Royal Berkshire NHS Foundation Trust

CLINICAL SERVICES STRATEGY

March 2022

Compassionate | Aspirational | Resourceful | Excellent

Introduction

Royal Berkshire NHS Foundation Trust

Our Trust vision is *"working together to provide outstanding care for our community"*.

Our Clinical Services Strategy (CSS) sets out the guiding principles we will follow and the unique positioning we will take in designing clinical services to best meet the evolving needs of the community we serve. Its purpose is to guide how we prioritise our resources, investment, time and attention as we pursue our vision.

In January 2021, the Trust's Executive Management Committee asked for a new CSS to:

- Capture the learning from new ways of working during the Covid-19 pandemic
- Define how services might optimally be delivered and configured to guide the developing vision for our estate
- Support the continued development of integrated care and response to the NHS Long Term Plan
- Move towards prevention, reduce health inequalities and improve access to care
- Identify where we need to invest resources into enablers such as workforce, digital and equipment

The new CSS is a product of extensive engagement with our stakeholders:

- Internally, a set of common themes emerged from discussions with the clinical, nursing and operational leaders of our services (over 30 in all) and set the direction of travel
- External partners and patient representatives reviewed these themes and gave feedback at various stages, contributing to the refinement of the strategy
- Trust leadership provided input and steering throughout, through discussions with and review by care group leadership, senior nursing forums, the operations management team, the executive management committee and the Board of Directors

Reflecting this work, our new CSS articulates a set of key principles and enablers. Together, these position statements set the direction for the development of our clinical services, informing investment decisions and future planning over the next 10-15 years.

Overview

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The new CSS recognises that:

- People in our community are living longer, but frequently with an increasing number of complex physical, social and mental health needs
- General shifts in consumer behaviours are also changing how people expect to interact with our services—there is a growing desire for more immediate access to care, more information around their care and greater involvement in decision making

To deliver the highest quality of care, our services need to be:

- Designed around pathways that more explicitly wrap our care around the patient journey
- Organised to deliver the right level of care, through the right channel, at the right time
- Personalised to individual needs by harnessing the power of digital innovation
- Accessible and inclusive to all
- Delivered by highly trained multidisciplinary teams

To meet the increasing needs of our population:

- We need to work seamlessly with a wide range of partners to ensure a joined up ‘one NHS’ is experienced by patients, the community and staff
- Build a relationship with our community throughout their lives, which focuses as much on prevention and supporting people to live well as it does on responding to periods of crisis

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Principles

Position statements indicating the key levers we will pull to deliver our vision.

- We will provide the highest quality care
- We will streamline our services to align with patient needs
- We will promote wellbeing and adopt a posture of prevention
- We will reach patients where it's best

We will provide the highest quality care

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Why?

As an organisation, our vision is 'working together to deliver outstanding care for our community.' By committing to providing the highest quality care, we honour the trust patients place in us to stay safe when they are most vulnerable, and make optimal use of valuable public funds and resources.

What this looks like:

Ensure care is **safe**:

- Prevent medical errors and avoidable adverse events
- Foster a culture of openness where we are willing to identify issues early, address them and learn from them

Deliver care **effectively**:

- Commit to a Getting It Right First Time (GIRFT) approach across all pathways
- Establish a culture of continuous quality improvement
- Meet and exceed national standards and expectations

Cultivate a **culture of excellence**:

- Imbue every aspect of our care with our values (Compassionate, Aspirational, Resourceful, Excellent)
- Commit to organisational excellence in how our teams are led, how they function, behave and collaborate, and how they steward resources
- Continue to grow our activity in research, clinical trials and innovation

Achieve **optimal outcomes**:

- Apply robust outcomes tracking and reduction in variation, using high quality and accurate data to drive positive change
- Eliminate health inequalities
- Capture, track and enhance the patient experience
- Obtain external validation (e.g., CQC 'outstanding')

This allows us to be:

Safe	▪ Safety measures directly targeted and optimised
Effective	▪ GIRFT approach implemented across all pathways ▪ CQI approach adopted across the organisation
Caring	▪ Trust values embedded across all aspects of care
Responsive	▪ Robust ability developed to capture and respond to measures of quality, safety, outcomes, patient experience, etc.
Well-led	▪ Organisational culture established embodying all aspects of our CARE values

We will streamline our services to align with patient needs

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Why?

As the prevalence of comorbidities and long term conditions rises, the health needs of those we serve are becoming increasingly complex. Adapting to these shifting needs by organising our services around pathways of care positions us to achieve the best outcomes consistently and efficiently.

