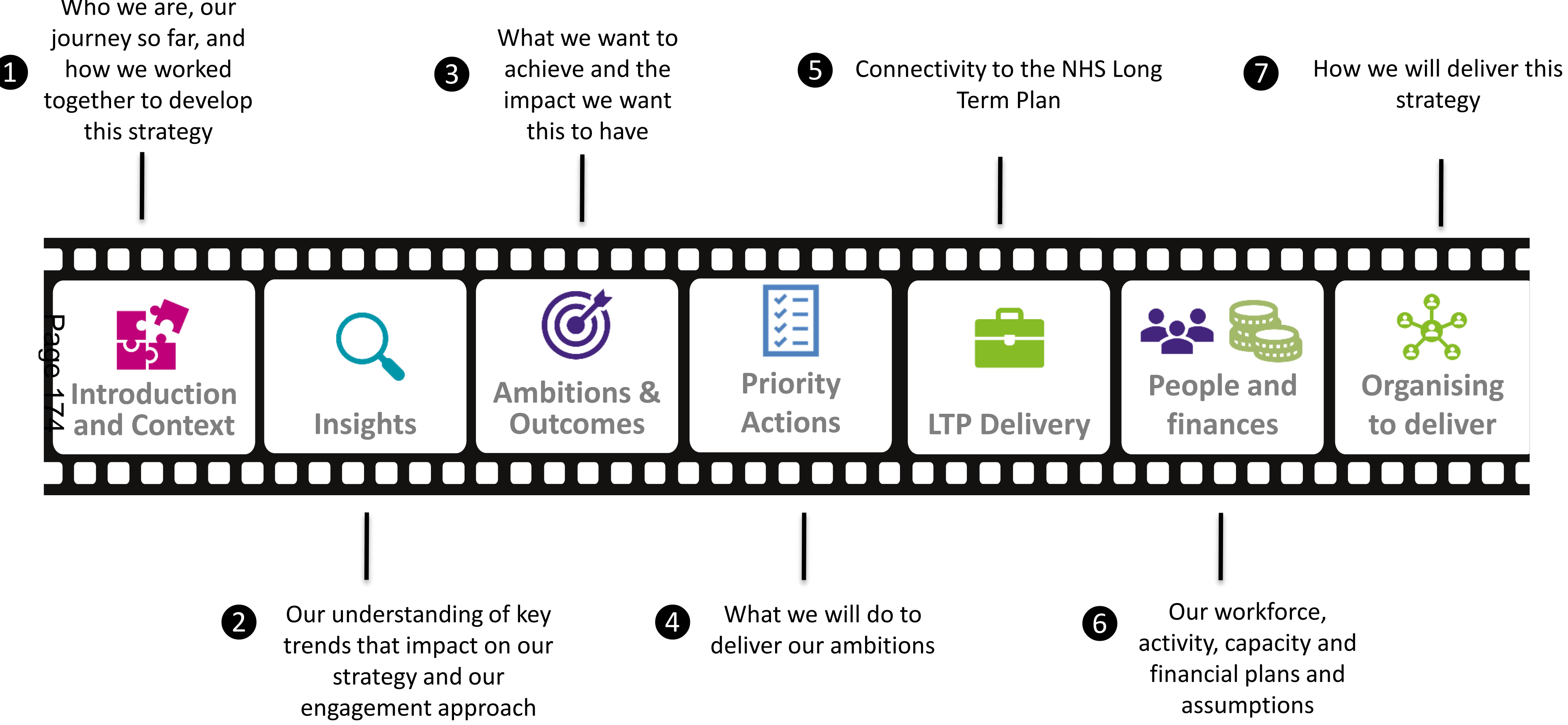
Frimley Health and Care

Creating Healthier Communities

Frimley Health and Care
5 year Strategy

ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • [illegible]DSOR

Contents



Foreword

Frimley Health and Care is an Integrated Care System (ICS) which is a partnership of the local authorities and NHS organisations. We have a shared ambition to work in partnership with local people, communities and staff. Our organisations are are committed in their collective drive to improve the health and wellbeing of every person, in each of our communities.

Put simply, we want every person across Frimley Health and Care to live their lives to their fullest potential.

To effect this degree of change requires a radically different relationship between organisations and local people. It will not, and cannot, be achieved by simply continuing to do what we have always done. It will require us to create new ways of working, to work flexibly, to invest in models of delivery, and to be brave enough to actively target resources to where we can make the biggest difference for local people.

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In return, it will require individual people to take charge of their own health and wellbeing, to make healthier choices and to influence their relatives, neighbours and friends to change their lifestyles.

The ICS is building from a strong base. We have worked hard over the last three years to earn each other's trust, to deliver tangible improvements and to make services more joined up and more efficient.

Our renewed five year strategy responds to our collective constrained resources. While NHS funding is increasing, demand is increasing faster. Local Authority funding is under great pressure and its future is uncertain.

In response our strategy is rightly ambitious and outward facing. Our focus is on "working with", rather than "doing to". We will work with our communities, however large or small, to better understand, develop and build on what's already working. We will invest where where we can make a real difference, whether in mental or physical health, across social and health-related conditions and across different times in people's lives.

We also want to create a deal with our staff that it will be an exciting and stimulating place for them to work. That means continuing to change the cultures so that every member of staff is encouraged and empowered to innovate and to make improvements.

Working together as Frimley Health and Care enables us to think differently. We have an opportunity to be brave, bold and transformational, to make the biggest collective impact for our local people by Creating Healthier Communities.

In 2025, when we have delivered this strategy, healthy life expectancy at birth will have improved by 2 years and the gap in healthy life expectancy between our least and most deprived communities will have reduced by 3 years.

Section 1: Introduction and Context

This section introduces Frimley Health and Care.

It describes the background to our system, the population we serve and the progress that is being made to improve outcomes, service quality and efficiency.

It also summarises how we have worked together to develop this strategy.

Frimley Health and Care Integrated Care System

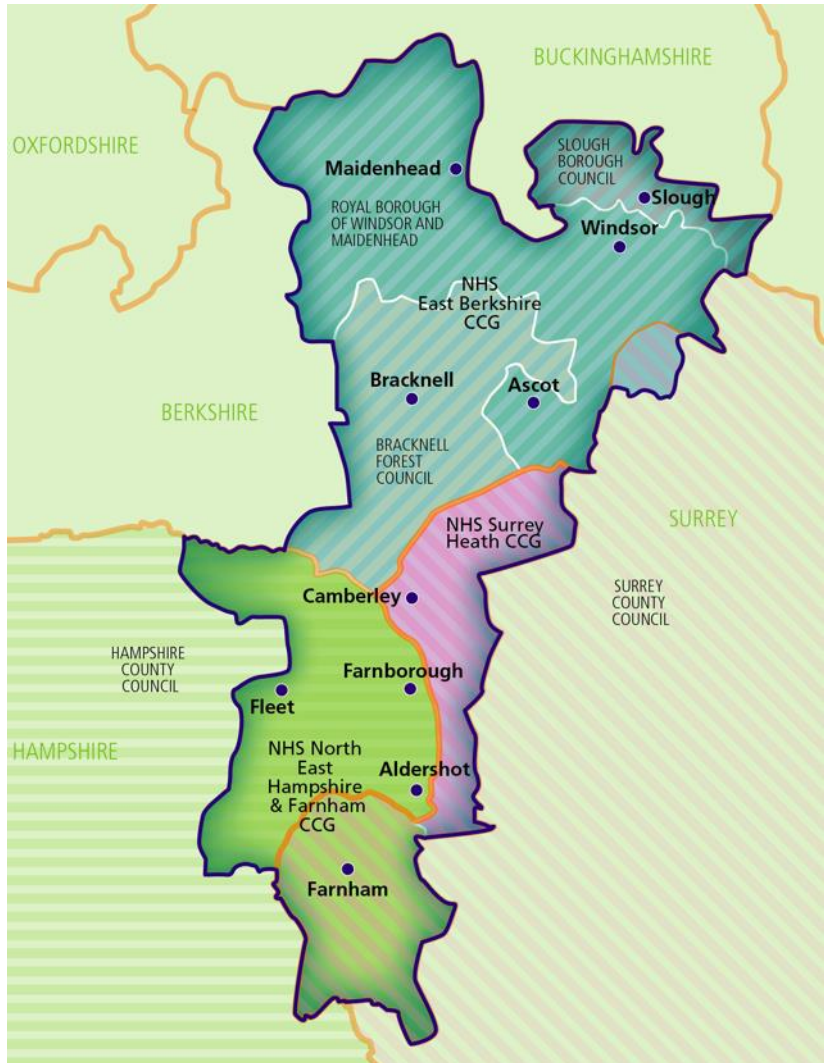
Frimley Health and Care brings together the Local Authorities and NHS organisations with a clear shared ambition to work in partnership with local people, communities and staff to improve the health and wellbeing of individuals, and to use our collective resources more effectively.

