Frimley Health and Care

# Frimley Health and Care Integrated Care System Our Plan for 21/22



# Introduction:

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

Effective partnership within and across systems is at the heart of our plan which is set against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.

This plan summarises how we will meet national NHS priorities and create healthier communities. It is aligned to our long term system ambitions and our aims to improve health life expectancy for all and reduce inequalities.

NHS national priorities for 21/22

- Supporting staff health and wellbeing and taking action on recruitment and retention
- Delivery of the NHS Covid-19 vaccination programme and continuing to meet the needs of patents with Covid-19
- Transforming how we deliver services, accelerating the restoration of planned care, including cancer, and managing the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and addressing health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments
- Working collaboratively across health and care systems to deliver these priorities

# Our ambition to reduce inequalities:

We are aware that Covid-19 has created unmet need and increased health inequalities.

We have been gathering a range of insights to identify specific cohort groups across our communities where we need to take further action. This is work that is cutting across all areas of our plans including elective recovery, mental health transformation and community redesign.

We are working with voluntary and local government partners to reach into minority communities whose access has been lost affected by Covid and/or the stronger shift towards digital contact. We have detailed plans to mitigate the risk of digital exclusion

We will be strengthening leadership in this area with the appointment of a system lead for equality, diversity and inclusion who will sit on our ICS Partnership Board.


In 2025, when we have delivered these ambitions:

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

# 1/ Our People

In order to understand the impact of COVID 19 on our system workforce and enable us to design plans to address the identified outcomes and risks, the ICS People Board, in conjunction with HEE, commissioned a detailed deep dive across our system in which discovery meetings were held with most of our partners to better understand their pressures. The scope included all elements of workforce risk – from staff health and wellbeing to the wider supply and skills agendas.

We recognise the burden that the pandemic has had on our people, exhaustion, stress, anxiety and the impact of long COVID. Consequently, our people plan has a significant focus on the need to support the health and wellbeing of our people to help them to also recover from the impact that the pandemic particularly as we move to deliver our System Strategy, Long Term Plan requirements and Recovery plans, alongside preparing for a potential further wave of Covid related demand and winter pressures.

Frimley Health and Care

# Plan on a Page

NHS
Frimley Collaborative
Partnership of Clinical Commissioning Groups

Our ambitions for our workforce are clear and aligned to our **Strategic Ambitions** for the communities we serve. Our priority areas to **improve attraction, recruitment and retention** of staff for the Frimley ICS . We know we need to transform our workforce so that we **skill up** our people and **attract** people to different roles to deliver our new models of care creating a **flexible workforc**e. We have worked closely with HEE to carry out **in depth modelling** to have a deeper understanding of our system workforce challenges. Throughout the COVID period we have worked in partnership and our organisations and teams have reacted with **agility and at pace** to meet the demands placed on the services. The development of an **MOU** across health and social care has allowed us to mobilise staff to areas of the greatest need. Our workforce plan focuses on the need to provide a sufficient level of **workforce supply** to manage the inevitable backlog of services, the onset of winter and potential second wave of COVID-19. The **values, culture and leadership behaviours** of our partner organisations will help us to deliver our **People Promise** as well as the broader outcomes set out below.

## The Frimley People Plan Priorities

- **Priority 1** – Looking after our people
- **Priority 2** – Belonging
- **Priority 3** – New ways of working and delivering care
- **Priority 4** – Growing for the future
- **Priority 5** – Supporting our people for the long term and delivering the Plan together

## System Workforce Workstream Projects for delivery 2020/21

- **Project 1** – Development of a People Promise with staff to establish Frimley ICS as a great place to work
- **Project 2** – Create workforce interventions to improve diversity & inclusion by focussing on Slough Borough and BAME mortality disparities
- **Project 3** – Develop a case management approach to support employee relations and to assist with conduct and grievance handling across the system
- **Project 4** – Develop and implement a system wide cultural diagnostic process
- **Project 5** – Utilise workforce modelling to ensure staff have the right skills and capabilities to deliver care for recovery and restoration
- **Project 6** – Understand the current & future mental health workforce risks with a shared ICS approach for the sustainable improvement in the supply of a workforce capable of working across boundaries
- **Project 7** – Digital passport beta plus with a view to scope the potential to extend the remit of the passport across social care and primary care
- **Project 8** – Scale up the apprenticeship scheme including rotational programmes
- **Project 9** – Development of a health and care Reservist programme
- **Project 10** – Operational Decisions
- **Project 11** – Health and Wellbeing

