Your Care, Your Future
Working together for a healthier west Herts

Building Resilient, Integrated Communities

By

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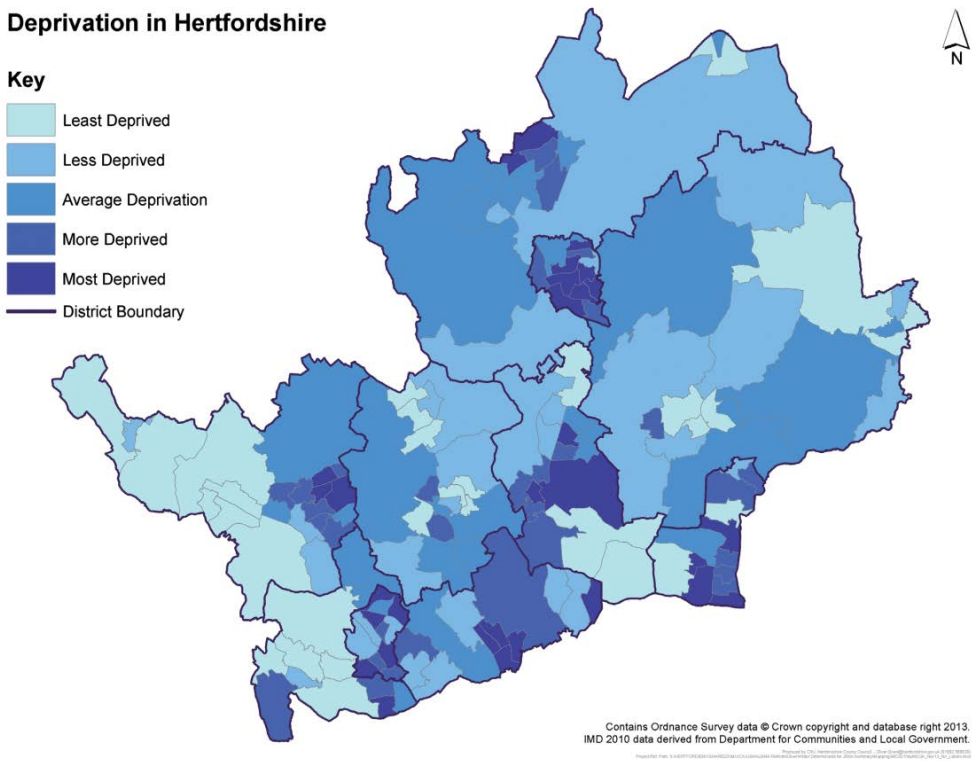
A long way from home…

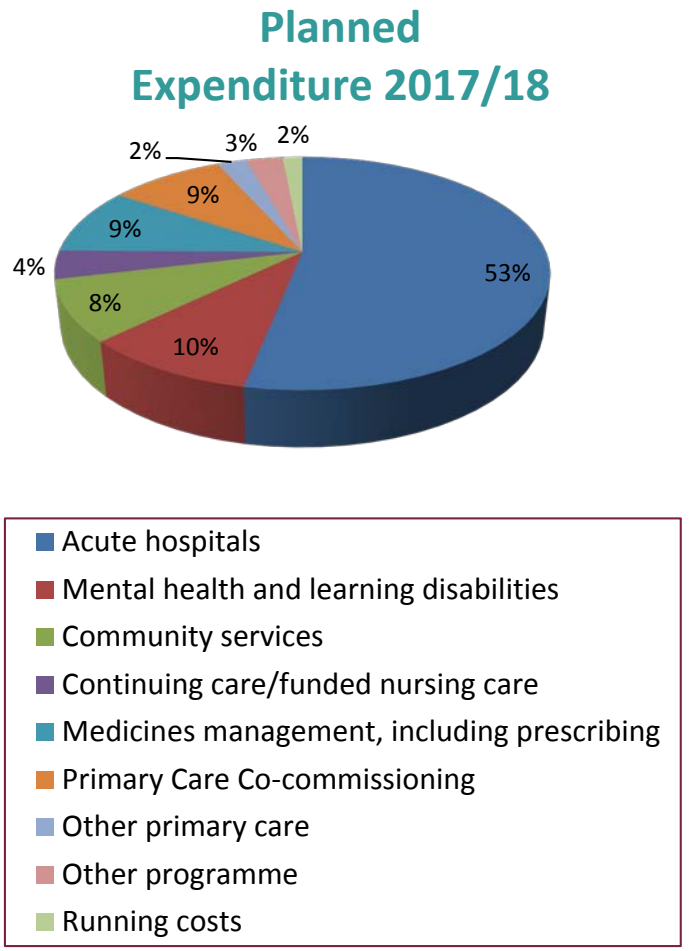
Who are Herts Valleys CCG?

