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Royal Borough of Windsor & Maidenhead

Frimley Health and Care System Sustainability and Transformation Plan

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The STP will provide benefits to the communities and individuals will:

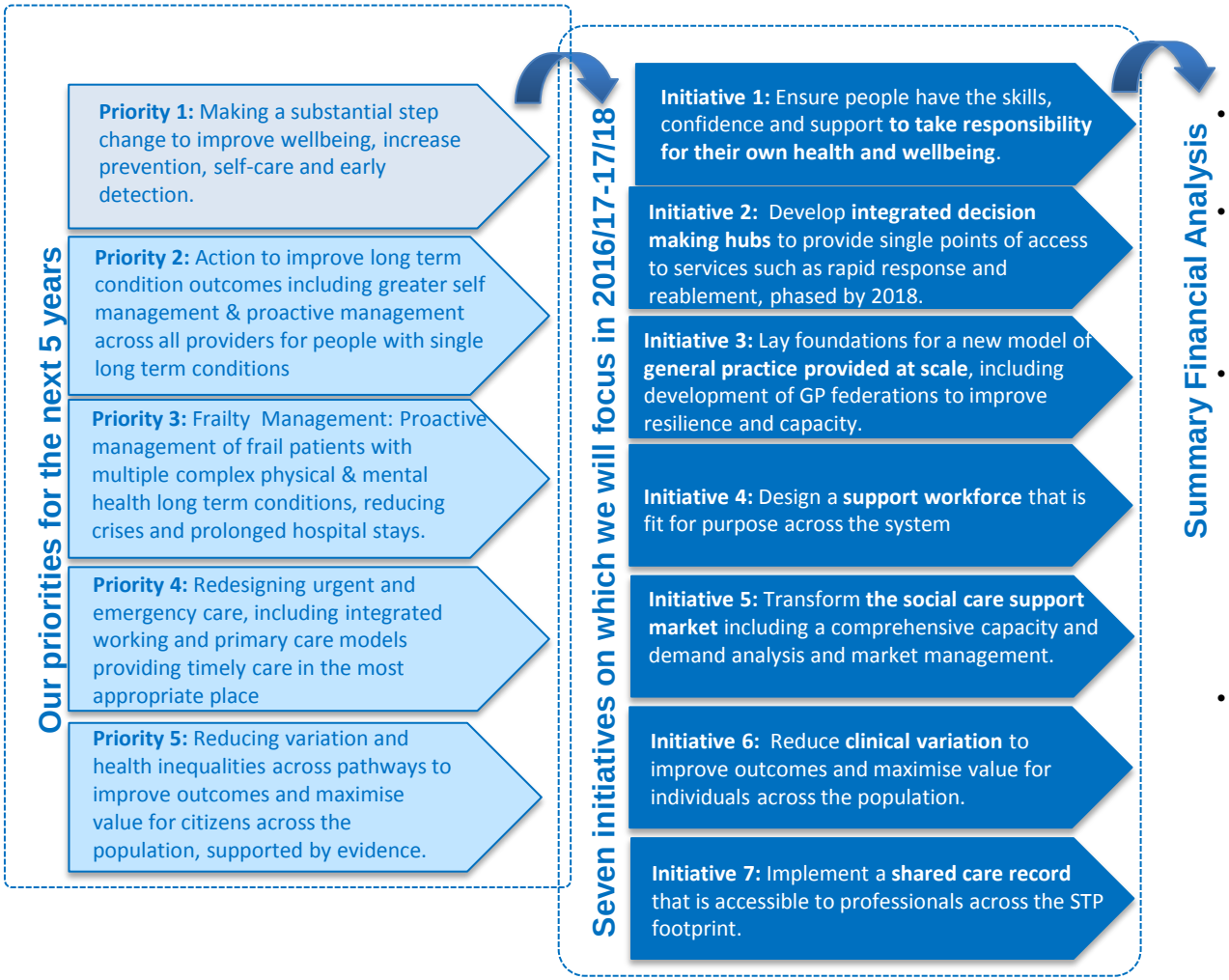
- Be supported to remain as healthy, active, independent and happy.
- Receive better coordination of heath & social care system - a ‘no wrong door’ approach.
- Know who to contact if they need help and be offered care and support in their home that is well organised, only having to tell their story once.
- 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, gives easier access to information & services.
- As taxpayers, be assured that care is provided in an efficient and integrated way.

The Frimley Health & Care STP

Many of our residents have the skills, confidence and support **to take responsibility for their own health** and wellbeing. We can do more to assist them in this and are committed to developing **integrated decision making hubs** with phased implementation across our area by 2018. Integrated hubs provide a foundation for a new model of **general practice, provided at scale**.

This includes development of GP federations to improve resilience and capacity and provides the space for our GPs to serve their residents in a hub that has the support of a fit for purpose **support workforce**. Delivering services direct to residents in locations that suit them, at times that suit them, supports our ambition to transform the **'social care support market'**. Through a personalised yet systematic approach to delivery of health and social care we have the possibility of reducing **clinical variation**. Change will be delivered through advances in technology and we will implement a **shared care record**.

