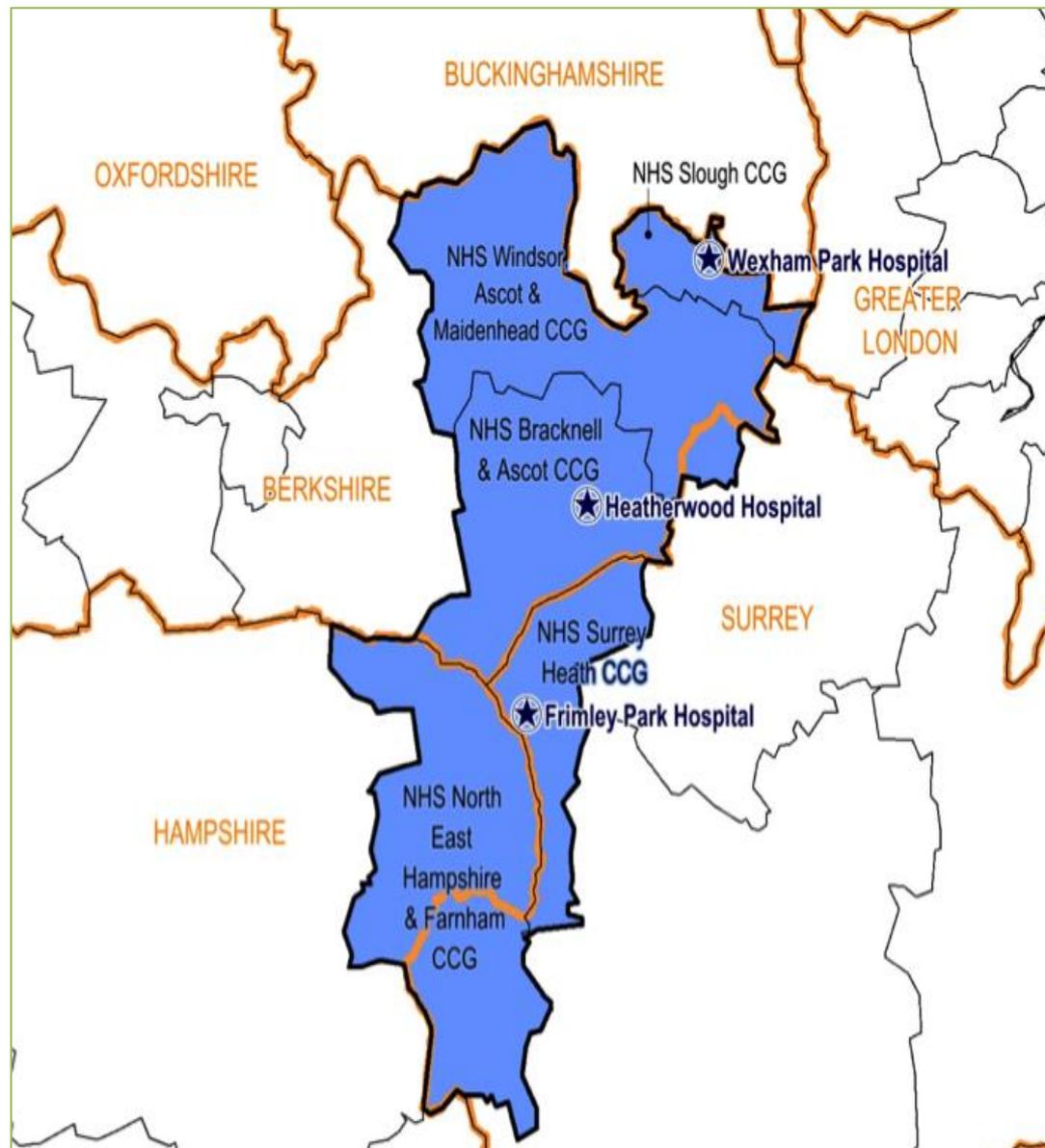


Frimley Health & Care STP  
Community Partnership Forum  
25<sup>th</sup> January 2017

# Introduction to the Frimley Health and Care System

The Frimley Health and Care planning footprint, is the population of **750,000 people** registered with General Practitioners in five CCG areas:

- Slough
- Windsor, Ascot & Maidenhead
- Bracknell & Ascot
- Surrey Heath
- North-East Hampshire and Farnham.



# System partners

## NHS Commissioners

- Bracknell and Ascot CCG
- North East Hampshire and Farnham CCG
- Slough CCG
- Surrey Heath CCG
- Windsor Ascot and Maidenhead CCG

## Acute care provider

- Frimley Health NHSFT

## Mental health and community providers

- Berkshire Healthcare NHSFT
- Southern Health NHSFT
- Surrey and Borders NHSFT
- Sussex Partnership NHSFT
- Virgin Care

## GP Federations

- Bracknell Federation
- Federation of WAM practices
- Salus GP Federation (North East Hampshire and Farnham)
- Slough GP Federation
- The Surrey Heath community providers

## GP out of hours providers

- East Berkshire Primary Care
- North Hampshire Urgent Care

## Ambulance Trusts

- South Central Ambulance Service NHS FT
- South East Coast Ambulance NHS FT

## County Councils (including Public Health)

- Hampshire
- Surrey

## Unitary Authorities (including public health)

- Bracknell Forest Council
- Royal Borough of Windsor and Maidenhead
- Slough Borough Council

## District and Borough Councils

- Guildford Borough Council
- Hart District Council
- Rushmoor Borough Council
- Surrey Heath Borough Council
- Waverley Borough Council

## 5 Year Forward View

- The Five Year Forward View identified three gaps facing the NHS:
  - Health and wellbeing
  - Care and quality
  - Finance and efficiency
- These gaps threaten the care provided to patients/residents and the sustainability of the NHS.
- Sustainability and Transformation Plans, STP, are the local system response on how, together, we might address the gaps between now and 2020/21.

# The Frimley STP priorities for the next 5 years

Our priorities for the next 5 years

P1

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

P2

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

P3

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

P4

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

P5

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

An underpinning programme of transformational enablers includes:

**A.** Becoming a system with a **collective focus on the whole population.** **B.** 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. **C.** Developing the workforce across our system so that it is able to delivery our new models of care. **D.** Using **technology** to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency. **E.** Developing the Estate

# The Frimley STP Initiatives for next 18 months

Seven initiatives on which we will focus in  
2016/17-17/18

1. Ensure that people have the skills, confidence and support to **take responsibility for their own health** and wellbeing.
2. Develop integrated care decision making hubs to provide single points of access to services such as rapid response and reablement with phased implementation across our area by 2018
3. Lay the foundations for a new model of **general practice, provided at scale**. This includes work to further the development of GP federations to improve resilience and capacity
4. Design a **support workforce** that is fit for purpose across the system
5. Transform the '**social care support**' market including a comprehensive capacity and demand analysis and market management
6. Reduce **clinical variation** to improve outcomes and maximise value for individuals across the population
7. Implement a **shared care record** that is accessible to professionals across the STP footprint

How do you want to be involved?



# Ideas....



- Online surveys
- Patient Panel group
- Task and finish groups e.g. to define “frailty”
- Representatives on steering groups

Based on these conversations, we will do a survey on HealthConnect and open the discussion to those who couldn't be here today as well.

# The role of CPF



## Oversight of the STP

- All work streams come and present to the group?  
E.g. next meeting could focus on the prevention agenda.
- Space on the agenda for key challenges  
E.g. how do we define “frailty”

# How do CPF members want to be kept up-to-date with work streams?

- Project updates to be sent around as and well available
- Milestone updates to be shared with the CPF
- What else?



Thank you!