- Population – 600,000
- 4 NHS Localities
- 5 District Councils
- 1 Local Authority
- Strong and diverse voluntary sector
- 60 GP practices
- Mixture of providers including acute, community, mental health and private organisations
- Overall health of the population is higher than national average but we have an ageing population to support

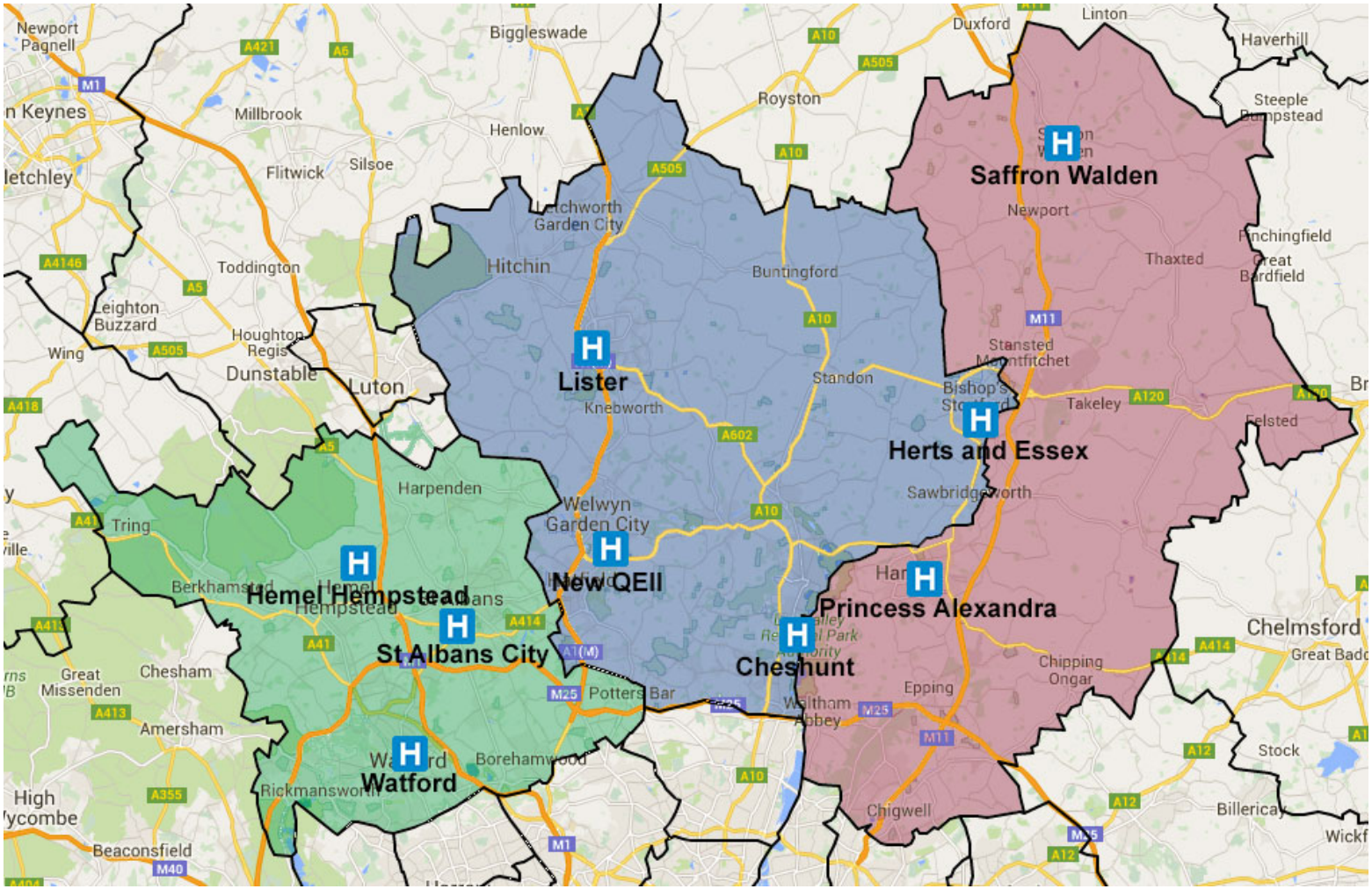


Herts Valleys CCG

- We plan and pay for health services with a fixed budget - a duty to meet financial targets
- Our annual budget for 2017/18 is approximately £838 million for around 630,000 people registered with a GP in west Herts. Now on a par with allocations elsewhere.
- Our financial position deteriorated in 2015 and 2016 and we are in "financial turnaround"