## Benefits and Outcomes

- High staff engagement and morale figures, increased retention
  Strengthening our reputation and employee value proposition
- Improved equality, diversity and inclusion indicators
  Increase in diverse representation in leadership roles
- Embedding a just and learning culture, reducing BAME disparities, improving professional practices
- Insights to drive actions to improve partnership working
- Understanding system demand, labour supply
  A refreshed system workforce strategy
- A clear understand of mental health workforce
  A system mental health recruitment & retention plan
- A more flexible mobile workforce
  Adoption of digital to delivery 21 Century care
- Increase in uptake of apprenticeship schemes and WTE in post
- A flexible workforce that can be deployed at short notice
- Supporting our staff to feel well, healthy and happy at work

# Health and Wellbeing

Summary of key actions for the next 6 to 12 months:

•An expanded offer from our 2 mental health resilience hubs with a continued focus on high risk groups and inclusion
•Embedding as part of our core offer innovative schemes developed as a response to the pandemic.
•Utilising our Wellbeing Guardians to review the local wellbeing agenda and work with partners to implement NHS Wellbeing Framework and at a local level co-develop staff centred resources and a network of workplace wellbeing champions.
•Enhance our occupational health offer for staff
•Promote and support the taking of annual leave
•Systematically share covid-19 risk assessment good practice across the system, monitor staff with 'high risk' scores to ensure they are being offered appropriate levels of support and evolve our understanding of the emerging guidance on clinically vulnerable and extremely vulnerable groups.
•Participate as a national pilot site for the implementation of the new NHS Violence Prevention and Reduction Standard



# Belonging to the NHS and addressing inequalities:

34.2% of the staff employed across the Frimley Health and Care ICS are from an ethnic minority group, making our system the most diverse in the Southeast. It is vitally important that we address the systemic issues that create disadvantage and limit opportunity in our system.

Our Workforce Planning, Widening Access & Participation programme will ensure that we address the barriers affect our staff from ethnic communities. The ICS has committed, through its People Board, to work across its health and social care partners to realise the benefits for our workforces and the communities we serve in joining up our approach to the Equality, Diversity and Inclusion agenda. We will appoint a Co-Chair for the ICS Partnership Board as part of our response to regional strategy 'Turning the Tide' to oversee this work and build in sustainability.

The People Board will oversee a range of system and organisational initiatives the support our system's People ambition, including action on equality, diversity and inclusion

# Embedding new ways of working:

To enable the wider transformation of the system we need to prepare our workforce so that our people with a mix of right skills, experience and support to allow them to flourish in the new roles needed to deliver our new models of care. Across the system staff are being supported to work more flexibility, including working from home where appropriate.

A number of innovations in ways of working involve working with partners in other ICS, with Frimley, Heartlands and BOB (Buckinghamshire, Oxfordshire and West Berkshire) working together on:

•Digital passports to enable staff to move across organisations more easily
•A shared temporary staffing platform through a collaborative bank model.

**We recognise it is important that these new practices are not at the expense of staff and patient's personal wellbeing (including driving inequalities) and maintaining strong team values, positive working cultures and keeping people connected.**

# Growing for the future:

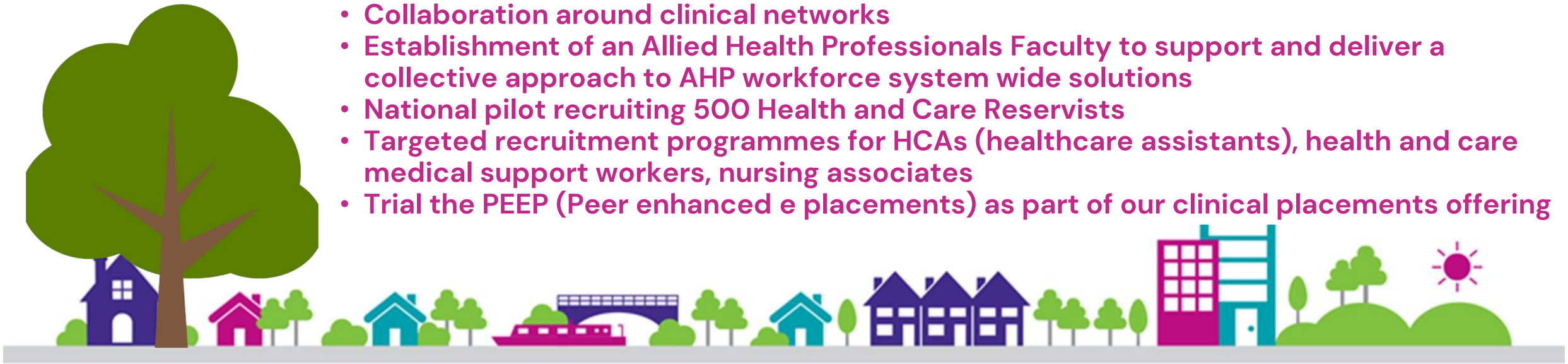
Significant work with partners has been undertaken over the past six months to understand the workforce requirements for both the Recovery and Strategic Plan delivery. We have also worked closely with Health Education England to carry out in depth modelling for a deeper understanding of our system workforce challenges and have developed detailed plans.

