services that we provide to CYP are struggling to meet demand

Our call to action comes with optimism about what we can collectively achieve. It has been shaped and developed by the key partners and stakeholders who will be instrumental in delivering it. They are committed to ensuring this plan succeeds and transforms the lives of Children and Young People across Frimley. The ICS has invested in a small team of experts to help lead its delivery, in partnership with our 5 places, voluntary sector, local authority and service leads.

This is an ambitious programme, shaped and agreed by the Place and CYP leads from across the system, with the support of colleagues in neighbouring ICSs. Their commitment is to work together to deliver this programme, alongside their day-to-day responsibilities for managing and leading Children's services across the ICS. As part of the Children and Young People portfolio review and subsequent strategy, a clear direction of travel and programme has been developed with 5 areas of focus, which includes Starting Well.

1. Starting well
2. Transforming neurodiversity services
3. Transforming CYP mental health
4. Supporting children with life long conditions
5. Improving SEND

Starting Well Priorities include:

- Addressing health inequalities through a focused approach to meeting the needs of vulnerable children who experience deprivation and poverty across our communities, including the newly published Core20PLUS5 framework for children.
- Babies and Children in the first 1001 days through to primary school, ensuring that every child is "school ready" for when they are ready to enter the education system
- Supporting and strengthening partnerships around health visiting and school nursing.

Children and young people in Frimley

Across Frimley ICS there are around 8,000 births a year

Slough has the highest fertility rate in England

1500 of those aged 0-19 are known to smoke

More than 8,000 children aged under 10 are currently living in deprivation and in poorly insulated homes

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

Approximately 15% of pupils have a special educational need

26% are from a BAME background. Ethnic diversity varies greatly. (13% in Bracknell Forest, 60% in Slough)

Starting Well

Benefits and sustainability

Children get the very best support for their health and care needs through the first 1001 days of life, beyond and through to primary school, enabling them to make the most of opportunities to thrive and flourish. We are committed to ensuring that childhood inequalities will be identified and addressed including those highlighted in Core 20 plus 5 framework for children (see adjacent panel).

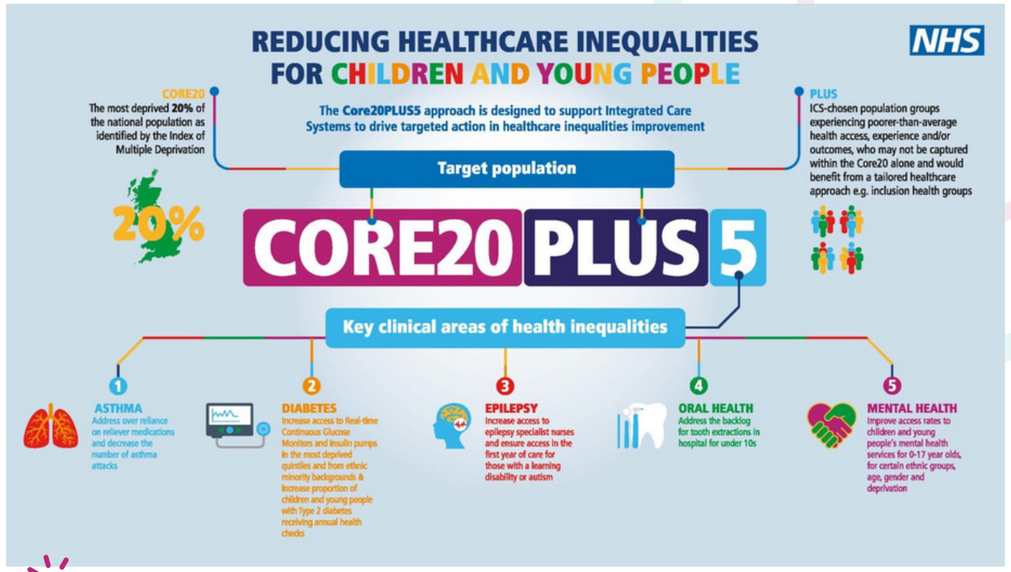
There will be a joined up leadership approach across local authorities voluntary sector and health, connected with places to share initiatives and good practice. Our collaborative endeavour will enable consideration of options to optimise and support public health nursing workforce.

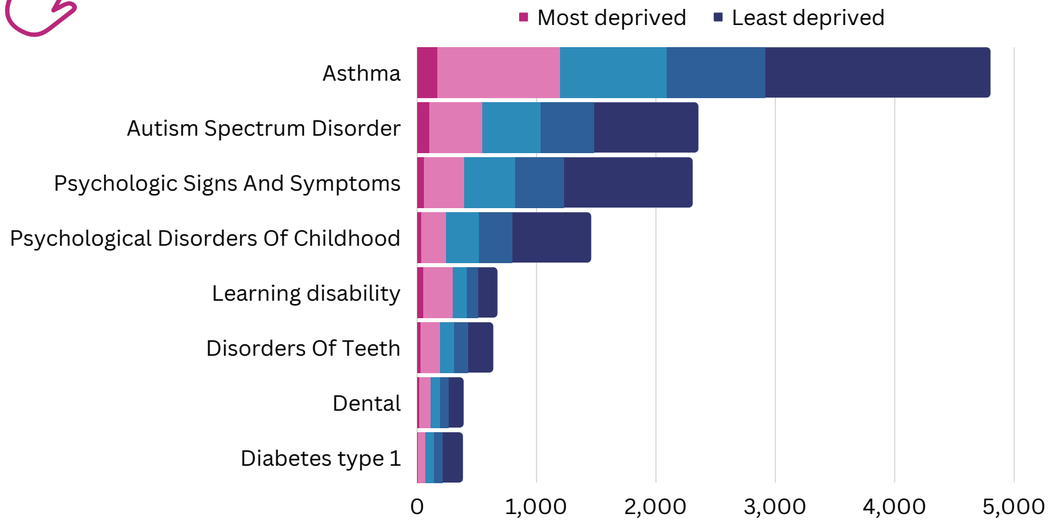
Starting Well will work alongside interdependent programs to deliver the following benefits:

- Local Maternity and neonatal System which will be delivering our perinatal Equity Plan focusing on resources, service delivery and workforce.
- Physical Health CYP-addressing conditions highlighted in the Core20plus5 framework for children
- Mental health CYP-addressing inequalities in access to CYP services

The benefits will include:

- Collaboration where partners can share good practice and collectively influence change
- A thriving and connected community and voluntary sector offer for families
- Improvement in health outcomes including healthy weight rates
- Supported families
- Accessible digital and physical translated resources including the Healthier Together platform
- Better understanding of public health nursing workforce challenges and consideration of opportunities to transform





174k

Children in our ICS

33k

Children living in our most deprived areas (IMD deciles 1-4)

11.7k

Children with conditions mentioned in the Core20Plus5 strategy, of whom 2.6k are also deprived

Strategic ambition two:

Living Well

The long-term sustainability of our health and social care system depends on people living longer in good health. Our aim is to identify and target the cohorts of people where physical and mental health problems can be prevented or outcomes improved with a focus on deprivation, inequalities and those with most complex needs. Data shows we have stark intra-area health inequalities, with poor, and worsening, health and wellbeing outcomes in our more deprived communities and other groups.

We want to help tackle the root causes of lifestyle behaviours, working together, to provide personalised support to address them. Co-production with our communities is an aspiration that shifts to a culture of prevention and self-care. We need to move away from a system that simply treats illness but works towards prevention, helping to create the right conditions to support residents and patients to live longer in good health. Health is about more than healthcare alone we must work in partnership with residents, local government, voluntary sector and wider stakeholders to reduce health inequalities through addressing the wider social determinants of health.

The challenges presented by the pandemic also meant that existing health inequalities have been compounded, those who are at risk of poor outcomes with long term conditions or health behaviours that are amenable to change. The Ambition therefore supports our general aims around helping develop strong, resilient and healthy communities. A system focus on effective primary prevention measures is crucial and a systematic and coherent preventative approach is necessary – not just looking at interventions that focus on individual behaviours but delivering a strategic approach to healthy places, strengthening and connecting into communities in a better way.

We aim to take a Population Health Management (PHM) approach to embed decision making based on evidence, across the development and monitoring of our programmes.

Individuals need strong stimuli to support their own health improvement and an environment that makes it possible. Places need to engage robustly with their communities about why living well is more challenging and what can be done to improve it. We will need to harness behavioural science and social messaging to support such changes.

Living Well

Achievements

To make a difference to health inequalities, those communities who are most affected need to be central to everything we do. Different solutions are needed for different communities with support for the most vulnerable and excluded people. We need a two-way approach: engaging with communities to share key public health messages and information, but also listening and learning from the communities themselves to understand their concerns/needs/views on how we can best partner with them and consequently bringing that learning back in a timely way to enable further responsive change.

Cardio Vascular Disease (CVD) Prevention

- Places are developing a tailored partnership plan to tackle hypertension (with links to NHS Health Checks and other modifiable risk factors)
- Building on our campaign work, targeting groups at a higher risk of CVD (Measurement month, Hypertension Day, Know Your Numbers, Smoking)
- Videos, leaflets, posters and Communications toolkit developed for hypertension
- Developing different community hypertension pilots including the Community Pharmacy Hypertension Service
- Remote monitoring of Blood pressure directly entered into the patient's clinical record
- Aligning to Core20PLUS5, to accelerate and augment implementation of the approach
- Making progress against NHS LTP high impact actions for stroke & cardiac care

Lifestyle

- Healthy Conversations - Making Every Contact Count
- Embedded the NHS Digital Weight Management Programme. Our ICS has the greatest uptake across the country.
- Whole Systems Approach to Obesity (WSATO) workshops delivered to tackle drivers of obesity
- Working closely with Sports Partnerships to address physical inactivity
- Smokefree Group established to reduce smoking prevalence and implement the NHS Long Term Plan objectives relating to tobacco (Inpatient and Maternity Tobacco Dependency Service)
- Community Stop Smoking Services
- Alcohol hospital specialist service and brief interventions
- Community Asset Based Approaches in Local Authority to support communities

Benefits already being seen and the impact on our communities:

- Closer collaboration and partnership working with Health, local government and the Voluntary, Community and Faith Sector will facilitate a more holistic, joined up approach to managing the health and wellbeing of all residents
- An improvement in health literacy and outcomes resulting in better prevention and self-management
- Our most vulnerable cohorts and populations have improved physical and mental health outcomes
- Strengthening communities through recognising, identifying and harnessing existing 'assets' - building trust, networks in the community
- Ensure people have the skills, confidence and support to take responsibility for their own health and wellbeing

Identified Outcomes:

- Health and Care Strategies across places, will align to the Ambition, bringing people together against an evidence base and a prioritised set of ambitions
- Strengthening the ability of the NHS to deliver prevention activities, e.g. workplace health, the influence of Anchor Institutions
- Residents feel more engaged, which supports delivery and helps improve outcomes and quality of life for people and communities
- An improvement in health literacy and outcomes resulting in better prevention and self-management
- Increased evidence-based decision making to improve health and act on inequalities
- Improved health outcomes of the most marginalised e.g. Sustained smoking cessation, healthy weight and physical activity
- Improved detection and management CVD risk factors
- Improvement in physical literacy
- Prevention of other non-communicable diseases
- Increase in the number of patients who achieve a 4-week quit that began in hospital

Living Well

Priorities

Despite the challenges of Covid, the Living Well ambition has made strong progress, building on the momentum of our previous partnership work together to hone in on those populations who can most benefit from this approach.

The work of the partnership to systematically identify specific population health improvements, most particularly with regard to **hypertension, obesity and tobacco** will make a step change in the long-term population health for local people and their families. The learning we have generated during the last three years will continue to be an important foundation for our future aspirations of working together, as we seek to scale and spread our interventions in order to reduce health inequalities and improve healthy life expectancy.

A system focus on **effective primary prevention measures** is crucial and a systematic and coherent preventative approach is necessary – not just looking at interventions that focus on individual behaviours but delivering a strategic approach to healthy places, strengthening and connecting into communities in a better way.

The Living Well ambition is delivered locally at each 'Place' but within a collective systematic approach. 10 Priorities included in the 'Living Well' Framework:

1. Smoking
2. Education, Employment and income deprivation
3. Reducing Health Inequalities
4. Obesity (incl. healthy diet) and Physical Inactivity
5. Family/social support
6. Targeted lifestyle support for those with the greatest need
7. Built environment
8. Healthy Hospital Strategy
9. Air Pollution
10. Ageing well
11. Supporting all ages at end of life

We will be continuing with our 3 main priority areas (**CVD Prevention, Healthy Weights, Smoking**). The priorities give a rounded mix of primary, secondary and tertiary prevention interventions. They contribute to the outcomes expressed in the Living Well framework and help address health inequalities.

Places have indicated other priorities from the framework, and that will continue, and these are priorities we will focus on together, collaboratively; the common thread across the 5 Places, to maximise the opportunities and impact.

