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NHS Frimley Health NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Meeting in Public

Friday 3rd May 2019, 08:30-11:00
Venue: Board Room, Admin Block, Frimley Park Hospital, Frimley GU16 7UJ
A G E N D A v4

TIME	AGENDA ITEM		PAPER	ACTION	LEAD
08:30	1.	**Welcome and Apologies for Absence**	Oral	-	Chairman
	2.	**Declarations of Interest**	Oral	-	Chairman
	3.	**Value in to Practice (VIP) awards**		-	Chief Executive
	4.	**Ward to Board-Education**	Attached	To Note	Director of Nursing & Quality
	5.	**Minutes of the previous Board Meeting held in public on 1st March 2019**	Attached	For Approval	Chairman
	6.	**Action Log from previous Meeting**	Attached	For Action	Chairman
QUALITY					
09:10	7.	**Chief Executive's Update and Quality and Performance Report**	Attached	For Assurance	Chief Executive & Executive Directors
09.25	8.	**CQC Action Plan** **Frimley Health CQC response to Must Do Actions required** **CQC recommendations Trust action plan**	Attached	For Assurance	Director of Nursing & Quality
FINANCE & PERFORMANCE					
09:35	9.	**9.1 Finance Report - month 12** **9.2 CIP-Month 12**	Attached	For Information	Director of Finance & IM&T, Directors of Operations
09:45	10.	**10.1 Internal Operating Plan** **10.2 Corporate Objectives 2019/20** **10.3 System Operating Plan 2019/20**	Attached Attached Attached	To Note To approve To endorse	Director of Finance & IM&T CEO Director of Finance & IM&T
GOVERNANCE AND COMPLIANCE					
09:55	11.	**Review Registers of Interests, Gifts & Hospitality**	Attached	To Note	Company Secretary
10:00	12.	**Senior Information Risk Owner (SIRO) Quarterly Report (to include Annual Report)**	Attached	For Assurance	Director of Finance & IM&T
10:10	13.	**NHSI Self-Certification**	Attached	For Approval	Company Secretary
10:15	14.	**Nurse Staffing**	Attached	For	Director of Nursing &

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				Assurance	Quality
10:25	15.	**National Staff Survey**	Attached	For Assurance	Director of HR & Corporate Services
10:35	16.	**Review Summary Minutes and Recommendations of the Board Committees**			
	16.1	**1 March Charitable Trustee**	Attached	To Note	Committee Chair
	16.2	**22 March- FIC**	Attached	To Note	Committee Chair
	16.3	**5 April-People**	Attached	To Note	Committee Chair
	16.4	**10 April-QAC (incl. Infection Control Annual report)**	Attached	To Note	Committee Chair
	16.5	**11 April PRC**	Attached	To Note	Committee Chair
OTHER BUSINESS					
10:45	17.	**Any Other Business**	Oral	-	All
10:50	18.	**Questions from Members of the Public**	Oral	-	All
11:00	19.	**Date of Next Meeting** Friday 5 July 2019 Lecture Theatre, PGMC, Wexham Park Hospital	-	-	Chairman

NB: An 'Acronym Buster' has been included at the end of the Public Board papers pack.

Service:

Brief Overall Service Description	**Coordination and delivery of Clinical Training across the Trust. Managing the LDA on behalf of the Trust**

Total Staff Numbers:	**63**
Patient/ Service Activity:	Education
Total Beds/ Theatres:	

Current CQC Ratings (date: xxx)

	Safe	Effective	Caring	Responsive	Well Led
Frimley					
Wexham					
Heatherwood					

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What do our patients /service users say about us?

Do well	Could do better
1) Supportive 2) Good Teaching Staff 3) Responsive	1) Infrastructure (Facilities and lack of them) 2) Meeting demand

Latest FFT Scores:	NA

Source:
LFG/Feedback Sheets

What do our staff say about us?

Do well	Could do better
1) Well supported &led; accessible managers; if we say we will do something it happens; they're happy 2) Review of programmes delivered is ongoing 3) Celebrate success of students/trainees	1) Physical working environments could improve – WPH Sim/Investment for Apollo 2) Feel like they should come to work when sick 3) Feel obliged work unpaid hours

Turnover Rate:	
Vacancy Rate:	12%
Sickness/ Absence Rate:	2.08%
Staff Survey Response Rate:	55%

Source:
Triangulation of staff FFT; staff survey data

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Performance on a page

Top 3 areas of performance	Areas of focus for improvement in performance
1) Workforce Impact: (Nursing; ACP; Medical Workforce) 2) Integration of Patient Safety & Experience Learning into Education 3) Positive external audits: (Defence Deanery/GMC Survey) 4) One Trust Working	1) Experience of Nursing Associate Trainees 2) Engagement of staff at Study Events 3) FY1 Experience of foundation training

Financial Performance YTD	
Planned	Actual
£2,587,318	£2,420,486

Performance:

Quality, Constitutional standards, Finance, Workforce – provide brief description and current performance

Top 3 Risks

1)	Inadequate Simulation facility at Wexham Park
2)	Future location of PGMC WP
3)	HWD training delivery

Notes:

Top 3 risks should triangulate with current risk register; brief written description & narrate actions being taken during presentation

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Top 3 strategic developments

1)	Implementation of Advanced Clinical Practice across Trust
2)	Increased Retention through the development of educational and support pathways (Clinical Leadership/RTT/Preceptorship/LTFT Lead/Pastoral Support)
3)	Enhanced Clinical Performance through Multi Professional Simulation

Notes:

Brief description of top 3 strategic developments - aligned to directorate strategy.

Top 3 Quality Improvements

1)	Increased training capacity and quality across the Trust (Medical Students/Educational Supervisors/Student Nurse Placement/Clinical Librarian/Student pathways/Practice Assessors)
2)	Review of formal training governance and assurance processes
3)	Increased efficiency and quality through use of In House Training

Notes:

Top 3 quality improvements taking place – provide description & key facts as required

Integrated Care System (ICS)

Key Areas of Involvement in ICS

Working with LWAB to develop a system wide process for student placements

Development of Frailty eLearning programme to be used across the ICS

Potential for developments of ICS Nursing Associate Programme

Offering study places to the ICS (Catheterisation/Clinical Skills/NGT)

Questions from the Board

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NHS Frimley Health NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC

Friday, 1st March, 08:30-11:00
Lecture Theatre, PGMC, Wexham Park Hospital, SL2 4HL

MINUTES OF MEETING

5

Present:

Pradip Patel	(PP)	Chairman
Neil Dardis	(ND)	Chief Executive
Janet King	(JK)	Director of HR & Corporate Services
Nigel Foster	(NF)	Director of Finance & IM&T
Duncan Burton	(DB)	Director of Nursing & Quality
Lisa Glynn	(LG)	Director of Operations WPH
Tim Ho	(TH)	Medical Director
Helen Coe	(HC)	Director of Operations FPH
John Weaver	(JW)	Non-Executive Director
Dawn Kenson	(DK)	Non-Executive Director
Ray Long	(RL)	Non-Executive Director
Mike O'Donovan	(MOD)	Non-Executive Director
Rob Pike	(RP)	Non-Executive Director
Thoreya Swage	(TS)	Non-Executive Director

Apologies:

Mark Escolme	(ME)	Non-Executive Director

In Attendance:

Lee Jones	(LJ)	Dir of Communications, Marketing and Engagement
Susanne Nelson-Wehrmeyer	(SNW)	Company Secretary
Kevin Jacob	(KJ)	Assistant Company Secretary
Chris Jarvis	(CJ)	Interim Asst Company Secretary (minutes)

1.	**Welcome, Introduction and Apologies for Absence**	
a	PP welcomed everyone to the meeting and thanked members of the public and governors for attending.	
b	Apologies for absence were received from Mark Escolme.	
c.	The Chair noted that this was the last Board Meeting that would be attended by Kevin Jacob, Assistant Company Secretary. On behalf of the Board, JK thanked Kevin for all that he had done in providing support to the Board and to the Governors during the three years that he had been at the Trust. Members of the Board concurred, noting that he would be a loss to the Trust and they wished him well for the future.	
2.	**Values in to Practice (VIP Awards)**	
a	The Chief Executive described the rolling out of the Values into Practice (VIP) Awards that would be taking place within the Trust at the start of each Board Meeting with newly branded VIP Certificates.	

b	He said that he was delighted to be making the award at this meeting to the Overseas Nursing Recruitment Team within the Trust and asked the members of the Team to introduce themselves to the Board.	
c	The Team described the range of functions that they each carried out including; • Placements • Staff benefits and accommodation • Resourcing • Branding and selling Frimley Health NHS Foundation Trust internationally	
d	Members of the Board were delighted to note the significant achievement of the Team enabling international students to pass their UK nursing qualifications – 6 months in a row at 100%.	
e	Reference was also made to the compassion and personal care provided by the Team to each individual from the moment they arrive at the Trust together with the significant amount of work being carried out in enabling a high level of integration to take place.	
f	The Board congratulated the Team in attaining this well-deserved award.	
	Reflections by Members of the Board	
a.	The Chair commented that the Trust was approaching the end of what had been a very challenging and difficult year and that the next two years would also present significant challenges. However, despite this, the Trust had also achieved some outstanding successes and he was therefore going to ask each member of the Board to give their own personal highlight from the year: • DK- The development of the renal service and the benefits that this has produced for patients • RP- The agreement to proceed with the development of Heatherwood • JW – The development of Heatherwood, and being present when the Council Planning meeting approved it • RL – The agreement to proceed with the development of Heatherwood with its challenges; and to go out and spend time with colleagues in trust. • TS- greater prominence of recognising and rewarding staff within the workforce • HC- winter pressures have been managed much better than previously with good ICS support • TH- 15th anniversary of working at trust and seeing how CF service has transformed; also seeing a colleague develop a nationally recognised service • JK- The development of the Emergency Assessment Centre (EAC) at Wexham Park, with the first services already moved in over the weekend of the 23rd and 24th February. • NF-the completion of the Greenwood offices in Heatherwood with space and facilities for support staff to work in • LG- (1) the Heatherwood development being authorised before Christmas and (2) seeing the new EAC come to life with simulation events and testing; then the process of moving in “for real” and seeing patients enjoying the building • MOD- bringing together Frimley Health in a positive way, resulting in the exciting developments now taking place.	

	• DB- (1) nursing associates; a group of 100 in training with 10 new qualifiers, providing opportunities to those people who have not had this before; (2) the provision of charity funding for some dementia activity coordinators last year and seeing the positive impact that this has had on elderly patients particularly in terms of sleeping patterns • KJ- such a privilege to be a part of the work of the Commercial Development and Investment Committee • SNW-the continuing infrastructure development, despite austerity in the public sector • PP - the impact on the Trust's services on patients' lives, with particular reference to its achievement in relation to cancer standards • ND-at end of the month I have been in post a year, and within 3 days of joining, I knew that I was involved in something very special. I was also very proud of the celebrations around NHS 70, for the country and at the Trust, summing up what this Trust is all about.	
b.	In summary, the Chair said it was important that Board Members remember the very positive achievements taking place within the Trust, even in challenging times.	
4	**Declarations of Interest and minutes of the previous meeting**	
a.	There were no declarations of interest.	
b.	The minutes of the meeting held on 11 January 2019 were approved subject to some minor typographical errors.	
5	**Action Log from the Previous Meeting**	
a.	**1 September 2017 – 18.e Meeting Review** For PP to keep this action on the log	
b.	**5 January 2018 - 18.e Meeting Review and 4 May 2018 -20.c Meeting Review** Action carried out and can now be closed	
c.	**7 September 2018 - 10.c Capital Investment Programme Update** Action carried out and now be closed	
d.	**5 October 2018 – 8.c Quality Improvement Plan as at September 2018** TH – rescheduled for the end of Q1 2019	
e.	**7th December 2018 – Review of Minutes and Recommendations** NF/SNW – BAF Development Session for the Board to be facilitated by BDO. Date to be confirmed by NF/SNW	
f.	**11th January 2019 -6.g Chief Executive's Update and Performance Report** Action carried out through correction of data, and can now be closed	
g.	**11th January 2019 – 10.d Infection Control Quarterly Report** QAC to follow through and the Board can be informed through QAC Minutes. The action can therefore be closed.	

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h	**11th January 2019 – 14.d Review minutes and recommendations of the Board Sub Committee -** ongoing	
6.	**Frimley Health Intensive Care Units, (ICUs)**	
a.	PP introduced the ward to board item on Frimley Health ICUs. He welcomed the following members of the Team; • Subodh Tote- Consultant • Amer Quereshi-Chief of Service Theatres and critical care • Diana Dodsworth HoN, covering critical care across site • Mary Virtue-ICU matron -Frimley Park • Ana Coelho came for Wexham	
b.	Members of the Team gave a presentation to the Board providing context and information relating to the service.	
c.	It was noted that the Critical Care ICU has 24 beds covering two sites. Nurse staffing is approximately the same for the two sites and with more consultant input at Frimley Park. This is continuing to be reviewed.	
d.	The current CQC ratings were noted. It was explained that only achieving a good rating for safe care at Wexham Park was as a result of an incident that had occurred from which shared learning had taken place.	
e.	The importance of listening to what patients/service users said about the team was emphasised, with particular reference given to areas where improvements could be made. This focused on ensuring a consistent line of communication for patients and relatives and in managing families' expectations when reducing high dependency care. Reference was also made to ensuring that staff could be identified, noting the differences between the two units, with one wearing scrubs and one uniforms.	
f.	In terms of staff feedback, it was recognised that the ICU provided excellent educational opportunities and that that it gave the opportunity for raising concerns to the senior team. Pay was recognised as a key issue where staff wished to see improvements take place, perhaps by setting up a cross site bank.	
g.	The top three risks were for the Unit were reported as (i) staffing, both medical and nursing rotas, where attempts to mitigate this were being made through links with universities and with a drive for overseas recruitment (ii) patient flow, with particular respect to delayed discharges with constraints identified on both sites and (iii) capacity – it was noted that the Unit had been running at over capacity since January 2018.	
h.	Questions and discussion followed:	
i.	RP asked a question about flow and capacity and which was the greater issue. ST responded that capacity presented the greater challenge, noting that if flow could be better organised, available capacity would increase. AQ noted that people were now being kept in recovery following surgery with appropriate treatment, instead of intensive care and high dependency areas, thus reducing the burden on ICU.	

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j.	JW asked a question about the vacancy rate, particularly in terms of any support that the Board could provide. Reference was made to the development of the nurse associate role and how this might help. AQ said that the shortage was caused in large part by the attraction of the big teaching centres. He said that measures that had been taken had not alleviated the shortage, and, in this context, expressed concern about the reliance and longevity issues within the service.	
k.	MOD asked what could be done to ensure a more consistent process of communication and whether the Board could help in this respect. Reference was made to empowering nurses to provide updates to patients and service users, as they were in the best position to be able to offer continuity of communication. This was felt to be particularly relevant in managing families' expectations on discharge of their relatives from the units.	
l.	RL said that this was an excellent report in highlighting the key issues. He asked a question about resilience and asked what the board could do in this respect. In response, it was noted that funding for a counsellor on the Frimley site would assist in addressing this issue, as had been evidenced when a counsellor had been loaned from Wexham Park. It was also noted that investment in debrief training and resilience training was important and may help to reduce the significant staff turnover within the units. TS asked about the difference in vacancy rates between the two sites, and, in response, it was noted that these rates varied at different times for each unit.	
m.	The chair summarised the session as follows; • He highlighted that 1500-1600 patients a year who were critically ill were looked after the units and for these patients, this level of care was critical. • He recognised the challenges presented in terms of (i) resilience (ii) the provision of appropriate debrief training and (iii) capacity of units • He recognised that this was very challenging work for the staff as they were looking after very sick patients and their families, who would also be very worried • He passed on the thanks of the Board to the presenting team and asked that all members of staff within the units were thanked for what they were doing.	
n.	The Chair asked the Board for their comments on the format of the report • DK said that it helped to focus on the issues of importance • JW said that he was happy with the format, but suggested that it may not be necessary to go through the whole presentation in detail, but, rather take the report as read and focus on the key issues of importance • HC emphasised the importance of other appropriate metrics, such as infection control, to be included in these reports • JK suggested that it would be helpful to have a more thorough description of service at the start of the report.	
7.	**Chief Executive's Update and Quality and Performance Report**	
a.	The Chief Executive provided an overview of strategy, partnership working, performance, achievements and other developments for the past month plus the performance and quality update for January 2019. Key issues noted through his report were as follows;	

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	• The opening of the new Emergency Assessment Centre at Wexham Park with the first services moved in over the weekend of the 23rd and 24th February • The publication of national reports on workforce and digital developments and RCS review • The Memorandum of Understanding agreed with Brunel University in relation to the University's intention to establish a medical school. The MoU is intended to promote cooperation and advancement of understanding between the University and Frimley Health • Cancer performance is at top end nationally, with everyone in the team to be congratulated, noting the enormous amount of work that has gone into improving practices and pathways to consistently be among the best in the country for cancer access • The challenging financial position, to be considered later in the meeting • The improvement in managing winter pressures, but noting that the challenges in meeting the national ED waiting time targets are ongoing	
b.	JW asked to what extent people were aware that Frimley Health was the top performing in the country for cancer performance. The Chief Executive confirmed that significant communication was being carried out in this regard.	
c.	JW asked what the reason was for the low delayed discharge of care figure that was recorded. LG said that this was attributable in part to a revised method of counting that had been implemented so that it is in-line with the most recent DToC guidance, however it was also down to some good work locally.	
d.	RL asked what measures the Trust took to obtain best practice and good ideas from other Trusts. The Chief Executive said that this occurred in a variety of ways, citing, for example the Wigan Deal, reflecting local issues and being transparent with the public.	
e.	DK made reference to the declining number of breaches in mixed sex accommodation and asked what steps were being taken to bring these to zero. DB outlined the changes taking place which should ensure that this was achieved, including the new EAC, changes planned for the medical day unit and within the Frimley Day Surgery Units.	
f.	MOD referred to benchmarking (selected measures), and noted the high staff Friends and Family Test (FFT) rating at Morecambe Bay. JK said that she was happy to follow this through and it was suggested that DB might want to connect with this, in terms of Freedom to Speak Up initiatives.	
g.	MOD said that activity levels were not reducing (other than overnight elective admissions) and asked why this was the case. In response, the Chief Executive said that part of this was attributable to the length of time that transformation needed in the context of a growing population. MOD said that it would be helpful to receive any benchmarking data on this issue.	
h.	TS noted that the Time to Hire figures were creeping up from November when it was recorded as 48 days. JK said that there were 10 posts where delays had been encountered and this was particularly the case with the shortlisting process. She added that the People Committee would be drilling down into the reasons for this. She also noted the importance of including the ICS in considering these issues.	

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i.	The Chair thanked the Chief Executive for his excellent report, which covered Trust, ICS and national level issues and insights. It was really helpful for the board. The Board duly noted the report.	
8.1	**Finance Report - Month 10 (January 2019)**	
a	NF presented an update on the current forecast financial position for the trust with the key issues as follows; • He advised Members of the Board that whilst the Trust is continuing to forecast meeting its 2018/19 financial control total of £6.6m surplus, it is important that the Board recognises that the challenges of meeting the financial control total have increased again this month. • He said that the month 10 position is £1.1m worse than expected as a result of (i) retrospective agency shifts, not previously accrued (ii) ward nursing pressures at FPH (iii) back ended CIP/forecast improvements in Theatres undelivered and (iv) high cost drug gain share and repack income lower than forecast (see next item) • NF emphasised the importance of staying within financial limits and focusing on controls; he said that every member of staff had an important role to play in this • NF also made reference to the risk associated with Provider Sustainability Funding for the A&E target of 95% within 4 hours for March. He also noted that there may be a redistribution of any funds left over at a national level, but that this would not be known until May.	
b.	The Board noted the report	
8.2	**2018/19 CIP Summary – Month 10**	
a.	HC presented the 2018/19 CIP Summary for month 10. Key issues noted through the report were as follows; • At the close of month 10, the Trust delivered £20m against the plan of £25.3m • Pay related CIPs remain the largest under-achieving areas reflecting the pressures reported in the Trust's financial position • Achieving the planned savings from the Waiting List Initiatives, Theatres and ED Departments on both sites are proving the most challenging as the organisation continues to experience increased activity and capacity	
b.	RP said that the Finance Assurance Committee (FAC) held on 14th February had been a good meeting, but that Members of the Committee had been disappointed to be informed of the £1.1m deterioration in finances, (referred to in the finance report above) about which they were not previously aware, caused in large part through unanticipated medical and nurse agency and retrospective shifts.	
c.	RP said that the FAC had been given an assurance that there would be no repeat of this. It was noted that the control totals would still be met although this would require use of reserves. It was agreed by Members of the Board that these situations should not be allowed to occur in the future.	

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d.	MOD asked what remedial action was being taken in relation to the retrospective agency costs and NF said that future costs in this category would be booked on the system in real time.	
e	There was brief discussion of the CIP Programme for 2019/20. HC said that there was a £30.4m CIP target of which £21.8m had been identified and £27m was thought to be achievable. She said that 2.5% saving would be required from each Directorate and the other 2.5% would be at Trust level. HC agreed to circulate the 2019/20 paper to the board.	
f	The Chair suggested that the Executive Directors might wish to consider carrying out a learning review for the way we managed Finance and CIP in 2018/19, as there may be some good learns for both for the coming year, which is going to be one of the toughest we have had for a long time.	
g	In summary, the Chief Executive said that it had been an uncomfortable month, noting the actions being taken to address the issues identified as;	
h.	➢ A thorough assessment of control processes ➢ Tight control of programming ➢ Meetings being held with each of the Directors in relation to Business Planning.	
i	The Board noted the report.	
9.	**Corporate Risk Assurance Framework**	
a.	A report was presented summarising the discussions regarding "high level" risks facing Frimley Health Foundation Trust at the January meeting of the Corporate Governance Group.	
b.	The Chair said that this would be last time that this document would be presented to the Board and that in future it would be considered at the Audit Committee, noting that it would be the Board Assurance Framework that would be considered by the Board going forward.	
c.	JW expressed concern about the length of time that it took to address urgent risks and asked whether this would be acerbated by the Corporate Risk Assurance Framework no longer coming to the Board. In response, DB said that more time could be spent at Board Committee Meetings in considering risk and that each Directorate was looking to refine the work that they carry out in relation to risk.	
d.	The Chief Executive emphasised the importance of risk appetite and culture in the risk management process and noted the intention to move to a revised Performance Management Framework at which relevant committees would have the greatest oversight of key risks.	
e.	It was agreed that DB and SNW would refine proposals for future consideration of risks in the RAF that should be taken to the appropriate board committees for further discussion.	**DB SWN**
f.	The Board noted the report.	

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10.	**HCW Flu Vaccination Uptake by Trust health care workers**	
a.	TH provided context and current data in relation to this report. Members of the Board were advised that the season had started well, but slowed markedly after several weeks and has remained lower than expected which was disappointing. It was noted that this response was reflected nationally and is thought to have been as a result of many interrelated factors including the warmer weather over the winter period.	
b.	It was also noted that further work was being carried out to ensure that the numbers of all those health care workers in the Trust that had vaccinated had been properly recorded.	
c.	DK asked whether there had been sufficient positive messages regarding the vaccination programme. In response, it was noted that the communications had been pitched in different ways to make the interventions as effective as possible.	
d	The Board noted the report.	
11.	**Frimley ICS and Frimley Health Operating Plan 2019/2020**	
a.	ND and NF gave a verbal overview of this report.	
b.	Members of the Board noted that it was a substantial document covering the Integrated Care System, still in draft at this stage.	**NF SWN**
c.	It was noted that when finalised, the report will be presented to the Council of Governors.	
12.	**National Seven Day Services Assurance Framework**	
a.	A paper was presented, advising the Board of national changes to the Seven Day Services Board Assurance Framework in relation to the 7DS standards including the four priority clinical standards.	
b.	In response to a question from DK, it was noted that Clinical Standard 8 was recorded by site	
c.	It was agreed that the document would be managed by QAC when ready for submission and taken to the Board through QAC Minutes.	**TH**
13.	**Review summary minutes and recommendations of the Board Sub-Committees**	
a.	**Performance & Remuneration Committee held 17th January** DK reported that the meeting considered a range of performance appraisal documentation for the Chairman's and Directors' appraisals; governor questionnaire on Board Performance and questions for Directors and Governors on the Chairman's performance.	
b.	The Committee confirmed the updated changes to Executive Directors' Remuneration Policy along with Executive Directors' and senior managers' remuneration for 2018/19	
c.	**Audit Committee held on 13 February** DK advised the Board that the Committee had considered a briefing paper presented by the Head of Medical Workforce and Medical Director which set out to improve the	

	process of consultant job planning by reducing bottlenecks and to improve rates of compliance with the process. The Committee welcomed the progress made so far to improve compliance.	
d.	DK advised the Board of reports received from Internal Audit and a draft Internal Audit plan for 2019/20, noting also that preparations for the 2019 external audit were progressing well	
e.	**Finance Assurance Committee held on 14 February** RP noted that issues arising in the meeting had been considered earlier in the Board Meeting.	
f.	He confirmed to Members of the Board that as from 1st April 2019 the workings of the FAC and CDIC will be combined and will be carried out by the Finance and Investment Committee (FIC).	
g.	Terms of Reference were presented to the Board for approval. JK asked whether there would be a set month to review the capital programme. In response, it was noted that there will be a rolling agenda, which would enable several meetings to deal with this issue.	
h.	Subject to minor amendments, the Board approved the Terms of Reference for the Finance and Investment Committee. It was noted that this would require an amendment to the other Board Committee Terms of Reference and the Constitution.	
i.	**Commercial Development and Investment Committee 14th February** A report was presented, briefing the Board on the main items discussed at the 14th February meeting.	
j.	RP summarised a report setting out the benefits realised and actual costs incurred from the development of renal services on the Frimley Park Hospital site versus those anticipated in the approved full business case. It was noted that there had been significant improvements to patient experience but that levels of activity had significantly exceeded expectations and this had resulted in higher costs than anticipated.	
k.	RP also summarised a report setting out the benefits realised and actual costs incurred from the expansion of the paediatric unit at Frimley Park Hospital. It was noted that the expected benefits in terms of improvements to the environment, patient care and privacy had been delivered and that the expansion had reduced pressure on the Emergency Department.	
l.	It was noted that the Committee agreed to recommend approval of the Full Business Case and contract award to the preferred supplier by the Board, in relation to the Thames Valley and Surrey Local Health Care Record Exemplar	
m.	Members of the Board passed on a huge vote of thanks to ME for chairing this committee with the large capital programme that this entailed, maintaining rigour and challenge through the process.	

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n.	**Charitable Funds Committee 21st February** A report was presented briefing the Board on the main items discussed at the meeting with specific reference to finance and recent highlights in relation to fundraising.	
o.	**Quality Assurance Committee 26th February** A report was presented briefing the Board on the main items discussed at the meeting of the QAC. MOD passed on his thanks to SWN for producing the minutes of the meeting so quickly. It was noted that the Committee had received update reports on a number of areas, including; ➢ Reducing preventable deaths by learning from mortality reviews ➢ Pressure ulcer prevention, noting that the Trust was part of the NHSI collaborative, involved in rolling out learning with a view to improving the approach to people with pressure ulcers to ultimately reduce the numbers. ➢ Improvement in complaints handling at Wexham Park and plans to expand the patient voice in the organisation ➢ A report highlighting key areas for improvement in relation to SIRIs including a focus on QI as a precursor to redesigning systems and process and developing human factors expertise ➢ Creation of a children's and young people's Board intending to bring services together for a more holistic view.	
p.		
14.	**Any Other Business**	
a.	There was no other business.	
15.	**Questions from Members of the Public**	
a.	Mary Probert, public governor- suggested that making staff more aware of the cost of the goods and services that they used could result in meaningful savings for the Trust.	
b.	Rod Broad, public governors-thanked Kevin Jacob for the excellent support he has given to governors and the public in his role as Assistant Company Secretary.	
18.	**Date of the Next Meeting**	
a.	Friday, 3 May 08:30 – 11am Board Room, Admin Block, Frimley Park Hospital	

DRAFT

These minutes of the meeting were duly approved by the Board:

Name:	Pradip Patel
Signature:	
Date:	

DRAFT

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Frimley Health NHS Foundation Trust

BOARD OF DIRECTORS MEETING – PUBLIC

Friday 3rd May 2019

ACTION LOG

AGREED ACTION	LEAD	END DATE
CLOSED ACTIONS		
5 January 2018 - 18.e Meeting Review and 4 May 2018 -20.c Meeting Review DB to reflect on the comments made in order to find the optimum format for consistency of Ward to Board session and the reports produced for this. Discussed at Board Meeting on 1st March 2019 and can now be closed	Duncan Burton	Completed
7 September 2018 - 10.c Capital Investment Programme Update Plan guided tours for staff and key stakeholders around the new ED in Wexham Park. Action taken as part of the opening of this facility and can now be closed	Janet King	Completed
11th January 2019 -6.g Chief Executive's Update and Performance Report NF to check performance data for accuracy, specifically activity data from CCG. Action carried out through correction of data and can now be closed.	Nigel Foster	Completed
11th January 2019 – 10.d Infection Control Quarterly Report MOD expressed concern about areas which were not meeting hand hygiene targets and asked that this be discussed more fully at the QAC. QAC to follow through and Board can be informed through QAC minutes. Action closed	Tim Ho	Completed
7th December 2018 – 11.d Review of Minutes and Recommendations BAF development session for the Board to be facilitated by BDO.	Nigel Foster Susanne Nelson-Wehrmeyer	Completed on 5th April
ACTIONS IN PROGRESS		
1 September 2017 - 18.e Meeting Review PP to undertake a review of board papers and work with the EDs to make the papers fit for board.	Pradip Patel	Work in progress
5th October 2018 – 8.c Quality Improvement Plan as at September 2018 TH to present the outcomes of changes to arrangements for hospital at night including MET/NEWS calls and number of unplanned escalation type events to QAC in Q1 2019	Tim Ho	Q1 2019
11th January 2019 – 6.k Chief Executive's Update and Performance Report	Helen Coe	6th September 2019

HC to bring a report back to the Board on stroke performance if this has not improved to a point that HC was satisfied with over a six month period from January 2019. HC and SNW to determine final date.		
11th January 2019 – 14.d Review minutes and recommendations of the Board Sub-Committee MOD to report on how the wider integrated care system would change the role of QAC.	Mike O'Donovan	6th September 2019
1st March 2019-9 Corporate Risk Assurance Framework DB and SNW to refine proposals for future consideration of risks in the RAF that should be taken to the appropriate board committees for further discussion.	Duncan Burton Susanne Nelson-Wehrmeyer	3rd May 2019
1st March 2019 – 11 ICS Operating Plan 2019/20 To be taken to Council of Governors Meeting when finalised.	Nigel Foster/Susanne Nelson-Wehrmeyer	21st May 2019
1st March 2019- 12 National seven Day Services Assurance Framework To be managed by QAC when ready for submission and taken to the Board through QAC minutes.	Timothy Ho	Q1 2019
ACTIONS OVERDUE		
None		

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NHS
Frimley Health
NHS Foundation Trust

Report Title	**CEO Report**
Meeting	BOD
Meeting Date	Friday 3rd May
Agenda No.	7.
Report Type	To Note.
Prepared By	Daryl Gasson
Executive Lead	Neil Dardis
Executive Summary	This months report includes a number of changes to the standard format including 1. The introduction of statistical process contro (SPC) charts for key performance indicators. The purpose of SPC charts is to help identify when a change is statistically significant as opposed to normal variation. Two SPC charts have been included this month as examples 2. Leading Indicators – the aim of this new section is for the board to monitor indicators that will impact on future performance as opposed to most indicators which are retrosoective. More work needs to be undertaken to indentify leading indicators which are relevant for FHFT 3. Process & Outcomes – this section is designed to show two or more indicators alongside each other to explore possible links in terms of cause and effect. This month we have plotted ward hand-hygiene compliance versus the incidence of C.diff infection. 4. The other new section is an in-depth focus of a performance indicator (in this case stroke performance) the aim of which is to give the Board more detail and explanation of an area that might be of particular interest or where the headline performance might not show the full picture.
Recommendation	The Board are asked to note the proposed new sections of the CEO report and provide feedback as to which they would like developed for 2019/20.
Appendices	Quality and Performance report

7

Version 5.2

Frimley Health NHS
NHS Foundation Trust

Chief Executive's report
including Quality & Performance update

March 2019

Committed To Excellence | Working Together | Facing The Future

Contents

This report covers the period from March 2018 to allow comparison with historic performance. However, the targets and exception reports relate to March 2019 for the financial year 2018/19

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Process and outcomes	
In depth	

RAG key

- Achieving target
- Between target and threshold (where applicable)
- Worse than target or threshold (where applicable)

Chief executive's overview (1)

Introduction

This report aims to highlight to Board members those areas that will benefit from focussed discussion in today's meeting, note the national context we are currently operating in, and recognise the developments and achievements of the Trust since we last met. Appended to the report is a summary of discussions and decisions made by the senior leadership team.

Strategic Developments

Development of the new Trust strategy continues and the team has made good progress over the last month. The Board is aware we have hosted a large number of executive-led engagement sessions within the Trust and with external stakeholders to build a long list of 492 options to tackle our strategic issues; these options are being assessed and refined and they will help us to shape our strategic ambitions that will frame our strategy.

The Board recently discussed our vision statement for #FutureFHFT and this will be finalised as we develop our strategic ambitions for the future, and ensure these are aligned with our values and the ICS strategy. There will be further plans to test our strategy before it is finalised in the summer.

Our new £49m Emergency Assessment Centre (EAC) at Wexham Park is now fully operational following the third and final phase of its opening, when the emergency department transferred services on 3 April. Following the successful transfer of short stay services in February and ambulatory and assessment wards in March, the opening of ED services to the new facility went smoothly thanks to extensive planning and groundwork beforehand. This included orientation tours, system training and major incident scenarios. Many staff worked through the night to ensure that patients in the old ED were assessed quickly and discharged, transferred or admitted in good time. It was an exciting and historic moment for staff and I am really pleased that we can now offer our patients and staff a much better care environment.

The building work at Heatherwood, which started in February, reached another milestone in April with a ground breaking ceremony attended by FHFT staff, contractors and others from the project team. It followed a stakeholder event in March, held at Ascot Racecourse, where we were able to thank everyone who had been involved in getting the building phase underway and outline how the project would progress up until completion in 2021.

Planning permission for a new inpatient and diagnostic unit in place of the Medical Records building at Frimley Park has now been given by Surrey Heath Borough Council. The plans include an expanded scanning centre and a new breast care unit, which was made possible by the completion of a successful fundraising campaign. Options for the rest of the available space in the new building are being discussed with clinicians and a full business case is being drafted for Board approval in the coming months.

Chief executive's overview (2)

National context and partnership working

Although the possibility of a no-deal exit from the EU appears to have reduced at this time, all scenarios stay open so our short term planning continues to focus on working with the national network to ensure supplies of drugs and consumables. Longer term contingencies relate to workforce and employee status, research and EU funding. Our director of operations continues to liaise with the national planning teams to support our preparations.

We welcome the news that the governing bodies of our Integrated Care System (ICS) commissioners – East Berkshire, North East Hampshire and Farnham, and Surrey Heath – have agreed to form a single governing body committee in common with a shared executive committee across the three CCGs (clinical commissioning groups). The move will allow the governing body to work more effectively and efficiently at making improvements across the Frimley Health and Care ICS and demonstrates a commitment to greater collaboration.

Led by consultant neurologist Dr Matt Craner, we have helped to redesign neurological care and treatment pathways across the ICS to create one of the first integrated community-based models of its kind in the country. The pathway will provide a better experience for patients with conditions such as Parkinson's disease, epilepsy, multiple sclerosis and migraine by reducing admission and length of stay in hospital and avoiding travel to London for specialist care.

Frimley Health and Care ICS has joined a partnership to allow residents to access their records and use digital services and apps to help them manage their own health and wellbeing. Thames Valley health and Care Partnerships, of which our ICS is a part, has joined a region-wide platform for securely sharing patient care records between organisations, building on the progress already made.

NHS England and NHS Improvement announced further progress on their integration with a move towards a single chief executive and chief operating officer (COO) model. The COO for both organisations will report directly to Simon Stevens, chief executive of NHS England. Reporting directly to them will be seven regional directors. Most of the regional team (south east) have also been appointed and include: Vaughan Lewis, medical director and chief information officer; Hannah Hilton, finance director; Caroline Beardall, director of workforce and OD; Claudia Griffith, director of performance and improvement; David Radbourne, director of strategy and transformation; Janet Meek, director of commissioning. The Board will be aware that Anne Eden was appointed as the regional director for this patch and we were delighted to host a visit to Wexham Park recently to show her the new EAC building.

Chief executive's overview (3)

Performance overview

Frimley Health has once again returned a positive set of results for the full 2018-19 year. The Trust can be especially proud of our cancer access performance over the year, when we have consistently been among the very best in the country on all aspects of waiting times. A huge amount of work has gone into making and maintaining these improvements in an area where waiting time has a critical impact on outcomes for patients.

We have also seen a marked improvement in healthcare associated infection in 2018-19, with no MRSA cases during the year and a 38% reduction in Clostridium difficile cases to 28. There were also marked reductions in gram-negative bacteraemia including Ecoli, Klebsiella and Pseudomonas aeruginosa.

We remain among a few trusts to achieve the 18 week referral to treatment target with more than 92% of patients' treatments commencing within the time period.

The four-hour A&E target remains the one key area where the trust did not achieve the required standard. We will continue to work with partners across the urgent care network to make improvements and we will be assessing how our new care pathways in the EAC at Wexham Park impact upon waiting and access times.

The Trust is one of 14 organisations across the country that has agreed to take part in field testing proposed new emergency care standards. Trusts were chosen in order to provide data from a range of locations, performance and demographics. The pilot will begin later this month and the trial standards will focus on time to initial assessment, treatment within the first hour for critically ill and injured, average time in A&E and use of same-day emergency care. The Trust will continue to measure the four-hour standard during the trial period.

During the month we saw a rise in mixed sex accommodation due to issues with new toilet facilities in Day Surgery 2 at Frimley Park that are currently under investigation. Responses to complaint times have continued to improve along with sepsis screening in ED. Wexham Park Hospital reached the national top ten scorers in the National Hip Fracture Database report 2018. This is a fantastic achievement for the department, which has seen a huge improvement in meeting the Best Practice Tariff (BPT) criteria in 83.7% of cases (national average is 57.1%).

Frimley Park Hospital has retained its A level rating in the Sentinel Stroke National Audit Programme. It has now achieved the top rating for the past four quarters and is the best performing hyper acute stroke unit locally.

Chief executive's overview (4)

Performance overview (continued)

The month 12 financial position has seen the Trust achieve all financial targets for the year end. The control total of £6.1m has been achieved in line with previous forecasts reported to the Board. Following a revision to the Q4 A&E target, the Trust is also eligible for the full value of the A&E element and so the Trust will get the planned £26.2m PSF (provider sustainability fund) value. By achieving the control total the incentive distribution awarded to the Trust for the year is an additional £12.4m PSF making a total of £38.6m. The system wide ICS control total was also achieved.

In the final accounts the Trust will report a surplus of £44.7m before impairments and donations (£38.6m PSF plus required control total delivery of £6.1m) and £39.1m bottom line after impairments. The cost improvement plan (CIP) achievement for the year created £23.7m efficiency gains against a plan of £31m (76% delivery / 3.4% of expenditure). Capital expenditure for the year was £75.8m, under plan by £0.6m, and cash balances are at £133m. While recognising some of this was achieved through one year benefits, I would like to thank all those involved for this achievement.

Developments and achievements

A series of 'To be' workshop have been held for staff to help develop the requirements for a new electronic patient record (EPR) system. A total of 350 clinical, administrative, secretarial and managerial staff from across the trust attended the workshops recently to help create a detailed understanding of what we want and need EPR to do to support the Trust now and in the future.

The Trust made significant improvements in safety culture, staff engagement and quality of appraisals according to the latest results of the 2018 National Staff Survey. Feedback on immediate managers also improved on 2017. These improvements reflected areas of focus from last year and overall the Trust once again scored significantly better than average. Advocacy scores were also good with 70% of respondents recommending FHFT as a place to work and 81% saying they would be happy with the standard of care the Trust could provide for a relative or friend. The national averages for similar trusts were 63% and 71% respectively.

Congratulations to our theatres team at Frimley Park who recently performed their 500th robotic partial nephrectomy. Frimley began using the robot for surgery remove a tumour or diseased section of a kidney while maintaining the organ almost 10 years ago. It is a regional centre performing more than 100 partial nephrectomies per year.

A new service has been set up by Frimley Health. The block room anaesthesia team, or BRAT, can numb arms, legs, broken ribs and surgical incisions without the need for general anaesthetics. The concept is used in North Americana and Scandinavia but the Frimley BRAT is thought to be the first in the NHS. Patients usually experience less pain and sickness with speedier discharge.
The Trust continues to be the top recruiter worldwide to the IntAct international study into the side effects of rectal cancer surgery, with the 25th person recruited this month – twice as many as any other organisation. In recognition, colorectal surgeon Mr Henry Tilney was invited to speak at the international investigators meeting at the Amsterdam Medical Centre recently.

Chief executive's overview (4)

Developments and achievements (continued)

Congratulations to Dr Lucy Abbott, consultant geriatrician, appointed the Trust's new End of Life Care lead with a remit to focus attention on helping patients nearing the end of their lives to live as well as possible until they die. She replaces Bruce Montgomery, who is retiring, and we are currently recruiting for Bruce's other role as Freedom to Speak Up Guardian. I would like to take the opportunity to thank Bruce for all his efforts and achievements for the Trust.

Further notable achievements include:

- Two of our students from our affiliation with the American University of the Caribbean (AUC) have achieved residencies in anaesthesiology and psychiatry in the United States of America. Bardia Azar and Goli Shenasan are grateful that their experiences at Wexham Park Hospital and letters of recommendation supported their residency applications.
- The Surrey Heath Frailty team was shortlisted for the BMJ's Care of the Older Person Team Award for its proactive and integrated approach to frailty management.
- Wexham Park's Paediatric Department once again had a good showing at the Oxford School of Paediatrics Awards for Training Achievement. The department was shortlisted for training department of the year for the third year running and Dr Johanna Aspel won trainer of the year.

Recommendation

The Board is asked to note the report

Performance Summary – key indicators at a glance

Note – these indicators are for the current month only (March 2019)

Safe	
C-Diff	2
MRSA	0
E-Coli	21
Never Events	1

Effective	
SHMI*	90.4
Overall	90.4
Non-elective	90.0
Elective	111.9

Caring	
Inpatient FFT	98.1%
Mixed Sex Accommodation	206

Key	Deteriorating performance	Improved Performance	Stayed the same
	↓	↑	↔

Responsive	
A&E > 4 hours	83.3%
RTT < 18 weeks	90.6%
Cancer 62 Day	92.3%
Cancer 62 day screening	85.0%*
Diagnostics < 6 weeks	1.3%
Complaints – 25 days response rate	87%

Well Led	
Vacancy rate %	10.6%
Sickness rate %	2.5%
Appraisal rate %	75%
MAST training %	89%
Staff FFT	82%
Projected variance vs. financial plan	£12.4m
CIP delivery	£23.7m
Agency Spend % of pay bill	5.4%

Demand & Activity		% Change on previous year	
	month	month	YTD
GP Referrals	16349	5%	2%
OP Atts	73014	1%	1%
Day cases	5902	1%	3%
All Electives (includes Day cases)	8496	0%	3%
ED Atts	20727	3%	2%
Non elective	9858	2%	5%

* The red rating for cancer screening is due to one patient choosing to delay their treatment

Statistical Process Control (SPC)

Statistical Process Control helps to understand what is the norm and what is different. Performance of a KPI is looked at over time and statistical analysis is used to calculate an "upper control limit" and a "lower control limit". Where performance has fallen above or below the mean for 7 consecutive months, the SPC chart is reset and mean and Control Limits are recalculated. These are labelled on the chart as "Reset"

If performance falls within the control limits, then it is seen as "normal statistical fluctuation" and does not need special attention. However, if performance has either risen above the "upper control limit" or fallen below the "lower control limit" then this needs special attention

The notation used in the SPC charts is

Blue line – FPH actual performance
Red line – Mean FPH performance over the time period on the chart
Green lines (dotted) – Upper Control Limit and Lower Control Limit

The following symbols are used:

Within normal statistical fluctuation

Above Control Limit – shows significant deterioration

Below Control Limit – shows significant deterioration

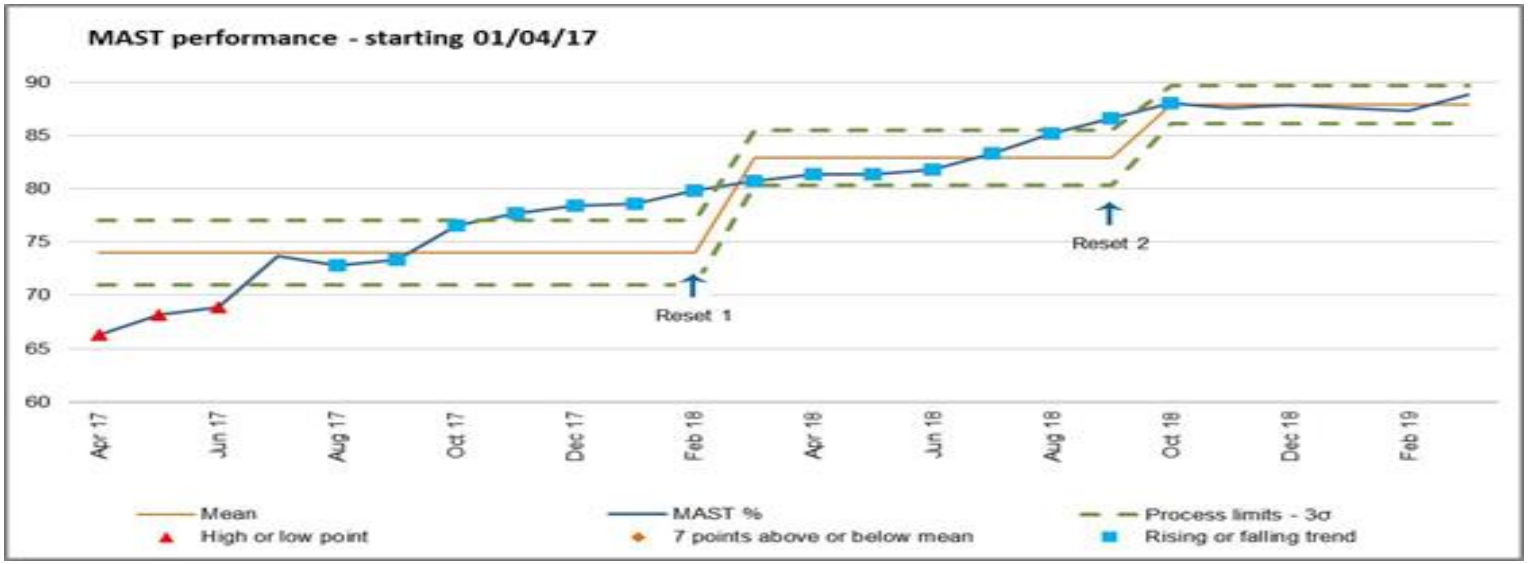
Above Control Limit – shows significant improvement

Below Control Limit – shows significant improvement

In addition, the charts have the following key:

Outside process limit	Points which fall outside the process limits are unusual and should be investigated
Rising or falling trend	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process
Seven points above or below mean	When more than 7 sequential points fall above or below the mean, that is unusual and may indicate a significant change in process

SPC – performance summary



Leading indicators

#NOF to theatre within 36 hours

Latest statistical analysis

Feb-19
84%

Compared to last period
Improvement
77%

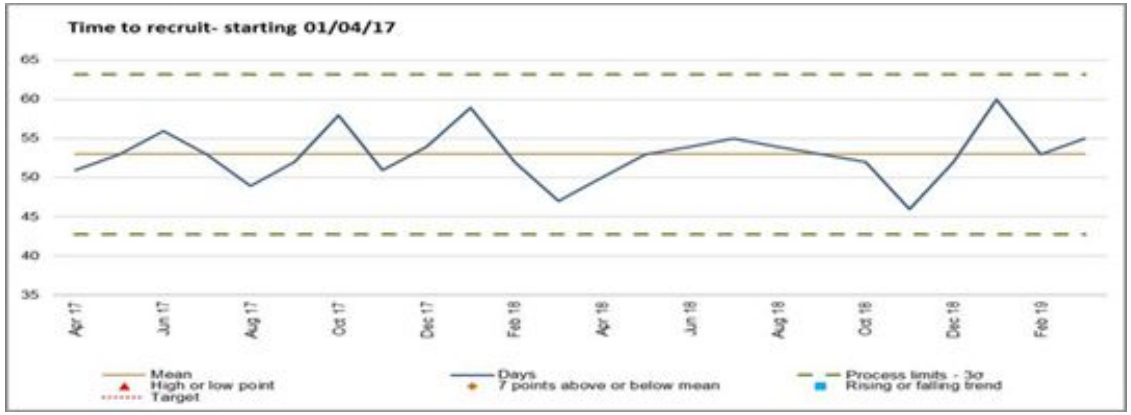
Target & Threshold		Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
>=90%	<80%	82	75	85	79	77	85	90	89	89	81	77	84

Average time to replace vacancy (days)

Latest statistical analysis

Mar-19
55

Compared to last period
Deterioration
52



Target & Threshold		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<=40	>=50	50	53	54	55	54	53	52	48	52	60	53	55

Sepsis CQUIN – exception report

Background / Issues

Standard: 90% or more of patients presenting to Emergency Department/who deteriorate during an inpatient stay are screened for and where appropriate treated for sepsis in a timely manner
Definition: All patients (Attending ED or inpatients) who have triggered a NEWS score of 3 in one parameter or 5 or more/who look sick should be screened for sepsis. Where a patient has triggered and infection is suspected IV Antibiotic administration within 1 hour should occur as part of the SEPSIS 6
Comments/context: The improving picture for inpatient screening for sepsis, and timely administration of Antibiotics continues. ED performance for screening maintained cross site. Challenges with Antibiotic administration in ED at WPH continue

Action Plan

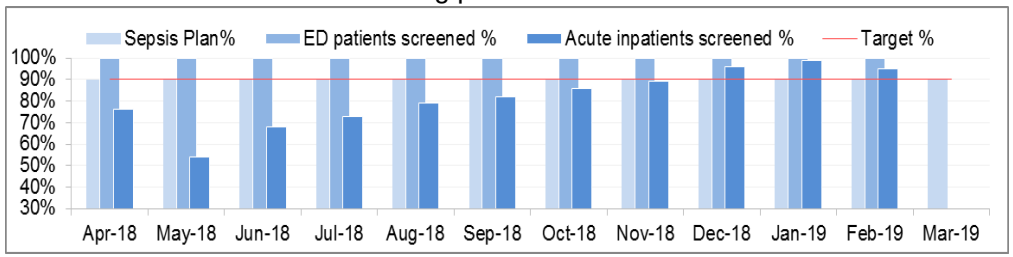
- Cross site sepsis committee to continue
- Trust wide sepsis intranet page launch
- Deteriorating patient educational updates/roadshow to take place in April across FHFT
- Call for Concern campaign posters to be launched
- E-observations to be implemented

Date and named person

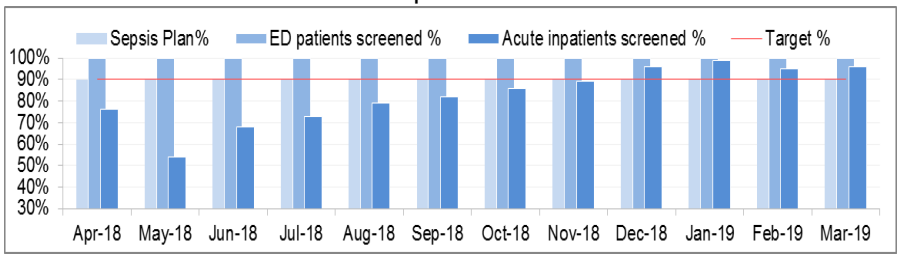
- Ongoing – Head of Quality, Beth Bal
- April 2019 – Head of Quality, Beth Bal
- April 2019 – Lead Nurse for Deteriorating Patient, Karen Britton
- May 2019 – Lead Nurse for Deteriorating Patient, Karen Britton
- July 2019 – Chief Nurse for IM&T, Kevin Percival

Trajectory for improvement

Screening performance



Treatment performance



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sepsis Plan%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
ED patients screened %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Acute inpatients screened %	76%	54%	68%	73%	79%	82%	86%	89%	96%	99%	95%	96%
Sepsis patients treated (ED) %	73%	75%	60%	80%	74%	63%	85%	82%	83%	89%	86%	89%
Sepsis patients treated (inpatients) %	85%	73%	82%	86%	89%	94%	91%	100%	96%	97%	97%	100%

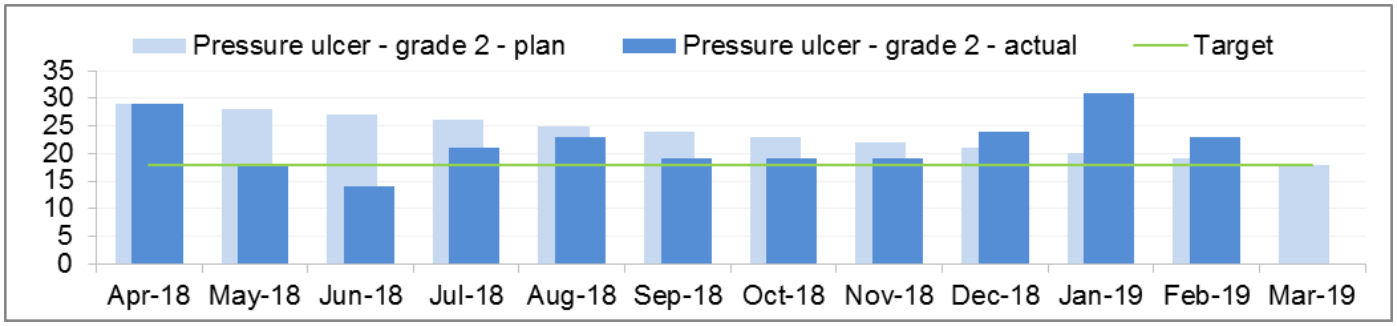
Executive Lead (s)

Duncan Burton

Pressure ulcer – Grade 2 – exception report

Background / Issues	Action Plan	Date and named person
Standard: The Trust is aiming to reduce the number of hospital acquired grade 2 pressure ulcers **Definition:** A patient who develops a grade 2 pressure ulcer (as per national definition) whilst in our care **Comments/Context:** The number of grade 2 pressure ulcers developed whilst an inpatient remains consistent over the monthly reporting	▪ Training continues on the risk assessment process and prevention of pressure damage at Patient Safety Training, care certificate and preceptorship training ▪ To implement NHSI guidance on Pressure Ulcer Classification across Frimley Health with new reporting categories built into the RL system ▪ Commenced the NHSI Collaborative on Pressure Ulcers focusing on early identification of pressure damage ▪ To develop a patient information video on the prevention of pressure damage whilst in hospital ▪ A task and Finish group to be established to further imbed the improvement work on the prevention of pressure damage	Tracey Coulson Head of Patient Safety Lisa Barbier lead Nurse for Patient Safety Lisa Barbier lead Nurse for Patient Safety – April 2019 Lisa Barbier lead Nurse for Patient Safety – April 2019 Maxine McVey Deputy Director of Nursing – April 2019

