Frimley Health and Care System Sustainability and Transformation Plan

21 Oct 2016 Submission

Contents

Introduction to the Frimley Health & Care STP

Aim: To serve and work in partnership with the Frimley footprint population of 750,000 people, through the local system leaders working collaboratively to provide an integrated health and social care system fit for the future.

Statement

All of the partners involved in the STP are committed to putting residents first. In practice this translates to people receiving/having access to seamless holistic services that meet their need at the earliest possible opportunity – right service, right time and right place. Through focussing on the individual, as opposed to structure, there is an increased focus on prevention and pro-active care rather than reactive treatment. The partners are taking collective responsibility for simplifying the system and making it easier for people to understand and navigate it.

The first two years of our five year STP will be delivered through seven system initiatives that integrate commissioning decisions and provider delivery. These are set out in detail in this submission.

Workforce

The priorities described in the STP will be underpinned by developing the right workforce with the right skills, knowledge and understanding to transform our services and pathways. Consequently one of our initiatives is dedicated to workforce development and the remaining six initiatives having to create a workforce plan. The STP Local Workforce Action Board is utilising Health Education England, universities and other education providers to drive the plans forward.

Summary of progress since June

Established all of the workstreams to provide a coherent plan that clearly demonstrates the impact of each initiative with defined deliverables and benefits to the population.

- Increased the breadth of ownership and leadership of our STP through broad engagement
- Engagement and workshops with providers and commissioners to support alignment of primary and community care strategy and workforce resilience.
- Established the Local Workforce Action Board to respond to the workforce issues arising from each initiative.
- Further aligned the Local Digital Roadmap to the STP Priorities.
- Given a stronger voice to mental health and ensured that all seven key initiatives build in the requirements of the Mental Health Five Year Forward Plan.
- Developed an STP wide Communications and Engagement Strategy.
- Developed and updated the financial plan to reflect guidance and feedback from the September submission.

The Frimley Health & Care STP will provide benefits to the communities and individuals will:

- *Be supported to remain as healthy, active, independent and happy as they can be.*
- *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 that gives them easier access to information and services.*
- *As taxpayers, be assured that care is provided in an efficient and integrated way.*

Plan on a page: The Frimley Health & Care STP

Section One

Introduction

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**.

Our priorities for the next 5 years

- **Priority 1:** Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.
- **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
- **Priority 3:** Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays.
- **Priority 4:** Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place
- **Priority 5:** Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

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

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

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

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

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**.

I1 Ensure people have the skills and support to **take responsibility for their own health** and wellbeing.

Lead Director: Lise Llewellyn, Director of Public Health; Project Manager, Ben Rowlands

Overall Objectives

- Develop a range of digital, telephone and face to face support for people with high risk lifestyle behaviours or mental health characteristics
- Introduce a digital support package that encourages behaviour change linking with the One You programme
- Supporting a healthy NHS workforce enhancing the Commissioning for Quality and Innovation initiatives to deliver sickness absence reductions and reduced agency requirements
- Year 1 and Year 2 priorities will be tobacco cessation in elective care, early cardiac detection, diabetes and physical inactivity utilising digital technology via a patient portal and nudge techniques as part of these programmes
- Learn from the Vanguard self-care initiatives, for example, healthy living pharmacies and safe haven model for mental health and replicating effective interventions across the STP footprint
- Support self-care through identification and use of digital platforms such as patient portal, patient facing technology and shared care record across the STP footprint to develop comprehensive care and support planning
- Work in collaboration with the Fire Service to enable joined up front line service delivery

Deliverables

1. Programme implemented across STP to detect higher than normal blood pressure within primary care and the community
2. Roll out of national diabetes prevention programme
3. Offers of quit support for smokers undertaking elective procedures
4. Alcohol Care Teams in hospital sites and brief intervention in health settings building on work of the alcohol liaison nurses
5. Training of staff to improve the understanding of lifestyle risks, maximising every contact counts
6. Obesity reduction programme setup throughout footprint
7. Develop and implement digital programmes to support healthy lifestyles e.g. to encourage inactive residents to increase physical activity
8. Roll out successes of Vanguard interventions

Interdependencies

- Digital transformation initiatives such as patient portal, patient facing technology, whole system intelligence and shared care record
- Health and wellbeing strategies
- Vanguard pilot in North East Hampshire and Farnham
- Underpinning all of the other initiatives within the STP

Milestones

Milestones	*Start Date*	*End Date*
Development of a project to increase referrals to the National Diabetes Prevention Programme	*Feb 16*	*Oct 17*
Project documentation approved	*30 Sep 16*	*17 Oct 16*
Model the financial impact	*Oct 16*	*Oct 16*
Agree definition and terms of reference for steering group	*17 Oct 16*	*17 Oct 16*
Submit the STP		*21 Oct 16*
National Diabetes Prevention Programme Pilot Schemes start		*28 Oct 16*
Develop and agree a detailed framework	*Oct 16*	*Nov 16*
Setup and agree project teams for deliverables	*Oct 16*	*Nov 16*
Develop and roll out programme to reduce the number of people smoking within footprint	*Oct 16*	*Dec 17*
A fully implemented primary care/community programme for early detection of high blood pressure	*Dec 16*	*May 17*
Develop and implement targeted health promotion to reduce alcohol consumption	*Mar 17*	*Oct 17*
Project to promote an increase in physical activity	*Mar 17*	*Oct 17*
Evaluate Vanguard self-care interventions and roll out if evidence supports	*Feb 17*	*Feb 18*
Develop, implement and evaluate a digital platform to support self-care	*Feb 19*	*Jan 20*

Key risks/ Issues

Risks	Mitigation
Lack of agreement on design principles / framework	Ensure maximum engagement ahead of required agreement date
Senior management support	Continual updates to System Leadership Reference Group
Public engagement and involvement	Co-production elements where possible and ensuring continual communication through a variety of conduits
Public health funding risk	Strong return of investment justifies funding

Scope and exclusions

- This project will focus on people within the Frimley footprint which covers 5 CCG areas and serves a population of 750,000.
- Digital enablement to encourage self-care and prevention
- Although other areas of prevention may interface with this project they will not be considered in scope.

Benefits

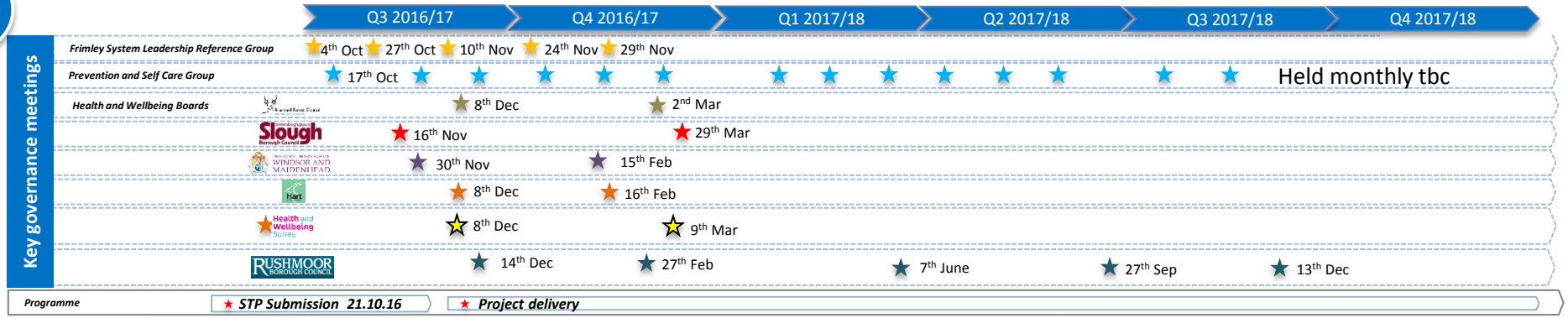
- Just over £7.6 million net saving over the 5 years
- Reduction in smoking and alcohol consumption
- Earlier intervention for diabetes and hypertension
- Reduced sickness, improving the economy and society
- Improved cohesion between NHS, Fire Service and Local Authorities
- Health and wellbeing improved within Frimley footprint
- Contact with hard to reach groups and increasing reach through digital platform
- Areas with the poorest outcomes will be prioritised in the roll out of all initiatives to ensure we address health inequalities
- Digital ecosystem setup that will encourage sharing of care records and ownership for their own wellbeing

Outcome measures

- Blood pressure detection matches best performer in comparator CCGs
- An additional 18,135 residents are identified through the national diabetes prevention programme
- Reduction in growth rates of diabetes incidence
- Through offers to quit support an additional 463 smokers quit per year
- Reduction in smoking related surgical site infections by 147 per yr
- Alcohol care teams setup across Frimley footprint
- Alcohol related deaths decreased by 20%
- Reduction in number of people with BMI over 30 by 2680
- Frimley footprint physical inactivity decreases to below 20%
- Increase in the availability of patient facing and patient portal technology
- Successful roll out of effective Vanguard intervention programmes

I1

Take responsibility for their own health roadmap - high level integrated view



	Initiation and Visioning	Designing and Planning	Creation and Delivery
Early detection of high blood pressure	• Engage Prevention and Self-Care work group • Model financial impact	• Agree a detailed design / implementation framework • Agree project team • Approve project brief	• Identify cohorts for high impact interventions • Continual monitoring and evaluation to work group
Increase referrals for diabetes	• Review project already underway • Engage Prevention and Self-Care work group	• Agree a detailed design / implementation framework aligned to current project • Agree project team • Approve project brief	• Select pilot areas for high impact interventions • Train staff in identified pilot area • Continual monitoring and evaluation to work group
Reduce number of people smoking	• Engage Prevention and Self-Care work group • Model financial impact	• Agree pathway and practical steps for service delivery • Undertake review of current offerings in footprint • Agree project team • Approve project brief	• Tender for provider • Communicate and train staff • Continual monitoring and evaluation to work group
Reduce consumption of alcohol	• Engage Prevention and Self-Care work group • Model financial impact	• Agree a detailed design / implementation framework • Agree project team • Review work undertaken by alcohol liaison nurses • Approve project brief	• Select pilot areas for high impact interventions • Communicate and train staff • Continual monitoring and evaluation to work group
Increase physical activity	• Engage Prevention and Self-Care work group • Model financial impact	• Agree a detailed design / implementation framework • Review digital technology opportunities • Agree project team • Approve project brief	• Select pilot areas for high impact interventions • Communicate and train staff • Continual monitoring and evaluation to work group
Implement digital platform	• Engage Prevention and Self-Care work group • Model financial impact	• Agree a detailed design / implementation framework • Review digital technology opportunities • Agree project team • Approve project brief	• Select pilot areas for high impact interventions • Communicate and train staff • Continual monitoring and evaluation to work group
Evaluate Vanguard Self-Care project	• Engage Prevention and Self-Care work group • Model financial impact	• Undertake review of Vanguard project • Agree pathway and practical steps for service delivery • Agree project team • Approve project brief	• Communicate and train staff • Roll out successful initiatives • Continual monitoring and evaluation to work group
Metrics and Evaluation	• Develop a draft logic model • Apply Vanguard evaluation strategy • Agree system wide high level metrics	• Develop the logic model based on development roadmap • Agree specific outcome measures across the system • Establish performance and outcomes baselines • Agree benefits realisation and evaluation strategy	• Establish measurement mechanisms • Develop a system wide digital dashboard • Refine the strategy and logic model

I2 Develop **integrated care decision making hubs** to provide single points of access to services such as rapid response and reablement, phased implementation by 2018

Lead Director : Fiona Slevin-Brown, Director of Strategy, East Berkshire CCGs; Project Manager, Haider Al-Shamary

Overall Objectives

- **System wide population based identification and proactive management of individuals with frailty**
- **Care Model Design:** Develop a system wide model, based on NHSE Frameworks, for multidisciplinary teams to deliver community based care
- **Digital Cohort Identification**: Utilise whole system intelligence, Right Care, and predictive modelling, to identify and proactively manage cohorts with frailty
- **Rapid Local Delivery:** Build on local success and accelerate delivery at pace and scale across the system, with General Practice at the core
- **Digital Enablers:** Use a Shared Care Record, real time analytics, digital care services and multi-media sign posting
- **Wider integration:** Between health, social care and our community partners
- **Mental Health Parity of Esteem:** Join up physical and mental health care for high-need groups, such as people with severe mental illness and older people with dementia
- **Prevention and Self Care:** Collaborate with local authority, voluntary, and community partners, promoting prevention, early intervention, and community support
- **Shared Processes:** Shared risk processes, assessments, and a single shared care plan, targeting high impact interventions to enable proactive and preventative care
- **Workforce Enablers:** Introduce new roles and new ways of working e.g. care navigators, health coaches, clinical pharmacists, and integrated mental health leads

Deliverables

- Identify frail cohort of individuals in order to enable proactive planning.
- Clinical and virtual hubs with co-located MDTs
- MDT coordination of complex care planning and frailty
- Targeted support for defined cohorts based on need
- Aligned crisis response, rehabilitation and reablement
- Rapid access to diagnostics and upstream diagnosis
- Social prescribing and asset based community support
- Aligned, integrated and simplified routes into UEC
- Streamlined primary, community and acute care interfaces
- Specialists and generalists working around the person
- Digital dashboard utilising whole system intelligence
- Flexible workforce able to work across the system

Milestones

Milestones	*Start Date*	*End Date*
System wide workshop on core elements	Aug 16	Sep 16
Modelling the financial impact	*Oct 16*	*Oct 16*
Review the draft STP project documentation	*Sep 16*	*Oct 16*
System leaders on 'TCSL' leadership course	Oct 16	Jan 17
Submit the STP		*21 Oct 16*
Agree delivery and evaluation framework	*Oct 16*	*Nov 16*
Develop logic model and evaluation strategy	*Oct 16*	*Nov 16*
Convene a steering group aligned with 'TCSL'	*Oct 16*	*Nov 16*
Map the current state of delivery	*Dec 16*	*Jan 17*
Agree phased implementation plan	*Jan 17*	*Feb 17*
Approve local planning and scheduling	*Feb 17*	*Mar 17*
Implement quick wins in fast followers	*Mar 17*	Sep 17
Refine the framework through rapid learning	Mar 17	Sep 17
Develop a system wide digital dashboard	Mar 17	Sep 17
Deploy refined framework at scale and pace	Sep 17	Mar 18

Key risks/ Issues

Risks	Mitigation
Lack of agreement on design principles / framework	Ensure maximum engagement ahead of required agreement date
Complex dependences between programmes of work	Programme governance and robust communications plan
Decision making needs to be coordinated across multiple statutory bodies	Robust critical path that takes into account decision making points and clear schedule of delegation

Interdependencies

- Other STP Initiatives and deliverables including Primary Care Transformation, Workforce, Unwarranted Variation, Social Care Support, Prevention and Self-Care
- Local Digital Roadmap and associated digital ecosystem
- Local Integrated Urgent and Emergency Care and NHS111 Redesign

Scope and exclusions

This initiative is concerned with the collaborative design of a system wide integrated care model framework for local delivery and implementation. The evolving scope will need to be aligned to the development of other STP initiatives and deliverables as they evolve.