What this looks like:

Organise services into three areas—**prevention & management**, **planned interventions** and **emergency care**

- From a coordination perspective, **these areas must join up**:
  - **With each other** to allow rapid escalation/de-escalation of care within the Trust
  - **With the system** to allow seamless transitions into and out of the Trust, connection to a broad system, and a joined-up 'one NHS' experience of care
- From an estate perspective, **these areas should be distinct**:
  - Clear physical separation between 'hot' and 'cold' spaces for greater safety, infection control, efficiency and focus of work

In each area, establish **patient pathways** focused on efficiently delivering the **optimal level of care**

- Organise services to simplify the patient journey rather than to align with specialties operating as independent 'islands'
- Adopt multidisciplinary workforce models that:
  - Support patients with **increasingly complex physical and mental health needs**
  - Are aligned to the **different levels of care in each pathway** (e.g., intensive care vs. same day emergency care)
  - Enable teams to be flexible in personalising care to individual needs
- Build and improve processes to free clinical teams to focus on providing care (e.g., improve streaming of referrals to secondary care through co-production of pathways, expand diagnostic capability across our sites, build digital integration and fluidity)

Adapt our offering as the population's health needs evolve

- Monitor health trends (e.g. in volume, complexity) to identify needs and opportunities
- Actively develop our service offering in line with these shifting needs, coordinating with partners to maximise the system's ability to meet the needs of its broader population while ensuring we continue to bring care closer to home
- Engage and leverage large clinical networks and provider collaboratives as appropriate
- Expand investment into prevention and chronic disease management, integrating with partners such as primary care networks and public health (see also subsequent slides)

This allows us to be:

Safe	▪ Improved infection control ▪ Reduced variation in outcomes ▪ Greater consistency and standardisation
Effective	▪ Minimised waste, simplified care journey, greater efficiencies and productivity, more joined-up approach
Caring	▪ Staff at all levels empowered to connect with and support patient progress ▪ Improved patient satisfaction
Responsive	▪ Care structure aligned with patient journey rather than the opposite
Well-led	▪ Stronger sense of identity as an organisation (as opposed to collection of specialties) ▪ Increased investment into prevention & management

We will promote wellbeing and adopt a posture of prevention

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Why?

As long term conditions become more prevalent, we need to adapt our approach to supporting the health needs of our community, moving from episodic "sick care" to longitudinal "health care"—focusing our services predominantly on acute needs is unsustainable. We will do more to actively support individuals to improve their wellbeing and prevent chronic disease.

What this looks like:

- Approach **every encounter as an opportunity** to **promote healthy behaviours**, **empower patients to co-manage** their health and wellbeing and if necessary, **intervene** to prevent conditions from developing or progressing
- Focus on tackling the well-established risk factors for chronic disease (e.g. diet, physical activity, weight, smoking, alcohol use), to try and **avert the onset of preventable disease**
- Support patients who are living with morbidity or comorbidity to "live well with their condition(s)", **preventing or slowing the progression of disease**, as well as reducing the risk of long-term complications / acute episodes
- Collaborate with our partners across Berkshire West and the Thames Valley to **progress population health management**, **tackle health inequalities** and **support mental health**, working to engage with service users, particularly those from minority demographic / deprived communities, in designing service improvements
- Promote **rapid flow through our services** and a **bias away from admission**, within strict safety controls, to prevent unnecessary escalation in the acuity level of a patient's treatment, minimise potential for hospital-acquired conditions and avoid "institutionalisation" (e.g., support investment in same day emergency care, rapid community discharge, direct admission)
- Become **environmentally sustainable** and work towards a net zero carbon footprint to reduce our contribution to pollution in the community, leading to improved health conditions for the population

This allows us to be:

Safe	▪ Reduced avoidable worsening of conditions and health issues ▪ Patients spend less time in hospital ▪ Minimised infection risk
Effective	▪ Reduced admissions through increased activity earlier in patient journey
Caring	▪ Patients spend more time enjoying a high quality of life
Responsive	▪ Services organised to catch and address issues early to avoid complications and worsening of conditions
Well-led	▪ Financial savings delivered through improved outcomes unlocks further reinvestment into patient services

We will reach patients where it's best

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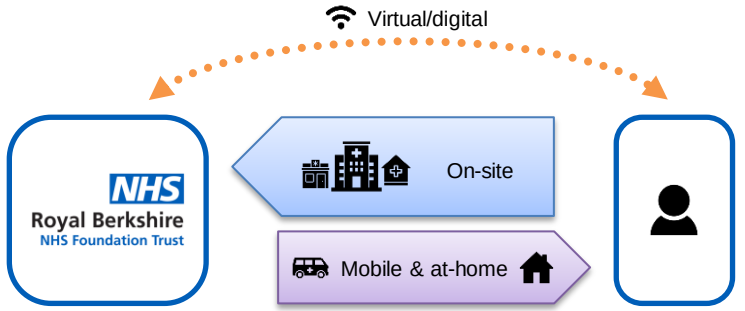
Why?

