

# **NHS Frimley**

## **Integrated Care Board**

Annual Report and Accounts  
**2024-2025**

# Reflecting on the year gone by

## Top performing organisation amidst an environment of change and challenge.

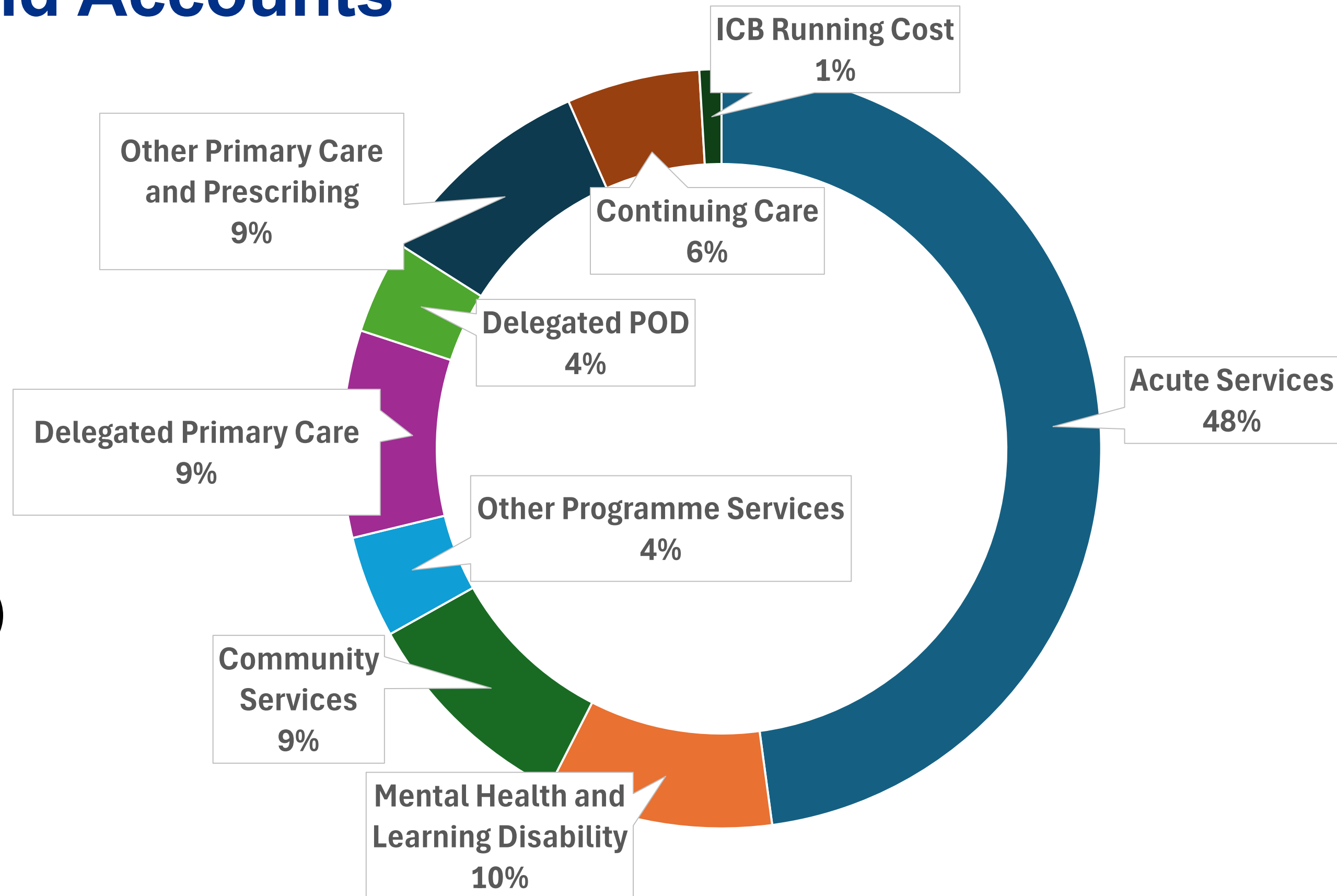
- Started the year with a challenging financial position
  - New Hospital Programme announced with Frimley Park Hospital to be in phase 1
  - NHS Frimley and Frimley Health and Care Integrated Care System continued to be a high performing system, often leading national leaderboards
  - Release of the Lord Darzi review and the Government's Three Shifts signaled a change of directions for the NHS and Integrated Care Boards
  - Fiona Edwards, Chief Executive, left NHS Frimley to join the NHS England national team
  - We have reached out to our communities to listen and engage and understand what matters most to them.
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- Throughout the changes and challenges, NHS Frimley continues to be at the forefront of innovation, tackling health inequalities head on and cultivating strong partnerships across the Frimley Health and Care system and beyond.