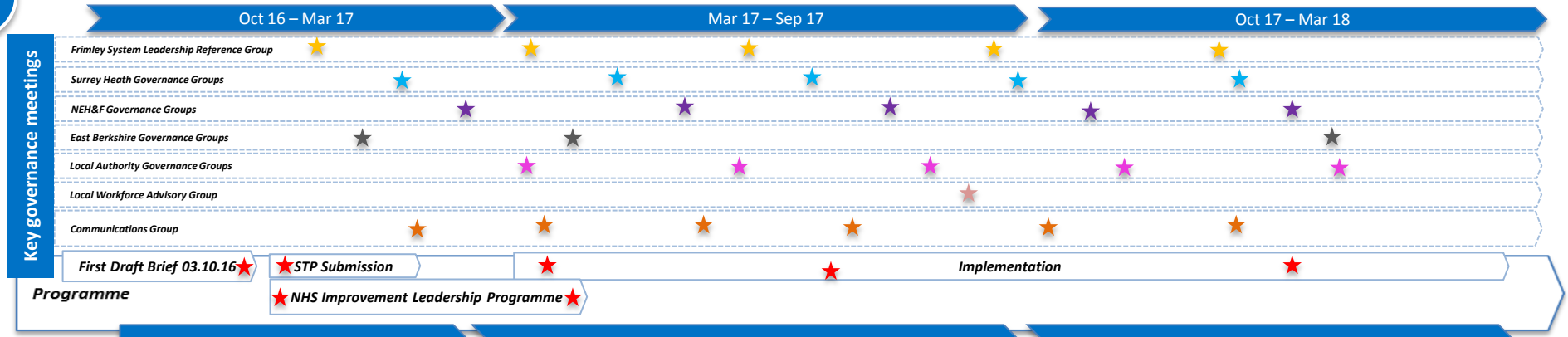
Benefits

- Early access to proactive integrated services for individuals identified as frail
- Adoption of single trusted assessments and care planning
- Use of a Shared Care Record accessible across all settings
- Individuals will only have to tell their story once
- Individuals supported by personal recovery guides and navigators
- Reduced crisis, impacting on emergency admissions, bed days and admissions into care homes to improve quality of care
- Enhanced supported discharge into community settings
- Improved experience of individuals and equity of access for all
- Helping people maintain independence and manage their own health and care e.g. through expanded use of social prescribing
- Optimising quality of life and increasing healthy lifespan
- Social, emotional and psychological support in partnership with the individual
- Care homes integrated into the wider system

Outcome Measures

1. Incremental reduction in non elective attendance towards 30% for the patient cohort identified as frail and managed within integrated hubs
2. Increase in frail cohort being treated proactively in same day/next day services
3. Reduction in proportion of people identified as frail readmitted within 30 days.
4. 75% of patients identified as frail have a proactive plan in place led by the integrated hub.
5. 50% of those identified as most frail will have a crisis prevention plan in place
6. Patient and carer satisfaction regarding care coordination and telling their story only once.
7. Staff satisfaction with integrated team working specifically regarding risk sharing.

I2 Integrated care decision making hubs Roadmap – high level integrated view



	Designing and Planning	Implementing and Refining	System Wide Rollout
Care Model Design	• Engage system leaders • Convene system wide workshop • Model financial impact • Agree core design framework • Align with NHSE Frameworks	• Agree a detailed design / implementation framework • Align to New Care Models implementation matrix • Map current state and agree implementation priorities • Align with other STP initiatives and deliverables • Develop local implementation schedules • Carry out digital frailty segmentation	• Develop the detailed financial and business model • Identify mild, moderate and high frailty cohorts for interventions • Build integrated care teams and hubs • Accelerate phased implementation
Metrics & Evaluation	• Develop draft logic model based on the NEH&F Vanguard model • Apply the Vanguard strategy to evaluation • Agree high levels metrics	• Develop the logic model based on agreed framework • Agree specific outcome measures across the system • Establish performance and outcomes baselines • Agree a system wide evaluation strategy • Develop a system wide digital dashboard	• Establish population-based measurement mechanisms • Refine the strategy and logic model
Empowering Patients, Citizens and Communities	**Applying the six principles of effective engagement and participation throughout the programme:**	**Care and support is person-centred: personalised, coordinating and empowering** Services are created in partnership with citizens and communities	**Focus on narrowing health inequalities** Carers are identified, supported and involved	**Voluntary, community, social enterprise and housing sectors are involved as key partners** Volunteering and social action as key enablers, including healthy living pharmacies
Leadership, Governance and Local Delivery	• 8 local leaders embarking on 'Transformational Change through System Leadership' (TCSL) programme	• Clinical and care leaders sharing expertise and supporting generalists / specialists to work together, sharing responsibility and accountability across MDT's • Establish a system wide steering group / learning network to feed into the Leadership Programme Cohort	• Utilise established local project delivery mechanisms to drive change in alignment with the care model framework • Learning Network to spread existing and emerging best practice
Workforce Redesign	• Identifying new roles / training needs • Connecting with LWAB and LETB for support	• Joint workforce mapping and modelling • Agree shared workforce strategy and align with regional networks • Training needs fully understood and planned	• Implement the new workforce model • Engage front line staff with training and delivery • Capture and build on what works • Clearly defined roles and responsibilities
Local Digital Roadmap	A digital ecosystem that delivers key enablers such as a Shared Care Record, Patient Portal, Technology Enabled Care Services, and system wide Business Intelligence		

I3 Lay the foundations for a new model of **General Practice provided at scale.**

Lead Director: Nicola Airey, Director of Planning, Surrey Heath CCG; Project Manager, Gazelle Robertson

Overall Objectives

- To deliver a sustainable model of general practice including a clinical, business and career model that delivers improved outcomes for our population
- To reduce variation in care and outcomes across the STP with a focus on:
  - Access
  - Mental Health
  - Prevention & early intervention
  - Patient experience
  - Urgent care pathway
  - Planned care referral thresholds
  - Long term conditions clinical outcomes
  - Use of technology to support access
- Generate pace and early delivery through:
  - Additional support to localities that need to strengthen foundations
  - Enabling pacesetters to develop transformational changes early
  - Identify fast followers to spread improvement at pace
- Clear articulation of system wide benefits of improvements in general practice

Deliverables

March '19 delivery of FYFV for General Practice across whole STP

- 8am-8pm Mon – Fri GP services including access for MH pts
- Weekend GP services including access for MH patients
- Improved working across primary, community & secondary care
- Early intervention for LTC and complex patients
- General practice working at scale through federations
- Patient portal supported by LDR
- Wider primary care workforce eg. Health navigators
- System wide recruitment, retention strategy
- Consultations using technology eg. Video, emails, telephone
- Real time analytics tools in collaboration with LDR

Interdependencies

Project Workstreams:

-Integrated care decision making hubs; -prevention & self care; -Social care; -Shared care record;

-Unwarranted variation; -Support workforce; -Mental Health

Enabling Workstreams:

-LWAB; -Technology; -Engagement - Estate

Milestones

Milestones	*Start Date*	*End Date*
Engagement exercise to: -develop system wide views on GP transformation -agree current good practice to spread across the system -agree how to work better together and identify potential wide STP activities	*Aug 16*	*Sept '16*
Financial Modelling	*Sep '16*	*Oct '16*
STP Submission		*Oct 16*
Project Brief sign off	*Sep '16*	*Oct '16*
Establish an overarching workstream steering group	*Oct 16*	*Nov 16*
Project Implementation	*Nov 16*	*Mar '19*
Evaluation process	Mar '19	Mar '20

Key risks/ Issues

Risks	Mitigation
Lack of engagement from general practice across the system	System wide ownership of STP priorities, engagement plan and commitment to achieve change
Insufficient resource to undertake associated workstream tasks	a fully staffed PMO driving and supporting the programme with leadership & input from across the system
General Practice workforce not fit for purpose to achieve change	-Workforce subgroup and link into wider workforce planning. -Future proofed business and career models -Retention strategies eg flexible working
Complexity of managing interdependencies across workstreams	PMO leads & system leads working closely together to ensure the alignment of priorities

Scope and exclusions

Working across the Frimley health & care system to achieve general practice transformation through

- care redesign & improved access;
- workforce, education & training;
- IT & infrastructure;
- workload;
- finance and engagement

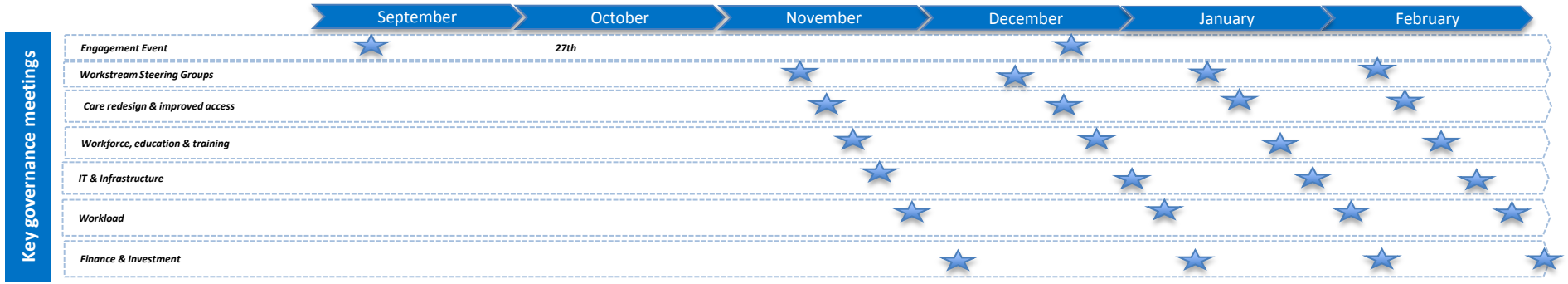
Benefits

- Improved access from an increased number of appointments
- Reduced variation in clinical outcomes and patient experience across the STP with specific ambitions to raise current levels of performance in Slough
- Increased capacity to deal proactively with complex patients including those with LTC
- Increased patient satisfaction and outcomes
- Sustainable and fit for purpose workforce
- Reduction in need to visit hospital services
- Collaboration across the system
- Increased general practice resilience
- Economies of scale & greater system wide efficiencies

Outcome measures

- Reduced variation in % of patients satisfied with opening hours & overall average increase – from 18/19
- % of patients rating their overall experience as good/very good, minimum 3% increase / 85% achieved – from Q4 17/18
- Additional number of appts outside core hours – from Q1 18/19
- Reduced variation in number of people with a LTC feeling supported to manage their care – 18/19
- Development of metrics to identify improvements in early detection & intervention eg cancer diagnosis via emergency routes – 18/19
- Examples of joint working across primary, community & secondary care – from Q1 18/19
- Increased general practice workforce incl. new roles – from Q2 18/19
- % use of digital platform to access general practice – from 18/19
- % of patients redirected to self care from 18/19

General Practice at scale roadmap – high level integrated view



Programme

- Engagement Event -Sept '16
- Financial Modelling – Oct'16
- Project Brief– Oct'16
- STP Submission – Oct '16
- Workstream steering group – Nov '16
- Programme Implementation –Nov '16
- Evaluation Process – March '19

Care Model
- Care re-design & Improved access
- Workload

Career Model
- Workforce, education & training

Business Model
- IT & Infrastructure
- Finance & ROI

Phase 1 - Oct '16-March '17

- Confirmed investment & phasing from NHSE
- Project management structure in place
- ROI finalised to feed into metrics
- System wide initiatives identified & delivery process
- Quick wins identified for STP spread
- Workforce plan in place

Phase 2 – April '17 – Sept '17

Clinical model implementation:
- Development / continuation of extended access models
- At scale working
- 10 high impact actions
- Support for struggling practices

Career model implementation
- Recruitment & retention schemes
- Develop new & supporting roles

Phase 3 - Oct '17 – March '18

- Explore alternative technology solutions for accessing general practice
- Identify sign posting & self care apps
- Develop premises strategy

Phase 4 – April '18 – March '19

- Implementation of premises strategy
- Contribution to overall financial sustainability of the Frimley Health & Care System
- Evaluation process

Metrics & Evaluation

- Develop a draft logic model
- Apply Vanguard evaluation strategy
- Agree system wide high level metrics

- Develop the logic model based on development roadmap
- Agree specific outcome measures across the system
- Establish performance and outcomes baselines
- Agree benefits realisation and evaluation strategy

- Establish measurement mechanisms
- Develop a system wide digital dashboard
- Refine the strategy and logic model

I4

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

Lead Director: Nicola Airey, Director of Planning, Surrey Heath CCG; Project Manager, Nick Willmore

Overall Objectives

We will work in partnership across the STP to recruit, retain and develop our support workforce to provide a joint workforce across organisations.

Initially we will complete a gap analysis on existing workforce, skills, vacancies and future requirements.

We will increase the pool of staff available in the footprint by:

- Improving recruitment through joint working and agreed terms and conditions across the system
- Improving retention by offering positions across social care, community and acute provision
- Supporting our current staff with the opportunity to move between health and social care, improving understanding of care delivery across the system
- Providing more development and progression opportunities within social care, community and acute care.

We are establishing a rotational apprentice scheme across social care, community and acute care which will begin in April 2017.

A pathway is being developed that will allow bands 1-4 to progress to pre-registration level, and have apprenticeships that will support band 4 staff to progress to band 5 registered nurses.

We will fully utilise the apprenticeship schemes to increase capacity, create new roles to support transformation and provide career progression for those looking for a professional role.

Deliverables

- Provide a workforce strategy that has identified the emerging roles, skills requirements and gaps in workforce provision across the system.
- Deliver a training and development plan that supports staff to work across a variety of settings, and see career progression.
- Establish a rotational apprenticeship scheme across health and social care employers that is increasing the workforce in line with demographic trends.
- Provide career progression programme for bands 1-4, and an opportunity for those who wish to progress beyond this to a first registered position.
- Establish a sustainable support workforce that provides an opportunity to develop new roles in the community.
- Provide the underlying technology infrastructure to support cross organisational working aligned with the LDR

Milestones

Milestones	Start date	End date
Develop STP Workforce Strategy and associated initiatives	13 Sept	31 Dec 16
Project agreement for apprentice scheme		31 Oct 16
Bid for Innovation Fund grant	16 Sept	01 Dec 16
Develop recruitment product for apprentices	1 Nov	31 Dec 16
Identify Training Manager for apprenticeships	1 Nov	30 Nov 16
Identify training provider	30 Nov	31 Jan 17
Recruit first cohort of apprentices	1 Jan	31 March 17

Key risks/ Issues

Risks	Mitigation
Lack of applicants	Working alongside existing hospital apprenticeship arrangements
Lack of placements	Working alongside existing hospital apprenticeship arrangements
Delays in confirming new models for services	Cross team working developing work stream plans
An increase in staffing without role redesign will become a net increase in the spend on services.	The Support Workforce strategy will bring together work stream transformation plans to inform role redesign
Metrics of success are input focused and do not identify added value for people	Design of metrics during scheme implementation.