The system has a diverse population of around 800,000 people in East Berkshire, North East Hampshire, Farnham and Surrey Heath.

As a result of the first five year plan agreed in 2016, 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.

This new strategy builds on that work and describes the shared ambitions and priorities which will be delivered and which will make the most difference to individual people's health and wellbeing.

Frimley Health and Care



Understanding our population

Our strategy is rooted in the health and care needs of the population.

This page provides an overview of the demographics of the population, and key facts about population needs.

Numbers in (brackets) represent national figures.

Best start in life

Estimated prevalence of mental health disorders in children and young people (5-16 years) 8.3% (9.2%)

72.7% 5 year olds who are free from obvious dental decay (76.7%)

18.4 % Prevalence of obesity among children in Year 6 (10-11 years) (20%)

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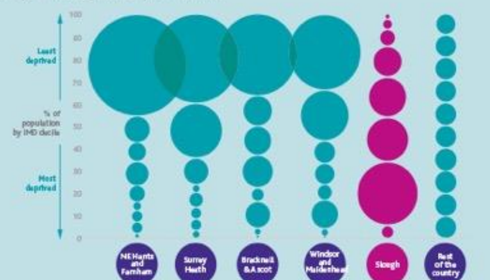
Deprivation

People that live in recognised areas of deprivation will often have poorer outcomes.

Most of our population do not live in an area of deprivation. Over 30% are in the 10% least deprived in society.

All areas contain pockets of deprivation but they can be less visible due to nearby affluence. In Slough there are more people living in deprivation.



Demographics

Population - 800,000

x100K

3% 3% of the population live in the most deprived areas of England, while the region also includes large affluent areas.

Population increase by 2036

6.4%

(about 47,000 people with largest increases in the over 60's and 13-18 age group)

16.8% (13.5%)

There is a diverse ethnic population with large communities of people from Nepal and South East Asia and the traveller community. There is also a strong military presence across the area.

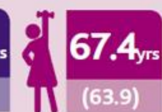
Life expectancy

81yrs (79.5)

84yrs (83.2)

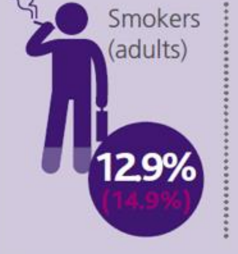
Healthy life expectancy

66.8yrs (63.3)



67.4yrs (63.9)

Adult life style



Smokers (adults) 12.9% (14.9%)

Physically active adults (150 mins of moderate activity each week) 65.5% (66%)

Adults classified as overweight or obese

61.4% (61.3%)

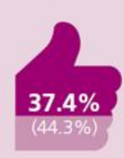
Long term conditions

12.9% (17.6%)

People who report a health problem or disability that limits their day to day activities lasting 12 months or more

78.7% (90.9%) Proportion of eligible population invited for an NHS health check (40-74 years)

Proportion of eligible population having an NHS health check (40-74 years)



37.4% (44.3%)

Partners in the health and care system worked together and with local people to develop the strategy

APRIL 2019

Frame

Partners worked together to achieve collective clarity on what the 5-year strategy is for, what it will do and how it will be developed in an inclusive way

MAY-JUNE 2019

Insight

Understanding what matters to local people and partners, the issues we want to impact and the key trends that drive our strategy

JULY-AUG 2019

Ambition

Developing a shared view and understanding of what we want to achieve and what success looks like for the Frimley Health & Care System

SEPT 2019

Prioritise

Agreeing the shared priorities to deliver our ambitions which are recognised by partners and local people

OCT 2019

Organise

Conclude the strategy, ensuring it is owned, understood and ready for implementation from 2020/21

Section 2: Insights

This section describes the insights which informed the development of our strategy:

- A survey of more than 1500 local residents
- An 'Inspiration Station' to hear the views of people working in our system
- Reviews of what we already know from our engagement with local people
- Analysis of key trends from more than 170 health and wellbeing indicators
- Review of national policy, including the NHS Long Term Plan

Healthwatch supported the Frimley Health and Care system to understand the views of local people

Healthwatch England was awarded funding from NHS England to support Integrated Care System's across the country to carry out local engagement with the public to support the development of our strategy. We worked with our local Healthwatch organisations (Bracknell Forest, Hampshire, Slough, Surrey and Windsor, Ascot and Maidenhead) to develop an engagement plan that included a range of activities including a bespoke survey, focus groups and events.

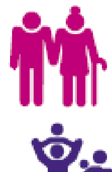
The survey was designed to capture feedback about access to services, wellbeing, self-care and prevention. We received **1510 responses** – one of the highest in the country; 1421 online and 89 (paper and easy read formats).

Who spoke to us?

There was good representation across our five neighbourhoods and a range of respondents of different ages, particularly 25-75+. There was a particularly high response rate from females and people who had no children living in their household. The mix of responses reflect the diversity of ethnicity across our population.

Approximately **20% recognised themselves as unpaid carers, 40% have long term health conditions, 15% considered themselves to have a disability and 65% regularly take prescribed medication.**

20.5% people said they work for an organisation that forms part of the Frimley Health and Care Integrated Care System.



Thank you to everyone who completed and engaged with the survey and our local Healthwatch and Frimley Health and Care ICS partners for their work in the designing and promoting of the survey.

Key themes

Generally people know where to go for information. The majority of respondents (76%), when looking for information for themselves, are very confident/confident. However 13.5% did score themselves as least confident.

When asked 'what stops you and family leading a healthy lifestyle?' people indicated **- lack of time, conflicting advice and information about healthy lifestyles, a lack of interest or motivation, a lack of money and a lack of support from health professionals.**

671 people commented on what would help them to live a healthy life. Themes included more **affordable healthy food, activities and facilities, better access to professionals who can give health, nutrition, wellbeing and lifestyle advice, more time, money and a better work/home balance.**

We asked where people would go to seek advice or information before making the decision to attend A&E – Out of 895, over 650 said NHS111 and a further 280 said NHS online. About 450 said their GP and 300 said pharmacist.

Feedback on experience

The survey asked people to reflect on recent experiences of health and care including what worked well and what could have been better. This generated over 1500 comments. 832 comments were about recent positive experiences of health and care and 764 comments about things that could have been better.

Positive themes emerged around NHS 111 referrals to other services such as out of hours and A&E, telephone consultations, e-consult and other on-line services.

When asked what could have worked better, themes included communication, issues around discharge and waiting times.

We also created an ‘Inspiration Station’ to hear the views of c250 people working in a wide range of roles in the system

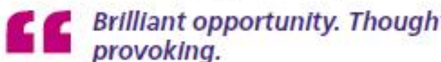
To collectively develop our strategy and ambitions, we developed the Inspiration Station to focus our collective energy, and change the way we work together. Over 250 people from a cross-section of our Integrated Care System organisations came through our ‘Inspiration Station’. This included people from all our partner organisations including public health, CCGs, hospital, Primary care, community and mental health clinicians and professionals, local authority, ICS board and programme leads, education, councillors, local community, voluntary sector colleagues and NHS England and NICE representatives.

The Inspiration Station took people through a series of rooms where we presented intelligence and insight from our system in a way we hadn’t presented before. The insight included information about our population, funding, key areas of work to date and patient and public engagement feedback. This provided a space for teams of people to explore and shape our future ambitions and priorities.

