Newsletter - November 2017

Frimley Health & Care

Sustainability and Transformation Partnership

Working together to transform the way health **and** social care is delivered locally.

Helping people to stay healthy

With a growing and ageing population, prevention has to be an important part of everything we do within the Frimley Health and Care Sustainability and Transformation Partnership (STP) and we need to work together to deliver this successfully. We need to work with people, giving them the information and resources they need and request to take control over their own health and stay healthy for longer.

We are bringing together existing self care initiatives from across the STP area as part of the project, such as the award winning 'Year of Self Care' initiative in Bracknell Forest, which focuses on a different topic each month with support from local community groups. Staying well, as we all know, involves becoming more physically and socially active and so we are bringing together self care initiatives from across the STP area such as 'social prescribing' programmes which provide opportunities for people who might feel isolated or lonely to take part in social activities, walking clubs, advice services or self help groups. One example is 'Making Connections', which was designed by the people living in North East Hampshire & Farnham.

We aim to work with local people so together we can:

Increase blood pressure screening: 'Increasing access to blood pressure screening to our population by offering this through clinical pharmacists and the Fire Service'

Encourage self-care: Enabling people to have the opportunity to provide their own care, as well as providing staff the skills, confidence and tools to encourage behavioural change through every possible contact made.

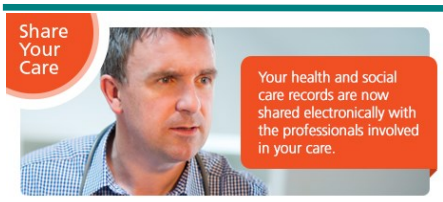
Use digital technology: Using technology to encourage people to become more physically active.

Reduce smoking: Introducing the 'Making Every Contact Count' programme where all our staff receive training to discuss with patients how they might wish to change their behaviour so they can improve their own health.

Reduce Obesity: Creating a partnership wide approach to tackling obesity

Prevent Diabetes: Offering education programmes to help people change their behaviour to prevent them from becoming diabetic, as part of the National Diabetes Prevention Programme.

Reduce alcohol consumption: Introducing an Alcohol Care Team at Wexham Park Hospital similar to the team at Frimley Park Hospital, and increasing the service availability from 5 to 7 days a week.



Connecting Care Records Together

Connected Care is the name of the new clinical system for sharing information about a patient's health and social care records across different organisations.

The system currently enables instant, secure access to patient and social care records across Berkshire, with neighbouring partners' information from Hampshire and Surrey becoming part of the system soon. The 'Share Your Care' campaign is currently running to help people understand the benefits of the new system and encourage them to participate in bringing together all their data in one place to have a more straightforward patient experience. Connected Care is making a difference to people across Berkshire as they only have to tell their story once. Connecting care records across our health and social care system will also help to achieve safer and faster treatment, reduce duplication of tests and results, reduce unplanned admissions and improved discharge times, and a provide a joined-up approach to the care people receive. Staff will also benefit from spending less time having to check patient details on different systems.

You can find out more about Connected Care at www.connectedcareberkshire.org

Better hospital experience is in the bag

Transforming NHS and social care services to improve patient experiences and outcomes can be a time-consuming, complex and costly business – but not always. Sometimes effective solutions can be remarkably simple. Care homes in North East Hampshire and Farnham are using a new tool to make hospital stays, transfers and treatments safer and more straightforward for patients and medical professionals and to reduce the length of hospital stays: a red bag.

The red bag takes the resident's clothes, has a handy pocket for hearing aids, glasses etc., and also an external pocket for standardised documents providing ambulance and hospital staff with the patient's details, and personal preferences on clinical treatments etc., as outlined in their Advance Care Plan.

The bag stays with the person throughout their hospital stay and within the first 48 hours the care home contacts the hospital to begin the discharge process. The bag and standardised documents can lead to patients leaving hospital sooner as clinicians recognise them as care home residents who have an existing care package to support them once they are discharged.

The idea originated in Sutton, in South London and was adopted by North East Hampshire and Farnham CCG and its partners in health and social care. There are plans to roll out the red bag scheme across the Frimley Health and Care STP and the scheme will launch before the end of the year in Surrey Heath and East Berkshire.

Helping patients prepare for surgery

A number of GP surgeries in East Berkshire, Surrey Heath and North East Hampshire and Farnham CCG areas have been looking to improve referral systems for surgery. Local Primary Care services have been working with the Trauma and Orthopaedics Department at Frimley Park Hospital to revise and test a form known as the Managed Referral Form. The reviewed form will ensure patients are as fully prepared for surgery as possible and give Frimley Park Hospital staff a greater understanding of a patient's previous treatments and referrals.

Sample physiotherapy self-help exercises used to support osteoarthritis patients

This work is part of the national Elective Care Rapid Testing Programme, also known as the 100 Day Challenge. This is a scheme which was offered to existing vanguard sites (in this case North East Hampshire and Farnham) to allow organisations to redesign and test treatment pathways in a much shorter timescale than they might otherwise be able to do.

Locally this project is focussing on orthopaedics – specifically for Osteoarthritis in the hips and knees. The Frimley Health and Care STP is unique in that '100 Days' projects are being tested across the whole STP footprint.

Other interventions being tested through this programme are a Patient Passport and an Early Diagnosis Masterclass. Together they aim to provide support, knowledge and reassurance to enable patients to make informed choices in their self-care and when accessing treatments.

STAY WELL THIS WINTER