# Annual Report and Accounts

Total expenditure:  
**£1,679.3m**

Spend per person:  
**£1,971**

Financial surplus:  
**£27,000**  
(2023-24 deficit = £14.7m)

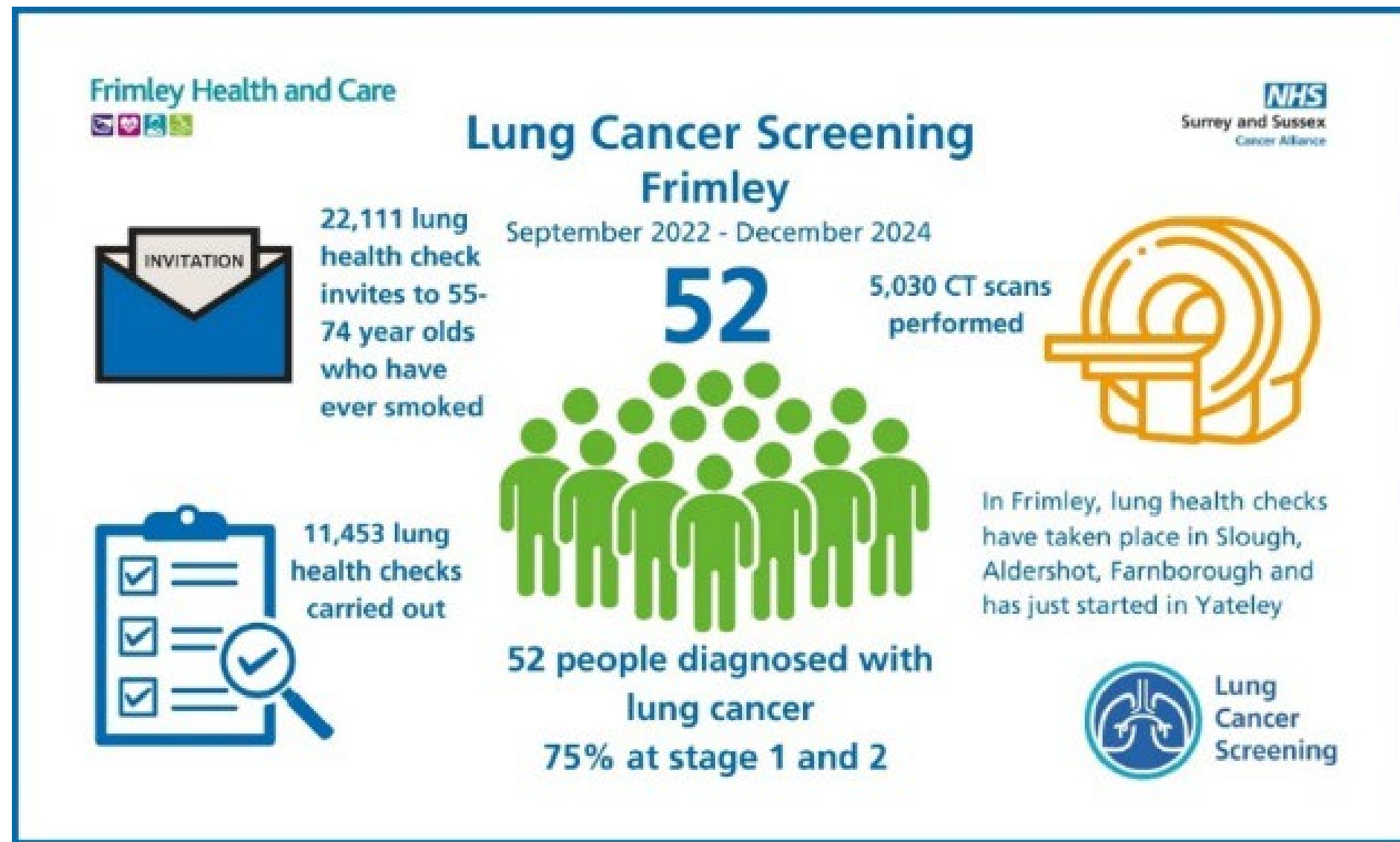


# Improving health outcomes for our communities

Throughout 2024-2025 NHS Frimley collaborated with communities, partners, local authorities, providers and voluntary, community and social enterprise organisations to better understand and improve health and care for the people we serve.



Winter vaccination programme.



Lung cancer screening programme.



Reconnect, Reset, Rebuild.



Bracknell Forest Centre for Health.

# Community Pharmacy



## Pharmacy First: increasing access, preventing ill health and improving collaboration and integration

- Over **81,000 consultations** occurred through community pharmacies with 100% General Practice participation.
- More than **5,000 GP appointments released**, easing pressure on general practices further supporting proactive care and urgent patient need.
- **Minor Ailments Management:** sore throat was the most common condition seen, with over **10,500 consultations** managed by community pharmacists.
- **Preventive Health Monitoring:** over **33,000 blood pressure checks** were conducted, identifying 8% of patients needing further Ambulatory Blood Pressure Monitoring (ABPM) investigation.

