Frimley Health and Care

Frimley ICS - NHS Joint Forward Plan

2023/24 – 2027/28

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

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

In June 2023

Frimley Health and Care

Introduction

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About this Document and Relationship to Other System Strategies and Plans

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

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

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

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

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

Introduction from Our Organisations to this Joint Forward Plan

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

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

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

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

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

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

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

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

Graham Wareham
Chief Executive
Surrey and Borders Partnership
NHS Foundation Trust

Julian Emms
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Berkshire Healthcare
NHS Foundation Trust

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Frimley Health
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Dr Huw Thomas and
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Board Partner Members

Fiona Edwards
Chief Executive
NHS Frimley
Integrated Care Board

Creating Healthier Communities – Our 2023 ICS Strategy

The Frimley ICS Strategy

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

Our Integrated Care Partnership

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

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

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

Frimley Health and Care

Our Population

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About the Frimley Health and Care System

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

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

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

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

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

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

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

Frimley Population Insights: Deprivation, Ethnicity and Disease Prevalence

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

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

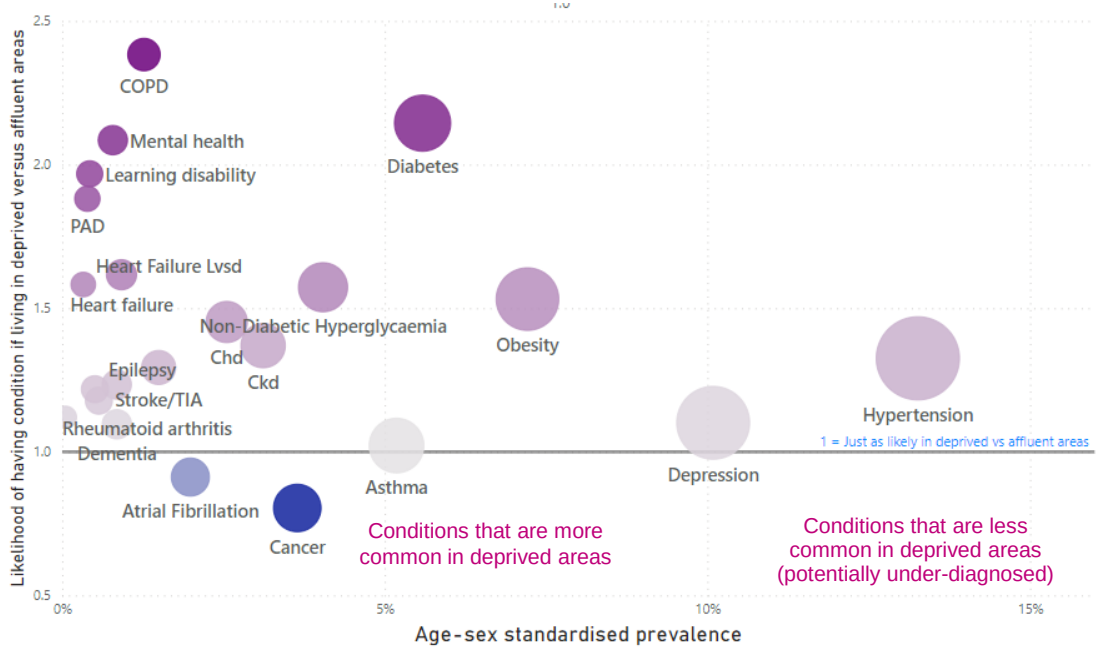
When looking at ethnicity data we notice the following:

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

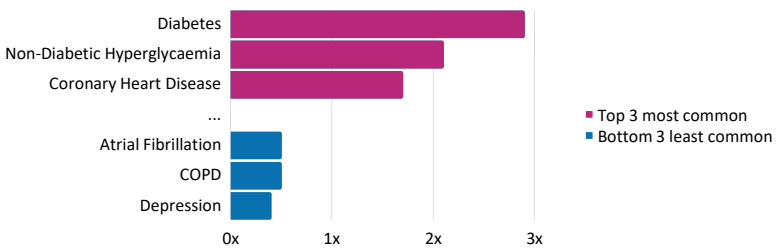
Slough, compared to other parts of the system, has a younger population, a higher percentage of BAME residents, more densely populated and multigenerational households, and is more deprived.

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

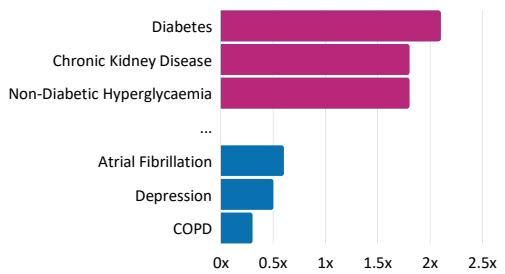
An increased prevalence of chronic diseases can lead to health inequalities, as well as increasing the risk of experiencing a disproportionate negative impact from community transmitted conditions, such as Covid-19.