As we move to design our services around pathways and toward prevention, we also need to shift from encounter-based care to relationship-based care which requires better access, convenience and frequency. Our current estate is not optimised for this, as we struggle to manage current demand and address inequalities in access and outcomes—we must innovate our care model accordingly.

What this looks like:

Three channels of delivery:

- Deliver care through a combination of **physical sites**, **virtual/digital care**, and **at-home/mobile in-person care**, to:
  1. Support patients closer to home
  2. Enhance our capacity to deliver longitudinal care
  3. Allow patients to be more involved in managing their care (e.g., patient-initiated follow-up, patient portal)
  4. Spread demand for lower acuity/complexity care away from high-acuity sites and free up resources/capacity
  5. Enable optimal deployment of staff across our footprint
  6. Build efficiencies into pathways (e.g. NHS 111 triaging)



Investment:

- Significant investment in digital solutions, education, and operational excellence to implement three-pronged delivery model

On-site care:

- When on-site care is required, channel delivery away from the high acuity site towards a combination of (as appropriate):
  - Smaller and lower acuity sites
  - Shared primary care / RBFT health centres
  - Other offsite premises
- When care on the main acute site is needed, utilise the lower acuity settings to their fullest potential, reducing demand for high acuity / complexity space (e.g., SDEC)
- Maintain a 'bias to discharge', within strict quality parameters, to return patients back to the safety and comfort of their homes as soon as possible
- Leverage digital to optimise efficiency and 'intelligence' of on-site care, patient flow, quality of care, and resource prioritisation (e.g. deploy AI and intelligent automation in procedures, processes, equipment tracking, pathway optimisation, etc.)

This allows us to be:

Safe	▪ Care is delivered in setting that is safest for the patient ▪ Greater access to care allows issues to be caught sooner ▪ Reduced strain on high-acuity sites
Effective	▪ Right level of care is provided to the right patient at the right time: higher-acuity staff can focus on those who need these services the most, while other cases seen sooner
Caring	▪ Increased access to services empowers patient ▪ Greater ability to accommodate the most vulnerable ▪ Positive impact on the environment
Responsive	▪ Three-pronged approach to care delivery allows Trust to expand its reach and address a broader set of needs
Well-led	▪ Improved utilisation of resources

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Enablers

Position statements highlighting the critical factors to successfully delivering our principles.

- We will prepare our workforce for tomorrow
- We will work as a team with our partners
- We will build a physical environment that supports healing
- We will leverage technology to its full potential

We will prepare our workforce for tomorrow

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Why?

Our ability to pursue the CSS principles will depend on developing a flexible and motivated workforce that is aligned to multidisciplinary pathways of care, deployed across multiple delivery channels and skilled in prevention as well as treatment of disease.

What this looks like:

Culture

- Strengthen our position as a great organisation to work for through our RBFT People Strategy

Development

- Promote 'upskilling' and cross-training to improve the flexibility and adaptability of our workforce
- Continue to enhance our clinical training and education portfolios, both internally and in collaboration with key external partners such as the University of Reading (e.g. establishment of a UoR clinical school)
- Align our skillset to support the growing number of patients with complex conditions, mental health needs and learning disabilities

Digital

- Deploy digital solutions that enable clinical staff to work to the top of their license and reduce the administrative burden
- Develop digital literacy and data science skills across our workforce

Care model innovation

- Adopt multidisciplinary models of work and learning that are aligned to pathways of care designed to address complex needs
- Invest in developing innovative roles and skills that support our shift towards prevention and management of chronic conditions
  - E.g., Clinical roles that cross boundaries across the system, joint provider posts, non-medical clinical roles (e.g., PAs, NPs), non-clinical roles (e.g., health coaches, care coordinators)
- Take an active role in innovating around the design, training and development of the 'clinical team of tomorrow' by building on our partnership with the University of Reading

This allows us to be:

Safe	▪ Highly trained, highly skilled staff
Effective	▪ Regular flow of new clinical insights and evidence to inform our care ▪ MDTs working collaboratively to deliver seamless pathways of care
Caring	▪ Increased opportunities for patients to participate in ground-breaking studies ▪ Patients cared for by best possible staff
Responsive	▪ Increased agency in shaping workforce to evolving needs of population ▪ Flexible and adaptable workforce
Well-led	▪ Improved staff engagement, motivation, morale ▪ Improved recruitment and retention

We will work as a team with our partners

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Why?

We cannot deliver our ambitions by working in isolation. We depend on close collaboration with our partners to build integrated pathways, move into prevention and bring care closer to home in a seamless experience that eliminates disjointed transitions across organisational boundaries.