The aim of the sessions was to bring different expertise and experience together to collaboratively discuss what is important for our people locally, where we need to focus our energy and the Frimley £, and how we work together to shape the ‘creating healthier communities’ plan for the next five years.

People really embraced the experience both in the room and with a renewed energy back in their places of work.

We received some great feedback and want to continue co-designing in this way:



Brilliant opportunity. Thought provoking.

Engaging and well laid out – positively stimulating

Innovative and informative

Really enjoyed this and know much more now

Amazing interactive experience – hope you get some really good ideas

Fantastic way of engaging with us – the more involved in this the better

Refreshing – good experience Fantastic facilitation well done

Packs of all of the information shared at the station can be found on our Frimley Health and Care website: www.frimleyhealthandcare. org.uk/ about/our-plans/creating-healthier-communities/

What we heard at the Inspiration Station

Work in a different way

- **A lot of great work has already been done**, but we now need to redirect our energy.
- **Be braver and more transformational**
- **Partnership working and relationships are central to this work** – develop our relationships and ways of working with all partners and local people.
- We want more **integrated people centred opportunities that can make the most impact at an ICS level** not focussed on small projects that are business as usual.
- Confidently understand that we can both **bring people together at an ICS level and build bespoke, tailored community models** that deliver the strategy.

More energy on prevention

- We need to **plan and deliver on things over longer periods** that may not have an immediate or short-term impact.
- **We should be-more proactive**; move our energy to help people stay well and avoid preventable ill heath, than focusing on reactive services when people are ill or require treatment.
- **We need more energy and funding for** on prevention, mental health and broader wellbeing.
- Ensure we engage with our local community to **better understand behaviours and culture that impact on confidence and ability to self-care.**
- **Focus on helping our children start well** through families and education within communities, and build on this through peoples journey of living well and ageing well.

Focus on health and wellbeing

- We need to consider wider **determinants of health** and not just medicines and treatment.
- We want to shift to real **community collaboration** across health, care, education, voluntary services and our local communities.
- Tailor and target in communities to improve healthy life expectancy and health inequalities where we can have the biggest impact.

Co-design what we do

- Activate communities to help us create happier, healthier, sustainable local places.
- Consider family, parents, carers and friends not just individuals to recreate what we do around people and positive outcomes, rather than traditional service models of care and organisational boundaries.
- Engage in different ways.
- Increase personal responsibility for health and wellbeing – developing a way of working with and talking with our community that makes sense and feels real to the the places people live and work.
- Be clear, consistent and flexible in our approach to our conversations with the public.
- Have shared messages that are jargon free and support people to understand how they can access and shape services in a different way.

Look after our people

- We need to make our **workforce sustainable** – take the opportunities that the ICS offers to work at scale, be creative, innovative and flexible.
- We want the ICS to be a good place to work – we need more focus on building and sustaining a **happy, healthy workforce** with people.
- We want to **recognise and grow our own talent**.
- We need to **create a culture where we all work collaboratively across across boundaries and inspire each other.**
- Make being part of an **ICS integral to our day to day way of working**.

Evaluate what we do and be evidence based

- Build in **better evaluation of impact at all levels**, performance and experience to understand what we stop doing, scale up, and continue with.
- Allocate alternative **community grown innovation funding**.
- **Target key areas** – be ambitious with how we focus our energy and resources to where we can make most impact.
- Use insight to make **evidence based decisions** and be transparent with how those decisions are made.
- **Finish what we said we would do, understanding when things become business as usual** and demonstrate and share how we have made a difference.

A review of 170+ health and care measures identified key trends and challenges that drive our long term strategy

Theme 1: *Our system level performance tends to be good but we must remain focused on the areas of variation that are often caused by deprivation and the wider determinants of health which are amenable to prevention*

Our performance tends to be good but we have **areas of variation** that are often caused by deprivation and areas that impact on health that could be preventable.

There are **some key areas where we are worsening at a steeper rate than nationally**, including potential years of life lost and mortality measures. This means that some people are dying from conditions where effective prevention and treatment interventions exist.

Deprivation plays a significant role in driving variation across the local authorities in our system. This is illustrated by high variation in healthy life expectancy at birth and physical inactivity. Whilst Slough is often an outlier, it serves as a proxy for deprived communities across the system.

Theme 2: *Our insight shows us we must focus on the worsening outcomes in our vulnerable groups, deprived communities, as well as children and young people*

We need to better **support people to help themselves**. The proportion of people who feel supported to manage their condition is low, with high variation across the system.

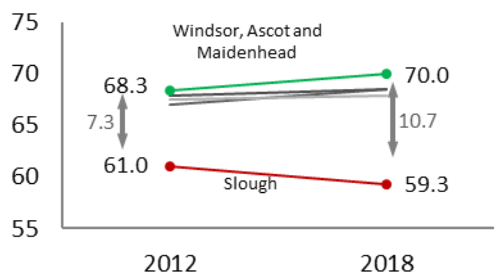
Some **infants and children** are getting a better start in life than others, with mortality data indicating that some do better than others over a life course. This is also highlighted by worsening trends and variation for measures such as school readiness.

Generally, we saw a high proportion of metrics that relate to **mental health** showing a negative trend, in comparison to those that reflect physical health

Access to services could be better for **vulnerable groups**, with a worsening trend in variation eg for people with a long term mental health condition.

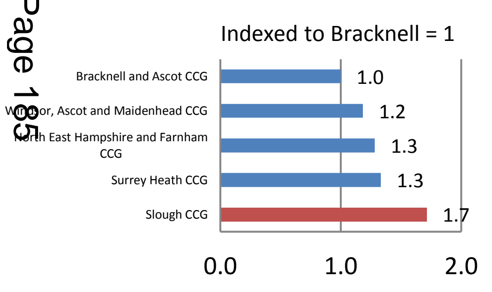
Examples from the data informing the key trends

HEALTHY LIFE EXPECTANCY AT BIRTH



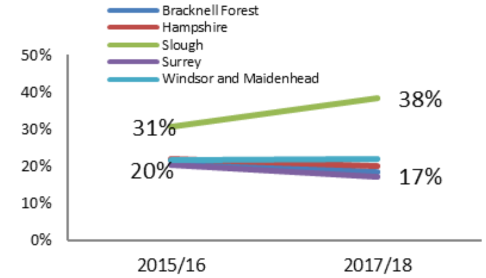
The gap in healthy life expectancy between the highest and lowest local authority areas has **worsened** since 2012

POTENTIAL YEARS OF LIFE LOST FROM CONDITIONS AMENABLE TO HEALTHCARE



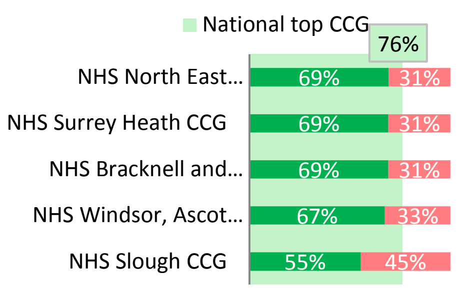
Significantly more potential years of life are lost in Slough than in Bracknell and Ascot

PERECENTAGE OF PHYSICALLY INACTIVE ADULTS



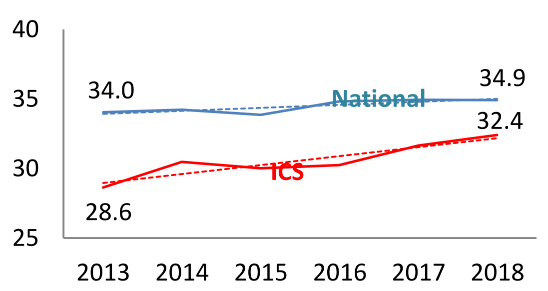
A significant proportion of the population are physically inactive and the **variation** across the system is **increasing**

PROPORTION OF PEOPLE WHO ARE FEELING SUPPORTED TO MANAGE THEIR CONDITION



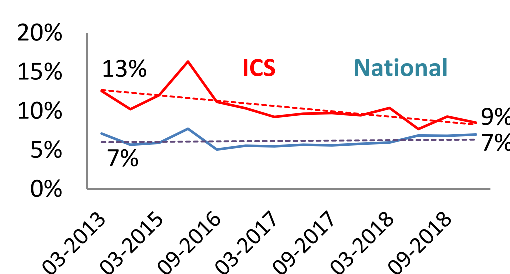
Across the system 31-45% of people **do not feel supported** to manage their condition

CHILD EXCESS WEIGHT IN 10-11 YEAR OLDS



The % of children with excess weight has **increased** from 2013 (28.6%) to 2018 (32.4%) compared to a flatter trend nationally

% OF ADULTS IN CONTACT WITH MENTAL HEALTH SERVICES IN EMPLOYMENT



The % of people with MH conditions in employment has **fallen** from 2013 (13%) to 2018 (9%) compared to a flat trend nationally

Section 3: Ambitions and outcomes

Insights from the Inspiration Station, Healthwatch survey and analysis of the key trends enabled the ICS Board to identify six Strategic Ambitions.