## Frimley is part of a national programme piloting further opportunities for community pharmacy clinical services using independent prescribing.

*“Being part of the IP Pathfinder programme has been an empowering experience. It’s enabled us as community pharmacists, to directly manage patient care, reduce pressure on general practice and bring a more agile, walk-in model of care to the heart of the community. It’s clear that this is not just a pilot – it’s the future of accessible, high-quality primary care.”*

Yousef - Independent Prescribing Pharmacist - Maidenhead

# Virtual wards

## Supporting the Left Shift and care closer to home strategies

Our Virtual wards aim to deliver care earlier in the pathway; support people in their homes and communities; prevent crises before they escalate; and aligns with the 10-Year Health Plan and Frimley ICS ethos.

### Key successes:

- High patient satisfaction (“I felt safe, supported, and cared for at home”), with 90% of patients treated safely at home without escalation. Faster recovery and maintained independence.
- Reduction in hospital admissions - 24,484 patients admitted to virtual wards (as of 26 Aug 2025)
- Improve flow and discharge - 22,118 patients discharged to date (as of 26 Aug 2025) with average length of stay between 1-4 days.
- Expanding remote monitoring and virtual consultations - currently Frailty and UEC linked with remote monitoring. Focus on building resilience and scalability for future demand.
- Plans progressing on the development of a virtual hospital.

# Virtual Wards: patient case studies

## Case study one: Frailty South Virtual Ward

- 78-year-old man with advanced frailty, Multiple System Atrophy and recurrent aspiration pneumonia; non-verbal but decision-capable, cared for at home by his wife who wished to avoid hospital.
- From May 2022, five serious episodes were treated entirely in the Frimley Virtual Ward with IV therapy, remote monitoring and multidisciplinary input.
- Patient avoided hospital admissions, enabled holistic support and advance care planning. Patient passed away peacefully at home in March 2024, in line with his wishes.




## Case study two: Oncology

- 53-year-old woman with Stage 2 ovarian cancer, recently completed chemotherapy.
- Presented with neutropenia and anaemia after ED assessment; treated with IV antibiotics, Filgrastim and fluids, then discharged directly to the Oncology Virtual Ward with oral antibiotics and close monitoring.
- Patient experienced rapid blood count recovery, avoided hospital admission and remained safely at home with multidisciplinary oncology support, demonstrating effective acute care and improved patient experience.



# Cardiovascular Disease Prevention

The hypertension programme aims to ensure 80% of patients are treated in line with NICE guidance by March 2025, helping to reduce heart attack and stroke risk — the leading causes of hospitalisation and mortality linked to hypertension.

- Current achievement is 74.4% (Connected Care data), showing year-on-year improvement.
  - CVDPprevent data reports 71.7%, reflecting national variations in methodology; local work is underway to align data sources.
  - Hypertension control (HYP007) at 71.7% is significantly above the national average, ranking 8th nationally and first in the South East for the second consecutive year.
  - Hypertension monitoring (HYP004) achieved 90.2%, again significantly above the England average.
  - For cholesterol management in high-risk patients (QRISK  $\geq 20\%$ ), 64.7% were treated with lipid-lowering therapy, ranking 14th nationally and the only ICB in the South East performing statistically above England.
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- Recovery from pandemic-related declines (47.8% in 2020/21 vs. 69.7% in 2019/20) highlights strong system-wide improvement.
  - Consistent focus on detection, monitoring and treatment is helping to reduce preventable cardiovascular disease, improving long-term health outcomes and reducing hospital pressures.
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# NHS Digital Weight Management Programme

The NHS Digital Weight Management Programme offers tailored, remote support to help people living with obesity improve their health, reduce risks of conditions like diabetes and hypertension, and promote healthier lifestyles.

- 1,802 eligible GP referrals made by March 2025, reaching 119% of the NHSE target — an improvement on last year.
- Ranked fourth nationally and first in the South East for programme uptake.
- Achieving 89% against the 90% quality improvement ambition for GP referrals.
- Programme delivered in partnership with Local Authority support offers.
- Shared best practice nationally through regional quality improvement projects, share-and-learn events and exemplar resources (weight management one-pager and ICS webpage).
- Improved access to tailored weight management support for people with obesity and related conditions (e.g. diabetes, hypertension).
- Flexible, remote format increased reach across diverse groups, including deprived communities, reducing health inequalities.
- Early data shows clinically meaningful weight loss, supporting long-term health benefits and reducing pressure on local services.



More information can be found in the NHS Frimley Annual Report and Accounts 2024-2025 on our website.

[www.frimley.icb.nhs.uk](http://www.frimley.icb.nhs.uk)