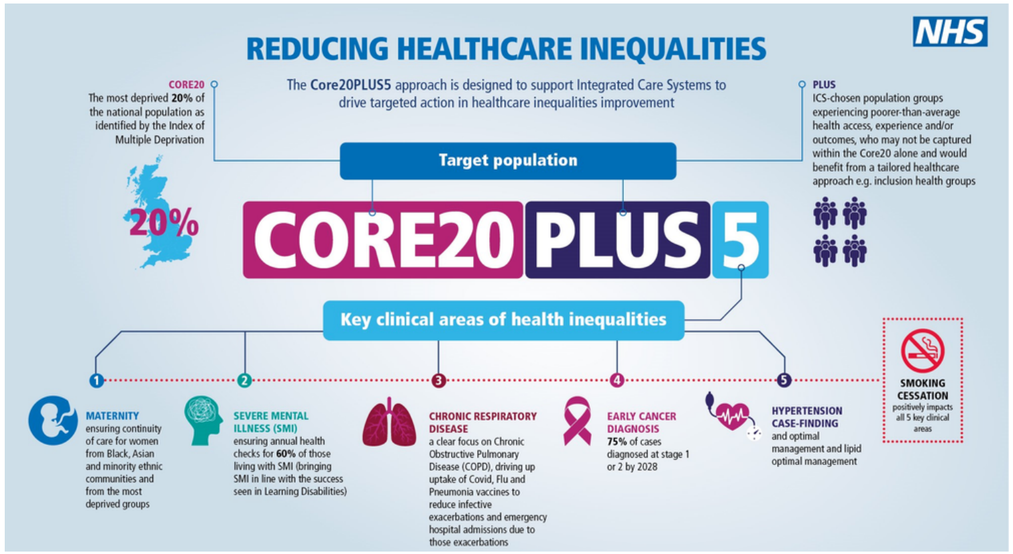
- **Focussing on Health Inequalities** - to improve and reduce variation in health outcomes across disease areas in our system aligning to the CORE20PLUS5 approach
- Support Health Improvement **behaviour change programmes** across the ICS
- **Healthy Conversations** – opportunistically encouraging individuals to consider their lifestyle and health with a view to identifying small but important changes.
- Identify communities and priorities in common with other ambitions particularly **Starting Well** and **Community Deal**
- Support **community engagement** with groups with poorer health & wellbeing outcomes to understand barriers and **co-produce solutions**
- Develop our capability to co-produce solutions to the **wider determinants** that cause poor lifestyle behaviours, which will be enabled by the Community Deal
- **Social Prescribing** to support vulnerable people, linking with community hubs.
- Ensure addressing **prevention** and **inequalities** is everybody's business
- Focus on addressing **equalities and inclusion** issues to ensure uptake (wider preventative interventions) is maximised in all communities
- Roll out **Tobacco Dependency programme**, to ensure the provision of a resilient, sustainable programme that supports more people to quit smoking.
- Renewed commitment to **smoke free sites** across our services and develop a tobacco control and e-cigarette strategy
- Develop a Frimley ICS **Healthy Weights Strategy** and action plan and delivery of the Health promotion campaign work
- Enhance **Physical Activity awareness** in secondary care – moving towards activity prescription in clinical practice and training for staff
- Explore **staff offers** of support around: Smoking, Healthy Weight and hypertension

Living Well

Benefits and sustainability

- Better health outcomes and lower health inequalities and variation across our population
- Preventing people from dying prematurely and a reduction in preventable ill health
- Improved design of our programmes to increase access reduce inequity focusing on health promotion, prevention, and the wider determinants of health
- Health and Social Care services will be co designed to improve access, experiences and outcomes, for these communities
- Intervening early to reduce prevalence and severity of long-term conditions and to manage them more proactively Promoting self-care and taking responsibility for your own health for those that can
- Improved health status of the population by raising awareness of health risks, availability of services, to change behaviour
- Increased evidence-based decision making to improve health and act on inequalities
- A community approach to promoting healthy weight in children, young people and families helping our communities live healthier and more active lives
- Engaging with communities to maximise use of community assets
- Increased physical activity and improved healthier eating as part of treatment regimens working towards personalised centred goals
- Better support for under-served and vulnerable groups to improve their health and improve equity - Building trust, networks in the community
- Health and Care Strategies, will align bringing people together against an evidence base and a prioritised set of ambitions
- Delivery of work based prevention activities to improve staff health and wellbeing and reduce staff absence
- Contribute to the prevention of other non-communicable diseases
- Sustained increase in referrals to existing community stop smoking services and the number of patients who achieve a 4-week quit

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.



Strategic ambition three:

People, Places and Communities

In 2019 this ambition started as the **Community Deal,** inspired by the work in Wigan and elsewhere in the country to focus on a new relationship with local communities. Over the last three years, this work has evolved and taken on a more local direction. In order to better reflect the work being undertaken we propose to change the ambition name to 'People, Places and Communities'.

Through the work of this ambition, Frimley Health and Care ICS has started to **build different relationships** with its communities and residents, as well as with its own staff, to work towards Creating Healthier Communities through relationships at neighbourhood, place and system level. More than anything this ambition is about **how we work with communities**, as an enabler to deliver on the other five ambitions to achieve the outcomes we have set. Collectively we will bring together local authority, voluntary sector, health, and wider partners such as housing , education, and employers to tackle health inequalities using population health management, data insight and focusing on the wider determinants of health to bring about **practical and tangible improvements** in the health and wellbeing of the people who live and work here.

Building on the expertise of our partners we will create **inclusive relationships** with communities across our diverse system at grassroots level, to harness individuals' and communities' strengths and assets through co-design and co-production finding solutions for our communities to help them live healthier lives, taking more responsibility for their own health and wellbeing. Fostering innovation through a range of **place-based initiatives** which support the population, linked with early intervention, reducing disparity, or focusing on preventative health and social care.

The ambition also supports the commitment to creating a system where **people are treated as individuals** by professionals they trust, and where people with 'lived experience' are often best placed to feedback to services on what will make a positive difference to their lives. It ensures that the voice of people with lived experience is integral to the development and delivery of personalised care, modelling the shift in relationship and supporting the culture change required to be people centered.

People, Places and Communities

The ambition to build new relationships with local people and communities, recognises that real change in the quality of people's lives cannot be achieved by organisations alone – everyone has a role to play. Over the last three years the 'Community Deal' ambition has focused on the principle of "doing with," not "doing to" people, encouraging people, families, and communities to take more responsibility for themselves and each other so that everyone can live in healthy and thriving communities.

Our original strategy was published just before the Covid-19 pandemic, and it is impossible for us to look back and understand the changes that have happened since then without understanding this context. Early in the pandemic, and particularly during the first lockdown, there was a blossoming of community support and activity aimed at protecting everyone in the community, ensuring people's basic needs for food, medicines and care were met. supporting people to remain socially connected to avoid isolation and loneliness. As the pandemic progressed this translated into more formal volunteering through Covid vaccination clinics, providing vital support during the dark days of winter to ensure our most vulnerable communities were protected. Across our population vaccination uptake was high and although new strains of Covid emerged that were more transmissible but less severe, life for the majority returned more or less to normal but being mindful that for those who have family and friends or are living with Long Covid, this may not be the case. However, we are still understanding and learning to live with the longer-term impact of the pandemic, on public health, and the wider determinants of health which fundamentally define and shape our quality of life.

The Pandemic has impacted the delivery of this ambition and has led to the emergence of new and changed needs across our populations. With the increasingly constrained public finances, there has never been a greater need to focus on prevention and early intervention and encourage individuals to take more responsibility for looking after themselves and each other, so that we can live in healthy and thriving communities

.

We aim to deliver this ambition by:

- Promoting the principle that everyone has a part to play in building and creating healthier communities concentrating on improving health and wellbeing.
- Delivering the narrative for the system on what we aim to achieve and how.
- Building on our progress on developing and spreading population health management approaches.
- Drawing in a wider range of partners through our place-based partnerships, to better coordinate and enrich the support we all provide to our communities.
- Working with local communities to identify and build on existing community assets at neighbourhood and place level.
- Developing effective co-production and co-design methodology and capability across all partners of the system
- Empowering staff to have a different conversation with individuals and communities.
- Giving individuals and communities the freedom to innovate, and design offers and services that meet their needs, supporting independence and what people do for themselves.
- Delivering personalised care by building new relationships and shifting the power in decision making.

By developing this approach, it will enable the delivery of the Starting Well and Living Well ambitions.

NHS Charities Community Partnership Grants and Innovation funding supported a range of place-based initiatives that foster the concept of community/ voluntary sector support to build a stronger co-production approach. The funding was linked to supporting early intervention, reducing inequality, or focusing on preventative health and social care, with a particular emphasis on diversity within the population.

£500,000 total funding in 2021-22 supporting 60 projects across Frimley

People, Places and Communities

Achievements

As an enabler, the Community Deal has been deployed in diverse ways across the five places and within their neighbourhoods, working with other programmes like Starting well, living well, NHS Charities Community Partnership Grants and Personalisation, to have a different conversation and engagement with residents and communities.

The last two years have been challenging due to the pandemic and has had devastating impacts on individuals and families. We have seen people spontaneously volunteering to do shopping for their neighbours, collect prescriptions or pick up the phone and have a conversation and because of that, vulnerable people were identified and supported before their needs escalated into crisis.
Each place has engaged with communities at various levels and in diverse ways based on the needs emerging from the pandemic community engagement. Examples across the system include:

- Community Based Assets workshop focus on poverty, children and young people and loneliness
- Development of community champions and #One Slough
- Royal Borough Windsor and Maidenhead creating #RBWMTogether with residents engaged in World Cafes identifying resident solutions through asset-based community development methods
- Bracknell Forest Thriving Communities programme focusses on collaboration: creating better outcomes through better partnerships to deliver improved health and wellbeing outcomes and reductions in health inequalities
- Healthier Communities in North East Hampshire and Farnham in conjunction with the local district and borough councils focusing on hypertension, mental health, and physical activity.
- Building local capability, learning with partners, on the concept of a “community deal.” through collaborative and creative work with communities with the poorest health outcomes in Surrey Heath
- Place are aligned with the Health and Wellbeing Strategy to enable empowered and thriving communities, and to ensure a cross-cutting approach on co-production, Co-design and Community led action.
- A Discovery Learning Programme for primary care, community members and local partners to create the conditions for Health Creation by working as equal partners with local people and focusing on what matters to them and their communities.
- Introduction of the Collaborative Practice Programme using population health management to understand and manage demand of services by our ‘frequent attenders’ and those suffering the greatest health inequalities to offer a service that meets their needs

Key areas of development across the system:

- The narrative setting out what the Community Deal is and what it means in Frimley is on the Frimley ICS website.
- The Community Deal Framework to assist and support places has been written and is regularly updated with national and local good practice.
- Personalisation is being incorporated into the work with Communities and how community groups can support health and well being
- Working with Healthwatch, voluntary sector, local authorities, primary care networks and providers to engage communities to reduce health inequalities
- A video has been created capturing the work as part of the Community Deal and how the NHS Charities projects have enabled the start of these different conversations.

The **#OneSlough** initiative was created at the start of the pandemic in March 2020. Bringing together, the voluntary, and business sectors and faith communities, with Slough Borough Council, resources and skills were combined, to deliver essential services to Slough residents. Together they met on a weekly online call, to work out the logistics of this huge endeavour.

#OneSlough

An incredible **12,273 food parcels and 708 prescriptions** have been delivered by volunteers to the vulnerable; a massive achievement by everyone involved.

Whilst food parcels and prescriptions are still necessities for some, other needs have surfaced. Domestic violence, unemployment and poverty have increased in the town and as a result several projects, funded from donations received by Slough Giving, have been established.

People, Places and Communities

Achievements

NHS Charities Community Partnership Grants funding supported a range of place-based initiatives that foster the concept of community/voluntary sector support to build a stronger co-production approach. The funding was linked to supporting early intervention, reducing disparity, or focusing on preventative health and social care, with a particular emphasis on diversity within the population.

The outcomes of these projects include:

- Individuals being supported to become more independent and integrated into communities supported by the VCS. including Cares support and signposting.
- The Wellbeing Circle project has been able to create a trusting and collaborative partnership across local authority, health, and the voluntary sector supporting individuals health and wellbeing at home through a personalised care approach.
- Supporting culture events with young activists against racism linking public health messaging to diverse cultural, faith and differences spiritual perspectives
- Promoting key health messages linking with the Diversity Calendar
- New links established with underserved communities e.g., Polish/ Gypsy Roma Traveller
- People are digitally connected with families and others reducing loneliness and Isolation
- Over seven hundred individuals are registered as community champions to support BAME population
- A community Innovation Fund established across places to support local community projects.

By working in close partnership, we will be able to create more opportunities for shared ownership across different work programmes to better reduce health inequalities.

Priorities

The impact of the pandemic has been felt by everyone and it is important that we understand the difficulties people are facing, whether they be related to health, housing, finances, or family. Building on the expertise of partners, voluntary sector, and charities we will work together to make fundamental change to collaborate with communities to make healthier choices. We also recognise that there is additional work which our partnership can do to better support Unpaid Carers which are a critical component of our health and care workforce.

The future priorities for this ambition are:

- Supporting the implementation of the South East Mental Health Compact which seeks to transform mental health services at scale and pace, including redefining the relationship between mental and physical care
- Creating relationships with all the Voluntary Community Social Enterprise (VCSE) organisations to be key strategic partners in shaping, improving, and delivering services, to tackle the wider determinants of health and create community asset partnerships
- A clear approach to engaging with our population at place and system levels, including representation at place-based partnerships and the ICS partnership to inform decision making
- Ensuring all of our diverse populations are represented with the creation of an ICS inclusivity framework
- Exploring citizen leadership and creating opportunities to develop decision making in our communities
- Using data and insight to focus on where the biggest impact can be made – for example children and families or those most affected by the increase in the cost of living and housing with fuel poverty
- Using the expertise in local authorities to develop a cross-cutting approach on co-production, co-design and promoting independence and sustainability to enable empowered and thriving communities.
- Identifying and supporting innovation through small scale grassroots community projects using the learning of the Innovation Funds project
- Continually looking for ways to measure success impact and outcomes in conjunction with the starting well and living well ambitions
- Collaborating with our communities to recruit those with lived experience to support a co-produced offer supporting and developing peer leaders for the system
- Working with partners to make best use of funding and joint working opportunities to deliver our commitments around the Serious Violence Duty
- Work with partners and those with lived experience across the system to develop a framework and policy as how to engage with those with lived experience at all levels with the ICS
- Support from Frimley Academy to provide opportunities for training and development of our workforce to hold community conversations and co-produce plans for improvement
- Sharing and spread of good practice in the diverse ways of working. to support the community deal approach.
- Working with people and communities around developing our shared approach to Palliative and End of Life Care, supporting people of all ages to die well and in a way that supports families and communities better cope with these difficult times.