Scope and exclusions

- The Support Workforce covers a range of roles in health and social care including rehabilitation, reablement, domiciliary and support workers, care and healthcare assistants and residential care staff.
- Staff are employed across the NHS, some local authorities and a wide range of private and third sector businesses.
- It will not cover administrative support roles, nor those identified for professionally qualified practitioners.

Interdependencies

- The detail of workforce changes will be defined by individual work streams and then picked up by this work stream for planning purposes.
- The apprentices will be part of the core workforce undertaking support roles appropriate to their experience.
- Delivery is based on access to the Frimley Health FHFT National Apprenticeship Scheme (NAS) infrastructure which has an anticipated levy of £1.7m pa to cover apprentice training.
- Underpins the effective delivery of integrated care, and enables us to influence and change the social care support market.

Benefits

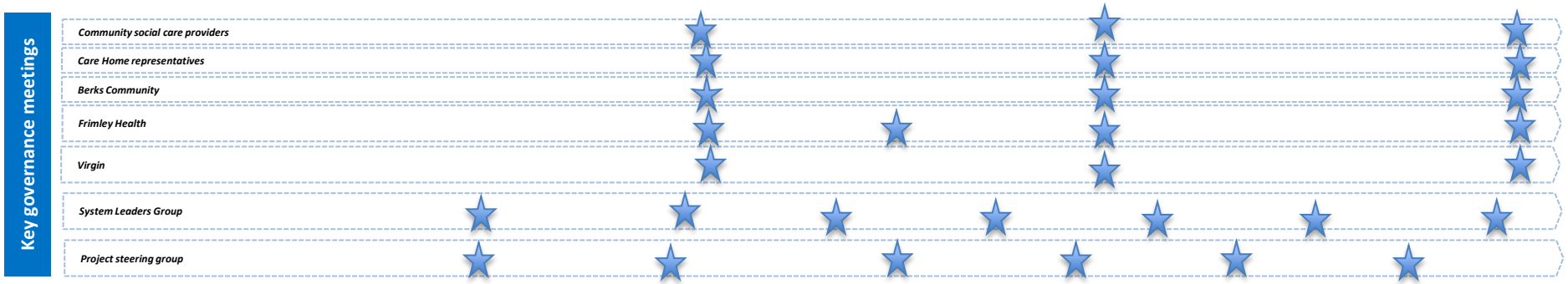
- Offer people seamless integrated care delivery
- Build greater confidence in individuals and their carers and families in the options for receiving care closer to home
- Reduce the risk of delays and gaps in provision by providing a sustainable workforce with more consistent skills
- A more flexible workforce able to pick up more skills and adapt to new roles in line with future challenges
- Attract more staff into these sectors by providing good consistent training across the footprint

Outcome measures

- Number of apprenticeships established in each year
- Improvement of % turnover of staff from current levels across all sectors
- Number of staff rotating across sectors
- Levels of skills attainment across the cohort
- Reduction in agency spend across the cohort

Support workforce roadmap – high level integrated view

October | November | December | January | February | March



Programme

- *Agree Project Brief*
- **Initiate quick wins**
- *STP Submission 21.10.16*
- *Support Workforce Strategy – analysis and planning*

Workforce Strategy

- Analyse workforce data
- Map gaps and vacancies across consolidated local workforce
- Identify potential new roles

- Develop plan to address demographic needs
- Identify opportunities to rationalise service use
- Work with stakeholders to identify new roles
- Link roles to new NAS standards and SCIE roles.

- Agree approach to recruitment
- Agree changes to service delivery
- Define workforce plans to support training and development

Resourcing Arrangements

- Quantify impact of demographic growth
- Identify potential to redefine roles to better utilise support workers

- Map growth against changes and quantify impact
- Identify duplication of time delivering services
- Review commissioning and clinical governance for support services

- Develop common role descriptors
- Define emerging roles
- Revise contracts to reduce duplication
- Develop integrated governance and contract monitoring arrangements

Rotational Apprentices

- Link with HEE apprenticeship lead
- Agree NAS lead employer
- Agree project governance

- Agree resourcing,
- Identify training officer
- Agree workforce contracts
- Align provider arrangements for staff

- Recruit apprentices
- Identify placements
- Confirm standards being used

Metrics & Evaluation

- **Develop a draft logic model**
- **Apply Vanguard evaluation strategy**
- **Agree system wide high level metrics**

- **Develop the logic model based on development roadmap**
- **Agree specific outcome measures across the system**
- **Establish performance and outcomes baselines**
- **Agree benefits realisation and evaluation strategy**

- **Establish measurement mechanisms**
- **Develop a system wide digital dashboard**
- **Refine the strategy and logic model**

I5

Transform the '**social care support' mark**et including a comprehensive capacity and demand analysis and market management

Lead Director: Alan Sinclair, Interim Director of Adult Services, Slough Borough Council; Project Manager, Nick Willmore

Overall Objectives

- There is a need to ensure that there is sustainable social care market in order to support the wider health and social care system. This is currently challenged by increases in demand and activity and the differential way in which care is purchased and delivered across the STP.
- The STP identifies the intention to make better use of home based care, to support innovation in the delivery of accommodation with support and to seek opportunities to make use of technologies that support independence, health and wellbeing in line with the LDR.
- To understand the local social care market in the STP and how best to ensure there is a good capacity and good quality of care at affordable prices
- Alternative care and support options are delivered including alternatives to care homes
- The needs of our most complex people – including people with mental health needs, learning disabilities and acquired brain injury - are understood and models of care are delivered that meet their needs in the least institutional environment
- People who live in care homes are supported well and only admitted to hospital when necessary and supported back home as quickly as possible, utilising digital technology where appropriate .

Deliverables

A market development plan that describes:
- an analysis of demand for social care services
- the modelling of alternative support options across the footprint
- how local authorities are engaging with the care market
- the role of non-institutional care in the community
- how we are promoting innovation and stimulating new models of care

Care Home support that:
- is reducing the number of urgent care admissions
- ensures that people return to care homes from hospital in a timely manner
- is making a difference to the experience of those in care homes
- better supports people with dementia to remain in familiar surroundings.
- has implemented the learning from the ECHC vanguards

A review of people with complex needs that
- has ensured that they are receiving the best possible support
- has increased their independence and control over the way they are supported
- has supported innovation in the way that needs are met
- has supported people to be closer to their natural support networks.

- Review of D2A initiatives to inform future developments

Milestones

Milestones	Start date	End date
Market development plan	3 Oct	31 Dec 2016
Market development plan options sign off	Dec	1Jan 2017
Market development options implemented	Jan 2017	Dec 2017
Care home support plan	14 Nov	1 April 2017
Complex needs review	Dec	April 2017
Complex needs options sign off	April 2017	May 2017
Complex needs options implemented	May 2017	

Key risks/ Issues

Risks	Mitigation
Failure to engage with social care providers (care homes and domiciliary agencies) .	Early joint planning with provider representatives through ASC engagement arrangements.
Impact of customers who are self-funders or from London Boroughs	Identify self-funders and other activity' to inform planning consents to new developments
Lack of new staff to deliver schemes	Initial scope required to use bank/agency staff pending local recruitment and development of rotational apprenticeship scheme
Insufficient activity in EBDs and admissions to allow for full benefits realisation	Detailed analysis of EBD and admission HRG code activity
Multiple grounds for EBDs and admissions could result in impact of schemes not being identified due to other issues	Triangulate data from the acutes against local records and weighting for demographic changes.

Scope and exclusions

- The measures planned will focus on the social care market provision.
- In order to maximise benefits the initial schemes will be focussed on care homes or groups of individuals who make the greatest demand on services in the community or in hospital. Initially this can be measured through hospital returns and levels of residential placements.
- The complex needs review will include people with a learning disability, with mental health needs or with acquired brain injuries.
- The five year strategy will need to develop local measures designed to support people with mental health needs and associated physical conditions.

Interdependencies

- Support workforce – stability and capacity for home based care
- Prevention and self-care – to manage demand for services and reduce need for on-going support
- Social care record – to maximise impact of services
- Integrated Care Hubs – managing demand for services
- Enhanced use of Technology Enabled Care Services to support people to remain at home
- Partnership working to increase housing options

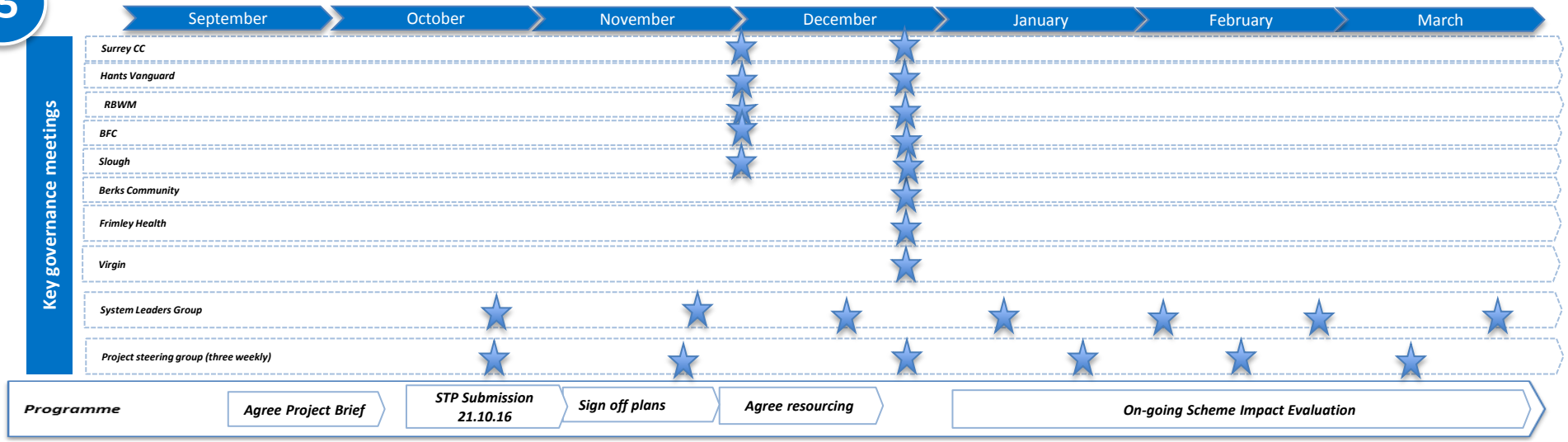
Benefits to local residents

- All services based on maintaining you in a familiar environment
- Reduce the risk of extended admissions to hospital
- Greater choice and control over type and place of care
- Increasing and retaining your independence

Outcome measures

- Care Home Support– Reduce acute admissions from care homes by 20%
- Complex needs review - Number of cases where support can be re-provided, target of 64 with total saving of £980,000

15 Social care support market roadmap – high level integrated view



Market Strategy

- Agree key areas for transformation
- Agree service intervention principles
- Identify areas of greatest impact
- Evaluate potential for change
- Link to mental health strategy

- Consult with providers on principles / potential innovation
- Map demographic needs against services
- Assess unmet need based on existing demand
- Map resources to identify investment needs
- Link to MH Forward View and LD programmes
- Identify digital solutions to link needs to market place

- Define key actions to transform the market
- Quantify impacts expected from strategy implementation
- Agree changes in services with providers
- Evaluate impact of changes in social care on the system.

Care Home Support

- Agreeing intervention model
- Define target group
- Identify high demand services
- Develop pathways to community services
- Link to shared care record

- Map current resources
- Align support to areas
- Identify resource gaps
- Agree resources to be created
- Develop service specification
- Develop governance

- Appoint staff team
- Locate base
- Define metrics for evaluation
- Agree first phase of homes to be supported
- Align with primary care support

Complex Needs Review

- Appoint project team to review complex needs support
- Agree scope and target group
- Undertake desk top review
- Develop plan for re-provision

- Undertake individual reviews
- Develop alternative support plans
- Develop transitions programme for service changes

- Agree providers for individuals
- Draw up service plans for individuals
- Support transitions between services.

Metrics & Evaluation

- **Develop a draft logic model**
- **Apply Vanguard evaluation strategy**
- **Agree system wide high level metrics**

- **Develop logic model based on development roadmap**
- **Agree specific outcome measures across the system**
- **Establish performance and outcomes baselines**
- **Agree benefits realisation and evaluation strategy**

- **Establish measurement mechanisms**
- **Develop a system wide digital dashboard**
- **Refine the strategy and logic model**

I6 Reducing **clinical variation** to improve outcomes and maximise value for individuals across the population.