- We ended 2016/17 £14.6m behind our plan



Getting to know the neighbours …Commissioning at scale



The challenge …

- Birth rates are increasing, and people are living for longer
- Public demand for specialist treatments is increasing and expectations of services are high
- We need to improve the way we prevent, diagnose and treat illnesses and conditions such as cancer, diabetes, circulatory disease and respiratory illnesses
- Patients with complex conditions require intensive health and social care support to live on into their old age

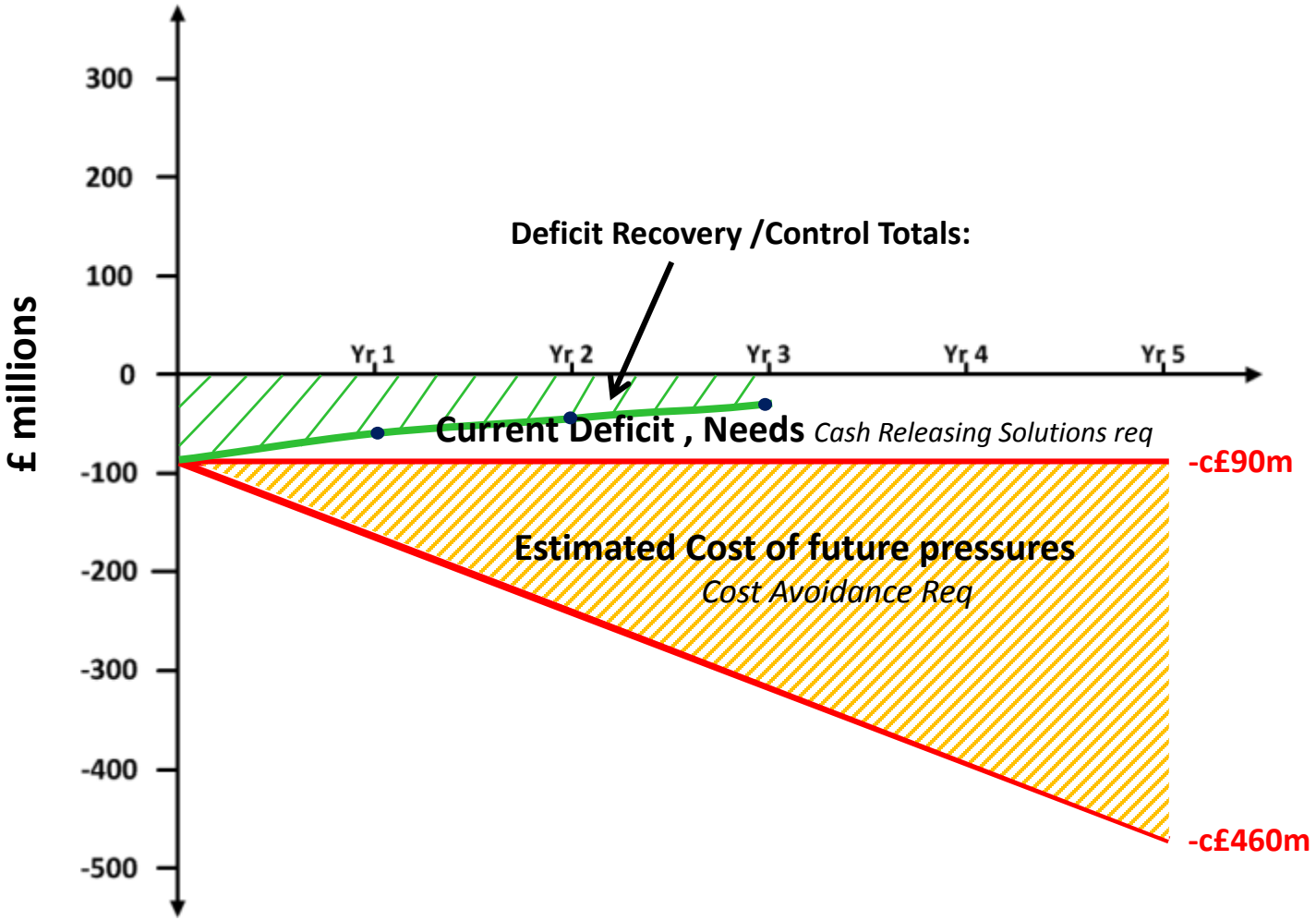
We currently **spend £2.8m per day on health care** alone. **By 2021 we would have to spend £4m per day** to keep up with demand, if we continue to provide services in the same way

