An Integrated Health and Care Strategy for a Healthier Future

EXECUTIVE SUMMARY

December 2018
This strategy is a blueprint for delivering a healthier future for the population of Hertfordshire and west Essex.

It is designed to guide our health and care organisations, staff, the voluntary sector and our population to work in partnership.

Our approach is based on the principles of population health management. This is a way of targeting our collective resources where they will have the greatest impact, improving the quality of care through improved, affordable services. Our key priorities are:

- Meeting people’s health and social care needs in a joined-up way in their local neighbourhoods, whenever that’s in their best interests - saving time and cutting out unnecessary tests and appointments. Health and care services will support people to live as independently for as long as possible.

- Adopting a shared approach to treating people when they are ill and prioritising those with the highest levels of need, reducing the variations in care which currently exist.

- Placing equal value and emphasis on people’s mental and physical health and wellbeing in all we do.

- Driving the cultural and behavioural change necessary to achieve the improvements we need. Care professionals, service users, families and carers will understand the role they have to play in creating a healthier future.

- Ensuring that we have the workforce, technology, contracting and payment mechanisms in place to support our strategy, delivering health and care support efficiently, effectively and across organisational boundaries.

All of the STP’s organisations are committed to working together to implement this strategy, so that we can make rapid improvements to the health and wellbeing of our population and the sustainability of our health and care system.

‘Care will be high quality, proactive and joined up, to deliver a healthier future for our population and our services’
What’s wrong now?

- We focus on what people can’t do
- Resources are not targeted effectively
- Care is built around organisational boundaries or individual illnesses and conditions, rather than taking into account the whole person
- Too many people are treated in hospital
- Care is often only provided when things go wrong
- Mental health and the health of people with learning disabilities is not routinely prioritised
- Health and care professionals take different approaches, leading to varied care and treatment for our population.
- Organisations and staff are not united by a common approach

What will be different?

- Our staff and population will be encouraged to work together to make the most of our strengths
- We will use evidence to target resources, using a population health management approach
- Health and care needs will be met in a joined-up way, based on each person’s needs
- Care will be provided as close to home as possible. High quality specialist hospital treatment will be there when it’s really needed
- Care will be proactive and better coordinated to help people to stay healthy and independent
- We will place equal value and emphasis on the mental and physical health of all of our population
- We will develop care pathways for everyone to follow, to reduce variation in outcomes and promote best practice
- Each organisation and professional will understand their role in delivering this strategy
What does the strategy cover?

Our **Integrated Health and Care Strategy** has been written for service users, patients, their families and carers and everyone who supports them. It covers the range of health and care services that our population of 1,520,500 use.

The strategy **builds on the foundation of our ‘Healthier Future’ summary plan published in 2016.**

It takes into account ongoing improvements to health and care services including local strategies developed by our Health and Wellbeing Boards, County and District Councils, CCGs, and Trusts.

This strategy is supported by our:

- population health management plan
- draft medium term financial plan and our
- workforce strategy.

It will inform our area’s neighbourhood strategies.
A population health management approach

‘Population health management’ is an approach which will enable our STP to target our collective resources where evidence shows that they will have the greatest impact.

Social care and health organisations, supported by the community and voluntary sector, will work closely together to deliver joined-up services to defined groups of the population. In this way, we will prevent, reduce, or delay need before it escalates; and prevent people with complex needs from reaching crisis points.

![Diagram showing the relationship between health status, cost, and need, with actions for each category.]

- **Generally healthy**
  - High cost
    - Actions: reduce risk and keep people well
    - Actions: prevent need from arising
    - Actions: meet urgent care needs when they arise

- **Diagnosed long term condition**
  - High cost
    - Actions: intervene early to reduce or delay need
    - Actions: reduce need for emergency care

- **Complex needs**
  - Low cost
    - Actions: have proactive, meaningful, personalised care plans
    - Actions: prevent people reaching crisis points
    - Actions: reduce need for emergency care

**Actions:**
- Reduce risk and keep people well
- Prevent need from arising
- Meet urgent care needs when they arise

**Existing curve**

**Achievable curve?**
Population health management in action - diabetes

- Unless we take preventative action, 60,000 in our STP area expected to become ‘pre-diabetic’ by 2023/24
- Total cost to STP CCGs of caring for our diabetic population is currently £52.8m
- A reduction in diabetes related hospital admissions by 5% over 5 years would save CCGs alone £3m

<table>
<thead>
<tr>
<th>Low cost</th>
<th>Generally healthy (pre-diabetic)</th>
<th>Diagnosed diabetes</th>
<th>Diabetes unstable or poorly managed and complex needs</th>
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<tbody>
<tr>
<td></td>
<td>Actions:</td>
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<tr>
<td></td>
<td>• support healthy lifestyles with</td>
<td>• agree personalised care</td>
<td>• care coordinator supporting all complex patients and their carers to avoid complications and reduce hospital admissions</td>
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<td></td>
<td>care navigators and social</td>
<td>plans with individual goals</td>
<td>• easy access to specialist care teams, e.g. continence/pain relief</td>
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<td>prescribing, through multi-</td>
<td>• regular care reviews to address physical and mental health needs</td>
<td>• monitoring using health apps to avoid crises at home or in care homes</td>
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<td></td>
<td>disciplinary teams in the</td>
<td>• advice and guidance in the local community from multi-disciplinary teams</td>
<td>• advanced care plans for those nearing the end of their lives</td>
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<tr>
<td></td>
<td>community</td>
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<td></td>
<td>• identify at-risk patients at</td>
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<td></td>
<td>GP practice level and refer to</td>
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<td>national diabetes prevention</td>
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<td>programme</td>
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<td></td>
<td>• use online digital resources</td>
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<td>to improve access to education</td>
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- 10% reduction in pre-diabetic population would benefit 18,500 people and save £1.1m by 2023/24
- 5% reduction in prevalence of T2 diabetes would benefit 3,450 people and save £5.2m by 2023/24
- 5% reduction in hospital admissions would represent 615 fewer admissions by 2023/24
Strategy overview