People, Places and Communities

Benefits and sustainability

The ICS aspiration is for people to live their lives to their fullest potential. To achieve this, it will require us to create new ways of working, to work flexibly, to invest in models of delivery, and to be brave enough to actively target resources to where we can make the biggest difference for local people. Key benefits include:

- The system understands and is working towards the ambition at all levels
- We have an effective co-production methodology and capability at all levels across the system
- Better outcomes for the most vulnerable
- Understand unique aspects of each community population and their priorities
- Understand population assets, needs, and priorities
- Targeted wellbeing offers that meets local needs and priorities
- Communities feel empowered to have a voice and make decisions that are right for them
- Strong relationships with organisations and the VCSE
- Good conversations with all our communities.
- Using the data and insights to target change with he the wider determinants of health
- Equity of offer across the system.
- Empowered communities with improved capacity to look after themselves and each other
- Ultimately resulting in mitigation of the demand pressures and financial constraints across the system

People and Communities Strategy

Frimley Health and Care ICS has a strong reputation for working with people and communities, built on trust and long standing partnership work with a wide range of stakeholders. We recognise that insight underpins and supports transformation. Delivery models are changing, and public involvement is essential. We are committed to delivering the best possible health and wellbeing outcomes for people who live within our local communities. This means adapting to new ways of working, ensuring a local focus but with the additional benefits of support, sharing good practice and learning across our system.

"People and communities have the experience, skills and insight to transform how health and care is designed and delivered. Working with them as equal partners helps them take more control over their health. It is an essential part of securing a sustainable recovery for the NHS following the pandemic. The ambition is for health and care systems to build positive and enduring relationships with communities to improve services, support and outcomes for people."

Statutory guidance for working in partnership with people and communities, NHS England, July 2022

Frimley Health and Care is developing a system-wide strategy for engaging with people and communities. This draft strategy for Frimley has been built upon insights and experience across the system and engagement with key groups and communities including ICS/ICB Board, CCG and partner staff, Healthwatch and voluntary sector partners and key patient and community groups.

The draft strategy has been shared with NHS England and will be shared with the ICP with the expectation that further refinement and engagement activity will take place throughout 2023, to ensure we actively listen to communities as we establish new ways of working.

To watch a short film about the work of the Community Deal ambition please click the icon or scan the QR code.

Insight & Involvement Portal

To access more information about the People and Communities Strategy please scan the QR code or visit:

insight.frimleyhealthandcare.org.uk/peopleandcommunities

Strategic ambition four:

Our People

Workforce challenges in health and care have been talked about for years, but the scale of challenge in the last two years have been unprecedented. Partners across the health and care system are working hard to ensure we have the workforce we need now and in the future. We need to be clear where we best deliver through a system focus- where we are stronger together to resolve some of our most difficult and longstanding workforce challenges.

- We want to be known as a great place to live, work, develop, make a positive difference.
- We want all of our people to have the opportunity to be physically and mentally healthy, fulfilled, effective and flexible in how they work and what they do.
- We want to attract our local population to careers in our health and care system.

Our People

Achievements

Equality, Diversity and Inclusion
Within the Frimley system we are passionate about equality, diversity and inclusion (EDI). This provides a golden thread for all that we we do but we are particularly proud of our '**Melting the snowy white peaks**' programme. This recognises the under-representation of Black, Asian and Ethnic Minority nurses in senior roles, despite these staff representing over 20% of nurses. In partnership with Surrey University, we have explored, 'how can we better prepare nurses from Black, Asian and Ethnic minorities for career progression?' Nurses described a need to be 'better allies for each other'. We have provided a case study of the programme to demonstrate the positive impact our students tell us they have experienced as a result. Learning is shared with other professional students eg midwives, paramedics and medicine and also with other universities who are exploring offering the programme to their students.

Temporary Staffing
24% of the Adult Social Care workforce are on temporary (zero-hours) contracts. In the NHS, 4/5 registered nursing vacancies and 7/8 doctor vacancies are filled by temporary staff. Temporary staff are a hugely important part of our workforce. Our programme is designed to create a culture where temporary staff are welcomed – seen as essential and valued, where we recognise that people want flexibility and choice. Working as a collaborative, Frimley, BOB and Surrey Heartlands are improving processes, increasing productivity and strengthening how we deploy an adaptable workforce. Other partners will be joining this successful model soon.

People in Partnerships
Integrated care requires teams to work together. The PIP programme aims to support teams to strengthen collaboration across the system. Achievements:

- A leadership programme aimed at integrated team leaders
- A series of webinars led by Prof. Michael West on compassion and collaboration
- Supporting teams to have a 'Culture conversations'
- An integrated team diagnostic

Allied Health Professionals (AHP)
AHPs are a diverse group of clinicians who deliver high-quality care to patients and clients across a wide range of care pathways and in a variety of different settings. Roles include occupational therapy, paramedics, physiotherapy, podiatry and radiography. AHPs are an essential core part of our workforce. The AHP workforce programme works across the system to strengthen recruitment, retention, transformation within primary care, and maximise clinical productivity. Achievements:

- Design and deliver the system AHP strategy – leading to improved AHP capacity through international cert and return to practice
- Increase placements by 255 in academic year 20-21 (84% uplift in placement capacity)

Just Culture, led by Berkshire Healthcare on behalf of the system, is an award- winning initiative which takes a fresh approach to promoting inclusion and compassion when incidents occur in the workplace. By improving understanding and increasing support to staff, disciplinaries reduced and staff survey scores improved.

This approach has saved over 600 hours of clinical time

Berkshire Healthcare take a 'Lead Investigator' approach across the Frimley Health system and provide highly trained, dedicated investigators for fact finding in disciplinary cases. Previously, clinicians were required to undertake investigations so this approach saves clinical time (600+hours) and improves the overall standard of investigation reports. The process encourages earlier resolution in cases resulting in reduced suspensions and disciplinaries.

Our People

Priorities

Workforce challenges in health and care have been talked about for years, but the scale of challenge in the last two years have been unprecedented. Partners across the health and care system are working hard to ensure we have the workforce we need now and in the future. We need to be clear where we best deliver through a system focus- where we are stronger together to resolve some of our most difficult and longstanding workforce challenges.

Our ambitions are aligned to the Frimley system strategy, and the initiatives we develop framed by the NHS People Plan.

We are undertaking a strategy refresh with our partners to agree our 'at scale' workforce transformation priorities – engagement and intelligence so far tells us we should focus on three target areas:

1. **Creating a joint workforce model for health and care – more connection, agility, equity and opportunity for our people, regardless of their employing organisation**
2. **Widening access to employment and keeping the people we have– working with our staff and our communities to remove barriers, truly listen to people to understand what they need to join us and stay with us**
3. **Strengthening partnership working and new models of care - Supporting our teams to drive transformation and to work in partnership to deliver high quality integrated care**

Many of our system programmes are truly making a difference. It is important to recognise what works well and use data to measure progress. It is also important to know when we need to take a different path. We will ensure everything we invest in has a clear purpose, is value adding and is transparently evaluated.

Our People

Benefits and sustainability

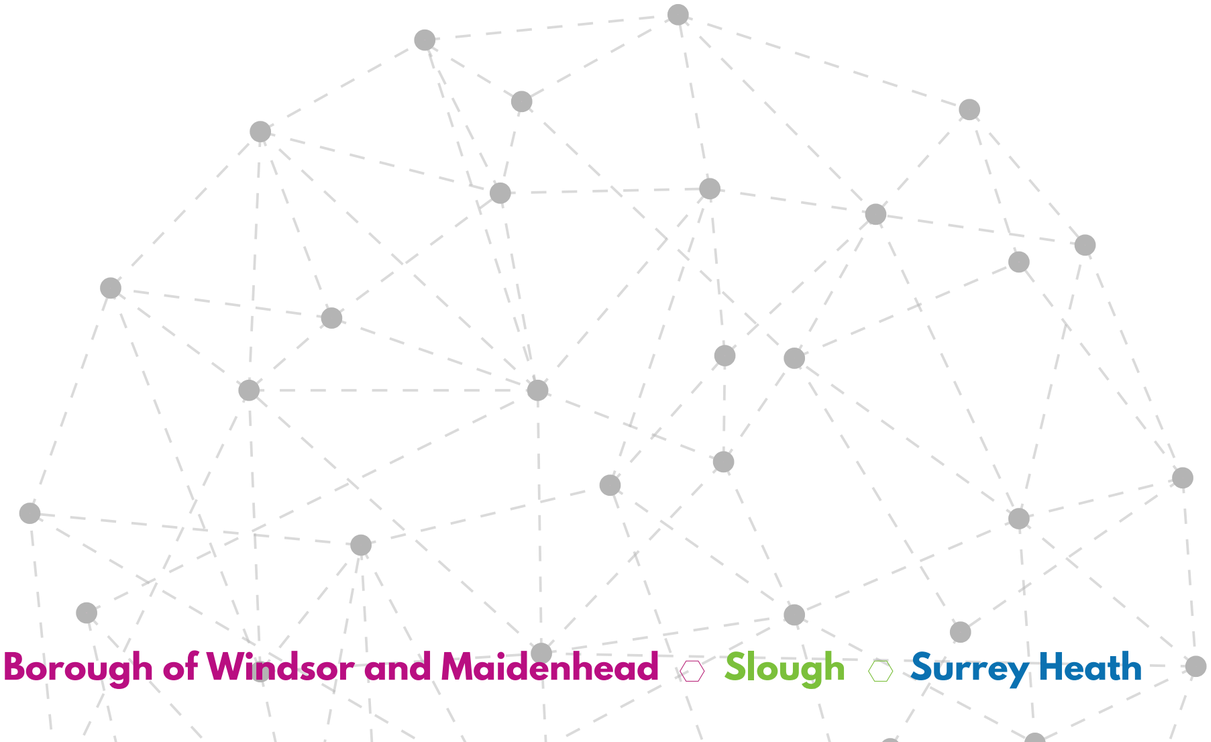
We have engaged with stakeholders across the system to find out what is important to them with regard to our People. They tell us we need to:

- Remove barriers to people accessing work or progressing
- Work more collaboratively as partners and better understand each other
- Improve parity between those working in health and those in care
- See all working or volunteering in health and care as valued and important
- Increase the diversity of our staff, particularly our leaders
- Better understand our communities and their employment needs
- Support the wellbeing of our staff, particularly as cost-of-living pressures rise
- Demonstrate care to each other and create compassionate leaders
- Create long term plans so that we have the workforce we need for the future

By focusing our system resources on our three target areas we will deliver or support initiatives which will:

- Reduce inequalities between our health and social care workforce – improving parity of terms and conditions, development opportunities and access to support
- Optimise our community assets to enable more people to access 'good work' through our Anchor Institutions programmes
- Improve our management of and support to temporary staff, extending our programme across the South East region and to primary and social care partners
- Strengthen our widening access and participation programme so that more people can join and progress within the Frimley Health and care system
- Retain and strengthen our Reservist workforce who volunteered to support the vaccination programme. Extend this across social care
- Reduce discrimination and achieve greater diversity in leadership roles
- Increase workforce capacity through local initiatives and international recruitment, creating robust workforce plans for the future
- Improve retention through; preventing violence at work, supporting health and wellbeing, enabling people to progress across health and care, embedding digital solutions and supporting staff with housing/cost-of-living challenges
- Enabling clinical leaders to redesign services and workforce models through our CLEAR programme
- Embed new roles such as Trusted Assessors to promptly assess hospital patients on behalf of care homes
- Support people across our system to be compassionate leaders who role model partnership working to deliver high quality integrated care
- Improve nursing pharmacy and AHP attraction, retention and development through increasing placements, attracting and retaining international staff, better supporting students, embed new roles and increase apprenticeships

Over the coming months we will again bring together workforce leaders across the system to prioritise and to agree who is best leading various programmes. We have had much success in the past at identifying strengths within our partner organisations and supporting them with resources to lead initiatives across the system and will continue with this approach.



Strategic ambition five:

Leadership and Cultures

Together with our communities and partners we will build kind and inclusive cultures which harness the rich diversity of experience, knowledge, skills, and capabilities from across our system. We will collaborate with others to co-design, integrate and inspire all our people to make a positive contribution in our neighbourhoods, across our places and throughout Frimley.

We will continue to:

- create opportunities for our partners to develop our cultures of compassion and belonging together
- cultivate whole system leadership and partnership working which finds new ways to tackle complex system challenges
- nurture the leadership potential in our people, in every part of our health and care system, equipping them to work across boundaries together with communities to improve outcomes through tackling inequalities
- engage with our communities to deliver improvements in the integration of services for better access, experience and outcomes
- embed the universal Freedom To Speak Up principles, ensuring our people feel empowered, supported and confident to challenge and offer suggestions to improve ways of working.

We will create a thriving environment which values the power and strength of our diversity and ensures our people feel empowered and confident to challenge when things are not right and to offer suggestions to improve ways of working. This will contribute to an inclusive leadership culture which enables equity of access to services, support and opportunities for our communities and staff through life and career.

Leadership and Cultures

Throughout our engagement on this strategy refresh we heard clearly from our partners that the need for developing our collective ability to lead improvement continues to grow. There was a recognition that our priorities and programmes under this ambition need to adaptive and responsive to the changing context in which we work. As such we will continue to ensure we evaluate, reflect and adapt our programmes on an ongoing basis. We also heard some key themes which we will address through our priority areas, these included:

- Ensure our voluntary, community and social enterprise partners, alongside residents and communities can engage and develop their leadership skills so they can make a difference in the communities where they live and work
- Continue to broaden access to our leadership programmes supporting underrepresented partners to take part in our offers (e.g. housing, fire, police etc)
- Work together with our children and young people and relevant partners to offer opportunities to develop our leaders of the future
- • Ensure a mixed offer of programmes and activities that can support more people to benefit (e.g. bite-size programmes, mix of virtual and face to face) and link to the outcomes of our system objectives
- Continue to support those people that have benefited from our leadership offers to make a positive difference in the work that they do on an ongoing basis – growing our 'community of practice'

In addition, we recognise that our culture is the sum of our behaviours, and our leadership behaviours have by far the greatest direct impact on our culture. We will continue embed our 'Frimley Way' through our partnerships and the way that we work together.

Achievements

Our Frimley Academy was established in 2018 and over the past four years we have been through several distinct phases which have shown how we have adapted to the changing environment around us. Phase one saw us respond to the priorities identified through the engagement we undertook on our 2019 strategy 'Creating Healthier Communities'. This strategy highlighted the ongoing need to provide unique opportunities for partners and people to come together, across a wide range of sectors, to develop their system leaderships skills and to tackle the complex change challenges we face. We adapted our flagship system leadership development programme '2020', which was rapidly followed by 'Wavelength' (a leadership programme focused on using digital to drive improvements), alongside several other programmes and offers that equipped our people to lead well in our emerging system context.