If we don't make changes:

- There will not be enough skilled health and social care staff to meet demand in our GP surgeries, local community health and care services and hospitals
- People will continue to die from preventable illnesses

Sustainability and Transformation Plan

Herts and West Essex Financial Overview



Our Vision:

“By 2021, we will make the best use of the funding available to deliver the right care at the right time and in the right place – with a focus on promoting good health and wellbeing.”

What would this mean for you?

Our plan puts residents at the heart of a high quality, sustainable health and social care system, which emphasises the importance of **personal responsibility**, **preventative care** and **partnership working**.

"I have the expert advice and tools I need to manage my long term condition"

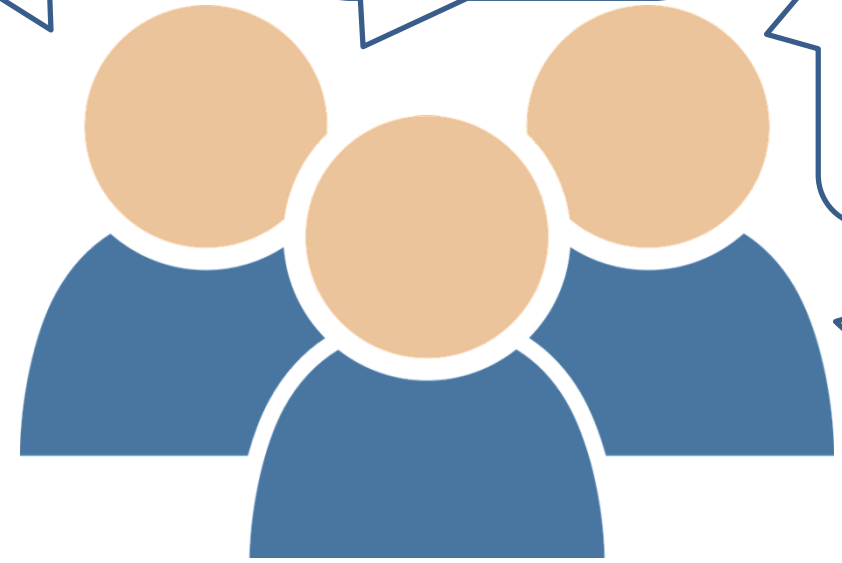
"I know that I will receive high quality care, regardless of who I see."

"I am empowered and motivated to look after my health and the health of my family"

"When I need expert help, I can go to a specialist centre with skilled staff"

"Simple treatments, procedures and consultations are available in my local area"

"I will be cared for at home, or close to home, whenever possible"



"I know where to go for health and care advice and support"

How will we get there?

Prevention and self-care

Working with people & communities to keep as healthy and as well as possible

More patients are supported to live well with their conditions:

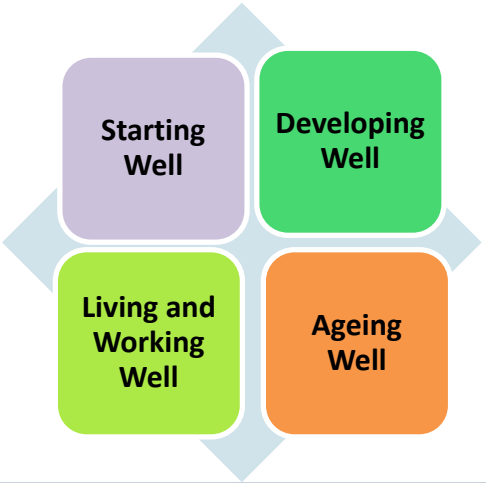
- personal health budgets
- use of voluntary sector
- supporting carers

SPOT THE SIGNS & SAVE A LIFE
SPOT THE SIGNS OF SUICIDE RISK AND YOU COULD SAVE A LIFE

Hertfordshire HHW Health Walks

Weight Watchers

Improving the health of NHS staff nationally could reduce sickness rates by a third, the equivalent of adding almost 15,000 staff to the national workforce, saving 3.3 million working days a year.