What this looks like:

- Strengthen collaboration with our partners in **primary**, **community**, **acute** and **social care** across Berkshire West and the wider Thames Valley, and with **local authorities**, **public health, patient advocacy groups** and the **voluntary sector**, working to foster an environment that supports the shared pursuit of our common agenda
- Proactively drive the integration of our collective services to improve outcomes, deliver a seamless experience of care, and operate more efficiently as a system; engaging around such areas as:
  - Cross-boundary clinical pathways (geographical and organisational)
  - Determining the optimal setting of care for patients
  - Transitions in care / seamless hand-offs
  - Population health management
  - Health inequalities
  - Shared care records and information flow
  - Mental health
  - Outpatients transformation
  - Musculoskeletal, Ophthalmology, Cancer and other clinical networks
  - Shared roles and investment to support prevention and management
- Continue to build our clinical education, academic and research portfolios through our partnership with the **University of Reading**
- Engage in partnerships and commercial opportunities across **the public and private sectors** to drive innovation, research, quality improvement, service development, training, and other improvements to patient care

This allows us to be:

Safe	▪ Increased accountability through strong, transparent and collaborative system relationships
Effective	▪ Improved know-how and insights leading to better outcomes
Caring	▪ Improved patient experience and satisfaction
Responsive	▪ Population needs met more rapidly and managed more effectively as system partners collaborate
Well-led	▪ Better resource use across system ▪ Strong R&D and innovation activity

We will build a physical environment that supports healing

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Why?

A high quality built environment that is designed around people and their needs will enable, rather than hinder, healing and recovery for patients. It will improve the experience for staff, promote safe and efficient care delivery, and support the wider community with convenient access to services.

What this looks like:

Human-centred spaces

	Design a built environment to:
For patients	▪ Minimise noise and light pollution to foster a peaceful environment conducive to rest, sleep and recovery ▪ Protect patients' privacy, sense of security and dignity ▪ Encourage and enable patients to regain physical activity, mobility and independence as quickly as possible ▪ Maximise the accessibility of our facilities ▪ Reduce risk of hospital acquired infections
For visitors, families and loved ones	▪ Reflect the importance families and visitors play in healing, comfort and avoiding loneliness ▪ Provide space to visit, rest and recover from long visits that can take a significant toll ▪ Ensure spaces are easy to navigate, featuring inclusive wayfinding ▪ Avoid exposure to sick patients in public spaces
For staff	▪ Promote efficiencies in staffing, time and motion through strategic 'zoning' that aligns our spaces to patient pathways and drives productivity ▪ Future-proof our spaces by designing for flexibility and adaptability ▪ Foster a learning culture by creating strategic adjacencies between teams and through purpose-built spaces for formal education and training ▪ Provide areas where staff can decompress, socialise and access outdoor greenspaces in privacy ▪ Embed technology into our physical space to improve staff's ability to monitor patients while also enabling higher single bed ratios, quiet and privacy for patients

This allows us to be:

Safe	▪ Improved infection control ▪ Quieter and more peaceful environments protect patients and staff from adverse effects of avoidable stressors
Effective	▪ Improved outcomes through application of evidenced-based design principles ▪ Faster recovery times
Caring	▪ Improved privacy protects each person's dignity ▪ Human environments that reflect our CARE values
Responsive	▪ A built environment design that aligns service delivery with the patient journey ▪ Flexible space that adapts to shifting needs
Well-led	▪ "Zoning" for efficient use of resources and asset management ▪ Space that supports a culture of learning and innovation

Spaces that connect with nature

- Provide ample access to natural light and ventilation
- Maintain easy access to green spaces, views of nature
- Maximise energy conservation, efficient use of resources and environmental sustainability

Spaces that enhance social value in our community

- Ensure our physical footprint remains easily accessible to our community through multiple means of travel
- Support the local economy by developing a footprint that encourages investment into the community, increased footfall into commercial hubs and strategic partnerships that elevate the region's national profile
- Locate a selection of health services in highly-frequented commercial areas so that people's daily shopping routines create opportunities to promote healthy behaviours, help manage conditions, and catch issues early

We will leverage technology to its full potential

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Why?

As technology increasingly becomes a core component of all our services, accelerates our ability to care effectively and efficiently, and unlocks new ways of creating value for our patients, it is becoming ever more important to focus our efforts in this space so that digital becomes an enabler to delivering the four principles of the CSS, rather than an obstacle.