Phase two was in response to the Covid-19 pandemic. We rapidly refocused our activities to support our people to deliver and manage well through those extraordinary times. Our refocused offers during the pandemic included 1:1 supportive conversations, bespoke support for teams and sharing of support and wellbeing resources for our people. As we emerged from the pandemic, we undertook a piece of work with a number of leaders from within, and beyond, our system to understand the leadership values that had helped them through one of the most difficult events in the history of the NHS. These values and behaviours are now being embedded across our system and are known as the 'Frimley way'.

We have now entered phase three and we have relaunched the work of our academy. Frimley Academy continue to provide nationally recognised system leadership and learning development programmes, which bring together leaders and professionals from all parts of health and social care, Ministry of Defence, local government, and the voluntary, community and social enterprise sector. We have expanded our system leadership and culture offers which strengthen our collective capability for system partnership working that makes a difference for our communities. This includes over the past year delivering 10 offers, reaching over 650 people and promoting the opportunities provided by our partners across the system.

Leadership and Cultures

Our collaborative network of partners is key to the work we have achieved so far in delivering our culture and leadership ambition. The strength of our partnerships comes from the support and commitment of partners and means that we have been able to increase the spread of our system offers and support – including access to individual coaching support networks, facilitation and team development coaching. The role our Frimley Academy plays as a system convenor and co-design support has meant we have been able to create the space to accelerate system development, foster relationships and enable genuine collaboration for spread and adoption.

In addition to the work of the Academy there has been significant progress made in our system on building our cultures of belonging and inclusion. Over the past year we have co-designed and agreed our five Frimley ICS Equality, Diversity, and Inclusion (EDI) Ambitions and have also held a series of system-wide events to explore our culture of inclusion and belonging, including the Frimley ICS EDI Conference attended by people from across all parts of the system and shared with many more.

"A fantastic way to broaden my horizons on the integrated care system and impact of digital transformation!"

"20/20 is energising, positive, exciting and progressive. Thank you Frimley Academy ..."

"I came away with a much better understanding and appreciation of the system and the people that make it work as a whole."

20/20 EMPOWER INNOVATE DELIVER Cohort One

Wavelength CONNECT EMPOWER TRANSFORM Cohort One

Using insights in our design

Focused response to Covid-19

FRIMLEY 10:100 EMPOWER INNOVATE DELIVER Cohort One

MARY SEACOLE LOCAL PROGRAMME

2018 — Launch — 2019 — Refocus — 2020 — Relaunch — 2021 — Refresh — 2022

Our purpose

Frimley Academy exists to nurture the leadership potential in all of our people in every part of our health and care system, equipping and supporting them to work across boundaries together with our people and communities to improve outcomes by tackling inequalities

We strive to provide inclusive opportunities and the environment which enables all of our people to develop together as system leaders who transcend boundaries

To inspire whole system community leadership networks which harness new ways of working to tackle complex system inequalities

20/20 EMPOWER INNOVATE DELIVER Cohort Four

Wavelength CONNECT EMPOWER TRANSFORM Cohort Three

Click here to learn more about the work of the Frimley Academy

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

Leadership and Cultures

Priorities

We will continue to ensure that we create opportunities for communities, people and partners to develop our cultures of compassion and belonging together. We will work to cultivate our whole system leadership and partnership working which finds new ways to tackle our complex system challenges. We will ensure we expand our system leadership and culture offers strengthening our collective capability for advanced system partnership working that makes a difference with our communities. We will also create the space to stimulate radical thinking, meaningful collaboration and bold action to tackle inequalities. We will base the way we work around the 'Frimley Way' so that we are building our cultures in the way we do our work together across the system.

We will deliver our system **equality, diversity and inclusion ambitions** – building on our equality diversity and inclusion strategy which is focused on being anti-racist, free of all forms of discrimination, bullying and harassment. We will build more diverse leadership, representative of the diversity of our system. These will be enabled through a range of supporting interventions:

- Frimley ICB mirror board
- Cultural Intelligence
- Reciprocal Mentoring

We will develop our system wide **Freedom to Speak Up strategy and vision** – empowering our people to speak up when things are not right and co-deisgn improvements. Embedding freedom to speak up in our inclusive culture and share learning across the system so we make a positve difference

By leveraging our **leadership networks** – we will accelerate the spread and adoption of system change and maximise the impact of those that have benefited from our leadership and culture interventions through a community of practice

Nurturing a **shared learning culture** will create the space to stimulate radical thinking, meaningful collaboration and bold action to tackle inequalities, harnessing collective intelligence and wisdom of all parts of our system to emerge. We will continue to broaden access to our leadership programmes supporting underrepresented partners to take part in our offers.

Enabling greater **community led capability** development will support and empower the communities we serve, in the places that they live. We will listen to what's important to them and develop our community and partner leadership skills together.

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

We will expand our **culture and leadership offers** – to reflect our system challenges and build our system leaders of the future and ensure a mixed offer of programmes and activities that can support more people to benefit

95% tell us that having the time and space to reflect on their role, their influence and how to improve and lead realistic change in their organisation is making a big difference in their working lives

100% strongly agreed that the programme enhanced their confidence and skills in connecting and collaborating across boundaries

To watch a short film about Courageous Conversations please click on the icon or scan the QR code

Leadership and Cultures

Benefits and sustainability

Our leadership and cultures ambition brings together key shared leadership and culture priorities, opportunities and challenges drawn upon the collective wisdom, insights and strategies of our partners. The ambition aims to deliver mutual benefits aligned to existing work of our partners, our future system partnership ambitions, as well respond to the recommendations of the recently published review of leadership in health and social care (June 2022).

Cultural competence and inclusion are integral to the future success of our ICS. As a system we recognise that we are all leaders, what distinguishes the culturally competent leader is the profound commitment to understand deeply the people they work with in their teams, our communities we serve, their unique priorities, challenges, and the strengths of each.

We will continue to develop the ambition as we move forward building our collective system capabilities, the learning from of our strong history of system working and our tried and tested leadership behaviours which describe how we work with our partners and the communities we serve. Our aspiration is that by focusing on 'the way we do things' - we will create a thriving system in which our residents and our people can make a positive difference to the lives of those that live and work in Frimley.

Through our actions we will:

- Continue to equip our people with the skills and capabilities to manage change in complex systems and deliver better outcomes in services and ways or working through our 'change challenges'
- Support our people to embed the 'Frimley Way' and develop connected and compassionate leaders
- We will increase the number of people that benefit from our programmes year on year and will develop new offers in new ways to increase the diversity and numbers of people across our system leading improvements
- We will deliver our system wide equality, diversity and inclusion priorities delivering an inclusive culture in which people feel they belong and use measures such as staff surveys and equality monitoring data to demonstrate improvements
- We will develop our system network to share learning from Freedom to Speak Up, demonstrating how we have made a difference through embedding improvements as a result of people speaking up
- We will create our community of practice which leverages the capacity and skills of our people to create positive change
- We will contribute to the opportunities for development for all people across all parts of our system supporting our communities and staff through life and career as demonstrated through measures such as retention and feedback from our communities and staff

Evaluation data on the personal and professional impact of our targeted system leadership development report **100% success** across all participants in the core areas of greater system awareness, enhanced skills and improved relationships and networks for system working across system.

We have nurtured and supported leaders at all levels to initiate over **200 system change challenges** with approximately 90 currently ongoing and 40 completed. Despite system demands we are seeing a marked increase in willingness for system activism.

Leveraging **greater leadership development diversity and inclusion:** Working with our partners we have successfully delivered a **300% increase in access to leadership development** through a combination of increased cohorts and system representative recruitment approach. The overwhelming feedback at place, partner and system level is that this has generated positive leadership and culture momentum that we must maintain and build on as a system. There are clear opportunities to do so.

Strategic ambition six:

Outstanding use of resources

Outstanding use of resources means that the system will collectively aim to deliver the greatest possible value to support the health and wellbeing of the population, with the resources available. Our long term commitment to reducing need and health inequalities will support the long term sustainability of health and care services. We have made digitally-enabled care a priority for this ambition.

We aim to be known for working together to maximise the impact of the skills and capacities of our staff, making decisions based on good intelligence, our digital capabilities, our ‘Frimley pound’, our local buildings and facilities. We will shift resources to maximise benefits.

The ICS will ensure joint prioritisation and effective utilisation of all our resources including financial, estates, digital and workforce, recognising these as our as our key strategic assets.

Although future financial resource flows are unknown, and national strategic workforce planning is a work in progress, it is clear that without transformation the system will be facing a financial gap that will only increase over time. The financial challenge across our partnership is a real "here and now" issue which is already leading to difficult decisions for organisations and elected representatives to have to take around which services can be offered to local people.

The strategy aims to close the resource shortfall by improving people’s health and wellbeing outcomes, thereby reducing the demand for resources in the treatment of poor health.

Outstanding use of resources



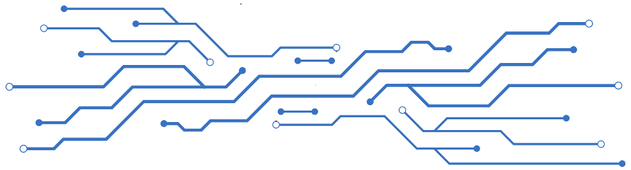
Achievements

The pandemic has influenced the delivery of this, as every other aspect of system strategy since 2019.

However, there is much learning to be taken from the world-changing events since then. The pandemic has been a catalyst for significant innovation and driven more collaborative working in areas that otherwise might have been the case.

New opportunities have arisen in areas such as digital wellbeing and connectivity, population health management, remote monitoring of health and wellbeing and remote working which has the potential dramatically to reduce resource consumption in non-clinical estate.

The ambition aims to seize the opportunities presented and to harness the new learning in pursuit of the system's key strategic ambitions.



We will future proof our system by having a **leading digital and analytics ecosystem** which will deliver practical improvement through **transformation** and cultural change using digital innovation.

We will develop a digital offer for patients, residents, staff and system that supports the delivery of all of our strategic ambitions. It will give us **greater insight** from our data to make informed decisions and target our improvement actions. It will give people the information they need to **prevent ill health** and manage their own health. It will **support automation** and more productive ways of working.


Digital

Since 2019, we have delivered some key achievements within Digital and Analytics

- Developed a nationally leading population health intelligence platform
- Established population health analytics support that is now embedded in decision making across the ICS at system, place and PCN level
- Developed digital enablers that improve access for residents to Primary Care
- Embedded evidence led improvement and transformation using population health management approaches
- Nationally leading use of remote monitoring
- First area in the UK to implement John's Hopkins' patient segmentation approaches
- 65k accesses from 5k unique users of the shared care record every month
- Use of population health management to improve diabetes and hypertension management and outcomes that has measurably reduced variation in deprived communities as well as driving support for residents hardest hit by the cost of living crisis
- Use of population analysis to target communication activity and spend to key cohorts
- Establishing close collaboration between clinical leadership, digital, transformation and analytics to drive change
- Increase the flexibility of our estate by maximising digital ways of working

Estates

Our estate is a key driver for transformational change. The system will invest in upgrading facilities in an aligned way across health and care, making best use of public money to provide flexible facilities close to where people need them. We want to enable our staff to work in the most efficient way by utilising the estate and digital capability to maximum impact.

We will focus on delivering a number of key estates programmes across our system including cross-sector initiatives and in developing and embedding a system evaluation and planning cycle for capital investments. Over the period of the strategy our achievements to date include:

- Heatherwood Hospital redevelopment and renewal.
- Investment in GP estate.
- Integrated Care Hub in Farnborough in partnership with Rushmoor Borough Council.
- Community hospital reconfiguration.
- Cross-sector partnership developments, including Heathlands in Bracknell.

Outstanding use of resources

Priorities

The system will work collaboratively to a **single system resource** envelope across the health and care system in support of clinical and operational strategies to deliver the key strategic ambitions.

We will work to enable more **fully informed decision making** in the use of the resources available to deliver the greatest possible value for the health and wellbeing of the population.

We seek to predict future demand under a “do-nothing” scenario and to develop our ability to:

- **reduce the need for costlier healthcare interventions** through investment in preventative and wellbeing interventions so that the money we spend on specialist and acute care is a lower proportion of our total cost base
- **utilise digital innovation** to deliver greater value for our population
- **optimise capacity** to meet demand and better mitigate demand that could be addressed more effectively elsewhere

The targeting of health inequalities is a key action for the delivery of a **sustainable service model** which provides the greatest possible value. It is well-evidenced that deprivation drives health inequalities which in turn drive greater utilisation of resource-intensive treatment. A focus on the improvement of health and wellbeing outcomes in our most deprived neighbourhoods will therefore have the greatest impact on consumption of resource in the treatment of poor health, which will free resource for reapplication in further preventative and wellbeing developments.

The development of planning and delivery **relationships with the voluntary sector, charitable organisations including hospices and commercial sector providers** has the potential to enable the application of a far greater level of resource than statutory organisations are able to bring to bear in the delivery of best value for our population’s health and wellbeing. This must therefore be a priority as we work to deliver this objective.

In light of the finite nature of our resource, the system should have a **conversation with the public** which seeks to articulate the limitations of our financial and workforce capacity in order that a more fully informed public is able to help us to prioritise our resource application.

Finally, our physical estates continue to experience signficant challenge with the need for urgent capital investment clearly visible. The most pressing example of this is the use of RAAC plank building materials across the Frimley Park Hospital site, reducing the ability to use the full estate for patient services. A priority for this period will include securing additional investment to address this challenge.