How will we get there?

Community and primary care

- Continue to bringing care closer to home – physical and mental health and social care support provided in the community, by multi-speciality teams.
- Work with our localities and GP Practices to support primary care services
- Making better use of community pharmacists
- Continue to work with the voluntary sector to deliver joined up community based services



How will we get there?

Acute services

We have already made significant changes in our area but we can do more:

- Standardised pathways of care
- Going to hospital for specialist opinions only when required
- Looking after people in the community will reduce the demand for hospital care
- Closer working between hospitals
- Improve our cancer care

The diagram below illustrates the future model of care (FMOC) building blocks.

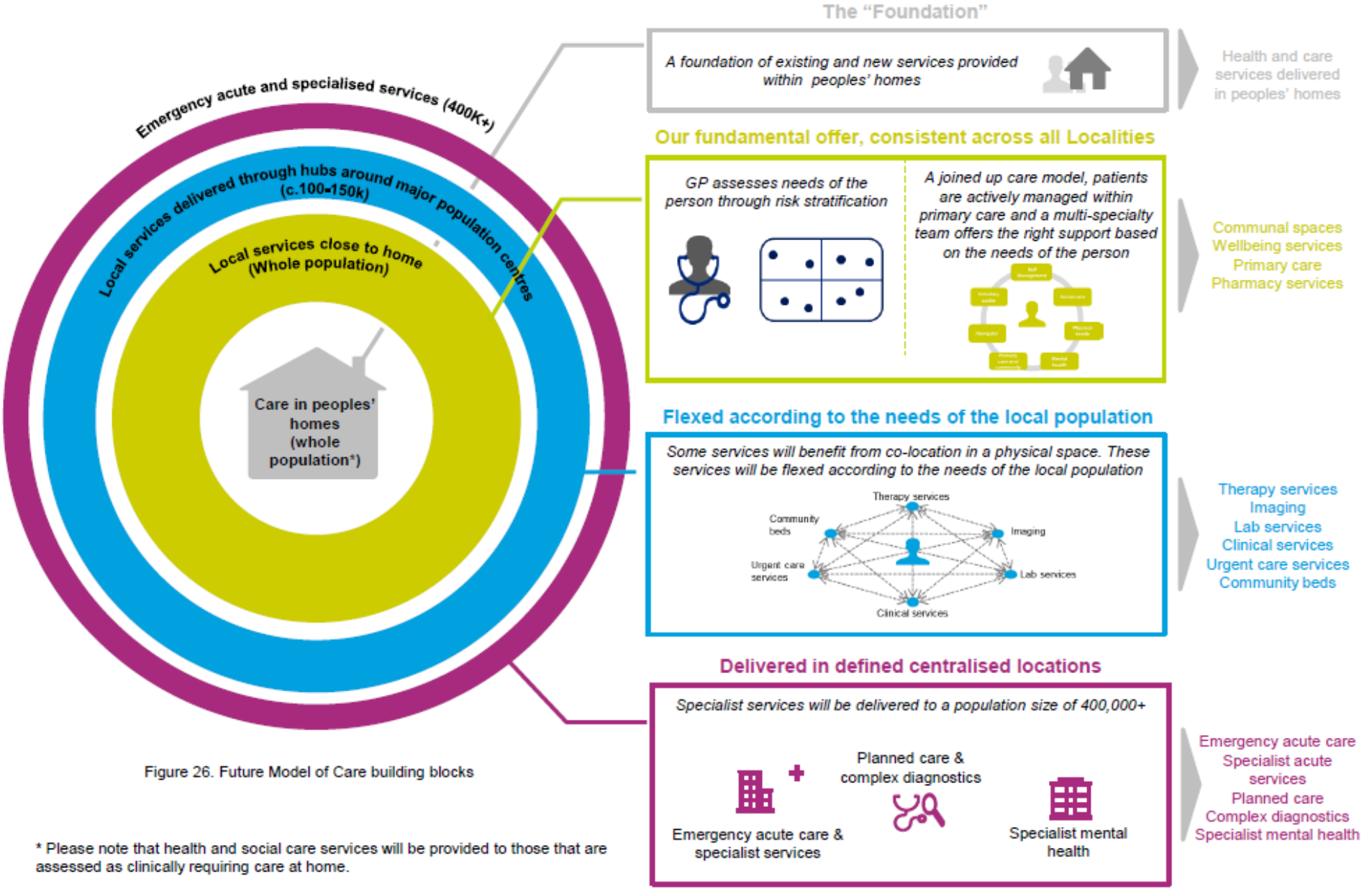


Figure 26. Future Model of Care building blocks

* Please note that health and social care services will be provided to those that are assessed as clinically requiring care at home.

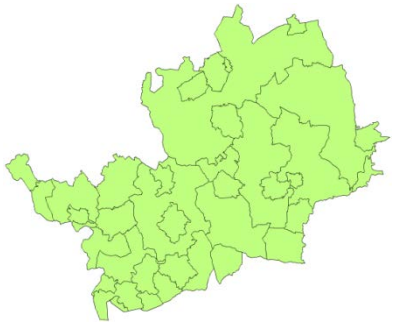
What is the Better Care Fund?

*"The Better Care Fund is a **single pooled budget** to support health and social care services to work more closely together in local areas…".*

NHS Planning Guidance, December 2013

For Hertfordshire, this means:

- ✓ Supporting joined up health and social care
- ✓ Bringing together CCG and social care older people budgets
- ✓ Includes Disabled Facilities Grant (**£6.3m** in 2017-18)
- ✓ Bringing together existing activity and newly agreed priorities into a single plan



BCF Plan 2017-19: Vision

"A system that delivers the right care and support at the right time and in the right place for individuals, their families and their carers"

How will we get there?

Bridging the financial challenge…

- Right staff, right skills, right places
- Improving prevention and supporting self care
- Standardised pathways of care
- Co-ordinating care and supporting people to avoid crisis
- Going to hospital for specialist services only
- Reducing demand on hospitals with effective local services
- Efficiencies in how we do things, including administration

NHS England Social Prescribing Work

NHSE working with partners to:

- **Map social prescribing** at CCG level
- Create **Common Outcomes Framework**