What this looks like:

RBFT's digital strategy focuses our work around five strategic themes, underpinned by two crosscutting themes:

1. Improving quality and safety
   - Develop our digital systems into a fully clinical and operational management system
   - Leverage EPR empowered analytics, timely data and device integration to enhance decision-making and personalise care and support CQI initiatives
2. Enabling integration and service development—*Support teams to provide care outside of the four walls of the hospital in partnership with primary, community and social care:*
   - Develop purpose-built virtual care programme
   - Empower in-person at-home care through digital (analytics and insights supporting logistics, blended in-person / virtual care, etc.)
   - Develop the interoperability and integration of clinical systems to support distributed care and system-wide pathways
   - Better utilise analytics of patient data generated across the system to inform and improve population health management
3. Empowering patients—*to become more active participants in their wellbeing and to co-manage greater portions of their care:*
   - Expand the ways patients can access care virtually and improve their digital experience (e.g., integrated experience across video, phone, text, app, Patient Portal, booking and check-in)
   - Adopt innovative tools and solutions that help patients adopt healthy behaviours and manage conditions, integrating these into our clinical pathways
4. Designing digital into our built environment
   - Research and embed innovative digital solutions when building new estate
   - Integrate clinical and corporate IT systems
5. Productivity through intelligence, innovation, partnerships and clinical research
   - Build capabilities to produce real-time insights about our performance (e.g., dashboards fed by EPR)
   - Develop our data science capabilities across descriptive, diagnostic, predictive and prescriptive analytics
   - Leverage systems (e.g., artificial intelligence, intelligent automation) to free up time for staff to spend on value-add activity and optimise our pathways
   - Support clinical innovation, commercial innovation and scientific research

Two crosscutting supporting themes:

1. Digital education and ensuring ease of use, enabling staff to work to the top of their license
2. Continued investment into infrastructure

This allows us to be:

Safe	▪ Right information delivered at the right time in clinical care ▪ New capabilities developed around safety (continuous outcomes monitoring, PHM, etc.)
Effective	▪ New treatments and models of care unlocked ▪ Reduced administrative burden leads to more efficient use of clinician time ▪ Optimised and enhanced clinical services (e.g., AI) ▪ Trust's reach expanded
Caring	▪ Clinicians able to spend more time interacting with the patient ▪ Patients empowered to co-manage their care ▪ Improved accessibility ▪ Good UX / UI ▪ More individualised care
Responsive	▪ Real-time monitoring of population health needs ▪ Real-time monitoring of clinical and operational workflows
Well-led	▪ Improved resource use management and planning ▪ Culture of innovation ▪ Reduction in wastage

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Our strategy in practice

The following slides describe ways in which the CSS's principles and enablers can be applied to adapt our services, followed by an overview of where we intend to focus our efforts to build momentum in delivering the CSS over the immediate and near term.

Care along the stages of life

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To align our services to the patient journey, we will:

Ensure our consistent levels of care deliver adaptive services and pathways **reflecting the changing nature of health care needs** through the key stages in life

- E.g., Emergency care (Paediatric ED vs RACOP)
- Inclusive towards patients with special needs (mental health conditions, learning disabilities, autism, dementia)

Adopt a **lifetime 'Relationship Management'** mentality:

- Our relationship with a patient and their loved ones doesn't begin and end with an encounter
- At each encounter through the stages of life, approach patients as individuals deserving best service (rather than 'users' receiving free services as a courtesy / obligation)
- Focus on families and early years of childhood; foster engagement with their health throughout life stages (e.g., through early learning centres and schools)
- Leverage this approach to reduce health inequalities and promote partnership working across the system

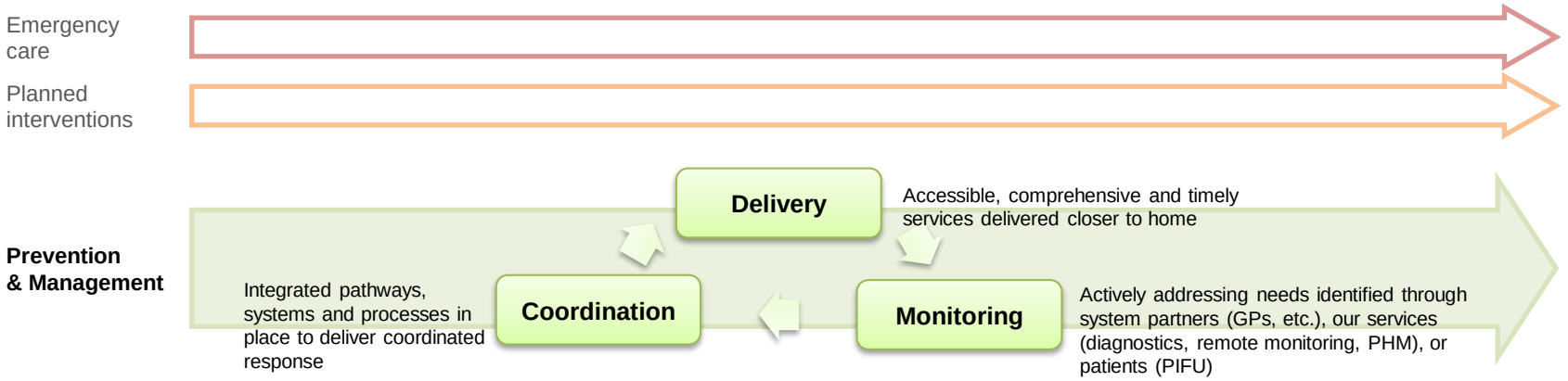
Collaborate strategically across each stage