These are the six areas which system partners will focus on and deliver over the next five years.

This section describes the six ambitions and the difference that delivering these ambitions will make for the Frimley Health and Care system.

These are the six Strategic Ambitions on which the system will focus and deliver over the next five years

1. Starting Well
We want all children to get the best possible start in life

2. Focus on Wellbeing
We want all people to have the opportunity to live healthier lives, no matter where in our system they live

3. Community Deals
We will agree with our residents, families and carers how we work together to create healthier communities

4. Our People
We want to be known as a great place to work, live, make a positive difference.

5. Leadership and Cultures
We will work together to encourage co-design, collaboration, inspiration and a chance to contribute.

6. Outstanding use of Resources
We will offer the best possible care and support where it is most needed in the most affordable ways

1 Starting Well
2 Focus on Wellbeing
3 Community Deals
4 Our People
5 Leadership and Cultures
6 Outstanding use of Resources

Our Strategic Ambitions

Create healthier communities with everyone

Strategic Ambitions 1-3

1. Starting Well

We want all children get the best possible start in life, including:

- Engaging children and young people in a different way, working with education and building on young people's creativity and energy
- Targeted support for children and families with the highest needs and those who are the hardest to reach
- Support supporting women to be healthy before pregnancy
- A safe birth
- Life choices and opportunities
- Increased happiness and decreased anxiety

We will deliver:

- Improved child mortality
- Improving school readiness
- Reduced prevalence & variation in obesity
- Reduced variation in childhood vaccinations
- Improved outcomes for our most vulnerable children

2. Focus on Wellbeing

We want all people to have the opportunity to live healthier lives, no matter where in our system they live.
You will be able to have more years of healthy life because you have opportunities in education, work, accommodation, healthy lifestyle choices and increased wellbeing. Our ambition is to Improve the health and wellbeing of the poorest and sickest fastest.

We will deliver:

- Closing the gap in life expectancy
- More years of healthy life expectancy
- Improved outcomes for our most vulnerable people
- Reduced health inequality
- Reduced smoking prevalence

3. Community Deals

We will develop 'community deals' with our local residents.
We will work with our local residents, families , volunteers and carers to agree how we collectively (as organisations and individuals and families) create healthier communities, supporting healthy choices and designing and delivering new ways of working to improve the health and wellbeing of our local population.

We will deliver:

- An effective co-production methodology and capability
- Community asset partnerships
- Support for children starting well
- Targeted wellbeing offers that meet local needs and priorities

Strategic Ambitions 4-6

4. Our People

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

We will deliver:

- High staff reported fulfilment
- A workforce that reflects our communities
- Improved recruitment and retention across our system

5. Leadership and Cultures

We will work together to encourage co-design, collaboration, inspiration and a chance to contribute.
Improvement and adding value will underpin how we work across all our staff, public service partners, voluntary sector and local businesses.
Our approach will include:

- Integrating teams at place and targeting our care
- Knowing our communities and being part of them
- 'With' our residents, not 'to' – co-designing all our work
- Listening to what is important locally

We will deliver:

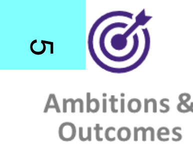
- More people participating in Leadership and Academy programmes
- More successful system-wide improvement projects
- An improvement culture

6. Outstanding Use of Resources

We will offer the best possible care, treatment and support where it is most needed in the most affordable ways using the best available evidence.
We will be known for working together to maximise the impact of the skills and capacities of our staff, making decisions based on good intelligence, our digital capabilities, our 'Frimley pound', our local buildings and facilities. We will shift resources to increase benefits.

We will deliver:

- A balanced financial plan
- Sustainable organisations
- No fragile teams or services
- Interventions and policies that are evidence based



What our system will be like in 2025

We have harnessed the strength of individuals to create healthier communities in the places people work or live. Different relationships have developed between public service providers and the people who use our services, working as equal partners playing an active role in shaping and implementing transformational change.

Together we have designed and delivered new models of care and different ways of working that are making a real difference to people and their local communities. People are able to innovate and make improvements where they live and work, and are proud to share how they are making a difference. We are working collaboratively across local authority, health, and voluntary sector to understand and build our communities, maximising the collective impact we can have on the health of our population. Our common approach provides strength and equality of opportunity, with the freedom and flexibility to respond in the most effective way to local needs, regardless of structures.

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In 2025, when we have delivered this strategy:

- ✓ healthy life expectancy at birth will have improved by 2 years
- ✓ the gap in healthy life expectancy between our least and most deprived communities will have reduced by 3 years

What our system will be like in 2025

Anticipatory Care

Jan is in her late 60s and is living with diabetes and arthritis which makes her more likely to require services in the future. Her GP has identified this early and in discussion with Jan and her family she has received more targeted information about options to manage her conditions. She has also been shown how to use simple apps on her phone to monitor her day to day wellbeing.

Mental Health Complex Care Teams

Marek is 51, he had his first mental health breakdown at the age of 20 and has had many encounters with mental health and hospital services in his life. He takes a range of medications for physical and mental health but struggles to keep on top of this and regularly misses appointments. He is isolated and has little contact with family or friends. A complex care team is now in place to support Marek to live an independent life. They look at all aspects of his life and support him with links to local support groups and peer networks, supported housing services to help with his daily routine and specialist mental health services to help manage his ongoing treatment. As a result he is coping better, feels more supported, often by people who have been through similar experiences and is managing his mental health more successfully.

Young Health Champions

Mo is one of 16 Year 12 students in Slough who promote health and wellbeing in their secondary school as part of the Young Health Champions Programme. He has been supported to set up a Wellbeing Group to promote emotional wellbeing and good health both within his school and at home. By completing the programme he has received a Public Health qualification and continues to share his passion and knowledge with others.

Digital connections

John attended his GP for an appointment. His GP felt he needed referring to hospital for further tests but took a pre-emptive blood sample there and then. When John went to his appointment, his consultant already had his blood test results and had easy access to John's medical notes so he didn't have to explain himself again. John was prescribed some medication and referred back in to his GP's care where his condition could be effectively managed closer to home. John is able to manage appointments and see his own notes on his personal computer and phone.

Section 4: Priority Actions

Part of our Insight for our new Strategy is that we should deliver our Ambitions by focusing our efforts **on a small number of high impact Priority Actions.**

This section describes the six Priority Actions we have identified to start the delivery of our six Ambitions.

These are where we will focus our collective actions to make a positive impact on the health and wellbeing outcomes of our population, the experience of our staff and the sustainability of our system. Further Priority Actions will be added in future years as we make progress with delivering our five year Ambitions.

Priority Action 1: A targeted and coordinated wellbeing offer to support children to start well

Priorities

Overview

We will support the pre-conception health of mothers, children in their first five years and as they grow and develop from 5 to 18 years. We will have a particular focus on the first five years of a child's life because these are critical to their future development and act as the foundation for building caring, productive and healthy families and communities. We will target those with the highest need and traditionally have been hardest to reach. Our approach will be co-produced with the families that we want to provide better support. Our offer will join up and coordinate the many models of care that support children, deliver greater equity and take an asset based approach to make a positive impact for communities.