Lead Director: Ros Hartley, Director of Strategy and Partnerships, NEHF CCG; Project Manager, Gazelle Robertson

Overall Objectives

- To use the Right Care Approach to reduce variation across our System for the five disease areas initially identified through the programme:
  - **Respiratory**: development of specialist clinics
  - **MSK**: consistent pathways rolled out to general practice
  - **Neurology**: community outreach clinics
  - **Circulation**: hypertension & stroke pathway development
  - **GU**: better end of life recognition and drug monitoring
- To establish an agreed process for identifying and reducing variation across further pathways within the system.
- To utilise the medical expertise across our system, and the wider NHS and Social Care community, to ensure care pathways are fit for future service provision with up to date technologies to improve patient care.
- To spread good practice across the STP area to reduce variation in quality and outcomes across the five disease areas

Deliverables

- Specific improvements and reduction in variation across five disease areas through:
  - -consistent pathway development across providers
  - -risk stratification and case management across providers
  - -establishment of community clinics
  - -standardised service specifications
- Intensive data sets across each of the disease areas by CCG and across the STP
- Joint working across primary, community and secondary care
- Reduction in financial spend across five disease areas

Interdependencies

- Integrated care
- Shared care record
- GP Transformation
- Mental Health

Milestones

Milestones	*Start Date*	*End Date*
Engagement exercise to reaffirm priority areas	*Sep 16*	*Oct '16*
Complete financial modelling exercise and identify savings and areas for investment	*Aug 16*	*Oct 16*
STP submission		*21 Oct 16*
Project brief sign off	*Oct 16*	*Oct 16*
Workstream steering group set up and establishment of subgroups with detailed action plans to undertake and complete actions within each of the disease areas	*Oct 16*	*Nov 16*
Programme implementation	Nov 16	Oct 17
Develop an evaluation process with measurable outcomes to ensure programme achieves its aims and delivers change		Oct 17

Key risks/ Issues

Risks	Mitigation
Quality of data to determine variation	Right Care Approach commissioning for value packs and SLA with CSU to obtain, monitor and analyse data
Lack of engagement across primary and secondary care	sign up from across the system and relevant clinicians feeding into workstream -continued engagement, -agreed principles and specific actions jointly developed
Focus on disease areas does not reduce variation	Right Care Approach and deep dive into data packs to reaffirm priority areas and continued monitoring of data to assess impact

Scope and exclusions

- Working across the Frimley Health system, using the Right Care Approach to reduce variation in:
  - -Respiratory – Phase 1 (Oct 16)
  - -Musculoskeletal – Phase 1 (Oct16)
  - -Neurology – Phase 1 (Oct 16)
  - -Circulation – Phase 2 (Sept 17)
  - -Genito-Urinary – Phase 2 (Sept 17)

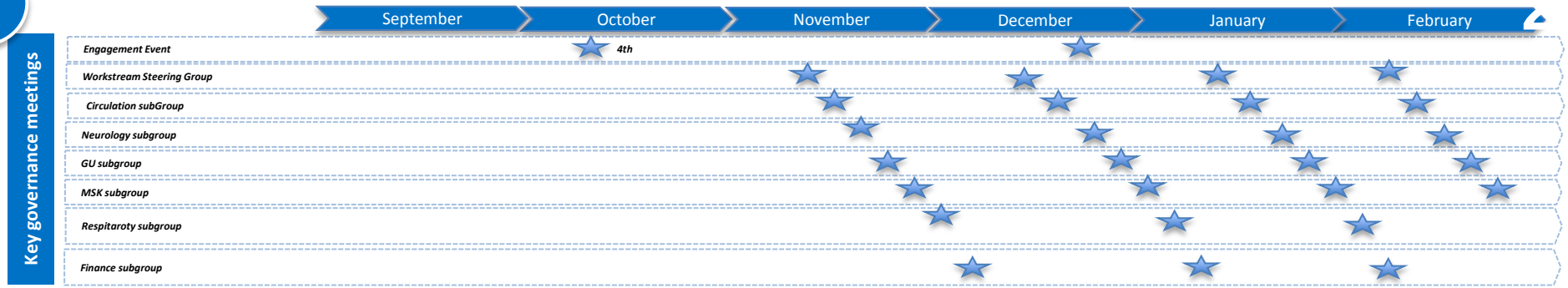
Benefits

- Reduced spend across each of the pathways totalling £37m, with recurrent savings in excess of £16m from Year 4
- Consistent alternative referral pathways for agreed conditions from Dec 2016
- Equitable health provision for our population
- Evidence based interventions developed across primary & secondary care
- Joint working across primary, community and secondary care
- Reduced variation benchmarked against national and STP data
- Improved outcomes for patients across physical and mental health

Outcome measures

- Continuity of care and clearer information about care choices through standardised pathways – Q4 16/17
- The extent of reduction in variation across the CCGs in each of the selected disease areas over 5 years:
  - Phase 1: -Respiratory
  - (Oct 2016) -MSK
  - -Neurology
  - to show improvements from April '17
  - Phase 2: -Circulation
  - (Sept 2017) -GU
  - to show improvements from April '18
- Financial savings achieved over the four year cycle

Reducing clinical variation roadmap – high level integrated view



Programme

- Engagement Events
- Workstream steering grp setup
- Financial Modelling
- STP Submission
- Set up subgroups
- Programme Implementation
- Phase 1: Respiratory, MSK, Neurology Implementation from Nov 2016
- Phase 2: Circulation, GU Implementation from Sept 2017
- Evaluation Process

Respiratory

- Set up subgroup – Nov 2016
- Subgroup to focus on: -community respiratory service; -case management for high users of urgent services; -standard hospital discharge checklist; -specific guidelines / referral checklist to access secondary care; -spread the learning from WAM & Bracknell & Ascot across the STP: Implementation from Dec 2016

MSK

- Set up subgroup – Nov 2016
- Subgroup to focus on: -consistent MSK pathway to be rolled out to all practices; -consistency of Tier 2 services starting with NEH&F. Implementation from Dec 2016

Neurology

- Set up subgroup – Nov 2016
- Subgroup to focus on: -East Berkshire Neurology programme and spreading the learning across the STP; -community outreach services; -reduction of admission rates. Implementation Dec 2016

Circulation

- Data deep dive into Stroke & Heart disease – May – June 2017
- Set up sub group – Sept 2017 to implement actions
- Determine community part of pathways
- Set up hypertension & stroke pathway
- Reduce A&E attendances related to heart disease
- Establish pathways on diabetes control

GU

- Data deep dive : May – June 2017
- Set up subgroup – Sept 2017 to implement actions
- Establish better end of life recognition
- Establish better drug monitoring
- Explore at home dialysis
- Risk stratification across providers
- Explore at home dialysis
- Primary care training for better management of patients

Finance

- Complete financial modelling – October 2016
- Review impact on savings – Nov 2018
- Review impact on savings – Nov 2019
- Review impact on savings – Nov 2020

Engagement

- Undertake workshop to confirm priority areas – October 2016
- Develop communication & engagement plan including key stakeholders, methods of communication and engagement and timescales

Metrics & Evaluation

- Develop a draft logic model
- Apply Vanguard evaluation strategy
- Agree system wide high level metrics
- Develop the logic model based on development roadmap
- Agree specific outcome measures across the system
- Establish performance and outcomes baselines
- Agree benefits realisation and evaluation strategy
- Establish measurement mechanisms
- Develop a system wide digital dashboard
- Refine the strategy and logic model

I7 Implement a **shared care record** that is accessible to professionals across the STP.

Lead Director: Jane Hogg, Integration and Transformation Director, Frimley Health; Project Lead, Sharon Boundy

Overall Objectives

The initial objective of this initiative is the collaborative development of a Shared Care Record with system wide agreement of clinical / care professional and citizen collaborative design, to achieve the following:

1. **Integrated Care:** Better informed decision-making across all health and care settings by allowing information generated in one care setting to be seen and acted upon in another, irrespective of geographical or organisational boundaries
2. **Self-Care and Prevention through a Patient Portal:** Citizen access to self-care and support tools via digital ecosystem
3. **Urgent and Emergency Care:** Having access to timely and relevant information will support care professionals. This information will reduce duplication and support the triage process.
4. **GP Transformation:** Supports with a person having to tell their story only once
5. **Unwarranted Variation:** Optimising the use of medicines, especially where such information is not even available.
6. **Infrastructure:** Information will flow safely and securely across all health and care settings

Deliverables

1. Setup shared care record workstream aligned with LDR
2. Achieve system wide agreement on the design framework
3. East Berkshire Connected Care Programme Go-Live
4. Agree phased implementation plan based on local readiness
5. Coordinate detailed process mapping
6. Develop the clinical and care professional led design
7. Turn the design into a functional shared care record
8. Operationalise the validated shared care record in pilot sites
9. Roll out the phased implementation
10. Embed new processes and refine the shared care record
11. Embed a continuous improvement cycle

Milestones

Phase	*Milestone*	*Start*	*End*
Visioning	Align the Shared Care Record and interoperable programmes to the STP	*Aug 16*	*Oct 16*
Planning	Agree principles of a unified system STP / LDR	*Sep 16*	*Nov 16*
	Model the financial impact of proposed scope	*Oct 16*	*Oct 16*
	Submit the next iteration of the STP		*Oct 16*
	Set up Shared Care Record work-stream aligned with LDR	*Nov 16*	*Nov 16*
	Achieve agreement on the design framework **(East Berkshire Connected Care Go-Live in November)**	*Nov 16*	*Jan 16*
	Agree a phased implementation plan based on readiness	*Jan 17*	*Jan 17*
	Develop a detailed iterative planning schedule	*Jan 17*	*Mar 17*
Design	Coordinate detailed process mapping	*Jan 17*	*Mar 17*
	Develop the detailed design – this design will evolve and refine as the shared care record is implemented in order to continuously develop the solution based on end user feedback	*Jan 17*	*Mar 17*
Build	Turn design into a functional shared care record	*Mar 17*	*May 17*
Deploy	Operationalise shared care record in pilot sites	*May 17*	*Jun 17*
	Roll out phased implementation – phasing will be based on three tiers; organisational and local area readiness, as well as the types of data being made available	*June 17*	*TBC*
Stabilise	Embed new processes and refine	*June 17*	*TBC*
Maintain	**Embed a continuous improvement cycle**	*June 17*	TBC

Key risks/ Issues

Risk	*Mitigation*
On-going discussions regarding alignment of interoperable solutions across the system	Managed through the STP LDR board
Suppliers not able / willing to deliver requirements	Apply a robust development and contract assurance mechanism

Interdependencies

- Local area requirements to work across more than one interoperable solution
- Formation of one STP LDR
- LDR work-streams
- Other STP initiatives

Scope and exclusions

The shared care record is concerned with the development of the clinical and care user interface to present a consolidated view of patient information. The project will be delivered through a phased iterative approach, with the initial phase focussed on gathering, agreeing and implementing the requirements across the system from a clinical and care professional perspective. The interface between these requirements and the essential development of the technical infrastructure will be a key dependency. Future iterations of the project will include a patient portal and integrated care planning as examples

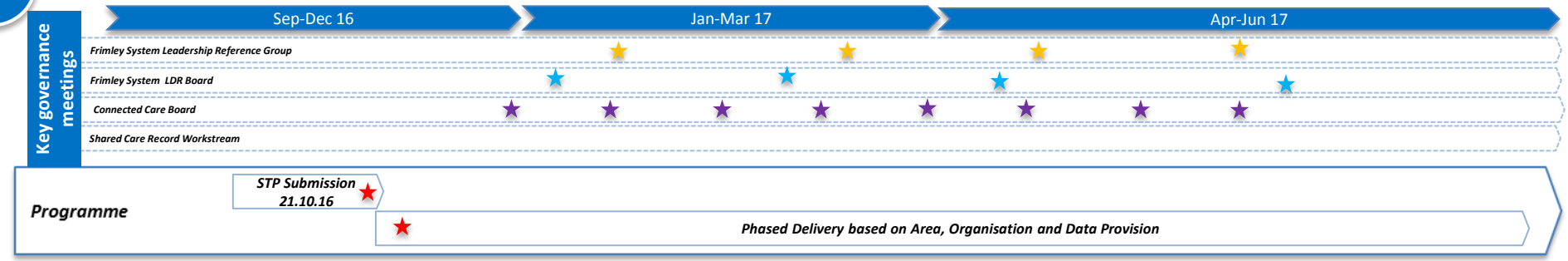
Benefits

Increased satisfaction (tell story once, increased confidence, personalised care)	Efficiency (e.g. reduction in letters, phone calls & faxes, triage and analyses, reduced referrals assessments and tests)
Improved efficiency (e.g. admissions and re-admissions,	Quality and safety of care (eg patient wishes including EOL, better decision making from seeing medical and social history)
Increased staff satisfaction	Improved safeguarding
Individuals engaged in their care- better management of health	Enhanced use of technology to support people to remain at home

Outcome Measures

- % of users who report time saved looking for information (75%)
- % reduction in duplicate tests due to information in shared record (40%)
- % staff who report shared record contributes to better clinical outcomes (75%)
- % of staff who report access to shared care record improved patient safety (70%)
- % of staff who report portal has saved time (regardless of task- e.g. could be admin staff or clinical) (80%)
- % of clinicians (across different settings/clinical specialities) who use portal routinely at point of care.

Shared care record roadmap – high level integrated view



Design

- Agree design principles
- Extensive engagement across all organisations
- Detailed clinical and care professional design
- Detailed process mapping
- Agreeing a phased implementation Plan
- Carry out comprehensive usability and clinical and care safety testing
- Enable the shared care record in pilot sites to refine its usability on the front line through continuous improvement and development

Continuous Improvement & Development

Agile feedback loop between design and delivery to enable a continuous cycle of improvement and development - informed by end users

Phased Delivery

East Berkshire Connected Care Go-Live **Nov '16**

Delivery will be phased according to three tiers of readiness

Area	Delivery planning will be aligned to the readiness of each area. E Berkshire will be followed by alignment with NEH&F and Surrey Heath
Organisation	Within each area, different organisations will be ready to deploy the shared care record at different stages, due to various factors including digital maturity. This will further influence who goes live and when.
Data Provision	Digital maturity will have a further impact within each organisation, limiting the data that can be extracted. Different departments and data items will therefore be available at different stages of deployment

Empowering Patients, Citizens and Communities

Applying the six principles of effective engagement and participation throughout the programme:

Care and support is person-centred: personalised, coordinating and empowering	Focus on narrowing health inequalities	Voluntary, community, social enterprise and housing sectors are involved as key contributors
Services are created in partnership with individuals and communities	Carers are identified, supported and involved	Volunteering and social action are recognised as key enablers

Metrics & Evaluation

- Develop a draft logic model
- Apply Vanguard evaluation strategy
- Agree system wide high level metrics
- Develop the logic model based on development roadmap
- Agree specific outcome measures across the system
- Establish performance and outcomes baselines
- Agree benefits realisation and evaluation strategy
- Establish measurement mechanisms
- Develop a system wide digital dashboard
- Refine the strategy and logic model

STP aligned Digital Ecosystem

Transformational Enablers

A Population Focus

Purpose: Becoming a system with a collective focus on the whole population we serve and support throughout their lives – not a system based on sectors, organisations, services or parts of the population.

- We are making good progress in becoming a system with a collective focus addressing the whole population. This has been recognised and welcomed by key stakeholders including Health and Wellbeing Boards and Health Watch
- We are working across physical, psychological and social wellbeing
- By taking this whole population approach we aim to ensure we're working for the benefit of the population and individuals within it rather than on the organisations who are fragmenting care and support by the current delivery mechanisms
- This is increasingly reflected in everything we do and is reinforced by our technology enabler, where the information is wrapped around the individual rather than from an organisational perspective
- We are focusing on those groups who are particularly vulnerable within the population, for example those with severe mental health conditions, learning disabilities or acquired brain injuries, where we know services and their impact needs to be significantly improved.

B Developing Communities

Purpose: 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.

- All our residents and patients live as part of one or several different communities and we are increasing our understanding and connections with these as we move to delivering our initiatives across our localities
- The support that communities can provide for people and their families is substantial in supporting people in crisis, preventative support and helping people to maintain their independence
- Working with all employers in the system will support them in promoting the health and well-being of their employees and encouraging social responsibility within their communities
- There are a plethora of community, faith and voluntary organisations across the Frimley footprint that are already supporting people and with more co-ordination they could support people in a more structured way
- There will be further opportunities for volunteers to actively participate in the health & wellbeing of their community and we are reviewing the social prescribing scheme already implemented in the Vanguard.
- A priority focus will be supporting people to be more included in their community and therefore reduce the impact of social isolation (at least 12% of older people report being isolated which increases the risk of illness)
- Social networks and friendships not only have an impact on reducing risk of illness they also help people recover when they have become ill
- Councils and CCGs are already funding and supporting community and voluntary groups and the focus of this funding will be reviewed
- There is a need to increase support to carers who fulfil a vital function and promote greater resilience and stability.