Digital, analytics and transformation priorities

- Further developing the breadth, capability and use of our Shared Care Record
- Continue to expand the nationally leading use of remote monitoring as a prevention opportunity
- Improving the seamless flow of data between organisations across the health and care system
- Improving data quality, timeliness and breadth of data being shared
- Improving digital literacy and the use of insights to drive evidence based decision making
- Embedding a system wide analytics operating model that optimimises the use of analytics resources and focuses on driving meaningful outcomes
- Scaling nationally leading, locally developed, population health intelligence tools to support other systems across the UK
- Increasing the use of evaluation to support decision making and rapid improvement cycles
- Moving from descriptive analytics to greater emphasis on predictive and prescriptive techniques and data science
- Greater focus on patient reported outcomes and better understanding the voice of our residents
- Greater insight supporting evidence based decision making at system, place and neighbourhood levels. Incorporating wider determinants and resident provided information to drive population health management and system intelligence.
- Support a move towards self-care and prevention by integrating the good work in health and social care with app and resident-facing technology integration.
- Harnessing Medicines Optimisation principles to improve access to the most effective therapies, reduce waste, minimise harm from inappropriate medicine use and promote sustainable low carbon impact medications
- Use digital tools and evaluation of our interventions to underpin work to reduce inequalities for residents across the system.
- Increase the flexibility of our estate by maximising digital ways of working
- Stronger integration with children’s social care and education to support targeted and coordinated wellbeing offer to children to start well.

Benefits and sustainability

The optimal use of resources will support the whole system in achieving its vision of improving the lives of our residents and addressing health inequalities. The use of digital technology will empower our workforce to work differently, creating capacity as well as improving quality outcomes for residents. Improving access and the use of technology will also support patients to better navigate the health and care system and empower patients to take greater ownership of their health and wellbeing.

The ambition directly addresses this issue, to drive a service which maximises health and wellbeing outcomes, minimises health inequalities and demonstrably delivers the greatest possible value for the resource entrusted to us on behalf of our population.

Research and Innovation

Creating a Culture of Learning Research and Innovation

Research and innovation play an active role in informing and enabling the system to prove value and achieve transformation through data driven evidence to address health inequalities and ensure sustainability. Our ICS will encourage and support innovation in organisations, communities, and as a whole system that improves the design, delivery and outcomes of health and care services.

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

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

With increasing demand for health and care services, tighter budgets, and a workforce shortage across the system we will look for innovation that will increase productivity and in a way that the public, patients, and families will interact with their local health and care system. Expanding on the use of technology to deliver remote monitoring, and consultation, introducing new medicines and helping patients manage their conditions better. Listening to the needs of our patients and stakeholders at all stages of the innovation pathway, from insights to delivery.

Working in collaboration with the Oxford Academic Health Science Network (AHSN), Oxford and Thames Valley Applied Research Collaboration (ARC) and the Local Clinical Research Network, Frimley Health and Care ICS will:

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

Below outlines a few examples of the work that the ICS has achieved with the Oxford Academic Health Science Network:

Maternity
- Preterm birth package of evidence-based interventions to reduce mortality and morbidity in preterm birth.
- Piloting and implementation of the national Maternity Early Warning Score, and the revised version of the Newborn Early Warning Track and Trigger tool

Cardiovascular Disease: Prevention
- Adoption of medicines such as high intensity statins, for the management of lipids
- Optimisation of Blood pressure using pathway mapping for patients with a family history of CVD through collaboration with Novartis.

Wound Management
- Support to implement the National Wound Care Strategy reducing lower limb wound prevalence, clinical time spent on care and spend on wound care products.

Our next steps together

Our Shared Commitment to Delivering Progress

This refreshed ICS Strategy is the first step in the next phase of our joint work together as partner organisations. We are committed to continuing our efforts to deliver improvements against our two Strategic Priorities, **Reducing Health Inequalities** and **Improving Healthy Life Expectancy**. This document sets out where we think the greatest opportunities lie ahead of us in making this a reality for our residents.

Our intention is to work with residents, staff, elected representatives and organisations in Q4 of 2022/23 to share this draft strategy and **hear further feedback** as to how it can be strengthened. We will seek to update the strategy to reflect as much of this feedback as possible, prior to the Integrated Care Partnership being asked to endorse this strategy at its meeting in March 2023.

As we enter 2022/23, we will seek to **work with partners** in their organisations and **Health & Wellbeing Boards** to ensure that we have credible plans for delivering improvement against these strategic ambitions as set out in this document. We have already signalled an intention to bring greater clarity to the expected benefits of this work for residents and staff, backed up by a clear understanding of the metrics and indicators which will tell us whether our shared work in this area is delivering tangible progress.

Delivering on the improvement opportunities identified in this strategy is a **collective responsibility**. We have highlighted these areas of focus because they are deliverable only with ambitious involvement from the organisations which make up our partnership. By **working together** in line with our **shared values**, we will hold each other to account for the delivery of our strategic purpose in the right way.

Over the past three years we have invested significant time in building new delivery capability, creating new vehicles for transformation which are not rooted in the traditional organisational architecture of the twentieth century. We will make the most of our ICP, ICB, Health & Wellbeing Boards and Provider Collaboratives to **achieve our goals** because we know that these partnership constucts will give us the best chance of success.

Addressing the wider determinants of health and wellbeing

Our greatest opportunities for achieving success together will come through addressing the broader factors which determine the health and wellbeing of our population.

In the months ahead we will embark on an ambitious agenda-setting approach to making best use of our Integrated Care Partnership to create the time and attention required to delivering shared improvement in these areas. Focus areas which have already been suggested by our partners for subject matter workshops include:

- **Social and Private Housing, Planning and Development**
- **Healthier Spaces, Leisure and Tourism**
- **Economic Development, Skills Development and Training**
- **Understanding the Social Care provider sector and exploring quality improvement opportunities**
- **Making best use of our collective Public Sector physical assets and anchor institutions**
- **Digital provision of health and care support to workforce, patients and residents**
- **Securing long term sustainability, including environmental improvement opportunities and the broader Green agenda**

Delivering improvement from this strategy and therefore improvement for our residents is contingent on identifying the opportunities for change which are present in all of the above. As the ICP continues to evolve and develop, it will provide a critical forum to secure this.

Staying in touch

Insight & Involvement Portal

We have created a page on our Insight and Involvement Portal that will be updated with progress on the development on the refreshed strategy. Please take the time to visit to share your views and to see the partnership work undertaken to develop the Strategy to date.

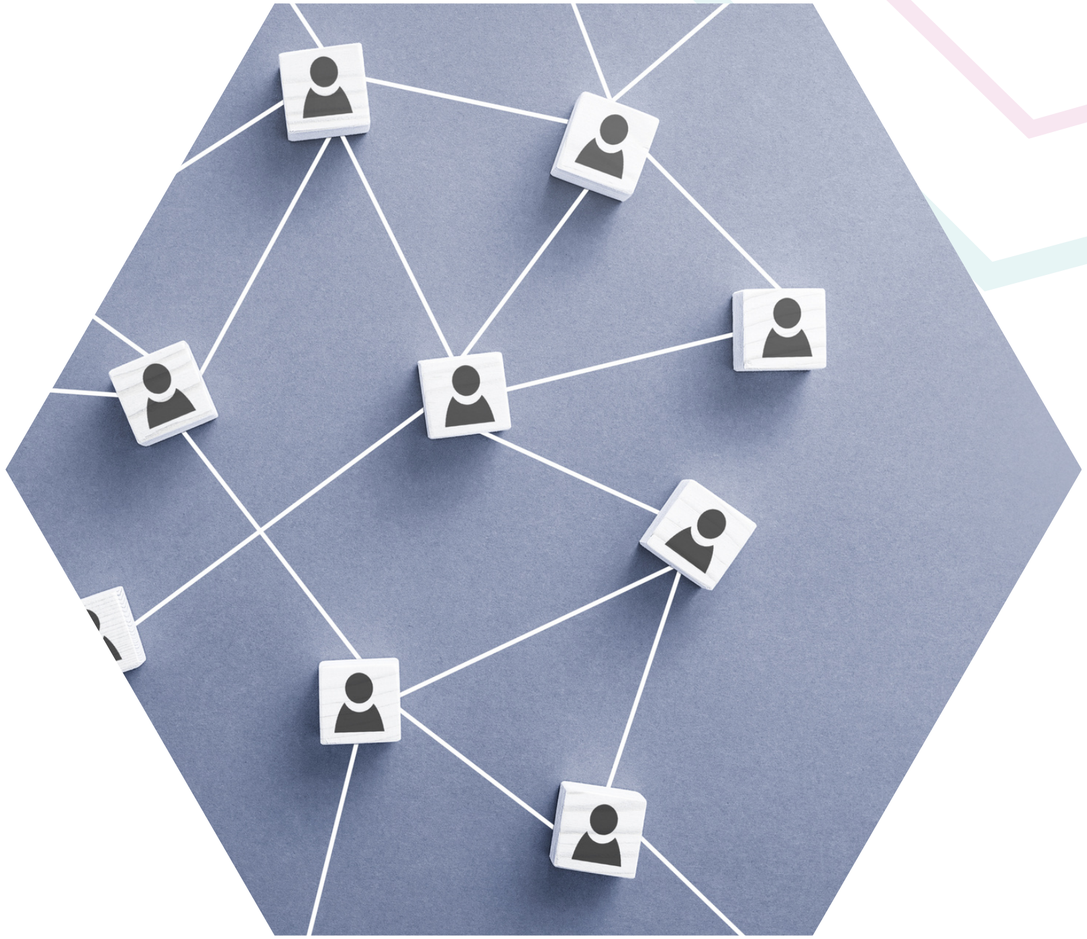
insight.frimleyhealthandcare.org.uk/strategyrefresh

You can also visit our system website for a wide range of information about Frimley Health and Care, how to get involved in our work and up to date health and care information and resources that can be shared with friends, family and colleagues.

www.frimleyhealthandcare.org.uk

Take a moment to check out our social media channels. Please follow and share to stay up to date with a wide range of health and care information.

If you are reading a printed copy and wish to access any of the digital content or if you require information in other formats, please email: **frimleyicb.public@nhs.net**



Frimley Health and Care

Frimley ICS - NHS Joint Forward Plan

2023/24 – 2027/28

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

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

In June 2023

Introduction

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

Contents

About this Document and Relationship to Other System Strategies and Plans

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

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

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

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

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

Introduction from Our Organisations to this Joint Forward Plan

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

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

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

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

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

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

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

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

Graham Wareham
Chief Executive
Surrey and Borders Partnership
NHS Foundation Trust

Julian Emms
Chief Executive
Berkshire Healthcare
NHS Foundation Trust

Neil Dardis
Chief Executive
Frimley Health
NHS Foundation Trust

Dr Huw Thomas and
Dr Prash Patel
Primary Care ICB
Board Partner Members

Fiona Edwards
Chief Executive
NHS Frimley
Integrated Care Board

Creating Healthier Communities – Our 2023 ICS Strategy

The Frimley ICS Strategy

Creating Healthier Communities was published in 2019 as the first Frimley Health and Care ICS Strategy. This was designed following significant co-production between partner organisations, the third sector, our workforce, patients, and the public. The ICS Strategy was heavily informed by the data and insight available from the Connected Care platform and led to the formation of six Strategic Ambitions which have comprised the programme architecture for delivery between 2019 and 2022. We have recently completed a new partnership-led refresh of the ICS Strategy which sets out our aspiration for long term improvement to the health and care of the population.

Our Integrated Care Partnership

The Frimley Integrated Care Partnership (ICP), established in July 2022, is a joint committee between Local Authorities in the Frimley ICS geography and the NHS Frimley Integrated Care Board. At its core is an ICP Assembly, bringing together clinical and professional leaders of public sector, voluntary sector, and charitable organisations, which have an interest in improving the health and wellbeing of over 800,000 people who reside in the Frimley ICS geography. The ICP provides a platform for a broad range of stakeholders who are committed to making this ambition a reality. Building on our engagement with our partners, the Frimley ICP was established to have a strategic role, considering what arrangements work best in our local area by creating a dedicated forum to enhance relationships between leaders across the health and care system. The agreed remit for the ICP is to:

- Consider and set the strategic intent of the partnership; act as final approver of the ICS Strategy, including the proposed programmes of work, outcomes, and intended benefits
- Act as an objective 'guardian' of the ICS vision and values, putting the population's needs and the successful operation of the ICS ahead of any sector or organisation specific areas of focus
- Provide a forum for consideration of wider determinants of health and health inequalities, taking fullest advantage of the opportunities arising to hear the views and perspectives of the broadest range of local stakeholders and democratic representatives.

The ICP is not an NHS construct and is, therefore, out of scope for this Joint Forward Plan. It will, however, continue to develop and evolve under the direction of a cross system partnership comprised of NHS, Local Government and VCSE expertise.

Frimley Health and Care

Our Population

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

About the Frimley Health and Care System

Frimley Health and Care brings together Local Authorities, NHS organisations, and the Voluntary Sector together with a clear shared ambition to work in partnership with local people, communities and staff to improve the health and wellbeing of individuals, and to use our collective resources more effectively.

The system has a diverse population of over 800,000 people in a broad geography which spans East Berkshire from Bracknell to Slough, inclusive of North East Hampshire, Farnham, and Surrey Heath.

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

As a result, considerable progress has been made promoting health and wellbeing, improving care and services, and making services more efficient. We have brought people together to integrate services and work across organisational boundaries, regardless of the system and architecture which regularly changes around us.