Actions

2020-21 actions

1. Work with families, staff and communities to **co-produce a model of care** that is integrated, with co-located teams, shared information and one set of outcomes.
2. Develop our collective **system insight into who and where we need to targe**t. Where are outcomes worse, where is variation greatest, who aren't we reaching? Identify the cohorts and places we need to work with.
3. Develop our **capability to co-produce** coordinated and integrated children's services, which will be enabled by the Community Deal strategic priority.

2021-23 actions

4. **Start the implementation** of integrated children, young people and family services. Measure our progress with metrics that have been co-produced
5. We will have rolled our **Connected Care** across children, young people and families.
6. Linked to the community deal we will have an articulated model of what a **community asset based approach** to delivery of services looks like.

Outcomes

- Infant mortality improves for all by reducing the variation
- Improved school readiness
- Reduction in the prevalence of childhood obesity
- Improved uptake of childhood vaccinations
- Improved physical and mental health outcomes for our most vulnerable children

Priority Action 2: A targeted wellbeing offer for the wider population

Overview

We will identify and target the cohorts of people where we know that physical and mental health outcomes are not well met by current approaches, with a focus on deprivation, inequalities and those with most complex needs. Our approach will be to co-produce with the people we want to more effectively support. Our aim is to understand the root causes of lifestyle behaviours and work together to provide personalised support to tackle them.

Actions

2020-21 actions

1. Develop our collective system insight into **who and where we need to target**. Where are outcomes worse, where is variation greatest, who aren't we reaching? **Identify the cohorts and places we need to work with in each Place**
2. Develop our **capability to co-produce** solutions to the wider determinants that cause poor lifestyle behaviours, which will be enabled by the Community Deal strategic priority
3. Co-produce **targeted offers of evidence based, personalised support** that address the causes of the behaviours that have the greatest impact on people's health including smoking, drugs and alcohol, diet and physical activity. The focus for this work will be within each Place using their **Community Deal(s)** enabling work

2021-22 actions

3. Evaluate our success in year one and continue to refine and improve our approach
4. Identify further cohorts of people that we will work with and provide personalised support

Outcomes

- Closing the gap in life expectancy across our population
- More years of healthy life expectancy
- Our most vulnerable cohorts and populations have improved physical and mental health outcomes
- Reduced health inequality
- Reduced smoking prevalence across all areas

Priority Action 3: Community Deals

Overview

Building on the expertise of the partners, we will collectively develop new relationships with people and communities that help them live healthier lives, while taking more responsibility for their own health and wellbeing. The organisations that provide support and care will work in partnership to make a fundamental change in how they work together with communities to make healthier choices. We will do this by developing two key approaches - co-production and strengthening our communities. This is how we will deliver the Starting Well and Targeted Wellbeing priorities.

Actions

2020-21 actions

Co-production

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1. Develop a narrative and vision for the development of Community Deals
2. Use the expertise in local authorities to develop our co-production methodology
3. Develop training and support for staff to hold community conversations and co-produce plans for improvement
4. By March 2021 agree community "deals" that support delivery of the Starting Well and Targeted Wellbeing priorities in each Place

Connecting and strengthening communities

1. Develop collective insight of the demand and need at neighbourhood and place level across our system
2. Build a map of the local community assets at neighbourhood and place level
3. Create community asset partnerships
4. Target assets towards local needs to support the delivery of the Starting Well and Targeted Wellbeing priorities

Outcomes

- An effective co-production methodology and capability
- Community asset partnerships
- Support for children starting well
- Targeted wellbeing offers that meets local needs and priorities
- Better outcomes for the most vulnerable

Priority Action 4: The Frimley Offer to our workforce and local people

Overview

We want a clear way of articulating the career and employment opportunities to our local population and current workforce. Better information about our population will help us to better target existing staff and people who live locally to encourage them to work in health and care and to develop their careers with us. The values and culture of the partner organisations is important to achieving this and we will engage our workforce to understand and develop this. The Frimley Offer will be a 'partnership agreement' with our staff that works alongside our community deals.

Actions

2020-21 Actions

Understanding our people

1. Use an **insights based approach to understand** the whole population and our current staff, including a cultural temperature check of all health and care staff
2. Use a **co-production approach** to listen to views of our staff and potential staff and better understand our people

Supporting our current staff

3. Create a **positive experience** of working in health and care, **develop a clear narrative** about a caring career, **promote health and wellbeing** and enable **increased flexibility**

Delivering the change

4. Partner **with education** and other key partner in the community, carers and volunteers
5. **Strengthen the LWAB** as the delivery vehicle for this priority

2021-22 Actions

6. Continue **strong co-production approach** responding to what we have learnt
7. Refine the **Working Together Framework** and articulate opportunities of partnership
8. Focus on improving the **ambition of our young people**, social mobility and inequalities

Outcomes

- High staff reported fulfilment
- A workforce that reflects our communities
- Improved recruitment and retention across our system
- Equity and diversity of our workforce reflects our communities
- Improved staff health and wellbeing

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Priority Action 5: Scaling up leadership for improvement

Overview

We want all of our people to roll out the good things we do across all of the places, communities and neighbourhoods where they might make a difference. We want to make it easy for them to do this by developing the Frimley way to make improvements. We want everyone to feel that they are empowered to make positive change and that they do this together with the staff, residents or patients it affects.

Actions

2020-21 Actions

1. **Create our improvement culture** by co-producing our 'cultural commitments' focused on embedding an improvement culture that shows openness to innovation, curiosity and learning
2. **Demonstrate our leadership commitment** through the Frimley Leadership and Improvement Academy's (FLIA) support to leaders in our communities and system
3. **Develop our leadership offer** by evolving our development opportunities in ways that support the strategic ambitions and drive improvement at scale
4. **Develop the 'Frimley Framework for improvement** – codesigned to give people the tools to work together with our communities to drive improvements
5. **Continue to spread learning** by proactively sharing beyond our system boundaries

2021-22 Actions

6. Evaluate the impact of FLIA and our programme of leadership development
7. Evaluate the impact of the 'Frimley Framework'
8. Continue to develop the Frimley Improvement Network

Outcomes

- More people participating in Leadership and Academy programmes
- More successful system-wide improvement projects
- An improvement culture
- improved retention

Priority Action 6: Digital innovation supporting change

Overview

We will future proof our system by having a leading digital ecosystem which will deliver practical improvement through transformation and cultural change using digital innovation. We will develop a digital offer for patients, residents, staff and system that supports the delivery of all of our strategic ambitions. It will give us greater Insight from our data to make informed decisions and target our improvement actions. It will give people the information they need to prevent ill health and manage their own health. It will support automation and more productive ways of working.

Actions

2020-21 Actions

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1. **Greater insight supporting evidence based decision making** at system, place and neighbourhood levels. Incorporating wider determinants and resident provided information to drive population health management and system intelligence
2. **Support a move towards self-care and prevention** by integrating the good work in health and social care with app and resident-facing technology integration
3. Further developing our system-wide **Shared Record** for all care settings
4. **Use digital tools and evaluation of our interventions to reduce inequalities** for residents across the system

2021-22 Actions

5. **Engage the public** with our technology using community deals and community panel
6. **Increase the flexibility** of our estate by maximising digital ways of working
7. **Automate/improve replicable or administrative processes** to free up capacity
8. **Stronger integration with children's** social care and education to support targeted and coordinated wellbeing offer to children to start well

Outcomes

- Interventions and policies that are evidence based
- A digital first culture promoting quality, efficiency and greater flexibility
- An environment where digital supports getting the right care at the right time in the right way and place

Section 5: Long Term Plan Delivery

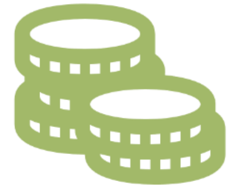
This section describes how the Ambitions and Priority Actions set out in this strategy support and enhance the delivery of the NHS Long Term Plan in the Frimley ICS.

A linked plan has been developed to describe in detail how Frimley ICS will deliver the foundation commitments made in the NHS Long Term Plan.

Delivering the Long Term Plan

The **NHS Long Term Plan** (LTP) was published in January 2019 and describes the key ambitions for the service for the next 10 years. Our new long-term system strategy, Creating Healthier Communities, shares its six Strategic Ambitions with the LTP and will enable us to deliver fundamental change and improvement to the health and wellbeing of the people who live and work in our communities and organisations. The table below shows how our six Strategic Ambitions will deliver the key ambitions of the LTP.