These two transformational enablers provide an ethos and approach across all of our work.

Transformational Enabler: C Workforce

Purpose: Developing the workforce across our system so that it is able to support self care and health promotion and deliver our new models of care, recognising that this transformation will be achieved through development and retention rather than recruitment and be within today's costs.

The **Local Workforce Action Board** (LWAB) has been formed and has an agenda to deliver a set of overarching priorities and respond to the workforce priorities from each initiative:

System workforce priorities:

Completing the analysis of the whole system's workforce to achieve collective understanding of hot spots and priorities
Identify the gaps, duplicates and crucial elements to deliver transformational change
Complete a comprehensive diagnostic of staff satisfaction, recruitment, retention and vacancies across the whole system
Designing and developing a system that provides effective leadership, mentorship and support as we move to a greater emphasis and development of our lower band workforce

Example workforce hotspots:

- 22% of GPs and community nurses are aged 55+ as are 22% of social care workers in local authority and private sector settings
- The number of GPs and community nurses/ 1000 population is lower in our system than the national average and significantly lower in East Berkshire
- Turnover rates vary greatly by sector and profession, with the highest turnover found in the independent home care and care home sector (33% during 2015)

Seven key initiatives workforce priorities:

Prevention and self management	• Developing prevention as a core capability of staff • Supporting the workforce to be healthy • Learn from the new roles supporting social prescribing in the Vanguard
Integrated decision making hubs	• Investing in new roles including care navigators, mental health leads, pharmacists and extensivists. • Leadership and team development programmes for MDTs • Training in best practice integrated care including case finding and care planning
General practice at scale	• Increasing the number of GPs and develop roles to support them • Develop skills in primary care through training and continuous professional development • Implement new roles, such as mental health therapists and clinical pharmacists • Provide career opportunities and planning, including shadowing and portfolio roles
Support workforce	• Complete a gap analysis of existing workforce, skills, vacancies and future requirements • Establish a rotational apprenticeship scheme across social care, community and acute care • Develop career pathways with level 2/3 qualifications leading to professionally based level 5 qualifications
Social care support Market.	• Maximise the scope of the existing market • Training provider staff to support more complex individuals • Ensuring staff have the skills to meet the changing expectations of the community
Clinical variation.	• Training non-medical staff to manage conditions as part of implementing new pathways • Developing skills in case management for high risk patients • Supporting staff to work across organisations
Shared care record.	• Ensuring the system has the change management capability and capacity to implement well and make the cultural and process changes to drive through the benefits • Support front-line staff to continue to shape design and implementation • Delivering effective training to all staff as part of implementation

Transformational Enabler: D Technology - LDR and STP alignment

Purpose: Using technology to enable individuals and our workforce to improve wellbeing, care, outcomes and efficiency.

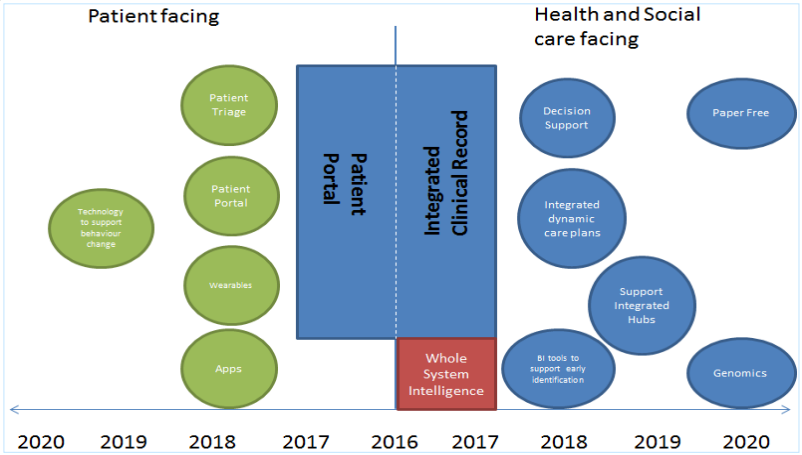
Local Digital Roadmaps

There are currently three LDR's within the Frimley STP footprint which cross multiple boarders. This introduces significant complexity when trying to provide a consistent and coherent digital approach to support the STP priorities. It is proposed that the Berkshire East LDR is dissolved and a single Frimley LDR is established with North East Hampshire and Farnham and Surrey Heath as partners so that it completely aligns with the STP footprint.

This is a primary objective of the STP/LDR leadership and programme teams, with a first meeting of the Frimley Digital Roadmap Board in November. First steps for this Board will be to align interoperable solutions with the Frimley STP footprint working across borders where possible.
In conjunction with the national objective around paper free at the point of care and the associated capabilities, the Frimley LDR will have an overarching vision to deliver three key objectives:

- An information sharing mechanism for health and social care professionals
- A patient facing portal
- Whole system intelligence/Population analytics for new models of care

As illustrated below, these are intrinsically linked and will support all the STP priorities.



Alignment with STP

It is recognised that technology has a significant part to play to deliver the whole system transformation agenda. The STP priorities and initiatives are now driving the whole digital strategy. Digital transformation threads through all the STP initiatives and significant opportunities have already been identified that can stretch the digital support offered. One example of this is an opportunity to provide behaviour change through to technology to the STP workforce. Learning from this can then be applied to a larger wellbeing agenda for our patients/residents. Details of the workstreams that have been established to support delivery of the universal capabilities and how these have also been aligned with STP priorities and initiatives are included as an **appendix**. This ensures that our workforce is delivering multiple technology and transformation objectives.

Delivering technology that will support the STP

Several workstreams have been proposed and some have already been initiated and more information on these are included as an **appendix**. These workstreams will have clear deliverables, mandates from Chief Executives, and accountability. These are important principles as multi-organisational projects are complex and historically have not delivered at the pace that is required to support STP's. There is a commitment from partners to work differently and at scale. This will not only support the STP, but will ensure that the universal capabilities progress, support paper free at point of care and ensure resources are utilised more efficiently. provides an example of how these workstreams are evolving.

Transformational Enabler: E Developing the estate

Purpose: to deliver an efficient and fit for purpose estate infrastructure across the STP footprint that supports delivery of the seven initiatives and new care models.

Priorities:

- Combining the One Public Estate work across the STP footprint to make optimal use of the estate and deliver co-location of services that improve integration of care and support and efficiency. Considering local options across the public sector for a shared approach to property maintenance and management.
- Securing a local agreement about the use of benefits from disposals and their support to develop our new care models
- Achieve a greater collective influence on NHS Property Services to prioritise the estate improvements required to deliver our STP – many of which are not fit for purpose.
- Address the immediate estate constraints in primary care to ensure it is fit for purpose. This will include:
    - Refurbishing buildings where they don't meet standards
    - Investing in new accommodation that expands the range of services and delivers new care models
    - Delivering co-location options
    - Identify locations for and develop integrated care decision making hubs across all localities by the end of 2018
- Deliver significant capital investment and reconfiguration of acute estate to transform elective care at Heatherwood Hospital and the emergency and maternity departments at Wexham Park Hospital to improve productivity and the quality of care.
- Ensure administrative estate is consolidated to facilitate Carter recommendations.

Mental health and learning disabilities

The Frimley Health and Care STP places a strong focus on supporting good mental health and physical health and will support the delivery of the Five Year Forward View for Mental Health and out local transforming care plans for people with learning disabilities. The delivery of the STP requires mental health and learning disabilities to be integrated throughout the plan and this has been embedded in each workstream. The following table describes this for each initiative.

Initiative	Mental Health Deliverables
Prevention & Self Care	Recovery focussed services: using evidence-based interventions to improve health and wellbeing and help people secure employment. Developing perinatal and child and adolescent mental health services in line with national guidance to reduce incidence of ongoing mental health problems. Tackling health inequalities through screening and treatment, eg. smoking cessation support. Expanding the use of online interventions and use of technology to increase access, choice and engagement in lifestyle change. Use of technology to keep people at home, eg. the innovative test bed programme for Dementia patients. Rapid access to support preventing escalation into crisis and avoidable hospital admission (including mental health liaison services and safe havens/crisis cafes).
GP Transformation	Integration of mental health practitioners in extended primary care teams; including Clinician to clinician video consultation , redesigned mental health practitioner roles, expanding talking therapies for long term condition use, and developing integrated physical mental health and learning disabilities pathways within primary care .
Social Care Support	Effective support to Care Homes including comprehensive training about dementia for leaders, training of staff and in-reach services to minimise non-elective admissions. Integrated community services to support people in their own homes, including effective support of carers.
Unwarranted Variation	Scale learning and spreading good practice including integrated approaches (Surrey Heath and NEHF Vanguard) and evidence–based interventions representing greatest value (Early Implementer site for Increasing Access to Psychological Therapies). Reduce variation in delayed transfers of care, bed occupancy rates and numbers of out of area placements.
Integrated Care Decision Making Hubs	Embed mental health practitioners in the integrated decision making hubs to ensure seamless interface between primary care, secondary care and the acute system for people with mental illness. Share learning from integrated physical and mental health approaches in Surrey Heath and NEHF Vanguard.
Support Workforce	Enabling delivery of safe, sustainable services and achievement of targets to reduce use of agency staff. Embedding psychologically informed approaches to assessment & interventions across the whole health & care workforce. Training in 'Making every Contact Count' and support of Shared Decision Making. Development of new roles to promote wider integration of peer mentors & wellbeing ambassadors. Recruitment & training to promote digital competence, enabling delivery of online and technology enabled interventions.

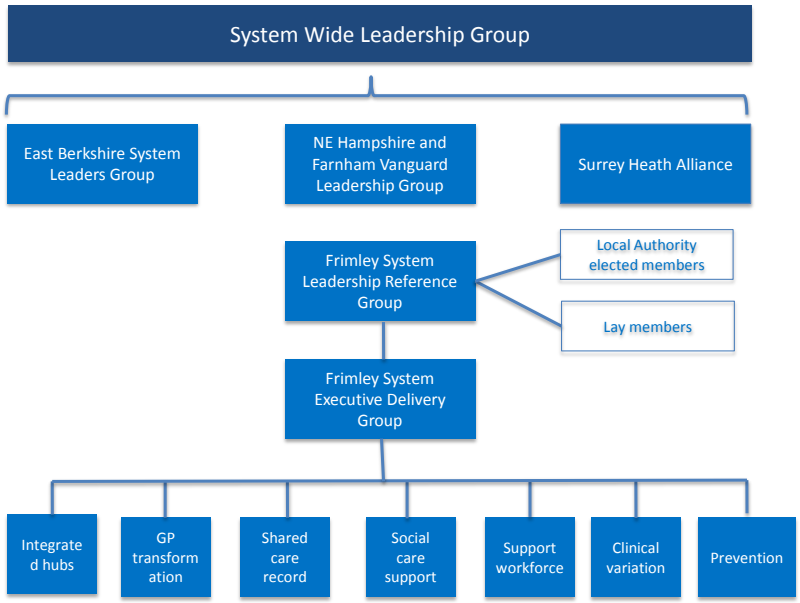
Leadership & governance for delivery

From successful planning to successful delivery

The Frimley system brings together a group of high performing and ambitious providers, commissioners and systems. The leadership and governance arrangements that we put in place to deliver our Plan have been successful. We have reviewed these to ensure that they are now focused on successful delivery and have added a new Executive Delivery Group that will provide programme management and support.

There has been some discussion and exploration across the vanguard and Surrey Heath alliance to identify ways of moving towards an **Accountable Care Organisation** governance structure which may be suitable to roll out across the STP in future years.

Initial discussions have taken place at System Leaders Reference Group about **System Control Totals** and agreement was reached to operate in shadow form across the STP for 17/18. Principles governing this are being developed for consideration. Where possible learning will be considered from national and regional examples where systems are ahead of ours.



Our governance structure

The bedrock of effective leadership and engagement across our footprint is the **3 established system leadership groups**:

- East Berkshire System Leadership Group
- North East Hampshire and Farnham Vanguard Leadership Group
- Surrey Heath Alliance

The **Frimley System-Wide Leadership Group** brings together all of the members from these three groups (50 people) to support collaborative leadership development and cross-system support and relationship building.

The Frimley System Leadership Reference Group
This group, chaired by Sir Andrew Morris, works on behalf of the three established system leadership groups to steer and lead delivery of the STP plan. It brings together the CCG Chief Officers and leadership representatives for the public, local authorities and clinicians.

Frimley System Executive Delivery Group
Comprised of Executive Directors representing the localities and sectors that form the STP. Provides programme management and support to the workstreams and reports to the Leadership Reference Group.

Initiative Delivery Groups
Will be established both from existing delivery groups within the STP areas and newly formed as appropriate, reporting into the Executive Delivery Group.

Wider stakeholders
Wider scale engagement has taken place with groups such Healthwatch, PPI groups and voluntary sector organisations. An Elected members and a Lay members group has been established with the support of the Local Authority as well as an advisory group for mental health.

Finance & efficiency – case for change

Where we are now

A whole system activity and financial model has been developed for all publically funded health and social care across our system. The model shows the size of the financial challenge for our system and the potential impact of introducing new models of care and efficiencies. This has been used to populate the national financial templates.

A 'do nothing' base case has been calculated showing the impact of demographic change, inflation and other growth factors including investments required to meet the priorities outlined in the Five Year Forward View such as delivering seven day a week services, improving mental health and enhancing general practice access.