Asian or Asian British compared to White population



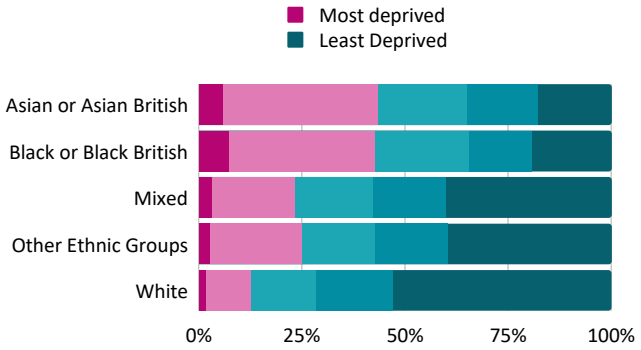
Black or Black British compared to White population



Frimley Population Insights: Wider Determinants of Health

CONNECTED CARE

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

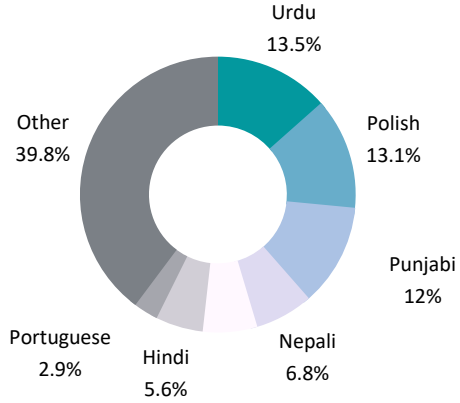


33.1% of BAME residents live in deprivation deciles 1-4, compared to 12.6% for White residents. Some key communities with known health inequalities are much more likely to live in deprived areas. For example, the Gypsy Roma Traveller community are almost seven times more likely to live in the most deprived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

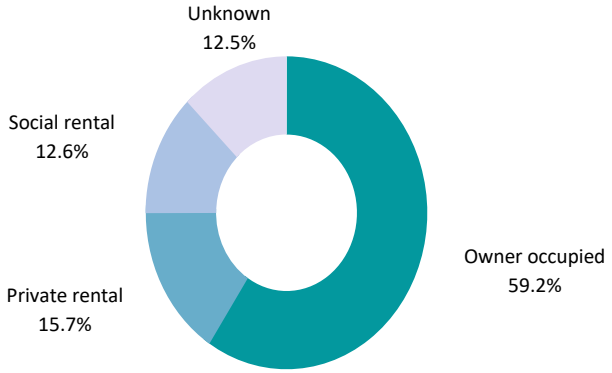
There are 122 different spoken languages in our population