Through this work we will also aim to reduce health inequalities for residents by collaborating with Education provider, local businesses, the Department of Work and Pensions (DWP) and Councils to embed structures that support young people and adults into careers in health and care.



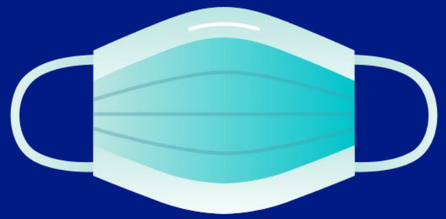
**A range of other initiatives are already in progress including:**

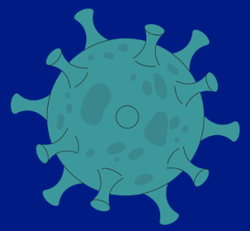
- **International recruitment**
- **Collaboration around clinical networks**
- **Establishment of an Allied Health Professionals Faculty to support and deliver a collective approach to AHP workforce system wide solutions**
- **National pilot recruiting 500 Health and Care Reservists**
- **Targeted recruitment programmes for HCAs (healthcare assistants), health and care medical support workers, nursing associates**
- **Trial the PEEP (Peer enhanced e placements) as part of our clinical placements offering**



# 2/ Continuing our response to Covid-19

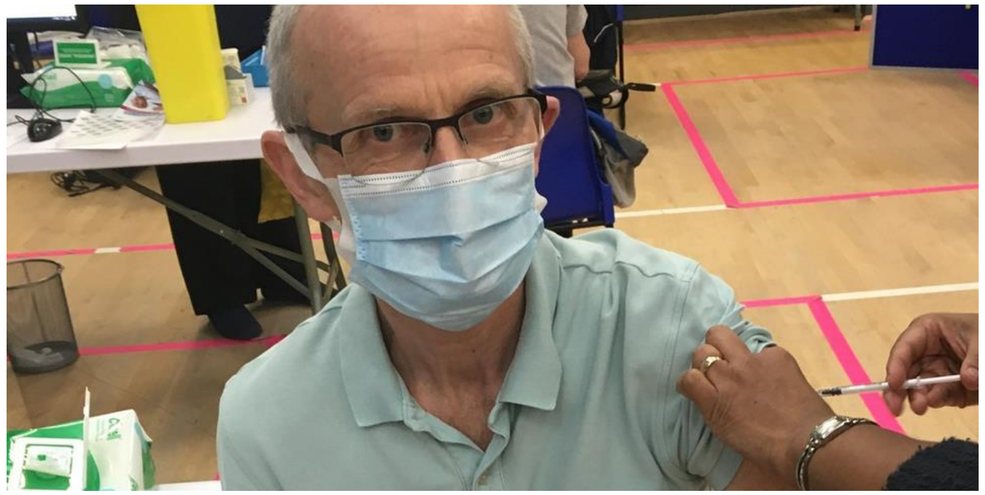
**As a system we continue to deliver the Covid-19 vaccination programme and look after patients suffering with Covid-19, including those with long-Covid**





# Vaccination programme:

Alongside vaccination centres and hospital hubs **general practice will continue to play a core role in our vaccination programme** through our GP-led vaccination sites, with their local knowledge being instrumental in supporting focused work with communities with lower vaccine uptake. We are confident in our ability to respond to further anticipated phases within the programme including re-vaccination, high seasonal flu vaccination ambitions and the vaccination of some children.