The '**do nothing**' base case split by sector is:

Frimley STP 'do nothing' gap	**2020/21**
NHS Commissioners	£100m
Local NHS Providers	£87m
Local Authorities	£49m
Total	£236m

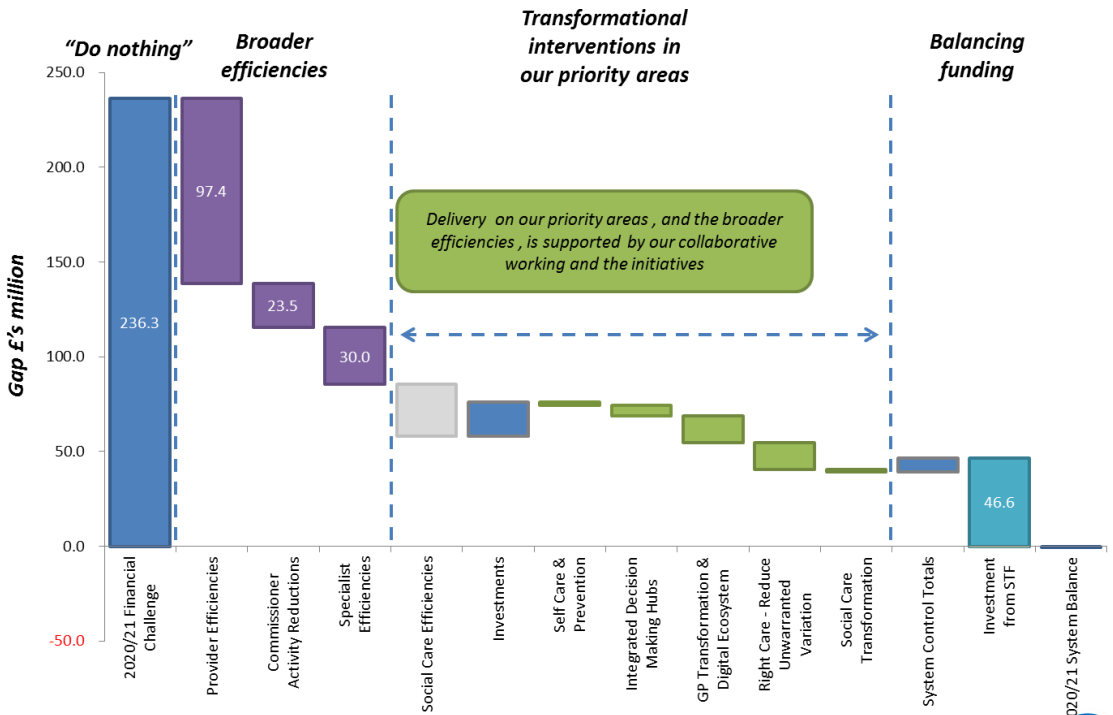
In addition to being unaffordable, the implied demand would require an increase in acute bed capacity of about 10%.

Bridging the gap in 2020/21

Recognising that the system will need to make broader efficiencies a second scenario has been modelled taking the gap of £236m and reducing demand by 1% and delivering 3% health provider savings each year, plus social care efficiencies. This scenario incorporates the medium term efficiency assumptions arising from the acquisition of Heatherwood & Wexham Park Hospital by Frimley Park in 2014. It also assumes that Specialist Commissioners are able to deliver their planned savings.

If this can be achieved it would reduce the gap to £85m, which would need to be met by a combination of transformational savings and an additional allocation from the national Sustainability and Transformation Fund (STF).

Although the broader efficiencies are largely commensurate with previous levels of delivery the challenge in delivering a further £151m of savings (64% of the gap) mustn't be underestimated. It will require applying Right Care principles to all our activities, and new ways of system-wide working to ensure overall costs are genuinely reduced, rather than just moved between organisations. Without our transformational interventions, these broader efficiencies will not be achieved.



Finance & efficiency – modelling assumptions (1)

Organisational control totals

At the beginning of October NHS providers and CCGs were issued with 'control totals' for 2017/18 and 2018/19. These are effectively the surpluses they are required to achieve. The CCGs in the Frimley Health & Care STP are able to 'drawdown' from surpluses accumulated in previous years by c£1m pa, but for the next two years providers are required to make in-year surpluses of £24m. (For Frimley Health FT this is roughly 3.5% of turnover). We have included these requirements in our plans. For the last two years of the plan we have assumed lower provider surpluses of 1%.

Activity assumptions

We have modelled the impact of existing commissioner activity reduction plans and our system wide solutions on the underlying trajectory for acute hospital activity. The 'do nothing' position reflects impact of the underlying population growth in our area, coupled with the rising demand of an aging population. We believe our solutions will both mitigate the rate of growth (through for example improved self care) and increase hospital efficiency so more patients can be seen within the same resources (through better pathway management and greater use of technology). We are therefore not planning for a significant change in the total acute bed stock

Social care assumptions

Our vision is for a financially sustainable health and social care system, therefore understanding the growing pressures on social care and the interrelationship with heath has been central to many of our solutions. For financial modelling we have taken a consistent approach across the three Unitary Authorities and two County Councils in our area, modelling adult social care, children's social care and public health costs. By 2020/21 we estimate a pressure on these services of c£22m (after taking account of solutions and precept changes). This is broadly matched by the remaining health surplus (having already delivered the assumed control total requirements

Capital investment plans

Significant capital investments are planned for Heatherwood Hospital (a full redevelopment to provide a state-of-the-art elective care centre) and Wexham Park Hospital (new emergency and maternity departments). These are all already provided for in Department of Health capital plans. CCGs are also bidding for capital funding to support primary care redesign, and as a system we are also asking for additional investment to develop our 'digital ecosystem'.

	2016/17	2020/21 'Do nothing'	Increase from 2016/17 %	2020/21 'Do something'	Increase from 2016/17 %
Outpatient Attendances	1,074,708	1,257,255	17.0%	1,100,176	2.4%
Elective Spells	132,176	144,338	9.2%	135,511	2.5%
Non-Elective Spells	134,685	147,366	9.4%	139,461	3.5%
A&E Attendances	462,566	507,604	9.7%	478,968	3.5%

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	Total £m
Approved schemes and primary care bids	71.5	57.6	21.5	12.5	163.1
Backlog maintenance	36.9	22.8	12.0	9.3	81.0
Sub Total	**108.4**	**80.4**	**33.6**	**21.7**	**244.1**
Total New Capital Expenditure Required To Implement Solutions	19.9	12.8	3.3	5.8	41.7
Total Capital Expenditure	**128.3**	**93.2**	**36.8**	**27.5**	**285.8**
of which is currently committed in DH plans	*79.2*	*58.4*	*0.0*	*0.0*	*137.6*

Finance & efficiency – modelling assumptions (2)

Specialist commissioning

Our detailed financial template incorporates expenditure estimates calculated by NHS England specialist commissioning teams. There is a key assumption that these costs can be contained with their published funding allocations. Although these rise by 16% between 2016/17 and 2020/21, in the underlying 'do nothing' position costs rise faster for specialist commissioning than for normal acute activity (by 34% compared to 17%) and therefore solutions which will save £30m are being identified by specialist commissioning colleagues.

For our STP modelling we have assumed that these solutions will deliver and will not have a detrimental impact on our local NHS providers (the majority of this activity is undertaken elsewhere in the country) and if there are definitional changes in what 'counts' as specialist commissioning, they will be fully matched by funding allocation changes

Commissioner funding allocations

Throughout our modelling we have used the allocations for the CCG, primary care and specialist sectors published in January 2016, and have adjusted for any subsequently agreed recurrent allocation changes.

Excluded items

It should be noted that costs and matching funding for the NE Hampshire and Farnham PACs Vanguard programme has not been included in 2017/18 (c£5m). Also excluded is the recently approved Talking Therapies expansion for Berkshire East.

Primary care assumptions

The financial plan incorporates all primary care (GP) funding, irrespective of whether these budgets are fully delegated to CCG yet. Primary care allocations are due to rise by 16% by 2020/21 whereas core CCG allocations only increase by 12%. This reflects some of the commitments made in NHS England's GP Five Year Forward View document to improve investments in primary care. In addition our solutions invest a further £8.5m in GP transformation over the period. Total primary care expenditure (excluding prescribing) is forecast to rise from £111m in 2016/17 to £136m, over 21%, a larger increase than either the acute or mental health sectors.

Funding support for Frimley acquisition

When Frimley Health FT acquired Heatherwood and Wexham Park Hospitals in 2014 a package of financial support was agreed between the Department of Health, NHS England and local commissioners. In terms of the STP submission our plan matches income to cost for the transaction money and integration so there is no net impact on the bottom line, and the deficit support is included in the overall Trust income assumption

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Deficit Support (DH)	16.6	13.8		
Public Dividend Capital (DH)			11.7	
Capital Expenditure Support (DH)	37.7	11.9		
Transaction Support (DH)	4.4	4.3	2.7	
Integration Support (CCG & NHSE)	1.7	1.5	1.2	
Total	**60.4**	**31.5**	**15.6**	**0.0**

Note: table based on original agreement, some rephasing has occurred

Finance & efficiency – solutions

Financial impact of solutions

Each of the initiatives described in Section Two has been supported by a project accountant who has undertaken the financial evaluation of the costs and benefits. The outputs from the individual workstreams have also be reviewed to ensure savings are not double-counted.

Overall savings are forecast to exceed £65m over the next four years. As shown in the table below, we have chosen to group the majority of savings against five initiatives, with the remaining two (the support workforce and implementing a shared care record) as 'enablers' rather than undertaking a further somewhat artificial apportionment of savings across more categories. But these areas or no less important. In addition, many of the initiatives also underpin the continued delivery of provider Cost Improvement Programmes (CIPs) at c3% pa. For example the Support Workforce programme which aims to improve recruitment and retention and to develop a rotational apprentice scheme, aims to deliver a net benefit of £2.2m over the next four years, but there savings are contained within provider CIPs. Our costings include £500k for programme management to support implementation of the seven initiatives.

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	Total £m
Self Care & Prevention	1.1	1.1	1.2	1.4	4.8
Integrated Decision Making Hubs	0.7	2.3	3.9	5.5	12.4
General Practice transformation	(1.6)	0.1	2.5	6.2	7.1
Right Care - Reduce Unwarranted Variation	4.3	6.3	11.8	14.1	36.5
Social Care Transformation	0.9	1.3	1.1	1.1	4.5
Total	**5.4**	**11.2**	**20.5**	**28.4**	**65.4**

The digital ecosystem

Our Local Digital Roadmap (LDR) describes our ambition to develop a digital ecosystem across health and social care, and further details are contained in the appendix. We have undertaken a comprehensive review of investment requirements across Frimley Health FT, Berkshire Healthcare FT, Primary Care and the local authorities in East Berkshire. Over the period to 2020/21 the system is already planning to invest £30m of capital and £8m of revenue on this agenda, however to make the Frimley Health and Care System a truly digitally enabled economy, there is a need to invest a further £33m of capital and revenue as shown below.

	Total Bid		
	Capital £k	Revenue £k	Estimated ROI £k
Information sharing	7,209	5,911	14,751
Patient facing technology	4,458	7,259	18,115
Paper free at point of care	4,964	3,395	8,472
Total	**16,631**	**16,565**	**41,338**

Mental Health investments

The other main area of investment, in line with the Five Year Forward View, is mental health, with budgets forecast to increase by over £5m (in addition to normal baseline growth)

2017/18 £k	2018/19 £k	2019/20 £k	2020/21 £k
2,727	3,055	4,254	5,437

Finance & efficiency – overall impact of our plans

Sustainability and Transformation Fund

A national Sustainability and Transformation Fund (STF) is held by NHS England to support local health economies. The amount in this fund increases each year, and rises to £3.8bn nationally by 2020/21. We were notified in June that for 2020/21 our share of this Fund is £47m, and we have incorporated this in our modelling.

At the beginning of October local NHS providers were allocated a share of the Fund to support their financial positions – approximately £22m for both of the next two years. A further £4m has been requested to support the position of Frimley Health for the next two years.

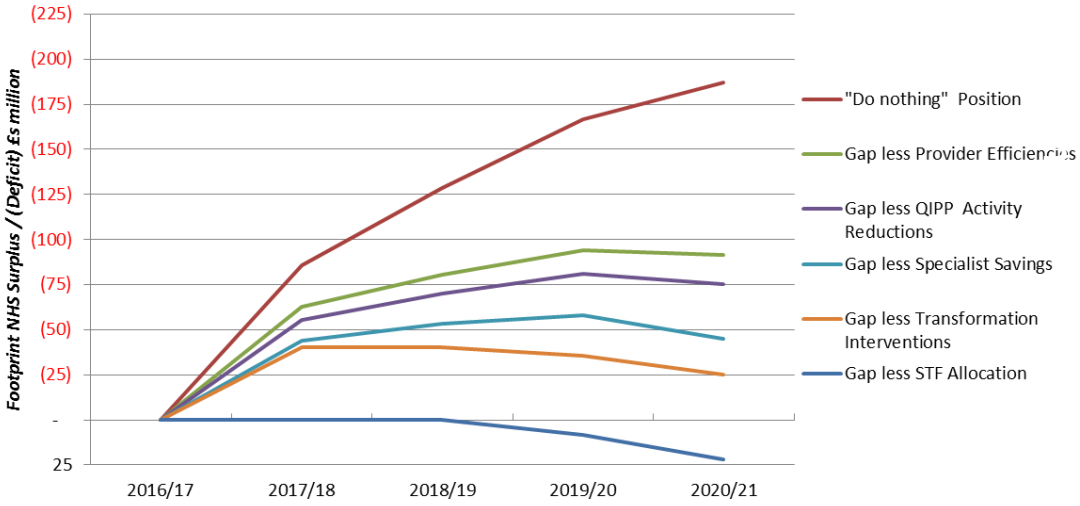
We also know that an additional £1.1bn is available for 'transformation' in these years. A pro-rata share of this for use would be £13.5m, which would help support funding of the solutions we have described in our STP, including the 'double-running' costs. But to continue at pace, deliver financial balance, and realise the benefits for our local population we need more than this. We are therefore requesting a further £2.5m each year. **Therefore the additional ask over announced funding is £20m** (£4m + £13.5m + £2.5m)

Balancing each year of the plan

The graph shows the financial gap for the health system if we 'do nothing', with the cumulative impact of or savings, efficiencies and solutions.

The table to the right gives a high level view of progress towards achieving financial balance across the Frimley Health and Care System.