Trajectory for improvement



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Pressure ulcer - grade 2 - plan	29	28	27	26	25	24	23	22	21	20	19	18
Pressure ulcer - grade 2 - actual	29	18	14	21	23	19	19	19	24	31	23	

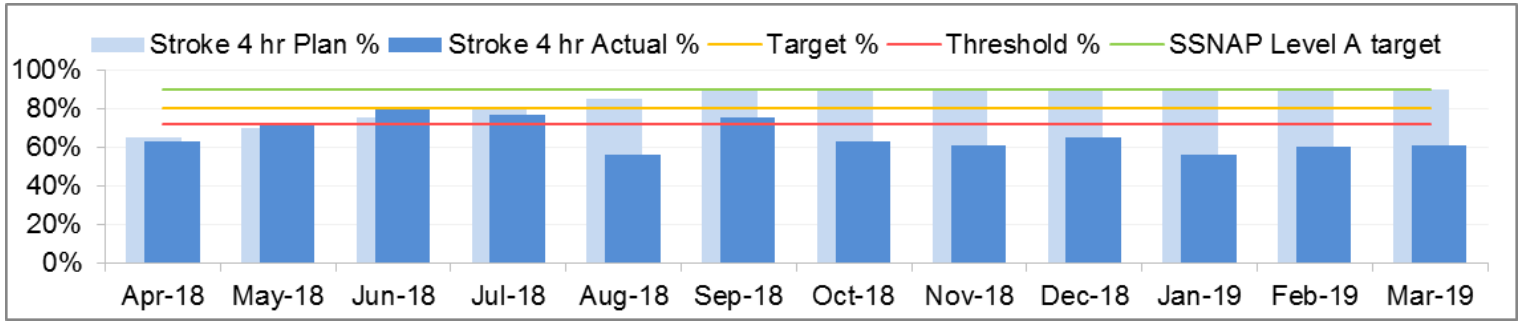
Executive Lead (s)

Duncan Burton

Stroke Unit – 4hr direct admission – exception report

Background / Issues	Action Plan	Date and named person
Standard: People with suspected acute stroke should be admitted directly to a hyper acute stroke unit (HASU) and be assessed for emergency stroke treatments by a specialist physician without delay **Definition:** Proportion of patients admitted directly to the stroke unit within 4hrs of clock start. National target of 90% to achieve Stroke Unit Sentinel Stroke National Audit Programme (SSNAP) level A and the internal target is 80% and the threshold is 70% **Comments / context:** Although our 4hr admission is not as we would hope, it should be put into context against the national average: 1) The national average across 142 HASU's participating in SSNAP is 60.2%. 2) FPH HASU is currently at 69.5%. 3) We are the 4th best performing Trust out of 14 within the South East Coast Network. 4) We are the 35th best performing Trust out of 142 across the UK. **GIRFT visit:** acknowledged as being one of the best Trusts in KSS deanery, but work required to improve 4 hour response	▪ Feedback from weekly breach reviews, led by stroke coordinator team. 1st 2 weeks of April = 64x admissions (all diagnosis) with 24x 4hr breaches (12x late referral, 4x bed availability, 1x clerking delay, 1x CT delay, 6x reasons not documented). Meeting with ED being organised to discuss delayed referrals, this may link in with training. Simulation day being planned and timing a few patients through the pathway, with key times being noted. Most breaches occurring in hours, which supports the need for AM discharges and ring-fenced beds. Reviewing the current discharge process to see how these can be brought forward in the day. Coordinators reminded to maintain documentation standards. ▪ Q3 SSNAP public reports have been published. Score for D2: Stroke Unit remains a C. It has not declined. We are still performing better than the national average. ▪ There are continuing recruitment challenges within the team; however, Dr Song joined in April as rehab consultant. A locum HASU consultant also started in April. Consultant advert has closed – no suitable applicants. Will need to re-advertise. Potential staffing gaps within therapy teams which may impact on 7 day working. Both added to stroke risk register.	AH on-going CB/TE on-going OS/therapy leads on-going

Trajectory for improvement



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Stroke 4 hr Plan %	65%	70%	75%	80%	85%	90%	90%	90%	90%	90%	90%	90%
Stroke 4 hr Actual %	63%	71%	81%	77%	56%	75%	63%	61%	65%	56%	60%	61%

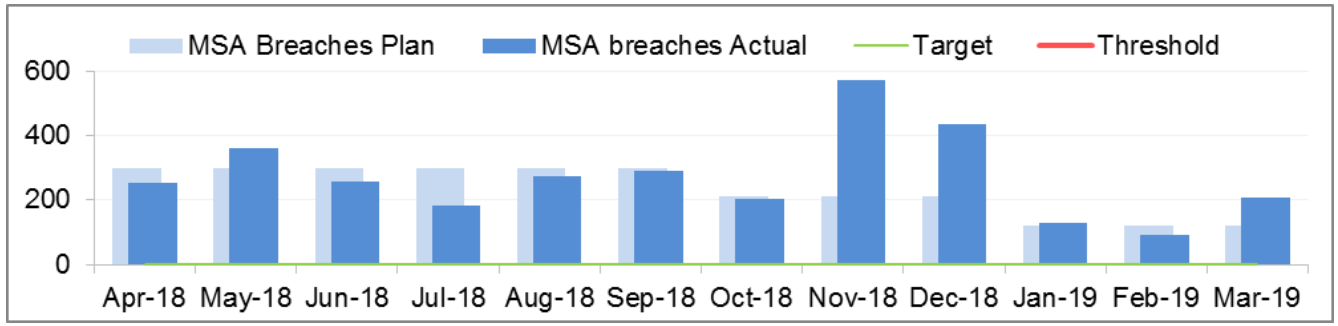
Executive Lead (s)

Helen Coe

Mixed Sex Accommodation breaches – exception report

Background / Issues	Action Plan	Date and named person
Standard: All NHS Trusts to eliminate mixed-sex accommodation, except where it is in the best interest of the patient, or reflects personal choice **Definition:** Breaches of sleeping accommodation must be reported for each patient affected. *"Sleeping accommodation"* includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight **Comments/context:** Rise in DSU 2 breaches at FPH this month due to issues with new toilet facilities. Small number of breaches in GI unit and MIDU at WPH noted. Some breaches reported in CCU FPH due to delayed step down of patients	▪ Director of Estates to investigate issues with new facilities ▪ Plans and timeframes for MIDU and GI unit moves to be confirmed	▪ Aprll 2019 - Director of Estates, Colin Mapperly ▪ April 2019 – Assistant to the Director of Operations. Elizabeth Head

Trajectory for improvement



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
MSA Breaches Plan	300	300	300	300	300	300	210	210	210	120	120	120
MSA breaches Actual	251	362	257	182	275	290	202	570	436	129	91	206

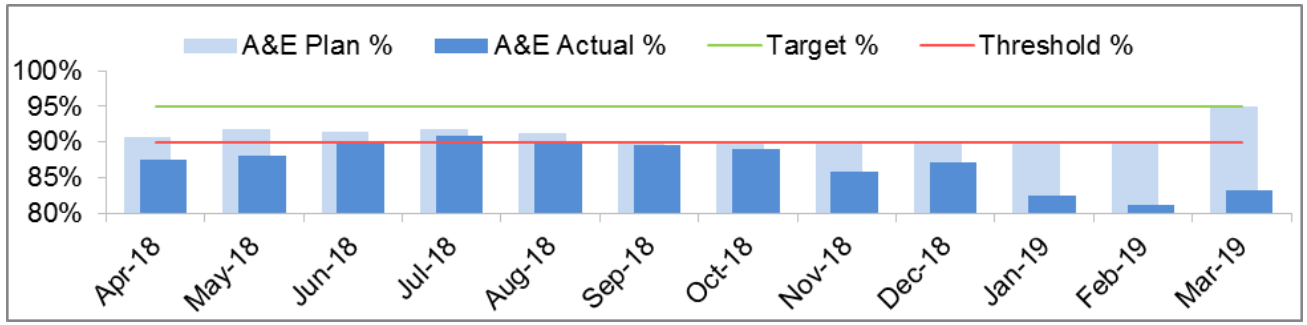
Executive Lead (s)

Duncan Burton

Emergency Department 4 hour target – exception report

Background / Issues	Action Plan	Date and named person
Standard: 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at A&E **Definition**: number of unplanned attendances to A&E that are admitted/ transferred/ discharged within 4 hours of their arrival as a % of the total number of unplanned attendances to A&E **Comment/Context** Bed pressures have had significant knock-on impact with 4 hour target on both sites; medical and clinical staffing remain challenging but improving. Volumes of patients similar to previous years, but acuity higher, reflected in majors activity	▪ Refreshed hospital pillar action plan 19/20 agreed; governed through Urgent & Emergency Care delivery Board. Emphasis on frailty, SDEC and LoS ▪ Action plan to reduce 21 day+ long stayers in line with NHSI expected trajectory agreed with system partners; governed through Urgent & Emergency Care delivery Board ▪ WPH EAC fully open - new processes being implemented/embedded to improve flow ▪ WPH Challenges with implementation of Symphony in ED. Focus on embedding new system continues ▪ ICS Urgent Care Board holding system to account for response to current issues which impact on flow & LoS as well an emergency care planning ▪ Daily actions taken for hot topics following dashboard analysis, huddles and task and finish groups ▪ Analysis of high volumes and acuity of patients in March/April to understand the causes at system level ▪ Focus on capacity and flow, through daily bed meetings ▪ Focus on accuracy of occupancy on Realtime system to inform live bed state to support improving flow	DM /KM completed April 19 DM, KM, HC, JT, Completed end of March '19 KM, JS, NP, Chiefs – on-going BAU KM, IM&T team – on-going BAU Helen Coe / Fiona SB on-going DM / KM, clinical leads, on-going DM – April 19 Fiona Sayers, Jo Coric on-going Heidi Barber & Jo Coric on-going

Trajectory for improvement



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A&E Plan %	90.6%	91.8%	91.4%	91.7%	91.2%	90.1%	90.1%	90.1%	90.1%	90.0%	90.0%	95.0%
A&E Actual %	87.6%	88.0%	90.0%	90.8%	90.1%	89.6%	89.1%	85.9%	87.2%	82.5%	81.1%	83.3%

Executive Lead (s)

Helen Coe and Lisa Glynn

Staff turnover – exception report

Background / Issues

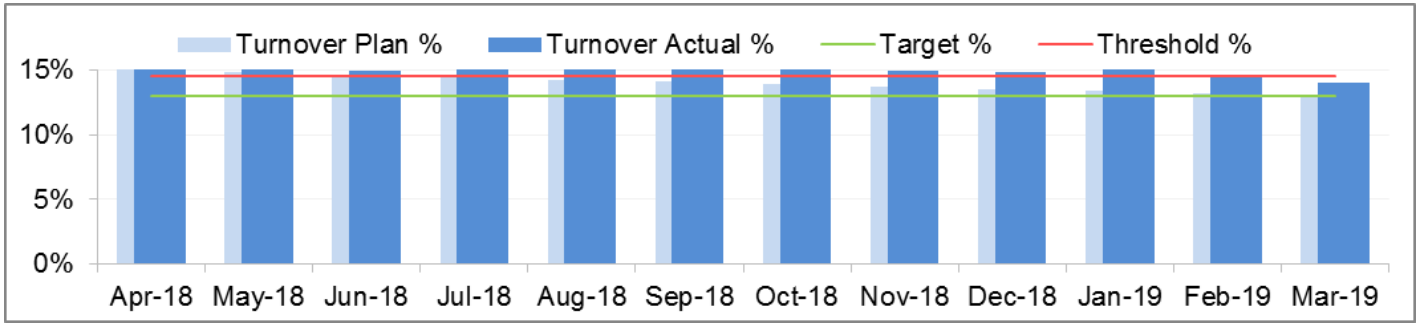
Standard: Turnover is currently 14.4%. The target is to reduce turnover to below 13% with a threshold of 14%

Definition: The number (FTE) of employees who leave over a 12 month period divided by the average staff in post

Comments/context: The stability index data from the Model Hospital shows that we are performing better than local trusts in regards to staff turnover

▪ Working with NHSI as part of their Retention Direct Support (Cohort 4) programme to develop retention initiatives and target key areas for improvement (NHSI postponed tot May)	Michael Ellis, May 2019
▪ Relaunch of existing retention initiatives to increase awareness – Retention Action Group formed to take forward	Michael Ellis, May 2019
▪ Updating retire and return policy and procedure to encourage retirees to re-join the Trust	Elaine Morgans, Apr 2019
▪ Local staff recognition fund to be launched	Eleanor Shingleton-Smith, May 2019
▪ Launch 'Each Person' staff recognition and benefits platform	Eleanor Shingleton-Smith, May 2019

Trajectory for improvement



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Turnover Plan %	15.0%	14.8%	14.6%	14.5%	14.3%	14.1%	13.9%	13.7%	13.5%	13.4%	13.2%	13.0%
Turnover Actual %	15.0%	15.1%	14.9%	15.0%	15.1%	15.0%	15.1%	14.9%	14.8%	15.0%	14.4%	14.0%

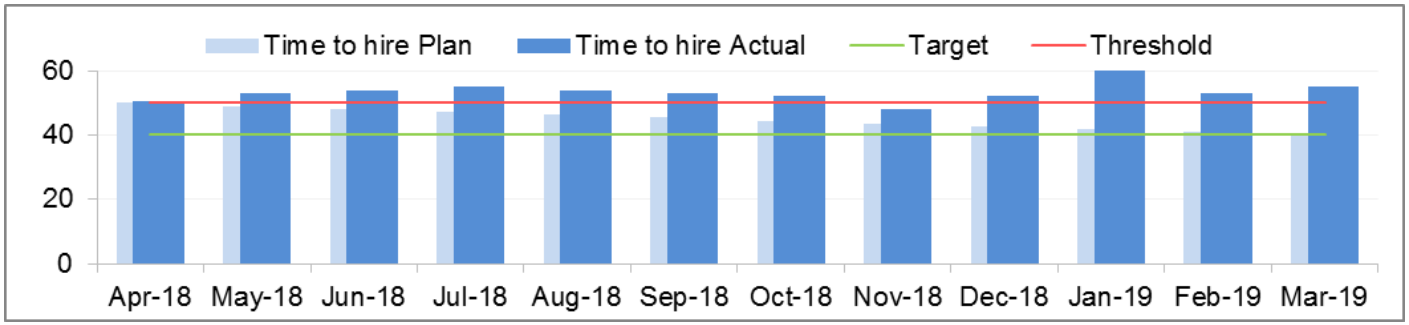
Executive Lead (s)

Janet King

Time to hire – exception report

Background / Issues	Action Plan	Date and named person
Standard: Time to hire is currently 55 days. The target is to reduce this to 40 days, and the threshold is 50 days **Definition:** Number of working days from the date vacancy created to unconditional offer **Comments/context:** Recent benchmarking ranked FHFT 16th (170 employers use the TRAC system) in regards to the time taken to complete employment checks. The Trust also scores favourably on the NHS Model Hospital benchmarking compared to many peers. 10 recruitment episodes (of 149) contributed to an increase in 6 days of the average time-to-hire this month	▪ Monthly time-to-hire data to be produced and circulated as part of workforce performance reports ▪ Undertake further benchmarking of peers and review time to hire targets ▪ NHS Streamlining Programme practices being adopted to improve the process and remove delays in pre-employment checks stage.	Michael Ellis, Apr 2019 Michael Ellis, Apr 2019 Michael Ellis, May 2019

Trajectory for improvement



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Time to hire Plan	50	49	48	47	46	45	45	44	43	42	41	40
Time to hire Actual	50	53	54	55	54	53	52	48	52	60	53	55

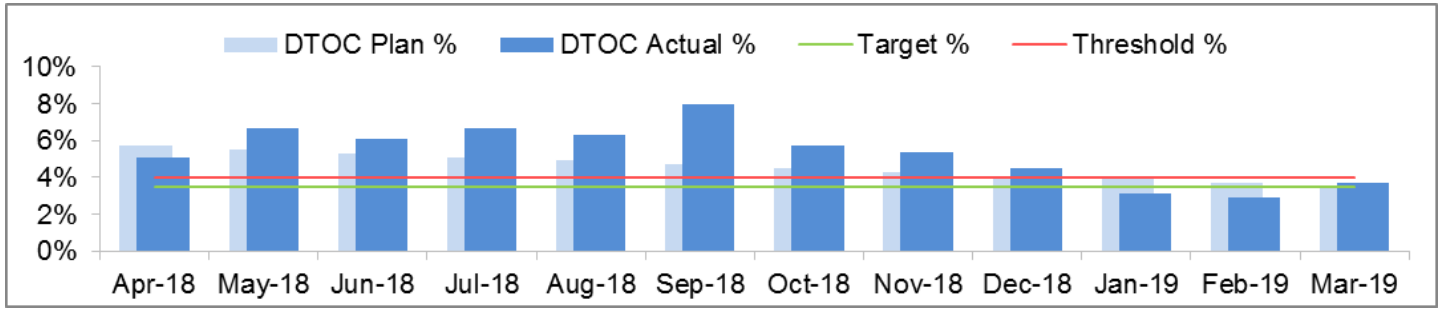
Executive Lead (s)

Janet King

Delayed Transfers of Care – exception report

Background / Issues	Action Plan	Date and named person
Standard: The national target for DTOCs is 3.5%, Frimley Health's performance has fallen below this for 2 months (January and February 2019) **Definition:** A delayed transfer of care occurs when a patient is medically fit for discharge from acute or non acute care and is still occupying a bed **Comments/Context:** There is a lack of available Packages of Care throughout for both CHC and Local Authority patients. CHC placement and palliative assessments/plans are increasing and generating significant health delay. NHS England requires 85% of CHC assessments to be completed outside of acute trusts. Due to the implementation of a variety of initiatives we have seen a reduction in the numbers of reportable DTOCs over the past few months	▪ Actions have been implemented to support the early identification of patients requiring support to prevent patients going into delay ▪ The refresh of delays review approach continues with particular success in some localities. ▪ The discharge passport has gone live for the North system ▪ The South system are piloting the electronic IRIS referral in April 2019 ▪ All previous actions are being continued and reviewed through Urgent Care Ops Groups, Hospital to Home Delivery Groups and Urgent Care Delivery Board ▪ The LOS trajectory and improvement plan agreed through South system UCOG and U&ECB is being implemented from April 2019 onwards	Shereen Bayat Katie Tripp

Trajectory for improvement



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
DTOC Plan %	5.7%	5.5%	5.3%	5.1%	4.9%	4.7%	4.5%	4.3%	4.1%	3.9%	3.7%	3.5%
DTOC Actual %	5.1%	6.7%	6.1%	6.7%	6.3%	8.0%	5.7%	5.4%	4.5%	3.1%	2.9%	3.7%

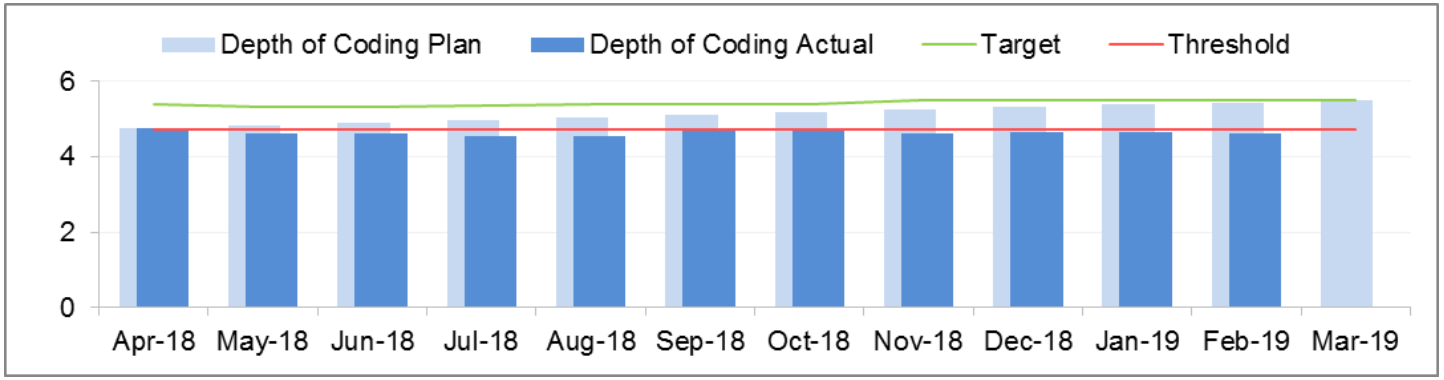
Executive Lead (s)

Helen Coe and Lisa Glynn

Coding performance – exception report

Background / Issues	Action Plan	Date and named person
Standard: 75% of activity should be coded by Flex, and the depth of coding should be greater than or equal to the national depth of coding. This varies each month but currently sits at 5.5 (and rising) **Definition:** 75% of all admitted patient care activity should be clinically coded by flex date. Depth of Coding is the average number of diagnosis codes assigned to admitted patients. It is an indicator of clinical complexity rather than a definition of quality of coding **Comments/Context:** The backlog in clinical coding is multifactorial. EDMS implementation and increased activity have put a strain on resources. This impacts on availability of timely data for Commissioners for validation, and Clinical Audits struggle to submit data on time for their national audits. Clinical coding depth is derived from the medical notes, and relies on documentation by clinicians of a full patient history, to enable the coders to refer back due to national coding standards	Depth of Coding performance will be addressed by: ▪ A paper presented to HEB with a proposal to tackle clinical education and improve documentation of patient history ▪ Ensure the future E-discharge process tackles the issue of pulling chronic co-morbidities through automatically ▪ The clinical coding strategy for 2019/20 looks to address clinical coding education for clinicians through the plan proposed in the HEB paper	Jayne Turner & Alex Hives

Trajectory for improvement

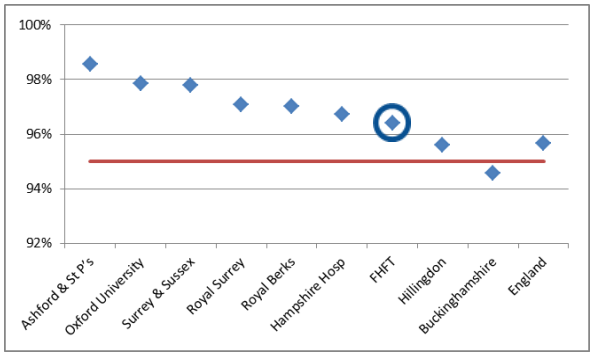
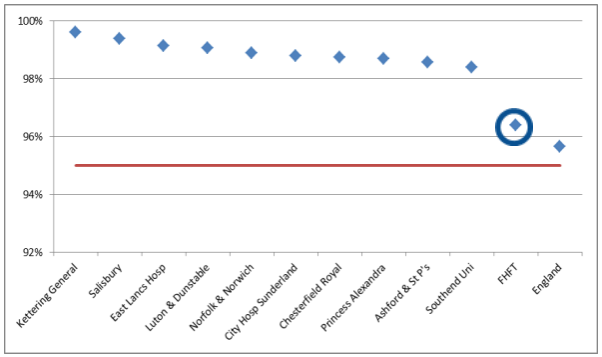
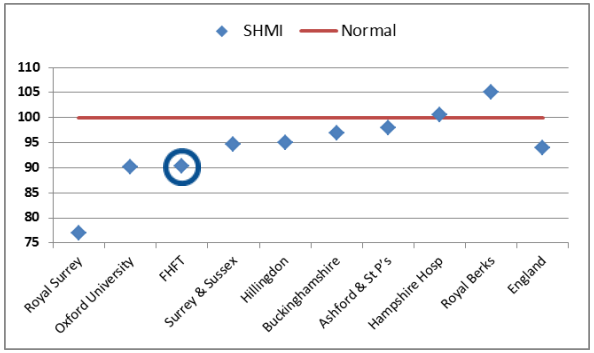
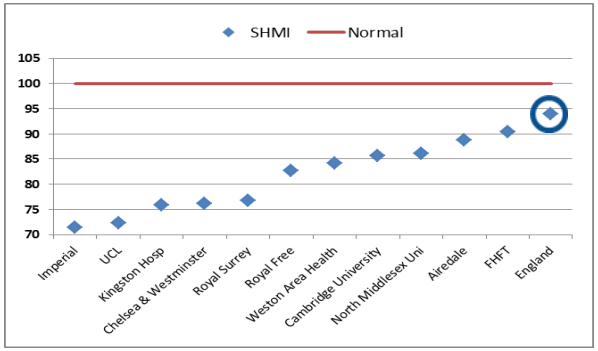
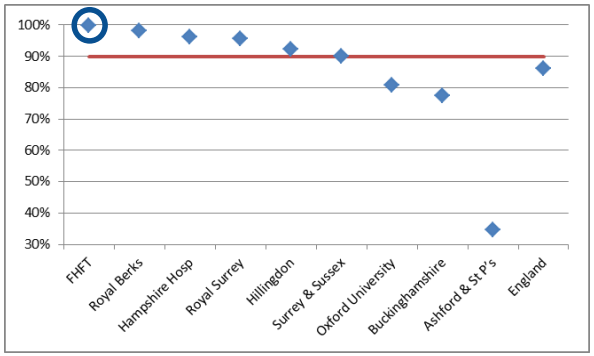
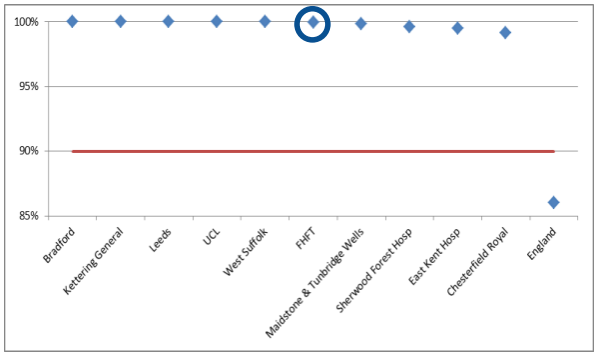


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Depth of Coding Plan	4.75	4.8	4.9	5.0	5.0	5.1	5.2	5.2	5.3	5.4	5.4	5.5
Depth of Coding Actual	4.75	4.60	4.60	4.55	4.55	4.73	4.73	4.60	4.64	4.66	4.61	

Executive Lead (s)

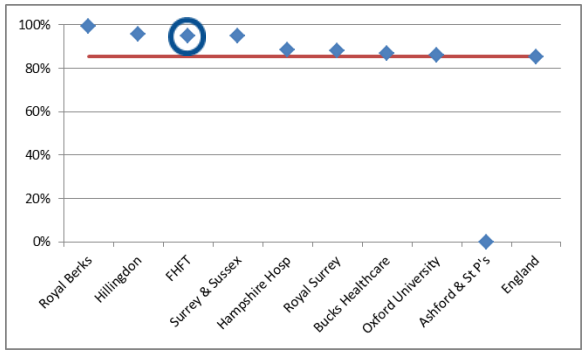
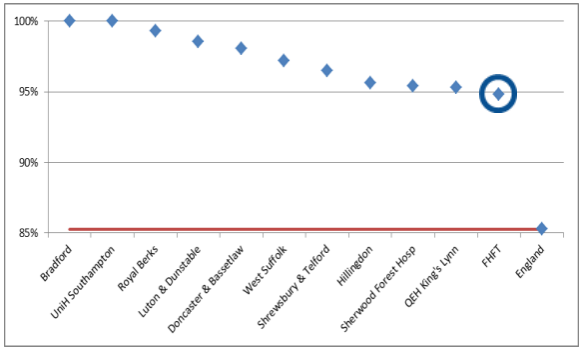
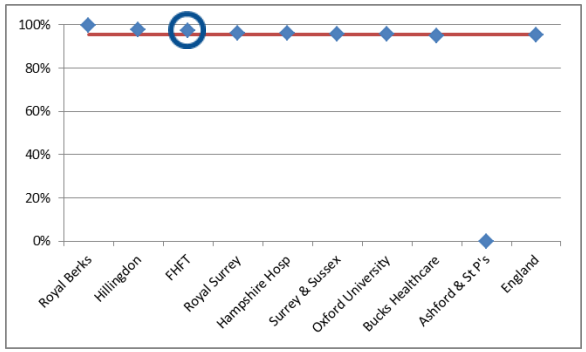
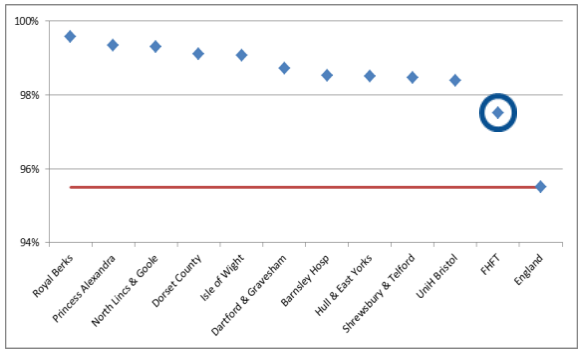
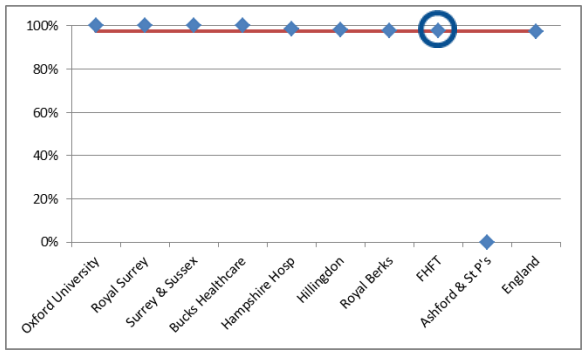
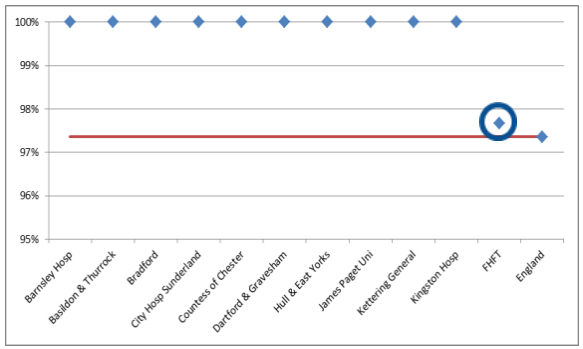
Nigel Foster

Benchmarking – selected measures (1)

	Local trusts	Best in class	Rank	Quartile
Safe VTE			37/88	2nd
Effective SHMI			15/88	1st
Caring Dementia			6/87	1st

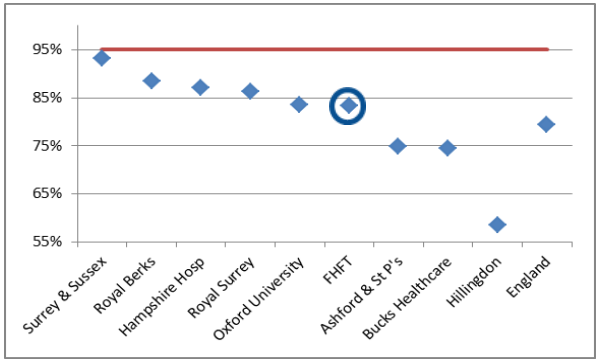
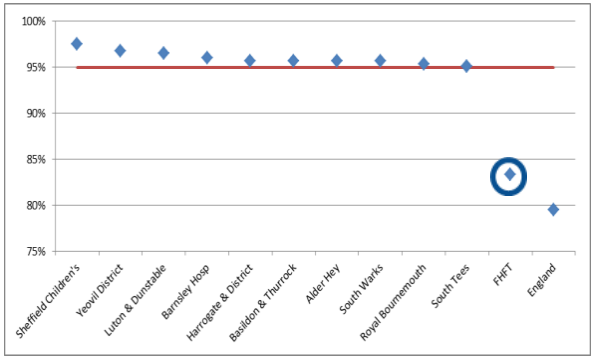
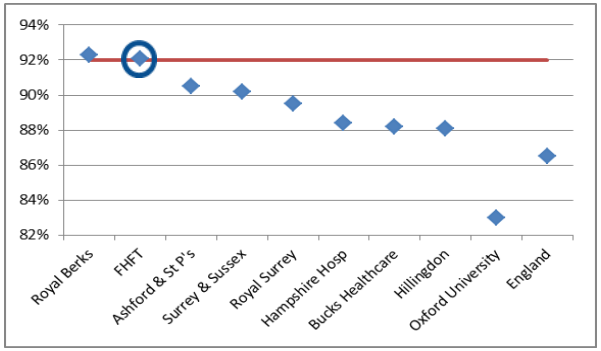
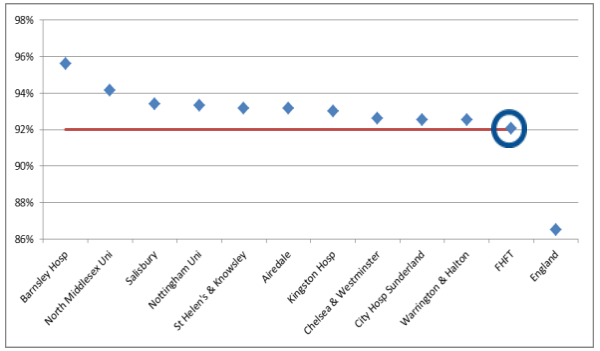
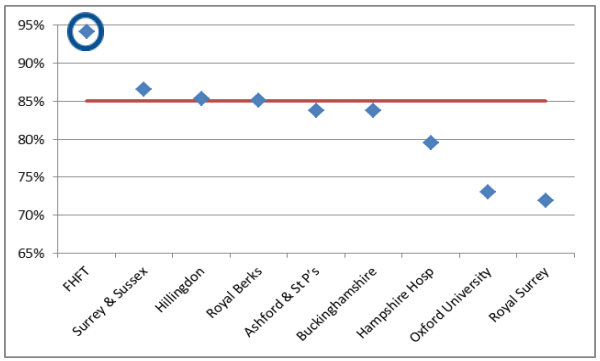
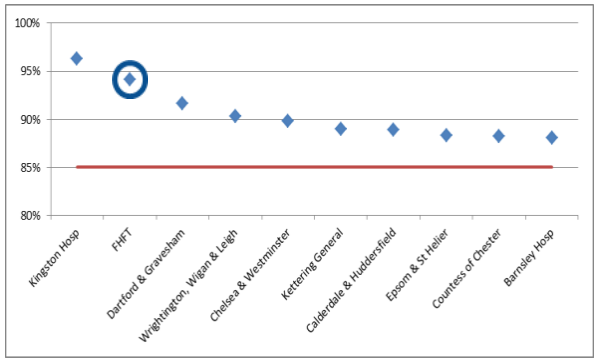
***NOTE** – for each graph, the position furthest to the left is the best performing trust and — is the target.*
***Data periods:** VTE = Q3 2018/19; SMHI = January 2018 – December 2018; Dementia = Q3 2018/19*

Benchmarking – selected measures (2)

	Local trusts	Best in class	Rank	Quartile
Caring ED FFT			14/89	1st
Caring Inpatient FFT			25/89	2nd
Caring Maternity FFT			57/87	3rd

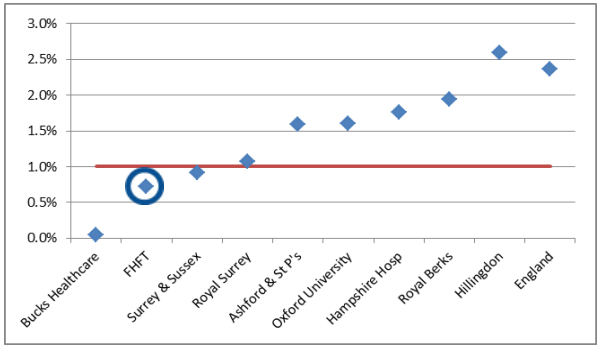
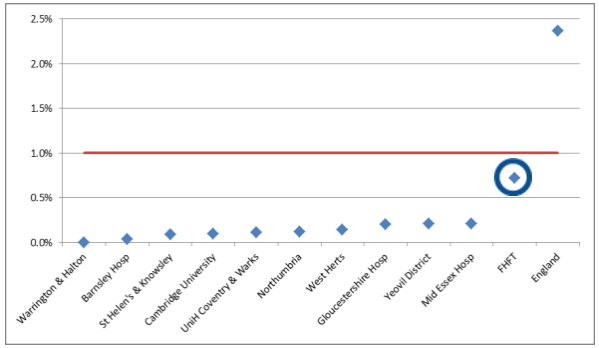
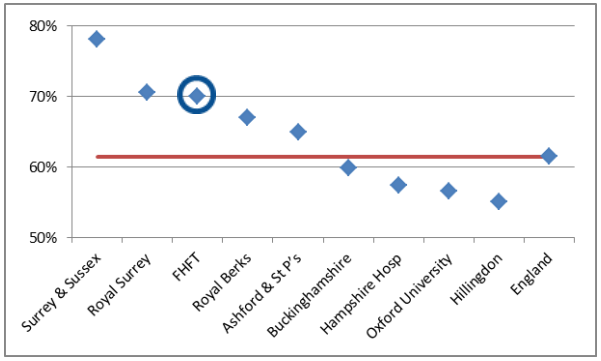
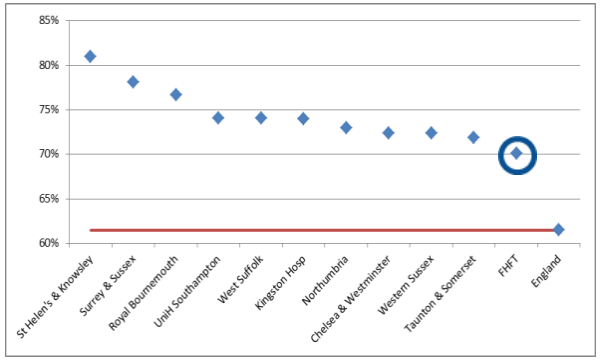
NOTE *– for each graph, the position furthest to the left is the best performing trust.* ***Data periods:*** *ED FFT, Inpatient FFT, Maternity FFT (friends & family test) = Feb 2019*
Maternity Best in Class is truncated alphabetically as there are more than ten trusts who are performing at 100%

Benchmarking – selected measures (3)

	Current cohort	Best in class	Rank	Quartile
Responsive ED 4 hour			55/134	2nd
Responsive RTT			17/87	2nd
Responsive Cancer			2/89	1st

NOTE** – for each graph, the position furthest to the left is the best performing trust.* ***Data periods: *A&E (4 hour target) = March 2019; RTT (incomplete pathways) = Feb 2019; Cancer = Q3 2018/19*

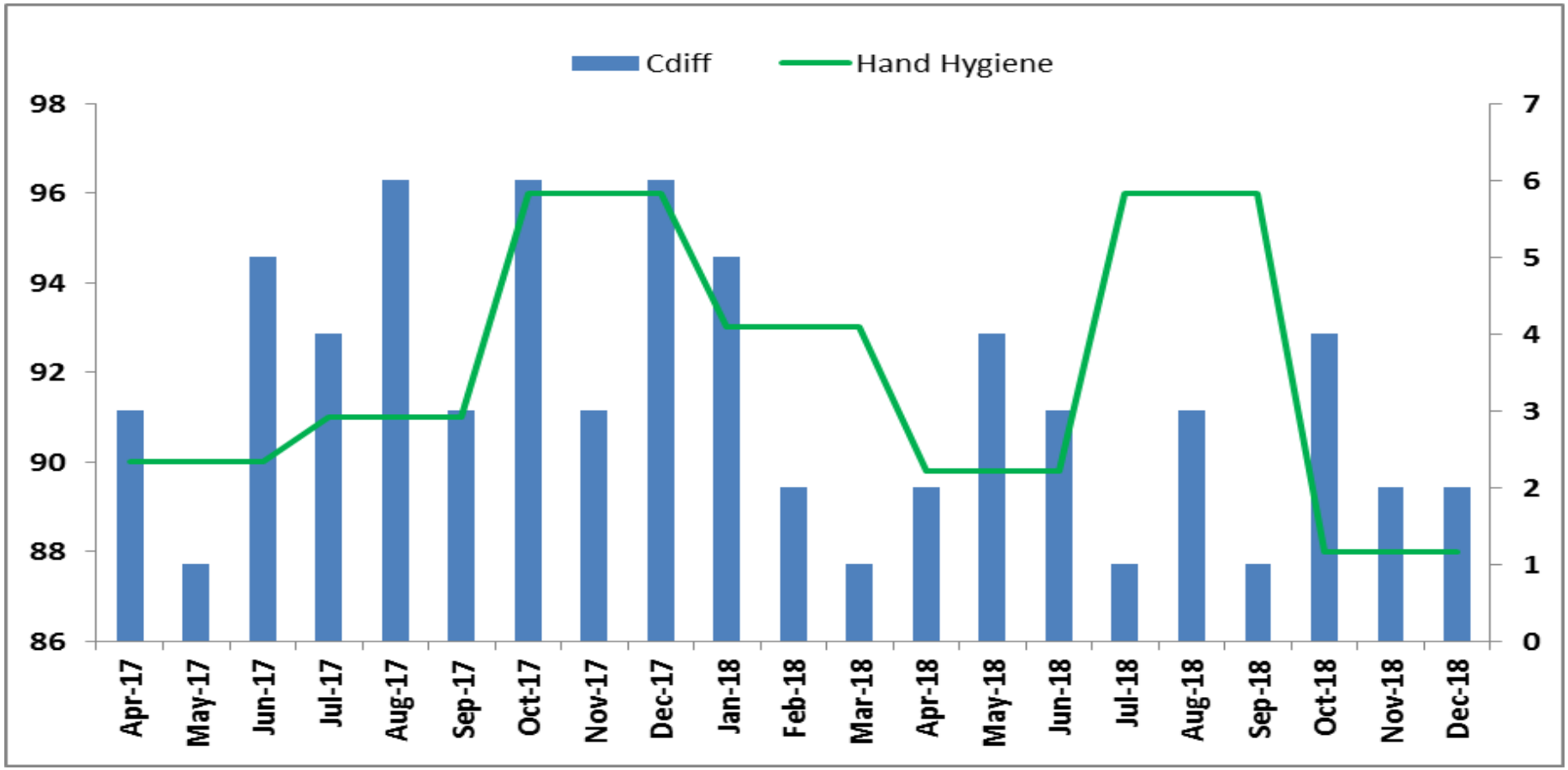
Benchmarking – selected measures (4)

	Current cohort	Best in class	Rank	Quartile
Responsive Diagnostics			38/89	2nd
Workforce Staff FFT			18/83	1st

***NOTE** – for each graph, the position furthest to the left is the best performing trust.* ***Data periods:** Diagnostic waits = February 2019; Staff FFT (friends & family test) = Q3 2018/19*

NOTE: This section of the report is under development

Process and outcomes – Hand Hygiene and Infection control



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Clostridium difficile - total numbers	3	1	5	4	6	3	6	3	6	5	2	1	2	4	3	1	3	1	4	2	2
Hand hygiene compliance		90			91			96			93			89.8			96			88	

Chart to show the link between hand hygiene compliance and infection control

NOTE: This section of the report is under development

In depth focus – Stroke services

Background

The FPH Stroke Unit has been part of a networked stroke service with the Royal Surrey County Hospital (RSCH) since 9th January 2017. This was a result of the Surrey Stroke Review and reconfiguration of stroke services. This original interim model is now permanently in place and we have agreed to commission 13 acute stroke beds from RSCH. Contractual and financial arrangements are still pending; however, the clinical model has now been embedded across both teams. As part of our commitment to improvement, we are continuing to participate in the Sentinel Stroke National Audit Programme (SSNAP) whose outputs are governed by standard national definitions. The following table shows our overall SSNAP performance over the last four reporting period

Reporting period	Dec17-Mar18	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018
SSNAP level	A	A	A	A
SSNAP score	80.8	90.0	94.0	90.0
Case ascertainment band	A	A	A	A
Audit compliance band	B	A	A	A
Number of records	228	183	189	178

The following table shows our SSNAP score for each of the 10 key indicator domains. Our key objective is to strive towards achieving A level ratings across all 10 of the SSNAP domains. This in depth analysis will focus on the hyper-acute aspects of the service, and this includes Scanning, Stroke Unit and Thrombolysis (D1, D2 and D3 in the table)

Reporting period	Dec17-Mar18	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018
D1: Scanning	A	A	A	A
D2: Stroke Unit	C	C	C	C
D3: Thrombolysis	B	B	B	C
D4: Specialist assessments	A	A	A	A
D5: Occupational therapy	B	A	A	A
D6: Physiotherapy	A	A	A	A
D7: Speech and language	B	B	A	B
D8: MDT working	B	A	A	A
D9: Standards by discharge	B	B	A	A
D10: Discharge processes	A	A	A	A

NOTE: This section of the report is under development

In depth focus – Stroke services

Breach reviews

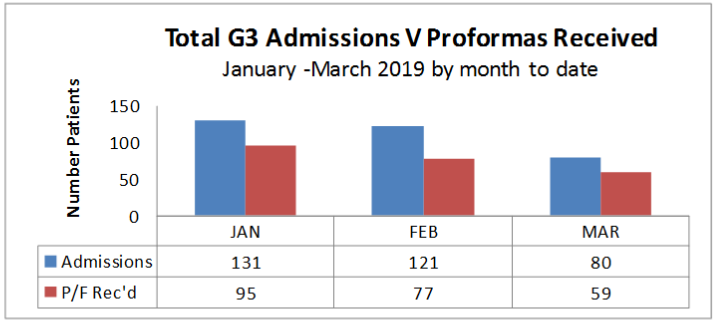
We have been providing exception reports to the Trust Board since August 2018 due to the dip in a 4hr admission performance. This should be put into context against what is being achieved nationally across all other providers:

- The national average across 142 Hyper Acute Stroke Unit's (HASU) participating in SSNAP is 60.2%
- FPH HASU is currently at 66%
- We are the 4th best performing Trust out of 14 within the South East Coast Network
- We are the 35th best performing Trust out of 142 across the UK

Since January 2019, reviews of all breaches of the 4 hour admissions target have been undertaken and discussed at the Clinical Governance Forum. Results are summarised below.

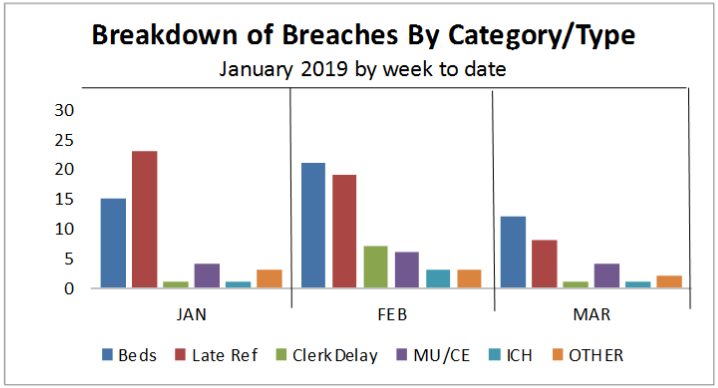
FHFT/FPH STROKE UNIT - 4HR ADMISSIONS JANUARY-MARCH to date 2019

STATS PERIOD TO DATE:	TOTAL ADMISSIONS	332	
	Total proformas rec'd	231	70%
	Total 4hr Breaches	134	40%
17% Breaches occurred between the hours of 5pm and 10pm	**Breach Breakdown**		
	Late Referral	50	37%
	Beds	48	36%
	Clinical Excep/MU	14	10%
	Clerking Delay	9	7%
	ICH	5	4%
	OTHER (NR/CT/MULTI)	8	6%



STATS BY MONTH:	TOTAL ADMISSIONS		332
	JAN	FEB	MAR
Admissions	131	121	80
P/F Rec'd	95	77	59
4HR BREACHES	47	59	28
Beds	15	21	12
Late Ref	23	19	8
ClerkDelay	1	7	1
MU/CE	4	6	4
ICH	1	3	1
OTHER	3	3	2

MARCH DATA UP TO 24/3/19 ONLY
Breach category 'OTHER' includes CT delay/MADU first ward/ 'no reason'



NOTE: This section of the report is under development

In depth focus – Stroke services – next steps

Agreed actions are:

- Stroke coordinators have started a weekly review of all admissions. Apart from identifying issues and trends with breaches, this will also identify what we are doing well and how we can learn from this.
- We had our first GIRFT away day with all other hyper acute stroke providers from South East Coast in November 2018. Direct admissions have been selected as one of five work streams.
- We are currently assessing the feasibility of running an ambulatory service for patients with a LoS <48hrs. This has the potential to greatly reduce our number of admissions and release bed capacity.
- 'Fast Track' and ROSIER (Recognition of Stroke in the Emergency Room) trial commenced Monday 11th March for the better management of stroke calls out of hours.

Priorities for the next reporting period:

- Finalise contractual and financial arrangement with RSCH.
- Implement our GIRFT action plan with particular focus on 1) 4hr direct admissions, 2) communication, 3) TIA service, 4) community and voluntary sector, 5) data quality and outcomes.
- Streamline our TIA referral process and work towards seeing all TIA referrals within 24 hours. This is in line with new national guidance
- Further Stroke Consultant recruitment and consider alternative recruitment options.
- Review staffing across all disciplines.
- Review nursing establishment and recruit into vacancies.
- Continue to support the Stroke Appeal.

[Copyright information needs to go here]
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150315-230733-KN-UK

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Report Title	CQC Report (2019): Actions taken to address recommendations
Meeting	Trust Board
Meeting Date	3rd Mary 2019
Agenda No.	8
Report Type	For assurance
Prepared By	Alison Szewczyk, Deputy Director of Nursing
Executive Lead	Duncan Burton, Director of Nursing & Quality
Executive Summary	This is to advise the Board on the actions taken to address the recommendations of the 2019 CQC inspection reports. These are available on the CQC https://www.cqc.org.uk/provider/RDU The CQC report made 2 recommendations that the Trust MUST take and an additional 25 recommendations that the Trust SHOULD take. Of the 25 Should do requirements 8 have so far been completed and the remaining 17 are in progress. Trust has submitted a report (appendix 1) to the CQC for those recommendations that the Trust MUST take to ensure that the Trust continues to meet the Health and Social Care Act 2008, associated regulations and other relevant legislation. An action plan is in place to address the recommendations that the Trust SHOULD take - appendix 2.
Background	The CQC completed an inspection in December 2018 and published their findings on the 13th March 2019. The CQC made 2 recommendations that the Trust MUST take: • Ensure midwifery staffing meets the acuity level set out in the Birthrate Plus tool on all shifts. • Increase compliance with mandatory training to meet 85% standard in all topics.

8

	Additionally, the CQC also made other recommendations that the Trust SHOULD take in the following areas: • Fit and proper person documentation. • Quality improvement methodology • SI investigations • DoLS documentation and procedures • Complaints response times • Appraisal rates • Fridge temperature management • Surgery and theatres • Maternity • Community inpatient services
Issues/Actions	MUST do recommendations: Progress will be monitored through Directorate review meetings and Quality Committee. • Training compliance. Enabling actions have been identified to ensure compliance of 85% (as a minimum) will be achieved by end of Quarter 3. Dedicated resource will be required to manage the project together with additional funding to provide back fill for staff to attend training whilst maintaining operation services. Board support is required. • Midwifery Staffing - In quarter 3 of 2018/19 the Trust undertook a workforce review of maternity services utilising Birth Rate Plus, and reported in early 2019. The need to make changes to midwifery staffing has also been noted by the CQC as a 'Must do' requirement. The Birthrate plus review identified that the service should be working towards achievement of a ratio of 1:25, (currently the service is funded at 1:30). Following careful review of the requirements of birthrate plus, the availability of future workforce, professional judgement, anticipated birth rates, balanced with financial planning the Executive approved a phased approach to move towards the recommendations of the birth rate plus tool from 2019 - 2022. During 2019/20 the establishment will be budgeted to a ratio of 1:28, an increase of additional 9.48 wte midwives and 7.7 wte maternity support workers (MSWs). These will need to be recruited to. During 2020/21 this will move to a ratio of 1:27 and this will be an additional 12.83 wte midwives and 1.31 wte MSWs. A further Birthrate plus assessment will be commissioned in 2020/21 to review ongoing requirements for changes in midwifery staffing. Outcome measures will continue to be monitored to assess of any further changes to the phased plan are required. A review of the key maternity outcome measures reported on the Trust quality & performance report has been requested in order to increase Board visibility of maternity outcomes on an ongoing basis.
Recommendation	The Board is asked to note the progress made and further actions required against the CQC recommendations, some which will require additional resources to be identified by the Executive. It is proposed that the Quality Assurance Committee of the Board monitor progress against the action plans and review assurance of completion.

Appendices	1. CQC report on actions the Trust plans to take to meet Health and Social Care Act 2008, its associated regulations, and other relevant legislation. 2. CQC recommendations Trust action plan.

Midwifery Staffing - In quarter 3 of 2018/19 the Trust undertook a workforce review of maternity services utilising Birth Rate Plus, and reported in early 2019. The need to make changes to midwifery staffing has also been noted by the CQC as a 'Must do' requirement. The Birthrate plus review identified that the service should be working towards achievement of a ratio of 1:25, (currently the service is funded at 1:30). Following careful review of the requirements of birthrate plus, the availability of future workforce, professional judgement, anticipated birth rates, balanced with financial planning the Executive approved a phased approach to move towards the recommendations of the birth rate plus tool from 2019 - 2022. During 2019/20 the establishment will be budgeted to a ratio of 1:28, an increase of additional 9.48 wte midwives and 7.7 wte maternity support workers (MSWs). These will need to be recruited to. During 2020/21 this will move to a ratio of 1:27 and this will be an additional 12.83 wte midwives and 1.31 wte MSWs. A further Birthrate plus assessment will be commissioned in 2020/21 to review ongoing requirements for changes in midwifery staffing. Outcome measures will continue to be monitored to assess of any further changes to the phased plan are required. A review of the key maternity outcome measures reported on the Trust quality & performance report has been requested in order to increase Board visibility of maternity outcomes on an ongoing basis.

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RDU
Our reference	INS2-6069496699
Location name	Frimley Health NHS Foundation Trust

Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Family planning** **Maternity and midwifery services** **Surgical procedures** **Termination of pregnancies** **Transport services, triage and medical advice provided remotely** **Treatment of disease, disorder or injury**	**Regulation 12** **Safe care and treatment** **How the regulation was not being met:** *The trust must increase compliance with mandatory training to meet its 85% standard in all topics.*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust acknowledges achieving the compliance with the regulation is essential to ensure patient safety and this is a key priority of the Board. This will be a key objective for each directorate and will be monitored through directorate reviews and quality committee.

Aim:

- To meet or exceed 85% compliance for all mandatory training, across all professional groups in every directorate by end of Quarter 3 2019/20.
- Establish mechanisms and governance arrangements to ensure continued a minimum of 85% compliance.

The Trust will take the following actions to achieve the above aims:

1. Establish proactive monthly trajectories for each professional group, and Directorate necessary to achieve 85% compliance (as a minimum) for all mandated training. Trajectories will consider the number of staff due to lapse per month, turnover of staff, availability of staff (annual leave, maternity etc),
2. On the basis of those trajectories, the Trust will align the provision of training. The planned deployment of staff will minimise non-attendance due to operational pressures.
3. Progress will be monitored through a project team reporting directly to the Director of Workforce & Corporate Services.
4. Directorates to scope number of staff that require training each month for each staff group for all mandatory training. This will enable the Directorates to plan how they are going to release the correct number of staff in each staff group each month to complete their mandatory training whilst maintaining operational services.
5. Ensure this is accurately reflected in MaST for all mandatory training and staff groups.
6. Directorates to produce operational plan of how to release staff to include contingency plans to ensure staffing shortfalls and sickness taken into consideration.
7. Non-compliance of the 85% standard to be recorded on directorate risk register by staff group to include mitigations and actions to be taken to recover the position against trajectories.
8. Risk register are presented and monitored at Corporate Governance monthly.
9. Board assurance regarding progress will be provided through the sub-committees of the Board QAC.