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

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

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

Frimley Population Insights: Deprivation, Ethnicity and Disease Prevalence

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

On average, many conditions are between 1.5 - 2.5 times more common in deprived areas versus affluent areas after adjusting for age and sex of the populations

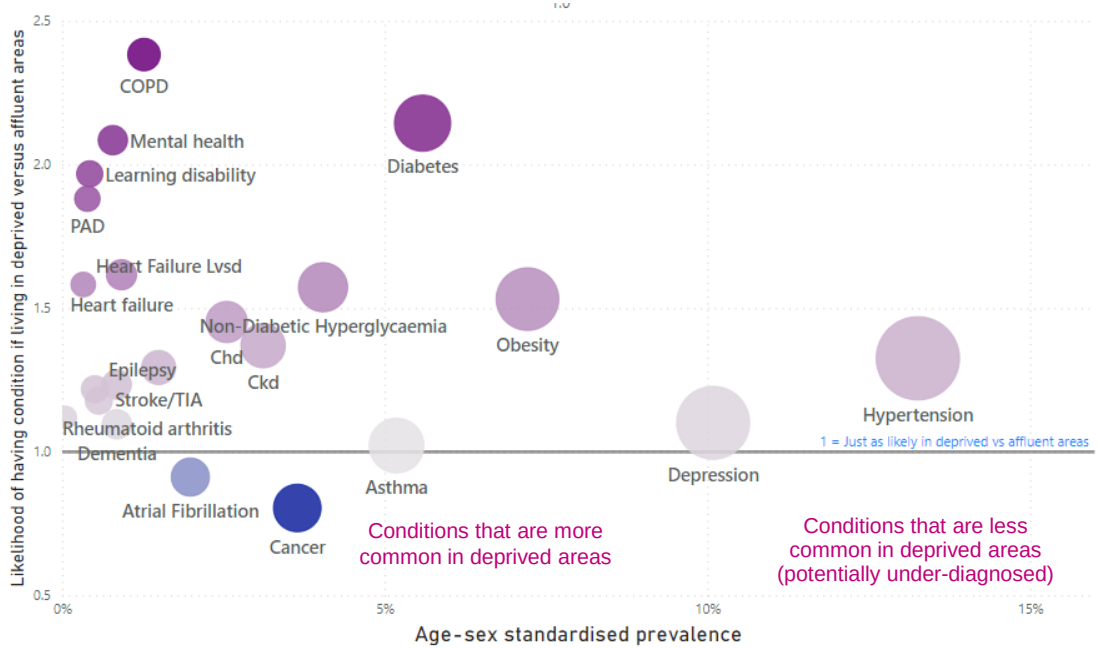
When looking at ethnicity data we notice the following:

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

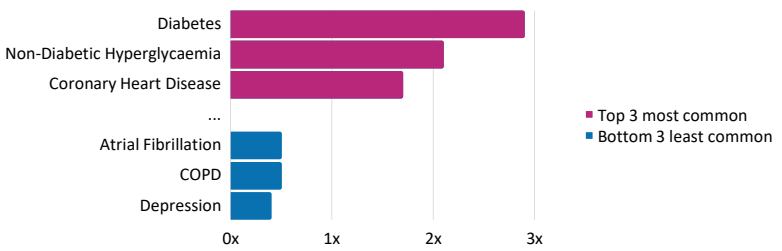
Slough, compared to other parts of the system, has a younger population, a higher percentage of BAME residents, more densely populated and multigenerational households, and is more deprived.

Adjusting for age and sex, Slough has a significantly higher prevalence of a wide range of conditions and risk factors. There are strong associations between deprivation, ethnicity, and prevalence of conditions, such as diabetes and hypertension.

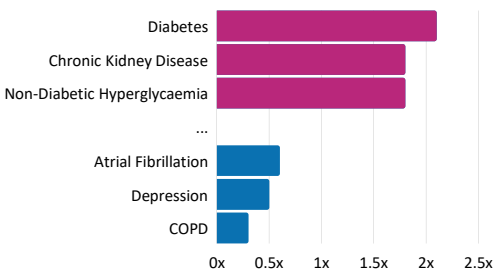
An increased prevalence of chronic diseases can lead to health inequalities, as well as increasing the risk of experiencing a disproportionate negative impact from community transmitted conditions, such as Covid-19.



Asian or Asian British compared to White population



Black or Black British compared to White population



Frimley Health and Care

NHS Surrey and Borders Partnership NHS Foundation Trust

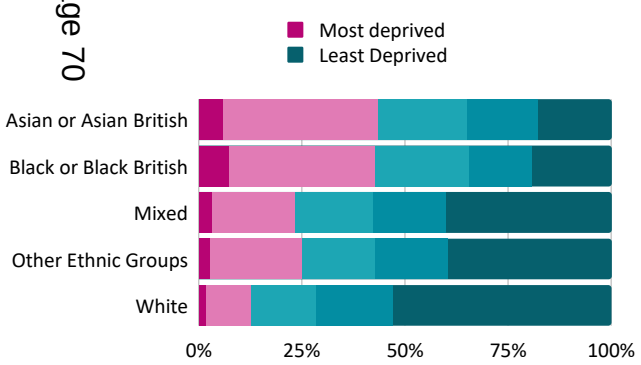
NHS Berkshire Healthcare NHS Foundation Trust

NHS Frimley Health NHS Foundation Trust

NHS Frimley Integrated Care Board

Frimley Population Insights: Wider Determinants of Health

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

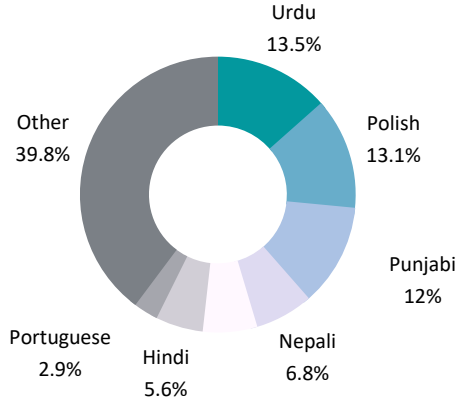


33.1% of BAME residents live in deprivation deciles 1-4, compared to 12.6% for White residents. Some key communities with known health inequalities are much more likely to live in deprived areas. For example, the Gypsy Roma Traveller community are almost seven times more likely to live in the most deprived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

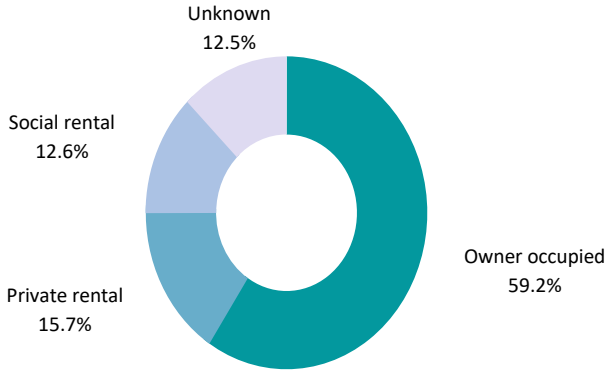
There are 122 different spoken languages in our population

98,000 residents in our ICS do not have English as their main spoken language, the most common are Urdu, Polish and Punjabi.

Language barriers can impact a person's ability to access and navigate health and care services



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



10.6% of the population are smokers

5.8% of the population have a BMI over 35

7.5% medium to high alcohol consumption

56k residents are at risk of fuel poverty

These patients are living in deprived areas and poorly insulated homes

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

In areas of deprivation, we see a higher prevalence of smoking and obesity (but lower alcohol consumption). Non-white ethnicities tend to have lower alcohol consumptions and are less likely to smoke (or have COPD). Smoking and alcohol rates are based on what is reported in GP records.

Frimley Health and Care

Service Transformation Priorities for our Population

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

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

Introduction

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

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

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

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

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

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

Core20 PLUS 5

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

Core20 PLUS 5 – Harnessing the National Methodology for Local Improvement

Background

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

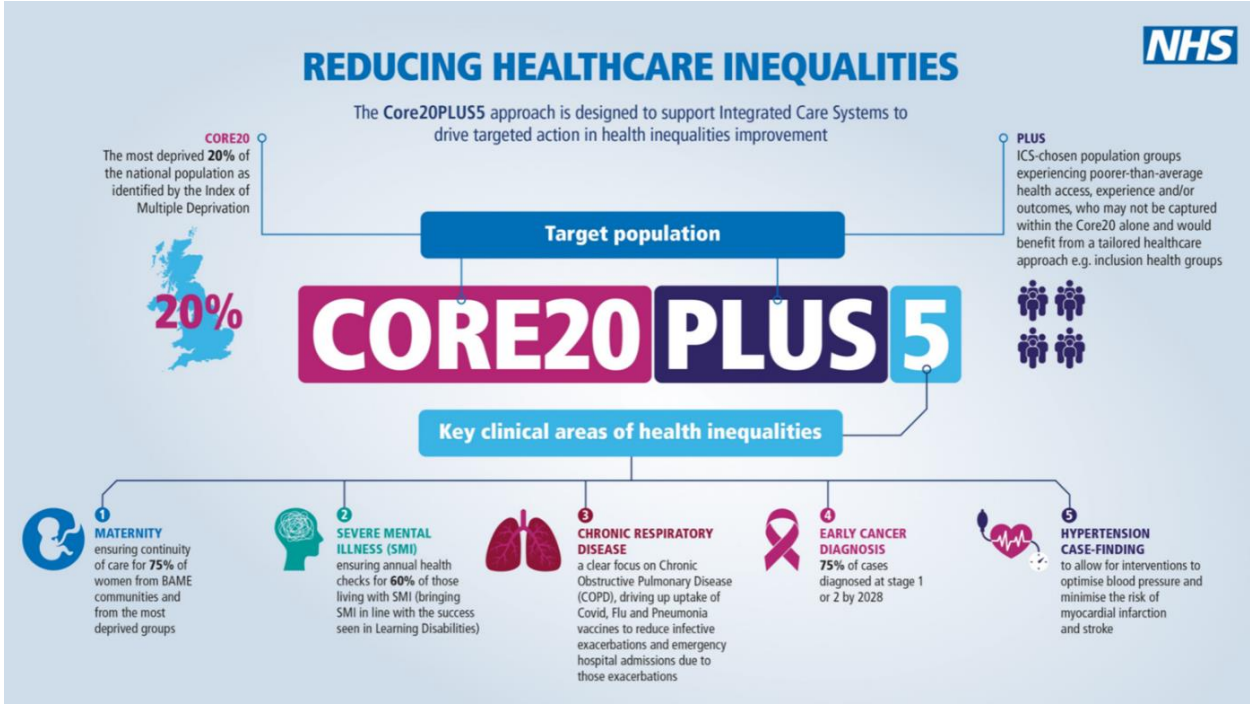
The approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement. The Core20 target population is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

Navigating this document using the Core 20 PLUS 5 approach

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

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

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



Using a data driven approach to reducing health inequalities

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

1. Children and Young People – Strategic Context

Introduction

The development of this new ICS Children and Young People (CYP) portfolio transformation plan marks a call to action. As the ICS looks forward, we are raising the importance of our work to improve the health and wellbeing of children and young people.

There is a clear case for greater and faster transformation of CYP care and services:

- A quarter of our population are CYP
- We know that there is variation in the care of CYP and their outcomes that we must tackle. This includes the health of children in care and care leavers.
- The pandemic has widened existing health inequalities and worsened the health of our CYP, particularly their mental health
- The cost-of-living crisis will affect low-income households more, predicted to bring half a million for children into absolute poverty this year, and this is set to worsen in coming years
- The health and care services that we provide to CYP are struggling to meet demand

Our call to action comes with optimism about what we can collectively achieve. It has been shaped and developed by the key players and stakeholders who will be instrumental in delivering it. They are committed to ensuring this plan succeeds and transforms the lives of CYP across Frimley. The ICS has invested in a small team of experts to help lead its delivery, in partnership with our 5 Places and providers.

1. Children and Young People – Key Challenges

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

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

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

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

Approximately 15% of pupils have a special educational need.

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

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

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

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

Sexual health

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

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

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

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

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

1. Children and Young People – Our Five Year Priorities

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

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

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

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

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

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

2. Neurodiversity – Strategic Context

Our Vision

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

Our Pledge

We will co-produce with experts by experience

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

We will improve knowledge and awareness about neurodivergence

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

Our Partnerships

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

2. Neurodiversity - Our Transformation Projects (1)

LDA Champion

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

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

CAMHS LD Service in East Berkshire

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

Pre- and Post Diagnostic Service for Autistic Adults

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

Autism Diagnostic Pathway for Adults

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

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

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

2. Neurodiversity - Our Transformation Projects (2)

Keyworker Service

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

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

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

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

Inpatient and Community Oversight

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

2. Neurodiversity - Our Five Year Priorities

Roll out the national programme of Oliver McGowan training

Ensure that opportunities to bring neurodiversity to the development of the Provider Collaborative are explored and developed

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

2. Neurodiversity – Our Logic Model Approach to Transformation

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

3. Mental Health Services – Strategic Context

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

We know from the latest data that:

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

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

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

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

3. Mental Health Services – Key Challenges

Inequalities

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

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

Demand and Capacity

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

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

Holistic Care (the whole person)

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

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

3. Mental Health Services – Our Five Year Priorities

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

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

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

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

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

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

Build on strong collaborations and a culture of co-operation
- Fully functioning Provider Collaborative, working across all sectors to add value

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

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

4. Primary Care – Strategic Context

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

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

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

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

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

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

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

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

Enabled through aligned programmes such as:

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

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

4. Primary Care – Key Challenges

Key challenges setting out the current position:

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

4. Primary Care – Our Five Year Priorities

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

4. Primary Care – Our Priorities for 2023/24

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

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

4. Primary Care – Dependencies and Risks to Delivery

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

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

Delegated Responsibility

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

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

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

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

Frimley's View

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

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

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

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

Increase focus and investment on **prevention**.

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

Current Issues

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

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

Dental Services

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

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

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

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

Community Optometry

Elective Care

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

Urgent Care

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

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

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

Community Pharmacy

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

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

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

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

5. Community Health Services – Strategic Context

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

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

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

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

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

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

5. Community Services - Key Challenges

Quality and access

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

Demand versus capacity

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

Health inequalities

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

Finance

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

Workforce

- Recruitment and retention

Integrated working

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

Community estate

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

5. Community Services – Our Five Year Priorities

Digital transformation

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

Developing community capacity

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

Transformation of services

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

Estate

- Prioritisation of estate across community and primary care

Workforce

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

Health inequalities

- Equity of service provision and reduction of variation

Improving local access to the right expertise and care

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

5. Community Services – Our Priorities for 2023/24

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

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

Dependencies

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

Enablers

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

Risks

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

* can be a risk and enabler

This page is intentionally left blank

Supporting Communities – A strategy to tackle deprivation and inequalities across Rushmoor

Executive Summary

Rushmoor is a generally affluent area and for most people it is a happy, healthy and safe place to live. However, despite its overall affluence, there are pockets of deprivation and some residents who do not have the same opportunities, hope or aspirations that others may have.

The unprecedented socio-economic crisis created by Covid-19, together with the more recent cost of living challenges and energy bills rising to unprecedented levels, have been extremely difficult for households, communities, and businesses across the borough. While the cost of living has impacted most households, the impact is greatest on those already living below the poverty line, and those on low incomes.

The Council recognises that there are factors that affect deprivation and poverty that we cannot directly control but we know that strong, resilient communities can help to reduce inequalities, increase social connections and improve the well-being of our communities. At a borough level we continue to respond and support people, working collectively to build longer-term resilience.