- Services across the system are disjointed / fragmented in different ways at each stage; collaborate to identify and close these gaps appropriately
- E.g., Joined up delivery of mental health services across community / primary / secondary care among young people

Pay special attention to transitions between each stage

- Seamless work/information sharing and collaboration across Trust and system to identify appropriate transition time and execute intentionally (e.g., rather than default cut-offs)
- Equip / inform / empower patient throughout these critical junctures
- E.g., Support young people to learn to manage their own care and be in control, ensure seamless transition into adult services focused on individual needs

Prevention & management



We work together to prevent the onset of disease and support patients with long-term conditions to stay well by:

Offering services that are **accessible**

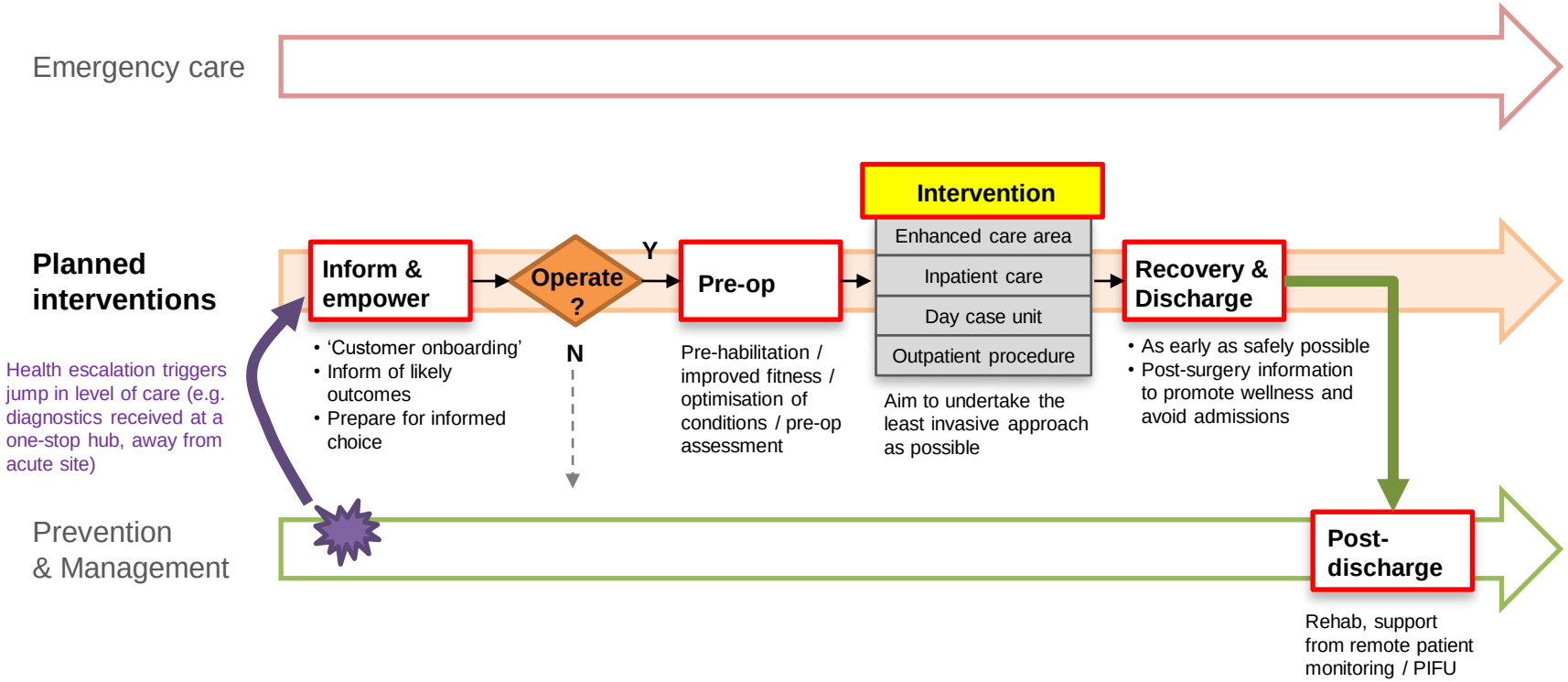
- **On-site care** provided in community settings, primary care, ambulatory care sites, drop-in centres and other non-healthcare settings
- **Virtual care** delivered through video, phone, text, app/chat, internet, connecting into a comprehensive patient portal
- **At-home** or **mobile care** (e.g., vans) delivered in-person