Our Ambitions	How our Ambitions support delivery of the NHS Long Term Plan themes
1. Starting Well	Our Starting Well ambition will enable us to deliver the LTP ambition for **a strong start in life for children and young people**
2. Focus on Wellbeing	The Focus on Wellbeing ambition demonstrates our collective commitment to taking **more action on prevention and health inequalities**
3. Community deals	Our Community Deal ambition is at the heart of our new strategy and provides a clear **focus on population health**. It will enable us to work with our communities to design and deliver not just our health and care services, but also education, employment, housing and transport. This will be our way of delivering **personalised care**, building new relationship and shifting the power in decision making. Our work to co-produce and strengthen communities will also deliver the **further integration of local health and care services**
4. Our People	Our People ambition is how we will ensure that **staff get the backing they need** and deliver the **interim people plan**. We are all committed to improving our staff experience at work, increasing their career opportunities and retention and recruiting more people from our local population
5. Leadership and cultures	The Leadership, Culture and Improvement ambition will **increase the scale of change** and improvement that we deliver
6. Outstanding use of resources	Through our Outstanding Use of Resources we will continue our collective focus on the 'Frimley pound' to make sure that **taxpayers' investment is used to maximum effect**. Our long term commitment to reducing need and inequalities will support **the long term sustainability of health and care services**. We have made **digitally-enabled care** an early priority for this ambition



Section 6: People and Finances

This section summarises the financial and workforce plans.

It describes how we intend to change the flow of funds across our system as we deliver our strategy over the next 5 years. It also describes how we will close the potential financial gap through improving outcomes, reducing the cost of poor health and through optimising our efficiency and effectiveness.

Our plans to invest in building infrastructure are set out.

We describe the work we are doing to understand and respond to our workforce needs.

People and Finances

How funds currently flow within our system

The system receives approximately £1,744 for each person

Total budget £1.4bn per year.

How we will focus our NHS Funds by 2023/24

By 2023/24 we will have £1.26bn to spend on NHS services, an increase of £181m from 2019/20, of which £18.7m is targeted Long Term Plan funding, which gives us an opportunity to fundamentally change how we deploy our resources.

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How we will focus our NHS Funds by 2023/24

In delivering these plans we will make a significant step towards our systems ambitions investing heavily in our key areas including Mental Health, Primary Care, and out of hospital community services including the voluntary and third sector.

Existing Resource Distribution

Other Programmes 5.7%
Primary Care 11.7%
Prescribing 8.8%
Continuing Care 6.4%
Community 6.4%
Mental Health 8.7%
Acute 52.2%

Future Resource Distribution

Other Programmes 5.7%
Primary Care 12.0%
Prescribing 8.3%
Continuing Care 6.3%
Community 6.9%
Mental Health 10.0%
Acute 50.8%

The challenge we face in order to deliver this change

People and Finances

Overview

Financial plans have been developed across the system covering each of the six NHS organisations. Plans seek to predict future costs of service delivery for our population, indicative activity levels, and investment plans to support the ambitions set out in this plan. To deliver this we will need to collectively deliver efficiency and effectiveness savings across all areas and a series of system driven transformational activities building on those already developed by the system since 2017.

Detail

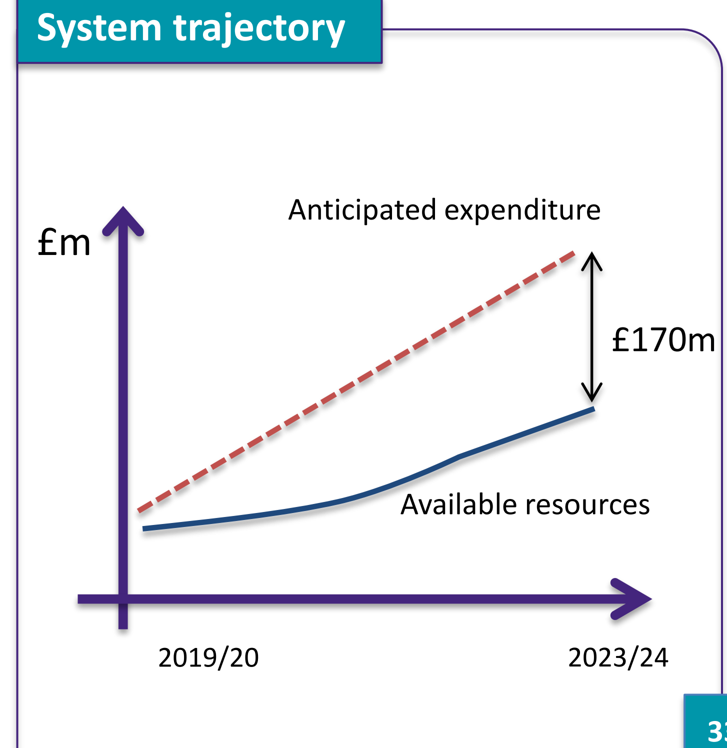
System wide assumptions utilise nationally published inflation assumptions, underlying do-nothing increases in demographic growth levels and underlying growth due to increased needs.

Plans developed assume challenging savings requirements for all organisations with an average 2 to 2.5% across each of the financial years to deliver £120 million of savings. There is an additional system saving requirement of £50 million.

As a system we recognise that we can only deliver our financial plans collectively focused on the system ambitions and priorities set out in this strategy. Alongside this ensuring we create the right conditions and resources to drive the changes required by the system.

At this stage, the impact of the financial challenges facing our Council partners, and neighbouring systems have not been factored in.

System trajectory



Closing the financial gap

Overview

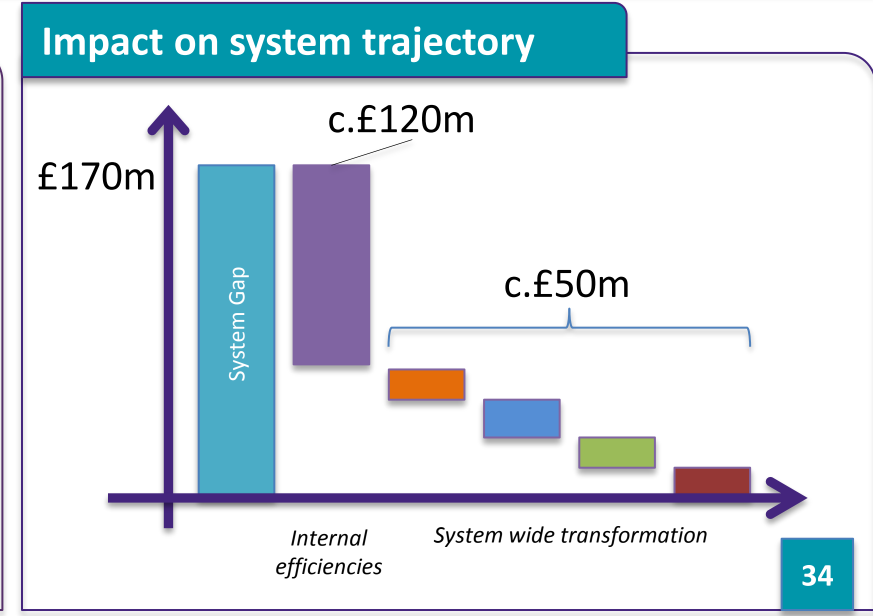
Our strategy aims to close our financial gap by improving people's outcomes, reducing the cost of their poor health for both health and local authority partners and through optimising our efficiency and effectiveness. We plan to do this by:

- Increasing the number of healthy years of life for all our population.
- Targeting some interventions so that we close the health gap between the most and least deprived and vulnerable in our communities so no-one gets left behind and our life expectancy gap is reduced by 3 years. National research suggests inequalities cost our NHS System approximately £300 million per year.
- Optimising our use of resources so that we get the best possible results from as little cost as possible.
- Reshaping our funding flows to increase the proportion of our budget on prevention and self management, early intervention, mental health and out of hospital services and reduce our reliance on the care home market and hospital bed based care.