Supporting stronger communities is about collaborating with partners to tackle the inequalities and focus our collective efforts on the most deprived families and communities in the borough.

1. Introduction

1.1 This report sets out the approach to Rushmoor's ongoing commitment to tackle inequality and deprivation. It provides an overview of the priorities and proposed action seeking to address local challenges in order to build stronger, resilient communities.

1.2 Strong communities are those where people have pride in where they live, where they are confident, resilient and able to respond positively to the challenges that they face. There is a need to strengthen communities in order to improve health and wellbeing and address the disadvantage that impacts on the long- term life chances for residents in our deprived communities.

1.3 Whilst no single action or even a series of actions will eradicate deprivation and poverty, the Council recognises it's role, to work with others, towards tackling the issues and addressing peoples' needs where we can.

1.4 The Strategy focuses on the improvements the Council and our Partners are prioritising in the next three years. It supports the Council Plan and the longer-term delivery of 'Your Future, Your Place' – a Vision for Aldershot and Farnborough 2030 which puts strong communities at its core with a strong emphasis on people and place.

1.5 Overall Objective:

***To work with partners, to tackle the effects of poverty and deprivation, and to have a positive impact on people's daily lives*.**

1.6 Priority Themes

The priority themes have been informed by partner organisations, data sources, and the aspirations and ambitions of our communities:

Economic Hardship

- To support people back into employment, raising skills and confidence

Young People

- To raise aspirations - increase access to businesses and role models
- To improve the participation of young people in education and employment through training

Physical and Mental Health

- To support physical and mental health and wellbeing provision

To support the objective of Public Health England to increase life expectancy at birth by two years and reduce the gap in healthy life expectancy between the least and most deprived communities by three years

Connecting Communities

- To increase levels of community engagement and specifically engage Black and Minority Ethnic (BAME) communities
- To reduce social isolation and loneliness
- To support digital enablement

Cost Of Living

- To support local residents with the cost-of-living challenges

2. Background

2.1 The Council has worked with partners, over many years, to address the issue of deprivation in the Borough. The focus of the work has included:

- Neighbourhood Renewal Plans
- Rushmoor Strategic Partnership – priority to tackle deprivation in Mayfield, North Town and Heron Wood wards
- My North Town – to assist North Town regeneration
- Prospect Estate Big Local (PEBL) – targeted to Cherrywood ward
- Skills and Employment programme, Skilled up, Rushmoor Employment & Skills Zone (RESZ)
- Mental health support in schools
- Physical activity in schools to tackle obesity
- Cohesion strategy and action plan
- Local coordination of national Troubled Families programme

2.2 Historically, the Council has delivered some successful initiatives to tackle the pockets of entrenched deprivation and this has primarily focused on Cherrywood. Despite this good work, it is acknowledged that it has not significantly altered deprivation levels in terms of the Indices of Multiple Deprivation (IMD) data and we must recognise that, due to how the IMD is measured, it is unlikely to do so in the near future.

2.3 Addressing significant deprivation is difficult and long term. For many communities that have experienced deprivation for some time, the causes are complex and multi- faceted and making real progress remains extremely difficult.

2. 4 Indices of Multiple Deprivation (IMD) Data

The Indices of Multiple Deprivation identifies that Rushmoor has three small areas of deprivation, in the 20% most deprived wards in England for multiple deprivation. They are:

Part of Cherrywood ward

Part of Aldershot Park ward

Part of Wellington ward

2.5 In addition to these locations, the data highlights key 'functional areas' where relatively speaking, Rushmoor does not generally perform well. This is also supported by other data from sources including Frimley ICS Shared Care Records, Public Health England, Acorn – Well-being Segmentation, Hampshire County Council's Rushmoor Covid-19 District Report and Active Lives Survey May 2018/19.

2.6 Functional areas

There are significant deprivation levels across the Borough for: Income, Health inequalities - especially mental health, self-harm, obesity and for Education, skills and training.

- **Income**: In Rushmoor, 11.2% of children live in low-income families. Wellington & Aldershot Park have high rates of income deprivation affecting older people.

- **Health** - Poor health in general compared to many other boroughs in Hampshire, with particular high levels of mental health issues and depression, falls in older people and injuries resulting from self-harm.

  Rushmoor has one of the highest levels of adult inactivity in Hampshire across its population (Active Lives Survey May 2018/19) and this is worsening. 71% of adults are categorised as overweight and we have above average levels of obesity in young people in Years R and 6.

- **Education, Unemployment & Skills** – Rushmoor has high levels of unemployment – particularly for those between 18-24 years of age. These levels have been further damaged by Covid-19. Compared to Hampshire and the South East, Rushmoor has a higher percentage of residents with no qualifications.

  Many of Rushmoor's primary schools are well below average for reading and writing levels and from our secondary schools three out of the four are below the Hampshire average.

3. Context

3.1 Partnership, collaboration and co-operation are the essential building blocks for tackling the inequalities and deprivation we know exist in the Borough. The commitment to tackling inequalities and deprivation and supporting stronger communities, is shared by partners and reflected in some of our mutual priorities and objectives.

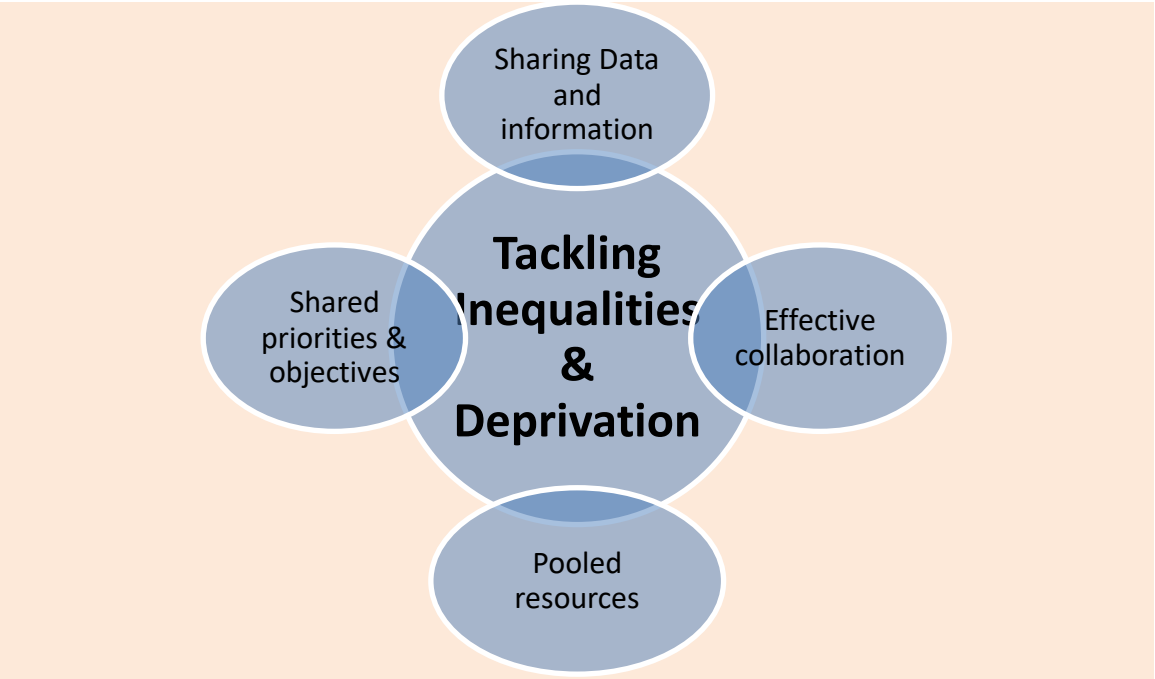
3. 2 We recognise that by having more honest conversations, understanding one another's priorities better and sharing data and resources, where possible, we can achieve more (Fig. 1).

3.3 The approach taken in preparing the strategy and action plan has taken account of:

- Indices of Multiple Deprivation - the official measure of relative deprivation in local communities across England
- Data, evidence and local insight and intelligence from partner organisations
- Partner workshops to identify joint priorities and future joint working
- The priorities in the Council Business Plan and specifically Strong communities – proud of our area
- The views of Members, local organisations and some community leaders, who have suggested a range of possible initiatives and opportunities.
- The views of RBC Service Managers
- Impacts of Covid-19 and the results from the Council's Covid-19 Survey of residents
- Healthier Communities Partnership Committee
- The uncertainty regarding re-opening of Council-funded leisure centres

3. 4 The document reflects the strong view of partners that local targeted action is the best approach to making a difference to people. It is supported by an action plan which details where effort will be focussed in the next two/three years ahead.

Fig. 1:



4. Covid-19 Impact

4.1 Covid-19 has highlighted, and in many cases exacerbated, existing inequalities across the Borough. Whilst much of the early commentary gave the impression that Covid-19 had no boundaries and was indiscriminate in who it affected, it has become increasingly clear that the impacts of the disease fall disproportionately on our most deprived communities and put a spotlight on the long-standing, entrenched health inequalities in the Borough.

4.2 Throughout the coronavirus pandemic the Council, alongside many partners, has worked hard to ensure that those most impacted by the crisis are able to access the support that they need, whether that be emergency food or medicine supplies, accommodation for rough sleepers, or digital support to enable people to stay connected.

4.3 A Community and Recovery Plan has addressed the immediate and urgent welfare response to supporting communities in the short term. This includes a particular focus on food and emergency provisions, but also engaging and understanding the impact on local communities better.

4.4 The plan includes an objective to facilitate the physical, mental and financial recovery of communities via the provision of appropriate, sustainable and community-based food initiatives. This includes developing longer term community led food provision such as community larders.

4.5 Some of the projects identified in this plan will complement the Community and Recovery Plan or, in some cases, continue the work that has been developed in response to Covid-19 to support stronger communities.

5. The Action Plan

5.1 The Action Plan has been developed with partners over the last nine months. It is a “live” document to acknowledge the rapidly changing situation and to ensure it is adaptable to changing needs.

5.2 It is based on the following:

- Place based – developing projects for specific locations based on need
- Function based – for example mental health or aspiration projects developed across the borough
- Empowering communities and enabling community led initiatives
- Working together to achieve more with our available resources

5.3 The plan will be updated annually in the same way that the Council Business Plan is refreshed so that priorities are reflective of local issues and partner priorities.

5.4 The partner working group will monitor and evaluate the delivery of the action plan.

6. Targeted approach

6.1 It is crucial that we target our approach to the areas of greatest need, where we can engage the local community and make the biggest difference to residents with our limited resources.

6.2 Based on data, existing partnerships and priorities the action plan will initially focus on the following areas:

- Cherrywood ward – via PEBL-related projects expanding into other areas of the ward
- Aldershot Park ward – focus on health projects
- Wellington ward/Aldershot Town Centre – focus on income and debt, recognising the importance of supporting communities in the wider regeneration context
- Tower Hill – focus on health and disability related projects
- Borough wide – Income, employment, education and skills projects

6.3 Whilst there will be a particular emphasis on targeted projects in these areas it is not at the exclusion of others. There remains a significant amount of work being delivered through Borough wide programmes and as part of the annual refresh the needs and issues within other wards will be considered for future initiatives.

7. The Role of the Council

7.1 Deprived communities experience poorer mental health, higher rates of smoking and greater levels of obesity than the more affluent. They spend more years in ill health and have lower life expectancy. Reducing health inequalities is an economic and social challenge as well as a moral one.

7.2 The Council recognises it has a moral and legal duty to challenge barriers and promote equality of opportunity for all our residents and that is why it has developed a renewed approach to supporting stronger communities in conjunction with our partners.

7.3 In recognition of the intrinsic link between health and deprivation the Council is in the process of developing a joint post with the CCG to oversee the delivery of the physical and health priorities and reduce health inequalities.

7.4 The Council recognises that it needs to remove barriers to opportunity and close existing equality gaps. To support this, the Council will commit to review its existing Equality Plan by focusing on the following proposals:

As one of the borough's major employers: The Council should lead by example and is committed to cultivating a workplace where diverse backgrounds and perspectives are valued. The Council's People's Strategy will promote engagement in order to encourage a wider diversity in its employment profile.

As a Community Leader: The Council will challenge inequalities in every community. Council Ward Members actively lead the work in their wards, engaging with local communities and groups to identify opportunities.

Increased community engagement: Rushmoor is a diverse borough; a home to many different communities, interests and perspectives. An equal Borough must ensure that all voices are heard and represented, by taking active steps to engage, listen and learn, especially from those who have traditionally struggled to be heard.

7.5 The Council will explore different models for engaging with communities and learn from the success the Council had when engaging on the response to Covid-19 and issues around tackling climate change.