- Enable **Regional Social Prescribing Networks** to share good practice and support innovation
- Create a **Kite Mark** for local schemes (quality assurance)

What ***is*** social prescribing?

1. **Health referral** – GP, nurse, consultant, physio…
2. **Link person** – 'co-producing' support plan
3. **The prescription**: service/s and connections in community

Key service in West Herts = **Community Navigator Service – face to face support to make links**

For people who don't need face to face support ***HertsHelp*** provides phone service

‘Asset-based community development’

Ambitions:

- ***All GPs to have access to link worker service***
- Voluntary, community and social enterprise groups to be nurtured and supported – not just connectors

CommunityFirst

Releasing the power of communities to help people stay well and independent

What is this strategy trying to achieve?

- Ensure our partners and public are aware of the voluntary and community sector offer
- Promote and build on the role communities play in supporting people
- Provoke a debate for doing things differently and making it easier for frontline staff and the public to access community support

Hertfordshire

How community networks can help

- 80% of determinants of health not clinical
- 20% GP face-to-face time on non-medical issues
- 15% GP time spent on ‘welfare’ issues
- Deprived and isolated people greater users of A&E

Non clinical determinants of health

- Helping OP exercise reduces need for social care http://www.bmj.com/content/359/bmj.j4609
- Loneliness 'as bad for health as a chronic long-term condition' and harmful as 15 cigarettes pd - (Holt-Lunstad, 2010) https://www.campaigntoendloneliness.org/resources/
- London School Economics: £1 spent on loneliness: up to £3 saved in health costs
- GPs can identify people and link them to local services (social prescribing)
- Commissioners need to fund early interventions so lonely people don't ***need*** to see GP

Social role in clinical determinants

- Can’t treat mental health of someone about to be evicted
- Carer stress and depression can be worsened by poor service responses
- Costs and dangers from medical non-adherence can be lessened by:
  - Patient engagement and motivation
  - Carer engagement
  - Peer support
  - Addressing disadvantage (cost of medication, transport, access to support)