Rationale

- Poor health is a driver of both NHS and local authority usage and costs
- People living in our most deprived fifth of neighbourhoods have 72% more emergency admissions and 20% more planned admissions to hospital than people living in the most affluent areas. Targeted actions with the most vulnerable in our community can reduce the incidence and overall burden of disease.
- People with long term conditions are the most frequent users of services, accounting for 50% of all GP appointments and 70% of all inpatients bed days and around 70-78% of people with long term conditions could be supported to manage their own condition.
- Mental health problems are one of the most common forms of co-morbidity . Integrated models of disease management have been found to deliver savings four times greater than the investment required.

Impact on system trajectory



Strategic activity modelling

Our strategy aims to manage the key factors that impact activity

The key strategic drivers that will increase the need for services

- An ageing population driving complex need
- Growth in the size of our overall population

Our strategy aims to reduce need and improve delivery

Our impact will reduce the need for health and care encounters by

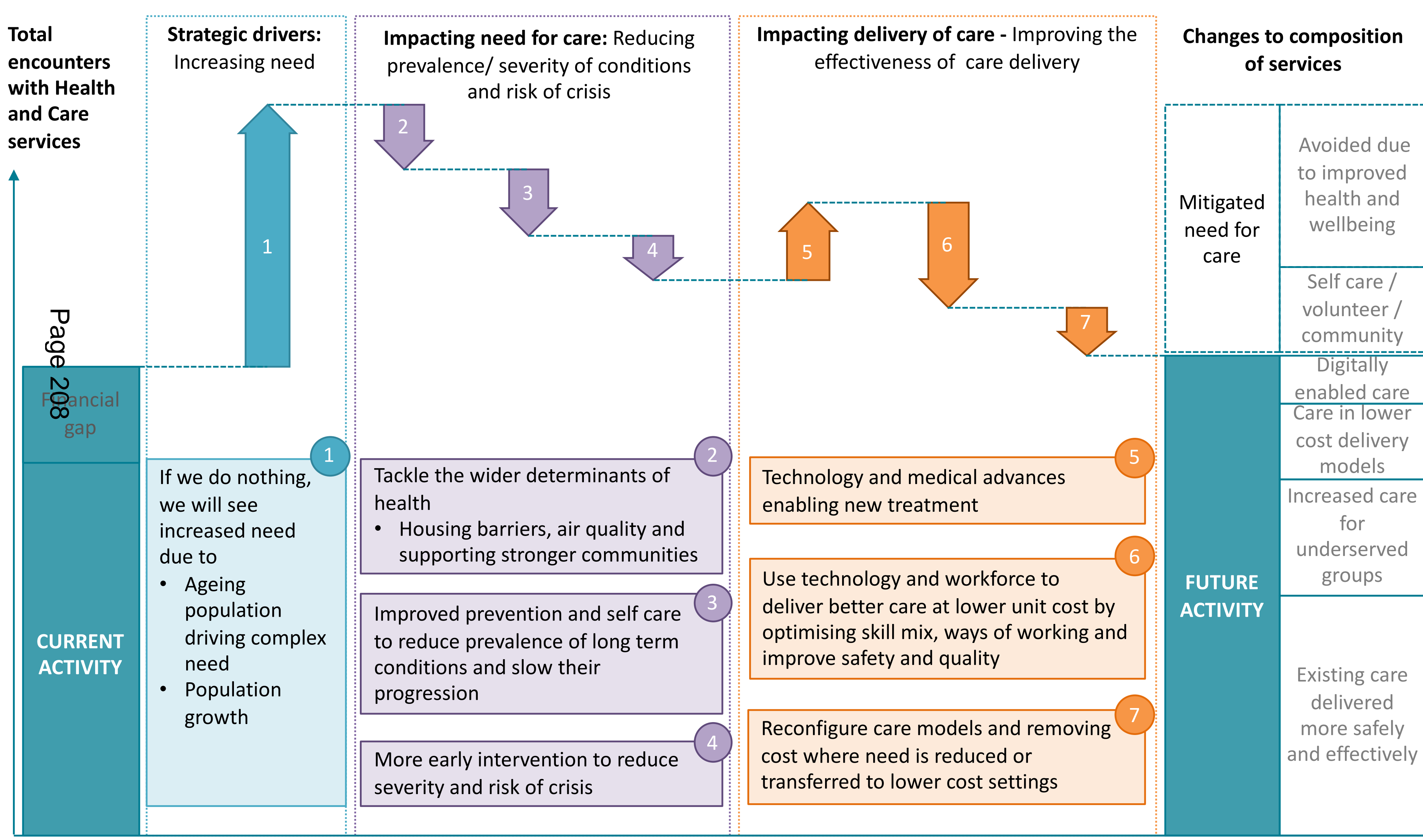
- **Improving** housing barriers, air quality and supporting stronger communities
- **Promoting self-care** and taking responsibility for your own health for those that can
- **Reducing** smoking and obesity rates
- **Intervening early** to reduce prevalence and severity of long term conditions and to manage them more proactively
- **Better support** for underserved and vulnerable groups to improve their health and improve equity
- **Increasing prevention** and wider determinants of health

Our impact on delivery of health and care encounters will improve care and sustainability by

- **Developing our workforce** by supporting and empowering them to redesign care so that it is closer to home
- **Improving safety and outcomes** by delivering care in ways that are evidence based and best practice
- **More inclusive and anticipatory care** that intervenes earlier to better manage conditions and reduce future need
- **Technology enabled care** that enables face to face encounters to be delivered differently using technology in community and primary care
- **Effective care** that focuses on encounters that add value, optimises staff skills and deliver care in the most effective setting
- **Releasing capacity** and costs as activity changes take place

Strategic activity modelling

Our strategic activity and capacity model predicts the effect of key factors during the delivery of our 5-year strategy



Investing in our building infrastructure

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

- Effective use of premises – deliver the "One Public Estate" principles
- Healthy premises supporting people to live and work well
- Local delivery of care
- People able to access the right setting of care at the right time
- Reduced non value added attendance through better use of clinical space and technology
- 70% of assets in satisfactory and acceptable condition
- 100% of decisions made in the right place with the right people

We will focus on delivering a number of key estates programmes across our system including cross-sector initiatives and in developing and embedding a system evaluation and planning cycle for capital investments.

Over the period of the strategy **our developments** include:

- Heatherwood Hospital redevelopment and renewal
- Investments in our community resources, including Integrated Care Hubs in Bracknell, Windsor, Maidenhead, Slough, Fleet, Surrey Heath, Farnborough
- Investment in GP estate, including a GP Hub in Ascot
- Community hospital reconfiguration
- Cross-sector partnership developments, including Heathlands in Bracknell
- Delivering backlog maintenance programmes and consolidation of non-clinical space across provider estates

Understanding the workforce needs of our system

Our ambitions for our workforce, our people, are clear and aligned to our Strategic Ambitions for the communities we serve.

Our priority areas to improve attraction, recruitment and retention of staff for our Frimley system also align to the national Interim People Plan. Further, we are actively testing national initiatives such as the ICS Workforce Development Tool to inform our broader workforce strategy and plans and influence the development of that tool for wider roll out. Already engagement in this work has created energy, greater alignment and clarity around where to focus our efforts going forward.

We know we need to transform our workforce so that we skill up our people and attract people to different roles to deliver our new care models. We need to work more seamlessly across health and care and to create a more flexible workforce.

We will also share our learning as we develop our ‘Frimley Offer’ for staff working in and across the system, including how we enable our offer for volunteers and align with offer for staff in local authority sectors. Our work will be anchored in our approach to leadership behaviours including improvement disciplines and creating learning cycles at all levels of the system.

We will be inclusive in all that we do in this, working with our local populations and our workforce to achieve this.

Lastly we will explore all opportunities to develop our people to take advantage of digital solutions to improve their working experience and help them to provide better care for the communities we serve.

Understanding the workforce needs of our system

We have reviewed our major workforce pressures and agreed priority actions to respond, recognising the limitations to significant growth in our future workforce and our need to focus on local recruitment and retention. We will take these actions alongside our strategic ambitions for Our People and Leadership and Cultures.