Our General Practice **Prioritisation Framework** will ensure that general practice capacity is appropriately prioritised (and/or supplemented) as part of our surge planning

# Continuing to look after patients with Covid-19:

Clinical leadership has ensured we are meeting the needs of patients with Covid-19 in a seamless way across primary and secondary care. We have additional capacity including services, such as pulse oximetry that patients can access in their own homes via digital technology and have put in place a clear long-Covid pathway that operates across our system.

We will be optimising the digital capabilities we have developed in the early stages of the pandemic, including remote monitoring and virtual wards to support more people at home and move to a more proactive and personalised care approach.

To prepare for future waves/outbreaks we have been modelling a range of scenarios including both Covid and other factors that we anticipate will affect demand and capacity.

# 3/ Recovering and transforming services:

Elective Activity: The pandemic has had a significant impact on our system, with our main acute provider (Frimley Health Foundation Trust) having some of the highest numbers of Covid inpatients in the country during the second wave and our Covid activity was also slower to reduce than in many areas.

# Hospital Plans – Elective Care

The pandemic has accelerated new models of care and we will be drawing on the learning during the pandemic to support our recovery plans and further transform the delivery of our services. Elective plans include:

•Increasing capacity through: theatre efficiency programme, additional weekend surgical activity, reviewing our sourcing and use of the independent sector, hospital discharge and bed capacity review, waiting list reviews and validation, opening of dedicated elective hub at Heatherwood Hospital, patient initiated follow-up and further expansion of specialist advise and guidance for GPs, additional diagnostic investment

•Transformation including day-case improvement programme, pre and post operative optimisation, GIRFT (Getting it Right First Time) review & plan, MSK (musculoskeletal), cardiac & eye National Pathway Improvement Programme implementation.

# 4/ Our plan for cancer services:

.The **ICS Cancer Steering Group** oversees activities to develop and transform cancer care. This ICS is geographically located in two Cancer Alliances. The ICS team works with Surrey & Sussex Cancer Alliance (SSCA) as host Alliance but continues to work closely with Thames Valley Cancer Alliance where appropriate and continues to be a member of both Alliance Boards. Through partnership working we have minimised the impact of the pandemic on cancer pathways with a return to good access to diagnostic tests and treatment early in the second wave.



The Cancer Transformation Programme will be targeting areas of particular challenges such as endoscopy access and specific tumour sites and we have identified four cross cutting work stream areas:

- Prevention and screening
- Early diagnosis, treatment and care
- Personalised care
- Focus on patient experience and engagement

In line with our overall system ambition there will be a focus on reaching under-represented groups and communities to support the reducing in cancer outcome inequalities.

We will also be implementing the Ardens Pro GP referral system which will support the reduction of unwarranted variation, improve patient safety and offer real-time monitoring of clinical data.

# 5/ Mental health:

Covid-19 has had a profound effect on many people within our communities including worries about the future, increased levels of stress and anxiety, feelings of boredom and higher levels of severe mental health conditions. Groups have not been equally impacted and there as been an increase in people requiring help that have not previously been known to mental health services. There has been a significant increase in the number of children with eating disorders.

Since the start of the pandemic our mental health workforce, partners and voluntary groups have been quickly and flexibly mobilised to ensure service provision has not been affected and additional investments have been made to strengthen services where significant demand increases have been seen. Across our services the people who need support are presenting with more complex needs.



We have accelerated digital plans to transform the ways we work, enabled 24/7 all age access in times of crisis, removed bureaucracy and proactively supported the emotional wellbeing and mental health of staff, carers, care homes, patients and their families.

We recognise the need to work in partnership to tackle the mental health inequalities impacting the most vulnerable groups in our population and reduce mental health stigma. This will involve collectively addressing the determinants of poor mental health that have been affected by Covid, such as financial difficulties and debt, bereavement, domestic violence and abuse, risky alcohol consumption, substance misuse and gambling addiction.