Enabling actions

1. Maximise online training opportunities (including use of apps) where effective and ensure directorates provided rostered time for staff to complete.
2. Accept training passports as evidence of completed training from other organisations.
3. Review trust training policy for mandatory training to review staff responsibility for maintaining their own training compliance.
4. Mandatory training to be reviewed for each individual at annual appraisal and action plans set for non-compliance and link to pay/increments.
5. Accept passport or evidence of learning other than mandatory. For example if staff have attended NLS then that equates to a new-born resuscitation session.

Who is responsible for the action?	Director of Workforce & Corporate Services

How are you going to ensure that the improvements have been made and are

sustainable? What measures are going to put in place to check this?	
Governance arrangements: • Compliance with the 85% mandated training target is a key priority for each directorate • Non-compliance of the 85% standard to be recorded on directorate risk register by staff group to include mitigations and actions to be taken to recover the position against trajectories. • Directorate risk registers are presented and monitored at Corporate Governance monthly. • Board assurance regarding progress will be provided through the sub-committees of the Board Quality Assurance Committee and/or People Committee. • Board reassurance report – compliance rates for mandatory training. **This will be sustained by:** 1. Ensuring operational planning and funding requirements are clearly understood at directorate level and fully supported by the Executive. 2. Proactive planning. Deploying staff to ensuring training is completed whilst maintaining effective operational services throughout the Trust.	
Who is responsible?	Director of Workforce & Corporate Services
What resources (if any) are needed to implement the change(s) and are these resources available?	
Resources: • Ensuring sufficient resources are available to meet trajectory requirements, eg. the capacity of subject matter expert training leads to deliver training, facilities and staff released from operational roles. • Where required additional funding to provide back fill for staff to attend training whilst maintaining operational services.	
Date actions will be completed:	End of Quarter 3 2019/20

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The Trust's first priority is to patient safety. The Trust acknowledges that failure to achieve that standard may impact on quality of care to our patients. The CQC inspection report acknowledges that staff generally have the skills and knowledge required to deliver safe care and therefore the risk is mitigated.

Completed by: (please print name(s) in full)	Duncan Burton
Position(s):	Director of Nursing and Quality
Date:	8th April 2019

Regulated activity	Regulation
Maternity and midwifery services	**Regulation 18 Staffing**
	How the regulation was not being met:
	There were insufficient midwives to provide care that met national standards.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust acknowledges the importance of achieving optimum midwife to birth ratios in line with Birthrate Plus recommendations and this is a key priority of the Board.

Aim:

- To provide midwifery staffing ratios that are aligned to national best practice.

The Trust will take (or has taken) the following actions:

- A business case for midwifery staffing across the Trust has been developed in response to the findings of the Birthrate Plus work force review undertaken in quarter 3 2018-19.
- The business case recommends the following trajectory to achieve 1:25 midwifery staffing ratio in line with national standards, and projections to recruit midwives and maternity support workers over the next four years.
    - April 2019- 2020 ratio 1:28
    - April 2020- 2021 ratio 1:27
    - April 2021- 2022 ratio 1:26
    - April 2022-2023 ratio 1:25
- The Trusts executive have approved 2019/20 & 2020/21 funding for ratio changes as outlined above with a further Birthrate+ exercise to take place during 2020/21 to confirm further investments
- Develop and implement innovative recruitment and retention strategies. The maternity service are currently participants in the NHSI recruitment and retention collaborative to support this work.

Who is responsible for the action?	Duncan Burton, Director of Nursing & Quality

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Governance arrangements:

- Staffing ratios and vacancies will be monitored using the acuity tool as part of the maternity monthly dashboard. Discussed and reviewed by the Director of Nursing and Head of Midwifery.
- Dashboard presented at:
    - Maternity Patient Safety and clinical governance committee monthly.

- Trust Quality Committee quarterly
- Board assurance will be provided to the Quality Assurance Committee.
- Agreed staffing ratio trajectories will be reflected in annual budget setting.

Who is responsible?	Director of Nursing and Quality

What resources (if any) are needed to implement the change(s) and are these resources available?

In line with business case

Costing increases for both sites over 4 years (static birth rate).

Identified Year (Ratio)	Total Cost increase over both site
2019/2020 (1:28)	**£696,838**
2020/2021 (1:27)	**£679,817**
2021/2022 (1:26)	**£732,155**
2022/2023 (1:25)	**£790,667**

Total cost increase over 4 year period= £2,899,487

Date actions will be completed:	Funding 2019/20 agreed in Apr 19. End Q3 2019/20 for year 1 changes as outlined (dependent upon successful recruitment to posts)

8

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The Trust's first priority is to patient safety. The Trust acknowledges the importance of not achieving the recommended midwife to birth ratios may have a detrimental impact on the quality of care provided to our patients and 1:1 care in labour may not always be achieved.

Maternity clinical outcomes are in line with national benchmarking and the Trust has robust escalation policies to support staff during times of increased activity.

Completed by: (please print name(s) in full)	Duncan Burton
Position(s):	Director of Nursing and Quality
Date:	8th April 2019

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CQC Action Plan

Frimley Health NHS Foundation Trust

Action complete
Work commenced and expected to finish by target date.
Work outstanding or not expected to finish by target date

Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
SHOULD take to improve								
1	The Trust should check that all Director personnel files contain all the information relevant to fit and proper persons requirements on an ongoing basis.	FPPR Policy specifies annual reviews. Director HR & Corporate Services has accountability for ensuring exec directors and tier 2 files are complete. Company Secretary has accountability for non-executive director files.	Exec: J King Operational: E Shingleton-Smith S Nelson-Wehrmeyer		Mar-19	Annual assurance in line with FPPR policy.	Completed	
2	The Trust should consider how it can embed a consistent and unified approach to quality improvement.	Link with QUEST for networking and access to othe QI experts. Develop project plan to support development of QI culture Establish further links/feedback loop with ICS Quality Improvement work Produce a formal quality improvement strategy that encompasses Trust vision and methodolgy for QI (BB)	Exec: D Burton Operational: A Szewczyk B Bal	Project lead recommended. A QI paper includes resource requirements circa £500,000.	Jun-19	Project plan for QI Academy and new quality strategy	Paper submitted to DoN with recommendations and costings for building QI Capability throughout Frimley Health following Quest Event and review of IHI dosing tool. Paper to be submitted to SLC and await decison regarding financial investment. Board session on building QI Capability to be run in May 19. Link with QUEST has now	
3	The Trust should require recommendations from incidents to include addressing underlying system issues or human factors.	Some human factors training currently covered on perceptorship training and ad hoc sessions. Business case is being developed to fund human factors post and Trust wide training programme. Human factors post appointed.	Exec: D Burton Operational: W Jewsbury A Szewczyk	Funding for human factors role and training programme.	Sep-19	Human factors trainer in post. Training and awareness regarding human factors. More focus on human factors and system failures through the SI investation process. Service redesign to reflect safer systems of work implemented.	SI panel reviews now include a focus on human factors and system design. Funding to be agreed for Human Factors trainer and training programme.	

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Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
4	The Trust should review its procedures for Deprivation of Liberty Safeguards to be assured they meet legislative requirements.	External expert peer review of current DOLs policy from Barts Health NHS Trust (Barts). Barts to review policy and practice across the Trust. Barts to share their policy. Trust to review other examples of DOLS best practice policies. Draft and consult on new Trust DoLs policy.	Exec: D Burton Operational: A Szewczyk T Coulson		Oct-19	Revised Trust DoLS policy. Implementation plan of changes to procedure. Audit compliance with new policy six months following implementation. External audit of compliance with the policy added to annual audit programme.	DoLS policy has been approved. As at 7 March 2019, Barts agreed to review policy and teleconference Mar 19 has taken place. Further call scheduled April 19. Reviewing other DoLS policies.	
5	The Trust should take steps to improve the timeliness of responses to complaints to meet Trust guidance.	Our new complaints and PALS logging system (RL6) to go fully live in April 19. Will support each specialty in accessing their complaints, allowing insight, ownership and more focused weekly tracking to achieve complaint deadlines. Specialty dashboards from 1.4.19 will hold complaints response rate data for 25 and 40 day complaint deadlines. Each Directorate to own the achievement of the 25 and 40 day targets and to have detailed plans to how they will achieve and sustain the timeliness of the responses to complaints.	Exec: D Burton Operational: M McVey K Roberts		Sep-19	Quarter 1&2 Patient Experience Report 2019,20. Continue to monitor through monthly Quality and Performance. Consistently achieving target.	RL has been successfully rolled out across the Trust. Current reponse times: 23 days (March 19) 87% 40 days (Jan 19) 72%.	

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Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
6	The Trust should make plans to enable all staff to have an annual appraisal.	1. AD/CoS/HON to report directorate appraisal compliance to Quality Committee on quarterly basis. 2. Fully implement 'appraisal season' approach.	Exec: J King Operational: C Quinn ADs/COS	Access to MaST system	30 June 2019 (MaST reporting) 30 Sept 19 (Appraisal season).	95% appraisal compliance reported on MaST and monthly appriasal tracker report.	1. AD's/CoS asked to report appraisal compliance at Quality Commitee to date. 2. Appraisal season for 2019/20 has just commenced and evidence of progress against complaince will not be available until end of Q1. Managers briefings were used to inform managers that the Appraisal season was fully operational in 2019/20.	
7	The Trust should take and record appropriate actions when ambient room temperatures and fridges storing medicines are outside of the required temperature range.	Implement a Trust wide fridge temperature monitoring system. All nursing teams/ward pharmacists to be reminded of existing trust policy on checking and actions related to Fridge temp and Room temp. Ensure robust local audit programme in place for medicines storage. Safer medicines storage audits and incidents to be overseen by new joint safer medications committee. Complete business case for Omnicell roll out across Trust (automatically monitors temperature)	Exec: D Burton Operational: D Lauder B Bal C Mapperley	All medicines storage rooms/clinical areas where ambient temperature is consistently above recommended levels will require permanent air conditioning/cooling requirements	01/09/2019 End 2021	All fridge temperatures are monitored and action taken when temperatures are outside the accepted range. Audit policy implementation. Joint safer medications committee established and evidence of reporting and actions b ased on audit findings. Report on clinical area requirements for air climate control and subsequent implementation.	Meeting to establish a single Trust wide safer medicines committee set for 13th May. Terms of reference to be reviewed and will include the recording of fridge temperature monitoring results. Re-audit of medicines storage due. Update on programme required. Omnicell now in situ in Emergency Assessment Centre WPH.	
Surgery, Frimley Park								

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Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
8	The Trust should check premises restricted to staff such as those storing substances subject to control of substances hazardous to health standards and sharp equipment are always kept locked.	Completed pre-CQC for all theatre areas - locks ordered and fitted as required; requirement documented in Trust wide Theatre SOP; adherence monitored in peer review documentation across all three sites. Review all clinical areas to ensure compliance as part of peer review.	Exec: D Burton Operational: S Vaughan M McVey B Bal	N/A	Jun-19	Theatre SOP and peer review documentation	Implemented in theatres. Ward audit to check storage due May 19.	
9	The Trust should keep store rooms and trolleys where controlled medicines locked when not occupied by a member of staff.	Ward security issues. Completed pre-CQC for all theatre areas - Medicines are not left prepared or unattended Review all clinical areas to ensure compliance as part of peer review. Requirement documented in Trust wide Theatre SOP; adherence monitored in peer review documentation across all three sites.	Exec: D Burton Operational: D Lauder S Vaughan B Bal	Investment in ID swipe locks for medicines room doors to be considered.	Aug-19	Incident reporting Updated SOP for response to locks/storage equipment issues Audit reports Peer review documentation.	Theatre actions complete. Ward audit to check storage due May 19.	

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10	The Trust should ensure treatment rooms (in Surgery at FPH) are suitable and have adequate space to safely prepare medication.	The Trust will undertake a review of the medication preparation facilities on F6 and F7 wards to identify an appropriate solution by June 2019. (CM) Pharmacy to be included in redesigning any treatment rooms (DL) Capital funding will need to be identified in order to implement changes. Review other areas beyond surgery which may require similar solutions.	Exec: J King Operational: C Mapperley A Stevens	Funding - dependent on solution identified.	Nov-19	Appropriate medications preparation areas provided and used appropriately and in line with best practice.	F7 (and F8) have dedicated drug preparation rooms. Undertaken a preliminary review of all surgical/orthopaedic wards. F4, requires capital investment in order to provide a dedicated drug preparation area. Capital form will be submitted in May 2019. F5 identified as having a small drug preparation area (prior to CQC) inspection and needs further review as felt to be insufficient at present. May also require capital investment. F6 has a small drug preparation area and requires estates work and infection control input in regards to compliance.	
11	The Trust should check signs to identify resuscitation and difficult airway equipment are clearly labelled and visible.	Review current signage in all areas and ensure conformity across the sites.	Exed: D Burton Operational: A Szewczyk T Coulson	None	Apr-19	The area identified has been rectified and is now in line with other Trust signage.	Completed	

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Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
12	The Trust should take steps to ensure patients are looked after in single sex accommodation.	DSU building and refurbishment work currently underway to support this (bays). DSU 1 already compliant. MIDU, GI unit at WPH site to be relocated to support reduction in MSA breaches Once new national guidance released process for reporting method to be moved to RL incident reporting system and policy updated. Continue with work to address flow issues through surgical/ICU and theatres pathways on WPH site.	Exec: D Burton Operational: M McVey B Bal	Estates project management (already assigned for DSU)	Aug-19	DSU Building and refurbishment complete. Reduction in breaches and improvement in patient experience survey.	Works continue in DSU, however issues with the new toilets blocking is impacting on the ability to stick to reduction target. Awaiting for decision on MIDU move on WPH site which will be necessary to eliminate these breaches.	
Surgery, Wexham Park								
13	The Trust should manage changes to the theatre list consistently and in line with their policy.	Revised process documented in Trust wide Theatre SOP; process discussed at Theatre Management Group and flow chart shared with anaesthetic and surgical services; non-compliance incident reported as appropriate.	Exec: T Hoe Operational: S Vaughan CoS Theatres/Surgery	N/A	May-19	Theatre SPO and incident reports. Regular audit of compliance with process for changing theatre lists on all sites. Results to be reviewed/monitored at TMG.	Agreed process has been added to the Theatres SOP and will be added to the monthly peer review. Non compliance will be escalated and reported via RL.	
14	The Trust should plan junior doctor's rotas in a timely way and have a designated guardian of safe working hours.	New Guardian of safe working hours appointed in November 2018. Plan to provide Jr doctor's rotas six weeks in advance.	Exec: T Hoe Operational: N Heyworth	None	Complete	Evidence of junior doctor compliant rotas 6 weeks in advance.	Complete	

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Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
15	The Trust should close the fire exit in the corridor to pre-assesment and monitor this.	Discussed at Theatre Management Group and Directorate Management Board for TACC. Matron has communicated requirement to keep the fire door closed and is monitoring this. Estates have confirmed fire door will be added to 'controlled-release' system to prevent it from being opened manually. Potential for air conditioning to be supplied to the area for ventilation being reviewed through capital bid.	Exec: L Glynn Operational: S Vaughan CoS	Estates external contractor will be visiting Trust to undertake work.	Jun-19	Spot checks on door being closed. External contractor has undertaken work. Fire exit is always closed.	Matron is monitoring. Spot checks being undertaken. Estates external contractor due to visit Trust. Fire door will be added to 'controlled-release' system. Fire Officer has inspected - no fire risk identified. Recommendation made to add management of door when open to SOP.	
Maternity, Frimley Park								
16	The Trust should check where policies are printed into hard copy, they are in date and the correct version and should take action to review and update all policies outside of their review date in a timely way.	All paper copies of guidelines to be removed from clinical areas. One folder of guidelines to be maintained as part of business continuity plans should there be an Information Technology failure. Guidelines to continue to be reviewed as per maternity guideline action plan. Outstanding guidelines to be reported to quartely cross site Obstetrics and gynaecology clinical governance commitee and then reported in the maternity quarterly report presented to the Trust Quality Committee.	Exec: D Burton Operational: E Luhr D Perkins	None	Dec-19	Confirmation that paper copies of guidelines have been removed will be minuted in clinical governance committee together with a statement describing how the single folder for business continuity purposes will be kept updated. Updated	Discussion held regarding number of guidelines requiring review to be documented in cross site obstetrics and gynaecology clinical governance committee. Minutes quartely and reported within the Maternity quartely report presented to the Trust Quality Committee.	
17	The Trust should ensure that cleaning checklists are consistently documented.	Review of all areas of maternity to be undertaken. Monthly quality and cleaning meeting to include data and complience relating to cleaning and infection control. Cleaning audit undertaken by Central Housekeeping. Findings added to action plan and sent to Matrons.	Exec: J King L Philp E Luhr D Perkins	None	Jun-19	Quarterly audit of compliance.		

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CQC Action Plan

Frimley Health NHS Foundation Trust

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Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
18	The Trust should ensure that clinical waste is appropriately labelled and in line with Health Technical Memorandum (HTM) 07-01 safe management of healthcare waste.	Action already undertaken within the department following intial feedback from the CQC. For review to be completed external from maternity to ensure complience undertaken in all areas.	Exec: J King Operational: L Philp E Luhr D Perkins			Sign off from review external to maternity. Ongoing audits carried out by Facilities annually. (LP)	Facilities have carried out an audit to confirm all bins correctly labelled 11 March 19. Results monitored through PLACE Committee.	
Maternity, Wexham Park								
19	The Trust should take action so that daily checks of critical equipment are completed.	Processes are now in place to ensure daily checks of critical equipment are completed in all clinical areas where critical equipment is held. Task is allocated at every handover.	DB E Luhr A Anderson		Apr-19	Statement in clinical governance committee minutes regarding process and responsibility for ensuring compliance and review audit results.	Daily checks are in place. Back to basics list sent to staff regarding critical equipment checking. Message added to fortnightly to the blog and message of the week.	
20	The Trust should take action to ensure out of date controlled drugs are promptly removed from clinical areas for destruction by pharmacy staff.	Monthly checks in place by pharmacy to remove out of date controlled drugs. Additional measures are in place for staff to alert pharmacy when controlled drugs require disposal. Currently 6 monthly CD checks on Lime.	Exec: L Glynn Operational: D Lauder E Luhr A Anderson		Mar-19	All out of date controlled drugs are removed from the area. Statement in both maternity and pharmacy clinical governance committees regarding monthly checks and alert processes together with responsibility for ensuring ongoing compliance.	All out of date controlled drugs are removed from the area daily. Drugs are checked daily via the controlled drug book in each ward area by 2 registered practitioners. Drug book signed and dated following the checks.	

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CQC Action Plan

Frimley Health NHS Foundation Trust

Action complete
Work commenced and expected to finish by target date.
Work outstanding or not expected to finish by target date

Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
21	The Trust should take action to review and update all policies outside of their review date in a timely way.	All paper copies of guidelines to be removed from clinical areas. One folder of guidelines to be maintained as part of business continuity plans should there be an Information Technology failure. Guidelines to continue to be reviewed as per maternity guideline action plan. Outstanding guidelines to be reported to Quartely cross site obstetrics and gynaecology clinical governance commitee and then reported in theh maternity Quarterly report presented to the Trust Quality Committee. There is now an ongoing solution to this.	Exec: D Burton Operational: E Luhr D Perkins A Anderson		Complete December 19	Discussion regarding number of guidelines requiring review to be documented in Cross site obstetrics and gynaecology clinical governance committee minutes quartely and reported within the Maternity quartely report presented to the Trust Quality Committee. Confirmation that paper copies of guidelines have been removed will be minuted in clinical governance committee together with a statement describing how the single folder for business continuity purposes will be kept updated	All paper copies of guidelines have been removed and are available on the intranet.	
22	The Trust should take action to continue to improve patient flow throughout the maternity department.	Patient flow is monitored at the daily 'safety hubs' There is ongoing project work on induction of labour. Implementation of outpatient induction for low risk women commenced January 2019.	Exec: L Glynn Operational: E Luhr		Apr-19	Statement describing new implementation of outpatient induction for low risk women minuted in clinical governance committee minutes together with responsibility for ongoing monitoring and clinical learning.	Building work completed therefore postnatal flow no longer an issue. All beds are open. Patient flow monitored on a daily basis through 'safety hub' Guideline of outpatient induction for low risk women minuted in clinical governance committee minutes together with updated guideline and patient information leaflet.	
Community Inpatient Services								
23	The Trust should implement processes to ensure learning from incidents is shared with all staff members, regardless of whether they attend meetings.	Formalised process agreed at the community directorate meeting: to include email cascade with read/receipt. Signing the minutes of team meetings have been read. Message of the day on white board/RIO. Line managers to agree with staff on long term sick and maternity leave, ways of keeping in touch so aware of changes etc.	Exec: D Burton Operational: N Seargent F Campbell A Szewczyk	Lead manager to over see. Task and finish group to include all bands to agree process.	May-19	Spot check as part quality walk arounds. Evidence via read receipt.	Implemented actions - further assurance requred to close.	

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CQC Action Plan

Action complete
Work commenced and expected to finish by target date.
Work outstanding or not expected to finish by target date

NHS
Frimley Health
NHS Foundation Trust

Action No	Action Required by CQC	Actions to be taken	Executive Lead/ Operation lead	Resource Required	Target Date of Completion	Evidence required of Completion	Progress	RAG
24	The provider should introduce tools and processes to ensure the ward is cleaned daily in line with the relevant internal requiements and guidance and that cleaning is recorded for auditing and evidential puposes.	The cleaning contractor (Medirest) to complete ward daily cleaning records in line with revised schedules monthly. Walk-round cleaning audit to be undertaken jointly by provider, landlord and contractor. Recorded results to be available to all three parties.	Exec: J King Operational: N Seargent F Campbell	Nil Identified	Aug-19	Minutes of provider to provider meetings. Local monthly audit.	Process reviewed in monthly review meeting between SHFT and FHFT. Discussion with SHFT regarding feasibility of taking over facilities management of community hospital. Qtly audit to be carried out by Central Housekeeping team.	
25	The provider should ensure that computers are available so staff can access Trust policies, procedures and training regardless of location.	All staff have SHFT and FHFT logins so they can use any desk top on site to access Trust policies, training etc. As new staff join they should be given appropriate log ins as part of induction process. All mobile staff have laptops.	Exec: N Foster Operational: D Axom N Seargent F Campbell	Head of Service	Mar-19	Ongoing assurance process: Audit from SHFT of staff logging in to IT system. Training records for completion of E training.	Complete	

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Month 12 (March 2019) Finance Report to Board of DIrectors**
Date of Meeting	3rd May 2019
Agenda Number	9.
Report type	To receive an update on the current forecast financial position of the Trust
Prepared by	Edward John (Director of Operational Finance)
Executive Lead	Nigel Foster (Director of Finance)
Executive Summary	The month 12 year end financial position has seen the Trust achieve all financial targets. The adjusted control total of £6.1m has been achieved in line with previous forecasts reported to the Board. Following a revision to the Q4 A&E target criteria the Trust is also now eligible for the full value of the A&E element and so the Trust will get the planned full £26.2m PSF value. As a consequence of achieving the control total the incentive distribution awarded to the Trust for the year is an additional £12.4m PSF resulting in a total PSF value of £38.6m. The system wide ICS control total as also achieved. ***On the face of the final accounts the Trust will report a surplus of £44.6m before impairments and donations (£38.6m PSF plus required control total delivery of £6.1m) and £39.1m surplus after impairments.*** The Board should note: • The exit run rate for costs in month 12 were in line with prior months suggesting a significant improvement is still required in April • The Trust was able to meet the control total for the year and hence be eligible for PSF through a release of balance sheet deferred income and a recognition of stock to the balance sheet. These are non recurrent measures along with deficit support (totalling £25.3m) which will need to be bridged in 2019/20. • Cash position remains healthy at £133m • The bottom line surplus of £39.1m, when PSF and other one-off in year benefits are removed results in an underlying deficit of £24.3m
Background	The Trust has set a budget of £32.8m surplus for 2018/19. This surplus plan includes £26.2m of PSF; £13.8m of DH support; and assumes delivery of £31m of cash releasing CIP. The plan is to generate a surplus of £6.7m before PSF. This plan was adjusted down to £6.1m by affecting an agreed control total transfer within the ICS.

Issues and Options	The Trust has delivered its forecast financial targets and met the issued control total. Income was greater than plan and costs were also higher than both plan and the commensurate increase in income. The balance of costs have been mitigated by one-off non-recurrent items and deficit support. The Trusts underlying deficit carried forward into 2019/20 is £24.3m
Recommendation	This report is for assurance only
Appendices	Key highlight report attached

Finance Board Report

Financial Performance

March 2019

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NHS Frimley Health NHS Foundation Trust

M12 Financial Dashboard

	Month 12				Year to Date				Full Year Outturn			
	Plan £m	Actual £m	Variance £m	RAG	Plan £m	Actual £m	Variance £m	RAG	Plan £m	Actual £m	Variance £m	RAG
Income	53.7	57.2	3.6		639.7	658.2	18.5		639.7	658.2	18.5	
Expenditure	(51.1)	(57.1)	(6.0)		(618.1)	(647.7)	(29.6)		(618.1)	(647.7)	(29.6)	
EBITDA (Income less expenditure)	**2.6**	**0.1**	**(2.4)**		**21.6**	**10.5**	**(11.1)**		**21.6**	**10.5**	**(11.1)**	
Financing costs / Exceptional items	(1.8)	0.4	2.2		(15.7)	(4.6)	11.1		(15.7)	(4.6)	11.1	
Provider Sustainability Fund	3.1	17.3	14.2		26.2	38.6	12.4		26.2	38.6	12.4	
Net / Surplus Deficit	3.8	17.8	**14.0**		**32.1**	**44.6**	**12.4**		**32.1**	**44.6**	**12.4**	
CIPs	3.0	1.7	(1.3)		31.0	23.7	(7.3)		31.0	23.7	(7.3)	
Cash Balance	113.6	133.3	19.7		113.6	133.3	19.7		113.6	133.3	19.7	
Capital Expenditure	4.7	9.2	4.5		76.4	75.2	(1.1)		76.4	75.2	(1.1)	
Use of resources score (1-4)	1	1			1	1			1	1		

Summary:
The Trust has delivered its forecast financial targets and met the issued control total. Income was greater than plan and costs were also higher than both plan and the commensurate increase in income because of discounts applied to ICS activity. The balance of costs have been mitigated by one-off non-recurrent items and deficit support. The achievement of the control total at both Trust and system level means that an additional PSF bonus of £12.4m has been awarded making £38.6m in total.

Key points:

- The month 12 the operational deficit was £2.4m (£11.1m ytd) due to capacity / activity pressures resulting in higher agency, bank and clinical supplies costs. Establishment expenses particularly in relation to the maintenance of the estate were also overspent
- The exit run rate appears to be consistent with prior months and will require a significant downturn in April to achieve the 2019/20 plan
- To enable the Trust to meet the control total non recurrent benefits of £25.3m have been used (see next slide). These contribute to the Trusts' underlying deficit position and, in part, to the large 2019/20 CIP target.
- Capital spend for the year was £75.2m which is £1.1m below plan. The main spend in the year was on the EAC build. Cash closed at £133m due to the month 12 closing working capital positions.

Income & Expenditure - Month 12 and Year End 2019/20 – Summary

Frimley Health	Current Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	53.7	57.3	3.6	639.7	658.2	18.5
Expenditure	(51.1)	(57.1)	(6.0)	(618.1)	(647.7)	(29.6)
Trust Financing (Excl. Impairment)	(2.5)	(2.3)	0.1	(30.4)	(29.8)	0.6
Net Revenue Surplus / (Deficit)	**0.1**	**(2.2)**	**(2.3)**	**(8.7)**	**(19.3)**	**(10.6)**
DOH Deficit Support	1.2	1.2	0.0	13.8	13.8	0.0
Accounting Adjustments	(0.6)	1.5	2.1	(0.6)	4.4	5.0
Inventory Recognition (Stock)	0.1	0.1	0.0	1.5	7.0	5.5
Control Total (Surplus)	**0.8**	**0.6**	**(0.2)**	**6.0**	**6.0**	**0.0**
PSF Funding	3.1	17.2	14.2	26.2	38.6	12.4
Net Revenue Surplus / (Deficit)	**3.8**	**17.8**	**14.0**	**32.2**	**44.6**	**12.4**

***£15.9m planned and £5.1m actual impairment is not shown within this table**
***** £0.6m Control Total adjustment reflected within Plan on accounting Adjustments**

Key messages:
The Trust met its NHSI control total the year following a £0.6m system control total shift and a further £0.7m release of deferred income.

PSF: Both the Financial and ED performance conditions were met in year, earning £26.2m. The performance metric for ED qualification was changed by NHSI meaning the Trust did qualify due to YTD achievement at a footprint level.
An additional £12.4m was earned by the Trust due to bonus payments and general distribution of PSF funds at a national level.

Operating Income: CCG income contributed £17m of the £18.5m overperformance in year. There was pressure against the Private Patient income target, particularly at the start of the year. There were also some gains on Bowel Screening income above plan.

Operating Expenditure: The activity cost of overperformance, including pass through drug cost, along with CIP under delivery were the 2 key factors of the operating expenditure overspends.
Agency costs did not fully reach NHSI control total levels and remained overall similar year on year although there were changes between staffing categories

Exceptional Items : DOH deficit support totalled £13.8m, Inventory Stock totalled £7m, £3.5m of DOH income (not offset with expenditure), a further gain on the Frimley Childrens Centre added £0.6m, finally a gain on donated asset against plan

Underlying Position: The exception items above have bolstered the position by £25.3m in 2018/19, all of these items are non recurrent.

Trust's Underlying Deficit

	INCOME £m	EXPENDITURE £m	TOTAL £m
M12 Forecast Surplus inc PSF and impairment	**710.6**	**(665.9)**	**44.6**
Adjust Back NR			
PSF	(38.6)		(38.6)
Impairements		(5.1)	(5.1)
Deficit Support	(13.8)		(13.8)
Stock Adjustment		(7.0)	(7.0)
Sale of Asset	(0.6)		(0.6)
2018/19 Ledger Benefits		(2.3)	(2.3)
Net Contract / Technical Items	(1.0)	(0.5)	(1.5)
Underlying Deficit into 2019/20	**656.6**	**(680.8)**	**(24.3)**

The 2018/19 Operational Plan identified a b/fwd underlying deficit of £26.5m

Income & Expenditure - Year End high level variances

Theme	Key Issues	Variance Year End £m
Income		
CCG/NHSE Income	Overperformance Including Pass Through Drugs & Devices	17.0
Non CCG Income	Private Patient	(1.1)
Corporate Income	ICS/Integration, Car Park, Catering	2.7
Total Income		**18.6**
Pay		
Medical Pay	Agency and Locum Costs above substantive Vacancy	(8.3)
Nursing & Ancillary	Nursing underspends offset through HCA overspends & Ancillary Elsewhere	(5.1)
Prof/Tech & Scientific	Agency Cover above vacancies	(3.3)
Admin & Management	Vacancies not all covered through bank/Agency	1.6
Total Pay		**(15.0)**
Non Pay		
Drugs & Clinical	Higher Drugs issues. Ongoing Theatres and Cardiology Items	(7.3)
Premises	Mostly Corporate Areas (Rates, Ulitilities, Maintenance, IM&T)	(3.0)
Other Non Pay	Purchase of External Healthcare, Other Establishment Expenses	(3.9)
Total Non Pay		**(14.2)**
Total Before Exceptional Items		**(10.6)**
Exceptional Items	**Inventory Recognition, EDMS and other iIncome, Sale Frimley Childrens Centre**	**10.6**
Grand Total		**0.0**

Key points:

- The Trust met its control total due to Exceptional Items
- Commissioner Income ended £17m ahead of plan
- CIP and operational pressure are driving the adverse pay
- Higher drug costs and issues , costs associated with activity, CIP non delivery and corporate overheads
- Inventory recognition of £7m, EDMS and Asset Sale make up the balance of Non Recurrent

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NHS Frimley Health NHS Foundation Trust

Income & Expenditure Month 12 – Directorate Positions

I&E by Directorate	Prior Year 2017-18			Current YTD 2018-19			Year on Year	
	Bud £ms	Act £ms	Var £ms	YTD Bud £ms	YTD Act £ms	YTD Var £ms	Bud £ms	Exp £ms
Directorate: Clinical								
Medicine: Frimley	76.5	77.9	1.4	79.4	81.9	2.5	2.9	4.0
Medicine: Wexham	63.4	65.0	1.6	67.3	69.7	2.4	3.9	4.7
ED WPH	13.1	14.4	1.3	13.3	15.3	2.0	0.3	0.9
ED FPH	12.7	13.9	1.2	13.3	14.7	1.4	0.5	0.7
Orthopaedics & Plastics	24.8	25.2	0.4	24.9	26.7	1.8	0.1	1.4
Paeds, Maternity & Gynae	53.0	53.3	0.3	54.8	55.0	0.1	1.8	1.6
Pathology	27.3	29.2	1.9	28.2	30.5	2.3	0.9	1.3
Private Patients	(3.4)	(2.7)	0.7	(3.8)	(2.6)	1.1	(0.3)	0.1
Radiology	23.2	24.5	1.3	24.2	25.7	1.4	1.0	1.2
Surgery	47.4	46.6	(0.9)	46.3	49.5	3.2	(1.1)	3.0
Therapies	12.6	13.0	0.4	13.8	13.7	(0.0)	1.1	0.7
Theatres, Crit Care & Anaes	70.5	73.9	3.4	71.2	77.3	6.1	0.7	3.4
Clinical Total	**421.1**	**434.2**	**13.1**	**432.9**	**457.3**	**24.4**	**11.8**	**23.0**
Directorate: Corporate								
Finance, IM&T, Contracts	18.9	20.5	1.6	20.6	18.6	(1.9)	1.7	(1.9)
HR & Corporate Services	40.5	43.9	3.3	42.0	45.9	3.8	1.5	2.0
Medical Director	(0.1)	(0.3)	(0.2)	0.2	(0.3)	(0.5)	0.3	(0.0)
Nursing & Quality	5.9	5.9	(0.0)	6.2	6.2	(0.0)	0.3	0.2
Operations: Frimley	16.4	16.3	(0.1)	16.8	15.4	(1.4)	0.4	(1.0)
Operations: Wexham	16.8	16.3	(0.4)	15.8	17.0	1.2	(0.9)	0.7
Corporate Total	**98.5**	**102.7**	**4.2**	**101.7**	**102.8**	**1.1**	**3.2**	**0.1**
CCG Income and financing cost	**(525.6)**	**(538.0)**	**(12.3)**	**(540.6)**	**(566.1)**	**(25.5)**	**(15.5)**	**(27.0)**
Subtotal Ex PSF	**(6.0)**	**(1.1)**	**4.9**	**(6.0)**	**(6.0)**	**(0.0)**	**(0.6)**	**(5.0)**
PSF	**(18.6)**	**(27.2)**	**(8.6)**	**(26.2)**	**(38.6)**	**(12.4)**	**(7.6)**	**(11.4)**
Grand Total	**(24.6)**	**(28.2)**	**(3.6)**	**(32.2)**	**(44.6)**	**(12.4)**	**(8.2)**	**(16.3)**

The majority of the budgetary pressure (£24.4m YTD) was felt within the Clinical areas of the Trust and on pay costs, in line with where the operational and CIP pressures lie – whilst this is mitigated somwhat by high comissioner income overperformance. There is also a material pressure within HR & Corporate Services and some non recurrent EDMS relief within Finance IM&T & Contracts

The year on year shows the annual budget movement (net of CIP) . More than 50% of the year on year growth is due to the Pay Awards within 18/19

Notes: In this analysis adverse variances are shown as a positive number

The budget shown in this schedule is the Trust's internal plan. Exceptional Items are recorded within CCG Income & financing cost – Impairment not shown

Total Trust Bank Expenditure (Excluding Integration)

Bank expenditure and utilisation was very high in March 2018 compared to earlier months

Total	Hospital Bank	M07	M08	M09	M10	M11	M12
	Medical	928,535	792,900	738,061	808,793	721,755	897,903
	Nursing	1,198,913	1,106,178	949,358	1,073,045	1,251,699	1,550,013
	Prof Tech & Scientific	166,691	156,323	143,653	139,278	156,416	131,846
	AHP	92,555	86,002	65,683	84,557	70,146	70,647
	Ancillary	759,974	759,611	738,753	791,123	804,329	946,984
	Admin	173,870	150,756	129,732	154,116	169,207	210,076
	Total Hospital Bank	**3,320,537**	**3,051,769**	**2,765,241**	**3,050,912**	**3,173,553**	**3,807,468**

Site	Hospital Bank	M07	M08	M09	M10	M11	M12
FPH	Medical	566,619	401,468	369,613	419,099	392,482	575,652
	Nursing	593,201	537,995	435,596	498,681	611,765	792,073
	Prof Tech & Scientific	134,410	121,610	124,737	115,449	127,788	110,288
	AHP	38,910	40,462	20,453	38,715	25,516	35,860
	Ancillary	492,085	480,800	489,459	518,261	517,788	617,104
	Admin	105,692	105,682	80,404	95,020	103,658	130,098
FPH		**1,930,916**	**1,688,016**	**1,520,263**	**1,685,227**	**1,778,997**	**2,261,075**
WPH	Medical	361,916	391,432	368,448	389,694	329,273	322,251
	Nursing	605,712	568,183	513,762	574,364	639,934	757,940
	Prof Tech & Scientific	32,281	34,713	18,916	23,829	28,628	21,558
	AHP	53,645	45,540	45,230	45,841	44,630	34,787
	Ancillary	267,889	278,811	249,294	272,862	286,541	329,880
	Admin	68,177	45,074	49,328	59,095	65,549	79,978
WPH		**1,389,621**	**1,363,753**	**1,244,978**	**1,365,686**	**1,394,556**	**1,546,393**
Total		**3,320,537**	**3,051,769**	**2,765,241**	**3,050,912**	**3,173,553**	**3,807,468**

Nursing bank demand and supply was particularly high in March leading to additional costs on both sites.

Medical bank costs were particularly high within Orthopaedics FPH due to additional WLI work.

Ancillary bank remains very high, particularly on the FPH site with additional demand, similar to nursing.

Total Trust Agency Expenditure (Excluding Integration)

Agency Costs fell to £2.0m in month. The overall spend is similar to 17/18 although categories have changed

Total	Hospital Agency	M07	M08	M09	M10	M11	M12
	Medical	640,526	666,800	678,961	756,138	819,201	714,192
	Nursing	534,398	478,968	669,349	865,191	772,281	597,197
	Prof Tech & Scientific	163,233	260,395	246,146	448,747	339,139	332,086
	AHP	223,249	137,659	200,631	189,292	156,308	265,845
	Ancillary	16,017	7,365	4,347	14,322	16,947	15,776
	Admin	62,607	81,051	90,465	-66,326	81,701	51,427
	Total	**1,640,030**	**1,632,238**	**1,889,899**	**2,207,365**	**2,185,575**	**1,976,522**

Site	Hospital Agency	M07	M08	M09	M10	M11	M12
FPH	Medical	106,187	113,598	110,455	253,684	204,812	112,084
	Nursing	160,541	157,960	241,312	254,381	212,355	163,434
	Prof Tech & Scientific	59,509	95,013	69,085	104,316	61,162	74,538
	AHP	99,620	64,420	109,770	90,477	94,422	145,734
	Ancillary	3,818	2,037	900	7,040	412	344
	Admin	29,067	52,715	57,354	-89,798	49,894	27,984
FPH		**458,741**	**485,744**	**588,875**	**620,101**	**623,057**	**524,118**
WPH	Medical	534,339	553,202	568,506	502,454	614,389	602,108
	Nursing	373,858	321,008	428,037	610,810	559,926	433,763
	Prof Tech & Scientific	103,724	165,382	177,061	344,432	277,977	257,548
	AHP	123,629	73,238	90,861	98,815	61,885	120,110
	Ancillary	12,199	5,328	3,448	7,282	16,535	15,432
	Admin	33,540	28,336	33,111	23,472	31,807	23,443
WPH		**1,181,290**	**1,146,495**	**1,301,024**	**1,587,265**	**1,562,518**	**1,452,404**
Total		**1,640,030**	**1,632,238**	**1,889,899**	**2,207,365**	**2,185,575**	**1,976,522**

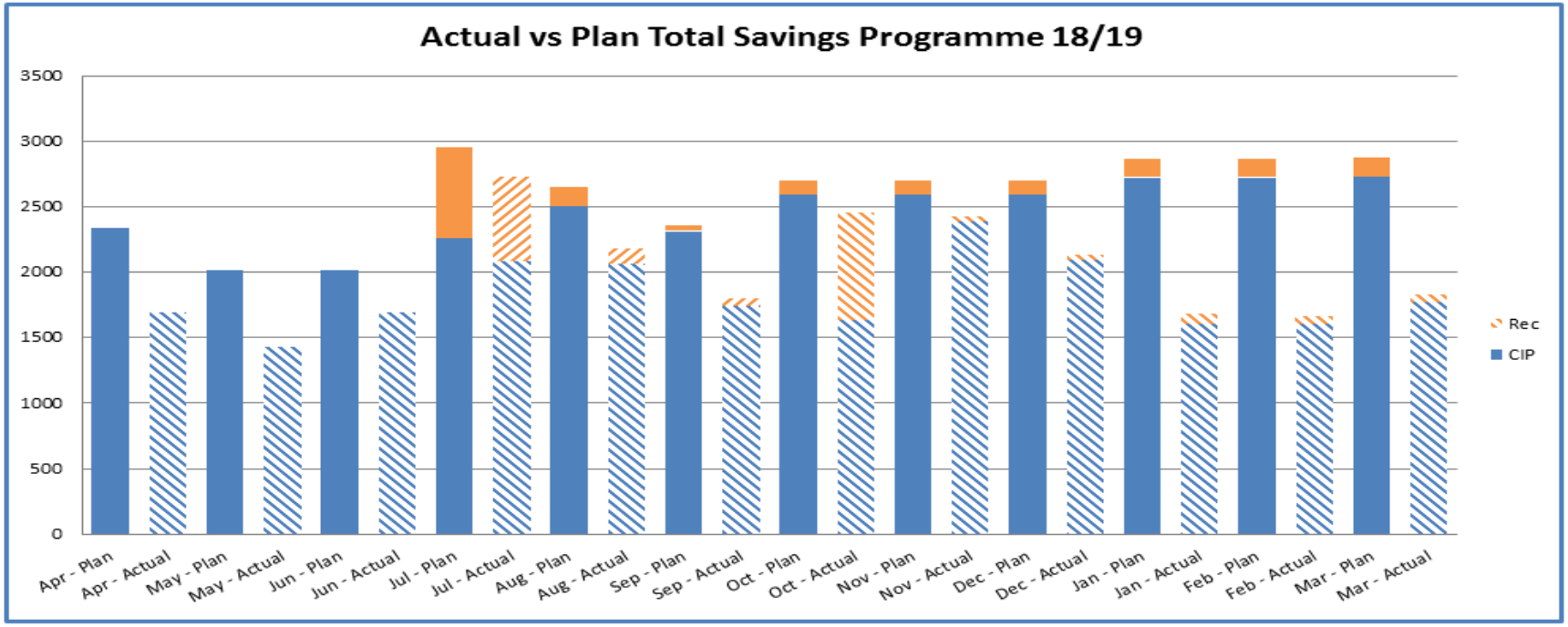
The spend returned to just under £2m in month following high retrospective shifts in January and February.

With the exception of AHP, agency was down overall across all categories in March compared to February.

Higher agency use within Radiology and Therapies drove the increase.

Trust Overview - 2018/19 CIP & Recovery Savings Programme

CIP/REC	Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
CIP	29,384	2,725	1,772	-953	65.0%	29,383	21,761	-7,622	74.1%	22,353	76.1%
REC	1,616	144	53	-91	37.0%	1,616	1,917	301	118.6%	1,877	116.1%
Total	31,000	2,869	1,825	-1,044	63.6%	31,000	23,678	-7,321	76.4%	24,230	78.2%



The in month position shows 63.6% delivery in month and 76.4% for the year, a high monthly in procurement and clinical stock reflects the lower February expenditure position.

The closing position was £683k worse than previously forecast due to higher than anticipated expenditure on bank staff in month 12 and some ambitious assumptions within some directorates.

All values in £000

Balance Sheet M12

	March Actual £m	March Plan £m	March Variance £m
Non-current assets			
Intangible Assets	8.238	5.651	2.587
Property, Plant and Equipment	399.762	399.716	0.046
Total non-current assets	**408.000**	**405.367**	2.633
Assets, Current			
Inventories	10.389	9.169	1.220
Trade and other receivables	86.388	70.926	15.462
Cash and Cash Equivalents	133.256	113.589	19.667
Total current assets	**230.033**	**193.684**	**36.349**
TOTAL ASSETS	**638.033**	**599.051**	38.982
Current Liabilities			
Trade and other payables	(73.986)	(67.721)	(6.265)
Deferred Income	(28.186)	(16.672)	(11.514)
Borrowings	(1.275)	(0.276)	(0.999)
Provisions	(0.321)	(0.289)	(0.032)
Total Current Liabilities	(103.768)	(84.958)	(18.810)
Total assets less current liabilities	**534.265**	**514.093**	20.172
Liabilities non current			
Provisions	(0.246)	(0.322)	0.076
Borrowings	(5.110)	(5.905)	0.795
Liabilities non current, total	(5.356)	(6.227)	0.871
TOTAL ASSETS EMPLOYED	**528.909**	**507.866**	21.043
Taxpayers and Others Equity			
Public Dividend capital	304.337	298.469	5.868
Income and Expenditure reserve	121.134	110.515	10.619
Other Reserves			
Revaluation Reserve	103.438	98.882	4.556
TOTAL TAXPAYERS' AND OTHERS' EQUITY	**528.909**	**507.866**	21.043

Frimley Health total assets employed at 31st March 2019 are £529m.

Items to note:

• The combined assets across all 3 sites, this is non-current and current assets combined are £638m, of which non current assets are £408m.

• Borrowings represent Salix Loans, which are for energy efficiency schemes.

•Cash finished the year at £133m this was £20m ahead of plan. The difference is cash at year end to plan can be explained by differences in working capital specifically trade and other payables. Trade receivables closed the year also ahead of plan at £86m.

• Current liabilities were (£11.5m) higher than planned. This is due to deferred income being much higher than planned.

2018/19 CIP Report M12
March 2019

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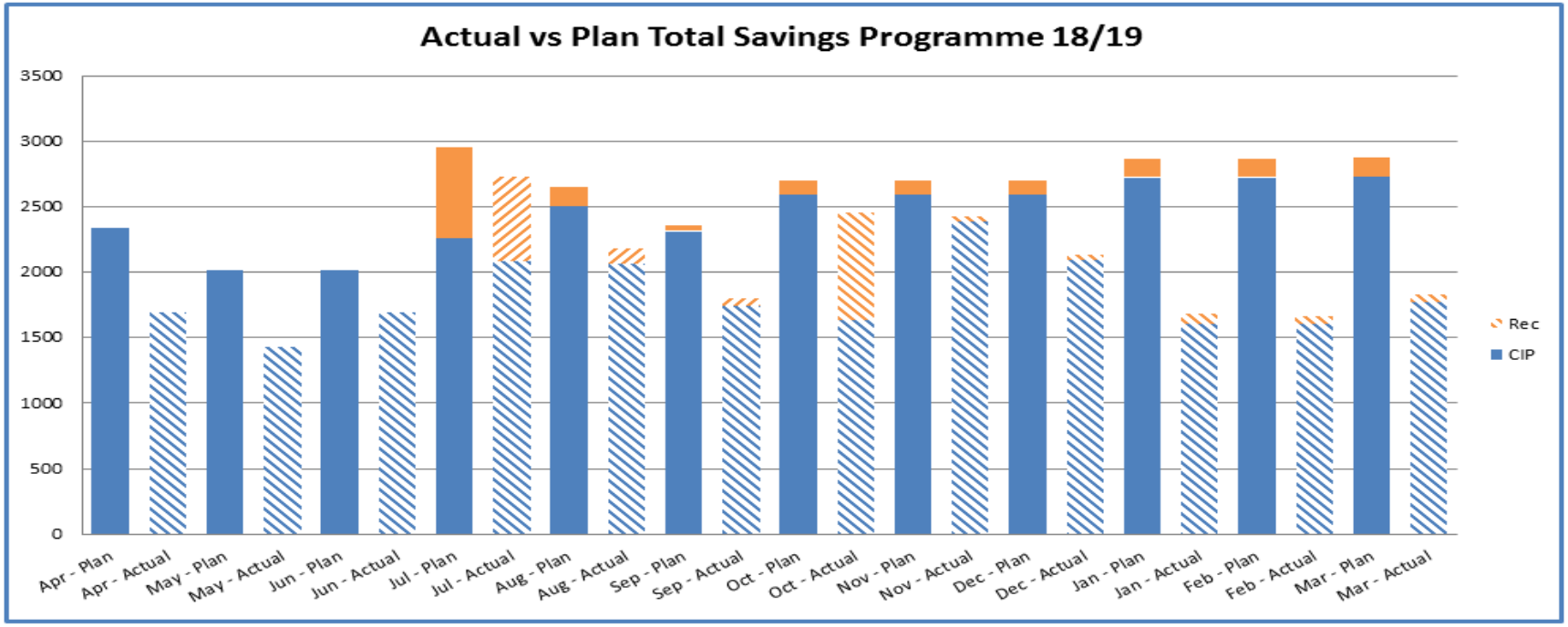
NHS Frimley Health NHS Foundation Trust

Trust Overview - 2018/19 CIP & Recovery Savings Programme

CIP/REC	Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
CIP	29,384	2,725	1,772	-953	65.0%	29,383	21,761	-7,622	74.1%	22,353	76.1%
REC	1,616	144	53	-91	37.0%	1,616	1,917	301	118.6%	1,877	116.1%
Total	31,000	2,869	1,825	-1,044	63.6%	31,000	23,678	-7,321	76.4%	24,230	78.2%



The in month position shows 63.6% delivery in month and 76.4% for the year, a high monthly in procurement and clinical stock reflects the lower February expenditure position.

The closing position was £683k worse than previously forecast due to higher than anticipated expenditure on bank staff in month 12 and some ambitious assumptions within some directorates.

2

All values in £000

CIP Performance by Category:

Cash Releasing	Annual Plan	YTD Plan	YTD Actual	Var	%
Not Specified	327	327	74	(253)	23%
Yes	27,991	27,991	20,422	(7,569)	73%
No	2,682	2,682	3,183	501	119%
Total	**31,000**	**31,000**	**23,678**	**(7,321)**	**76%**

CIP Type	Annual Plan	YTD Plan	YTD Actual	Var	%
Pay	14,062	14,062	8,225	(5,838)	58%
Non-Pay	12,787	12,787	11,561	(1,226)	90%
Income	4,151	4,151	3,894	(257)	94%
Total	**31,000**	**31,000**	**23,680**	**(7,321)**	**76%**

CIP Themes	Ann Plan	YTD Plan	YTD Actual	YTD Var
Admin/Back Office Staff	2,896	2,896	2,403	(493)
Agency & Locum	2,564	2,564	1,898	(666)
Estates & Facilities Staffing	860	860	455	(405)
Medical Staffing	2,725	2,725	871	(1,854)
Nursing Staffing	2,271	2,271	1,199	(1,072)
Other Clinical Staffing	1,605	1,605	1,451	(154)
Clinical Supplies & Services	4,514	4,514	3,414	(1,101)
Corporate Non-Pay	771	771	529	(242)
Estates & Facilities Non-Pay	1,505	1,505	566	(939)
Other Non-Pay	1,303	1,303	1,997	694
Pathology	887	887	919	32
Pharmacy	608	608	888	281
Procurement	3,290	3,290	3,514	223
WLI	670	670	0	(670)
Theatre Utilisation	750	750	0	(750)
Other Income	1,895	1,895	2,184	289
Private Income	1,134	1,134	1,012	(122)
Clinical Income	461	461	379	(82)
Ignore	0	0	0	-
GAP	180	180	0	(180)
NHS Income	111	111	0	(111)
Grand Total	**31,000**	**31,000**	**23,678**	**(7,321)**

Key Messages:

- Cash releasing schemes are £3m below the required target of £31m, unfortunately they are also £7.8m short YTD meaning the impact is being felt within the expenditure position of the Trust
- The majority of the schemes behind plan remain within Pay, although non pay is also £1.2m (mostly theatres)
- WLI, Theatre Utilisation and Medical Staffing Savings struggled to meet planned levels.

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CIP Performance by Directorate:

Directorate	Total (£k)	YTD Plan	YTD Actual	YTD Var	Comment
Theatres Crit Care & Anaes	2,963	2,963	628	(2,335)	Theatre Utilisation, Stock Control & Premium Staffing
Estates & Facilities	2,817	2,817	1,809	(1,009)	Slippage on Housekeeping, portering, hybrid mail
Surgery	2,239	2,239	1,367	(872)	Ward Modelling and WLI Savings
Orthopaedics & Plastics	1,296	1,295	553	(743)	ED & Ward Based Staff Savings
Medicine Wexham	2,638	2,638	1,763	(875)	Predominantely Medical Staff Savings
Outpatients WPH	1,026	1,026	569	(457)	Decomissioning of HWD Library and Patient Transport
HR	687	687	309	(378)	Management Review
Medicine Frimley	3,825	3,825	3,331	(493)	ED & Ward Based Staff Savings
IM&T	342	342	162	(180)	Management Review
GAP	180	180	0	(180)	Mitigated through additional CNST in Maternity
Radiology	630	630	396	(234)	Agency AHP Savings
Pathology	1,350	1,350	1,283	(67)	BSPS Reporting
Therapies	173	173	47	(126)	Patient Appliances
Nursing & Quality	260	260	178	(82)	IMS Savings now in 19/20
Strategy & Performance	290	290	215	(75)	
Pharmacy	608	608	888	281	
Medical Director	6	6	6	-	
Outpatients FPH	731	731	752	22	
Finance	2,868	2,868	2,957	90	
Procurement	3,290	3,290	3,514	223	
Private Patients	1,083	1,083	1,041	(41)	
Paeds Mat & Gynae	1,700	1,700	1,910	211	Additional Maternity CNST Savings
Grand Total	**31,000**	**31,000**	**23,678**	**(7,321)**	

CIP Performance vs Forecast by Directorate:

Directorate	Current FOT	'YTD Actual	Var	Comment
Estates & Facilities	1,906	1,809	(98)	Ambitious Assumptions
Finance	2,901	2,957	56	
HR	310	309	(1)	
IM&T	162	162	0	
Medical Director	6	6	0	
Medicine Frimley	3,456	3,331	(125)	Stock reduction offste with Procurement
Medicine Wexham	2,112	1,763	(349)	High staffing expenditure M12
Nursing & Quality	178	178	(0)	
Orthopaedics & Plastics	699	553	(147)	High WLI spend
Outpatients FPH	758	752	(6)	
Outpatients WPH	551	569	18	
Paeds Mat & Gynae	1,906	1,910	4	
Pathology	1,227	1,283	56	
Pharmacy	547	888	341	Gainshare above expectations
Private Patients	1,267	1,041	(225)	Low Overseas in month 12
Procurement	3,433	3,514	81	
Radiology	453	396	(56)	High Agency Month 12
Strategy & Performance	215	215	(0)	
Surgery	1,573	1,367	(206)	Ambitious Assumptions
Theatres Crit Care & Anaes	647	628	(19)	
Therapies	54	47	(7)	
GAP		0	-	
Grand Total	**24,361**	**23,678**	**(683)**	

CIP was £683k worse than forecast as above

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Top 10 Worse Performing CIPs YTD

Ref	Scheme Name	Directorate	Annual Plan	Curr Mth Plan	Curr Mth Act	Curr Mth Var	YTD Plan	YTD Actual	YTD Var
14.11	Stock Control- All Theatre Items	Theatres Crit Care & Anaes	1,082	90	-	(90)	1,082	88	(994)
14.12	Theatre Utilisation	Theatres Crit Care & Anaes	750	63	-	(63)	750	-	(750)
11.10	Theatre Inc Utilisation	Private Patients	750	63	-	(63)	750	34	(716)
13.22	WLI	Surgery	470	39	-	(39)	470	-	(470)
3.16	Ward Model Adherance ED	Medicine Frimley	440	37	-	(37)	440	-	(440)
3.06	Medical ED Savings	Medicine Frimley	400	33	-	(33)	400	-	(400)
8.02	Medical Agency Savings	Orthopaedics & Plastics	398	33	-	(33)	398	63	(335)
4.05	Medicine Medics Agency	Medicine Wexham	320	27	-	(27)	320	-	(320)
4.07	Nursing Seasonal	Medicine Wexham	300	-	(134)	(134)	300	28	(272)
4.20	Ad Op Medical Rates Reduction	Medicine Wexham	265	29	-	(29)	265	-	(265)
8.17	Ad Op Medical Rates Reduction	Orthopaedics & Plastics	161	18	18	(0)	161	89	(72)
11.06	Theatre Utilisation	Private Patients	30	3	-	(3)	30	3	(28)
3.21	Ad Op Medical Rates Reduction	Medicine Frimley	8	1	6	5	8	39	31
Grand Total			**5,374**	**435**	**(110)**	**(545)**	**5,374**	**344**	**(5,031)**

Key Messages:

- The top 10 worst performing schemes were £5m short.
- The schemes are broadly unchanged from last month
- These 10 schemes make up **68%** of the total £7.3m underdelivery
- The schemes are dominated by Theatres, ED and Medical Agency schemes.