Collaborating with our partners to deliver a **'One NHS' experience of care**

- Patients shouldn't be able to tell where primary care ends and secondary care begins
- Much greater blurring of physical, process, and organisational boundaries between partners
- Seamless work / information sharing across the system allowing active and prompt identification & management of needs
- Partners work together to simplify journey for patient (e.g., GP referrals, NHS 111 pathway optimisation)

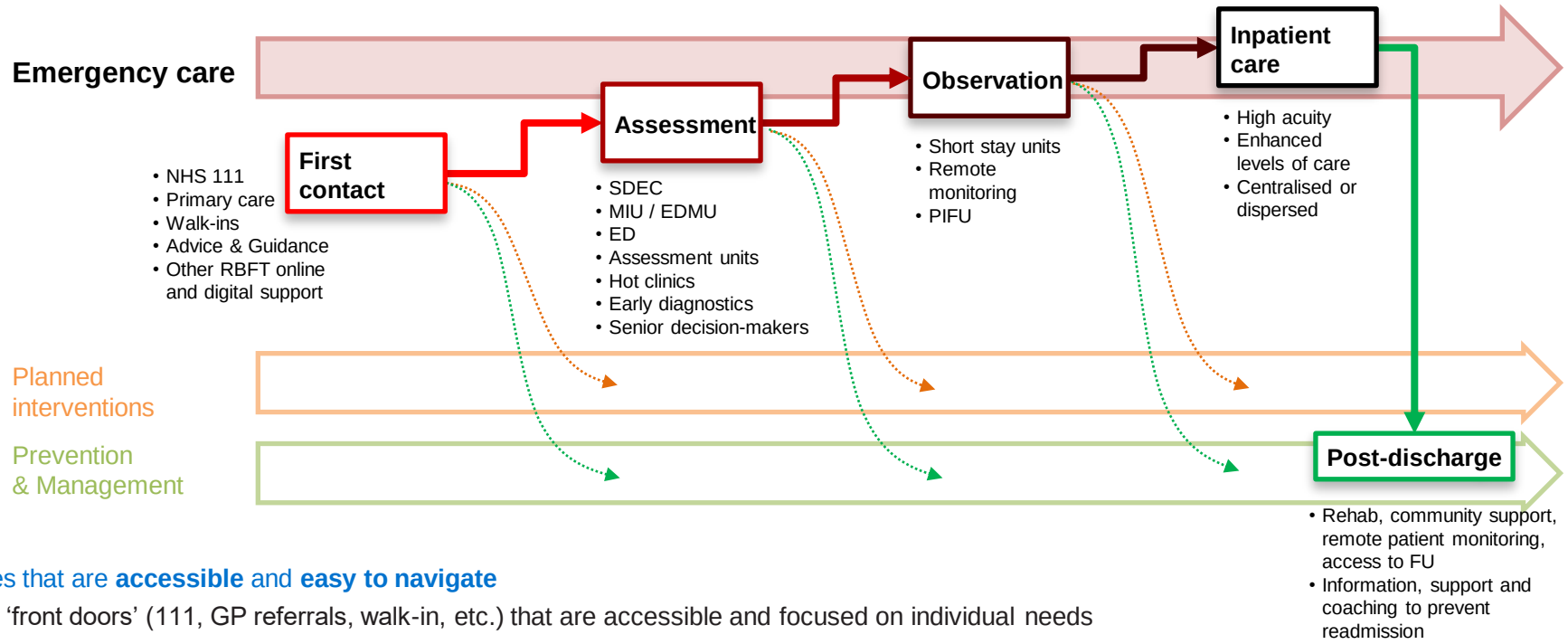
Making the most of every opportunity to empower the patient to co-manage their care (e.g., education/information, patient portal, PIFU, etc.)

Planned interventions



- Decision for surgery / intervention is **a trigger for a system wide response** across a perioperative pathway, focusing on shared decision making, optimising health and lifestyle in the perioperative period to maximise the positive impact of the intervention.
- Pathways are defined by **levels of care required** (e.g. day case vs. inpatient), opting for the least invasive and most local option that delivers a high quality outcome. This allows the Trust to cohort expertise, skills and resources, which optimises delivery to be efficient, cost effective and scheduled. Patients and carers receive clear communication around the expected timelines and support they will need at home, in turn reducing the frequency of cancelations.
- Volume of inpatient care required is maintained at relatively fixed levels, while accepting that those patients who do require inpatient care will be more complex and require a higher degree of monitoring, as well as a multidisciplinary approach to their care.
- Focus is maintained on **minimising length of stay**, safely discharging patients to their home with appropriate monitoring, support and knowledge.