Appendix One

Supporting Communities Action Plan

Summary of Projects to be delivered/continued by the Council and/or Partners in 2023

Physical & Mental Health			
Objective /Project Outline		**Partners**	**Timescales**
Talk Mental	Continue to support delivery and development of Talk Mental. Identify local premises for drop-in sessions and provide connections to mental health partners to support targeted workshops for attendees.	Talk mental RVS	On going
Health inequalities	Primary Care Trust led project focused on local health needs.	RBC NHS NEHF Place team	On going
Whole system approach to obesity	Support the reduction of obesity levels in Rushmoor – including supporting healthy weight in children focus group and work with schools, Gloji – Weight management programme for adults	Public Health-HCC NHS Voluntary Sector RBC HCC	On going Move more programme launching in Sept 2023

Increasing Physical Activity	Increase physical activity levels. Including: Increasing physical activity in schools Increase use of green space Empower communities by encouraging them to take an active approach in their health and wellbeing Deliver Healthy Walks programmes	Schools RVS RBC Potters	On going
Increasing Physical Activity	Seek to establish a sports kit 'bank' to support families in reducing costs of clothing, footwear and sports equipment.	Schools RBC	TBC
Cycling & Walking	Increase awareness of safe cycling routes for residents to ride their bikes for pleasure and walking routes including heritage trails. Support Balance, Glide and Ride Access funding for a walks co-ordinator post	RBC HCC	April – July Cycling programme delivered Funding secured - Post being advertised
Green spaces	Improvement to green spaces – (SPF projects)		
Ward grants supporting physical & mental health	• MCP 'Stitch it, don't ditch it' classes • Memorial bench • Family therapy • Social outing for older people's group • Special education needs training • TBC Cosy Hub • Military Christmas Fair • Early Years outdoor provision improvements	RBC Grants	October – July 2023

Economic Hardship			
Objective/Project Outline		**Partner**	**Timescales**
The Grub Hub	• Develop the project board more formally to increase skill and number. • Continue to develop connections to partners who can add value to CGH visitors. • Continue to deliver food support and community wardrobe • Maintain and secure delivery of the CGH longer-term, with particular focus on new venue and potential project development this might enable.	GH RBC CA Voluntary Sector	On going
Connect for Communities	To provide support to most vulnerable families with food, energy and water bills, food vouchers and holiday playschemes.	Funding secured	On going
Cost of Living Crisis (CA)	Research project on the cost of living crisis - understanding the impact on local residents Outcomes shared	CA	Concluded and shared Feb 2023
Cost Of Living – Winter Campaign 2022 and 2023	Get Ready for Winter Campaign/Support - Work with partners to be as prepared for increasing winter pressures as possible and provide information to people.	CA, RVS Mental Health charities, Schools, health partners, the Vine RBC	On going

	Focus on signposting residents to the range of existing resources around welfare, housing, finances and wellbeing including: • identifying and promoting a network of welcoming spaces/venues where people can access warmth but also get a social connection and interaction. • Use social media/arena to promote support and advice available • Projects to align with the work/findings of the Council Tax Support group.		
Ward grants supporting economic hardship	• TVC Cosy Hub • Family therapy		October – July 23
Connecting Communities			
Objective/Project Outline		**Partner**	**Timescale**
Rushmoor Community website	Creation of a community website to access all community/partner events and activities for use by professionals and community.	RBC, RVS	September 2023
Rushmoor Repair Café Funded by the Armed	Repair café opened 17th December 2022 at the West End Centre. This is a volunteer led project with CIO status. First session proved very popular. 2023 will see the continued development of the cafe	RBC, RVS, Aldershot Town Football Club and Stoll Housing	Opened Dec 2022

Forces Covenant Fund Trust.			
Integration Ukraine support	To ensure appropriate support is proved to asylum seekers. Continued involvement with HCC's Family Support Service to support Ukrainians and their host families.	Finefair Voluntary sector HCC	On going
Gardening Clubs	Develop local gardening clubs to encourage social interaction and physical activity	RVS	On going
PEBL wellbeing day	Develop PEBL wellbeing day - linking in with health partners/PCN's	PEBL, GP surgeries	March 23
Ward grants supporting connecting communities	• MCP 'Stitch it, don't ditch it' classes • Family therapy • 'Disability confident' job fair • TVC Cosy Hub • Military Christmas Fair		October – July 23
Young People			
Objective/Project Outline		**Partners**	**Timescale**
Engagement	• Continue engaging with Young People through Rushmoor Youth Influence • Creation of the Youth Charter	RBC, Schols and Colleges	On going

	• Develop Youth Forum with youth partners		
Ward grants supporting young people	• ‘Disability confident’ job fair • Social outing for older people’s group • TVC Cosy Hub • Military Christmas Fair	Range of Local partners	Oct – July 23
HAF	Delivery of Free, fun and educational activity sessions for vulnerable children and young people, including those eligible for free school meals.	Local providers DfE	Summer 2023
Youth Club	Providing local provision and activities for young people in Farnborough	RBC	September 23
Youth Café	Deliver Youth Café project with local partners – providing a place for young people to meet and take part in tailored activities. One purpose of the project is to reduce anti-social behaviour	West End Centre, Wellesley, RBC, The Source. Police	Autumn 2023 (Pending funding decision)

Supporting Communities Action Plan –

Summary of Projects and Achievements 2021/22

Physical and Mental Health	
Project	Achievement
Talk Mental Walk and talk mental health group for men	Support to establish and expand a resident-led project delivering mental health support to men.
Delivery of local Health Checks	Council and partners working with PCNs to establish initiatives to provide health checks for local residents, particularly with those at risk or showing the symptoms of hypertension. PEBL wellbeing day – 150 health checks completed with 18 health checks of which were Prospect Estate residents Garrison health fairs – RBC supported alongside health partners Know Your Numbers Week – Health checks by partners across Aldershot venues.
Be Healthy Be You Weight & Activity Programme	6-month programme supporting people, some who have health conditions, to manage their weight, become more confident in themselves and be more motivated to participate in activity. Group and one-to-one support offered.
ORCA Befriending	Befriending Co-ordinator and volunteers recruited at RVS, incorporating buddy support.

Healthy Walks Funded by HCC Get Going Again Grant	Practitioner wellness walks for 3 months. The free weekly walks for local people aimed to increase physical activity, focus on well-being and reduce social isolation. The group became friends and continue to be in touch/walk since the official walks ended. A comprehensive list of local walks has been collated and shared with local PCN's/social prescribers for wider use. Including Aldershot and Farnborough Heritage Trails.
Rushmoor Accessibility Action Group	Group created to bring together people with varied abilities and organisations supporting those with differing abilities, to support access to services, identifying and addressing issues locally. Future meetings to look at transport accessibility and polling stations.
Ward grants supporting physical and mental health	• Community gardens/planters • Crafty Culture and the Mandala Project at the West End Centre • Men's Shed in Farnborough • Friends of Queen Elizabeth Park conservation work • Resources hub to help autistic young people • Learn to ride sessions in two schools and a wellbeing ride course for adults • Aldershot Heritage trails • Training and supervision for project addressing addictions of army veterans • Sports equipment • Community defibrillator

Economic Hardship

Project	Achievement
The Community Grub Hub	• Achieved full independence in October 2022. Reaches one year since opening in December. • Current membership stands at 877, made up of roughly 53% households without children and 47% with. Average number of visits per week is 124. • Since opening 58 tonnes of food, household and personal hygiene items have been redistributed. • Community Wardrobe remains popular with approx. 35% of visitors accessing it each week.

	• Funding from the Connect4Communities Community Grant has helped purchase and distribute slow cookers to 107 residents concerned about fuel and food costs. Further funding will support the provision of warmth items heading into winter. • Partnership with CA has developed further with the start of a CA Advisor on-site fortnightly, funded by an Aviva crowdfunding campaign. Partnership working between the CGH and CA continues to ensure fuel support grants are widely distributed. • Further partnerships developing/on-going – Aldershot Social Prescribers, Fleet & Aldershot Lions (IT support) and Energise Me/Public Health colleagues.
RBC Virtual Job Club	Virtual Job club was established to offer support during lockdown and supported 61 residents with 80% moving into known work or training courses. In September 2021 it was agreed to end the service, with physical job clubs now reopened and offering a hybrid service it was felt it no longer represented value money.
Ward grants supporting economic hardship	• Community larder • Christmas hampers for families with children and perishables for Vine Dining Covid meals
Connecting Communities	
Project	Achievement
Keep Well & Stay Connected Delivered by RVS and funded NHS/Captain Tom money	Digital Inclusion Project for older vulnerable people. 32 people digitally connected through the programme – accessing local groups and information via their TV sets. Project helped to connect individuals socially, improve physical and mental health and provided bespoke health related support.
Integration	Working with agencies to support integration and improving aspirations of minority groups, including asylum seekers. Regular liaison and enabling support with local hotel, contractor and local partners.

Ukraine support	Support for Ukraine - Partnership event with HCC's Family Support Service delivered in December 2022 to inform support in place in 2023. Event to acknowledge hosts' contributions delivered in December 2022 Information on RVS website for guests, hosts and community supporters.
Men's Shed Supported through ward grants	Men's shed established in Farnborough
Nepali Community Champions	Recruit, train and support Nepali champions to identify those experiencing hardship, provide interventions. This project aligned closely with the Reaching People Together Hampshire project.
Ward grants supporting connecting communities	• Memorial benches/trees and seating around the borough • Play equipment for toddler group • Community noticeboard • Community gardens/planters • Men's Shed in Farnborough • Facilities improvements for sports clubs used by other users of the clubs
Repair café	Officially opened in December 2022 – West End Centre. Encouraging people to bring in broken items for repair and not to throw away.
Young People – Aspirations	
Project	Achievement
Climate Change Schools Project	Engaged 70 young people in a schools climate change project involving every school in the borough including Private schools.

North Hampshire Youth Hub	Working with and providing support for young people to improve their employability skills via bespoke Employability resource website. The hub was only able to open once a fortnight due to funding. The young people that engaged found the service helpful, but many were exhibiting mental health and confidence issues that needed addressing before employment could be considered. Surrey Boards mental health team and Richmond fellowship attend to deal with the complex issues Homepage | North Hants Employment Skills Zone (esznorthhants.org.uk)
Supporting Families Programme	Coordination of joined-up support by children and family professionals for vulnerable families. Hart & Rushmoor is the best performing Hampshire district for significant and sustainable progress by families nominated to the programme (evidenced in 65% of families, next best was 54%).
Hart & Rushmoor Local Children's Partnership	Parent support & Back 2 Basics programme roll out / CYPP 2022-25 / Community pantries / Holiday Activities and food programme. 30K of HCC grant support (+30K pending) for partnership plan activities
Kickstart RBC/CA	Supported 20 young people into employment via the Kickstart programme RBC committed to two rounds of kickstart with placements in: 1 x Economy 4 x Maintenance 1 x Community 1 x Licencing Out of the 7 – 1 staying in the Maintenance team till the new year, and 4 moved straight into employment.
Shine project	Delivered a range of targeted projects supporting young people: including Barista Training, cooking courses, media workshops and arts and social projects

Delivered by the Vine and funded by National Lottery	
My Space Delivered by the Vine, funded by RBC	Digital support project for Young People. The Project helped young people to identify skills, write CVs, using Universal Job Match, apply for jobs online and practise interview skills. Free access to computer and internet access in a dedicated site IT area and a social space to support young people generally.
Friday Night Youth Club	Providing a safe and welcoming place for young people with access to youth workers who support, engage and supervise weekly (term time only). Work done around bullying as this has been highlighted as an issue at school by many of the young people. Average of 15-20 young people attending each week. Christmas present provided to all young people by BMW.
Rushmoor Youth Influence	Forum created to engage with young people. First forum took place on 16th November. 19 young people attended with the theme of mental health. Presentation and support provided by Fortify and Ahmadiyya Muslim Association. Next session planned for Feb
Schools	60 students from Alderwood visited Gulfstream for an aspirational visit Support provided to Cove and Fernhill careers days 5,629 students across Hampshire attended Pioneers of Tomorrow
Ward grants supporting young people	• Facilities improvements at Scouts/Pre-school/sensory room • Equipment/banners for schools and sports clubs • Learn to ride sessions in two schools • Resources hub to help autistic young people

POLICY AND PROJECT ADVISORY BOARD WORK PLAN

The purpose of the work plan is to plan, manage and co-ordinate the ongoing activity and progress of the Council's Policy and Project Advisory Board, incorporating policy development work carried out through working groups.

(A) CURRENT WORKING GROUPS APPOINTED BY THE POLICY AND PROJECT ADVISORY BOARD

GROUP	MEMBERSHIP 2023/24	CURRENT POSITION	CONTACT
Elections Group	Policy and Project Advisory Board Vice-Chairman (Cllr Jess Auton), Portfolio Holder responsible for Elections Matters (Cllr Sue Carter), Corporate Governance, Audit and Standards Committee (Cllr Peter Cullum) and Cllrs Craig Card, Keith Dibble, Calum Stewart and Becky Williams		Andrew Colver Contractor andrew.colver@rushmoor.gov.uk Elections Team 01252 398824 elections@rushmoor.gov.uk
Transformation Task and Finish Group	Policy and Project Advisory Board Chairman (Cllr Marina Munro), Portfolio Holder responsible for transformation (Cllr Jonathan Canty), and Cllrs Ade Adeola, Abe Allen, Jules Crossley, Peace Essien-Igodifo and Thomas Mitchell		Karen Edwards Executive Director Tel: (01252) 398800 karen.edwards@rushmoor.gov.uk

(B) OTHER ISSUES/MATTERS FOR THE WORK PROGRAMME

ISSUE	DETAILS	CONTACT DETAILS
PLACE		
PEOPLE		

	OTHER MATTERS	

POLICY AND PROJECTS ADVISORY BOARD

AGENDA PLANNING – 2023-2024

27th June 2023	• Regeneration – Community Engagement and Structure
25th July 2023	• Hampshire Health and Wellbeing Strategy - Mental Health Concordat
26th September 2023	• *Anti-Social Behaviour Policy*
29th November 2023	• *Communications Strategy*
24th January 2024	• *Council Plan*
21st March 2024	• *Procurement Strategy* • *Climate Change Action Plan*
Potential items to be considered for 2023/24	• County Deal

PROGRESS GROUP MEETINGS

Membership: Cllrs Marina Munro (Chair), Jess Auton (Vice-Chair) and Michael Hope, Thomas Mitchell, Mike Roberts, Calum Stewart and Gareth Williams

28th March 2023 Annual Review	Data Hub	File in Members SharePoint to be set up with data set information – *Completed and to be shared with new Members once appointed*
	UKSPF	Consider a sub-group in new MY to scope projects
	Items going forward	RB/AT to meet and pull together a list of all items for consideration for new MY – *list compiled awaiting feedback*
5th July 2023	Farnborough Town Centre Regeneration - Workshop	Need for a Masterplan Strategy for Farnborough.
	Mental Health Concordat	Proposal for 25 July: - How HCC's Public Health Strategy links with the concordat - What the ICS is doing that links with the concordat - How the Supporting Communities Strategy work links with the concordat - How the concordat applies to the Council and how it can be taken forward - Finance, resource implications and partnership working
	Potential future items	Climate Change Action Plan Artificial Intelligence/Cyber Security Policy Farnborough Town Centre Masterplan Aldershot Town Centre Strategy *Armed Forces/Veteran Engagement - OSC*

	HCC Budget Consultation	Deadline - 23rd July Feedback from PPAB – 14th July Special Hybrid meeting week commencing 17th July with PPAB (possible 19th July)
	Transformation T&F Group – Terms of Reference	Agreed
5th September 2023		
1st November 2023		
4th January 2024		
28th February 2024		

This page is intentionally left blank