Quality Impact Assessment / PID 2018/19

The planning process for 18/19 required PID and QIA sign off only for schemes over £100k

The CIP Tracker highlights 88 schemes that required a PID in 2018/19

Further reporting will be further developed in Months 11 & 12 ahead of the new financial year when detailed reporting will be included.

Within 19/20 Planning, we require a PID for every scheme with QIA still needed for over £100k

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Final Draft of FHFT Internal 2019-20 Operating Plan**
Meeting	Board of Directors
Meeting Date	3rd May 2019
Agenda No.	10.1
Report Type	FHFT Internal Operating Plan to note
Prepared By	Danny Bailey
Executive Lead	Nigel Foster
Executive Summary	The purpose of this Operational Plan is to refresh our activity, quality, workforce and financial plans for 2019-20 which will build upon the progress that was made during 2018-19. It describes our key objectives for 2019-20, and shows how our plans are aligned to the wider Integrated Care System (ICS). The operating plan will also provide the detail of the robust platform which will underpin the long-term organisational strategy which is currently in development.
Background	When the 2019-20 planning guidance was released and throughout the planning period, it was agreed that the focus would be the development of a system-wide operating plan, as such, system partners have produced a detailed operating plan incorporating the key operational elements of each of the organisations within the system. This internal operating plan is brief document and provides a high-level summary of the key aspects of the FHFT operational objectives for 2019-20, the focus of which continues to be the provision of exceptional health services in a financial environment which is ever more challenging.
Issues / Actions	This draft of the FHFT internal operating plan is aligned with and consistent with the system operating plan. Crucially, our financial and activity plans fit with the system plan and the key operating activities for 2019-20 support the transformational change that system partners are looking to achieve as well as

10.1

	delivering key aspects of the acute element of the plan.
Recommendation	Board to note contents of plan
Appendices	Final draft of 2019-20 FHFT Internal Operating Plan

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Frimley Health Internal Operating Plan 2019/20

April 2019

10.1

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Section 2: Activity Plan

Section 3: Constitutional Standards

Section 4: Quality Plan

Section 5: Workforce Plan

Section 6: Finance Plan

Section 1: Introduction and Summary

The purpose of this Operational Plan is to refresh our activity, quality, workforce and financial plans for 2019-20 which will build upon the progress that was made during 2018-19. It describes our key objectives for 2019-20, and shows how our plans are aligned to the wider Integrated Care System (ICS). The operating plan will also provide the detail of the robust platform which will underpin the long-term organisational strategy which is currently in development.

As agreed when the planning guidance was released and through the planning period, system partners have developed a detailed operating plan incorporating the key operational elements of each of the organisations within the system. This internal operating plan is brief document and provides a high-level summary of the key aspects of the FHFT operational objectives for 2019-20, the focus of which continues to be the provision of exceptional health services in a financial environment which is ever more challenging.

As in previous years, the Trust will continue to deliver the constitutional and local standards. As highlighted in previous years, there continues to be a number of risks around the delivery of these standards and the Trust's primary capacity concerns which may impact upon our achievement of key operational standards in 2019-20. These risks will be mitigated through a combination of our own internal Transformation Programme and the work streams being delivered by the ICS, further detail on which can be found in the aforementioned ICS operational plan. The difference between this year and last is that there will be a greater focus on system working and the joint development of plans and projects to help manage demand and improve efficiencies. This will be a key focus for the organisation and we will be continuing the work towards integration across the Frimley Health and Care Integrated Care System. By working in partnership with our population and local partner organisations we will develop an integrated health and care system fit for the future.

This operating plan highlights key elements of the long-term strategy as well as the key elements of the ICS and Trust operating plan. For Frimley Health NHS Foundation Trust (FHFT) there are a number of the key themes which emerged from the Chief Executive's 100 Day Programme which can be seen below and overleaf. Our vision for FHFT will be underpinned by the following six strategic themes:

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

The CEO embarked on his 100 Day Programme in order to speak with staff, patients and health partners to understand the key issues and challenges that faced the organisation going forward. Work is well under way to define our strategy to meet the NHS challenge of growing demand with limited resources and elements of that work feature throughout this operational plan.

This operating plan will also reflect a number of key elements that have emerged from the NHS long-term plan which helps to define the long-term vision of the health and care landscape over the next 10 years. The long-term plan also provides significant detail on the financial arrangements over the next 5 years providing greater clarity for the organisation and system partners over that time period.

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Outcome from the 100 Day Programme: Facing our Future

1. One Frimley Health

Reduce variation and consistently deliver the best care for patients.

We will be:
Using national data to benchmark our services and explore new ways of improving care and services across the Trust

2. A learning organisation

Make sure we are always improving and putting patients at the centre of our service design.

We will be:
Agreeing a standard approach to learning and quality improvement, with the patient and staff voice at the centre

3. Investing in leaders

Support our leaders to be the best and enable them to support our great teams.

We will be:
Launching a new leadership network

4. Recognising our people

Be the best employer, value and empower staff, to share and celebrate successes.

We will be:
Introducing a new recognition and reward programme and developing long-term plans for our future workforce

5. Our future #FutureFHFT

Building on past successes and think ahead to what our services can be in 10 years' time.

We will be:
Developing our 5-10 year vision and organisational strategy

6. Joined up

Work better with GPs, social care, providers and volunteers to join up care and develop services focused on wellbeing, and less on treating sickness.

We will be:
Aligning our work with the Frimley Health and Care Integrated Care System

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Summary of FHFT Local Priorities for 2019-20

The current ICS operating plan includes detail on how FHFT will work with system partners to deliver the key priorities for the year. FHFT will reflect both national and ICS strategies and priorities in our local priorities for 2019-20. Our local priorities for 2019-20 will be shaped by our longer-term thinking for the future of the organisation, a key element of which is the development of our 5-10 year organisational strategy.

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

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

10.1

Section 2: Activity Plan

Although growth in demand continues in a number of areas, the Frimley Health and Care ICS has made good progress on managing activity demand across the acute sector. Managing acute demand allows the ICS to divert funding to support the provision of care for our community closer to home.

A&E attendances, non-elective admissions and elective admissions are used by the system to monitor changes in the flow of patients and as a barometer for the pressure on the acute hospital which acts as an early indicator for the system.

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

Internally, FHFT is developing a new model, empowering our Directorates to manage their activity, finance and performance against their set targets for the year. By adopting a Balance Scorecard approach, the Trust will be working towards an Autonomy Model of management by defining clear accountability and empowering our leaders to deliver business outcomes. Detailed activity and capacity plans will be a key element of this model and will sit along side the financial, workforce and quality data making up the full balanced scorecard.

Activity Plan – 2019-20 Assumptions

As previously mentioned, the Frimley Health and Care ICS has made good progress on managing activity demand across the acute sector which in turn enables funding to be diverted to support the provision of care for our community closer to home. A&E attendances, non-elective admissions and elective admissions are used by the system to monitor changes in the flow of patients. The high-level assumptions that supports this work and provides the baseline for 2019-20 can be seen in the table below.

There is still more to do in terms of managing demand and delivering transformational change and there are a number of projects that will impact the activity in 2019-20, the forecast activity, taking account of a number of key projects, can be seen on the following page.

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

	2016-17 Growth	2017-18 Growth	2018-19 Planned Growth	2019-20 Planned Growth
A&E Attendances	2.2%	1.8%	0.1%	1.3%
Non-Elective admissions (same day & overnight)	7.1%	-1.7%	-0.7%	3.5%
Elective Admissions (same day & overnight)	5.7%	-1.4%	0.6%	2.2%

Activity Plan – FHFT Assumptions

The following table provides further detail on the FHFT activity plans for 2019-20. This table includes some high-level assumptions of the impact of transformational projects.

		ICS Growth values			T2 Transformation			Final plan ICS + T2		
Ics Growth Summary (Low Yield)	18/19 FOT	**19/20 ICS plan (inc. Wexham ED, Neuro, ICDM)**	**Growth 18/19 - 19/20 ICS**	**18/19 to 19/20 ICS plan**	**Outpatient Transformation**	**EBI transformation**	**Frailty**	**19/20 ICS plan plus Transformation**	**18/19 - 19/20 (post Trans)**	**18/19 - 19/20 post Trans %**
E.M.10a: Elective day case spells	56,374	59,126	2,752	4.9%	0.00	-956		58171	1797	3.2%
E.M.10b: Elective ordinary spells	10,653	10,687	34	0.3%	0.00	0		10687	34	0.3%
E.M.11a: Non-Elective zero LOS spells	29,822	32,321	2,499	8.4%	0.00	0		32321	2499	8.4%
E.M.11b: Non-Elective 1+ LOS spells	42,226	43,245	1,019	2.4%	0.00	0	-1725	41520	-706	-1.7%
E.M.12: Total A&E Attendances	182,591	188,167	5,576	3.1%	0.00	0		188167	5576	3.1%
E.M.21: Consultant led outpatient procedures	115,212	117,747	2,535	2.2%	0.00	0		117747	2535	2.2%
E.M.8: Consultant led first outpatient attendances	303,656	305,524	1,867	0.6%	-1951	0		303572	-84	0.0%
E.M.9: Consultant led follow-up outpatient attendances	341,121	350,106	8,984	2.6%	-8836	0		341269	148	0.0%

- Orange section: Shows 2018-19 growth rates applied to 2018-19 forecast outturn less the impact of a number of key projects, those being; ICDM, Neurology and Wexham ED (T1 projects)
- Green section: Shows the addition of further agreed ICS transformation, Outpatients, Evidence Based Interventions and frailty (T2 projects)
- Blue section: Shows a combination of both the above to arrive at the net ICS activity for FHFT in 2019-20

Section 3: Constitutional Standards

The Long Term Plan highlights a number of key priorities that are fundamental to achieving further progress in transforming the provision of urgent and elective care. As in previous years, FHFT plans to deliver and report on all such key constitutional and local targets. However, there are likely to be some developments in the access standards during the year following a clinically-led review which resulted in a number of recommendations being made making 2019-20 a transition year between the current and the proposed new standards.

The new standards will be tested in the field at a number of sites, the data and information from these field tests reviewed then further action planned later in the year in terms of adopting the new standards. The current operational plan is based on achieving the current access standards in place with a view to shadowing the new standards. From May FHFT will actually be one of 14 trusts piloting new clinical standards that could replace the four-hour target in ED. These will consider factors such as time to initial assessment, the start of treatment for serious conditions within one hour, and average wait for treatment.

Urgent and Emergency Care

- Although the 95% standard remains in place, unprecedented demand for urgent and emergency care has led to a situation where very few Trusts are achieving it. As a result, organisations have been asked to submit a realistic trajectory to the end of the year up to 31st March 2020. FHFT has submitted a trajectory that results in achieving 90% at the year-end.
- Alongside the current standard, as mentioned above, FHFT will be taking part in shadowing the new standards which will be tested through the spring of 2019. Data and learning from the field testing period will be considered, alongside expert advice from stakeholders to inform further recommendations to any further roll out from the autumn.

Referral to Treatment

- With regards to the achievement of RTT, again, the Trust's plan is to achieve the target set nationally. The aim is to achieve 92% and also to reduce the number of waiters whose pathway is incomplete when compared to the level of the previous year.
- The Trust plans to ensure that no patients are waiting over 52 weeks for treatment.

Cancer Targets

- The Trust will continue to deliver the current standards and will be preparing to be in a position to the achieve the proposed standards that could be introduced later in the year.

Section 4: 2019-20 Quality Plan

FHFT is in the third year of implementation of our current Quality Strategy. We are currently focusing our improvement programme on nine key aims across the three areas that patients and staff tell us are most important to them; safety, outcomes (effectiveness), and experience (these, and our objectives relating to each of them can be seen below). These areas have been selected in partnership with our staff, patients and healthcare partners, based on learning from incidents and emerging local and national risks and concerns.

As we implement this final stage of our 3 year strategy we will be looking to our future developments and ideas for quality improvement. Further detail can be seen on the following page.

2019-20 - Quality Improvement Strategy

FHFT has a vision to become a national centre for excellence for delivering, sharing and teaching quality improvement (QI). As such, one of the key objectives for 2019-20 is to develop and implement a 3 year quality improvement strategy for the Trust with an implementation plan approved by the end of Q2.

The strategy will define how FHFT will develop the expertise, purpose, drive and capability to create a culture of continuous quality improvement. By embedding a culture of quality improvement the Trust will succeed in securing improved patient experience and outcomes as well as achieving financial and productivity benefits. A co-ordinated, systemic cross organisational approach to quality improvement will enable all staff within the organisation to apply their energy and ideas for change with the support of QI experts as well as engaging patients, their families and carers in quality improvement.

The Institute for Healthcare Improvement (IHI) methodology 'The Model for Improvement' is both simple and powerful in accelerating improvement which makes it ideal for a busy and diverse Trust population to apply. Other advantages are that it facilitates the use of teamwork to make improvements, provides a framework to use different QI tools and allows project plans to adapt.

The model (fig. 1) has two parts, the first part looks at setting aims, establishing measures to understand if change leads to an improvement, and what change can be made to result in improvement.

The second part is the Plan-Do-Study-Act (PDSA) cycle to test the change. It can be used for both small scale and wider scale quality improvement and is transferable across different specialities and organisations. This model will align with Frimley Health system quality improvement methodology and existing QI training/tools used in the organisation

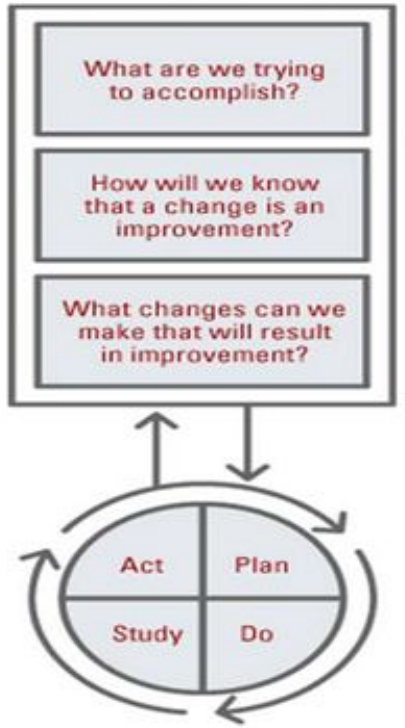

Fig. 1: IHI Model for Improvement

2019- 20 - Improving Quality Across the System

In conjunction with the implementation of the current Quality Strategy, FHFT is working closely with our partners across the ICS to define and deliver a system-wide approach to quality. Together with the ICS, we have described our ambition and plans for the coming year; in 2019-20 we will focus on making quality everybody's business and to support the delivery of consistently high quality care. We will develop an integrated and collaborative approach to quality governance and assurance across the Frimley Health and Care system that minimises duplication, reduces variation and delivers tangible improvements for local people and staff satisfaction. Our strategic approach to assurance and improvement includes the following:

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

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

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

Section 5: 2019-20 Workforce Plan

The effective recruitment and retention of staff within the Trust remains a key corporate responsibility to ensure that the Trust is able to meet the needs of its stakeholders and effectively and safely deliver our goals.

There are a number of internal and external factors that influence our activities in this area, including the NHS Long Term Plan, the impact of Brexit, the Trust's People Strategy 2018-21 and targets and plans submitted of NHS Improvement. These factors highlight a number of key areas that the Trust should focus on, including reducing temporary staffing spend, developing further plans to reduce vacancies in key areas and the adoption and development of the use of transformational roles, such as Nursing Associates and ACPs as well as the utilisation of the apprenticeship levy.

The development of a high level workforce plan will allow the Trust to effectively monitor the progress made in these areas, as well as highlighting areas that require further investigation.

The Trust's current People Strategy 2018-21 sets out the delivery model in order to support all that we do to attract, recruit, develop, support, retain and reward our staff and teams to meet future goals and aspirations. The strategy outlines a number of critical success factors relating to the recruitment and retention of our workforce:

- decrease the nursing and midwifery vacancy rate to 200 vacancies
- decrease the medical vacancy rate to 50 vacancies
- decrease agency spend to meet our NHSI agency ceiling
- recruit over 400 nurses per annum
- reduce overall staff turnover to 13%

2019-20 – System Workforce Plan

Integrated Care System (ICS)

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

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

Workforce Planning:
Create sustainable system performance by providing the basis for decision making about our future workforce needs

Organisational (system) and Leadership Development:
Support the making and managing of the behavioural changes we need to make as a system

Human Resource Management:
Ensuring we have the technicalities of the employment cycle in place to ensure the system has the "right skills, in the right place at the right time" including new mechanisms to increase flexibility between organisations

2019-20 Workforce Plan – Key Metrics

Turnover and Retention

As a Trust, FHFT has a number of key objectives in place to help both improve recruitment and retention and drive efficiency. Trust turnover is currently at 15.0%, which results in losing around 1250 FTE per year. One of our key objectives for the year is to improve retention rate from 83.3% (NHSI, Nov, 2018) to 85.6% (national peer median) through improving staff engagement and morale. For each 1% reduction in the turnover, this would mean the Trust would see around 80 FTE fewer leavers. If we are able to achieve such reductions, this would either contribute to further reducing the vacancy rate, or reducing the volume of recruitment the Trust would need to undertake to maintain staffing levels.

There are a number of corporate initiatives which support retention already in progress, and work will continue in 2019/20 to develop, embed and promote these. These include:

- Reviewing the flexible working policy and guidance materials
- Update of the retirement policy and the retire and return procedure, promoting this as an option for those towards the end of their careers; development of guidance and communications of other options staff may take towards the end of their career to encourage them to stay
- Refresh of the 'Helping You Stay' programme, with a Retention Action Group being established to develop action plans and drive forward initiatives across all staff groups
- Corporate recognition programmes, including the new Board Values into Practice 'ViP' awards, increasing the long service awards to recognise a greater range of length of service
- Extending health and wellbeing initiatives to include financial wellbeing and education, mental health awareness / first aid training, and continuing promotion of the Employee Assistant Programme
- Actions to drive leadership quality, including actions to improve the quality of appraisal conversations, plans to extend the Leadership Summit (held in October) to create a wider Leadership Network, and continued promotion of Leadership Development Programmes (i.e. Mary Seacole)

Workforce Plan – Key Metrics

Efficiency

A number of 2019/20 CIP schemes across directorates have identified savings of around £10.8m on pay spend, however the majority of these are linked to agency and bank reductions which will largely be achieved through conversion into substantive posts. Internal planning with vacancies will likely mean changes or removal of some posts, however there are no substantive workforce reductions planned.

Workforce KPIs

The table below shows the key metrics that we will be working towards in 2019-20

WORKFORCE KPIs	Mar-19	Mar-20
Sickness Absence	3.00%	3.00%
Turnover	15.00%	14.80%
Mandatory Training	88.00%	90.00%
Appraisal (Non-Medical)	78.00%	80.00%
Appraisal (Medical)	93.00%	95.00%

Source: Draft NHSI 2019/20 Workforce Planning Return (Feb 2019)

Workforce Plan – Key Metrics

NHS Improvement Overall Workforce Plan

In February 2019, the Trust submitted its draft workforce plan to NHSI, outlining the current (March 2019) and planned staffing position for 2019/20. This outlined planned changes to substantive, bank and agency.

Summary FTE Changes (Total Workforce)

The table below provides the summary workforce plan and outlines the changes in substantive, bank and agency FTEs by staff group, taken from the data submitted for the draft NHSI Workforce Planning Return.

TOTAL WORKFORCE	Mar-19	Substantive change	Bank change	Agency change	Mar-20	FTE change 2019/20	% change 2019/20
Nursing & Midwifery (Registered)	2678.49	97.63	9.68	-10.02	2775.78	97.29	3.63%
Allied Health Professionals	469.93	24.80	-1.24	-4.58	488.90	18.98	4.04%
Other Scientific & Technical	438.62	6.63	-1.08	0.98	445.16	6.53	1.49%
Healthcare Scientists	180.13	3.24	-1.77	0.52	182.11	1.98	1.10%
Support to Clinical Staff	1774.93	23.10	-6.03	0.00	1792.00	17.07	0.96%
NHS Infrastructure Support	2366.39	31.33	-36.88	9.13	2369.97	3.58	0.15%
Others	51.55	0.00	-4.09	0.00	47.46	-4.09	-7.93%
Medics (Consultants)	508.51	13.61	-7.98	-10.43	503.71	-4.80	-0.94%
Medics (Career Grades)	210.48	9.34	-2.73	-3.62	213.47	3.00	1.42%
Medics (Trainee Grades)	508.40	6.32	2.53	-11.80	505.45	-2.95	-0.58%
Total FTE	**9187.43**	**215.99**	**-49.58**	**-29.82**	**9324.02**	**136.60**	**1.49%**

Source: Draft NHSI 2019/20 Workforce Planning Return (Feb 2019)

Section 6: Finance 2019-20 Budget

I&E by Directorate	Month 11 FOT 2018-19 Bud £ms	FOT £ms	Var £ms	Proposed Budget 2019-20 Adjusted Baseline	CIP **	Final
Directorate: Clinical						
Medicine: Frimley	79.4	81.5	2.1	83.0	(1.4)	81.6
Medicine: Wexham	67.3	70.0	2.8	70.4	(1.2)	69.2
ED WPH	13.3	15.2	1.9	15.3	(0.4)	14.9
ED FPH	13.3	14.6	1.3	14.5	(0.4)	14.0
Orthopaedics & Plastics	24.9	26.5	1.6	26.3	(0.7)	25.6
Paeds, Maternity & Gynae	54.8	54.9	0.1	55.3	(0.3)	54.9
Pathology	28.2	30.4	2.2	30.3	(1.5)	28.9
Private Patients	(3.8)	(3.1)	0.7	(3.2)	(0.2)	(3.4)
Radiology	24.2	25.6	1.5	26.6	(0.6)	26.0
Surgery	46.3	49.6	3.3	50.0	(1.1)	48.9
Therapies	13.8	13.7	(0.1)	13.8	(0.5)	13.3
Theatres, Crit Care & Anaes	71.3	77.2	6.0	77.4	(6.1)	71.3
Clinical Total	**433.0**	**456.2**	**23.2**	**459.6**	**(14.3)**	**445.3**
Directorate: Corporate						0.0
Finance, IM&T, Contracts	20.3	18.2	(2.2)	22.3	(1.3)	21.1
HR & Corporate Services	42.0	46.5	4.5	47.7	(2.5)	45.2
Medical Director	0.2	(0.2)	(0.5)	(0.2)	(0.1)	(0.3)
Nursing & Quality	6.2	6.2	(0.0)	6.5	(0.4)	6.0
Operations: Frimley	16.8	15.4	(1.4)	16.0	(0.4)	15.7
Operations: Wexham	15.9	17.0	1.2	17.1	(0.6)	16.5
Corporate Total	**101.5**	**103.0**	**1.5**	**109.4**	**(5.2)**	**104.2**
CCG Income and financing cost	**(541.1)**	**(564.6)**	**(23.4)**	**(547.3)**	**(5.8)**	**(553.2)**
Control Total Excl. PSF/New MRET	**(6.6)**	**(5.3)**	**1.3**	**21.6**	**(25.4)**	**(3.7)**
PSF	**(26.2)**	**(23.4)**	**2.7**	**(13.3)**		**(13.3)**
New MRET				**(9.1)**		**(9.1)**
Control Total inc. PSF/New MRET	**(32.8)**	**(28.8)**		**(0.8)**	**(25.4)**	**(26.2)**

As an organisation we are setting a budget for 2019-20 which will deliver the financial 'control total' set by NHSI (a £3.7m surplus which, if achieved it will unlock a further £22.5m of cash funding which can be used towards our capital projects).

We are also targeting CIP Programme of £30.5m (of which we have identified c£25m)

The budget reflects a non-recurrent £8m reduction to our control total (although future control total arrangements are uncertain), and a further £4.5m of non-recurrent support.

* Excludes £15.9m Impairment 18/19 & £1.7m Impairment 19/20

** Includes £1m unidentifed CIP as at 03.04.2019

Finance – 2019-20 Control Totals

2019/20 Control Totals

	FHFT £m	BHFT £m	S&BP £m	CCGs £m	System £m
Operating Surplus	3.7	-0.1	-0.7	0.0	**2.9**
Provider Sustainbility Fund	13.3	0.9	0.4		**14.6**
MRET /FRF	9.2		0.3		**9.5**
Total Control Total	**26.2**	**0.8**	**0.0**	**0.0**	**27.0**

The Trust has been set a financial control total surplus of £3.7m. By agreeing to this we have access to £13.3m of Provider Sustainability Funding (PSF) and £9.2m of 'Marginal Rate' (MRET) funding. Both of these are cash items which can be used for capital expenditure in future years but not for revenue spend. The MRET funding is paid quarterly to all acute trusts who have agreed to their control totals.

The PSF is dependent on the overall system financial performance. If the system misses the system control total then PSF is reduced by £1.50 for every £1 that the target is missed.

The numbers for Berkshire Healthcare Foundation Trust (BHFT) and Surrey & Borders Partnership (SABP) represent 40% and 22% respectively of their organisational totals, representing the share that falls within the Frimley Health & Care ICS

Finance – 2019-20 CIP Plan

Area / Directorate	2.5% Target Division £000	CIP Plan Division £000	CIP Plan Division %	2.5% Target Transform £000	CIP Plan Transform £000	CIP Plan Transform %	CIP Plan Total £000	Risk Adjustment %	Full Potential £000
HR & Corporate Services	1,399	1,399	100.0%	1,399	1,095	78.3%	2,494	97%	2,569
Finance, Procurement & IM&T	534	584	109.4%	534	701	131.3%	1,285	96%	1,342
Medical Director Total	43	50	116.3%	43	0	0.0%	50	100%	50
Medicine Frimley	1,507	1,420	94.2%	1,507	0	0.0%	1,420	100%	1,417
ED Frimley	346	439	126.9%	346	0	0.0%	439	88%	497
Medicine Wexham	1,368	1,205	88.1%	1,368	0	0.0%	1,205	98%	1,229
ED Wexham	376	400	106.4%	376	0	0.0%	400	100%	400
Nursing & Quality	203	103	50.7%	203	345	170.0%	448	63%	713
Orthopaedics & Plastics	628	639	101.8%	628	80	12.7%	719	100%	719
Operations FPH	411	356	86.6%	411	0	0.0%	356	95%	375
Operations WPH	461	368	79.8%	461	200	43.4%	568	92%	618
Paeds Mat & Gynae	1,317	320	24.3%	1,317	0	0.0%	320	100%	320
Pathology	879	906	103.1%	879	549	62.5%	1,455	100%	1,455
Pharmacy		0		3,178	1,304	41.0%	1,304	62%	2,109
Private Patients	167	209	125.1%	167	250	149.7%	459	67%	689
Procurement		788		0	984	984000.0%	1,772	58%	3,054
Radiology	645	575	89.1%	645	0	0.0%	575	90%	642
Surgery	1,039	1,042	100.3%	1,039	20	1.9%	1,062	100%	1,062
Theatres Crit Care & Anaes	1,856	1,910	102.9%	1,856	3,090	166.5%	5,000	79%	6,336
Therapies	372	345	92.7%	372	128	34.4%	473	95%	497
Trustwide	66	68	103.0%	66	2,455	3719.7%	2,523	50%	5,079
Grand Total Frimley Health NHSFT	**13,617**	**13,126**	**96.4%**	**16,795**	**11,201**	**66.7%**	**24,327**	**78%**	**31,172**

Target	Plan	
30,412	24,327	80.0%

Finance - 2019-20 System Position

The Frimley Health & Care ICS has a combined NHS funding allocation of almost £1.1bn, plus additional out of system funding of £0.3bn (in addition our two County Councils and three Unitary Authorities have combined funding allocated to the system of £0.3bn.

The ICS Board has agreed a system operating plan, which reflected the Trust's position. The residual financial planning gap across the system was £4.6m, with a further £6m of risks identified. However, there were offsetting contingencies (particularly the 0.5% planning contingencies CCGs are required to hold at the start of the year). This was agreed as an acceptable position across the system.

The ICS has submitted a balanced plan for 2019-20, with a system control total of a surplus of £26.9m. The system is a self-governing system and the delivery of the control total is reliant on the delivery of the consolidated financial position of the six NHS partners within the ICS.

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

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

During the early months of 2019-20 FHFT will be working with partners to improve the way we work in order to manage the system finances; this work will involve:

- Further improving the financial reporting across the system
- Clarification as to how the governance for sharing risks across the system will work
- Ensuring that the focus is on cost and cost reduction as we plan future budgets

Finance – Reforming System Payment Mechanisms (1)

There are four overarching principles to support system working to achieve financial control; these form part of the 2019-20 National Financial Framework for ICS's and are listed below:

- Putting the system at the centre of managing financial resources, promoting new ways of working and behaviours
- Encouraging collaboration between individual organisations to support integrated models of care and achieve system financial balance
- Strengthening system governance and decision-making mechanisms
- Acting as a test bed for further system-focused changes to the NHS financial framework

Alongside the continuing development of a different way of working to achieve financial control across the system, a significant amount of work will be carried out in 2019-20 in order to reform the payment mechanisms within the system. This work will be vital in order to deliver a system control total and we will work collaboratively to manage pressures across the system, ensuring that remedial actions are identified that deliver improvements for the 'Tax-payers' pound, not just moving pressures between organisations. These risks will be monitored monthly by the ICS Finance Reference Group where Chief Finance Officers/ Finance Directors of all NHS partners and Heads of Finance from local authority partners are in attendance.

The system has been working with the national payment teams and KPMG to develop these options for implementation in 2019-20. Any changes will be made transparently and in a way which avoids unintended consequences. The diagram below shows the work that has already been done to support this work and that which will be carried out in 2019-20 and beyond.

Finance – Reforming System Payment Mechanisms (2)

The diagram below shows the aims and intention to reform the payment mechanisms going forward. This work, as well as supporting the development of a system approach to financial control, also resonates with elements of the NHS Long-term Plan

2018/19

Current payment approaches

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

2019/20

Interim payment approaches

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

Long term (5+ years)

Long-term aspirations for payments

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

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Report Title	**Board Objectives 2019/20**
Meeting	Board meeting in public
Meeting Date	3rd May 2019
Agenda No.	10.2
Report Type	For Approval
Executive Lead	Neil Dardis, Chief Executive Officer
Executive Summary	To seek Board approval for the 2019/20 objectives.
Background	The PRC has reviewed the content and structure of the reporting process in advance of the corporate objectives being reported to the board. Wherever possible, the team have adopted a SMART approach.
Issues / Actions	The Board is required to consider and approve the proposed draft corporate objectives.
Recommendation	The Board approve the draft objectives for 2019/20.
Appendices	Draft Board Objectives 2019/20

DRAFT Corporate Objectives 2019/2020

Objective SMART			Target	Exec Lead
	Leadership	Board Assurance Framework	Board Assurance Framework model reviewed and refined by end of Q1 to identify all high level risks and controls and work to ensure appropriate risk-management approach	ND
		Succession/ Talent Management	To have a Critical Posts Register in place, with approaches evaluated and refined with talent pools or successors identified for each critical post - process established and evaluated by Q4	JK
		Senior Leadership Development	Targeted development plan for Board/Exec team/Chiefs/ADs that equips and enables them to lead services, connect, influence, share and grow, and execute the Trust strategic plan by Q2	JK
	Workforce	Advanced Clinical Practice	For the Trust to have a clear vision and agreed implementation plan for Advanced Clinical Practice for a 2019 cohort to commence in Q3	DB
		3 Year Plan	Trust to align a 3 year workforce plan aligned with Trust strategy by refreshing the 3 year workforce plan 2018/21	JK
	Retention Plan	Retention	To improve retention rate from 83.3% (NHSI, Nov, 2018) to 85.6% (national peer median) through improving staff engagement and morale and participation in NHSI collaborative programme	JK
	Health & Wellbeing	Flu Vaccine	For 75% of front-line staff to have received the vaccination in 2019/20	DB/TH
		Smoking, Fitness & Mental Health	Develop implementation and plan to improve staff smoking cessation, mental health and fitness	DB / TH
Quality	Maternity	CQC rating	To achieve a rating of Good/Outstanding across all CQC domains for maternity services	DB
		CNST Objectives	Achieve all 10 CNST objectives & 35% of women booked on to continuity of carer requirements by March 2020	DB
	Patient Voice	Visible Patient Voice	For the Patient Voice to be visible and integral part of QI at all levels of the Trust through the development of a 2 year Patient & Public engagement strategy (PPI) by end of Q2	DB
		Patient & Staff Survey	To seek a 20% improvement in patient survey and staff survey questions related to visibility of feedback mechanisms, & using patient information for improvement	DB
	QI	QI Strategy	To develop and implement a 3-year quality improvement strategy for the Trust, with an implementation plan approved for the QI programme by end of Q2.	DB / TH
	Deteriorating Patient	E-observations and Clinical Alert System	Deploy e-observations & clinical alert system across the Trust in order to reduce NEWS-related Serious Incidents during Q3-Q4 by 50%	DB/TH
	Urgent Care	EAC at WPH	To deliver the successful opening of the new EAC, with an improvement in friends and family scores >90%, with 36% of acute medical and surgical admissions managed through AECU, an LOS reduciton of 0.25 days for Frailty patients, reduction of ED medical vacancies to <12% and a reduction of ED nursing vacancies to <16% by Q4.	LG

		ED New Standards	To pilot new ED standards with the National team, with potential implementation by Q3.	HC/LG
Money	Capital Plan	HW	To ensure progress on time, and to budget with strong stakeholder engagement.	JK
		IP & Diagnostic Unit	To complete FBC for Board approval by end of Q1 and delivery milestones linked to programme	JK//HC
	Digital	Procurement of EPR	Agree specification for, procure and select an EPR provider, commencing the implementation plan in Q4.	NF
		Implementation of Office 365	To roll-out O365 across the Trust in Q3.	NF
	Transformation	OPD	To reduce the footfall through OPD facilities by introducing virtual/ICS alternative pathways, through enhanced use of digital technology, work with the EPR team and improving efficiency to reduce face to face copntacts by 2%	HC
		WOS	To provide FBC in Q1 and deliver implementation plan in Q3	JK
	Community Services	Community Services Bid	To establish a partnership to bid for SH/NEHF community services leading to the successful award of contract by Q3	HC
	Finance	Delivery of Trust Control Total	The Trust to meet a financial control total of £3.7m and an overall control total including PSF of £26.2m	NF
		CIP Delivery	To have a CIP plan for £30.5m with a requirement to deliver £25.5m of cash-releasing CIP savings in year. Deliver £25.5m by Q4	NF/all Execs with responsibility for schemes in their Directorates
		System Financial Performance	To deliver a system financial control total of £4.5m and an overall control total including PSF of £27m once agreed new financial governance arrangements focusing on organisational costs and cost drivers, and having prepared a 5-year system financial plan in Q2	NF
		Financial Grip and Control	To ensure there is a robust financial control environment delivering CIP programme and budgetary responsibilities. Review of 'Grip & Control' action and framework and finalise 2020/21 CIP plan by Q4	NF
Strategy	Trust Strategy	Initiate Implementation of Trust Strategy	To develop a 3-5 year strategy by end of Q2 with demonstrable engagement and communication plan. Approved Trust strategy to be supported by detailed implementation plans and evidence of delivery against said plans by Q4.	ND

NOTE: ICS Objectives in addition to those above to be developed with system partners

DRAFT April 2019

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NHS
Frimley Health
NHS Foundation Trust

Report Title	Integrated Care System Operating Plan 2019-20
Meeting	Board of Directors
Meeting Date	3rd May 2019
Agenda No.	10.3
Report Type	To endorse
Prepared By	Jane Hogg, Nigel Foster, ICS "Team"
Executive Lead	Neil Dardis
Executive Summary	The Integrated Care System Operating Plan describes the collective priorities and actions for the providers, commissioners and local authorities that make up the Frimley Health and Care Integrated Care System (ICS). The plan outlines how we will continue to deliver the overall vision of improved integration driving quality health and care improvements across our system. As our ICS continues to develop, 2019-20 will be a significant year as we build upon on the successful changes implemented in 2018-19 whilst forming the foundations for future years and our longer term strategy. By working in partnership with our population and local partner organisations we will develop an integrated health and care system fit for the future. In general, our population is relatively healthy and performs well against national averages but there are inequalities and challenges within the system. As this plan will form the foundations to support the refreshed 5 year strategic plan, the ICS Board has identified specific areas where collective system leadership, ambition and support will deliver accelerated improvements to deliver our longer term plan: • Promote a focus on prevention across all of our transformation initiatives and cross cutting programmes and build a cross programme view of the impact of these initiatives on the future incidence of serious conditions and disease to inform longer term planning

10.3

	• Continue to support and empower people to manage their own health and well-being with an increased focus on pro-active early intervention and greater access to self-management tools and resources • Enabling everyone within our system to fulfil their potential by reducing inequalities and improving their mental well-being. Within our current transformation and cross cutting programmes, identify areas where outcome improvement should be targeted to particular cohorts of our population in addition to tracking outcomes for the whole population. We will deliver significant improvements within year for these targeted populations demonstrating a reduction in inequalities across the population as a whole. By the end of the year, we will agree a systematic approach for identifying and tackling inequalities and reducing unwarranted variation in care that will support delivery of our longer term plan • Create sustainable "place based" delivery models building on established health and local authority footprints, integrated community care teams, community assets and emerging primary care networks. We will establish the infrastructure needed to support the long term planning aspiration of a fully integrated community based health and well-being service with a focus on prevention, proactive care, mental well-being and reducing inequalities. By the end of the year we will agree those functions and activities that will be delivered across the system and those where accountability will sit within more local community footprints (places) • As a system we have real challenges to address around children's services (for both health and local authorities). We are committed to ensuring that all elements of a child's health needs (both physical and mental health and well being) are considered. During 2019-20 we will embed a programme of improvement including the following key priority areas: Neurodiversity support, crisis and urgent care, and the promotion of well being and personal responsibility • We recognise that in order to deliver successfully across 2019-20 and into the future we will need to have a skilled and committed workforce that understands the challenges for people and works as increasingly integrated teams to deliver change and improvements. We will identify new roles and different ways of working that create capacity to allow our staff to have the time they need to deliver care and drive improvements. Through our Academy we will promote and support a learning and empowered culture, supporting people through innovative programmes and collaborative leadership styles

	Delivering this Plan is our opportunity to continue and to accelerate our plans to transform and improve the health, care and wellbeing of our population and to further build a system that is sustainable and that will continue to improve. By the end of this year we will have: • Delivered on the priorities set out in this plan for the forthcoming year • Developed an ambitious local vision and plan for the next 5 years co-designed with our population and supported by system partners across health and care. The plan will reflect national priorities for health and care but identifying the specific areas of focus for our populations • Prioritised and concentrated our resources in our change programmes of work that will have the most impact for our population • Made changes to the way our system makes decisions and reduced the barriers to successful delivery of improvements for our population
Background	This is the second year that a comprehensive System Operating Plan has been produced for the ICS instead of detailed individual organisational plans. A draft version of the Plan was taken to the March private Board meeting.
Issues/Actions	
Recommendation	Board to ENDORSE the Integrated Care System Operating Plan for 2019/20
Appendices	Integrated Care System Operating Plan 2019-20

Frimley Health and Care

System Operating Plan 2019-20

FINAL 11th April 2019

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Executive Overview

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

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

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

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

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

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

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Executive Overview

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

PUBLIC Board of Directors - 3 May 2019-24/04/19

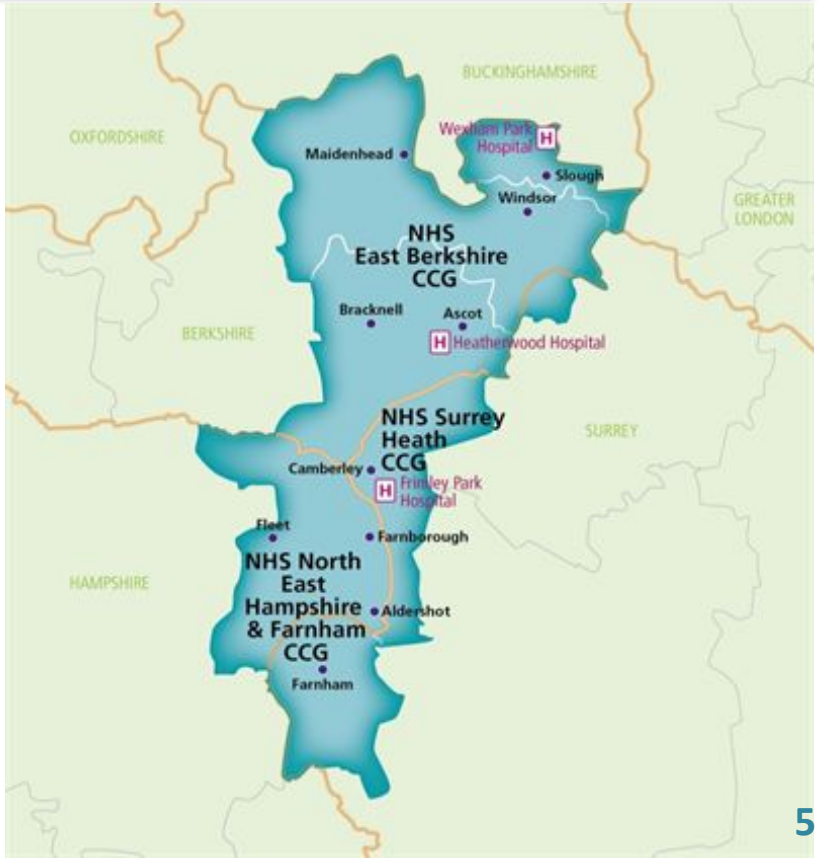
Introduction

Our Vision

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

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

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



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System Progress: Our strategic approach

Our Aims

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

To achieve this we will:

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

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

System Progress: Where we are now

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

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

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

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

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

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

Our population, communities and individuals will:

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

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System Progress: Benefits already seen

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

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

The Needs of our Population

Our Frimley Health and Care 2018-19 Operating Plan priorities were based on the evidence of health needs from the five local Joint Strategic Needs Assessments (JSNAs). Whilst the overall shape of these health needs changes quite slowly, we need to take account of some important future trends:

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

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

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

- **Infrastructure:** We are enhancing the data within our Connected Care information system to include wider determinants of health and wellbeing such as socio-economic data. A large scale communication programme is being developed to discuss with residents how use of this data helps us improve health, wellbeing and services. We will continue to protect residents' personal data through strong governance of information and it will not be used outside the health and care system
- **Intelligence:** The information available is becoming much richer than that previously available. We are working with clinicians, and particularly with GPs, to draw out the insights at a neighbourhood level, and with experts in Public Health and elsewhere to explore how we can better identify emerging needs. These activities will reshape our 2019-20 Operating Plan and underpin our 5 year strategic plan
- **Intervention:** We will use the insights about local needs to make joint decisions across Health and Local Authorities about the priorities and action needed in each locality as well as system-wide. The Health and Wellbeing Boards will have a primary role in this to create comprehensive local health and wellbeing plans

3

The Wider Determinants of Health

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

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

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

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

Action plans for each priority area will be developed in the coming months as part of our response to the NHS Long Term Plan.

System Plan on a Page

Five Year Priorities

National

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

Local

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

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

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

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

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

Transformation Initiatives

1. Prevention and Self-care: Ensure people have the skills, confidence and support **to take responsibility for their own health and wellbeing**

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

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

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

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

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

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

Cross cutting Programmes

Cross cutting Programmes

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

Enablers

Enablers

- Workforce
- Estates
- Digital & Technology
- Communication & Engagement

4

Our Local and Organisational Priorities for 2019-20

Aim

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

Highlights

- Most of the delivery of the system plan occurs within local geographies with local populations and through front line staff. Consequently, many of the areas highlighted reflect place and/or organisational details that will deliver the system plan. These details are often critical for **local population** and **staff engagement Quality, safety and a positive experience** for people are important drivers. Delivering these outcomes are important to the ICS and a system wide structure had been put in place to provide leadership and support as detailed in the System Governance section of this plan
- **Enablers to delivery change** are focus areas for stakeholder organisations: **Workforce, Estates and Digital and Technology transformation** are key areas of operational focus. The ICS is reviewing as part of its preparation for 2019-20 the interface between system enablers, the capacity required to manage change in these areas, the delivery that takes place within organisations and how learning is shared
- **Securing the right services** for people is important for all organisations. Going forward, the system will explore the full range of options for commissioning the right services for our population based on analysis of need
- The redesign of our **Continuing Healthcare Services** has been highlighted by each of the three CCG areas. This is due to the complex geography of the ICS and its work across multiple local authority footprints and we will share the learning from this across the ICS whilst recognising the appropriateness of these planning and delivery footprints to each local area
- The is a strong programme of activity around services for **children and young people**. The ICS has added to this year's plan a delivery structure and cross cutting programme for children and young people (see Section 7 Cross Cutting Programmes)

Challenges and Opportunities

- The local and organisational priorities highlight some current service gaps, and some risks around non-recurrent funding sources supporting care delivery. The ICS partners will develop more collective approaches to **funding and investment decisions.** This will require open and transparent conversation with our communities on how we provide the best possible care within a limited financial resources
- There is an opportunity as part of the development of the ICS long term plan to bring together our current thinking as a system to form a coherent single strategy for health and wellbeing for our population

PUBLIC Board of Directors - 3 May 2019-24/04/19

Our 2019-20 Transformation Delivery Programme

5

The Frimley Health and Care system has an established a transformation and delivery programme through which this system plan will be operationalised. The programmes of work are designed to transform the way care is delivered to the benefit of the system population and enable delivery of the system and national priorities. Each initiative consists of a portfolio of work to support delivery of our transformation agenda. There are also a number of transformational enablers that underpin the work including workforce, estates, digital, communications and engagement and technology that are described more fully in Section 7 in this plan.

Context

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

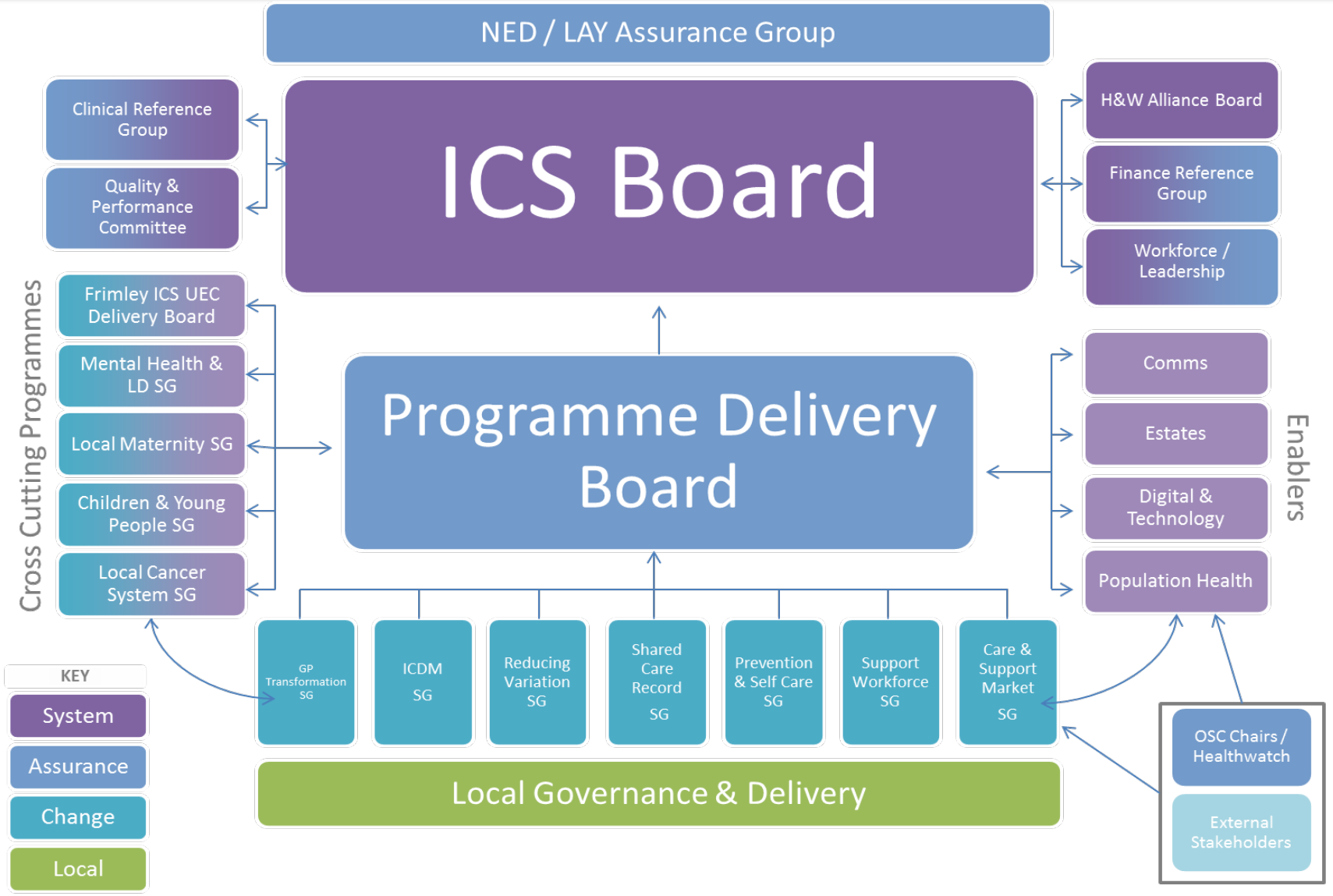
Plans have been developed with input from all partners across the Frimley footprint with a strong focus on being clinically led where appropriate. As a system we have in place a robust investment planning process to support the initiation and delivery of our transformation projects. For 2019-20, each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

Our Transformation Initiatives	
1. Prevention and Self-care	5. Care and Support Market
2. Integrated Care Decision Making	6. Reducing Clinical Variation
3. GP Transformation	7. Shared Care Record
4. Support Workforce	

Our Cross Cutting Programmes
• Urgent and Emergency Care
• Mental Health and Learning Disabilities
• Maternity
• Children and Young People
• Cancer
• Medicines Optimisation

5

Emerging Delivery Structure



1. Prevention and Self-care

Aim

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

Description

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

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

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

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

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

1. Prevention and Self-care

Deliverables

Social Prescribing

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

Making Every Contact Count (MECC)

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

Hospital Based Alcohol Services

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

Physical Activity Initiatives

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

Links to Other Work streams

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

1. Prevention and Self-care

How will services look by the end March 2020?

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

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

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

Outcomes and Benefits

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

Key Risks and Mitigation

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

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1. Prevention and Self Care

Outcomes and Benefits

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

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1. Prevention and Self Care

Milestones

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

2. Integrated Care Decision Making

Aim

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

Description

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

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

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

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

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

2. Integrated Care Decision Making

Description

The overall objectives are as follows:

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

How will services look by the end of March 2020?

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

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

2. Integrated Care Decision Making

Deliverables

Network

- **Agreed Locality Access Points (LAPs):** To enable timely access to integrated interventions, triage and case management
- **Community Integrated Care Teams:** Multi-disciplinary teams (MDTs) working across organisational boundaries in our communities, co-located with Primary Care services where feasible and staffed with an appropriate skill mix to effectively manage people at high risk of hospital admission or re-admission
- **Regular MDT Cluster meetings:** MDT approach which results in a structured individual care plan that involves active interventions which promote opportunities for recovery to independence , and reduce demand on crisis and urgent care services
- **Embedded Anticipatory Care approach:** Proactive case finding/risk stratification of patients which identify patients who are at high risk, enabling pro-active interventions to avoid unnecessary hospital admissions and reducing the need for long term care

Place

- **Supporting delivery of the NHS Long Term Plan:** Place-based mapping of primary and community requirements undertaken in order to support delivery of the Plan
- **Alignment:** Ensure that integrated care aligns with the requirements of General Practice and Primary Care Networks, social care, urgent care, prevention and wellbeing, and mental health redesign, and the estates and technology transformation programmes
- **Improve independence:** Helping people maintain independence and manage their own health and care e.g. through expanded use of social prescribing, social, emotional and psychological support in partnership with the individual

System

- **Shift demand:** Reduced crises, impacting on pressures and targets associated with unplanned emergency activity, reduced bed days and admissions into long term care
- **Decrease secondary care activity and support the reduction in costs:** Sustained shifts of activity and demand will enable long term financial sustainability
- **Improving the health outcomes and independence of those most at risk in our populations:** Enabling people to remain independent in their own homes for longer

2. Integrated Care Decision Making

Outcomes and Benefits

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

Key Risks and Mitigation

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

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2. Integrated Care Decision Making

Outcomes and Benefits

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

2. Integrated Care Decision Making

Milestones

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

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3. General Practice Transformation

Aim

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

Description

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

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

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

For patients and carers: Joined up services, access to a wider range of professionals and diagnostics, different ways of getting advice and treatment, shorter waiting times, greater involvement in care decisions and an increased focus on prevention.
For practices: Greater resilience by sharing staff, buildings and other resources, a more sustainable work/life balance, more satisfying work with a greater ability to focus on the tasks they do best, greater influence on decisions made elsewhere in the system and the ability to provide better treatments.
Wider health and care partners should experience: Cooperation across organisational boundaries, primary care providers as core partners in system decision making, alternatives to default acute services and more resilience primary care.