The Frimley Health & Care STP



Summary Financial Analysis

- The Frimley system will spend c£1.4bn on health and social care in 2016/17.
- Although there are modest increases in funding over the period to 2020/21, demand will far outstrip these increases if we do nothing.
- We have assumed health providers can make efficiency savings of 3% pa, and demand can be mitigated by 1% pa. This is in line with historic levels of achievement and existing efficiency plans following the acquisition of Heatherwood & Wexham Park hospital in 2014. Including broader efficiencies from Social Care will deliver about £176m by 2020/21.
- If a further £28m can be saved across our main priority areas, this coupled with an allocation of £47m from the national Sustainability and Transformation Fund (STF) will bring the system into balance by the end of the period

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

Lead: Lise Llewellyn

Joint Strategic Needs Assessment used to identify shared challenges across footprint, and as basis for prioritising local commissioning intentions and operating plan.

Key local initiatives:

- Detection of raised blood pressure.
- Diabetes prevention programme.
- Smoking cessation support for those awaiting elective procedures.
- Obesity reduction.
- Development of digital programmes to support healthy lifestyles.

Broader approach to complex case management and implementation of “House of Care” model.

Culture change in social care - Each Step Together, a community based whole system of support. Aims to help residents stay in their homes with the right support in the community, known as 3 Conversation Model. First Innovation Site in Old Windsor and currently being developed across the Borough in partnership.

Initiative 2: Develop **integrated decision making hubs** to provide single points of access to services such as rapid response and reablement, phased by 2018.

Lead: Fiona Slevin-Brown

Re-development of St Marks as an integrated hub for Maidenhead: Engaging with NHS PropCo regarding possibilities.

Integrated hub in Windsor

Local initiatives:

- MDT co-ordination of complex care planning and frailty, shared frailty index.
- 75% of those identified as frail to have a proactive plan in place led through the hub.
- Expansion of social prescribing options.
- Aligning crisis response, rehabilitation and reablement.

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

Lead: Nicola Airey, Surrey Heath

Development of quality bundle for GP enhanced services:

- Outcomes-based.
- Gathers multiple contract fragments.
- Aim to provide at scale, to avoid inequality ‘dark spots’.

Improving practice resilience: identification of vulnerable practices and support package:

- Workforce
- Quality
- Financial

Support for federated working across practices:

- Cross-practice approaches to home visits and, potentially, urgent appointments.
- Opportunity for 111 direct booking pilot.

Initiative 4: Design a **support workforce** that is fit for purpose across the system

Lead:

Challenges in GPs, paramedics, nurses, non-regulated workforce domiciliary care workers.

Local initiatives:

- Map current provision and gaps including use of agency.
- Establish career development track for bands 1-4 and into first registered position.
- Develop cross-trained Healthcare Assistants (HCAs)/ Domiciliary Care Workers that operate both in hospital and community: rotational apprenticeships.

Underpinning work on IT conformity to support cross-system transfers.

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

Lead: Alan Sinclair

Local initiatives:

- Collaborative approach to placement procurement and market management.
- Development of Discharge to Assess model.
- Development of system-owned capacity for hard to find placements for example, high end mental health.
- Rapid implementation of Airedale remote support model.
- Development of an integrated enhanced Care Home support package; lead homes identified for 7/7 discharge.
- Review of all complex needs placements.

Integration opportunities:

- Review of s117 with view to budget pooling.
- Shared Mental Health commissioning.
- Single Safeguarding Board.

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

Lead: Ros Hartley, NEH&F CCG

Focus areas identified through the Joint Strategic Needs Assessment and Rightcare analysis

Local initiatives:

- Respiratory – underway now.
- MSK – underway now.
- Circulation – planned autumn 2017.
- Genito-urinary – planned autumn 2017.

Practice level data now provided:

- Peer and locality review against benchmarks.

Initiative 7: Implement a **shared care record** that is accessible to professionals across the STP footprint.

Lead: Jane Hogg, FHFT

Consolidated view of key patient information shared across system at point of care delivery.

Development of a patient portal to support self-care and prevention.

Local milestones:

- East Berkshire Connected Care Programme go-live (November 16).
- Phased implementation roll out across STP footprint (June 17).

Programme of transformational enablers

- Becoming a system collective focus on the whole population.
- Developing communities and social networks so that people have the skills and confidence to take responsibility for their own health and care in their communities.
- Developing the workforce across our system so that it is able to deliver our new models of care.
- Using technology to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.
- Developing the Estate.

Finance & efficiency

STP 2020/21 Summary	Do Nothing £m	Solutions £m	Do Something £m
Commissioner Surplus / (Deficit)	(100)	89	(11)
Provider Surplus / (Deficit)	(87)	80	(7)
Footprint NHS Surplus / (Deficit)	(187)	169	(18)
Indicative STF Allocation 2020/21	-	-	47
Surplus /(Deficit) after STF Allocation	(187)	169	29
Social Care Surplus / (Deficit)	(49)	27	(22)
Total Surplus / (Deficit)	(236)	197	7

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