Our ‘house’ of integrated care

1. Develop integrated, person-centred models of care, designed to meet the needs of our population, delivered in local neighbourhoods wherever possible.

2. Put in place the staff, culture and systems we need to support the transformation we need.

3. Transform key pillars of our health and care system, to ensure they are sustainable, resilient, and deliver integrated care.

4.

- Effective and efficient health and care is delivered in the right place, by the right person, at the right time.
- Shift care from reactive to proactive when possible, and standardise our approach to treatments.
- Agree the improvements we want to see and report back on their success.

Transform population health management approach – designing care around our population

- Generally healthy
- People with a diagnosed long term condition
- People with complex needs

- Self Care
- Primary and Community Care
- Maternity and Children’s Care
- Mental Health Care
- Secondary Care
- Social Care

- Commissioning, Contracting and Payment Mechanisms
- Culture and Leadership
- IT and Digital
- Workforce
- Estates
- Medicines Optimisation
- Communications and Engagement
Delivering integrated care

How will health and social care be organised, commissioned and delivered in the future?

ICS
1.5m people

ICAs
x3

Localities
100-150,000 people

Neighbourhoods
30-50,000 thousand people
Delivering integrated care

How care will be organised, commissioned, and delivered

**Integrated Care System**
- Responsible for delivering the Integrated Health and Care strategy – improving the health of the population
- Strategic commissioning based on need, identified through a population health management approach
- Provides professional leadership for system
- Works in a cross-organisational way
- Oversees planning assumptions, sets financial principles and budgets
- Is responsible for delivering a sustainable system that delivers services that meet national standards
- Ensures we have the workforce, culture and systems we need to support the transformation we need.

**Integrated Care Alliances**
- Responsible for joint and ‘place based’ commissioning
- Organisations that provide health and care services working together collaboratively
- Shared transformation programmes to improve services
- Local risk and reward mechanisms, alignment of incentives, and new contractual forms.
Enabling staff across organisations to work together in an integrated way, meeting the needs of the population

Development of integrated care hubs

Single operating policies and procedures

Localities

100-150,000 people

Urgent Treatment Centres, planned care in the community

Neighbourhoods

30-50,000 people

Integrated multi-disciplinary teams, GPs, opticians, pharmacies, social prescribing and support, continuing health care, nursing and care homes

“I know how to look after my family’s health and how to find the right help when I need it.”
What do we want to achieve?

We want to make changes that improve the quality of care and health and wellbeing outcomes for our population; and ensure we have a skilled and motivated workforce in place to deliver these changes. This will help create an effective and affordable health and care system.

<table>
<thead>
<tr>
<th><strong>Our population</strong></th>
<th><strong>Our staff</strong></th>
<th><strong>Our system</strong></th>
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<tbody>
<tr>
<td>Improved health and wellbeing, better quality care, closer to home</td>
<td>Highly skilled and motivated staff who understand their role in delivering our strategy and are empowered to make changes</td>
<td>A sustainable health and care system</td>
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Next Steps

The delivery plans required to put this strategy into action will be co-produced with professionals across our health and care system.

01 Programme Design / Governance
- All STP Boards to sign off draft strategy alongside medium term financial plan by end Jan 2018
- Review and reset current STP work streams to deliver the changes set out in this strategy by end Jan 2019
- Revise the design of the programme to reflect new priorities by end Dec 2019
- Expand membership of clinical oversight group to include wider range of professionals
- Engagement stakeholders in strategy (January – March 2019)
- Align strategy & NHS long-term plan

02 Model the impact of our plans
- Agree baseline and resource proposal by March 2019
- Undertake detailed modelling work to quantify the impact of the interventions set out in this strategy by March 2019
- Review the modelling outputs in light of the activity and financial assumptions set out in the medium term financial plan by 2019
- Iterate delivery plans for each workstream by March 2019
- Quantify targets for outcomes and objectives by March 2019

03 Develop detailed delivery plans
- Establish an integrated, system wide transformation and implementation methodology by January 2019
- Co-produce detailed delivery plans with care professionals across the system
- Agree what will be delivered in the next 1, 3, and 5 years by June 2019
- Develop implementation plan on a page by March 2019
- Review the modelling outputs in light of the activity and financial assumptions set out in the medium term financial plan by 2019
- Iterate delivery plans for each workstream by March 2019
- Quantify targets for outcomes and objectives by March 2019

04 Implementation
- Adopt a robust portfolio management approach to manage implementation and realise benefits by March 2019
- Regular reporting against delivery plan milestones and benefits by 2019/20
- Regular programme reviews to ensure work continues to be aligned with objectives and outcomes, reporting to each stakeholder by 2019/20