Annual Impact



	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Do nothing Health Gap	-85.6	-128.4	-166.6	-187.1
Provider CIPS	24.5	49.6	74.0	97.4
Commissioning QIPPS	9.8	14.4	18.8	23.5
Specialist solutions	11.4	16.9	23.0	30.0
Transformational solutions (net)	-0.3	4.7	12.2	18.4
Control Totals	-23.2	-23.2	-7.2	-7.4
Other	22.0	24.2	16.1	0.0
Agreed STF funding	21.3	21.8		47.0
Requested STF funding	20.0	20.0	38.0	
Health Position	**0.0**	**0.0**	**8.2**	**21.8**
Remaining Social Care Gap	-8.3	-11.9	-13.7	-21.9
System Position	**-8.3**	**-11.9**	**-5.6**	**-0.1**

Finance & efficiency – summary to 2020/21

	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	Increase from 2016/17 %
Secondary Care							
- Acute	485	499	502	510	515	523	5.0%
- Mental Health	71	75	81	83	86	89	18.9%
- Community	58	56	62	62	64	67	20.5%
Continuing Care	63	67	71	76	81	87	31.3%
GP Prescribing	94	94	97	101	105	110	17.0%
Primary Care	104	112	120	124	129	136	21.4%
Running Costs	16	16	16	16	17	17	4.3%
Other CCG	15	16	34	36	36	37	138.3%
Specialist	170	180	182	190	199	209	16.4%
Social Care & Public Health	256	272	277	282	285	295	8.4%
Total	**1,332**	**1,385**	**1,440**	**1,481**	**1,516**	**1,571**	**13.4%**

Key financial messages

- Our current ways of working are not sufficient to bridge the financial gap, and our broader efficiencies leave a £85m gap.
- The increases in CCG funding only cover the costs of inflation, not the demographic impacts – so effectively we have to "meet tomorrow's demand with today's funding"
- Commissioners and providers planning collaboratively will bring the system into balance, and will avoid the unintended consequences of traditional planning and contracting arrangements (for example stranded costs).
- We are not planning for any significant change in physical acute capacity (beds) but existing capacity needs to be redesigned to be used much more productively.
- There is alignment between providers and commissioners on the size of the challenge.
- We have a plan which meets the published control totals for NHS Trusts and CCGs for 2017/18 and 2018/19, and delivers financial balance across the health and social care economy by 2020/21
- To deliver this we need additional Transformation Funding of £20m in 2017/18 and 2018/19

Communications and engagement

Purpose: To support the launch and the delivery of the STP by combining and coordinating the tried and tested communication and engagement channels right across our system. We will continue to build on the successful engagement with and involvement of our workforce, lay members, elected members, PPI/PPE leads and Healthwatch and wider engagement with the voluntary sector and public. We believe that better decisions are made when the public and professionals work together.

Priorities:

- The STP Communications and Engagement Group is well established and has completed the groundwork of mapping the existing engagement activity and channels across the system, developing standard messages, templates and engagement logs.
- Our plan doesn't include any issues that require public consultation so we are aiming for an early publication and launch. We are completing plans for this which will include a series of launch events with a clear description of what our STP offers the public. Case studies are being developed to support communication, including learning from NHS England on key messages.
- We want to continue to learn from and adopt best practice in engagement and co-production developed by the Vanguard, the Surrey Health Alliance programme and the New Vision of Care initiative. All of these have benefited from working closely across health and local authorities and building on the expertise that exists within our local authority partners.
- Our priorities and initiatives reflect the priorities we have heard from our residents and patients through those programmes and we hope to drive change through the local parts of the system through schemes they already recognise and have helped to shape.
- Our plans include extending the Community Ambassadors programme, which has 80 active volunteers involved in change programmes, supported by a dedicated post with the voluntary sector, induction and training programmes. The Patient Involvement Assessment Framework and KPIs for engagement will also help support delivery of the STP.

The **Communications and Engagement Action Plan** and **STP Engagement Plan** are included as **appendices.**

Appendices

1. Public facing narrative – draft
2. Communication and engagement action plan
3. STP engagement plan
4. STP/LDR workstreams
5. STP technology investment case
6. STP general practice at scale investment case
7. Project brief example – Integrated care decision making hubs (separate document)

Appendix 1: Public facing narrative

Frimley health and care system

- The Frimley health and social care system is performing well and most towns satisfaction with GP services is among the highest in England. However, Frimley want to do more.
- Over the next four years, Frimley will invest £69 million in frontline NHS and care services to improve wait times, treatment and home care for local people.
- An extra £7 million every year will mean people can get a GP appointment from 8am to 8pm Monday to Friday, that's 420,000 more GP appointments across Frimley.
- At weekends, specialist and family doctors, community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists will offer treatment at the 14 new 'health hubs' likely based in Farnham, Fleet, Farnborough, Aldershot, Yateley, Surrey Heath, Bracknell and Ascot, the Royal Borough of Windsor and Maidenhead, and Slough.
- An additional £11 million for mental health services means patients who need specialist care will no longer have to travel out of the area.
- This extra investment will also fund more community mental health nurses, seven days a week so people can get the right support when they need it.
- A new multi-million pound radiotherapy centre built on the Wexham Park Hospital site will reduce travel times for local cancer patients.
- Frimley will invest in its frontline staff, GPs will more time to see patients and increase the number of community nurses and pharmacists.
- By putting £30 million into technology, patients will only have to share their medical history, allergies and medication details once, regardless of whether they are in A&E or GP surgery.
- Patients will be able to access their medical record online, and for those with diabetes, heart or breathing problems, technology can monitor things like blood pressure remotely, alerting the doctor to any problems.
- Working with people to tackle preventable ill-health, including help for 18, 000 people to prevent diabetes, reduce alcohol related deaths by 20 per cent, and reducing surgical infections by 150 a year by encouraging people to give up smoking for three weeks before their operation.
- Across the area, £130 million will be invested to bring the NHS up-to-date, including replacing the old Heatherwood Hospital in Ascot with a purpose built new hospital for operations such as hip and knee replacement, upgrading the Emergency Department and maternity unit at Wexham Park Hospital.
- And for GPs, millions of pound of investment for new GP hubs and upgrading GP surgeries across all areas.

Appendix 2. Communications and engagement action plan

The development of the Frimley Health & Care STP is supported by tried and tested co production and engagement channels used to support transformation with the public, voluntary sector, faith groups, and users of our services . We have liaised with our lay members, local authority elected members, PPI/PPE leads as well as local Healthwatch representatives and are planning a wider stakeholder engagement workshop to capture the local voluntary sector organisations. The STP has an established group who's aim is to coordinate the communications providing a consistent approach across the wider STP footprint.

AIM	ACTIONS	Lead	Completion date	RAG
Develop and implement a communications and engagement event with all the leads from each of our stakeholders to identify how to develop communications & engagement for the STP across the system	Developed Communications network & planned	TW & SW	Last mtg 22/09/16	
	Develop broader communications network across partner organisations in the STP	TW. Ac & SW	Held 6/10/16	
Develop list of communications and engagement leads for Frimley Health and Social Care STP	List agreed but following event on 6/10 further amendments made	GR	22/09/16	
	List being reviewed and asking for formal sign up from organisations	TW/SW	21/10/16	
Communications across the system - We will reinforce the connections and ensure consistent messages which will provide clarity for staff, patients and the public.	TW agreed to send progress updates to Network	TW	04/10/16	
	Communication briefings developed to be shared across the system - We will target messages at a local level through the relevant organisation & jointly develop key messages that can be used in all settings to describe and explain the purpose and vision of our STP	SW	20/10/16	
Develop network meeting and governance structure	Meetings now planned monthly and agendas, action log and future actions all noted	ALL		
Map engagement activity across the footprint to support the delivery plan, making clear linkages between STP and local activity. We will build on successful and productive engagement already carried out and will learn from, share and replicate best practice.	Template for collating information designed and distributed. Needs to be ready to help support our messaging and priorities prior to launch	SW/ALL	8/11/16	
Develop comms and engagement plan for sharing our draft ambitions through a pro-active public launch that tells the story in simple, clear language, using local examples of where changes have or are already taking place to build confidence in the proposed changes and demonstrate the real, local benefits for patients and staff.	Developing ideas for a video message that can be shared widely Planning a launch event/series of events to launch the STP Briefings as above	ALL	Dec	

Appendix 3: Frimley Health & Care STP Engagement plan

As part of the STP planning process we have strived to involve clinicians across all the initiatives but there is still more to be done. As we enter the delivery phase our staff, stakeholders and local communities will be key to its success and ongoing dialogue is essential.

Stakeholders	Staff & Clinicians	Patient / Public/ Voluntary
System Wide Leadership Group – April, June, Nov 2016	Surrey Heath Alliance	Healthwatch briefings June/ Sept
System Leadership Reference Group - Fortnightly	East Berkshire System Leaders Group	PPI/PPE/Healthwatch meeting Oct 16
Frimley System Directors group – Weekly/ Fortnightly	NE H& F Vanguard Leadership Group	Wider Stakeholder event - Nov
Wellbeing Boards – ongoing Overview & Scrutiny committees – ongoing Lay members of Governing bodies Aug/ Sept	Priority Setting Workshops – May/ June Away days x 2 with FHFT wider leadership team GP Federations LMC reps	Local patient and public engagement events
LA Authority Elected Members Reference Group - June/ Sept	Integrated Care Decision making hubs - Sept	AGMs
Thames Valley Senate - July	GP Transformation workshop - Sept	Annual members meeting for Frimley
TV Urgent & Emergency Care - July	Unwarranted Variation meetings & workshop – Sept/Oct	
Royal Berkshire Fire & Rescue Service Aug/ Oct	Mental Health Workshop – June/ Nov	
LWAB -Oct	Frimley Staff Council	
STP wide Communications event - Oct	AGM Annual members meeting for Frimley	
STP progress updates	STP Progress Updates	STP Progress Updates

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

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

Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
LDR Capabilities: Record, Assessments & Plans					Record Sharing Workstream	
LDR Capabilities: Transfers of Care						
LDR Capabilities: Orders & Results Management						
LDR Capabilities: Medicines management & Optimisation	E-prescribing Workstream					
LDR Capabilities: Decision Support						
LDR Capabilities: Remote & Assistive Technology	Patient Facing Technology/ Preventative Care Workstream	Patient Facing Technology/ Preventative Care Workstream			Patient Facing Technology/ Preventative Care Workstream	
LDR Capabilities: Asset & Resource Optimisation		Infrastructure Workstream				

Outcomes/Benefits

- We are targeting a reduction in obesity, smoking & alcohol for people with mental health conditions, learning disabilities, and for young people & families
- We have prioritised identifying people with hypertension and diabetes earlier, & improving their self care and management
- More people will be supported at home and in their community using digital information, the voluntary sector and health and care professional advice
- People will experience improved reported wellbeing and health confidence and reduced social isolation
- We will achieve earlier diagnosis, improved self-care and clinical management of diabetes and hypertension. This will enable people to avoid developing related complications, reducing their need to use health and care services.

Our aim is to change the focus from managing ill health towards one of prevention, early detection and self care. Overall the health of our population is good so our aim will be to focus on closing the health and wellbeing gap in our communities with poorer health outcomes. We will give greater support for individuals to take responsibility for their own health and care. We want staff in every part of our system to promote healthy messages to our population as part of the care we deliver every day.

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Progr Board
- BE IM&T Committee

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

STP 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.					
Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
LDR Capabilities: Record, Assessments & Plans	Care Planning Workstream				Record Sharing Workstream	
LDR Capabilities: Transfers of Care						
LDR Capabilities: Orders & Results Management						
LDR Capabilities: Medicines management & Optimisation						
LDR Capabilities: Decision Support						
LDR Capabilities: Remote & Assistive Technology	Patient Facing Technology Workstream					
LDR Capabilities: Asset & Resource Optimisation		Whole Systems Intelligence Workstream				

Outcomes/Benefits

- Many more people understand and take control of the management of their long term condition
- Effective best practice pathways will be in place across our system, supported where necessary by the combined expertise of the appropriate health and care professionals
- There will be fewer people in our system with multiple long term conditions and co-morbidity
- Carers will be supported to enable the person they are caring for to manage their condition and to reduce the emotional stress of being a carer
- People with long term conditions will report that they have improved health, more confidence, increased wellbeing and that they feel supported
- There will be fewer crises and a reduced use of urgent and emergency services
- We will achieve greater integration in the care provided by all of the sectors in our system with reduced duplication, including integrating physical and mental health.

20% of our population has one long term condition, 9% have two and 10% have more than two. Our aim is to improve the management of LTCs before they get to a stage where they are complex and multiple. We want to improve the care and outcomes for people with these conditions and to avoid or delay them acquiring more. We know that there is a particular need to make improvements for people with severe mental health, learning disability and acquired brain injury.

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

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

Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
LDR Capabilities: Record, Assessments & Plans					Record Sharing Workstream; Children's Sharing Workstream	Care Planning Workstream
LDR Capabilities: Transfers of Care						Referrals/Discharge Workstream
LDR Capabilities: Orders & Results Management						
LDR Capabilities: Medicines management & Optimisation	E-prescribing Workstream					
LDR Capabilities: Decision Support						
LDR Capabilities: Remote & Assistive Technology						
LDR Capabilities: Asset & Resource Optimisation	Whole Systems Intelligence Workstream	Infrastructure Workstream				

Outcomes/Benefits

- People are involved in and understand their care and feel supported and in control
- A standardised evidence based approach is used to risk stratify our population and identify patients with greater needs
- Effective multi-disciplinary teams with joint decision making and strong clinical leadership are established
- People report improved health status, confidence and wellbeing among our complex and frail patients
- There are fewer crises and reduced use of urgent and emergency services
- More people are supported to live in their own home with fewer permanent admissions to care homes
- High levels of staff and team satisfaction and more opportunities for personal and role development.

Evidence from the leading international integrated care systems shows that health and wellbeing are improved and costs reduced when there is a systematic delivery of population risk stratification, multi-disciplinary assessment and care planning, effective care coordination and care navigation and proactive care. We will use local, national and international best practice to design and develop effective proactive care in all of the natural communities/ localities across our system.

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

STP Priority 4	Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place					
Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
LDR Capabilities: Record, Assessments & Plans					Record Sharing Workstream	Care Planning Workstream
LDR Capabilities: Transfers of Care			Referrals/Discharge Workstream			
LDR Capabilities: Orders & Results Management						
LDR Capabilities: Medicines management & Optimisation						
LDR Capabilities: Decision Support						
LDR Capabilities: Remote & Assistive Technology		Patient Facing Technology Workstream				
LDR Capabilities: Asset & Resource Optimisation						

Outcomes/Benefits

- The public experience a simplified system, have easy access to effective advice on self-treatment and care, and are directed to the most appropriate service where they will be seen quickly
- All patients are able to receive an urgent general practice appointment on the day, 7 days a week
- A responsive integrated care decision making team provides more assessments in the community, supporting professionals to manage patients with urgent care needs
- Patients who require emergency care from acute and/or mental health specialists will be quickly assessed and streamed into the most appropriate management, with fewer delays
- Patients receive supported discharge from hospital into an appropriate community environment, once the acute phase of their care is over
- There is more timely care, with shorter waits across the whole system
- We achieve improved flow through the system including ambulance turnaround, urgent advice and treatment from primary and community services, social care, A&E, within hospitals and after acute discharge
- People report improved outcomes and improved experience of using urgent and emergency care services.

Priorities 1-3 aim to reduce avoidable ill health, care for people in their homes, avoid crises and reduce the need for urgent and emergency care. For patients who still require urgent/emergency care, we will ensure that we have an effective, easily navigated and joined up system. Care will be delivered as close to home as possible and appropriate for both physical and mental health.