Staff group	Where we are in 2019	Priority actions for 2020
Acute nursing	Vacancies improved from 16% to 14% (418 FTE) Turnover improved from 14.1% to 12.9% 54% of new starters from overseas (106 FTE)	Further investment in overseas recruitment to reduce vacancies to 9.7% (287 FTE). 91 Nursing Associates in training at Frimley Health.
Mental health	Average reduction in workforce of 3.3% pa predicted to rise to 4.8%. Particular difficulty with nurses and allied health professionals	Fresh approach to recruitment and retention to attract staff to Frimley system. Innovative development of a 'wellbeing workforce' from wider statutory services.
Support workforce	Over 15,000 support workers in the system at present, estimated to need to increase by c.1000 FTE. Sector struggles to recruit and retain and emerging competency gaps.	A clear understanding of the provision required and the products that enable workforce growth and integration. Career pathways linked to apprenticeships and new suite of training.
Maternity	35 FTE vacancies (15% at Wexham Park and 7% at Frimley Park). ONS data suggests stable/ falling birth rate. 9.5 FTE more midwives to meet agreed ratio.	Increasing the number of Midwifery Support Workers and pilot new skill mix for postnatal pathway. Recruitment and retention plans include preceptorship, return to practice, wellbeing and resilience.
Primary care	No expectation of an increase in GP numbers, with more part time workers. Focus on retention and recruitment of existing and new roles as 20% of GPs and 55% of nurses aged over 55. Modelling predicts a 167 FTE gap in 5 years without action. Additional roles only will not close this gap.	New contract allowing some investment in social prescribing link workers, clinical pharmacists, physician associates, first contact physios and paramedics. Only social prescribing fully funded, the others require 30% practice investment. A demand and capacity tool to support PCNs to model these new roles.

Section 7: Organising to deliver

This section sets out how we are organising to deliver our six Strategic Ambitions and the NHS Long Term Plan Foundation Commitments.

It signals a move to goals based governance for our work together as a system to deliver our new strategy.

It describes how we will transition to new programme arrangements that ensure our success and how we will work together as partners at multiple levels.

We come together as an ICS to co-ordinate delivery of our renewed 5-year strategy

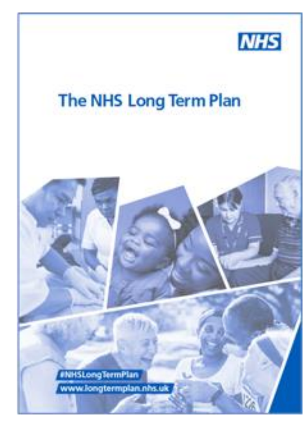
- We have described the action we need to take to deliver both our Strategic Ambitions and the Foundation Commitments for the NHS Long Term Plan.
- Each of our organisations is subject to regulatory arrangements – rules and procedures that are designed to elicit compliance *(Rules based governance).*
- As we come together as partners in the ICS we have set ourselves a series of ambitions, and our ICS governance needs to support our organisations, leaders and teams towards the achievement of these ambitions *(Goal based governance).*
- Our ICS governance is goals based, and our important statutory accountabilities and regulatory architecture remain at an organisational level.

Organising to deliver

Frimley Health and Care

Creating Healthier Communities

NHS Long Term Plan
Foundation Commitments



- ICS Board-level sponsor and programme convenor/facilitator for each ambition
- Distributed teams drawn from across the system for delivery of each ambition
- 'Ambition' programmes and NHS LTP Foundation Commitments programmes are connected and mutually supportive
- The key to our success will be inclusion in everything we do, understanding what is important to people and working with them

- CCG Accountable Officer as the ICS Board member who takes responsibility for co-ordinating our collective activity to deliver the NHS Long Term Plan
- Workstream convenor for each foundation element drawn from across senior leadership
- An NHS Long Term Plan programme structure that supports delivery of this work
- Reconsider name and membership of ICS Board to reflect future ways of working

Transition from current to new arrangements

The process through which we transition to new programme arrangements includes:

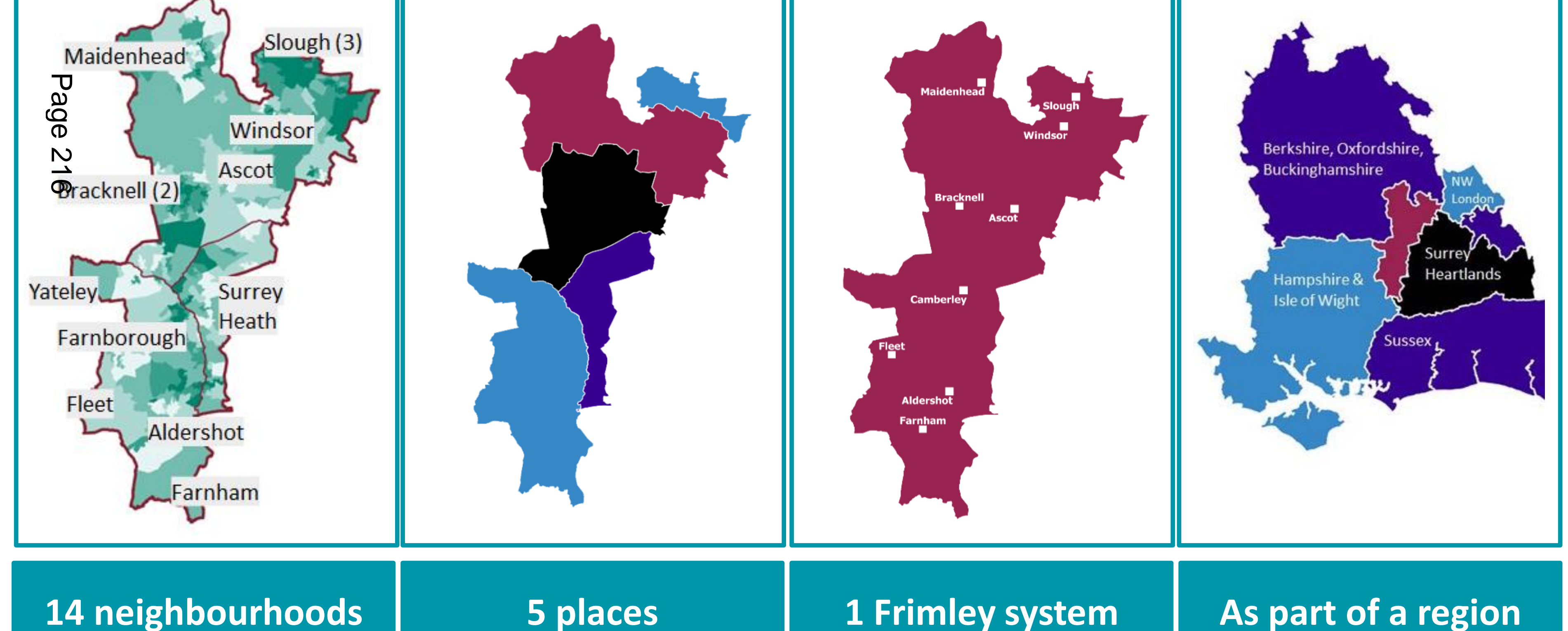
1. Agreeing the achievements, skills and capacity we need in future in the ICS to support and enable us to deliver
2. Reviewing how and where the current programme processes and arrangements support and meet our future needs
3. Identifying gaps and filling /closing those gaps
4. Effective programme support and arrangements in place to deliver the strategic ambitions and Long Term Plan

We have already recognised together the need to build capability in population health management, digital, workforce and analytics

We work together as partners at multiple levels

We work together at system level, in each place, in neighbourhoods and with other ICS/STPs to co-ordinate our collective action. In each we have one or more 'convenors' – the individuals who take responsibility for bringing partners together, supporting collaboration, harnessing and aligning the contribution of all Alliance partners around a shared vision.

The ICS lead fulfils this role for the ICS Board, and PCN clinical directors fulfil this role for each of our PCNs at neighbourhood level. Local authority leads will represent Place at a system level.



14 neighbourhoods	5 places	1 Frimley system	As part of a region

Creating Healthier Communities

Frimley Health and Care 5 year Strategy

First published December 2019

Further information and contact details can be found at frimleyhealthandcare.org.uk

ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • [illegible]DSOR

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