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

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



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



10.6% of the population are smokers

5.8% of the population have a BMI over 35

7.5% medium to high alcohol consumption

56k residents are at risk of fuel poverty

These patients are living in deprived areas and poorly insulated homes

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

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

Frimley Health and Care

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

Frimley Health and Care

Service Transformation Priorities for our Population

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

Introduction

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

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

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

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

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

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

Core20 PLUS 5

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

Core20 PLUS 5 – Harnessing the National Methodology for Local Improvement

Background

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

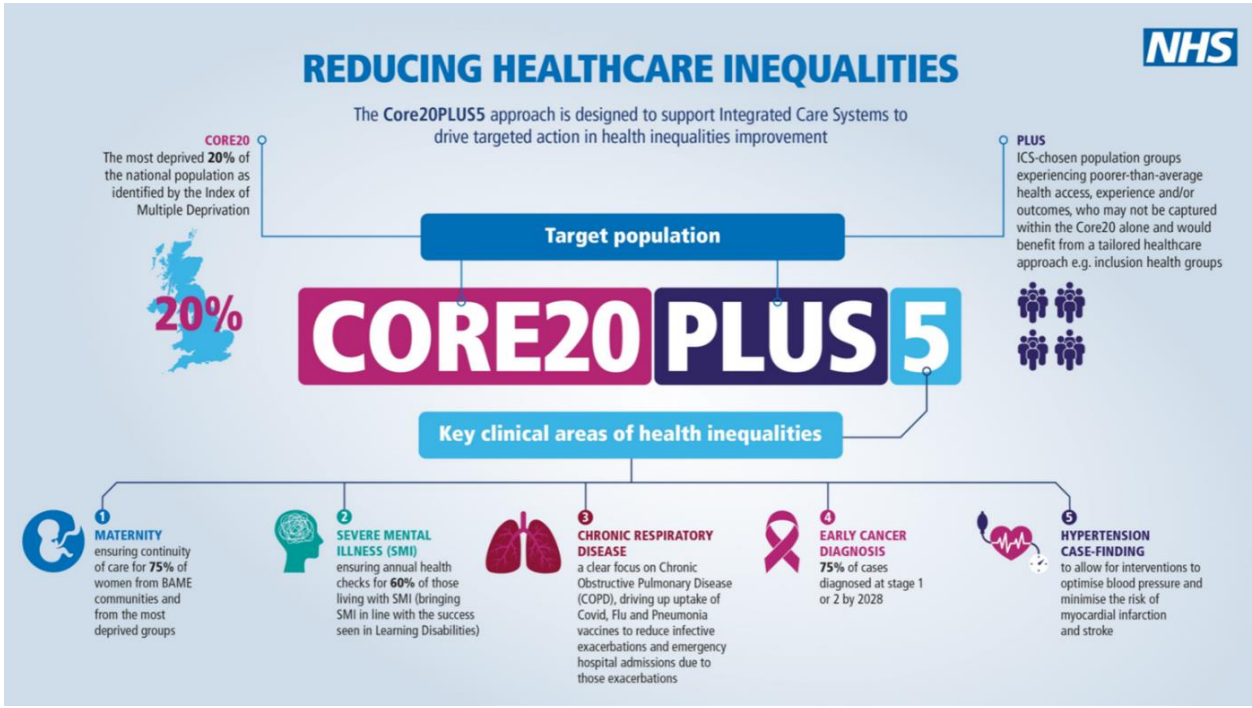
The approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement. The Core20 target population is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

Navigating this document using the Core 20 PLUS 5 approach

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

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

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



Using a data driven approach to reducing health inequalities

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

1. Children and Young People – Strategic Context

Introduction

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

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

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

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

1. Children and Young People – Key Challenges

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

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

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

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

Approximately 15% of pupils have a special educational need.

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

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

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

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

Sexual health

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

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

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

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

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

1. Children and Young People – Our Five Year Priorities

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

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

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

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

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

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

2. Neurodiversity – Strategic Context

Our Vision

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

Our Pledge

We will co-produce with experts by experience

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

We will improve knowledge and awareness about neurodivergence

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

Our Partnerships

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

2. Neurodiversity - Our Transformation Projects (1)

LDA Champion

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

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

CAMHS LD Service in East Berkshire

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

Pre- and Post Diagnostic Service for Autistic Adults

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

Autism Diagnostic Pathway for Adults

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

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

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

2. Neurodiversity - Our Transformation Projects (2)

Keyworker Service

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

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

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

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

Inpatient and Community Oversight

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

2. Neurodiversity - Our Five Year Priorities

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

2. Neurodiversity – Our Logic Model Approach to Transformation

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

3. Mental Health Services – Strategic Context

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

We know from the latest data that:

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

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

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

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

3. Mental Health Services – Key Challenges

Inequalities

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

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

Demand and Capacity

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

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

Holistic Care (the whole person)

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

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

3. Mental Health Services – Our Five Year Priorities

Prevention and early intervention

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

Population health based and data driven

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

Improving equality and inclusion

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

Whole person care, including mind and body integration

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

Proactive management of our urgent and emergency response

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

Strengthen our workforce

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

Build on strong collaborations and a culture of co-operation

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

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

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

4. Primary Care – Strategic Context

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

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

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

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

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

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

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

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

Enabled through aligned programmes such as:

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

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

4. Primary Care – Key Challenges

Key challenges setting out the current position:

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

4. Primary Care – Our Five Year Priorities

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

4. Primary Care – Our Priorities for 2023/24

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

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

4. Primary Care – Dependencies and Risks to Delivery

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

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

Delegated Responsibility

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

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

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

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

Frimley's View

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

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

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

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

Increase focus and investment on **prevention**.

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

Current Issues

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

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

Dental Services

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

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

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

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

Community Optometry

Elective Care

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

Urgent Care

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

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

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

Community Pharmacy

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

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

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

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

5. Community Health Services – Strategic Context

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

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

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

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

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

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

5. Community Services - Key Challenges

Quality and access

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

Demand versus capacity

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

Health inequalities

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

Finance

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

Workforce

- Recruitment and retention

Integrated working

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

Community estate

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

5. Community Services – Our Five Year Priorities

Digital transformation

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

Developing community capacity

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

Transformation of services

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

Estate

- Prioritisation of estate across community and primary care

Workforce

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

Health inequalities

- Equity of service provision and reduction of variation

Improving local access to the right expertise and care

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

5. Community Services – Our Priorities for 2023/24

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

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

Dependencies

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

Enablers

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

Risks

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

* can be a risk and enabler