3. General Practice Transformation

Description

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

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

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

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

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3. General Practice Transformation

General Practice Programme Delivery Areas (Delivery Role)

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

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

The General Practice Transformation Programme will undertake the following:

- **Workforce:** Analysis undertaken during 2018-19 has provided a GP practice workforce modelling tool that will assist in the development of a primary care workforce plan for Frimley ICS ensuring that the right people are available with the right skills at the right time. Modelling shows that without taking action there will be a "workforce gap" in our GP and nurse numbers. The focus during 2019-20 will be to attract people into (and back into) primary care and actively support the retention of existing staff. We will develop the **new primary care multi disciplinary team**, making the following workforce available to all GP practices: Paramedics, clinical pharmacists, advanced physiotherapists, mental health practitioners, advanced nurse practitioners, care navigators. In addition we will implement plans to recruit and **retain GP workforce** at both ends of their career and develop consistent **recruitment support tools** to be available for all GP practices. The building blocks to better support the workforce into posts and offer their training and development throughout their career will be agreed
- **Workload:** The current workload intensity in general practice is unsustainable and demand on primary care services is set to increase. Nationally general practice undertakes 90 per cent of NHS activity for 7.5 per cent of the cost, seeing more than 320million patients per year. Initiatives introduced during 2018-19 such as online consultations and document management training will be optimised across the Frimley system in order to improve practice efficiency, release clinical capacity and improve patient experience/self-care opportunities. Optimising the use of technology will improve services for our patients, enable increased self-management and release clinical capacity. Online activities will increase such as appointment booking and prescription ordering
- **Care Redesign:** Primary care networks build on core primary care services and provide a working relationship that may improve GP practice sustainability in the future. Working "at scale" across groups of practices will be a key area of care redesign during 2019-20. For patients, good access to their general practice is important and this will mean different things for different people. During 2019-20 local initiatives for improving the way patient demand for same day access is managed will be tested as part of informing the delivery of a more clearly articulated urgent care offering from general practice as part of its Primary Care Strategy.
- **Clinical Variation:** There is variation across general practice in a number of areas. The general practice work stream will be focusing on reducing clinical variation in three key areas learning disability health checks, vaccination and screening rates. During 2019-20 primary care will also participate in reducing variation in a number of other clinical areas and it will be important to manage the multiple requirements on general practice
- **Infrastructure** We will ensure that the interface with new digital and estates programmes is actively managed and includes strong primary care leadership

3. General Practice Transformation

Deliverables

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

Workforce

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

Workload

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

Care Redesign

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

Variation

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

3. General Practice Transformation

How will services look by the end March 2020?

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

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

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

Outcomes and Benefits

Workforce

- Increased staff satisfaction with more staff retained resulting in a more sustainable workforce

Workload

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

Care Redesign

- More patients who are satisfied with access to general practice (score in GP survey)
- More patients who describe their overall experience of general practice as 'good' (GP Survey)
- Improved patient experience with general practice services

Variation

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

Key Risks and Mitigation

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

3. General Practice Transformation

Outcomes and Benefits

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

3. General Practice Transformation

Milestones

Focus area	Q1	Q2	Q3	Q4
Workforce Increased staff satisfaction with more staff retained resulting in a more sustainable workforce	**Retention scheme** • Initiate "Next Generation GP Programme" • Project Initiation document for "Wise 5 GP (W5GP) support" project approved by steering group • Initiation of phase 2 projects (focusing on maternity leave returns, advanced nurse training and practice manager development)	• W5GP implementation plan signed off steering group and initiated • Initiation of phase 2 implementation plan		• End of year outcomes and benefits progress review
	Creation of new primary care workforce • Investment Case approved by ICS board • Implementation plan signed off by GP steering group. • International GP Recruitment plan developed	• Sign off tools/guidance to initiate implementation plan	• Commence implementation across all Networks	• Quarterly reporting of workforce gap (on-going reporting)
	Workforce satisfaction • All practices to agree to an annual system wide GP satisfaction survey	• Baseline survey completed in all practices	• Survey results analysed and shared at GP Steering Group	• Processes put in place for annual survey (Q2 2020-21)

3. General Practice Transformation

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Milestones

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

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3. General Practice Transformation

Milestones

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

4. Support Workforce

Aim

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

Description

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

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

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

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

4. Support Workforce

Deliverables

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

Outcomes and Benefits

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

Key Risks and Mitigation

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

4. Support Workforce

How will services look by the end March 2020?

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

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

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

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

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

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

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4. Support Workforce

Outcomes and Benefits

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

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4. Support Workforce

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Milestones

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

5. Care and Support Market

Aim

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

Description

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

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

5. Care and Support Market

Description

Our programme components include:

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

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

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

5. Care and Support Market

Deliverables

The key deliverables for 2019-20 are:

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

Outcomes and Benefits

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

Key Risks and Mitigation

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

5. Care and Support Market

How will services look by the end March 2020?

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

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

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

5. Care and Support Market

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Outcomes and Benefits

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

5. Care and Support Market

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Milestones

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

6. Reducing Clinical Variation

Aim

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

Description

The overall objectives are as follows:

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

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

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

6. Reducing Clinical Variation

Description

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

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

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6. Reducing Clinical Variation

Description

- **Respiratory:** We are focusing on supporting primary care identification of patients with or at risk of developing COPD or asthma. We are reviewing how prescribing and use of latest technology can be optimised across the ICS to support patients to take greater ownership of their condition. We are working across agencies within the system to deepen our understand of how patients engage and interact with our services and the outcomes they receive. This will inform our approach to an integrated respiratory service across the ICS and validate the decisions made
- **Diabetes:** Continue the successful delivery and implementation of structured education courses, to reduce variation across the ICS and maintain improvement from 20%. Improve the achievement of HbA1c, cholesterol and blood pressure treatment targets from 42% and second best nationally. Improve the timeliness of referrals from primary care to a multi-disciplinary diabetic foot team (MDFT) and increase the provision of inpatient Specialist Nurses

How will services look by the end March 2020?

Patient experience:

- Our patients and residents will feel involved in the development of our program so that the patient voice remains strong and shapes the work being done
- Our patients will be central to and inform our understanding of "value" and what this means to them. We will enable the environment and connections between system partners to support this recognition and understanding with patients at the heart of the discussion
- Our patients and residents will have greater understanding of their condition in line with those which our program prioritise
- Our patients and residents will benefit from innovative technological solutions to health delivery which can be locally accessed and easily understood
- Our patients and residents will see the shift of resource which provides localised more accessible solutions to them in their local community
- Our patients and residents will feel informed and knowledgeable about the local resources available to them which can be easily navigated when needed
- Our patients and residents will be supported and feel empowered to build the resilience and structure of their local communities including all partner organisations so that health and social care work in conjunction, responding to the needs of the whole person
- Our patients and residents will benefit from early detection and intervention to enable better outcomes
- Our patients will receive appropriate and timely access to diagnostics enabling better understanding of the patient about their condition

Staff experience :

- We shall work with integrity so that our staff are considered, consulted and listened to as we work to deliver a flexible and responsive approach to service delivery
- We shall develop our staff equipping them with the best and most appropriate skills for the roles they fill whilst enabling them to be adaptable and flexible in the way they work within the health system
- We will build the infrastructure to support interoperable working of our teams across organisations

6. Reducing Clinical Variation

Deliverables

We are working to achieve specific service improvements and reduction in clinical variation across the five areas through:

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

Outcomes and Benefits

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

Outcomes and Benefits

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

Key Risks and Mitigation

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

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6. Reducing Clinical Variation

Outcomes and Benefits

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

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6. Reducing Clinical Variation

Milestones

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

6. Reducing Clinical Variation

Milestones

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

7. Shared Care Record

Aim

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

Description

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

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

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

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

7. Shared Care Record

Deliverables

Technical Feeds

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

Shared Record Group (care professional development of product)

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

Connected Intelligence Platform

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

Share Your Care (Personal Health Record - PHR)

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

7. Shared Care Record

How will services look by the end March 2020?

Population

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

Workforce

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

System

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

7. Shared Care Record

Outcomes and Benefits

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

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

Key Risks and Mitigation

- There is a risk that other workstreams will not be able to transform current operational and clinical practice at pace and scale to inform digital enablement

- The technical implementation is complex and can lead to delays. Mitigating actions include bringing organisational and supplier teams together to work closely and flag exceptions as early as possible. It is important for it to be seen as a clinical transformation programme rather than a digital programme to ensure adoption continues

- The quality of information is dependent on the quality of information already in primary source systems. This is variable across organisations currently. This will be mitigated through our professional group setting standards and then collaborating with organisations in order to ensure that the information needed is recorded in a way that can feed into the shared care record

7. Shared Care Record

Milestones

Level	Pop. Size	Outcomes	Benefits (Financial and Workforce)
Neighbourhood	~50k		
Place	~250-550k		
System	1m+	• Releasing time to care and improving experience for care professionals and residents • Improved patient safety by providing critical patient information at the point of care • Residents empowered to take greater ownership of their wellbeing supporting them to live better for longer	• Improved quality of shared information • Improved efficiency for health and social care staff by having access to information or having signposts to who holds the information • Improved use of health and care resources across ICS and borders

7. Shared Care Record

Milestones

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

Delivery Vehicle

Patient Portal Technical Deployment Shared Record Group Intelligence Platform

Urgent and Emergency Care

Aim

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

Description

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

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

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

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

Urgent and Emergency Care

Deliverables

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

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

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

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

Urgent and Emergency Care

How will services look by the end March 2020?

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

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

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

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

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

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

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

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

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

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Urgent and Emergency Care

Outcomes and Benefits

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

Key Risks and Mitigation

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

Urgent and Emergency Care

Outcomes and Benefits

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

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Urgent and Emergency Care

Milestones

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

Mental Health and Learning Disabilities

Aim

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

Description

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

Priority 1: Developing a Joint Strategic Plan

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

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

Mental Health and Learning Disabilities

Description

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

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

Priority 3: Out of Area Placements (OAPs)

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

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

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

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

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

Mental Health and Learning Disabilities

Description

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

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

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

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

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

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Mental Health and Learning Disabilities

How will services look by the end of March 2020?

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

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

Key Risks and Mitigation

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

Deliverables

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

Outcomes and Benefits

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

Mental Health and Learning Disabilities

Outcomes and Benefits

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

Mental Health and Learning Disabilities

Milestones

Q1	Q2	Q3	Q4
Priority 1: Set up a joint strategic planning, delivery and assurance initiative within the ICS • Principles established for a joint strategic planning, delivery and assurance approach to be delivered via the MH Steering Group, bringing together commissioners and provider organisations	• Financial analysis undertaken to establish the level of MH spend across the ICS and the actual cost of individual pathways for MH services	• Investment strategy developed, informed by the FYFVMH and NHS Long Term Plan	
Priority 2: Children and Young People's access to Mental Health services • Deliver 32% increase in access to CAMHS	• Map flows and identify areas for improved efficiency	• With the CYP programme, co-develop a CAMHS access and improvement strategy based on the results of the mapping exercises	
Priority 3: Reducing inappropriate Out of Area Placements (OAPs) • Reduction of inappropriate OAP bed days across the ICS from 351 to 314 • Q1 Data evaluation report completed to assess how often someone is discharged back to same placement after an admission • Service improvement options paper finalised including reference to the evidence base and cost efficient commissioning	• Reduction of inappropriate OAP bed days across the ICS from 314 to 273 • Service Improvement Delivery Plan completed	• Reduction of inappropriate OAP bed days across the ICS from 273 to 238 • Service improvement implementation commenced	• Reduction of inappropriate OAP bed days across the ICS from 238 to 199
Priority 4: Pathway of care for people with a personality disorder (PD) agreed across the Frimley ICS	• Review completed of best practice available relating to care and treatment of PD	• Gap analysis completed including review of current Care Pathways and wider determinants of mental health (e.g. housing and accommodation) to consider people with PD at place and system level	• Future design of pathways/services proposed • Business case completed to secure investment

Mental Health and Learning Disabilities

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Milestones

Q1	Q2	Q3	Q4
Priority 5: Development of primary care mental health and wellbeing support • Business case completed for additional funding to develop primary care mental health services across our system. Including review of existing local initiatives and workforce capacity and capability across Primary and Mental Health Care (in line with workforce expansion targets)	• Mobilisation of Place-Based Wellbeing Service in East Berkshire • Business Case submitted to Programme Delivery Board for approval to test new primary care model in NEHF/Surrey Heath	• New model of primary MH service mobilised in NEHF/Surrey Heath	• Six months post-implementation review of the Place-Based Wellbeing Service in East Berkshire completed • Recommendations developed for system wide scaling of primary care MH model(s)
Priority 6: Improving access to crisis services for people of all ages • Task and Finish Group established to develop ICS Framework for improving access to crisis MH Services. Identifying where value can be added and where partnership working can be enhanced. • Gap analysis report produced to identify gaps in existing provision	• Peer review visits undertaken including best practice for care planning and crisis planning • ICS Framework proposals developed • Interdependencies with other workstreams identified.	• ICS Framework proposals implemented • Monitoring process established	• ICS Framework proposals implemented • Monitoring process established
Workforce • ICS workforce planning lead recruited and in post	• Financial analysis undertaken to establish the level of MH spend across the ICS and the actual cost of individual pathways for MH services • Review of workforce plans completed	• Investment strategy developed (including workforce plans), informed by the FYFVMH and NHS Long Term Plan	

Maternity

Aim

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

Description

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

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

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

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

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

Maternity

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Description

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

Digital

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

Preconception and Maternal Health

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

Workforce

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

Safety

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

Choice and Personalisation and Community Care

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

Maternity

How will services look by the end March 2020?

- Women will feel supported in making choices that are right for them have healthier pregnancies and births. Women will feel that their care is personalised and flexible including when and where they receive antenatal and post natal care with the option of being seen in a hub at a time outside of normal working hours
- Women will feel supported through the use of social media and have access to peer support and education including breast feeding and healthy eating and exercise
- Women will feel empowered to use technology to improve their health and to manage their healthcare and feel able to shape future services and care through membership and engagement with our local Maternity Voices Partnership
- Our workforce will feel supported and enabled to develop and to shape future services, through opportunities such as our local leadership and organisational development programme
- Midwives will feel supported through working with colleagues in hubs and will be able to network and integrate with co-located services and will feel that they are spending less time travelling across the system
- Labour ward midwives will feel empowered in caring for diabetic women as they will be part of a 'diabetes team' and will have had additional support

Outcomes and Benefits

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

Deliverables

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

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

Key Risks and Mitigation

- Risk: Lack of digital interoperability with the challenge of having two patient administration systems across the Trust. This risk will be mitigated by continuing to link with Connected Care work streams and the Local Health and Care Record development
- Risk: Workforce risk with continued challenge of vacancies. This risk will be mitigated through work with our workforce group to understand local challenges and prioritise solutions
- Risk: Complexity of different working on different sites. This risk will be mitigated by prioritising a standardised approach
- Risk: Different approaches from different local authorities to healthy lifestyle support. This risk will be mitigated by continuing to work at a system-wide level, identifying inequalities and addressing them

Maternity

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Outcomes and Benefits

Level	Pop. Size	Outcomes	Benefits (Financial and Workforce)
Neighbourhood	~50k	• Improved satisfaction of women with their maternity services • Improved levels of motivation in maternity workforce • Increased levels of workforce feeling supported	• Optimised Workflow in general practice (tbc) • Released space in GP practices • Improved levels of motivation in maternity workforce • Increased levels of workforce feeling supported
Place	~250-550k		
System	1m+	• Improved health status of women and babies – Fewer women will lose their baby – Fewer women receiving Continuity of Carer will experience pre-term birth or have an episiotomy • Women will have informed choice of care • Improved women's experience • Improved satisfaction of women with their maternity services	

Maternity

Milestones

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

Children and Young People

Aim

The aim of this programme is to establish a system wide approach that will focus on those issues where working at scale and over a Frimley ICS footprint adds measurable value in terms of improved health outcomes for children and young people. We have now agreed that the focus for 2019-20 is to develop a work plan which will inform a longer term programme of work which responds to the requirements of the NHS Long Term Plan.

Description

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

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

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

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

We are seeking to engage with children, young people and their parents and carers in a variety of ways, and on a range of subjects to inform our decision making and in line with our explicit commitment to co-production. We will seek to also engage with a wide range of partners including education colleagues recognising the significant role that education providers play in early identification of need and support in the improvement of outcomes for children and young people.

Children and Young People

Deliverables

As a system we will ensure there is a strong focus on supporting the good physical health and wellbeing of our Children and Young People (CYP) and a commitment to ensuring that all elements of a child's health needs are considered. We have set system priorities which will support local place based collaborations to jointly plan and develop integrated services for CYP in Hampshire, Surrey and East Berkshire.

Resourcing to support the programme

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

Building the knowledge base

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

CYP focus to existing Prevention and Self care (P&SC) projects

- Extend CYP focus to work of P&SC Programme e.g. asset mapping, social prescribing, MECC, physical activity, social campaigns

Parental health literacy

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

Urgent and Emergency Care

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

Neurodiversity

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

Children and Young People

How will services look by the end March 2020?

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

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

Outcomes and Benefits (expected over lifetime of programme)

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

Key Risks and Mitigation

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

Children and Young People

Outcomes and Benefits

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

Children and Young People

6

Milestones

Q1	Q2	Q3	Q4
• Funding approval from Programme Delivery Board (PDB) for dedicated programme resources to support the group • CYP focus extended to work of ICS Prevention and Self care Programme • Baseline established of CYP health needs - including engagement with Public Health England to undertake a 'School Readiness' data pack for ICS • Project initiation document completed for programme of work to map demand and assess baseline of current urgent and crisis care services for CYP with respective sub group established • Sub group established to lead neurodiversity work stream	• Funding identified and Qualitative assessment completed of health and wellbeing in CYP including neuro-diverse children and young people • Business case to expand social prescribing/community assets model to cover CYP presented to PDB • New piece of work to assess parental health literacy initiated • Shared vision developed for transforming universal and specific services to cater for the needs of a neurodiverse child and adolescent population • Gap analysis for urgent and crisis services completed and priority next steps presented to the CYP and UEC Programme Boards	• Coherent neuro-developmental pathway for children and young people developed, to include early identification and ongoing support post diagnosis • Business case to create a parent health literacy programme produced • Future optimum urgent care pathways and models completed, and associated business cases produced for recommendation for approval at PDB	• Business case completed and presented to PDB for a responsive support programme for families and schools at the first identification of neurodiversity, support/adaptation needs including the adoption of a screening profile tool • Parent health literacy programme implemented • Implementation initiation of urgent care pathway changes

Cancer

Aim

This programme aims to improve the survival rates and experience for our patients living with and beyond with cancer across the ICS. This will be achieved by working in partnership with our cancer Alliances to achieve the national cancer strategy 2020 targets and to meet the terms of our NHS England Memorandum of Understand (MOU). We will focus on utilising the resources available to provide high quality cancer pathways with seamless integration throughout the patient journey.

Description

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

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

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

Improving support for people living with and beyond cancer will be achieved through an enhanced recovery package which includes the effective use of holistic needs assessments and treatment summaries, and improved quality of Cancer Care Reviews (CCRs) helping to tailor services towards individual patient needs. These measures will be effective in meeting both national and Alliance deliverables. A third key aspect of this programme is the further development of risk-stratified follow-up pathways in which patients who have completed their acute treatment then follow a self-management rather than a professionally-led pathway. We will implement these developments through the introduction of a prostate cancer stratified pathway and work towards further pathways in other tumour groups.

Cancer

Description

The work is led by the ICS Cancer steering group. This group is made up of stakeholders from primary and secondary care, commissioners, both Cancer Alliances, Macmillan Cancer Support, and Cancer Research UK. The group has been established to provide leadership and a collective vision for cancer in the ICS and to work in partnership to deliver improved outcomes. This work is supported by each organisation and by national cancer transformation funding and aims to share best practice, innovation, and learning across and beyond the ICS. The group is supported by a patient reference group.

Deliverables

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

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

Prevention and Early Diagnosis

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

Treatment and Care

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

Cancer

Deliverables

Living with and Beyond Cancer:

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

Patient experience and engagement

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

Health Information Exchange (HIE)

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

Strategy

The ICS cancer steering group will devise a 5 year plan for cancer during 2019.

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Cancer

How will services look by the end March 2020?

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

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

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

Outcomes and Benefits

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

Key Risks and Mitigation

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

Cancer

Outcomes and Benefits

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

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Cancer

Milestones

Q1	Q2	Q3	Q4
• Measures of cancer care agreed and monitoring process in place • Q1 Report completed (all data items in the 28 day faster diagnosis standard) • Record sharing between Cerner and Graphnet in place to support record sharing with the tertiary centres in the north • Agreed plans for LINAC in partnership with provider cancer centre, supported by specialist commissioners • Prevention plans agreed with public health and ICS partners • Screening targets agreed and locality actions initiated • National timed pathway for suspected colorectal and prostate cancer implemented • Stratified follow-up pathway for prostate cancer initiated • One health and wellbeing event delivered	• Progress with screening plans reviewed • Project initiated for vague symptoms pathway at Frimley Park Hospital (pending S&S Cancer Alliance funding) • Patient information needs assessment completed (pending Alliance funding) • Increase in health needs assessments, treatment summaries and cancer care reviews delivered • Actions agreed as result of the national cancer patient experience survey implemented • One health and wellbeing event delivered • All referrals for suspected cancer follow NICE guidance and are being sent via the e-referrals system with all the appropriate information required • Vague symptoms pathway at Wexham Park Hospital implemented	• National timed pathways for suspected upper GI and lung cancer implemented • Risk stratified follow up pathway for colorectal cancer implemented • Two health and wellbeing events delivered • Symptomatic FIT testing roll out initiated • 5 year plan for cancer agreed • Symptomatic FIT pathway roll out initiated • Direct access to diagnostics review initiated • Prevention plans implemented	• Vague symptoms pathway at Frimley Park Hospital implemented • Health and wellbeing event menu developed and in place • Health Information Exchange Website revised to provide patient focused information • Deliver agreed screening targets • Work with Genomic Laboratory Hubs to implement the national genomic test directory, having patient choice offer and fresh-frozen pathways in place • Support delivery of regional plans for implementation of phase 1 of the cancer workforce plan once the plan is known • One health and wellbeing event delivered

6

Medicines Optimisation

Aim

To work together as a whole system to create a consistent, cost-effective, evidence-based approach to medicines optimisation, leading to improved outcomes for our local people. The focus for 2019-20 will be to build on the initial scoping work undertaken in 2018-19 across the system and to establish an ICS wide Medicines Optimisation Board to ensure consistent, robust decision making in relation to medicines and appliances.

Description

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

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

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

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

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

Medicines Optimisation

Deliverables

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

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Medicines Optimisation

6

How will services look by the end March 2020?

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

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

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

Outcomes and Benefits

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

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

Key Risks and Mitigation

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

Medicines Optimisation

Outcomes and Benefits

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

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Medicines Optimisation

Milestones

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

Our People Strategy

7

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

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

Challenges

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

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

Approach

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

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

Our staff are being supported in career progression/portfolio careers programmes maximising use of the apprenticeship levy. New roles are being developed to replace or support hard to fill roles including nursing associates and advanced clinical practitioners. Our shared workforce plan increases opportunities for rotation across organisations, giving staff greater experience and enabling them to deliver better care by working more effectively around the individual rather than within organisational boundaries.

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Workforce Planning: Vision and Deliverables

The ICS vision is clear - *whatever the individual's need, staff throughout the care system will give greater support for individuals to take responsibility for their own health and care*. This has substantial implications for the health and social care workforce in every organisation across Frimley Health and Care including the voluntary sector, informal networks and carers.

Six System Wide Principles

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

Key actions from the Workforce Strategy

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

Workforce Deliverables

Our plans during 2019-20 and beyond include:

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

System and Leadership Development

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

Leading System Development

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

System Design

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

Supporting System and Leadership Development

The Frimley Leadership and Improvement Academy (FLIA) was established in May 2018 providing oversight and expertise to ensure the right portfolio of leadership programmes are in place. All our programmes will be designed to enable staff to work collaboratively and lead change at any level within the system. Our Improvement Network (IN) will draw from people across the system with improvement skills and expertise and will:

- Offer guidance and mentoring in Quality Improvement (QI) approaches
- Cascade the development of system leadership and QI skills, tools, mind sets and behaviour across the ICS
- Connect people working on improvement across the system
- Establish and grow a library/knowledge bank of quality improvement best practice

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

System and Leadership Development Deliverables

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

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Human Resources Programme

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

Achievements in 2018-19

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

Challenges

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

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

Approach for 2019-20

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

Digital and Technology

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

Description

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

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

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

Alignment with ICS workstreams

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

Alignment with wider system

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

Information Governance

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

Collaborative Infrastructure

To support the workforce, a final priority area is to explore opportunities to align the infrastructure between ICS organisations. This will support professionals communicate more efficiently and ensure we are making the best use of resources. It will also encourage sharing of best practice and more flexible working.

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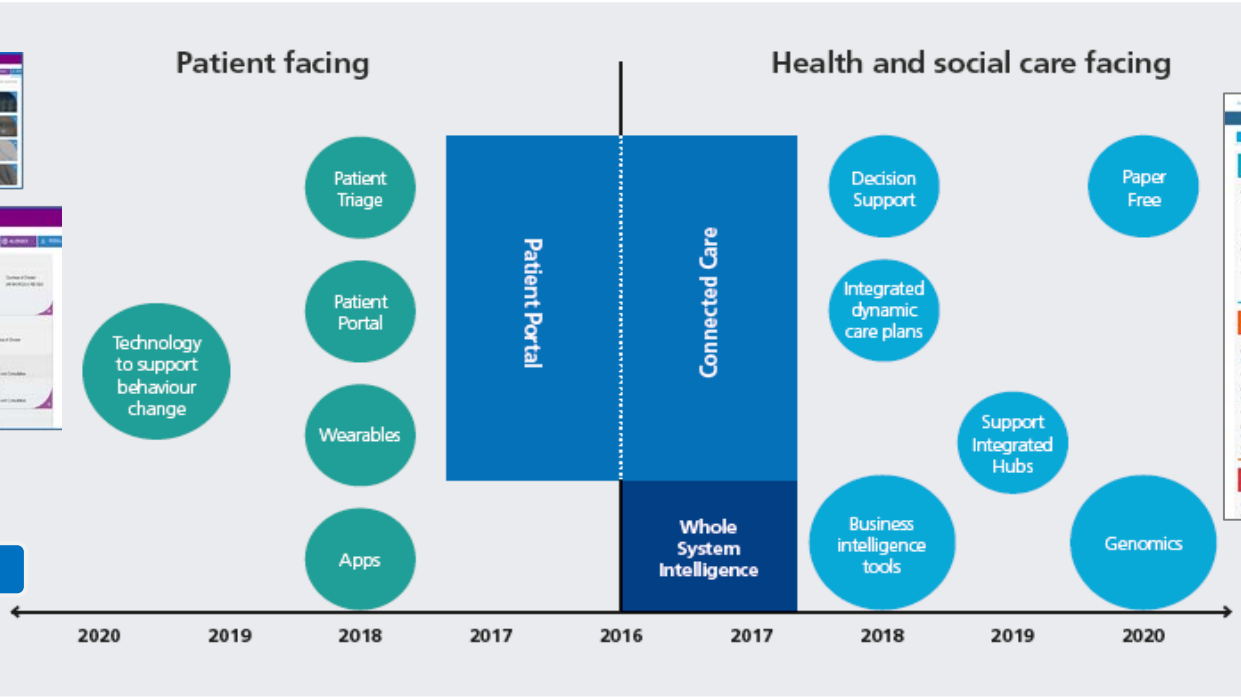
Digital and Technology

Patient Portal

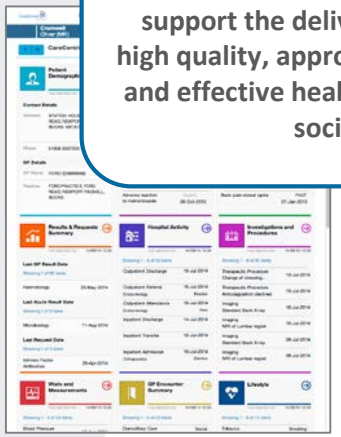
Helping People to Manage their Own Health and Wellbeing

PATIENT AND STAFF EXPERIENCE



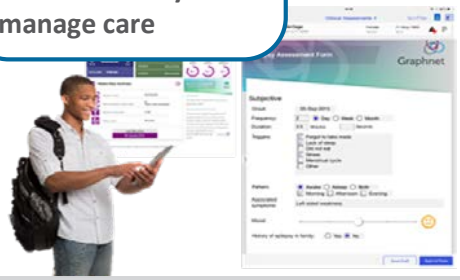
Shared Care Record

a single view of an individuals' care data to support the delivery of high quality, appropriate and effective health and social care



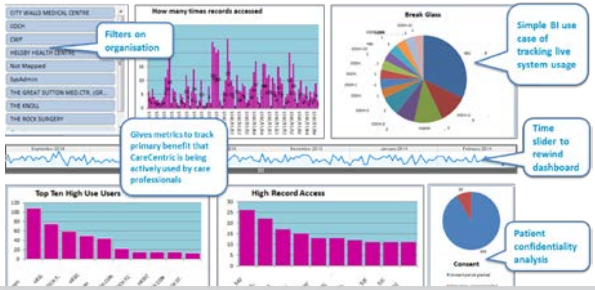
Apps and Wearables

Supporting: New Models of Care, enhanced patient participation and innovative ways to manage care



BI – Population Analytics

New business intelligence and reporting tools



We have had a consistent vision since 2016 around our digital priorities which has allowed us to move forward in a coordinated manner. This has increased the benefits of each component part as each deliver area is interlinked.

Estates

Aim

To deliver the ICS estates programme described in the ICS Estates Strategy submitted in the summer of 2018. The Strategy specifically supports the delivery of the Estates Technology and Transformation Fund (ETTF) and ICS business case submissions designed to support the delivery of key transformation programmes across the ICS.

Description

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

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

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

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

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

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

7

Estates

Description

Urgent and Emergency Care:

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

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

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

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

Estates

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Description

Programme	Local Initiative	Purpose	Funding Route	Timelines
Surplus land disposals	East Berks CCG - Review and declare land surplus to requirements		N/A	Governing Body paper Dec 2018
ICS Estates strategy refresh	In light of impending funding decisions estates strategy will be reviewed	Ensure strategy up to date and reflective of maturing clinical strategies	N/A	Aug 2019 to ICS board
Frimley Health NHS Foundation Trust Modernisation programme	Emergency assessment centre	Improve patient flow through Emergency Department	Trust capital	2019-20
Frimley Health NHS Foundation Trust Modernisation programme	Diagnostic centre	Provide MRI / CT scanning facilities	Trust capital	TBC

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Improving Quality

Aim

We will develop a vision, framework and programme for system wide quality and a shared commitment to further developing a culture of quality improvement focusing on effective care, safety and ensuring people have a positive experience of care.

Description

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

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

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

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

Improving Quality

8

Description

Reducing Gram-Negative Blood stream Infections (BSIs)

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

Sepsis

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

Person's Time

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

Care home Quality

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

Improving Quality

Description

Mortality Reviews

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

Learning Disabilities Mortality Review Programme (LeDeR)

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

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

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

Falls

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

Improving Quality

Description

Pressure Ulcers

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

Safeguarding

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

We will also:

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

Improving Quality

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Description

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

Out of Area Placements (OAP)

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

Zero Suicide Ambition – safety planning

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

How will Quality look by the end March 2020?

Local Population

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

Staff

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

Improving Quality

Outcomes and Benefits

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

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

Key Risks and Mitigation

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

Improving Quality

Milestones

Q1	Q2	Q3	Q4
• Quality Operational Group established and identified leads • Implementation completed of the quality governance assurance and data flow mechanisms • Scope of human factors training to support system wide improvement in learning from incidents completed • ICS action plan agreed for the Gosport review	• Review and refinement of the quality dashboard completed • Review completed of the Quality and Equality and Diversity Impact Assessments • System-wide serious incident review process implemented • Quality impact assessment on workforce challenges completed • Work with the other workstreams on the concept of 'person's time' mapped and embedded within the service redesign processes	• Shared definition, vision and understanding of quality to establish a single view of quality across health and social care, including the voluntary and 3rd sector developed • A single Frimley system quality account developed • Human factors training across ICS implemented	• Benefits of the quality dashboard evaluated • Shared definition, vision and understanding of quality agreed • Single Frimley system quality account signed off • System-wide serious incident review process embedded • ICS action plan for the Gosport review implemented • Implementation of actions from the Quality impact assessment. • Audit of learning from person time activity completed
• Sepsis data reviewed and areas for improvement identified. Sepsis dashboard scoped for implementation	• Catheter project developed to reduce the number of long term catheter insertion by 20% by 2020. Audit catheter numbers for baseline	• Improvement data shows improve outcomes for patients Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions	• KPI data trajectory reviewed for reduction of Gram negative BSIs. • Reduction in the number of catheters • Suspicion of Sepsis Insights dashboard implemented

Improving Quality

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Milestones

Q1	Q2	Q3	Q4
• Plan of care home quality work presented to ICS Quality and Performance Committee. Annual review for 2018-19 completed • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee. • Learning and improvements on falls from the work undertaken by FH and BHFT shared and ICS actions to reduce the number of falls identified	• Quarterly review of progress against the plan completed • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee.	• Improvement data shows improve outcomes for patients Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions. • Quarterly review of progress against the plan completed and for ICS Quality and performance committee. Any quality issues identified particularly around support from Primary Care • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee.	• Quarterly review of progress against the plan completed (and taken where?). Any quality issues identified particularly around support from Primary Care • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee. • Number of falls across the system reduced by 10%
• Baseline data reviewed from 2018-19 CQUIN on improving services for people with mental health needs by identifying a new cohort of patients. Milestones as per the CQUIN • Baseline data reviewed on the number of children and young people being cared for in an unsuitable environment • Baseline data reviewed for all organisations on the number of days where there has been no pressure ulcers developed. Public messaging for prevention developed and circulated	• Quarterly report presented to Quality and Performance Committee on progress and improvement • Quarterly numbers of pressure ulcers identified across the ICS reported to the Committee	• Quarterly report to Quality and Performance Committee through the Quality report on progress and improvement • Quarterly numbers of pressure ulcers identified across the ICS reported to the Committee	• Quarterly report to Quality and Performance Committee through the Quality report on progress and improvement • Reduction achieved in number of incidents reported from the baseline in Q1 • Celebration event for those services who have improved or had no pressure ulcers over the year. Public messaging evaluated • Reduction achieved from the baseline on number of pressure ulcers across the ICS

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Improving Quality

Milestones

Q1	Q2	Q3	Q4
• Consistent approach for definition measurement and reporting Baseline data established. % reduction agreed across the ICS			
• To develop a plan on how to work across the system on youth violence initiatives	• Ambulance forums established • Standard practice across the ICS when considering safeguarding adult reviews aligned • Audit completed on the robustness of systems for determining mental capacity	• Safeguarding resource and information flow across the ICS developed • LAC designated professionals network extended to Hampshire and Surrey professionals Priority workstreams from South East feed into the national LAC framework	• Annual report on activity completed • Audit completed on the practice across the ICS • Evaluation report completed on plan Monitor the implementation of the plan and evaluate whether this has been successful • Audit completed on the robustness of systems for determining mental capacity

Financial Sustainability: Overview

9

Frimley Health and Care Integrated Care System (ICS) is submitting a balanced plan for 2019-20, with a system control total of a surplus of £26.9m. The system is a self-governing system and the delivery of the control total is reliant on the delivery of the consolidated financial position of the six NHS partners within the ICS.

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

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

Detail

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

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

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

Financial Sustainability: Overview

Context

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

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

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

	2018-19 Cotrol Total	2019-20 Planned Control Total
NHS East Berkshire CCG	-0.8	0.0
NHS North East Hampshire and Farnham CCG	-0.3	0.0
NHS Surrey Heath CCG	0.0	0.0
Frimley Health NHS Foundation Trust	33.3	26.2
Berkshire Healthcare NHS Foundation Trust (40%)	1.0	0.8
Surrey and Borders Partnership NHS Foundation Trust (22%)	0.9	0.0
Total Frimley Integrated Care System (NHS)	**34.1**	**26.9**

Underlying Financial Position and Efficiency plans

9

Underlying financial position

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

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

Efficiency plans

	Expenditure efficiency plans within ICS £'m	%	Total Efficiency plan within ICS £'m	%
NHS East Berkshire CCG	8.9	2.8%	12.8	2.0%
NHS North East Hampshire and Farnham CCG	5.0	3.0%	9.0	2.7%
NHS Surrey Heath CCG	1.5	2.0%	2.5	1.7%
Total CCGs	**15.4**	**2.8%**	**24.3**	**2.2%**
Frimley Health NHS Foundation Trust	25.4	3.8%	25.4	3.8%
Berkshire Healthcare NHS Foundation Trust (40%)	3.1	3.0%	3.1	3.0%
Surrey and Borders Partnership NHS Foundation Trust (22%)	1.5	3.4%	1.5	3.4%
Total Providers	**30.0**	**3.6%**	**30.0**	**3.6%**
System Stretch	10.3		10.3	
Total Frimley Integrated Care System (NHS)	**55.7**	**3.1%**	**64.6**	**3.1%**

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

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

Frimley Health has set an internal CIP target of £30.5m to deliver this. Berkshire Healthcare and Surrey & Borders figures reflect the ICS's share of their overall savings plan

Financial Sustainability: Reforming system payment mechanisms

For 2019-20 we will continue to operate under a shared system control total to deliver improved system outcomes. Under the full system control total the financial performance of the six NHS organisations will be managed first on collective financial performance, then their individual performance.

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

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

2018/19

Current payment approaches

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

2019/20

Interim payment approaches

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

Long term (5+ years)

Long-term aspirations for payments

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

Financial Sustainability: Reforming system payment mechanisms

9

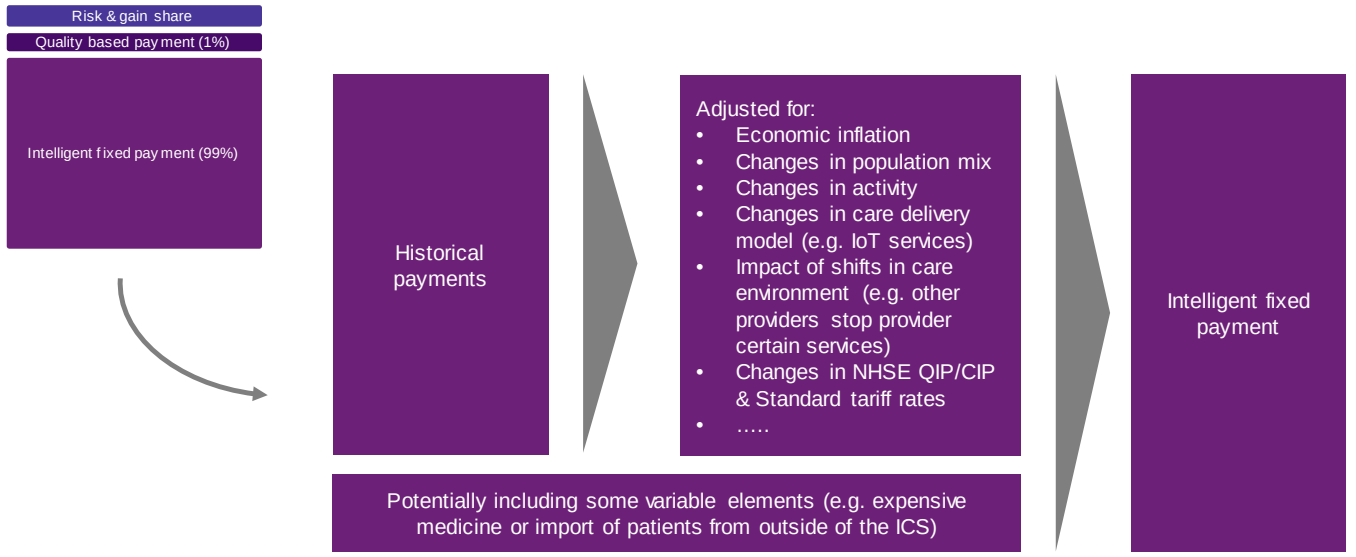
Payment reform can help because it can:

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

…because:

- It is an **incremental method** to help providers take on risk and manage care better.
- It can help get the **care priorities aligned** with the 5YFV through the reimbursement of care based on quality measures

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



Activity Assumptions

Context

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

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

Detail

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

	2016-17 Growth	2017-18 Growth	2018-19 Planned Growth	2019-20 Planned Growth
A&E Attendances	2.2%	1.8%	0.1%	1.3%
Non-Elective admissions (same day & overnight)	7.1%	-1.7%	-0.7%	3.5%
Elective Admissions (same day & overnight)	5.7%	-1.4%	0.6%	2.2%

Communication and Engagement

Aim

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

Description

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

Our Communications and Engagement Strategy is to have:

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

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

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

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Communication and Engagement

Deliverables

During 2019-20 we will deliver the following:

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

How will services look by the end March 2020?

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

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

Communication and Engagement

Outcomes and Benefits

Patient experience

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

Service Integration

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

Outcomes and Benefits

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

System Sustainability

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

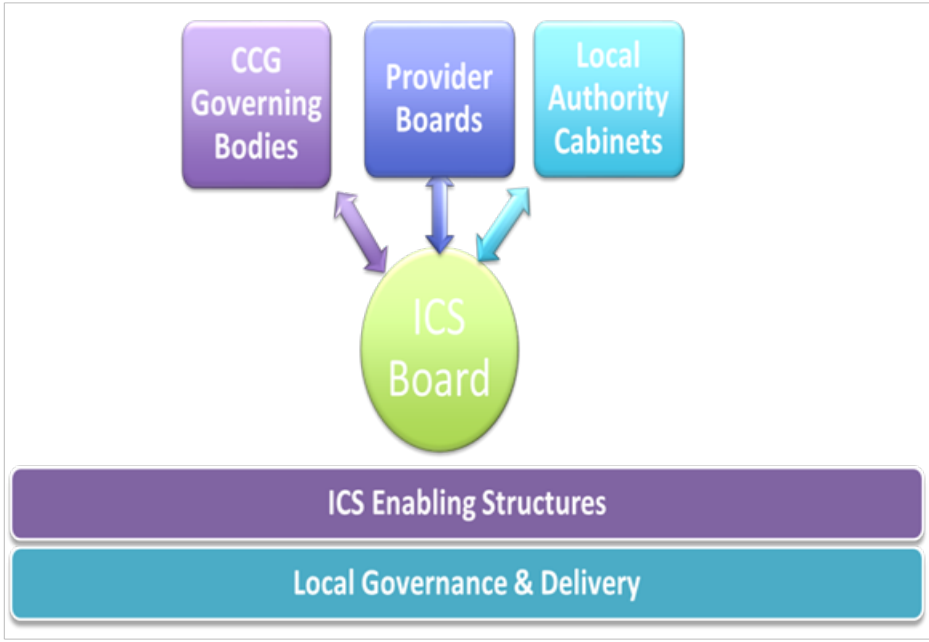
Key Risks and Mitigation

- The key risks are limited available communication and engagement capacity. In order to mitigate these risks, a NHS England funding bid has been submitted and further work to review how we can co-ordinate roles across the system needs to be undertaken.

System Governance

Our ICS continues to develop through consolidating partnership working, supporting relationship building, operating a system control total and making partnership based local investment decisions to support our change programme. Our local organisations have agreed a delegated responsibility structure to support our ICS Board role in system maturity and development. We aim to reduce duplication, so that in the system we do things only once. We are developing stronger assurance processes within the system to support a changed relationship with regulators, while reducing the overall administration. The system will focus on enabling transformational change whilst strengthening self assurance.

System Governance



ICS Mechanisms and Enabling Structures

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

The ICS enabling structures include:

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

System Governance

Risks and Assurance

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

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

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

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

Risks and Assurance

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

Appendices

Appendix 1: Key Principles

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

Appendix 3: System Logic Model

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

Appendix 5: Our Local Authorities' Local Priorities for 2019-20

Appendix 1: Key Principles

Key Principles that underpin our ICS

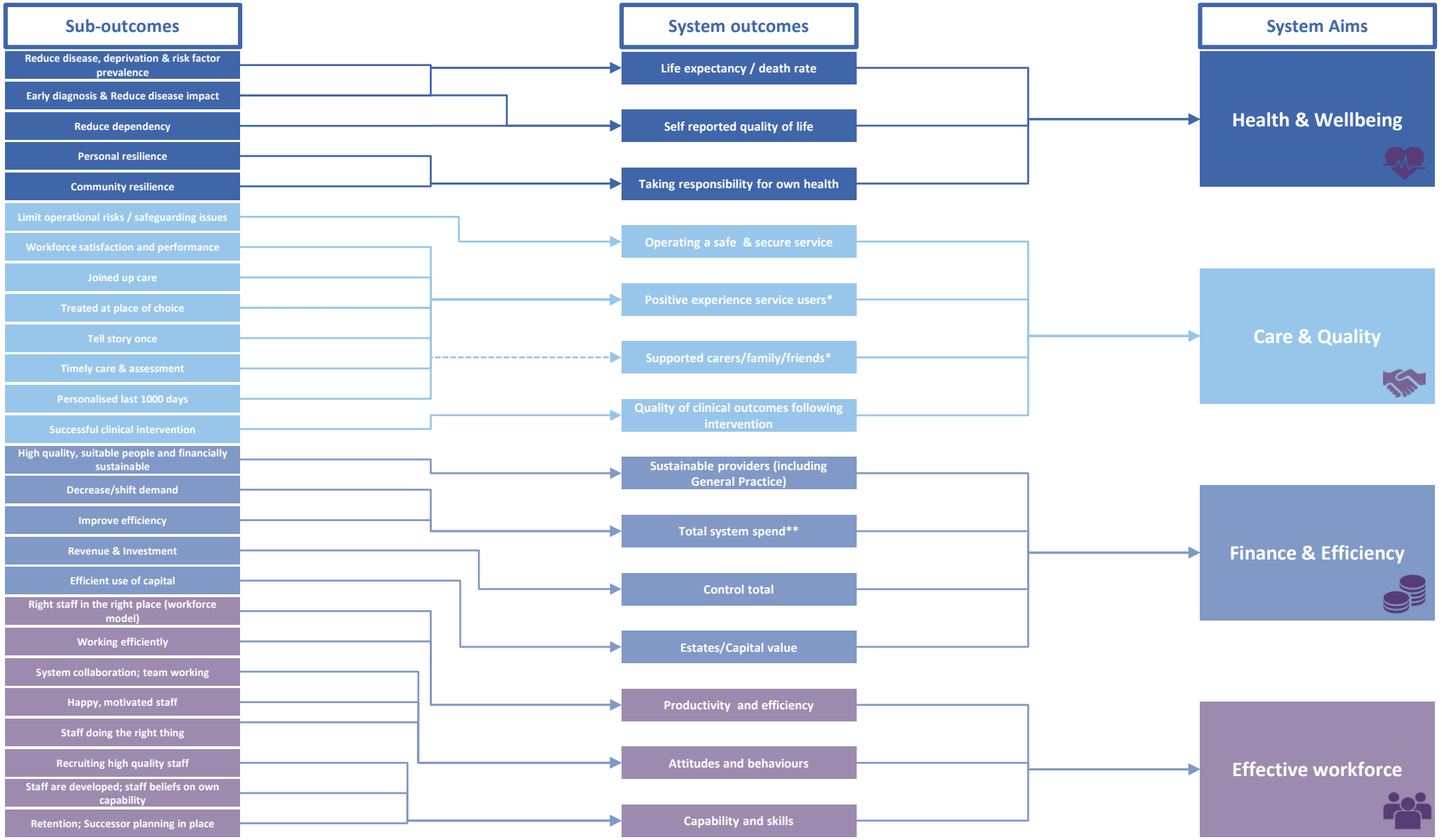
1. Established and driven by data and evidence
2. Supported by new ways of contracting/commissioning – removing traditional boundaries between health and social care, commissioners and providers
3. Driven by strong clinical leadership – including secondary care, GP and community clinicians - across current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

Appendix 2: Frimley STP submission

Link to Sustainability and Transformation Plan October 2016 submission:

https://www.fhft.nhs.uk/media/2388/frimley-stp-oct-submission-for-publication.pdf

Appendix 3: System Logic Model



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

Aim

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

East Berkshire CCG

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

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

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

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

Our CCGs' and Providers' local priorities for 2019-20

Surrey Heath CCG

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

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

Local Procurements:

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

Local Integration:

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

North East Hampshire and Farnham CCG

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

Local Procurements:

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

Local Priorities:

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

Our CCGs' and Providers' local priorities for 2019-20

Berkshire Healthcare NHS Foundation Trust

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

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

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

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

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

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

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

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

- Reducing the number of people who receive mental health inpatient services outside of Berkshire (Out of Area Placements)
- Reducing numbers of suicides (Zero Suicide)
- Providing a more effective response to people who do not need secondary mental health services, with quicker access to talking therapies and sign-posting to community and voluntary sector organisations (Wellbeing Service)

Our CCGs' and Providers' local priorities for 2019-20

Frimley Health NHS Foundation Trust

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

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

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

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

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

Our CCGs' and Providers' local priorities for 2019-20

Surrey and Borders Partnership NHS Foundation Trust

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

Sustainability to maintain

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

Working Age Adults transformation

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

Children and Young People's services

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

People with Learning Disabilities

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

24/7 Programme

- Re-development of inpatient facilities to achieve required privacy and dignity improvements for people living in our North West Surrey and East & Mid Surrey communities i.e. those currently using Abraham Cowley Unit, Chertsey
- Digital transformation e.g. TIHM (Technology Integrated Healthcare Management) optimising the learning and outcomes achieved through the research project within our core services and commencing our re-procurement for our Electronic Patient Record (EPR) system in line with its contract

Appendix 5: Our Local Authorities' local priorities for 2019-20

Aim

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

Royal Borough of Windsor and Maidenhead

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

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

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

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

- Implementing new ward boundaries from May 2019, following all out elections on 2 May 2019
- Continuing to embed commissioning arrangements across the council
- Overseeing the significant regeneration of Maidenhead

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Our Local Authorities' local priorities for 2019-20

Optalis

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

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

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

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

Achieving for Children

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

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

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

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

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

Our Local Authorities' local priorities for 2019-20

Slough Borough Council

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

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

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

- Delivering a new customer strategy and approach to working with residents and a new customer insight function
- Our staff working better to meet customers needs
- A new accommodation and hub strategy – including moving to a new town centre headquarters
- A new digital strategy with a digital by default approach

Our Local Authorities' local priorities for 2019-20

Surrey County Council

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

SCC Community Vision

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

Our ambitions for people are:

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

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

Our ambitions for our place are:

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

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

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

Our Local Authorities' local priorities for 2019-20

Surrey County Council

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

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

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

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NHS Frimley Health NHS Foundation Trust

Report Title	**Register of Gifts and Hospitality and Register of Interest**
Meeting	Public Board of Directors
Meeting Date	3 May 2019
Agenda No.	11
Report Type	For Assurance
Prepared By	Susanne Nelson-Wehrmeyer, Company Secretary
Executive Lead	Janet King, Director of HR & Corporate Services/ Neil Dardis, Chief Executive
Executive Summary	**Register of Gifts and Hospitality** All of the Board of Directors are required to comply with the Trust's standards fo business conduct and anti-bribery policy as required by the constitution. All Board members are required to comply with the requirements of the Code of Conduct and accountability for NHS Boards. The Company Secretary maintains a record of gifts/hospitality received by the Directors and the HR Department maintains one for the staff as well as for staff declarations of interest. Any gift or hospitality with a value exceeding the threshold £35.00 or two gifts to £35 each from the same supplier within a 12 month period must be declared by the employee/ Board member promptly (within 2 weeks of receipt) in writing for inclusion in the register. Gifts below the threshold do not need to be declared. There is an annual requirement to review this register and it is a record subject to external audit. **Register of Interest** In accordance with constitutional requirements the Register of Interests is mandated for review every six months. It is timely to review the register at the end of the financial year. The Register is a publicly available document. The Chairman is obliged to take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.
Background	**Register of Gifts and Hospitality** The Bribery Act 2010 which repeals existing legislation has introduced the offences of offering and or a receiving a bribe. It places specific responsibility on organisations to have in position sufficient and adequate procedures to prevent bribery and corruption taking place. Under the act Bribery is defined as: 'Inducement for an action which is illegal, unethical or a breach of trust'. Inducements can take the form of: 'gifts, loans,

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	fees, rewards or other privileges'. Corruption is broadly defined as: 'The offering or acceptance of inducements, gifts or favours, payments or benefit in kind which may influence the improper action of any person'. Corruption does not always result in a loss. The corrupt person may not benefit from their deeds: however they may be unreasonably using their position to give an advantage to another. To demonstrate that the organisation has sufficient and adequate procedures in place and to demonstrate openness and transparency all staff and the Board are required to comply with the requirements of the Declaration of Interests policy. **Register of Interest** The constitutional requirements for the Register of Interests are contained within Annex 8 of the constitution which covers the standing orders for the practice and procedure for the Board of Directors. The Company Secretary maintains the Register which formally records the declarations of interests of the Directors and includes details of all directorships and other interests which have been declared by both the Executive and Non-Executive Diretcors of the Trust. It is updated on a quarterly basis and published on the website.
Issues / Actions	The Board is asked to review and update the register where appropriate.
Recommendation	To note and for assurance
Appendices	Register of Gifts and Hospitality 2018/19 Register of Interests 2018/19

BOARD OF DIRECTORS
REGISTER OF HOSPITALITY & GIFTS for Q1, Q2, Q3 and Q4 of 2018-19

	Description of Gift/Hospitality	Date Received	Received from: (name of host/organisation)	Estimated Value (£)	Accepted Yes/no	Reason for Gift/Hospitality	Comments (e.g., if gifts shared with other staff/passed to fund raising team for raffle etc.)
EXECUTIVE DIRECTORS							
Neil Dardis, Chief Executive							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Janet King, Deputy Chief Executive and Director of HR & Corporate Services							
Q1 (Apr-Jun 18)	Ascot races	22.06.18	Grundon Waste Mgt	70.00	Yes	Annual event for clients	CEO - shared with 1 x colleague
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	Football match	02.02.19	Potter Rapier	Not known	Yes	Corporate Hospitality	
Nigel Foster, Director of Finance and IM&T							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	Oracle OpenWorld conference	17.01.19	Oracle	90.10	Yes	To attend conference	
	Dinner	07.03.19	Graphnet System C	35	Yes	Evening meeting to discuss upcoming speaking engagement	
Duncan Burton, Director of Nursing & Quality							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A

	Description of Gift/Hospitality	Date Received	Received from: (name of host/organisation)	Estimated Value (£)	Accepted Yes/no	Reason for Gift/Hospitality	Comments (e.g., if gifts shared with other staff/passed to fund raising team for raffle etc.)
EXECUTIVE DIRECTORS *cont…*							
Helen Coe, Director of Operations (FPH)							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Lisa Glynn, Director of Operations (HWPH)							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Timothy Ho, Medical Director							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
NON-EXECUTIVE DIRECTORS							
Pradip Patel, Chairman							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Mark Escolme, Non-Executive Director							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A

	Description of Gift/Hospitality	Date Received	Received from: (name of host/organisation)	Estimated Value (£)	Accepted Yes/no	Reason for Gift/Hospitality	Comments (e.g., if gifts shared with other staff/passed to fund raising team for raffle etc.)
Dawn Kenson, Non-Executive Director (Senior Independent Director)							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Ray Long, Non-Executive Director							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Mike O'Donovan, Non-Executive Director							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Rob Pike, Non-Executive Director (Deputy Chairman)							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
Thoreya Swage, Non-Executive Director							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A
John Weaver, Non-Executive Director							
Q1 (Apr-Jun 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q2 (Jul-Sep 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q3 (Oct-Dec 18)	None	N/A	N/A	N/A	N/A	N/A	N/A
Q4 (Jan-Mar 19)	None	N/A	N/A	N/A	N/A	N/A	N/A

BOARD OF DIRECTORS

Declaration of Interests for Q1, Q2, Q3 and Q4 of 2018-19

	a. Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies):	b. Pecuniary interest (majority or controlling share-holding or ownership or part-ownership) in organisations likely or possibly seeking to do business with the NHS:	c. A position of authority in a charity or voluntary organisation in field of health and social care:	d. Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services:	e. Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks:	f. Any other interests:
Executive Directors						
Neil Dardis (Chief Executive)	None	None	None	None	None	None
Janet King (Deputy CEO and Director of HR & Corporate Services)	-	-	-	HR services provided to SHCCG	-	1. CBI representative/lay panel member Employment Tribunal 2. CQC – specialist advisor **(not declared for Q4)**
Nigel Foster (Director of Finance and IM&T)	-	-	-	Secondment agreement for Director of Finance role with Bracknell & Ascot CCG, Slough CCG and Windsor Ascot & Maidenhead CCG (18 days pa) plus line management of CCG Associate Director of Finance	-	-
Duncan Burton (Director of Nursing & Quality)	-	-	-	Honorary senior lecturer for Kingston University	-	-
Helen Coe (Director of Operations FPH)	-	-	-	-	-	Independent inspection chair for the Care Quality Commission

	a. Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies):	b. Pecuniary interest (majority or controlling share-holding or ownership or part-ownership) in organisations likely or possibly seeking to do business with the NHS:	c. A position of authority in a charity or voluntary organisation in field of health and social care:	d. Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services:	e. Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks:	f. Any other interests:
Executive Directors						
Lisa Glynn **(Director of Operations HWPH)**	None	None	None	None	None	None
Timothy Ho **(Medical Director)**	-	-	Responsible Officer for Thames Hospice	-	-	Independent Inspection Chair for CQC (since August 2015)
Non-Executive Directors						
Pradip Patel **(Chairman)**	-	-	-	GS1 UK Healthcare - advisory board member *(resigned October 2018)* **(not declared for Q4)**	-	-
Rob Pike **(Deputy Chairman)**	Rob Pike Associates Ltd	-	-	-	-	-
Mark Escolme **(Non-Executive Director)**	1. Mallow & Marsh Limited 2. OPPO Brothers Limited 3. Escolme Limited 4. Bromsgrove School Foundation 5. Pet Food (UK) limited 6. Gumboots (UK Charity) trustee *7. Newincco 1402 Limited (resigned April 2018)*	-	-	-	-	-

Dawn Kenson (Senior Independent Non-Executive Director)	-	-	-	-	-	1. NED at Northern Ireland Office 2. NED at Raven Housing Trust
	a. Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies):	**b. Pecuniary interest (majority or controlling share-holding or ownership or part-ownership) in organisations likely or possibly seeking to do business with the NHS:**	**c. A position of authority in a charity or voluntary organisation in field of health and social care:**	**d. Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services:**	**e. Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks:**	**f. Any other interests:**
Non-Executive Directors						
Ray Long (Non-Executive Director)	Director and owner, Ray Long Consulting	-	-	-	-	1. Warden and Court member, The Worshipful Company of Information Technologists (City Livery Company) 2. The Worshipful Company of Information Technologists, warden and court member 3. QI Consulting, associate consultant 4. Doherty Stobbs, associate consultant 5. The Open University, associate lecturer 6. Dods Training, associate trainer 7. Parity, Civil Service Fast-Stream assessor 8.Trustee and Director of Gresham Collage **(Council Member of**

						Gresham College from Q4)
Mike O'Donovan **(Non-Executive Director)**	-	-	-	-	-	1. MS Society Member 2. Board of Trustees, South Hill Park Arts Centre
Thoreya Swage **(Non-Executive Director)**	Thoreya Swage (sole trader)	-	-	-	-	1. NED at Barts Health NHS Trust 2. Employer member for the North East London Advisory Committee on Clinical Excellence Awards (from Oct 2018).

	a. Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies):	b. Pecuniary interest (majority or controlling share-holding or ownership or part-ownership) in organisations likely or possibly seeking to do business with the NHS:	c. A position of authority in a charity or voluntary organisation in field of health and social care:	d. Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services:	e. Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks:	f. Any other interests:
Non-Executive Directors						
John Weaver **(Non-Executive Director)**	-	-	-	-	1.VP of Contract design at BT Global Services – contact and influence over colleagues in BT plc who provide services to NHS organisations in England and Scotland. No management responsibilities for team that might deal directly with FHFT **(not declared for Q4)** 2.NED with ThirdSpace Ltd	-

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NHS
Frimley Health
NHS Foundation Trust

Report Title	SIRO Report
Meeting	Trust Board
Meeting Date	Friday 3rd May 2019
Agenda No.	12.
Report Type	For Assurance
Prepared By	Nicola Gould
Executive Lead	Nigel Foster
Executive Summary	This is the summary of the IG work programme for 2018-19. Whilst the Trust managed to achieve 95% of staff completing IG training, the Trust submitted a not satisfactory submission for the Data Security and Protection Toolkit at the end of March, due to 3 IM&T requirements not being completed.
Background	This is a six monthly report to the Trust Board on the information governance work programme for the Trust.
Issues/Actions	None to note
Recommendation	To accept the report
Appendices	SIRO Report April 2019

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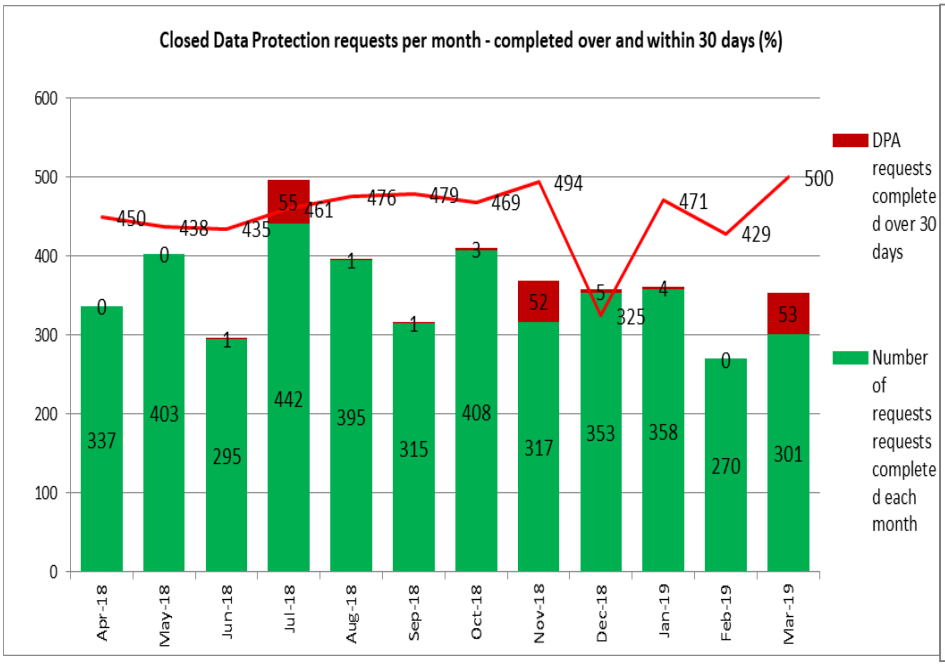
Frimley Health NHS
NHS Foundation Trust

SIRO Report

Below is a final report for 2018-19 from the Information Governance Department.