# Mental health plans:

Some of the work we are doing to embed and expand services is detailed below:

- Reducing the number of people being looked after outside our area
- Expand crisis support services for adults and children ensuring home treatment offer is consistent across the system
- Reduce the amount of time people spend in mental health beds through improved access to multidisciplinary group, including peer support and role for the voluntary sector
- Expanding and reducing unwarranted variation in perinatal mental health services
- Improve physical health check uptake for those with severe mental illness (SMI)
- Review of children and young people eating disorder services, including support to general practice and schools
- Reviewing and transforming mental health ambulance and NHS 111 responses
- Launch of the Frimley Maternal Mental Health pilot
- Improving access to psychology therapy services, including support for those with long Covid
- Expanding our integrated community mental health services across the system in partnership with PCNs (primary care networks) including recruiting new mental health roles
- Improved identification and post diagnosis support for dementia (individuals and their carers)
- Work with partners to support those with poor emotional wellbeing find employment through individual placement support
- Engagement and communication programme to raise awareness about services and how/where they can be accessed



# 6/ Services for people with a learning disability and/or autism:

Our plans include:

- Making progress on the delivery of annual health checks and improving the accuracy of GP learning disability registers, specifically addressing those areas where prevalence is under recorded
- Reviewing the prescribing of psychotropic medication for children (national review) and adults linking annual health checks and including any training needs for GPs
- Reduce reliance on inpatient care for adults and children with a learning disability through several linked developments identified as priorities through coproduction with service users
- Implement 100% of the actions coming out of LeDeR (Learning Disability Mortality Reviews) within 6 months of notification including recruiting Experts by Experience, establishing LeDeR reviews for autistic people, optimising the impact of learning through broadening the scope and membership of the LeDeR Operational Group.

We will expand and improve services for autistic people by working with our local authorities, voluntary sector partners and experts by experience to implement the national autism strategy. This will include reducing waiting times for diagnosis, strengthening pre and post diagnostic support, increasing training and expertise across the workforce, and improving access to specialist support when required



# 7/ : Improving maternity care


The Frimley Local Maternity and Neonatal System (LMNS) brings providers, commissioners and local maternity voices together to focus on delivering the best start in life for our residents as part of our “Starting Well Ambition”, as well as responding to the recommendations of the Ockenden Review (an independent maternity review at the Shrewsbury and Telford Hospitals, December 2020).

Our Maternity Transformation Plan includes:

•Recovering all aspects of maternity care including removing any restrictions to access support or face to face appointments and wider visiting of family and friends

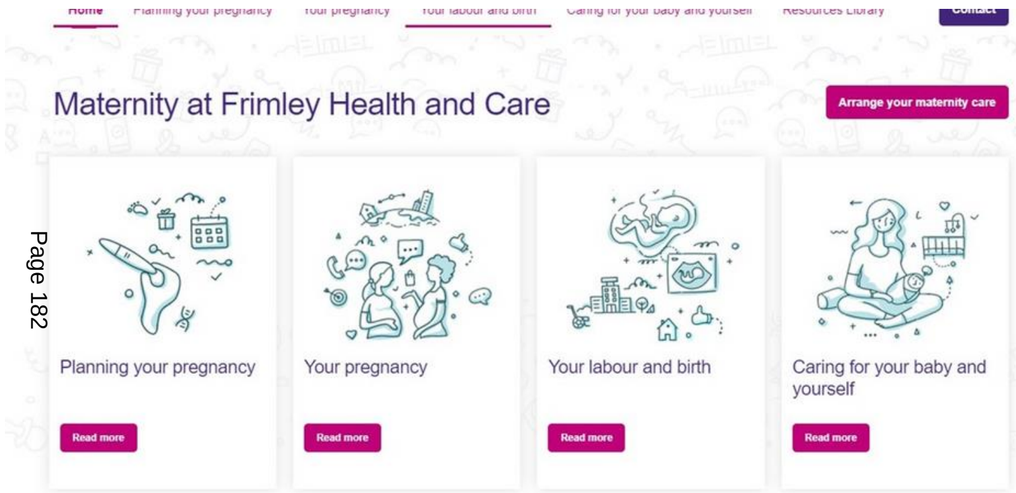
•Expanding our community maternity hub model

•Taking positive action to support women from ethnic minority backgrounds including mapping our community assets and workforce and deliver cultural awareness learning from our ongoing engagement

•Supporting our staff and developing workforce plans

•Continuing to deliver the maternity transformation measures set out on the NHS long term plan including: our co-produced digital maternity personalised care and support plan, implementing all elements of the Saving Babies’ Lives care bundle, reducing the number of women who smoke during pregnancy, continuity of carer improvement, and neonatal improvement plans.

# Improving maternity care:




The LMNS reports into our ICS Board and additionally into the system's quality surveillance group, linking into neighbouring systems to share learning. We will review these **governance arrangements** to see if there are any requirements to further strengthen system oversight.