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

STP Priority 5	Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.						
Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions	**Outcomes/Benefits**
LDR Capabilities: Record, Assessments & Plans					Record Sharing Workstream		• Reduction in variation across five areas: circulation, neurology, GU, MSK & respiratory to realise 65% of the target savings • Appropriate repatriation of physical and mental health work currently sent to specialist centres across the country • A demonstrated improvement in the way we give choice and options to people to enable a shared decision making process • Clinicians have a clear discussion with individuals about the risks and benefits of specific interventions. • Improved outcomes for patients across physical & mental health • Stronger patient involvement through shared decision-making • Reduced clinical variation benchmarked against national and cluster data.
LDR Capabilities: Transfers of Care							
LDR Capabilities: Orders & Results Management							
LDR Capabilities: Medicines management & Optimisation							
LDR Capabilities: Decision Support							
LDR Capabilities: Remote & Assistive Technology							
LDR Capabilities: Asset & Resource Optimisation	Whole Systems Intelligence Workstream	Whole Systems Intelligence Workstream					

Our aim is to use Right Care methodology to achieve a significant reduction in variation for our patients across the Frimley footprint. We will develop a culture of value & population-based decision making involving clinicians across primary and secondary care to deliver the reduction in variation. We will achieve this by working in the following way:

- Ensure patients are able to make informed decisions about their treatment, and encourage aligned conversations about the risks and benefits of interventions
- Ensure patients access both primary and secondary care, across physical & mental health, as a seamless single clinical system
- Develop a system wide approach to specialised commissioning, including primary, secondary, physical, mental health care
- Beginning a conversation with the local population and stakeholder groups about the need for evidence based medicine, and the potential impact of this upon local services
- Ensuring that clinicians have a clear discussion with individuals about the risks and benefits of specific interventions

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

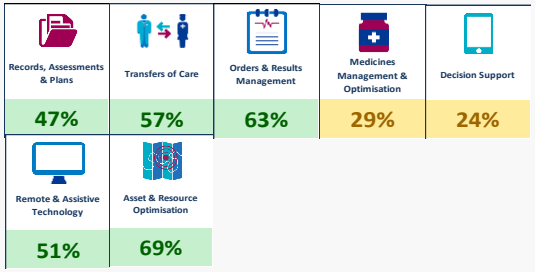
Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

Appendix 5: STP Technology investment case

LDR- Current State

- Through the LDR process, it is now known that there are gaps in technology maturity that need to be closed in order to best support the STP.
- Nationally there are seven capabilities that need to be at levels close to 100% in order to deliver the national target of paper free at point of care. At a system level we are at:



- In addition, there are 10 Universal capabilities that need to be progressed, and organisational priorities that need to be supported by technology.

Local Context

- In addition to the national priorities outlined above, there are local challenges and opportunities that need to be progressed in order to support the STP priorities.
- A substantial opportunity exists around information sharing projects that are underway across the STP footprint. All health and social care organisations are engaged in complex information sharing projects requiring strong cross organisational boards. In short, partners are used to working at a system level on complex IT projects. Consequently, Frimley STP is well placed for receiving funding to support these and other initiatives as the existing structure supports rapid mobilisation.
- A core challenge is ensuring all organisations are at the same level of digital maturity, in order that that whole system projects can fully deliver. Frimley Health has distinct challenges as they continue the work to merge legacy IT systems across three hospitals., following acquisition. This needs to progress at pace to ensure organisational benefits already identified. Without progress, the broader system benefits will not be achievable. Digital has been identified as a key enabler for all the STP priorities and will affect the realisation of the objectives listed.

Options

No Funding Provision

- This option is to continue funding the digital transformation agenda using existing finite funding streams.
- We are proposing that this is not a viable option in light of the national requirements around paper free at point of care, the wider digital agenda across health and social care and the emphasis on information sharing to improve patient care. Significant progress has been made on information sharing across the system, but this has been at the detriment of other initiatives to drive digital innovation.

Progress with limited national funding

- Partial funding of the overall request will enable the system to focus on gaps in digital maturity to eventually enable some aspects of the transformation required to support the STP.
- Priority will need to be given to the core building blocks in each organisation to ensure that investment in cross organisation projects will deliver the associated system benefits, but this approach risks enforcing silo working and fragmented progress towards interoperability and digitisation, ultimately impacting on the quality of care.

Progress with requested funding

- With the full amount of funding being requested, partners have an opportunity to develop internal systems to progress their digital maturity to ensure a solid equitable foundation.
- There will also be an opportunity to progress the significant transformational projects which will fully support the STP priorities. These include patient portals, remote and assistive technology and whole system intelligence.

ROI

- The technology initiatives can be broken down into three categories- Information sharing, patient facing technology and paper free at point of care.
- Projects are a mix of organisational specific and cross system

Information Sharing

- Medicines optimisations- reduction in adverse drug reactions, waste, corrective treatment , misappropriation
- Reduction in attendances/admissions/re-admissions/delayed discharges/ambulance conveyances
- Reduction in length of stay in high cost beds
- Eliminate costs associated with maintaining legacy systems
- Eliminate paper by using electronic- systems for communication
- Reduce adverse events- through e-alerts- e.g. MRSA prevention, electronic observations.
- Staff reductions – fewer administrative requirements/agency staff

Paper free at point of care

- Improved quality of care through decision support systems
- Enabling timely clinical decision making
- Reduction in duplicate/unnecessary tests
- Time saving/increased staff productivity/efficiency
- Reduction in adverse events
- Medicines optimisation

Patient facing Technology

- Reduction in attendances at A&E, GP, & walk-in centre
- Ability to monitor multi co-morbidity patients from home, reducing returns to A&E
- Increased capacity in primary care- redirect patients to self care and alternative services e.g. pharmacy
- Remote triage higher number of patients
- Reduction in elective/outpatients
- Improve quality of care and outcomes through more consistent monitoring, improvement in long-term health and population outcomes and supports prevention agenda.

Appendix 5: STP Technology – benefits breakdown

Information sharing

Locally information sharing has been identified as key priority. Pre-dating LDR and STP, North East Hants and Farnham participated in the Hampshire Health Record, East Berkshire in Connected Care and Surrey Heath in the Surrey Interoperability programme. Moving forward, we are working towards alignment of these programmes within the STP footprint which is being supported with information sharing identified a key deliverable of the STP and LDR process.

The importance of this is reflected in the request for £13m across the health and social care system to support information sharing projects, including: Shared Care Record, referral management and e-prescribing.

Substantial benefits have been identified to support the investment. These include:

- The improved ability for decision making (staff and patients). Across the system this will result in substantial quantitative savings and qualitative improvements.
- Using data to support health and wellbeing and the better management of conditions to enable individuals to remain as independent as possible for as long as possible and support full recovery following physical and or mental illness regardless of social situation. Projects that support this have identified significant savings including a reduction in admissions, readmissions, delayed discharges, and length of stay.
- Enables better coordination of care ensuring that potential avoidable crisis are averted. These projects will lead to reduction in admissions/re-admissions and outpatient appointments
- Supports integrated team working by enabling the development of integrated care plans for individuals being managed by integrated teams. This supports better care management which will lead to a reduction in admissions and improvements in health outcomes.
- Supports prospective care planning
- Reduction in time looking for information= leading to an increase in clinical efficiency/productivity
- Reduces adverse events and improves clinical safety
- Supports transfers of care, delayed discharges as next of kin and care information (including care plans) will be available to care professionals resulting in a reduction in length of stay or transfers to care homes

Patient Facing Technology

Patient facing technology has the potential to provide the greatest financial saving across health and social care. Substantial transformation behavioural change (staff and patients) will need to take place, but supporting individuals take greater control of their care at a whole system level has enormous potential to reduce pressure across the STP footprint.

Proposed projects to fully exploit the potential of patient facing technology across the STP include a patient portal, telehealth solutions including care companion, self care signposting, read/write access to patient record and appointment reminder technology.

Although evidence is not as strong for financial savings with patient facing technology, there is a drive to deliver whole system change involving patients.

The potential benefits of patient facing technology include:

- The ability for individuals to input data into their own record will create a shared responsibility between people and health and social care services. Increased ownership and monitoring in this way had been shown to reduce A&E attendances, outpatient appointments, walk-in centres, GP attendances and delivered improved health outcomes and management of long term conditions.
- Developing shared responsibility potentially increases individual satisfaction (increased confidence and health/self awareness) and staff levels of satisfaction (reducing vacancies and need for agency staff), reduces system costs in terms of non attendance, reducing waiting times and increased utilisation of staff.
- Ensuring that care professionals have access to information recorded by an individual prior to an initial consultation resulting in efficiency savings and improved qualitative improvements and higher quality of care.
- The ability of staff and patients to monitor health supports the prevention agenda, safeguarding and wider population health outcomes.
- Greater capacity for self care and uptake of alternative care services e.g. pharmacy.

Paper free at point of care

Paper free at point of care is the core deliverable as part of the LDR process and there are substantial benefits in achieving this. There are distinct challenges to achieving this within the Frimley STP with organisations at differing levels of digital maturity. Frimley Health have a substantial work programme to deliver as a result of the merger of three hospitals. This integration work is a fundamental enabler prior to being able to support transformation programmes linked to the whole digital ecosystem. There are also challenges for local authority partners and ensuring they have access to the N3 network and NHS numbers to support social care systems linking with health systems.

Projects to support paper free at point of care include projects to integrate systems across Frimley Health, Electronic Document Management System and E-referrals. In Primary Care, there are opportunities to look at stronger collaboration with care homes including a 24/7 health hub supported by video conferencing

The benefits of paper free at point of care include:

- Reduces administrative costs in paper handling. Distribution of paper at Frimley Health is a substantial outlay using existing systems.
- Benefits in releasing time to patient care as clinical staff become used to paper free system across the system.
- Potential reduction of costly errors with system monitoring of drug, interactions, blood types, inventories, etc.

Notes

- The above cash releasing benefits are dependent on whole system transformation initiatives as part of the STP delivering benefits.
- There is a risk of double counting benefits at this early stage and work will be done to identify what return on investment can be directly attribute to the technology.
- Recent reports (e.g. Wachter) note the cumulative affects of broad health IT as the whole organisation transforms from many initiatives. Full realisation does not occur until 7-10 years post implementation of major health IT projects.

Appendix 6: STP General practice at scale investment case

Going further faster

Frimley STP is able to go further, faster with the transformation of General Practice and delivery of the resulting benefits. This is because:

- We have the foundations in place to deliver at scale and pace. Underpinned by good leadership and engagement, clear gap analysis, evidence within local systems and a compelling case for change.
- Delivery will be based upon spread of good practice across the whole of the STP to give both stability and redesign of services with a reduction in variation between localities (Year 1)
- We are identifying clinical leaders and managerial support to push at our traditional local boundaries (technology, business models with scale, patient empowerment and primary/ secondary care interface) – to give full delivery of FYFV and transformation and sustainability roadmap by 2010 (Year 2)

Illustrative of what Surrey Heath have achieved – investment circa £3M additional

July 2016 National GP Experience Survey

	Surrey Heath CCG	National Average
Overall GP experience good	92%	85% (+7%)
Overall experience in getting an appointment good	85% ↑	73% (+12%)
Satisfied with opening hours	83% ↑	76% (+7%)

Financial investment

The following investment is required to support us to go further faster and accelerate early delivery of benefits:

1. Investment for the STP for all new **workforc**e role mentioned in FYFV in year 1 across all localities (five CCGs) irrespective of whether already part of PMCF or GP Access Fund. Mental Health Therapists, clinical pharmacists, care navigators and medical assistants.
2. All localities(CCGs) across the STP to receive Funding to Improve Access to General Practice Services in Year 1 (2017/18) irrespective of whether already part of PMCF or GP Access Fund. £6 per head of STP population.
3. Early response to Estates and Technology Transformation Fund local bids (end Dec) so that estates support to transformation can be planned – a vital ingredient to our plans
4. Early release to system of funding for reception and clinical staff training and online consultation systems (full sight of tranche's early so that full programme can be scheduled) to enable cohorts of training & increased pace
5. Pump priming money (non-recurrent) to enable full STP wide workforce assessment & development plan, Integrated Care Hubs across the STP to optimise out of hospital care & upskill other health and care professional to manage less complicated problems. (Support workload transformation)

Non-elective Admissions age > 65 from A&E
Rolling 12 months average/1000

Appendix 6: STP General practice at scale

Local Context

System Wide Strengths:

- Stable & experienced clinical leadership across all areas
- High levels of practice engagement
- Commitment to GP at scale . GP federations in place covering all the population
- Practices with strong training history/workforce innovation
- Population recognises role of general practice at heart of health and care system & local political support
- GP risen to challenge as leader of system change. Role recognised by wider system.
- Clinical & managerial partnership approach
- Strong clinical interface between secondary & primary care

System opportunities

- Outcomes variable, inequalities & scope for spread of good practice (access, LTC management, early identification, self care & prevention)
- Strong case for change - No locality sustainable in "do nothing scenario"
- History of pockets of innovation – can deliver at pace individually (see below)
- Variable investment: negating opportunities for scale

However some areas for improvement:

- High levels of GP referrals
- High and rising levels of emergency admissions
- Some areas lower quartile performance

Evidence of Successful Initiatives

Workforce

Direct Access Physio in General Practice

- Booked by Receptionist
- 15 minute appointments
- Extended scope practitioner
- Referral for exercise, on going physio, injection, investigation, referral to secondary care or GP.
- 20% reduction in physio and secondary care referrals
- 95% FFT

Access

8 to 8 Working (M-F)

- Rapid implementation from concept to delivery
- Data sharing agreement with access to EMIS web
- Larger practices operating solo, smaller practices operating across 2 or 3 sites
- Above national average patient satisfaction (92%)
- Reduced NELs for >65yrs

Infrastructure

Infrastructure investment enabled

Phase 1: Establishment of Integrated Care Decision Making Hub with GP as core member

Phase 2 GP Urgent care hub (from early Nov)

- Same day appts access across 5 GP populations
- Releasing time to offer longer appointments for patients with LTC this initiative improves both urgent appointments and personalised LTC management

Complex Needs

Proactive Care for Complex Needs

- Risk stratification identifying patients who benefits from more intensive support through a period of regular appts with GP
- 20 mins appts every 3 weeks
- Evidence of reduced hospital admissions & A&E attendances

STP Fund

- Early investment
- No phasing
- Across all localities
- Scale and pace of delivery

Workload

Needs based referral

- Single point of referral for integrated community services using a "needs based" approach
- Saves GP time
- Optimises use of integrated community MDT
- Improved access to social and voluntary sector for general practice
- No door is wrong door approach for professional

Future State

- Eliminate variation between localities so collectively are the highest performing general practice system nationally
- Meeting all components of the GPFV before 2020 (March 2019)
- Investment delivers within 2 years STP wide:
  - Sustainable Clinical Model
  - Workforce strategy and clear sustainability plan
  - Business Model that works for practices and health and care system
- Embedded network of innovation & shared learning for general practice
- Urgent care models and resilient system that draws on GP information as part of a "live" system of demand and capacity management
- Fully integrated use of technology throughout the general practice care pathway from appointment booking to self management