Data Protection Requests

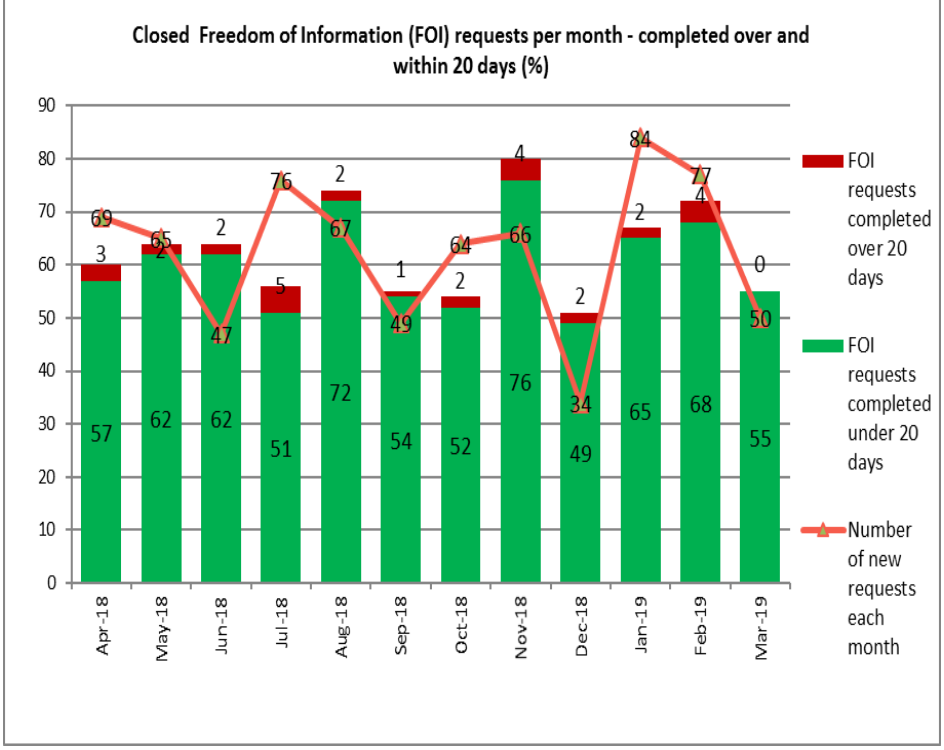


Since May 2018, the number of requests has been steady increasing, due to patient's being aware of their right to obtain a copy of their information free of charge.

Despite 50% vacancies in the team, they have managed to get within 30 days. This is due to the implementation of system which can send information out securely

The breaches in March 19, is due to Wexham x-ray department not providing x-rays within the legal timescales.

Freedom of Information Requests



Every month the Trust has failed to ensure all requests are responded to within the 20-day legal timeframe.

The departments who have failed to provide the data within the required timeframe for the past 3 months are:

- Finance
- Information
- IM&T
- Estates

The reasons provided for the delay by the department are:

- Varied engagement
- Reluctance to disclose
- Delay in executive sign off
- Complexity of request

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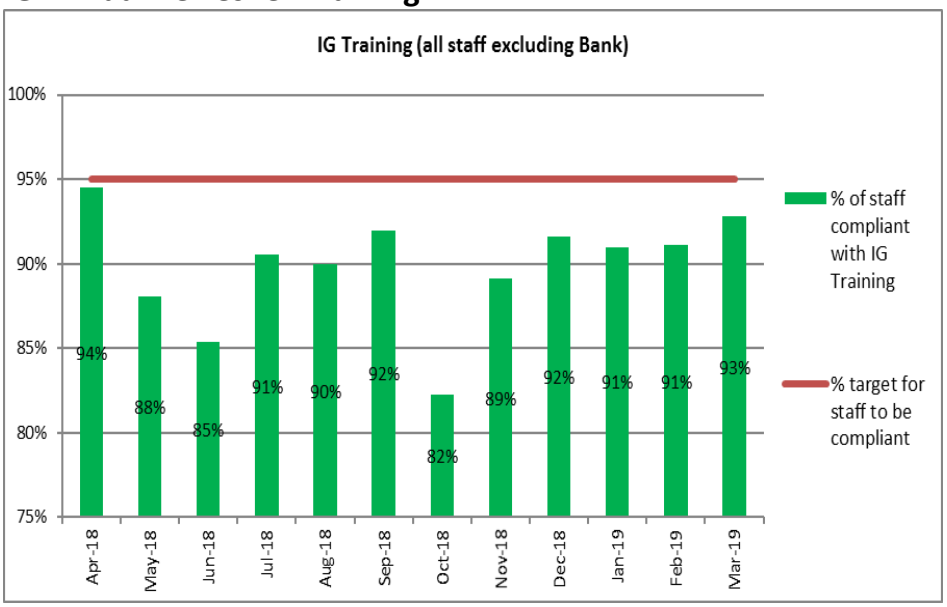
Frimley Health NHS
NHS Foundation Trust

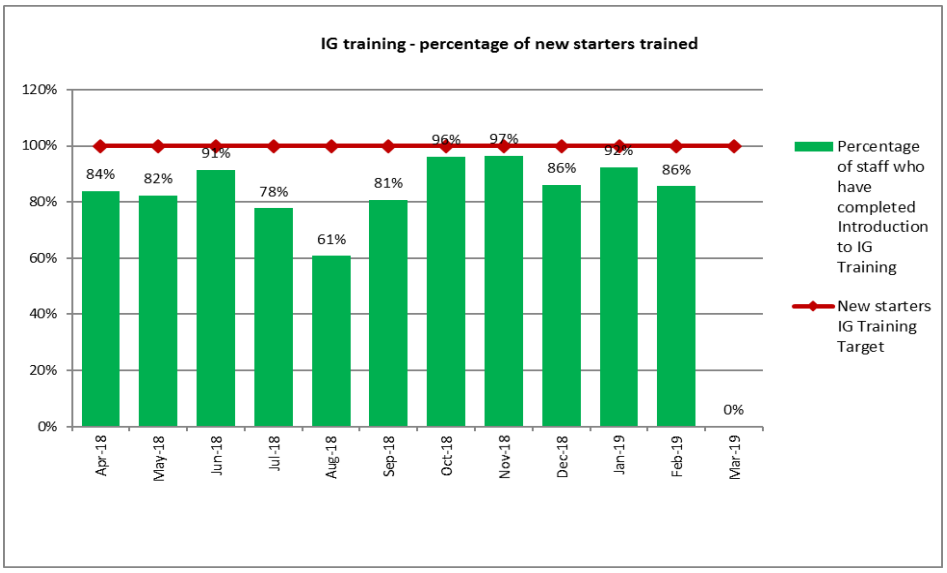
IG Annual Refresher Training



This year the percentage of staff that have completed their IG training is being taken from the MAST reporting system.

Whilst compliance is sat at 93%, there are several mitigating factors that have not been considered. Further narrative and analysis of the year end training figures have been provided in **Appendix 1.**

IG Training of New Starters



New starters are monitored to ensure that they have completed IG training within 6 months of starting in the Trust.

There is a noticeable drop at Wexham as PC Induction is not in place. This is being looked at to implement alongside a refreshed new account creation process giving consistency at both sites.

Note: Waiting on March new starters from HR.

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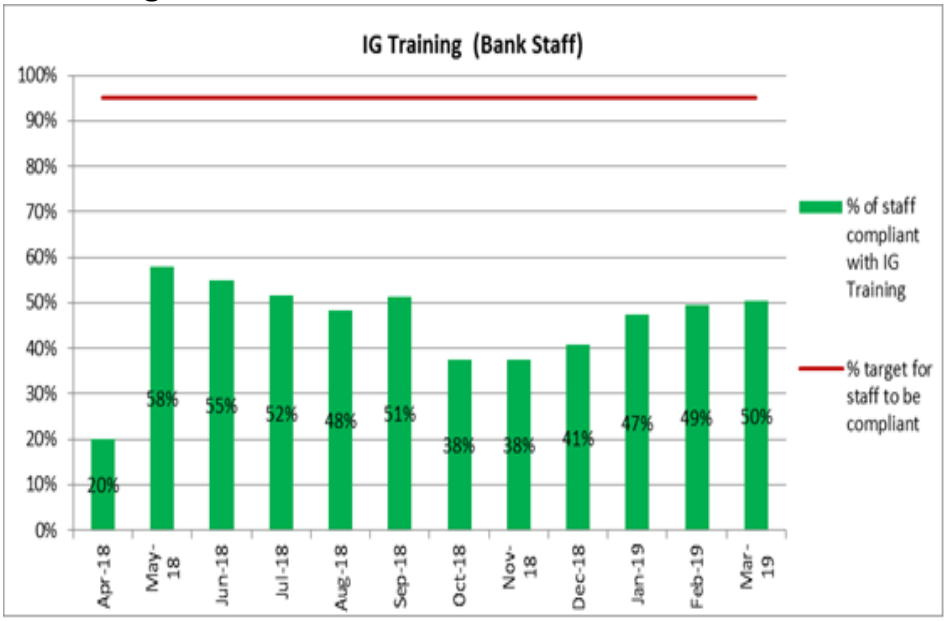
Frimley Health NHS
NHS Foundation Trust

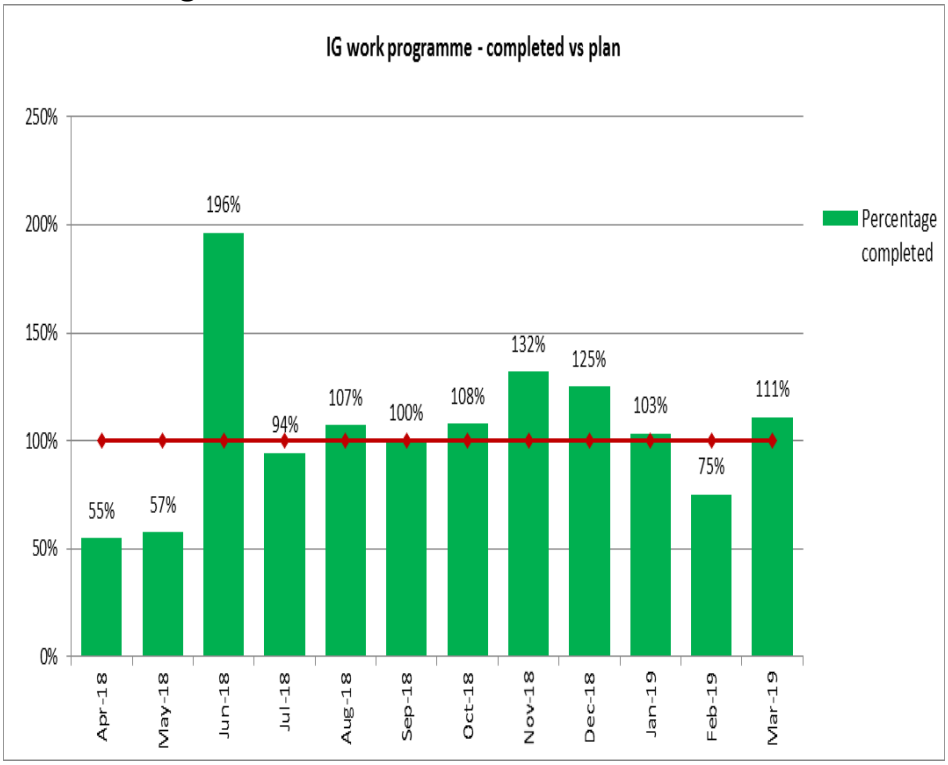
IG Training of Bank Staff



Bank staff are now being reported on MAST but are not visible as part of the overall training compliance.

Whilst compliance is sat at 50%, there are several mitigating factors that have not been considered. Further narrative and analysis of the year end training figures have been provided in **Appendix 1.**

IG Work Programme



Overall, 94% of the IG work programme has been completed.

Areas which were not completed due to capacity/issues with other departments:
BSPS - work to reduce identified risks in BSPS processes
IM&T - implementation of a new process for management of network accounts
Electronic Information Asset Register- delay in approving finance to develop a system to manage the 278 systems in the Trust

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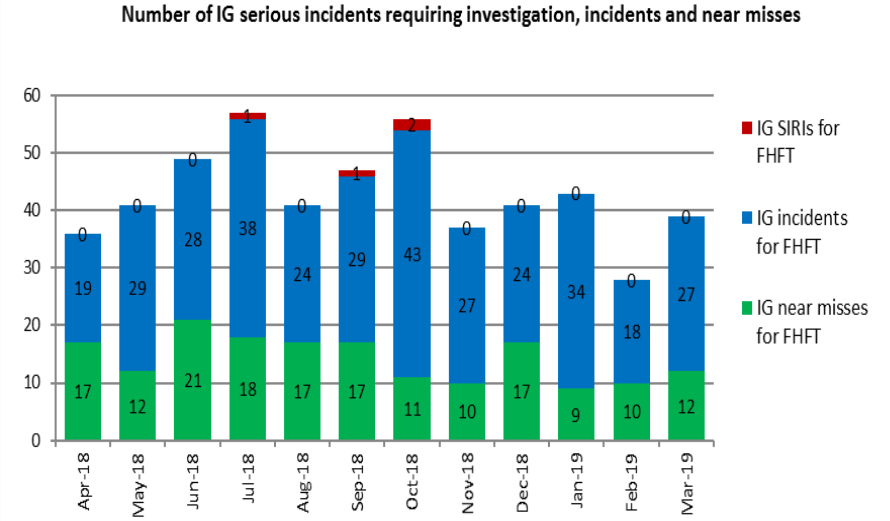
Frimley Health NHS
NHS Foundation Trust

IG Incidents



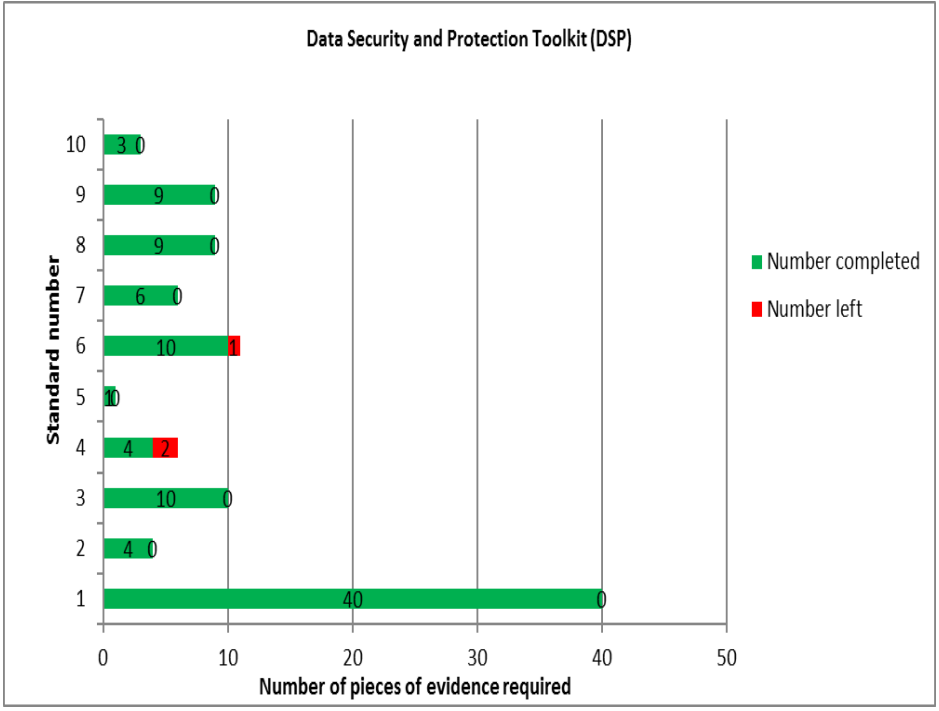
There has been a decrease in the number of incidents reported this quarter; we believe this is due to the migration to the RL reporting system and user delays in reporting incidents on the new system.

Common themes this quarter are

- patients discharged with another patient's information
- staff sharing logins.

Data Security and Protection Toolkit (DSP)

The IG toolkit has been revamped for the first time in 15 years, being rebranded "The Data Security and Protection Toolkit" placing a greater emphasis/ focus on Cyber Security and changes in line with the General Data Protection Regulation. There are 10 standards which all must be completed fully to pass the toolkit; there are no longer performance levels to achieve.



The Toolkit was submitted on the 31st March. Overall, 97% of the toolkit submission was completed.

The Trust submitted an Improvement Plan for 3 items which were not completed due to a lack of implementation and evidence to support the assertion. These are:

Audit of user accounts
System Administrators have signed agreements in place
Vulnerability incidents

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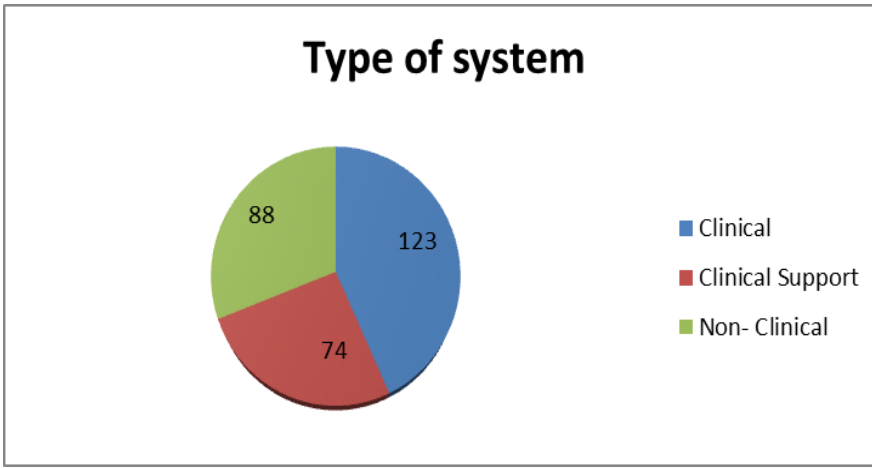
NHS Foundation Trust

Electronic System Report



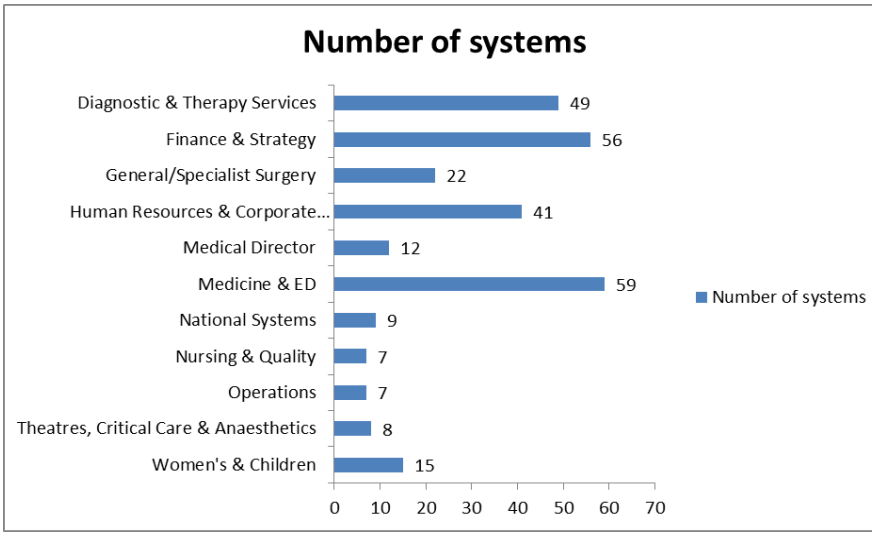
IG maintains an asset register of all the electronic systems run/operated in the Trust.

These systems are classified by 3 criteria.

Clinical e.g. PAS, PACs

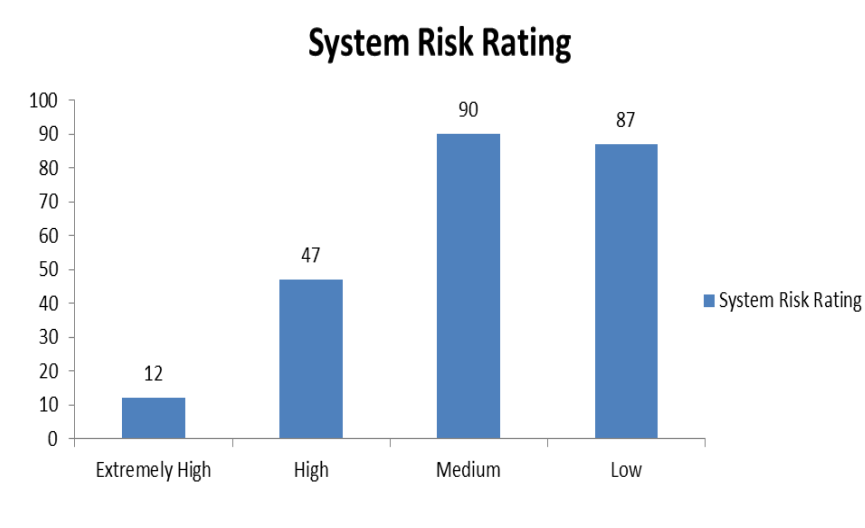
Clinical Support e.g. Datix

Non-Clinical e.g. HR systems, Finance systems



This graph shows the number of systems by Directorate across the Trust.

Work is on-going to validate the number of systems in use across the Trust and work with IM&T to reduce the use/number of systems where possible.



The IG Department assess every system against the NHS Digital Security standards.

Where a system is scored as a high risk, it means that the system does not meet the required security standard e.g. complex passwords. Work is on-going with the system supplier to improve the risk rating.

12

Appendix 1 - Training Summary

To meet Standard 3 of the Data Security and Protection Toolkit, the Trust must ensure that 95% of its staff have completed their training between 1st April and 31st March.

The Trust uses MAST to monitor its overall compliance with regards to mandatory and statutory training, information is updated within the system at differing times which can cause compliance to vary. As a standard, the following is in place:

- Employee headcount – updated once a month
- E-assessments – updated daily
- National system training via ESR – updated weekly
- PolicyHub/manuals – updated once a month
- Induction – updated within 10 working days.

The IG Department uses a blended approach for training via MAST and PolicyHub, the MAST training report is fully updated at the end of the month with all completions.

The differing time frames for information to feed through to MAST causes the discrepancies in the reporting and leads to delays while compliance is validated.

Additionally, there has been issues with validating staff training, as the records of training completed in February and March has been lost in the system. The suppliers have been notified and are seeking a resolution.

Permanent Staff

Training calculations

On the 31st March **95%** of staff had completed their mandated training since the 1st April 2018. This figure is based off 9,184 permanent staff that the Trust had employed at the end of January 2019. Due to the consistently changing figures of starters and leavers, and the inability to obtain an accurate report from MAST, the Trust has used the figures from OLM for its toolkit submission:

	OLM	MAST
Total number of staff	9,184	9,179
Total excluded*[1]	103	-
Total number of staff compliant	8,669	8,519
Percentage	**95%**	**93%**

Bank Staff

All active Bank staff were encouraged to complete their training via iPDF as it is available to them both inside and outside the Trust. During November, work was undertaken by the IG Team to send out assessments the home addresses of bank staff in addition to the reminders being sent to those with network accounts.

	Staff paid in November	MAST
Total number of staff	1,760	1,605
Total excluded*	39	-
Total number of staff compliant	772	813
Percentage	**44%**	**51%**

[1] staff are excluded where they are identified as being on long term sick, maternity leave, absent from the Trust. This must be done manually in OLM reporting but is done so automatically in MAST

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Frimley Health NHS
NHS Foundation Trust

Report Title	**NHSI Self-Certification Declarations**
Meeting	Public Board of Directors Meeting
Meeting Date	Friday 3rd May 2019
Agenda No.	13.
Report Type	To discuss and approve the self-certification templates.
Prepared By	Susanne Nelson-Wehrmeyer-Company Secretary
Executive Summary	NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. Providers need to self-certify the following after the financial year end: NHS provider licence condition; i) The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)); ii) The provider has complied with required governance arrangements (Condition FT4(8)); iii) If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) The aim of self-certification is for providers to carry out assurance that they are in Compliance with the conditions. It is up to providers how they carry out this process. Any process should ensure that the provider's board understands clearly whether or not the provider can confirm compliance. The attached templates may be helpful for the board in its consideration but no returns are required at this time. The Board needs to be confident that the certifications are accurate and underpinned by robust evidence.

	From July, NHSI will contact a select number of NHS foundation trusts and trusts to ask for evidence that they have self-certified. This can be done through provision of completed templates if used, or provision of the relevant Board minutes and papers recording sign-off.
Background	The relevant provider licence conditions and their requirements are provided below and the templates for each requirement are supplied in the appendices. **Condition G6** **Systems for compliance with licence conditions and related obligations** 1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS. 2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) Regular review of whether those processes and systems have been implemented and of their effectiveness. 3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition. Condition G6(2) requires NHS foundation trusts to have processes and systems that: a). identify risks to compliance b). take reasonable mitigating actions to prevent those risks and a failure to comply from occurring. Providers must annually review whether these processes and systems are effective. Providers must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6 (4)). If using the template, providers should choose 'confirmed' or 'not confirmed' as appropriate for the declaration. Providers choosing 'not confirmed' should explain why in the free text box provided. **Condition FT4** 2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. [Long list of standards, requirements and objectives]

	8. The Licensee shall submit to Monitor within three months of the end of each financial year: (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. Providers should review whether their governance systems meet the standards and objectives in the condition. There is no set model, although it is expected that any complaint approach would involve effective board and committee structures, reporting lines, and performance and risk management systems. The training of governors is also subject to review, although not a licence condition this is a requirement of S151(2) of the Health and Social Care Act, which requires that providers must take steps to secure that the governors are equipped with the skills and knowledge they require to undertake their role. There are no set requirements for governor training as this is provision is left to the discretion of providers. If using the template, providers should choose 'confirmed' or 'not confirmed' as appropriate for the declaration. Providers choosing 'not confirmed' should explain why in the free text box provided. Each response should also detail risks identified to achieving the governance standards and any mitigating actions taken to avoid those risks. **Condition CoS7** 1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. 2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. 3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services". (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. The template requires foundation trusts to select 'confirmed' for one of three declarations about the resources required to provide designated services: a). the required resources will be available over the next financial year

	b). the required resources will be available over the next financial year but specific factors may cast may doubt on this c). the required resources will not be available over the next financial year. Required resources include: management resources, financial resources and facilities, personnel, physical and other assets. Only one declaration should be confirmed (and providers do not need to state the other two are not confirmed). Providers should explain the reasons for the chosen declaration in the free text box provided. The board must sign off on self-certification, taking into account the views of governors, on the basis of the annual CoG evaluation of the Board's performance appended below, general feedback from BoDCoG meetings and facilitated feedback taken from governors as part of the Well-Led review.
Recommendation	The Board of Directors is recommended to confirm self-certification against the requirements of General Conditions G6 and CoS7 of the NHS Provider Licence by 31 May 2019 and to confirm the self-certification against condition FT4 and the training of governors, as appropriate by 30 June 2019.
Appendices	Condition G6 & CoS7 template Condition FT4 template Training of governors template Annual questionnaire results from the CoG on Board performance 2018/19.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed — OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed — Please fill details in cell E22

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Financial Plan delivered a surplus of £6.1m before PSF. As at 31 March 2019, the Trust has a cash holding of £133m.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Pradip Patel	**Name**	Neil Dardis
Capacity	Chairman	**Capacity**	Chief Executive
Date	03 May 2019	**Date**	03 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	As evidenced in the Annual Governance Statement	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Bi-monthly board reporting cycle with board seminare meetings in fallow months and a detailed annual planner enables new business or guidance to be brought to the attention of the board in a timely manner.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Annual review of the Constitution and recent review and changes to the Board sub-committees structures and reporting cycles, including the recent reconfiguration of the Finance Investment Committee and new addition of the People Committee. Annual review of individual sub-committees terms of reference and over view by the board. Internal review of governance by the chief executive.	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	1. CQC external review conducted during 18/19 along with Use of Resources and well led assessment which included governor and stakeholder input.2. Annual Governance Statement, Quality report along with Annual Report documenting compliance with regulatory requirements.3.Regular board and sub-committee meetings undertaking reviews of planned work and including regular oversight of performance information, financial information and the corporate risk register and new board assurance framework.4.Robust external and internal audit processes have confirmed no material concerns on key internal controls and processes.	Please complete Risks and Mitigating actions

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	1. Quality issues are standing items on board agendas by way of monthly reporting on the Quality Improvement Plan and monthly reporting of SIRIs.2. The Quality Assurance Committee, a board sub-committee meets regularly for oversight on quality issues. 3. There is an established governance framework for a number of meetings which regularly report to the Quality committee. 4.There is a governor committee for patient involvement and experience and a number of other groups which engage with patients and stakeholders through surveys and other forms of feedback.5.The annual Quality report is subject to external audit.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Regular board and committee reporting on the organisation's establishment, recruitment and retention initiatives, safe levels of staffing and succession management and leadership training. The Performance and Remuneration committee meets regularly to consider succession planning, board renewal and training and undertakes recruitment of new non-executive directors with the NERC, a governor committee.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Pradip Patel **Name** Neil Dardis

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Pradip Patel	**Name**	Neil Dardis
Capacity	Chairman	**Capacity**	Chief Executive
Date	03 May 2019	**Date**	03 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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COUNCIL OF GOVERNORS' QUESTIONNAIRE ON BOARD AND COG PERFORMANCE
Year to March 2019

SUMMARY

Of the 19 governors asked to complete these questionnaire responses were received from 14 equating to a 73.7% response rate. A number of these were also returned after the specified deadline.

The scores from the governors ranged from 3.3 (out of 5) to 4.5 with an average of 3.9, which demonstrates improvement.
In comparison with the last year's results, the effectiveness of the Board and CoG is rated higher and there are no more areas of very poor performance.

BOARD PERFORMANCE
The questions that scored the highest were those concerning the delivery of a high quality & safe service to its patients and those to determine and monitor governance arrangements with an average score of 4.5. Monitoring trust performance and protecting and promoting the Trust's reputation scored an average of 4.4.

The area which did not perform as well is that of communicating with local population and generally with an average score of just 3.6.
The average score was 4.2 indicating very good performance from the board and an improvement from last year's 3.9.
Overall, 62.4% of respondents rated the Board's performance as good, 27.8% as excellent and 9.8% as fair.

Individual comments indicate there is a general improvement. The Governors feel more involved with both Board members and staff members. That is seen as a result of both meetings and walkabouts.
It was highlighted there are many opportunities for the governors to become positively engaged in the meetings.
In general, the governors feel more recognised and valued through the Trust.
The feedback indicates that the engagement and communication with the Board has improved and the Governors are given the opportunity to consider key issues.
The general worry is around lack of information on ICS. Few governors expressed an interest in receiving further information so they can understand its impact on local services.

COG PERFORMANCE
The scores were generally lower than that of the board with an average of 3.5. The least performing area is that of canvassing the opinion of the members on the Trust's forward plans. The feedback indicates that the level of communication with the public is on ongoing challenge.
The response was more favourable regarding monitoring the performance of the Trust with a score of 3.8 out of 5.
Overall, 45.1% of respondents rated the CoG's performance as fair, 43.1% as good, 5.9% as excellent and 5.9% as poor.
Feedback indicates that the reduction in the number of governors has a positive impact and has improved the communication with the Board.

Total scores and individual comments can be found in the tables on the following pages.

1. REVIEW OF BOARD'S PERFORMANCE **How do you rate the Trust Board's performance in the following areas:**	**Very Poor (1)**	**Poor (2)**	**Fair (3)**	**Good (4)**	**Excellent (5)**	**Don't Know / New Governor**
Setting clear strategy and having clear vision for the future	0	0	0	10	4	0
Consulting with the Council of Governors on the forward plans	0	0	1	11	1	1
Delivering a high quality, safe service to its patients	0	0	0	7	7	0
Determining and monitoring governance arrangements (e.g. clinical governance, risk management, financial management)	0	0	0	7	6	1
Following good governance principles e.g. being transparent, open, consistent	0	0	1	7	5	1
Monitoring Trust performance and that of the management team	0	0	0	8	5	1
Communicating with the Council of Governors	0	0	2	10	2	0
Maintain the two way flow of information between the governors and Directors	0	0	3	8	1	2
Communicating with local population and generally	0	0	5	8	0	1
Protecting and promoting the Trust's reputation	0	0	1	7	6	0

2. Please provide evidence/comments to support your ratings above.

- The majority of elements are scored "good" because I see much that is good; better than many other organisations but not as good as the best. I attend the Clinical Governance Committee and again, the way the committee is run, the papers and scope are excellent, but there is always at least one agenda item that gives cause for concern. This may be a problem that should have been picked up sooner had monitoring been more effective, or actions that are slightly misaligned with the root cause (ie they address part of the problem but not all).
- I have scored "communicating.." as "fair. This is because, while I see a lot of excellent communication, it does not cover all the issues that the public want. The recent drop in session exposed a strong desire in the public to know more about the ICS. The ICS is not getting a lot of clear coverage in FHFT comms to the public. The same is true of patient transport and discharge. So communication is good on the issues that are covered, but some issues that are important to the community are not getting good coverage.

- I have scored "Protecting reputation…" as fair. The Board do protect the reputation well, but a number of problems – one example is a department with poor leadership (found by the CQC), another was a nurse without required qualifications, have gone on for some time before being dealt with. Either they were not known (a monitoring failure) or there was inaction over a period, these events are damaging and the Board and management could do better to identify problems and take action.
- It has been a much improved year for relations between Governors and the Board – Board sub-committee presentations have assisted with this, along with improved early strategy discussions – although real input into strategy still could benefit from development.
- The restructuring of reports to focus upon key areas has been helpful.
- The strategy development in relation to the system ICS has not yet been opened up with Governors and this is reflected throughout the population where public engagement to date has not been strong – although this is scheduled to improve with the NHS 10 year plan and planned consultations through Healthwatch - the CCG's are also organising engagement sessions. The FHFT Governors could have an understanding deficit in respect of ICS system plan and development.
- Improvements have been put into place to improve communication between the Board and Governors which has assisted – along with the smaller Governor body making connections easier.
- Two way flow of communication is dependent upon informal contacts after/during meetings.
- Good communication with local population remains difficult to achieve, other than to a small core of interested parties – despite best endeavours. This has been very good in relation to public consultations (leading to good public support) – but as the reputation improves there tends to be less public involvement. Communication with/through other trusts/CCG's could assist this – which will be important as we move to an ICS. The new Governor/Member meetings appear to offer a good channel to assist with improving membership engagement.
- The improvements and developments relating to services Wexham are brilliant and are increasingly being recognised by the local population, along with the FHFT capital investments which are greatly aiding public perception of the Trusts improving progress.
- Good CQC results in a challenging environment were a great result – the preparation and involvement of Governors in the CQC inspection was excellent.
- I've always felt reassured by the content of the meetings and the communications that the Trust is very serious about strategy, risk and operations.
- Another year of major challenges for the Trust with a new CEO bedding in, significant financial constraints, a CQC inspection, and major capital projects compounded by the continued evolvement of the ICS.
- The Board continue to be open and transparent with the wealth of performance information presented to the governors and public. Board meeting are well chaired with quality of papers and presentation having undergone a steady improvement over the year making them more succinct, focused and much more readable.
- The completion of the ECA at WPH and the successful approval of the full business case for the new Heatherwood hospital and the start of the build are notable high points.

- Drops in some performance and patients experience are disappointing and the outcome of the CQC assessment visits has rated the FH good, which is fair considering where the combined trust started. Please that FPH if rated on its own would have maintained its Outstanding rating.
- Will be interested to see where we still have to improve especially in the new well lead and use of resources categories.
- Excellent two way communications with staff and Governors. This includes Chief Executive Staff Briefings, BOD/COG workshops, Inform Magazine, Governor Drop In Sessions and open channels of communication between Governors and the Chairman and Board Members. Communications are encouraged and always fully responded to. There has also been closer working between Board Members and a slimmed down Council of Governors through the COG sub committees, "Walkabouts" of Wards and between the Lead Governor and Chairman.
- The Board has also listened to and acted upon Governor's wish to be involved in setting the Trust's strategic objectives through joint working at BOD/COG meetings.
- The Chairman has encouraged and acted upon ideas from Governors in setting agendas for COG and BOD/COG meetings.
- The Trust has also working to support and facilitate Governors in communicating effectively with constituency members.
- The Trust sets clear strategic objectives and reports on progress at public board meetings.
- Following discussions at a BoD/CoG workshop last year, the Board agreed to involve the governors in the strategic planning process. During the following 2 workshops governors were given the opportunity to consider key issues.
- Performance data shows that the Trust is delivering high quality, safe service. CQC report on Wexham shows significant improvements.
- Governance arrangements are excellent. The Board is transparent about risks and how they try to mitigate them. Financial management is sound and reported in summary form at public board meetings.
- The restructuring of the Council of Governors has been positive with a smaller Cog leading to a more collegiate relationship.
- The Trust communicates well with the local population in general, but people are keen to understand the ICS agenda and its likely impact on local services.
- There has been a concerted effort to make sessions more interactive.
- Observation through committees, walkabouts, personal meetings and public meetings.
- From my experiences of the BoDCoG and public events, I have seen at first hand good interaction at all levels.
- I am new to the governors role so do not have much experience of the communications between governors and the Board.

3. How do you think the Board could improve its effectiveness?

- I have referred to the misalignment between the issues being raised by the community (ie the ICS) and those being communicated by the Trust. The recent event (Governors' drop / meet session) that really raised this could be the start of

solving this problem. Supporting this and taking the issues raised forward may be sufficient.

- There are some significant "structural" issues within the health sector – for example skill shortages that affect the whole of the UK. The Board are concerned with these issues and working hard to address them. My fear is that intractable problems like this need really big changes and whole new approaches. The new strategy sessions are a good start, but we need to see how ready the Board are to embrace major change.
- From VISIBLE activity the overall effectiveness can be classed as good to excellent; the improvements in communication and early involvement are helping to improve this and focus needs to be maintained.
- Look for/encourage any external experiences that could bring a different viewpoint to the Trust (This "appears" to be taking place).
- Encourage more informal opportunities for discussion between CoG and Board members.
- Explore more methods of communication with the public – possible use CoG members more in this role.
- Look for methods to involve public/patients more in service feedback, provision and design.
- Clarify a more structured method of feeding back the wider populations patients/public views – this is increasing needed (as shown with the feedback from the newly trialled engagement meetings).
- Consider, and communicate, how the Trust will operate as part of an ICS, especially where the best decisions for the ICS may not be optimal for the Trust.
- I sometimes find the NEDs can be a little dismissive of Governors – although I've personally only had one example of this and so can't substantiate for how others feel.
- With a move to bi-monthly Board meetings, with a prime reason to give the Board more time to look forward with its strategic direction instead backwards reflecting on performance, I feel is positive step. However, for Governors to maintain their statutory role the regular BOD/COGs must be structured to ensure that governors are kept fully informed and involved with both strategy and performance.
- Learning and actions emanating from the CQC visit (well led and use of resources)
- Hearing more directly from the CEO on the purpose and outputs from the new Senior Management Team Meeting (where does /if this sit in the Trusts Governance Structure, who attends where and to whom are outputs communicated?)
- Continue to actively listen to and effectively respond to stakeholders.
- Compared with Boards of other NHS organisations I think there is cause for complaint.
- Whilst governors have been included in consultation during the strategic planning process, the BoD/CoG exercises could have been given more time. At the January meeting a lot of information was provided on slides and it was difficult for use to absorb and reflect in a meaningful way – all a bit rushed. Maybe provide sight of the material beforehand with an indication of the purpose of the exercise. The plenary was also short whereas it had the potential to provide an overview of the 4 key issues for everyone. It felt as though we were informed and involved but not fully engaged. Not sure if we will have a further opportunity e.g. when letters go out to ICS and network partners asking for input.

- Keeping us up to date about the ICS – though I believe this is on the next BoD/CoG agenda – perhaps this should be a standing item as the ICS evolves.
- I think some of the skills of the governors are not used to support NEDs & executive as well as they could.
- Already very effective.

4. *REVIEW OF CoG's PERFORMANCE* **How do you rate the Council of Governors' performance?**	**Very Poor (1)**	**Poor (2)**	**Fair (3)**	**Good (4)**	**Excellent (5)**	**Don't Know / New Governor**
In demonstrating to the public that the CoG has held the Board properly to account	**0**	**1**	**7**	**4**	**0**	**2**
In canvassing the opinion of the members on the Trust's forward plans	**0**	**1**	**6**	**5**	**0**	**2**
In monitoring the performance of the Trust's Board	**0**	**0**	**4**	**9**	**1**	**0**
In communicating with the Trust's members, stakeholders and the local population	**0**	**1**	**6**	**4**	**2**	**1**

How could the CoG's performance in these areas be improved?

- Regarding the "demonstration to the public", my score of "fair" is not a criticism, this is a very hard objective. We need to look again at how we use the public sessions. I think this is improving.
- Re canvassing opinions, this is improving, but the ICS is often absent from public sessions and open questions.
- The recent Governors' drop in and the issues raised has shown that we have been missing the target, but it also shows that there is a path to improve.
- Supporting communication with the local/wider population is difficult – the Constituency meetings are a good conduit and the format is being developed – the newly trialled Governors/Members meetings appear to be a good conduit for communication. These will be continued and developed. Developing ways to promote these meetings to the wider population, rather than just Members would be beneficial.
- Use of Social Media is helping and could be developed.
- Methods to improve engagement have been/are being looked at – more CoG presence at "events" (e.g. public consultations and other related Trusts meetings) and local groups could assist.
- Ensure informal discussion opportunities are nurtured e.g. Refreshments after BoD/CoG meetings – some informal discussion time after Board meetings, promotion of Drop-Ins etc.
- Continue to develop the BoD/CoG and CoG meeting agendas to facilitate two-way communication with focus on key issues.

- Maintaining good communication with respect to the ICS development, relations with other trusts/CCG's and governance development updates.
- Continue to promote areas where Governors and Board members can work (and communicate) together, such as the QA walk-abouts.
- Promote the ability of Governors to be involved in PLACE inspections.
- Promote Governors supporting fund raising and charity events.
- It is difficult to demonstrate to the Public that the CoG has held the Board to account.
- A significantly improved CoG this year. Cohesive, constructive and a better feeling of real engagement with the Board.
- Implementing the outputs from the Task and Finish group are beginning to reap the benefits that the governors were seeking; earlier engagement in strategy, clear and concise reports of the Board subcommittee by the NEDs and more meaningful engagement with the public members.
- The piloting of the Meet your Governors café style session has proved a positive way forward and look forward to rolling this out over the coming year.
- Better use of CoG sub committees and groups to take delegated monitoring of performance and issues (e.g PEIG, Clinical Governance,)
- Continue to develop recent initiatives to improve opportunities for Governor contact with members, stakeholders and the public and by scheduling more time for discussion at Constituency meetings.
- The constraints placed on members of the Council regarding communication with members continue to inhibit their ability to have a useful two-way conversation with constituents. The Trust does not support individual initiatives to stimulate such conversations and debate in general. What communication there is, is limited to 'glossy brochure' type of information which is outbound only. No attempt is made to engender or solicit views from the membership on strategic matters, be they clinical, organisational or administrative.
- Council meetings (and, in general, the workings of the Council) should be, wherever possible, held in public. It is not sufficient to put four chairs at the back of the room and assume the job is done.
- Whilst the CoG tries to discharge its role of holding the board to account there are few ways of demonstrating this to the membership or the wider population. Constituency meeting provide us with an opportunity to explain our role and we have recently held the first Governors meeting with members, where it was possible to go into more detail. This may be an appropriate forum to canvass opinions of members on the Trust's forward plans, though I would not currently feel sufficiently informed to do so. The CEG is constantly looking at ways of improving our engagement with members/wider population. Perhaps we could also make better use of In Touch to explain our role.
- There have been problems with attendance of stakeholder governors at BoD/CoG meetings. Given the development of the ICS I think it is important for us to have their input.
- Meeting with the NEDs more often to discuss issues to break down barrier.
- The wide geographical area that makes attending all the meetings across the district very difficult for some.
- Recently much Improved.
- I have been a trustee for many years receiving the magazine but I am unaware of

anything else that the Trust do to engage with the public.
- Provide public from website.

Do you think there are any barriers which prevent the CoG from carrying out its duties?

- There is a fine line around what can be shared with regards to "holding to account" and what cannot. I am not sure this can ever be resolved and so performance on this may always appear modest.
- CoG awareness of the local health and social care organisations and their roles.
- Being aware of pending developments.
- Having a better channel of communication between the CoG and the Public.
- More awareness of events where Frimley may be presenting and Governors could attend may assist with contact with the Public.
- Yes
- After prior year difficulties the new smaller CoG has, I feel, made great stride with improved relationships with the Board, greater communications and a good start with early involvement with strategy.
- Overall the CoG is, I feel, becoming more recognised and valued throughout the organisation through involvement in Walk-Abouts, Place Inspections and committees that involve the Board and other staff members.
- From a personal perspective I feel that there is also a greater members understanding being developed of the role of the CoG.
- No
- I feel we are definitely going in the right direction and it is essential that we continue to harness the positive energy that the CoG is now experiencing and not allow it to dissipate.
- Should we review all subcommittee and groups with their ToR to ensure we are making best use of these resources?
- Limited time at Constituency Health Events for discussion between and Constituency Members. This is now being addressed.
- Apart from the constraints mentioned above regarding access to members and meetings in public, I think the Trust has achieved much in balancing the needs of Council members in recognising their role and carrying it out.
- I would like to see members of the Council playing a more prominent role in the Trust: involvement in celebratory initiatives like staff awards, for example. I get the impression that the Trust encapsulates it's Council in an external bubble – holds it at arm's length you could say as opposed to embracing it wholeheartedly.
- Engagement with the public is the most challenging aspect of our role. It would be good to hear how other CoGs in other Trusts achieve this – maybe some Govern Well courses or networking opportunities.
- Only self created ones.

Do you think that the CoG has performed better this year than last year? Please give examples of areas where the CoG has performed well.

- Yes, most definitely. The sessions are now two way, there is a feeling of real consultation and listening that was absent before. A huge improvement. The strategy session has really made a big difference.
- Much better than in previous years. There is now much closer working relationship

between Governors and Board members and joint working. Examples of which are given above.

- This is difficult to discern. The term 'performance.' usually requires an outcome that can be measured. By definition, the role of the Governors is to hold a watching brief over the activities and actions of the Non-Executive Directors and more generally (and assumed) the Trust's performance as a whole. I believe the Council has done this as well as could be expected this year.
- A smaller CoG seems to have improved relationships. There is a more collegiate and respectful relationship between the Governors and between the Governors and the Board. Negotiating the agenda is a good idea and allows us to ask for a focus on specific areas – most notably updates on the ICS.
- Communication has improved.
- Much better. Smaller and more effective.
- Yes, due to less numbers.

On a personal level, what have you done to improve the effectiveness of the Council of Governors?