We have a Maternity Voices Partnership involves groups of women meeting and shaping the changes that we are making. We wants care to be personalised and people to understand the choices available to them. The Frimley Health and Care maternity site - www.frimleyhealthandcare.org.uk/maternity - provides people living across the area with a 'one-stop shop' for all the resources and information that they might need. Local women helped midwives and doctors to design and test the site to ensure that it has the right information, is focused on a woman's maternity journey and is presented in a simple and accessible way.

# 8/ Improving access to primary care, outcomes & addressing local health inequalities

General practice providing more consultations than ever before with a combination of face to face, online and telephone appointments. Practices are typically reporting demand at least 20% above peak activity levels in previous years. Despite additional activity, patients report difficulties in access in some areas.

Our access improvement plans include:

- Optimising the benefits of new technologies and ways of working, utilising digital tools such as online and video consultations, total triage models and digital messaging services. Making sure patients are offered choice around how and when they contact primary care.
- Implementing General Practice Appointment Data (GPAD) tools enabling a more evidenced based approach to understanding capacity and demand
- Restoring Improved Access appointment outside core hours
- Fully utilising the range of additional roles (ARRS Scheme) available and the rollout of the Community Pharmacist Consultation Service to bring additional workforce capacity.
- Utilising population health insights and approaches to support workload prioritisation
- Additional resources to support anticipated additional pressures over the winter period



# Addressing local health inequalities

Covid-19 has shone a light on the correlation between poorer health outcomes and ethnicity and deprivation. During the pandemic we have accelerated our use of population health management approaches, data segmentation and risk stratification to provide insight into those with greatest health inequalities and/or complex needs that would benefit from local targeted, personalised, multidisciplinary support.

We are participating in the NHSE Population Health Management Development Programme and continuously exploring additional opportunities to use Connected Care data and the digital platforms established as part of our Covid response.

# Specific health outcome improvements

The NHS Long Term Plan set out a path for improvements for people with specific conditions which we now know are also associated with poorer outcomes with Covid-19. Our plan addresses improvement in these areas and we have used population health management approaches to support inequalities reduction alongside whole population improvement.

- Improving uptake of the NHS **diabetes** prevention programme
- Making progress on **cardiovascular** (CVD) prevention as part of our Living Well ambition including rolling out BP@home and CVD Prevent. Working with our **stroke** delivery partners and networks to ensure services are coherent and effective across the whole ICS , support prevention and improve access to thrombectomy services.
- Establish an ICS **respiratory network** to improve treatments and support including delivering tobacco dependence treatment services, improve access to our rehabilitation offer, review spirometry services and our pneumonia pathway, link with our Medicines Optimisation Board on medication and clinical education

# 9. Transforming community, urgent and emergency services

The Frimley system has operated a “home first” approach to support people remaining and returning to their own homes as early as possible, if appropriate. The pandemic provided additional impetus to put in place actions to improve flow through our hospitals (acute and community) freeing up capacity for Covid patients and latterly also for the restoration of elective activity.  Our plans now embed  and improve on this work:

- Reducing the average length of stay with a particular focus on those more than 14 and 21 days
- Delivering a full discharge (D2A) model across Frimley
- Offering 7 day extended hours medical and therapy models to support discharge
- Provision of rapid community discharge services
- Integrated Referral and Information Service (IRIS) on both acute hospital sites enabling system grip on individual patient discharge plans and any emerging blocks to flow
- Accelerate the use of NHS 111 as the primary route for urgent care, including booked time slots in our emergency departments and exploring 2 way direct booking between primary care and ED,  and optimising benefits for patients and system demand management
- Expand the services supporting direct referrals from NHS 11 to same day emergency care
- Use the Emergency Care Data Set within services to monitor pressures



# 10. Working collaboratively across our health and care system

The **relationships across our system are highly valued** and are seen as central to the success of Frimley Health and Care.

Since the publication of the Government White Paper we have been collectively reviewing how best to develop our system and we are now preparing to become a statutory organisation from April 2022.

To respond to this changing policy context, Frimley Health and Care want to **build on the strengths** within the system. In particular, ensuring there is **effective partnership** working between NHS organisations, local authorities and other public sector bodies and the voluntary sector to deliver on our strategic ambitions and help the NHS support broader social and economic development.

It is also crucial to **work with residents and communities to drive change**, and empower them to take ownership of their own health outcomes. The non-coterminous borders with two County Councils also necessitates dedicated attention on how public sector partners can best work together to address the wider determinants of health.

As these new arrangement evolve we are **committed to continued engagement** with all our partners.

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