Emergency care



Critical services that are **accessible** and **easy to navigate**

- Several 'front doors' (111, GP referrals, walk-in, etc.) that are accessible and focused on individual needs

A **streamlined pathway** that simplifies the patient experience

- Rapidly funnels patient to the most appropriate clinical team and optimal level of care and reduce duplication of assessments
- Comprehensive suite of offers to segment demand (EDMU, MIU, HDU, etc.)
- Minimise demand for high-acuity space and inpatient care (maximise SDEC and supported care at home)
- Those who are admitted will have higher care needs

A service that is **interconnected with our partners**

- Improved connectivity, visibility and flow from community to the Trust
- Develop shared EPR to support pathways, decision making and flow through different care settings across the system
- Work with the PCNs and integrated services to ensure we consider long term physical and mental health needs, opportunities for screening and educating / empowering patients and families—**every contact is an opportunity** to improve long term health & wellbeing
- Support and collaborate with PCNs to manage 'urgent care' needs in the community (illnesses or injuries that require urgent attention but are not life-threatening)

Looking ahead—cross-cutting initiatives

Significant activity is already in motion which can be built upon over the next 12-18 months as we begin to deliver the CSS:

- Strategy development:
  - **Provide the highest quality care**: Progress the work to build a culture of continuous quality improvement across the Trust
  - **Preparing our workforce for tomorrow**: Progress work on the people strategy, education strategy and strategic partnership with the University of Reading
  - **Working as a team with our partners**: Work with colleagues across Berkshire West and the Thames Valley to develop a shared vision for collaboration that highlights specific areas where integration can be achieved at pace and yield high returns (e.g., exploring provider collaboratives around elective care)
  - **Leveraging technology to its fullest potential**: Progress work on developing and delivering our new digital strategy
  - **Reflect the changing nature of health care needs along the key stages in life**: Deliver the new children and young people's strategy, develop a maternity/women's health strategy and an ageing well strategy
- Service development:
  - **Streamlining services to align with patient needs**:
    - Link in with estates to help reorganise how services are physically configured around pathways, separating emergency services from planned services and facilitating new ways of working
    - Plan how we might develop the ability to proactively optimise our portfolio of services as the population's health needs evolve, accounting for factors such as the establishment of provider collaboratives, collaboration with the independent sector and integration with partners in community care and social care
  - **Reaching patients where it's best**:
    - Continue to develop a vision for outpatient care that brings care closer to home
    - Determine our model for mobile/at-home care and virtual care
    - In light of the above, develop a long-term vision for the Royal Berkshire Hospital site in Reading that determines which pathways to deliver in addition to high-acuity, high-complexity care, particularly around areas such as lower-complexity outpatient procedures, diagnostics and day case surgery

Looking ahead—by service area

- **Prevention and management**:
  - Determine our model for mobile/at-home care and virtual care (see previous slide)
  - Establish a clear vision for location of care that is to remain on-site (e.g., what is delivered in other RBFT locations, in the community, with GPs, in new drop-in centres, etc.)
  - Work with primary care partners to establish a shared vision and model for collaboration, clarifying roles and expectations and planning how we will co-deliver shared goals around prevention, chronic disease management and other interdependencies in the delivery of acute care
  - Progress our partnership with Public health
  - Deliver our patient portal and build on this to develop a suite of curated digital tools for patient co-management of their care
- **Planned interventions**:
  - Progress the preoperative programme of work to expand into a perioperative programme across multiple pathways, driving use of technology, health coaches and patient co-management
  - Determine vision for enhanced care areas (once hot block has been developed and ring-fenced—see below) including questions of ownership and integration of pathways
  - Develop an approach to shift volume from inpatient to day-case to outpatient, establishing a model for reaching the target of 85% of surgical activity being delivered as day-case. Explore the implications (e.g., on estate) of setting up a dedicated pathway to accomplish this.
  - Gain a clear understanding of interdependencies between services to understand which services must be co-located, especially as we move to separate planned services from emergency services
- **Emergency care**:
  - Progress work to plan the development of a new 'hot block' in lockstep with our work for the New Hospitals Programme, as well as the model for acute care across each level of care (e.g., single-organ level 1, co-located levels 2-3)
  - Develop our model of outreach and support for primary care—e.g., around advice and guidance
  - Develop SDEC model across all pathways, supported by remote monitoring and virtual wards, as well as exploring the potential to develop off-site SDEC and UTC locations in the community
  - Understand the interdependencies between services and plan accordingly to optimise efficiency of delivery for emergency care, including development of a plan for diagnostic support (incl. POCT / hot lab / imaging) and for theatre capacity and design