- I now find many more opportunities to become positively engaged in meetings, this is a two way street, the meetings are better too. My main contribution is on the Clinical Governance Committee where I find my skills and experience are relevant.
- I have supported the CoG and members as appropriate on the various working groups/committees that I have been involved in/been a member of.
- Having taken over the Chair of the CEG I have helped to drive the new Governors/Members meetings – the first of which has been highly beneficial.
- Having been involved with, and attended, many local health and social care groups/meetings knowledge gained from these has assisted with discussions of, and improved understanding within, the CoG.
- Along with many others I have supported public engagement meetings, planning meetings and other discussions in support of the new Heatherwood Hospital. CoG and Members support has been beneficial is helping this project clear some of the hurdles.
- Separate to the CoG, although feeding into the CoG, I have also undertaken PLACE inspections and Patient Experience surveys on Wards and Out-Patients which, along with QA Walk-Abouts, enabled more informed discussions and feedback.
- I think it has – there's been more engagement on strategy.
- I regularly attend the public Board meetings, helping me to see how the NEDs analyse and question the Boards presentations and reports. I have also been an active member of the NERC and CEG subcommittees
- As chair the PEIG and together with subcommittee members on behalf of the COG have sought to ensure that our patients' experiences and quality of care received has been analysed and explanations on variations and exceptions sought, giving feeding back to the COG.
- I have attended the Annual NHS Provider Governors Focus Conference sharing our good practice with and learning from other Foundations Trust Governors from across the country.
- I have also attended a national focus group with NHS Providers and the CQC to improve the CQC guidance to be given to all governors helping to understand the role of the CQC and how to prepare for CQC assessment visits

- I am an active member of the NERC, the PEIG, the CEG and the Governor representative for the Infection Control Committee at Frimley Park. I attend all COG meetings, many Walkabouts and the Board Meetings.
- In my various volunteering roles, I have offered support to hundreds of patients and many family members. Spending time in the wards each week gives me a detailed understanding of the services provided to patients and the support provided to their loved ones. These experiences enable me to take an effective contribution at COG and Sub Committee meetings and to highlight good performance and raise areas of concern.
- I have attended events relating to the ICS and the Community Partnership forum relating to integrated care with service providers to improve my understanding of how they impact constituency members.
- I have, often unsuccessfully, argued in favour of a more open and outward-looking stance for the Trust and the Council.
- Not really. I have been attending as many events/meetings as possible and doing Quality Walkabouts which I feel helps us develop our relationship with the board members and staff and to understand the real issues facing staff and patients.
- Encourage discussions on the role of governors and suggest changes.
- Many personal meetings with board including NEDs and Company Secretary.
- Getting involved with the Nepalese groups.

General Comments

- This year really has been much better in terms of being able to make a contribution.
- The “structural” problems in the sector, skill shortages, agency staff, continue to frustrate and it’s hard to see how to break out of these.
- The ICS is still a mystery to many and we really need to bring more clarity and communicate this along with being honest about the problems
- Frimley Health is an excellent trust and this has been a brilliant year with major improvements in care at Wexham being widely recognised and the major capital programme showing results, especially with the EAC and new hospital at Heatherwood.
- The CQC results are very pleasing and achieved in a difficult environment. The challenge is to keep improving.
- The new CEO has a challenging history to follow and build upon - the phased introduction worked well; with the changes in communication and style are beneficially showing through, especially of note is the public acknowledgment and motivation of staff.
- The management challenge continues to be delivering improvements in a tight financial situation whilst also transitioning to an ICS – Governors can play a key supportive role in these challenges provided they are kept in the loop and given early opportunities to input where possible.
- On a personal level, although not directly supporting the CoG, I have been pleased and privileged to initially take the meeting chair role for the STP/ICS (ARG) Analytics Reference Group and subsequently the meeting co-chair for the ICS (IDG) Information Delivery Group, which has helped to develop my awareness and understanding of many of the organisations involved in development of the System.
- Generally, very satisfied with my experience.

- I again look forward to the coming year hearten by my perception that we are now a much more cohesive and productive group. We have an enormously challenging year ahead with severe financial constraints and operating within an evolving ICS. It is imperative that we all pull in the same direction, keep actively involved, ensuring that we are constructively challenging when and where required.
- Despite adverse external pressure, the Trust continues to perform well – and certainly above the performance levels of comparable trusts nationally. This success is, undoubtedly, attributable to the calibre of our senior management team and, in particular, the non-executive directors of the Trust who provide clear and decisive leadership in critical areas of decision making.
- I am particularly impressed that the non-executive directors generally have, as a result of discussions held last year, increased their involvement with the Council and had provided insightful and comprehensive overviews of their work and given forward views of the future. I think the Council feels more involved in the "big issues" of the Trust as a result.
- We were all delighted to have been invited to the grand opening of the EAC and the tour around the building. Wow! Roll on Heatherwood – so pleased that its actually happening at last. Well done to the Board (especially Janet and Mark) for perseverance.

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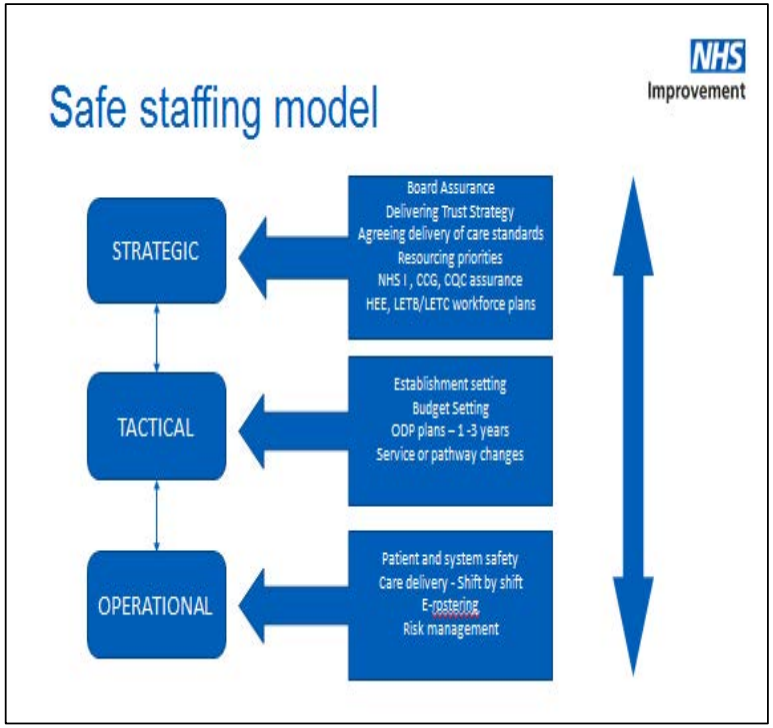
Frimley Health NHS
NHS Foundation Trust

Report Title	**Six monthly Nurse and Midwifery Staffing update: May 2019**
Meeting	Public Board
Meeting Date	3rd May 2019
Agenda No.	14
Report Type	Assurance
Prepared By	Neil Webb: Safe Staffing Matron
Executive Lead	Duncan Burton (Director of Nursing and Quality)
Executive Summary	This paper provides the Trust Board with an overview of nursing and midwifery staffing levels across Frimley Health as required every six months in line National Quality Board expectations. Key to improvement in nursing & midwifery staffing is action on recruitment and retention which is covered in the workforce report to the Trust Board rather than this paper
Background	This report builds upon the previous September 2018 Nursing and Midwifery Staffing paper presented to Trust Board and meets the requirement of a six monthly update. Demonstrating and publishing transparent, sufficient staffing levels for Nursing and Midwifery is one of the essential standards in order to be complaint with NHSi and CQC requirements
Issues / Actions	Set out in the report below.
Recommendation	The Board is asked to note: • The nursing, midwifery and care staffing information provided in this report is in line with the National Quality Board Safe staffing Guidance, (July 2016) • The requirements set out in the NHSi Developing workforce safeguards (October, 2018) document. • The specifc changes to midwifery staffing • Next step actions to improve compliance with the NHSi Developing workforce safeguards (October, 2018) • This paper assures the Board that the Director of Nursing & Quality is satisfied that staffing is safe, effective and sustainable.
Appendices	**Appendix 1:** Feb 2019 NHSd Nursing and Midwifery Trust return Staffing fill rate % /CHPPD at ward level with Red Flag numbers raised in the month.

1.0 Safe Staffing

1.1 National Quality Board (NQB, 2016), Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (July 2016) requires healthcare providers to ensure they have the right culture and leadership skills in place for safe, sustainable and productive staffing. This Trust is compliant with NQB safe staffing expectations, which includes the mandated reporting metrics as outlined in this document. Nursing and Midwifery vacancy and retention data and actions to address any areas of concern are not included in this report. This information is included in the HR workforce Board report to avoid duplication.

1.2 **Developing workforce safeguards**: from April 2019, as a Trust we will be expected to deliver on the content within the 'Developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing (October 2018). The ambition of this document is to bring together Nursing and Midwifery, Allied Health Professionals and Medical workforce and look at staffing safety in organisations as a whole. NHSi recognise the positive progress over the last 12 months in which many Trusts have grasped the workforce planning challenge in terms of safe and effective staffing, however observe such variations in how providers approach design and implementation and how they arrange their governance around workforce. The document looks to ensure all Trusts within their workforce planning processes follow:



For FHFT to meet this guidance, HR and Nursing and Midwifery/Allied Health leads are working closely in developing an action plan that will also support both these expectations and the new annual CQC inspection requirements.

Some of the key themes we have identified in our Trust action plan:

- **Quality Impact Assessment use (QIA) & Sign off process (Governance):** Strong and effective governance frameworks and a systematic and structured approach to workforce changes: QIA Agree Template & Governance process of sign off/approval.
- **Evidence Based Tool for patient acuity measurement:** actions to move forward at FHFT, the full rollout of Safecare within our inpatient bedded areas by August 2019. We are currently compliant in using the nationally accredited/licensed SNCT acuity measurement tool with work currently underway with the external validation of data recorded.
- **Monthly Board update:** Current needs being met by the Integrated quality and performance report and under further development the nursing and midwifery quality dashboard. Reporting to Board any clinical areas of concern, alongside action plans to address/mitigate.
- **6/12 N&M Workforce outcomes of review to Board:** Currently in place, this report.
- **Annual update on Trust Workforce Pan:** Updates reported back to Board
- **DON/MD: Statement of compliance contained within the six monthly N&M workforce updates** that staffing is Safe, Effective and Sustainable.
- **Assurance we are meeting clinical speciality staffing guidance** in nursing and midwifery, AHP and medical workforce.

The document is not explicit on the AHP and Medical workforce review evidence required so we are working with other organisations (and NHSi) to see how this is interpreted nationally over the coming months.

1.2.1 **Six monthly workforce reviews:** Between November 2018 and February 2019 the Director of Nursing undertook an in-depth 6 monthly workforce review of all the inpatient and large Non-Inpatient services, including outpatient and community teams. A discussion with the senior leadership of each department (Senior Sister, Matron, Head of Nursing, AD, Finance, HRBP's) utilised finance, workforce metrics and (where available), patient acuity data to review the current budgeted establishments. Professional judgement of the speciality subject matter experts alongside compliance against any national workforce standards framed each review meeting i.e. JAG guidelines being met for Endoscopy services, Critical Care services and Emergency Department (ED) national staffing guidance and NNU BAPM recommendations.

In the majority of the reviews only minor changes were proposed for the 2019/20 budgets, previous reviews had addressed any large changes in service requirements. Administrative budget lines in each service were also examined.The most significant changes to report to the Board were within Elderly care inpatient services at Wexham Park through the combining of wards 17 and 18 into the clinical environment of the old AMU space. The increase of 22 elderly care beds and new clinical environment required an uplift in the size and shape of the workforce establishment to safely meet the needs of our patients. These changes were previously signed off by the executive team. The Wexham Elderly Care Unit budget will be monitored closely to ensure it safely meets the needs of our patients in this speciality over the next six months prior to the next workforce review cycle. This will be reviewed earlier if required. Wexham Emergency Ambulatory centre (under the new build configuration) were other departments whose workforce size and shape required changes due to the new build. This once again was approved by the executive team. In both areas it is recognised there is an increased importance to closely monitor the quality metrics over the coming months to ensure we have set the correct size/shape of workforce.

1.2.2 **Critical Care nursing workloads tool review of the evidence,** our Advanced Critical Care Practitioner at FPH has been a co-author of a published systematic review to understand the workload tools that measures nursing activity and workload specifically within intensive care settings. This was a collaborative project with all the leading critical care nursing organisations in the UK (RCN, BACCN and CC3N) and Newcastle University (who provided academic support). The outcome of this concluded there is currently no perfect workload tool. Critical care nursing organisations together nationally have started a project to develop a nursing activity assessment tool for ICU. A programme development grant is currently being requested from NIHR.

1.2.3 M**aternity services** In quarter 3 of 2018/19 the Trust undertook a workforce review of maternity services utilising Birth Rate Plus, and reported in early 2019. The need to make changes to midwifery staffing has also been noted by the CQC as a 'Must do' requirement. The birthrate plus review identified that the service should be working towards achievement of a ratio of 1:25, (currently the service is funded at 1:30). Following careful review of the requirements of birthrate plus, the availability of future workforce, professional judgement, anticpated birth rates, balanced with financial planning the Executive approved a phased approach to move towards the recommendations of the birth rate plus tool from 2019 - 2022. During 2019/20 the establishment will be budgeted to a ratio of 1:28, an increase of additional 9.48 wte midwives and 7.7 wte maternity support workers (MSWs). These will need to be recruited to. During 2020/21 this will move to a ratio of 1:27 and this will be an additional 12.83 wte midwives and 1.31 wte MSWs. A further birthrate plus assessment will be commissioned in 2020/21 to review ongoing requirements for changes in midwifery staffing. Outcome measures will continue to be monitored to assess of any further changes to the phased plan are required. A review of the key maternity outcome measures reported on the Trust quality & performance report has been requested in order to increase Board visibility of maternity outcomes on an ongoing basis.

In addtition to the above changes the Executive have agreed a temporary change to the the split of midwives to MSW's in postnatal care (postnatal ward and community teams) within the Wexham site. This is a temporary change which will see the split change from 90:10 to 80:20, and allow testing of the success of this and time to recruit additional midwives. This is in response to the ongoing challenge of recruiting midwives within the Wexham Park site. This change was proposed by the Head of Midwifery and supported by the Director of Nursing & Quality. The MSW increase will be able to increase support the midwifery role and provide support in areas such as infant feeding, general baby care and parent education. There would be the ability to directly refer to a midwife in case of concern to woman and babies physical health, woman's mental health and also any issues related to safeguarding. The trial of this workforce adjustment is to run over 2019 and will be evaluated to determine its success; the Head of Midwifery will provide regular updates to the Director of Nursing and executive team. Outcome measures such as Friends and Family scores, maternal and neonatal readmission rates, will be monitored monthly for signs of adverse impact.

1.3 **Community Services:** Workforce size and shape of the budgeted wte establishment within Frimley community nursing services is historically been based upon the number of patient contacts each band/type of staff encounter in a full working day (without travel). Patient contact time and workloads per staff member is closely monitored weekly to ensure patient safety. An annual acuity measurement is also conducted based on a community acuity model to guide the number of community nurses required for the current patient caseload. There is no national set safe caseloads numbers for adult community nursing currently of the contacts a community worker (band/type of worker) would do in a full working day (without travel). Professional opinion from the subject matter experts framed a discussion within their review to ensure the budget was set safely for the 2019/20 financial year.

1.4 **Revalidation lapses**, two have occurred in the last 6 months through either nurses/midwives being on long term sickness or maternity leave. Revalidation process requires a nurse or midwife every three years to meet a number of requirements set by the NMC.

1.5 **SafeCare:** The roll out of SafeCare has commenced. SafeCare is an adjunct IT application that works alongside our current Healthroster (eRostering system) for Nurses and Midwives in the Trust. Commencement of the project began in January 2019 with a pilot; rollout to the wider Trust has now commenced. SafeCare will enable the real time recording of patient acuity during the day and night shifts and give us Trustwide visibility for the first time of our staffing requirements in each inpatient department based on patient acuity. Once full rollout has been completed (July 2019), we will be able to accurately have a Trustwide picture of our actual staff on duty in each department which will assist us in both daily staffing allocations and identifying those areas at staffing risk that require mitigating. Outputs from the acuity data collated will also assist the six monthly workforce reviews. This will also bring efficiency for our Senior Sister/Charge Nurses in reporting mandated national staffing levels each month.

1.6 **N&M Performance Scorecard:** Since the last report a revised Nursing & Midwifery performance scorecard has been produced, this contains the triangulation of workforce and quality outcomes presented under the five CQC inspection domains. Visibility of ward level performance under these domains will allow the identification of those clinical areas that are achieving and areas where additional leadership support may be required. Currently previous data from 2017 is being loaded into each ward dashboard to create 'run charts' for each area metrics. Clarity of the governance of where these dashboards will be discussed and monitored is currently being worked through to ensure accountability is maintained. The development of these scorecards is an important precursor to the next phase of developing a ward accreditation scheme within the organisation.

1.6.1 **Nursing Associate role at FHFT:** The first ten qualified Nurse Associate roles will be in place in the Trust by June 2019. They will be registered with the Nursing Midwifery Council and work under the same professional code and registration/revalidation requirements. The implementing of these roles has followed best workforce practice with Quality Impact Assessments being completed for the introduction of the role into the Trust. Through the workforce review process, we have identified the need of further investment of these roles to support the current clinical teams utilising the apprenticeship levy for training costs. Below is a summary of training numbers already commenced and those that are anticipated to be recruited as trainee Nursing Associates this year. The course consists of a two year work based and university attendance resulting in level 5 foundation degree level and registration on the Nursing Midwifery register. Roles and scope of practice of both the trainee and qualified Nursing Associate role has been shared with all clinical teams to ensure safeguarding of our patients and protecting the role of the Nursing Associate.

Summary FHFT Nursing Associate numbers (Training/Qualifying):

Nursing Associates Training / Qualifying at FHFT	Totals for Trust
Started Training in 2018 (May)	23

Started Training in 2018 (Sept)	30
Total 2018 started training	53
Total June 2019 Qualifying (from pilot 2017)	10
Started Training in 2019 (Jan)	11
Started Training in 2019 (March)	11
Anticipated Training in 2019 (May)	12
Anticipated Training in 2019 (November)	27
Total 2019 started training	61
Overall Trust Total once qualified	**124**

1.6.2 **NHSi Retention programme.** As a Trust we are currently involved in cohort 4 of the NHSi retention programme. We have a six point action plan drafted to address this programme (in partnership with HR) with an aim of reducing our Trust turnover % (Increasing retention). Reviewing of current data on exit interviews/themes, retirement age profiling, retire and return policy review are amongst some of the areas/actions involved in this project. NHSi will supply the organisation with best practice examples from other organisations to support the Trust's action plan.

1.6.3 **Student Nurse Capacity:** The Government has committed to an additional 5000 student nurse training places from September 19. The Trust has responded to a request from HEE to identify 25% additional placement capacity from September 2019. The following table outlines the Trust has responded to this reyeqtes currently at FHFT we have the below capacity of student nurses at any given time:

Field of training	Trust Current student 2018/2019	Additional placement capcity from	Total 2019/20 Placement capacity
Adult Nursing	316	80	396
Theatres (ODP)	32	-	32
Midwifery	110	28	138
Childrens Nursing	39	14	53
Total	**497**	**122**	619

To support meeting this additional capacity we are developing new placement options – for example within teams such as corporate quality & safety; research nursing and with specialist nurses. Key to the success of additional placement capacity, is attracting sufficient applicants through the Higher Education Institues (HEI's). The Trust has in the last year increased the number of HIE's we are working with such as London South Bank, Solent University and Winchester (which opens a School of Nursing in Sept 2019). We continue to monitor the quality of learning environments to ensure any increase in placement demand which does not negatively impact student experience or increase attrition rates. These considerations include include Nursing Associate Trainees and the ten individuals the Trust is supporting through the the Registered Nurse Degree Apprenticeship (RNDA).

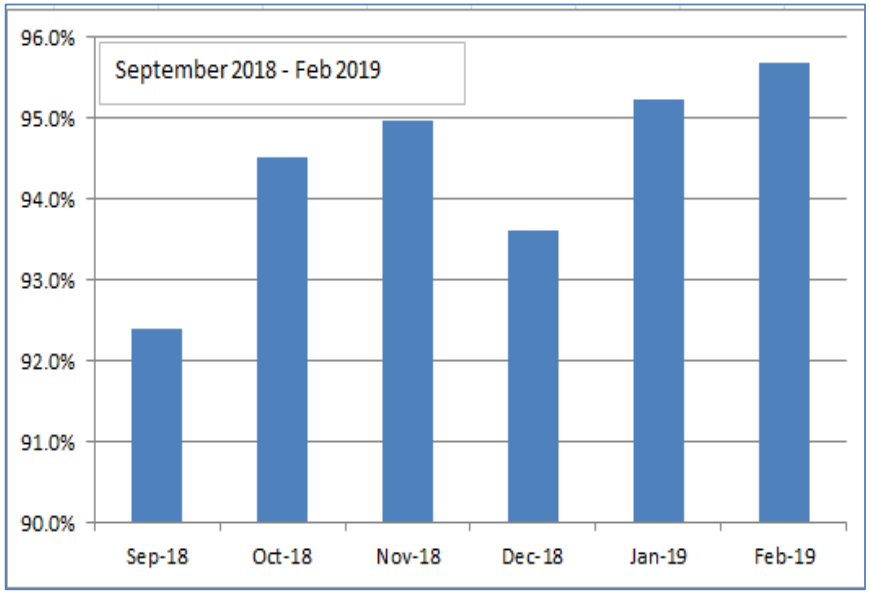
The Trust has led a bid on behalf of the ICS to pilot a new model for allocating and distributing clinical placement funding (Education Tarriff) and are collectively working on a further proposal to take a joint approach to managing placement capacity across the ICS. This follows a request for bids against ring fenced monies for Directors of Nursing to support increases in placement capacity and work with HEI's to ensure these places are filled.

Monthly Safe Staffing levels/CHPPD: Summary with Model Hospital data summary

2.0 **Monthly Staffing levels:** The Trust reports monthly national NHSd Staffing information of all inpatient planned and actual nursing hours. Planned nursing hours reported are based on the budgeted establishments. Below is a high level summary of the Trust hours (Registered and Unregistered combined) for the Trust. Nationally published nursing and midwifery data now solely focusses on CHPPD as a comparison metric between organisations, within the Trust we currently internally monitor both.

The graphs below show the % fill rate. Appendix 1 contains the last months information by ward area submitted to NHSd month of February 2019 alongside the number of ward level Red Flags raised within the month and the total number over the rolling 6 month period.

2.1 Over the last six months the **Trust % overall fill rate is as follows (RN & Care Staff cross site, FP, HW, WP combined)**



Registered Nurse average fill rates at site level, 6 month period, September 2018 – Feb 2019: *(Data in brackets is previous 6 month period average)*

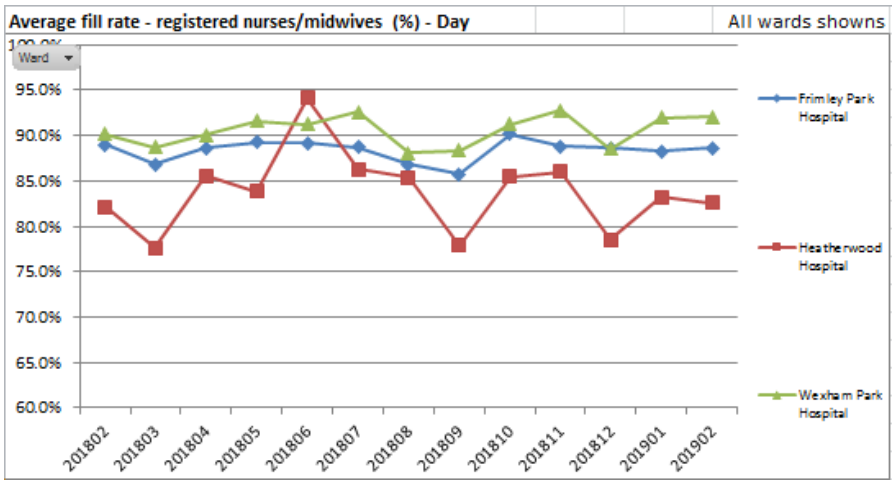
- **FP:** RN Day average % fill rate: 88.41% (88.23%)
- RN Night average % fill rate: 92.17% (93.15%)
- **HW**:RN Day average % fill rate: 82.45% (85.27%)
- RN Night average % fill rate: 96.41% (93.76%)
- **WP:** RN Day average % fill rate: 90.8% (90.4%)
- RN Night average % fill rate: 97.12% (96.89%)

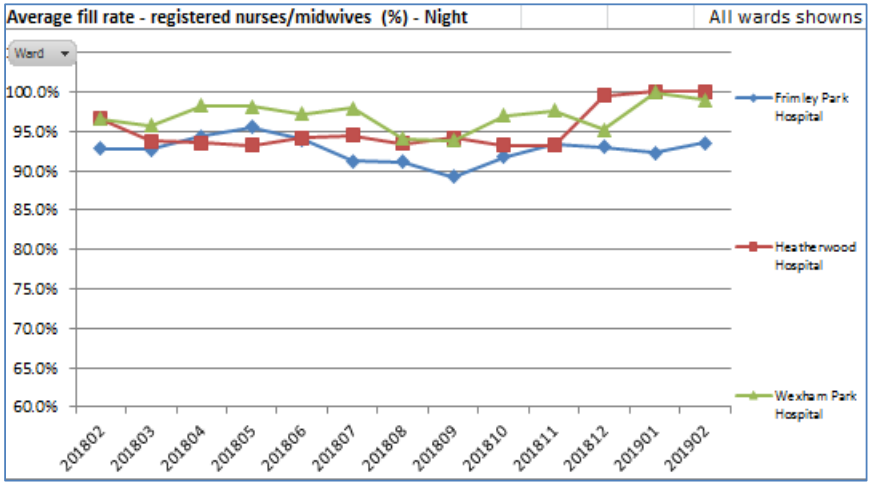
At FHFT level, combined average breakdown(Over 6 month period):

- Trust level RN Day average % fill rate: 89.4% (89.1%)
- Trust level RN Night average % fill rate: 94.5% (94.9%)
- Trust overall average Day & Night (RN & HCA combined): 94.4%

3.0 **Fill rate % and CHPPD**: February 2018 - February 2019

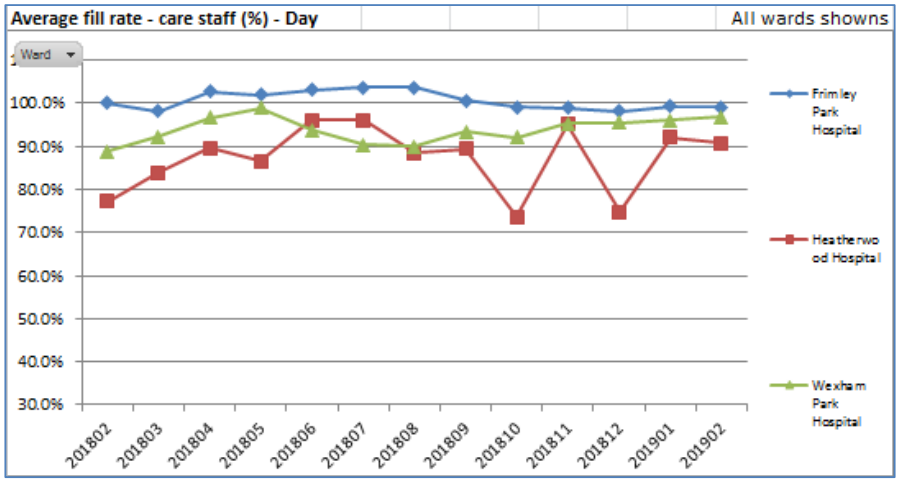
Average fill rate % Registered nurses/midwives Day & Night (Feb 2018 – Feb 2019) by site:

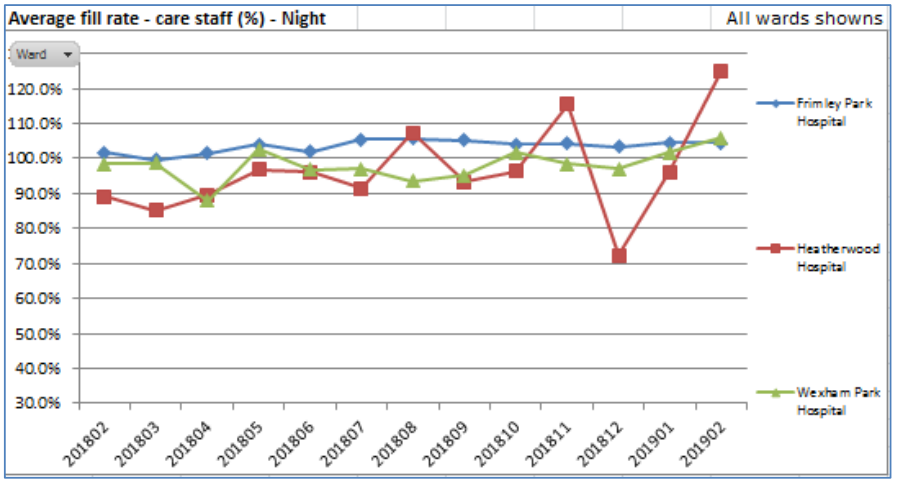




**NB: Heatherwood % fill rates will be lower due to fluctuating nursing hours demands/patient numbers within elective othopeadic surgery. % average fill rates will be lower, however safe.*

Average fill rate % Non-Registered Staff (Care Hours) Day & Night (Feb 2018 – Feb 2019) by site

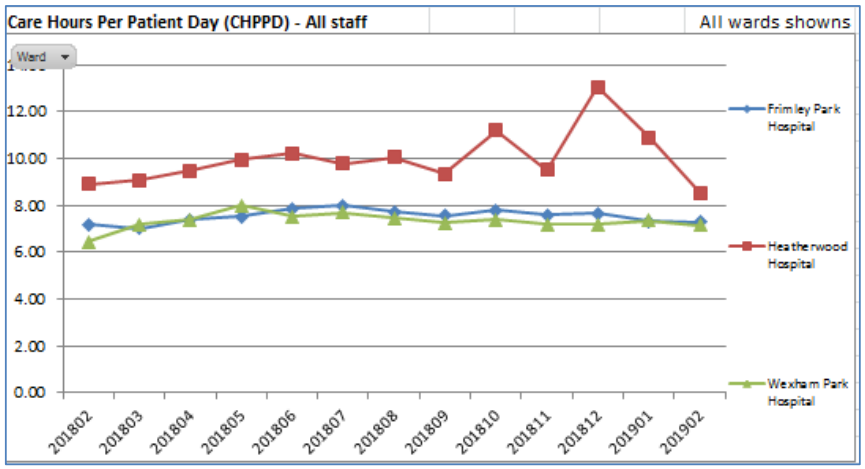




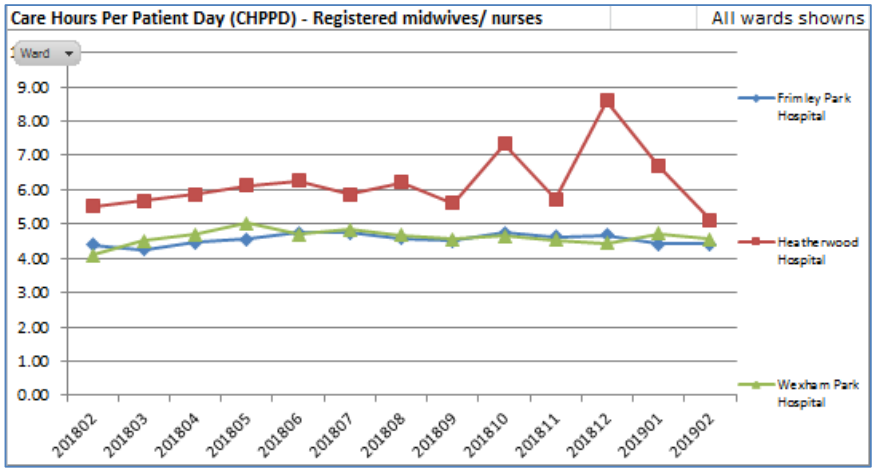
CHPPD are calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients in beds at midnight. As a monitoring tool this has some benefits; however it the methodology does not take into consideration any activity variances throughout the day or the acuity dependency levels of patients which all reflect in the workforce demands in a clinical area. CHPPD monitoring is a mandated NQB requirement alongside NHSi and NHSE. Since September 2018 CHPPD staffing indicator is the key measure of staffing within a Trust to benchmark with other organisations nationally, moving away from fill rate %, (NHSi, 2018). Model Hospital data on CHPPD indicates we are on average comparable with our peers and national median.

The Trust Overall CHPPD average for the last 6 months is: 7.7 (RN & HCA combined)

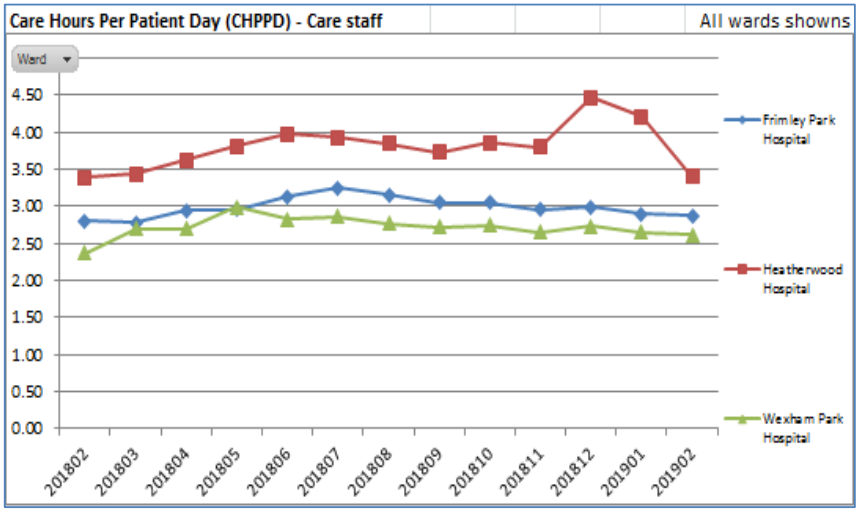
1. Site average (RN & HCA combined) CHPPD Feb 2018 – Feb 2019



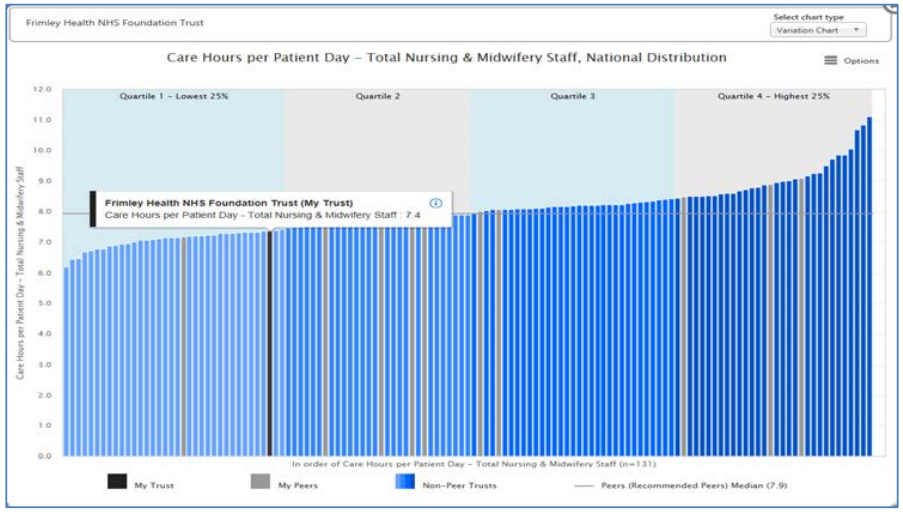
2. Registered Nurse/Midwife CHPPD Feb 2018 – Feb 2019



3. Trust overall average Care CHPPD Feb 2018 - Feb 2019



4. **Trust overall CHPPD** (source: Model Hospital) FHFT: 7.4 *FHFT is within Quartile 1 against peer/other care organisations nationally (Data period: Jan, 2019). Recommended Peer and National Median = 7.9 for Jan 2019*

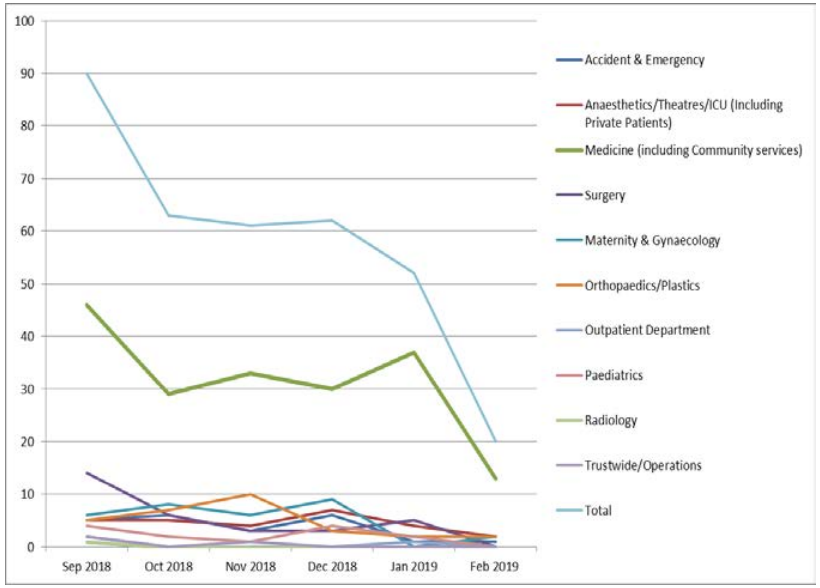


4.0 Red Flags:

4.1 Raising a Red Flag is a professional judgement where a Nurse in Charge (NIC) escalates to a senior nurse where they feel that patient care could, or is, compromised due to either a lack of numbers of nurses or appropriately skilled nurses for the level of acuity /dependency of the patients. Reporting a Red Flag verbally (and within our Trust incident online reporting system) to a senior Nurse/Midwife is viewed as not being negative but one that protects both our patients and staff. All Red Flags are reviewed by a senior nurse at the time it is raised and any mitigating actions taken to protect the safety of our patients. All Red Flags raised on the Trusts incident reporting system are viewed by the Trust's Nursing & Midwifery Safe Staffing Matron in addition to the location manager where the red flag was raised.

Frimley Park Red Flags raised between September 2018 – February 2019

FHFT (Cross site combined)	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Total
Accident & Emergency	5	6	3	6	1	1	22
Anaesthetics/Theatres/ICU (Including Private Patients)	5	5	4	7	4	2	27
Medicine (including Community services)	46	29	33	30	37	13	188
Surgery	14	6	3	3	5	0	31



Maternity & Gynaecology	6	8	6	9	0	2	31
Orthopaedics/Plastics	5	7	10	3	2	2	29
Outpatient Department	2	0	0	0	1	0	3
Paediatrics	4	2	1	4	2	0	13
Radiology	1	0	0	0	0	0	1
Trustwide/Operations	2	0	1	0	0	0	3
Total	90	63	61	62	52	20	348

4.2 As reported in the previous Board update, cross site medical directorates have raised the larger number of Red Flags, this correlates with size of service, the current higher levels of vacancies and lower % fill rates in some areas within the registered nurse workforce. The Senior Nursing teams within these directorates (and site teams) ensure that mitigating measures are taken to provide safe care to our patients. Mitigations include Senior Sisters and Matrons being highly visible within the clinical areas, or moving staff to support acuity and dependency needs of our patients. The resourcing department alongside Safe Staffing Matron are working closely with clinical directorates to ensure recruiting and retention strategies and action plans are in place to monitor progress. Further details of resourcing plans can be found in HR workforce updates to the Board.

5.0 **Next Steps & Conclusion:**

This paper has given an overview of the position of the Trust against the National Quality Board (NQB) expectations (including staff fill rates and CHPPD) alongside the Developing Workforce Safeguards NHSi document, *supporting providers to deliver high quality care through safe and effective staffing*.

There are some further key actions which will be taken to strengthen compliance with these documents to enhance the Trusts ability to monitor safe nursing & midwifery staffing over the coming 6 months. These actions include:

- Completion of the next set of nursing & midwifery staffing reviews and reporting back to Board any significant changes to establishments, this will be reported in the next 6 monthly Board update or sooner where there is a need.
- Continued support of recruitment & retention activities, as outlined within HR updates to Trust Board and People committee.
- Complete the full inpatient roll out of the 'Safe Care' module' by August 2019.
- The Board are asked to note the 'Developing Workforce Safeguards NHSi document' which outlines the need for a framework for Trusts to strengthen their evidence-based approach to workforce planning alongside new recommendations on governance processes and formal reporting from ward to board. NHS Improvement and CQC will be formally assessing Trusts on this issue, which will come into effect from April 2019.
- **Director of Nursing assurance statement:** This paper assures the Board that the Director of Nursing & Quality is satisfied that staffing is safe, effective and sustainable.

Appendix 1: Feb 2019 NHSd Nursing and Midwifery Trust return Staffing fill rate % at ward level with Red Flag numbers raised in the month and rolling six month totals

			Care Hours Per Patient Day (CHPPD)				Day		Night			
Hospital Site name	Ward name	Main Specialties on Specialty 1	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Red Flags raised in the month of Feb 2019	Red Flags six month rolling total (September 2018 - Feb 2019)
FRIMLEY PARK HOSPITAL	Bourne (Farnham)	430 - GERIATRIC MEDICINE	2.1	3.0	0.0	5.2	94.4%	97.1%	96.4%	100.0%	0	1
FRIMLEY PARK HOSPITAL	CCU	320 - CARDIOLOGY	9.8	1.8	0.0	11.6	95.5%	61.9%	92.8%	74.4%	1	17
FRIMLEY PARK HOSPITAL	CFU	340 - RESPIRATORY MEDICINE	5.0	3.8	0.0	8.7	100.0%	100.0%	100.0%	100.0%	0	0
FRIMLEY PARK HOSPITAL	Calthorpe (Fleet)	300 - GENERAL MEDICINE	2.7	3.0	0.0	5.7	100.0%	96.5%	98.2%	99.4%	0	0
FRIMLEY PARK HOSPITAL	F1	420 - PAEDIATRICS	9.0	4.8	0.0	13.8	83.3%	95.8%	83.9%	117.9%	0	12
FRIMLEY PARK HOSPITAL	F10	410 - RHEUMATOLOGY	2.7	2.5	0.0	5.2	96.3%	97.0%	99.9%	102.3%	0	0
FRIMLEY PARK HOSPITAL	F14	430 - GERIATRIC MEDICINE	2.7	2.2	0.0	4.9	81.9%	116.9%	98.2%	115.4%	0	2
FRIMLEY PARK HOSPITAL	F15	502 - GYNAECOLOGY	4.8	2.4	0.0	7.2	100.0%	100.0%	100.0%	96.4%	1	1
FRIMLEY PARK HOSPITAL	F2-Vascular	100 - GENERAL SURGERY	3.1	2.6	0.0	5.7	84.3%	89.1%	100.0%	100.0%	0	1
FRIMLEY PARK HOSPITAL	F3	300 - GENERAL MEDICINE	2.7	2.3	0.0	5.0	89.0%	113.8%	93.5%	102.0%	1	8
FRIMLEY PARK HOSPITAL	F4	110 - TRAUMA & ORTHOPAEDICS	3.1	3.2	0.0	6.3	84.1%	106.9%	74.1%	130.2%	0	2
FRIMLEY PARK HOSPITAL	F5	110 - TRAUMA & ORTHOPAEDICS	3.5	3.8	0.0	7.4	78.2%	110.4%	81.8%	146.4%	1	15
FRIMLEY PARK HOSPITAL	F6	110 - TRAUMA & ORTHOPAEDICS	2.9	3.3	0.0	6.2	58.8%	89.0%	65.5%	101.0%	0	10
FRIMLEY PARK HOSPITAL	F7	100 - GENERAL SURGERY	2.8	2.5	0.0	5.3	79.4%	91.5%	100.0%	98.8%	0	12
FRIMLEY PARK HOSPITAL	F8	100 - GENERAL SURGERY	2.9	2.6	0.0	5.5	78.5%	93.8%	97.6%	100.0%	0	5
FRIMLEY PARK HOSPITAL	F9	301 - GASTROENTEROLOGY	2.7	2.5	0.0	5.2	87.9%	100.0%	100.0%	98.4%	0	0
FRIMLEY PARK HOSPITAL	G1	303 - CLINICAL HAEMATOLOGY	4.0	2.1	0.0	6.1	100.1%	88.5%	100.0%	148.8%	0	1
FRIMLEY PARK HOSPITAL	G2A	430 - GERIATRIC MEDICINE	3.3	2.5	0.0	5.7	100.0%	107.5%	98.2%	118.9%	0	4
FRIMLEY PARK HOSPITAL	G2B	430 - GERIATRIC MEDICINE	3.1	2.7	0.0	5.7	116.3%	99.4%	110.7%	132.2%	0	0
FRIMLEY PARK HOSPITAL	G3	328 - STROKE MEDICINE	4.0	3.6	0.0	7.6	94.6%	99.5%	90.0%	97.5%	2	4
FRIMLEY PARK HOSPITAL	G5CAVELL	340 - RESPIRATORY MEDICINE	2.7	2.5	0.0	5.2	85.4%	114.5%	89.3%	105.0%	0	6
FRIMLEY PARK HOSPITAL	G5PAGET	340 - RESPIRATORY MEDICINE	2.6	2.8	0.0	5.4	105.0%	92.9%	101.8%	137.5%	1	6
FRIMLEY PARK HOSPITAL	G6	430 - GERIATRIC MEDICINE	2.5	2.9	0.0	5.3	98.8%	95.2%	100.0%	98.8%	0	2
FRIMLEY PARK HOSPITAL	G9	320 - CARDIOLOGY	3.7	2.4	0.0	6.1	79.5%	87.3%	98.8%	88.5%	1	25
FRIMLEY PARK HOSPITAL	Hale (Farnham)	430 - GERIATRIC MEDICINE	2.3	2.4	0.0	4.6	100.9%	103.9%	98.2%	139.3%	0	0
FRIMLEY PARK HOSPITAL	ICU	192 - CRITICAL CARE MEDICINE	18.7	2.3	0.0	21.0	100.4%	75.7%	98.6%	91.6%	2	13
FRIMLEY PARK HOSPITAL	MADU	340 - RESPIRATORY MEDICINE	10.0	2.7	0.0	12.7	93.1%	92.7%	91.1%	107.9%	0	0
FRIMLEY PARK HOSPITAL	Maternity	501 - OBSTETRICS	12.2	4.1	0.0	16.2	90.0%	88.8%	89.5%	79.2%	0	4
FRIMLEY PARK HOSPITAL	MAU-AMU	300 - GENERAL MEDICINE	6.8	4.0	0.0	10.8	90.5%	91.4%	92.3%	100.0%	5	16
FRIMLEY PARK HOSPITAL	NNU	420 - PAEDIATRICS	7.1	1.8	0.0	8.9	79.3%	100.0%	96.4%	103.6%	0	0
FRIMLEY PARK HOSPITAL	Parkside	100 - GENERAL SURGERY	4.6	3.1	0.0	7.7	80.5%	124.8%	93.8%	98.8%	0	3
FRIMLEY PARK HOSPITAL	Renal	101 - UROLOGY	12.4	1.5	0.0	13.9	99.9%	-	100.0%	-	0	7
FRIMLEY PARK HOSPITAL	SADU	100 - GENERAL SURGERY	9.6	3.4	0.0	13.0	94.2%	89.0%	94.3%	101.2%	0	1
FRIMLEY PARK HOSPITAL	SAU	100 - GENERAL SURGERY	6.0	3.9	0.0	9.9	83.2%	123.5%	132.3%	100.0%	0	3
FRIMLEY PARK HOSPITAL	SSS	100 - GENERAL SURGERY	3.0	2.8	0.0	5.8	80.6%	97.5%	100.0%	100.0%	0	0

			Care Hours Per Patient Day (CHPPD)					Day		Night			
Hospital Site name	Ward name	Main Specialties on Specialty 1	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Red Flags raised in the month of Feb 2019	Red Flags six month rolling total (September 2018 - Feb 2019)
Wexham Park Hospital	Ward 01 Orthopaedic (WP)	110 - TRAUMA & ORTHOPAEDICS	3.4	3.1	0.0	0.0	6.5	86.4%	83.6%	95.0%	99.3%	0	1
WEXHAM PARK HOSPITAL	Ward 02 General Medicine (WP)	301 - GASTROENTEROLOGY	3.1	2.8	0.0	0.0	5.8	85.2%	107.6%	108.0%	139.3%	0	7
WEXHAM PARK HOSPITAL	Ward 03 Geriatric Medicine (WP)	430 - GERIATRIC MEDICINE	2.8	2.9	0.0	0.0	5.7	79.2%	110.9%	101.2%	146.4%	0	3
WEXHAM PARK HOSPITAL	Ward 04 Cardiology plus Diuretic Lounge (WP)	320 - CARDIOLOGY	3.2	2.2	0.0	0.0	5.4	98.8%	100.0%	100.9%	128.6%	0	0
Heatherwood Hospital	Ward 04 Orthopaedic (Hwd)	110 - TRAUMA & ORTHOPAEDICS	5.1	3.4	0.0	0.0	8.5	82.6%	90.7%	100.0%	125.0%	0	0
WEXHAM PARK HOSPITAL	Ward 05 General Medicine (WP)	302 - ENDOCRINOLOGY	2.6	2.4	0.0	0.0	5.0	87.9%	115.5%	107.1%	110.7%	0	3
WEXHAM PARK HOSPITAL	Ward 06 General Medicine (WP)	410 - RHEUMATOLOGY	2.7	2.4	0.0	0.0	5.1	89.2%	104.3%	100.9%	121.4%	0	6
WEXHAM PARK HOSPITAL	Ward 07 Acute Medical Unit and GP Unit (WP)	300 - GENERAL MEDICINE	5.0	2.7	0.0	0.0	7.7	98.5%	90.3%	100.0%	89.9%	1	3
WEXHAM PARK HOSPITAL	Ward 09 General Medicine (WP)	340 - RESPIRATORY MEDICINE	3.2	2.3	0.0	0.0	5.5	97.1%	104.7%	100.9%	106.0%	0	4
WEXHAM PARK HOSPITAL	Ward 09 Medical Acute Dependency Unit (WP)	340 - RESPIRATORY MEDICINE	8.5	2.4	0.0	0.0	11.0	96.4%	64.3%	95.2%	100.0%	0	3
WEXHAM PARK HOSPITAL	Ward 10 Surgical (WP)	100 - GENERAL SURGERY	3.1	2.7	0.0	0.0	5.9	87.4%	76.8%	101.2%	100.0%	0	2
WEXHAM PARK HOSPITAL	Ward 11 Surgical (WP)	100 - GENERAL SURGERY	3.8	2.5	0.0	0.0	6.2	99.1%	97.6%	100.0%	96.7%	0	0
WEXHAM PARK HOSPITAL	Ward 15 Eden (WP)	315 - PALLIATIVE MEDICINE	3.8	2.2	0.0	0.0	6.0	76.2%	119.7%	97.6%	95.3%	0	6
WEXHAM PARK HOSPITAL	Ward 16 SRU (WP)	328 - STROKE MEDICINE	2.7	2.4	0.0	0.0	5.1	88.4%	110.3%	101.2%	135.7%	0	32
WEXHAM PARK HOSPITAL	Ward 17 General Medicine (WP)	430 - GERIATRIC MEDICINE	2.6	2.0	0.0	0.0	4.6	89.0%	106.5%	100.0%	96.4%	0	0
WEXHAM PARK HOSPITAL	Ward 18 General Medicine (WP)	430 - GERIATRIC MEDICINE	2.8	2.3	0.0	0.0	5.1	89.3%	116.3%	100.0%	98.2%	0	2
WEXHAM PARK HOSPITAL	Ward 20 Gynaecology (WP)	502 - GYNAECOLOGY	4.0	2.4	0.0	0.0	6.5	97.3%	88.4%	139.3%	98.2%	0	0
WEXHAM PARK HOSPITAL	Maternity Unit (WP)	501 - OBSTETRICS	8.4	4.5	0.0	0.0	12.9	94.6%	89.5%	93.8%	95.4%	0	8
WEXHAM PARK HOSPITAL	Ward 24 Paediatric (WP)	420 - PAEDIATRICS	11.0	2.7	0.0	0.0	13.7	98.0%	81.7%	98.9%	92.9%	0	0
WEXHAM PARK HOSPITAL	Christiansen Unit (WP)	100 - GENERAL SURGERY	5.3	5.0	0.0	0.0	10.3	96.4%	78.6%	100.0%	95.3%	0	5
WEXHAM PARK HOSPITAL	Coronary Care Unit (WP)	320 - CARDIOLOGY	7.7	0.5	0.0	0.0	8.2	89.3%	-	103.6%	-	0	1
WEXHAM PARK HOSPITAL	Intensive Treatment Unit (WP)	192 - CRITICAL CARE MEDICINE	22.1	1.0	0.0	0.0	23.2	89.2%	80.2%	90.0%	-	0	3
WEXHAM PARK HOSPITAL	Parkside (WP)	100 - GENERAL SURGERY	4.5	2.5	0.0	0.0	7.1	100.8%	89.8%	100.0%	100.0%	0	0
WEXHAM PARK HOSPITAL	Neonatal Unit (WP)	420 - PAEDIATRICS	6.3	2.4	0.0	0.0	8.7	88.3%	152.7%	95.0%	132.1%	0	1

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Frimley Health
NHS Foundation Trust

Report Title	**National Staff Survey 2018 Results**
Meeting	Public Board of Directors Meeting
Meeting Date	Friday 3rd May 2019
Agenda No.	15.
Report Type	To note.
Prepared By	Claire Quinn, Assistant Director Learning and OD and Eleanor Shingleton-Smith, Deputy Director of HR and OD
Executive Lead	Janet King, Director of HR and Corporate Services
Executive Summary	This paper highlights the results of the 2018 National Staff Survey. The Trust undertook a census survey in 2018 and had a 43% response rate (3764/8807 staff). This was a 5% improvement since 2016 and brings us closer to the acute trust average response which was 44%. The Trust rated eighth in terms of overall positive scoring across all acute provider Trusts in the NHS and fifth overall in respect of consistency of scores over time. (LiA 2019 NSS18 Results LiA Scatter Map) An overview of the 10 key themes and how we compare with all 89 acute trusts across the country is shown at Appendix 1. The old style reporting of 32 key findings with benchmarking for the top 20%, etc, has now gone. Appendix 1 demonstrates Frimley Health's strong performance against the 10 themes, with statistically significant improvements against 4 of these themes and no change in the other 6 (Appendix 2). The significant improvements in 4/10 themes from 2017 to 2018 are: ✓ Improved – Immediate Managers ✓ Improved – Quality of Appraisals ✓ Improved – Safety culture ✓ Improved – Staff engagement

15.1

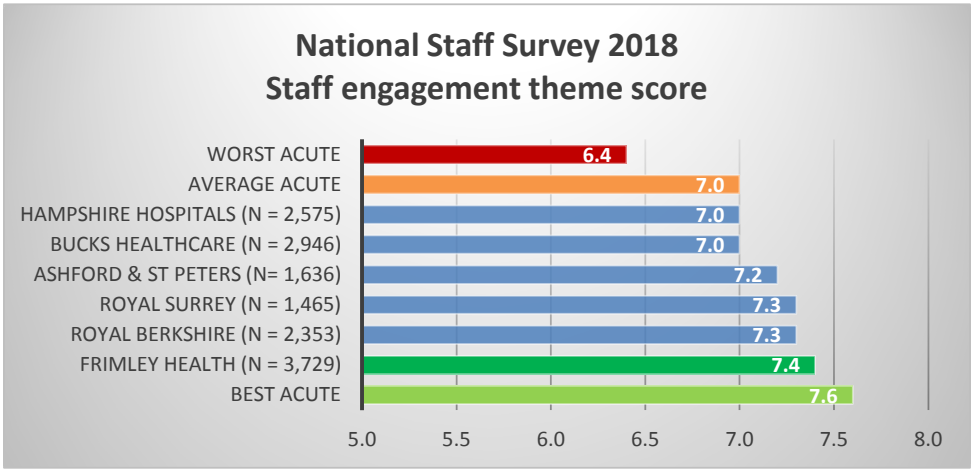
Some examples of questions within the themes that have led to the improvement include:

Example items	2017	2018
How satisfied are you…with the value the organisation places on my work	49%	55%
My line manager values my work	71%	76%
How satisfied are you…with the recognition you get for good work	55%	62%

Background

Following the 2017 survey results, significant action was taken with managers regarding the quality of appraisals as well to encourage them to recognise and appreciate staff at the local level. This had a significant impact on improving the results on both the Immediate Managers and Quality of Appraisals theme in 2018. The improvement in Quality of Appraisals was seen by Picker as being so significant that they invited our Learning and OD to present at the Picker National Survey Review events.

Appendix 3 demonstrates how we compare across the 88 staff survey items with the 43 Trusts for whom Picker administer the survey. This shows that the Trust is significantly better on 71 items, similar on 17 items and significantly worse on just two items. These questions are shown in Appendix 4i on additional paid hours worked and 4ii on discrimination at work from patients and service users.
The Trust's advocacy scores (Recommendation of trust as a place to work and have treatment) are consistently good – please see Appendix 5i and 5ii. Recommendation of trust as a place to work has improved by 4% between 2017 and 2018.
The NHS defines overall staff engagement as a combination of nine items and the Trust's score continues to be one of the best of the 89 acute trusts at 7.4 / 10 (see theme 10 in Appendix 1). The graph shows how the Trust compares to local neighbouring acute providers on the staff engagement theme.



The highest and lowest ten scoring teams at FHFT are highlighted below, and compared with 2017 rankings.

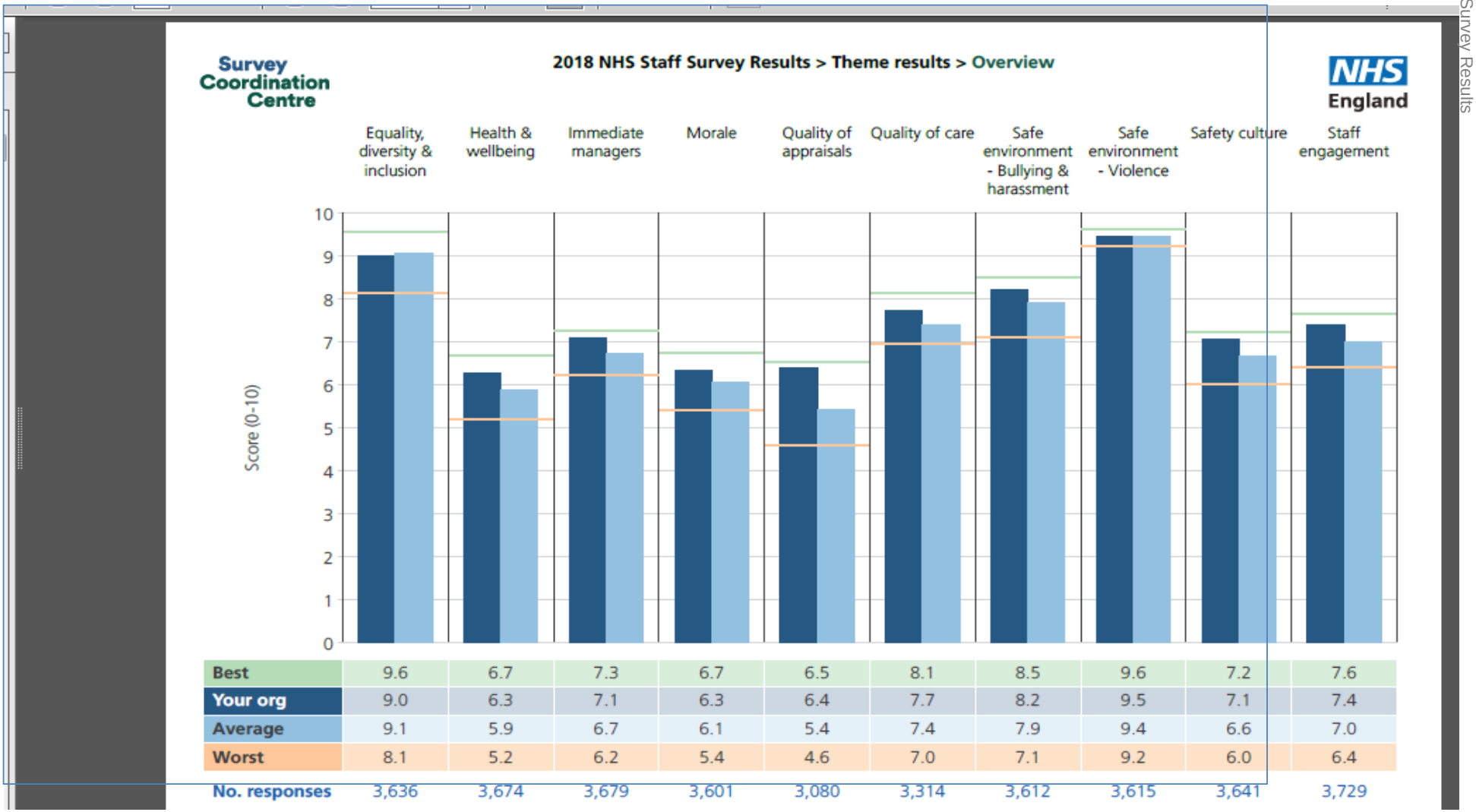
Highest Overall Rated Teams 2017	Highest Overall RatedTeams 2018
FPH Ward G1	FPH Ward G3 Stroke Unit (n = 54)
WPH Ward 2	WPH Nurses Paediatrics (n = 26)

15.1

	Speech and Language Therapy	FPH DSU 1 (n = 33)
	FPH Ward G5 Respiratory	HWPH Outpatients (n = 61)
	FPH Medical ED	FPH Clinical Management (n = 51)
	FPH Ward F14	HWPH Medical Paediatrics (n = 39)
	FPH Endoscopy Unit	FPH Ward F1 Paediatrics (n = 55)
	HWPH Cardiology Services	FPH Medical Paediatrics (n = 40)
	HWPH Outpatients Dept. Group 2	FPH Ward F8 (n = 39)
	HWPH Medical Paediatrics	WPH Speech & Language Therapy (n = 12)
	Lowest Overall Rated Teams 2017	**Lowest Overall Rated Teams 2018**
	IM&T	O&G Admin & Clerical (n = 52)
	Cancer Services	HFPH Estates Services (n = 42)
	Medical Secretaries General Surgery	HFPH Catering Services (n = 89)
	Portering HWPH	HWPH Orthopaedics Admin & Clerical (n = 19)
	Patient Records	HWPH Radiology Services (n = 135)
	Orthopaedic Admin and Clerical FPH	FPH Patient Registration (n = 39)
	BSPS Infection and Immunity	FPH Theatre Emerg & Gen Surg Team (n = 50)
	Maternity WPH	HWPH Clinical Management (n = 98)
	Patient Records (Group 2) FPH	WPH Catering Services (n = 72)
	Radiology	WPH Maternity (n = 190)
		Yellow highlights areas in same category for two consecutive years
Issues / Actions		
Recommendation	The overall recommendation is to ensure that there continues to be meaningful use of survey results, in a way that will boost staff engagement, throughout the organisation. See appendix 7- Improvement Plan for detailed actions To be reviewed at Operational People Committtee	
Appendices	Appendix 1 – Overview of 10 themes Appendix 2 – Statistically significant improvements in 10 themes Appendix 3 - Comparison with Picker Trusts on the 88 NSS questions Appendix 4 – 2018 NHS Staff Survey Results- your health, well-beeing and safety at work Appendix 5 –2018 NHS Staff Results – your organisation Appendix 6 – local review templates Appendix 7 - Improvement Template	

National Staff Survey 2018 Results

Appendix 1 – Overview of 10 themes



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.0	6.3	7.1	6.3	6.4	7.7	8.2	9.5	7.1	7.4
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	3,636	3,674	3,679	3,601	3,080	3,314	3,612	3,615	3,641	3,729

National Staff Survey 2018 Results

Appendix 2 - Statistically significant improvements in 10 themes

Survey Coordination Centre

2018 NHS Staff Survey Results > Appendices > Significance testing – 2017 v 2018 theme results

NHS England

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2018 score is significantly higher than last year's, whereas ↓ indicates that the 2018 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.0**	3332	**9.0**	3636	Not significant
Health & wellbeing	**6.2**	3378	**6.3**	3674	Not significant
Immediate managers	**6.8**	3347	**7.1**	3679	↑
Morale		0	**6.3**	3601	N/A
Quality of appraisals	**6.2**	2658	**6.4**	3080	↑
Quality of care	**7.7**	3002	**7.7**	3314	Not significant
Safe environment - Bullying & harassment	**8.2**	3302	**8.2**	3612	Not significant
Safe environment - Violence	**9.5**	3283	**9.5**	3615	Not significant
Safety culture	**6.9**	3357	**7.1**	3641	↑
Staff engagement	**7.2**	3444	**7.4**	3729	↑

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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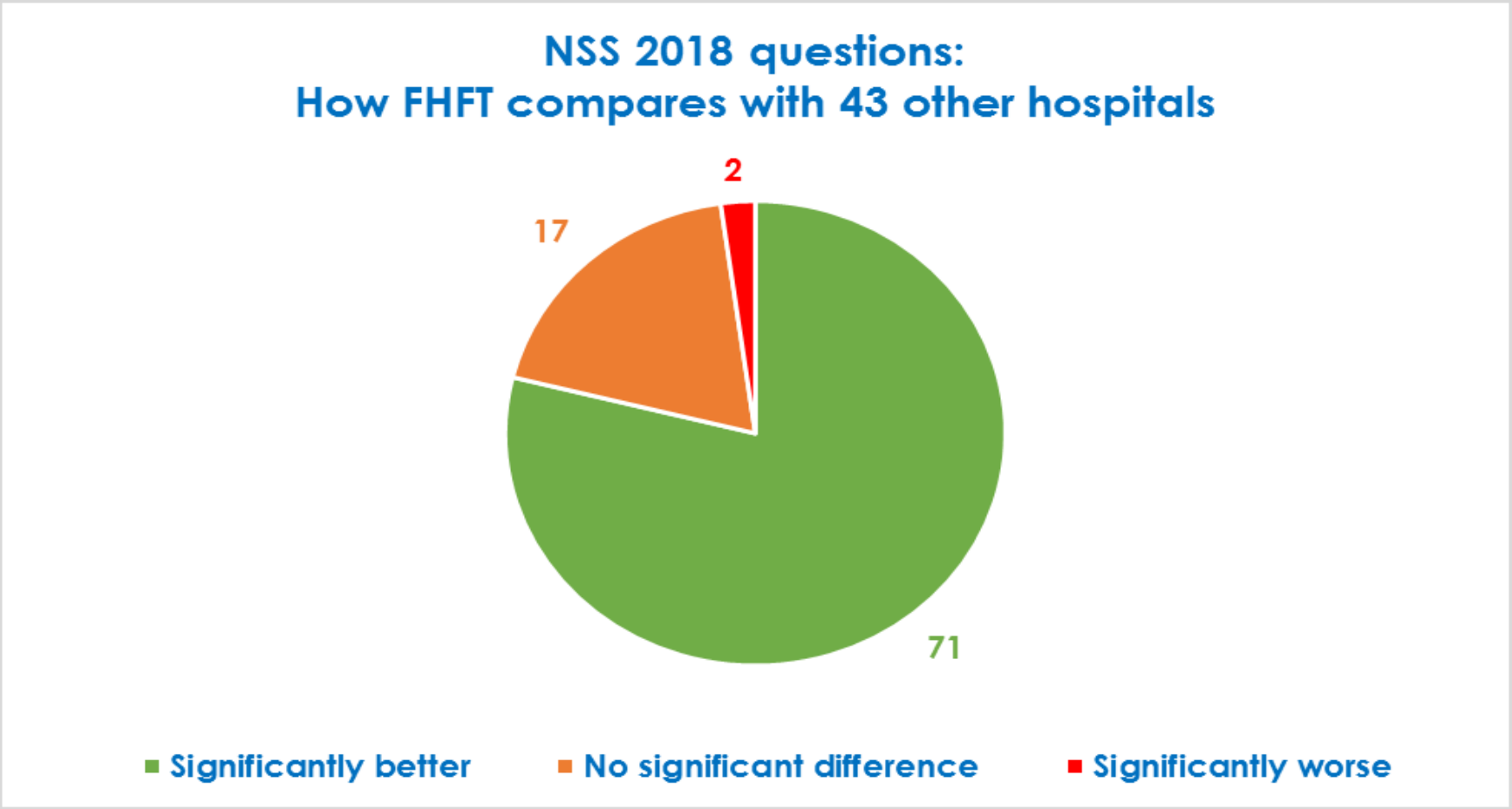
National Staff Survey 2018 Results

Appendix 3 - Comparison with Picker Trusts on the 88 NSS questions



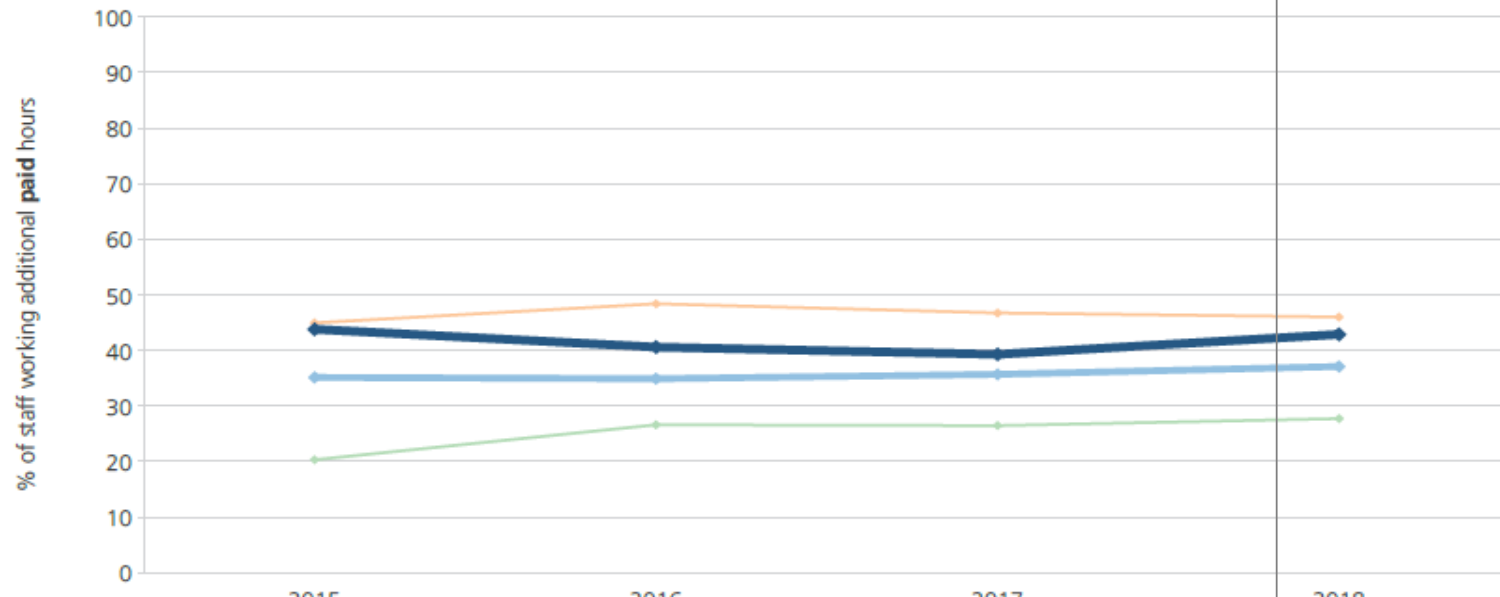
National Staff Survey 2018 Results

Appendix 4 i)

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q10b > On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?

NHS England



	2015	2016	2017	2018
Worst	45.0%	48.4%	46.7%	46.0%
Your org	43.8%	40.6%	39.3%	42.9%
Average	35.1%	34.9%	35.7%	37.1%
Best	20.3%	26.6%	26.5%	27.7%
No. responses	295	2,922	3,272	3,540

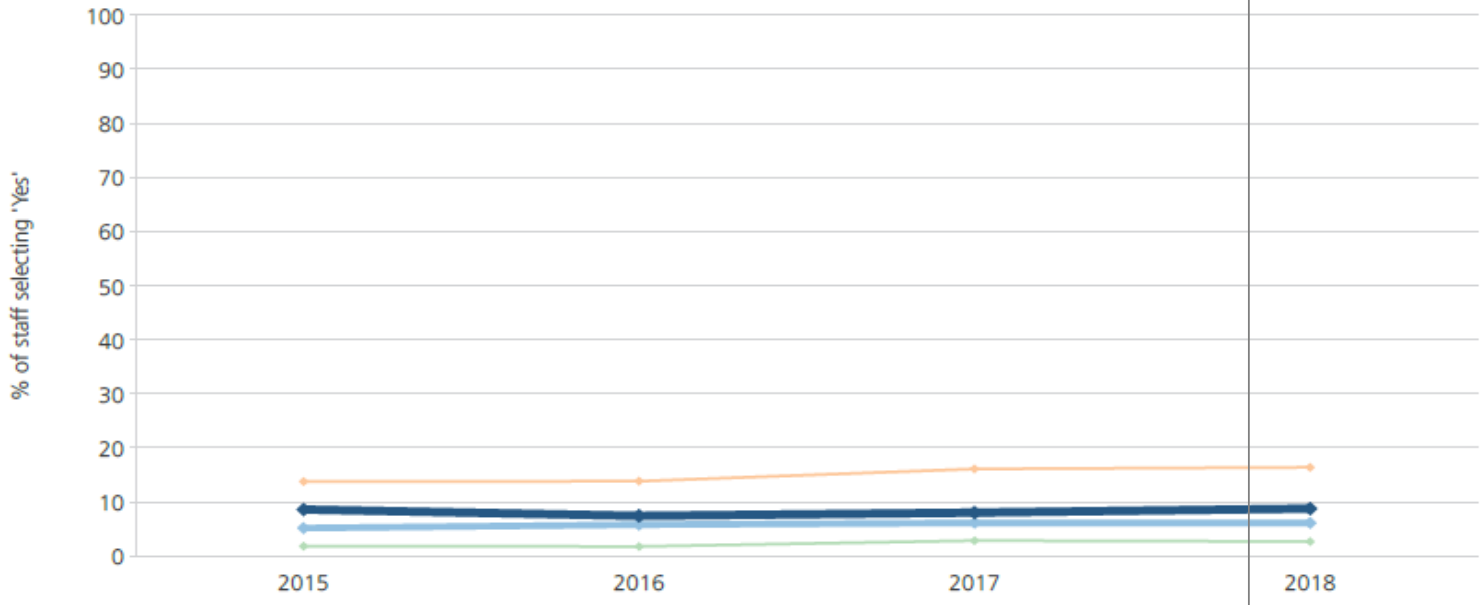
National Staff Survey 2018 Results

Appendix 4 ii

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q15a > In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?

NHS England



	2015	2016	2017	2018
Worst	13.8%	13.8%	16.1%	16.4%
Your org	8.6%	7.4%	8.0%	8.8%
Average	5.2%	5.8%	6.1%	6.1%
Best	1.8%	1.8%	2.9%	2.7%
No. responses	303	2,990	3,332	3,635

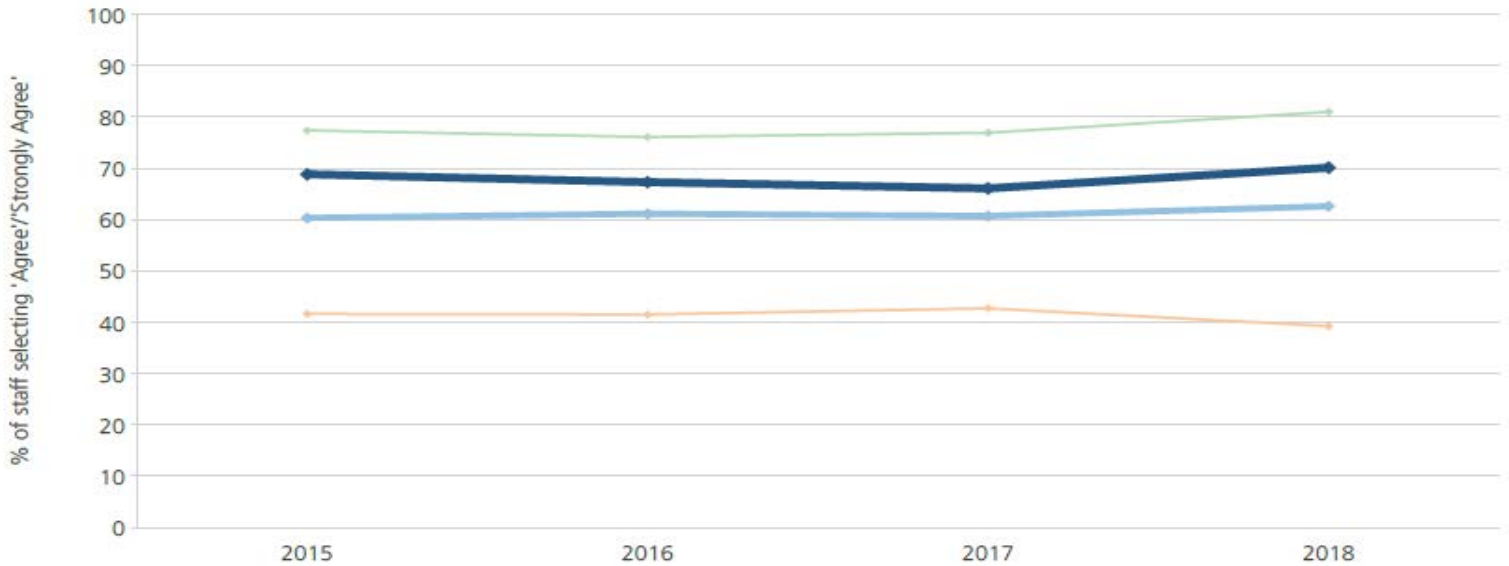
National Staff Survey 2018 Results

Appendix 5 i

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation
> Q21c > I would recommend my organisation as a place to work

NHS England



	2015	2016	2017	2018
Best	77.4%	76.1%	76.9%	81.0%
Your org	68.8%	67.3%	66.1%	70.1%
Average	60.3%	61.1%	60.7%	62.6%
Worst	41.6%	41.5%	42.7%	39.2%
No. responses	304	2,967	3,304	3,599

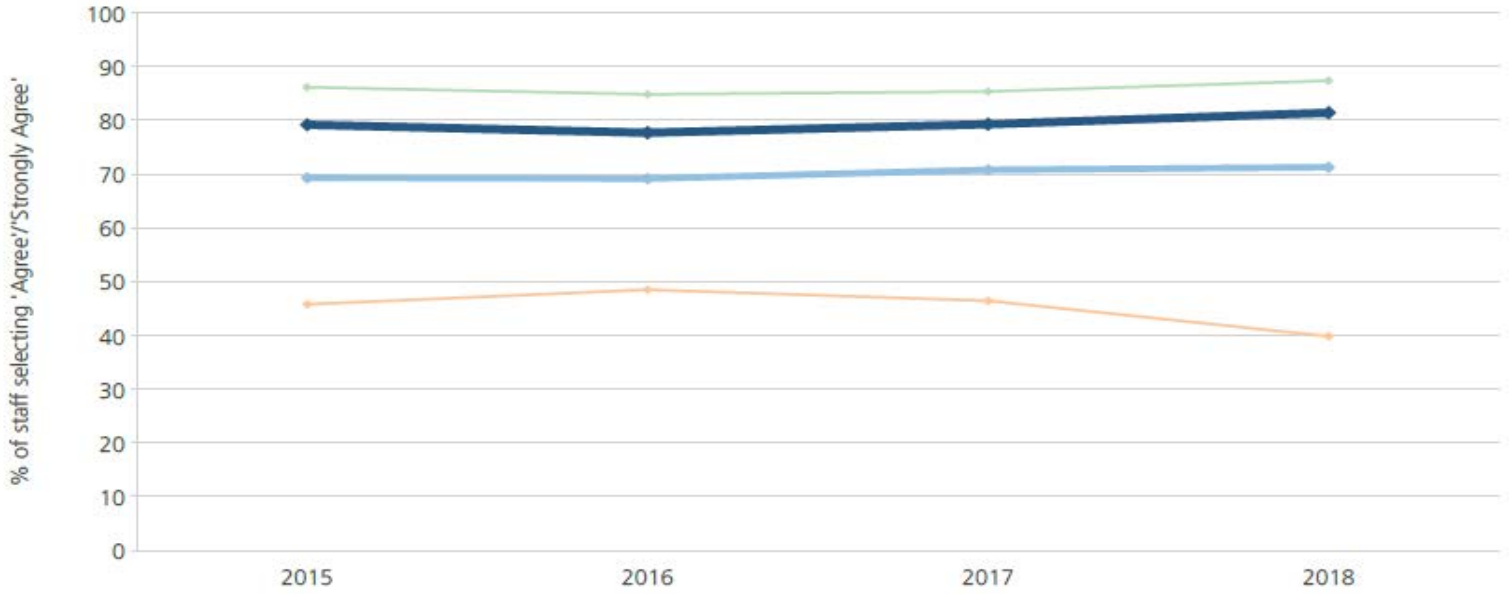
National Staff Survey 2018 Results

Appendix 5 ii

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation > Q21d **>** If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

NHS England



	2015	2016	2017	2018
Best	86.1%	84.8%	85.3%	87.3%
Your org	79.2%	77.7%	79.3%	81.4%
Average	69.3%	69.1%	70.8%	71.3%
Worst	45.8%	48.5%	46.4%	39.8%
No. responses	303	2,959	3,280	3,588

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Learning and OD

NATIONAL STAFF SURVEY RESULTS 2018 - OUR SUMMARY

Team Name _____

NHS
Frimley Health
NHS Foundation Trust

We scored significantly better than the average for the Trust on the following questions			
Qu. #	Question text	Our team %	Organisation %

We scored significantly worse than the average for the Trust on the following questions			
Qu. #	Question text	Our team %	Organisation %

PTO - Page 1 of 2

Get connected Learning and OD

NATIONAL STAFF SURVEY RESULTS 2018 - OUR INTERPRETATION

NHS Frimley Health NHS Foundation Trust

Team Name _____

Our results mean…

Date(s) discussed	
Number of staff involved	

Summary bullet points:
- [insert here]

We will celebrate these results…

Which survey question	What and how	Who will lead	By when

We will improve on these results…

Which survey question	What and how	Who will lead	By when

Template completed by		Date completed	

National Staff Survey 2018 Improvement Plan

<table>
<tr><th>Area</th><th>National Staff Survey Evidence</th><th>Action</th><th>Owner</th><th>Deadline</th></tr>
<tr><td>Drive up response rate across organisation with a goal of being above average for acute trusts.</td><td>43% response rate in 2018 (3763/8807 staff) with average acute trust response rate being 44%</td><td>1. Increase the numbers of staff regularly accessing NHS emails from 68% to 90%
2. Understand what can be learnt from organisations achieving the best response rates
3. Explore option of utilising personal email addresses recorded in ESR
4. Publicise ambition to increase our response rate – message from Neil
5. Run a ‘get ready’ campaign including ‘Myth Buster’ ahead of Staff Survey Launch
6. Implement a ‘You Said – We Heard’ type campaign to demonstrate that the results are listened to</td><td>Claire Quinn/ Kevin Percival
Claire Quinn
Claire Quinn
James Taylor
Claire Quinn
Claire Quinn/James Taylor</td><td>Q2
Q1
Q1
Q2
Q1/2
Q1</td></tr>
<tr><td>Focus actions to improve the worst two questions for the Trust (additional paid hours and discrimination at work from patients and service users) bringing them in line with averages for acute trusts</td><td>Additional paid hours: 42.9% of staff reported working additional paid hours – the average 37.1%.

Discrimination at work from patients, relatives or other members of the public: 8.8% of staff reported discrimination – the average 6.1%</td><td>1. Understand the extent to which additional paid hours of work correlate to levels of work related stress and absence using NSS RAG reporting and HR dashboard)
2. Support/develop line managers to pay attention to changes in additional paid hours (via HealthRoster) and use appraisal and 1:1 conversations to understand what is driving increased hours
3. Understand the groups and locations that are most effected by discrimination from patients, relatives and the public
4. Review our Trust approach to communicating our expectations of service user behaviours and how we respond when these are flouted.</td><td>Michael Ellis
Dawn Estabrook
Duncan Burton
Duncan Burton</td><td>Q1
Q1
Q1
Q2</td></tr>
<tr><td>Provide direct support to the lowest ten rated areas to help them to improve, with intensive support offered to those who consistently in the bottom ratings over consecutive years</td><td><table><tr><th>Lowest Overall Rated Teams 2017</th><th>Lowest Overall Rated Teams 2018</th></tr><tr><td>IM&T</td><td>O&G Admin & Clerical (n = 52)</td></tr><tr><td>Cancer Services</td><td>HFPH Estates Services (n = 42)</td></tr><tr><td>Medical Secretaries General Surgery</td><td>HFPH Catering Services (n = 89)</td></tr><tr><td>Portering HWPH</td><td>HWPH Orthopaedics Admin & Clerical (n = 19)</td></tr><tr><td>Patient Records</td><td>HWPH Radiology Services (n = 135)</td></tr><tr><td>Orthopaedic Admin and Clerical FPH</td><td>FPH Patient Registration (n = 39)</td></tr><tr><td>BSPS Infection and</td><td>FPH Theatre Emerg &</td></tr></table></td><td>1. Email lowest scoring areas informing them of support and expectation
2. Meet with managers from lowest scoring areas and support them to develop improvement plans inc. triangulation with HR dashboard data
3. Review progress with line managers</td><td>Janet King
HRBP and Claire Quinn
HRBP</td><td>Q1
Q1
Q2/3</td></tr>
</table>

	Immunity: Gen Surg Team (n = 50) Maternity WPH: HWPH Clinical Management (n = 98) Patient Records (Group 2) FPH: WPH Catering Services (n = 72) Radiology: WPH Maternity (n = 190) Yellow highlights areas in same category for two consecutive years			
Increase the extent to which local managers are accessing their NSS results, having conversations with their teams and creating plans to celebrate success and identify opportunities for improvement	Following the NSS2017 only 30 teams created a success and improvement plan as a result of reviewing staff survey results The hierarchy of the NSS18 was re-engineered to take account of team structures in order to create more meaningful team level reporting.	1. Increase expectation that local success and improvement plans will be created and shared with HRBP's 2. Locate all local reports on Trust intranet to improve ease of access 3. Managers to take account of free text comment for their areas in developing local action plans 4. Local managers to create local 'We Said – We Did'	Janet King Claire Quinn All managers with locality level 3 report All managers with locality level 3 report	Q1 Q1 Q1 Q2
Themes from NSS18 freetext	Some staff groups feeling under-represented Career progression (esp. band 5) Therapy services consultation having negative impact CQC preparation "rushed and false" Informatics capability and infrastructure across organisation Trust integration challenges still exist Short staffing and the importance of valuing breaks and handover Operational pressure ED, flow and theatre start times Levels of pay Too many managers, lack of visibility and poor communication from top Skills development for managers	1. Create opportunities for front line staff to be heard 2. Professional leads to clarify progression pathways 3. Review and understand impact of process and engage with staff to plan measures to address 4. Communications that 'we have heard this' and will be doing differently in future 5. Increase visibility of informatics activity via 'you said – we did' campaign 6. Drive forward 'One Frimley' agenda 7. Plan and implement approaches to value and protect time for breaks 8. Identify and address specific issues 9. Communication of NHS T&C review changes 2019/20 10. Promote Face2Face. 11. Expand visibility of Execs to include AD's 12. Launch managers 'Nuts and Bolts' programme	Lee Jones Duncan Burton Amy Olley Duncan Burton/ Lee Jones Dave Axam Lee Jones Duncan Burton Sally Vaughan/ David Milwood/ Kirstin McDonald Michael Ellis Lee Jones Lee Jones Dawn Estabrook	Q1 2019 Q2 2019 Q1 2019 Q1 2019 Q1 2019 Q2 2019 Q2 2019 Q2 2019 Q1 2019 Q1 2019 Q2 2019 Q2 2019

15.4

	Lack of feedback from incidents Finance and concerns about state of the Trust Fear of harassment/violence from patients	13. Fully realise the benefits of RL System 14. Communication campaign 15. Review what the best organisations are doing (as measured in NSS) and implement approaches	Tracy Coulson Nigel Foster/ Lee Jones Duncan Burton	Q2 2019 Q1 2019 Q2 2019

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NHS
Frimley Health
NHS Foundation Trust

Report Title	**Summary minutes for Charitable Trustee 1st March 2019**
Meeting	Public board meeting
Meeting Date	3 May 2019
Agenda No.	16.1
Report Type	For Information
Prepared By	Pradip Patel- Chair of Charitable Trustee Susanne Nelson-Wehrmeyer - Company Secretary
Executive Lead	Nigel Foster - Director of Finance
Executive Summary	This report briefs the Board on the main items discussed at the 1 March 2019 meeting of the Charitable Trustee Committee.
Background	The following was discussed by the committee: The Frimley Health Charity Annual Report and Accounts received a clean opinion form the auditors with no issues arising. The Trustee approved the accounts for 2017-2018. The Charitable Fund Balances report was noted by the Trustee and work is on-going with fund holders on spending the funds. The terms of reference of the Charitable Funds Committee were discussed and the Trustee approved the following changes: 1) Amendment of the membership of the Committee to replace the Director of Finance and IM&T with the Director of Operational Finance and the Director of HR and Corporate Services with the Director of Communications, Marketing and Engagement with full voting rights. 2) That consequential changes be made to the Administration of Charitable Funds Policy and financial standing orders as required. On the administration of Charitable Funds Policy The Trustee approved the recommended changes subject to the amendment of Expenditure

	Authorisation Limits to add the following: 1) £10,001 to £25,000 - Director of Operational Finance and Director of Communications, Marketing and Engagement 2) £25,001 to £100,000 - Director of Finance and Director HR & Corporate Services. Frimley Health Charity update on fundraising and weekly lottery showed good progress. Highlights are that grant applications will achieve £200k income and many smaller donations from the likes of Tesco. The Stroke appeal anticipated £313k over the next few months. Children's critical care was now complete and exceeded the target raising £340k with a further £10k expected. The lottery is going well and an application for a larger gambling licence had been submitted to the Lotteries Commission. An Arts Co-ordinator has been appointed to stimulate funding through arts projects.
Recommendation	The Board is asked to **NOTE** the summary.
Appendices	NA

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NHS
Frimley Health
NHS Foundation Trust

Report Title	Summary minutes for FIC 22 March 2019
Meeting	Public board meeting
Meeting Date	3 May 2019
Agenda No.	16.2
Report Type	For Information
Prepared By	Rob Pike - Chair of FIC Susanne Nelson-Wehrmeyer - Company Secretary
Executive Lead	Nigel Foster - Director of Finance
Executive Summary	This report briefs the Board on the main items discussed at the 22 March 2019 meeting of the Finance Investment Committee.
Background	The following issues were discussed by the committee: **Terms of Reference** The new terms of reference for FIC were agreed and signed off. **M11 finance report** It was reported that M11 was better than M10 due to some of the forecast reductions emerging. As a consequence the trust was £300k better off than anticipated. He also noted that A&E PSF would not be achieved for Q4 which would result in a £2.7m negative variance; but the financial CT would be achieved and the operational position would be in deficit. Any improvements would be in non-pay. RP explained that the missing PSF meant less cash in the bank account, and thus cash which could be used to contribute to future capital spend would not be available. So the trust was £2.7m (of cash) worse off but there would be no penalty on the financial control total. **Financial Plan for 2019/20** EJ presented the report. Based on the February submission and final submission on 4 April, the numbers showed £25m CIP and generation of a surplus of £11.7m with PSF of £13m. It was agreed that to hit a CIP target of

	£25m the Trust would need to target savings of £30m. Draft budgets were to be issued on 29 March and then there would be a series of meetings with execs and ADs and chiefs to sign off budgets in each area. There was much discussion about the allocation of CIP targets and budgets in general across the directorates but in summary, the committee felt that, whilst not perfect the process was much more robust this year than it had been in previous years. The discussion encompassed the challenge of measuring efficiency savings in a complex environment which involved volume changes, price changes etc. JW articulated the challenge as 'PVEO' which considered an assumption on price, volume, efficiency and other. If a budget was set on this basis it was then relatively easy to measure and track changes. **The ICS financial plans** NF summarised the decisions from ICS board meeting a few days ago and made the following points; • The ICS has a combined total income of £1.4bn. This covered local CCG funding allocations of £1.1bn and some additional income from other areas, . Once this was spent, the only part of debate was which organisation reflected the over spend. Starting with a balanced budget in a new financial year was important to the system and at present there remained a small system gap. RP noted the Board's challenge was to reach two numbers; the control total for the trust and the control total for the system. The trust would only be rewarded for meeting the system control total but for that to be achieved required the Trust to hit its own control total.. There was much discussion as to whether the committee felt the Trust was yet in a position to sign off on the Trust Control Total. Whilst there were still issues to be resolved the consequences of not signing it off were significant, particularly in relation to future PSF funding. The decision to sign off had been delegated to PP, ND, NF and RP. **5 Year Plan** The committee spent some time reviewing the 5 Year plan and in particular the projected income in the light of the Heatherwood programme. It had always been agreed by the Board that a min cash balance of £50m was prudent and the forward view confirmed that this was achievable but did require cash releasing CIP's to be delivered as planned. **The financial strategy** The committee took time to discuss the financial strategy of the Trust. NF presented a high level view of the strategy dividing it into 4 areas; service optimisation, process optimisation, commercial optimisation and structural optimisation.

	C.I.P. 2019/20 HC presented the report noting the position was the same as the projection. As at 12 March £25.4m was being reported and £30.3m represented the full potential position. **Procurement** VJ provided a brief update noting that the KPIs were focused on contracts and pricing. Performance on efficiency was going well. There was still some work on pathology and catering to be done but there was a plan. CIPs had been delivered and internal investment was on track. **Capital Schemes** There were no schemes to approve at this meeting but RP requested that officers map out the timescales for these cases along with the benefits realisation cases and that ideally only one FBC or one benefits realisation case came to each meeting. If one off meetings were required to approve urgent cases then these could be convened.
Recommendation	The Board is asked to **NOTE** the summary.
Appendices	NA

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NHS
Frimley Health
NHS Foundation Trust

Report Title	Summary minutes for People Committee 2019
Meeting	Public board meeting
Meeting Date	-2019
Agenda No.	16.3
Report Type	For Information
Prepared By	Thoreya Swage - Chair of People Committee Susanne Nelson-Wehrmeyer - Company Secretary
Executive Lead	Janet King - Director of HR & Corporate Services
Executive Summary	This report briefs the board on the main items discussed at the inaugural meeting of the People Committee held on 5th April 2019
Background	The members were welcomed to the inaugural meeting of the people committee and the draft terms of reference were reviewed. It was agreed to add to the first bullet point reference to the national agenda and to consider the impact of Quality Improvement following completion of the strategy work. The introductory report to the People Committee was presented identifying the three key issues for focus including improving the Trust's stability index, supporting the delivery of an affordable and transformed workforce as well as approving the workforce plan and planning for future leaders. There followed discussion on the People strategy, created in 2017, which covered the period from 2018-2022 and had a focus on developing leadership, succession planning and talent management for 100 posts on and around tier 2 level and the possible inclusion of students in future workforce planning. The committee also noted the work on workforce at the ICS level where a number of initiatives are being discussed and implemented across the system. This included the streamlining of recruitment processes, mandatory and statutory training, occupational health and doctors in training to

	facilitate the movement of staff between different NHS organisations within the system. The Agenda for Change reforms were discussed where the band 1 posts have now been abolished and the actions to support affected staff are in place as well as how pay progression would be managed in the future. The draft workforce resourcing plan was discussed, highlighting the aim to recruit more nurses and doctors as well as reducing turnover during 2019/20. The National Staff Survey 2018 results were presented with improvements in four areas including relationships with immediate managers, the quality of appraisals, safety culture and staff engagement. More work was needed to be done to address the lowest rated issues (additional paid hours and discrimination at work from patients). Amendments to the annual planner included an annual report on education and training and communications plan with staff on people initiatives and surveys. The committee noted the requirements of the Kark review of the Fit and Proper Person test, Implications of the UK Corporate Governance Code and received a verbal report on the gender pay gap report.
Recommendation	The Board is asked to **NOTE** the summary.
Appendices	NA

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NHS
Frimley Health
NHS Foundation Trust

Report Title	**Update Summary from the Quality Assurance Committee, (QAC)**
Meeting	Public Board
Meeting Date	Friday, 3rd May 2019
Agenda No.	16.4
Report Type	Information
Prepared By	Mike O'Donovan, Chairman of the Quality Assurance Committee and Chris Jarvis, Interim Assistant Company Secretary
Executive Leads	Duncan Burton, Director of Nursing and Tim Ho, Medical Director
Executive Summary	This reports briefs the Board on the main items discussed at the 10th April 2019 meeting of the Quality Assurance Committee.
Background	**1. Maternal Safety** Comprehensive presentations were given by Members of Midwifery, Paediatrics and Neonatal Services covering the safety of maternity services and neonatal services within the Frimley Park and Wexham Park sites. The report on maternity services demonstrated risk management activity within the obstetric department outlining the incident reporting profile, including serious incidents requiring reporting and other related governance activity. The report on Neonatal Services presented the findings of a external review of the Trust's response to neonatal death serious incidents in 2017 to provide external reassurances to the Board that the appropriate measures had been undertaken in response to these cases and in implementing the recommendations arising from the review. **2. Performance Report Review** The performance Report for the period from February 2018 was presented, with the key issues being; • Actions already taken and the action plan in place to address the causes of recorded breaches in relation to mixed sex accommodation • Changes to the model of cleaning services at Frimley Park Hospital • The work being carried out in tackling the increase in Grade 2 Pressure

	Ulcers • A recorded improvement in response rates in relation to complaints at Wexham Park Hospital indicating that progress is continuing to be made • Benchmarking of Emergency Department four hour waiting. **3. Infection Control** The Medical Director presented a report providing the Quality Assurance Committee with an update on Trust healthcare associated performance for January to March 2019 in which it was noted that there had been a reduction in infection rates when compared to the same period in 2017/18. Other issues noted were the importance of ensuring a common approach across the sites by the Infection Control Teams and consideration of how assurance could be provided to the Committee in relation to hand hygiene and other issues associated with infection control . **4. Quality Account 2018/19** The draft Quality Report for 2018/19 was presented. It sets out; • Achievements in quality 2018/19, including a Statement on quality from the Chief Executive • Priorities for improvement and statement of assurance from the Board • Review of Quality Performance Members of the Committee commented on the Report, noted that it was still work in progress and were asked to give any further comments to its authors. **5. CQC Action Plan** The Committee considered a report on actions planned by the Trust in relation to mandatory training and also the provision of midwives as identified by the CQC . The Committee noted that Mandatory Training would be a key objective for each directorate and would be monitored through directorate reviews and the QAC. An enabling action is to maximise online training oporunities where effective and ensure that directorates provide rostered time for staff to complete. The Committee also noted that the Trust was committed to achieving optimum midwife to birth ratios in line with Birthrate Plus recommendations. It will develop and implement innovative recruitment and retention strategies. Maternity Services are currently participants in the NHSI recruitment and retention collaborative to support this work. **6. Patient Safety – update on key issues** Members of the Committee considered a paper on patient incident reporting to the National Reporting and Learning System. They were pleased to note that incident reporting times are reducing through the use of healthcare incident and risk management software.
Recommendation	That the Board note the update report.

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Report Title	**Summary report from the Performance & Remuneration Committee held on Thursday 11th April 2019**
Meeting	Public Board
Meeting Date	Thursday, 11th April 2019
Agenda No.	16.5
Report Type	For information
Prepared By	Susanne Nelson-Wehrmeyer, Company Secretary
Executive Lead	Dawn Kenson, Senior Independent Director and Chair of PRC
Executive Summary	The PRC met on Thursday 11 April 2019. The items considered included: - CEO progress report on Executive Directors' appraisals and objectives for 2019/20; - There was no central update available as yet on senior managers 19/20 remuneration award; - An update on the NHSI Board development programme which the Trust Board will be undertaking from May 2019 – March 2020; - Formal approval of the salary ranges for the new roles of Chief Operating Officer and Director of Transformation, Innovation & Digital Services; - A review of NED terms of office; - Progress update on talent management and succession planning; - Review of the draft Corporate Objectives for 2019/20; - Draft Remuneration Report for the 2018/19 Annual report; - Kark review of Fit and Proper Person Test; - NHS Confederation briefing note on Pensions Taxation.
Recommendation	To Note.

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ACRONYMS & INITIALISMS* BUSTER

A

A&E - Accident and Emergency
ACS - Accountable Care System
ACO - Accountable Care Organisation
AD - Associate Director
ADT - Admission, Discharge and Transfer
AfC - Agenda for Change
AGM - Annual General Meeting/Annual Governance Meeting
AHP - Advanced Health Professional
AKI - Acute Kidney Injury
AMM - Annual Members Meeting
AMR - Antimicrobial Resistance
AMU - Acute Medical Unit
AOS - Acute Oncology Service
ANP - Advanced Nurse Practitioner
AR - Annual Report
ASPH - Ashford and St. Peter's Hospital

B

BAF - Board Assurance Framework
BAU - Business As Usual
BBE - Bare Below Elbow
BME - Black and Minority Ethnic
BCF - Better Care Fund
BMA - British Medical Association
BMI - Body Mass Index
BoD - Board of Directors

C

CAMHS - Child and Adolescent Mental Health Services
CAS - Central Alert System
CAU - Clinical Assessment Unit
CCG - Clinical Commissioning Group
CCU - Coronary Care Unit
CDI - Clostridium Difficile Infection
CDIC - Commercial Development and Investment Committee
Cdif/C.Diff - Clostridium Difficile
CEA - Clinical Excellence Awards
CEO - Chief Executive Officer
CFO - Chief Finance Officer
CHC - Continuing Health Care
CHD - Coronary Heart Disease
CIO - Chief Information Officer
CIP - Continuous Improvement Plan
CoG - Council of Governors
CoS - Chief of Service
CoSec - Company Secretary
CoSRR - Continuity of Service Risk Rating
CPA - Care Programme Approach
CQC - Care Quality Commission
CQUIN - Commissioning for Quality and Innovation
CRAB - Copeland's Risk Adjusted Barometer
C.Section - Caesarean Section
CSU - Commissioning Support Unit
CT - Computerised Tomography
CTG - Cardiotocography
CVC - Central Venous Catheter

D

DBS - Disclosure Barring Service
DGH - District General Hospital
DH/DoH - Department of Health
DIPC - Director of Infection Prevention and Control
DNA - Did Not Attend
DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
DNAR - Do Not Attempt Resuscitation
DNR - Do Not Resuscitate
DoLS - Deprivation of Liberty Safeguards
DoN - Director of Nursing
DoO - Director of Operations
DPA - Data Protection Act
DSU - Day Surgery Unit
DVT - Deep Vein Thrombosis

E

E&D - Equality and Diversity
EAU - Emergency Assessment Unit
EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
ECG - Electrocardiogram
ECIST - Emergency Care Intensive Support Team
ED - Emergency Department
EDD - Estimated Date of Discharge or Delivery

EDMS - Electronic Document Management System
EEA - European Economic Area
EEG- Electroencephalogram
EHR - Electronic Health Record
EHRC - Equality and Human Rights Commission
EIA - Equality Impact Assessment
ELSCS - Elective Caesarean Section
EM - Emergency Medicine
EMLSCS - Emergency Caesarean Section
ENT - Ear, Nose and Throat
EOLC - End of Life Care
EOLCA - End of Life Care Audit
EPR - Electronic Patient Record
EPRR - Emergency Preparedness, Resilience and Response
ERS - e-Referral System (electronic)
ESD - Early Supported Discharge
ESR - Electronic Staff Record
ETP - Electronic Transmission of Prescriptions

F

FAC - Finance Assurance Committee
FBC - Full Business Case
FFT - Friends and Family Test
FH - Frimley Health
FHFT - Frimley Health NHS Foundation Trust
FOI - Freedom of Information
FPH - Frimley Park Hospital
FRR - Financial Risk Rating
FT - Foundation Trust
FTE - Full Time Equivalent
FYE - Financial Year End

G

GI - Gastrointestinal
GMC - General Medical Council
GMS - General Medical Services
GP - General Practitioner
GRE - Glycopeptide Resistant Enterococci

H

HAI - Hospital Acquired Infection
HASU - Hyper Acute Stroke Unit
HCA - Health Care Assistant
HCAI - Healthcare-Associated Infection
HDU - High Dependency Unit
HEB - Hospital Executive Board
HED - Healthcare Evaluation Data
HEKSS - Health Education Kent, Surrey and Sussex
HETV - Health Education Thames Valley
HH - Heatherwood Hospital
HICC - Hospital Infection Control Committee
HoN - Head of Nursing
HR - Human Resources
HSE - Health and Safety Executive
HSMR - Hospital Standardised Mortality Ratio
HTC - Hospital Transfusion Committee
HWB - Health and Wellbeing Board
HWD - Heatherwood
HWP - Heatherwood and Wexham Park
HWPH/H&WPH - Heatherwood and Wexham Park Hospitals

I

I&E - Income and Equity
IC - Information Commissioner
ICM - Integrated Case Management
ICP - Integrated Care Pathway
ICS - Integrated Care System
ICU - Intensive Care Unit
IG - Information Governance
IGT/IGTK - Information Governance Toolkit
IM&T - Information Management and Technology
IPCN - Infection Prevention and Control Nurse
IPCT - Infection Prevention and Control Team
IPR - Individual Performance Review
ITU - Intensive Therapy Unit/Critical Care Unit
IV - Intravenous

J

JAG - Joint Advisory Group

K

KPI - Key Performance Indicator

L

LA - Local Authority
LCFS - Local Counter Fraud Specialist

LD - Learning Disability
LHRP - Local Health Resilience Partnership
LiA - Listening into Action
LINAC - Linear Accelerator
LOS/LoS - Length of Stay
LUCADA - Lung Cancer Audit Data

M

M&M - Morbidity and Mortality
MADU - Medical Acute Dependency Unit
MAU - Medical Assessment Unit
MDT - Multi-Disciplinary Team
MHPS - Maintaining High Professional Standards
MIDU - Medical Investigations Day Unit
MIG - Medical Interoperability Gateway
MIU - Minor Injuries Unit
MRI - Magnetic Resonance Imaging
MRSA - Methicillin-Resistant Staphylococcus Aureus

N

NBOCAP - National Bowel Cancer Audit Programme
NCASP - National Clinical Audit Support Programme
NED - Non-Executive Director
NEHF/NEH&F - North East Hants and Farnham
NHS - National Health Service
NHS FT - NHS Foundation Trust
NHSE - NHS England
NHSI - NHS Improvements (formerly Monitor)
NHSLA - NHS Litigation Authority
NHSP - NHS Professional
NICE - National Institute for Health and Care Excellence
NICU - Neonatal Intensive Care Unit
NMC - Nursing and Midwifery Council
NNU - Neonatal Unit
NOGCA - National Oesophago-Gastric Cancer Audit
NRLS - National Reporting and Learning System/Service

O

O&G - Obstetrics and Gynaecology
OBC - Outline Business Case
ODP - Operating Department Practitioner
OHD - Occupational Health Department
OLM - Oracle Learning Management
OOH - Out of Hours
OP - Outpatient
OPD - Outpatient Department
OSCE - Observed Structured Clinical Exam
OT - Occupational Therapist/Therapy

P

PACS - Picture Archiving and Communications System
PACU - Post-Anaesthetic Care Unit
PALS - Patient Advice and Liaison Service
PAS - Patient Administration System
PAU - Paediatric Assessment Unit
PbR - Payment by Results
PCI - Percutaneous Coronary Intervention
PD - Practice Development
PDC - Public Dividend Capital
PDD - Predicted Date of Discharge
PE - Pulmonary Embolism
PEAT - Patient Environment Action Team
PFI - Private Finance Initiative
PHE - Public Health England
PICC - Peripherally Inserted Central Catheters
PID - Patient/Person Identifiable Data
PILS - Patient Information Leaflets
PID - Project Initiation Document
PLACE - Patient-Led Assessments of the Care Environment
PMS - Personal Medical Services
PMO - Programme Management Office
POD - Pre-Operative Department
POSSUM - Physiological and Operative Severity Score for the enUmeration of Mortality and Morbidity
PPE - Personal Protective Equipment
PPI - Patient and Public Involvement
PSED - Public Sector Equality Duty
PSF - Provider Sustainability Fund

Q

QA - Quality Assurance
QAC - Quality Assurance Committee
QI - Quality Indicator
QIP - Quality Improvement Plan
QIPP - Quality, Innovation, Productivity and Prevention
QIA - Quality Impact Assessment
QOF - Quality and Outcomes Framework

R

RAF - Risk Assurance Framework
RAG - Red Amber Green
RBH - Royal Berkshire Hospital
RCA - Root Cause Analysis
RCN - Royal College of Nursing
RCP - Royal College of Physicians
RCS - Royal College of Surgeons
RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RN - Registered Nurse
RSCH - Royal Surrey County Hospital
RTT - Referral to Treatment

S

SADU - Surgical Day Unit
SAU - Surgical Assessment Unit (FPH)/Surgical Assessment Unit (WPH)
SCAS/SCAmb - South Central Ambulance Service
SCT - System Control Total
SDIP - Service Development and Improvement Plan
SECAMB - South East Coast Ambulance Service
SH - Surrey Heath
SHMI - Summary Hospital-level Mortality Indicator
SHO - Senior House Officer
SI - Serious Incident
SIRI - Serious Incident Requiring Investigation
SIRO - Senior Information Risk Owner
SID - Senior Independent Director
SLA - Service Level Agreement
SLR - Service-Line Reporting
SLT/SaLT - Speech and Language Therapy
SME - Subject Matter Expert
SMR - Standardised Mortality Ratio
SoS - Secretary of State
SPS - Surrey Pathology Service
SSI(S) - Surgical Site Infections (Surveillance)
SSNAP - Sentinel Stroke National Audit Programme
SSS - Short Stay Surgical Unity
STF - Sustainability and Transformation Funding
STP - Sustainability and Transformation Plan/Partnership
SUI - Serious Untoward Incident

T

TACC - Theatres and Critical Care directorate
TIA - Transient Ischaemic Attack
TLC - Turn off, Lights out, Close doors
TMG - Theatre Management Group
TNA - Training Needs Analysis
TPN - Total Parenteral Nutrition
TTA - To Take Away
TTO - To Take Out
TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

UCB - Urgent Care Board
UI - Untoward Incident
UGI - Upper Gastrointestinal
UTI - Urinary Tract Infection

V

VfM - Value for Money
VSM - Very Senior Manager
VTE - Venous Thromboembolism

W

WAM - Windsor and Maidenhead
WHO - World Health Organization
WLI - Waiting List Initiative
WPH - Wexham Park Hospital
WTE - Whole Time Equivalent

Y

YTD - Year to Date

** An acronym is an abbreviation formed from the initial letters of other words and pronounced as a word (e.g. PIN, NICU). An initialism is an abbreviation consisting of initial letters pronounced separately (e.g. BBC, NHS).*