Drafting a Common Outcomes Framework for Social Prescribing

NHS England

Example of Community Supporting the Community

Carer Peer Mentoring:
From 17 completed relationships:

How confident do you feel in your caring role?
Pre: Average: 4.4/10
Post: Average: 6.6/10

Do you know where to go to find information and support?
Pre: Average 4.4/10
Post: Average 7.7/10

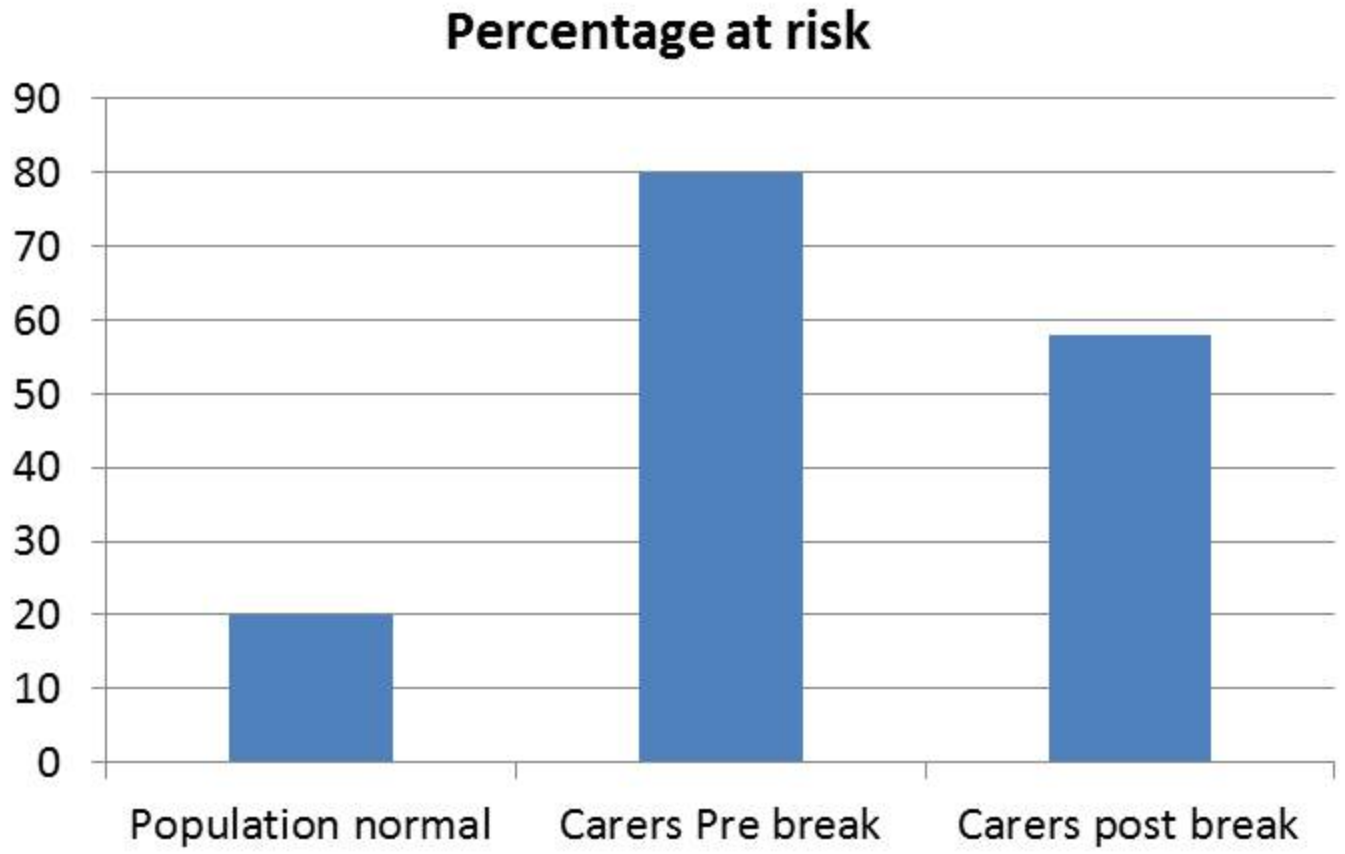
Carers in Hertfordshire

Make a Difference for Carers

Risk of Depression Scores

2009-2015

Carers in Hertfordshire



www.carersinherts.org.uk

Carers' Champions: Primary Care

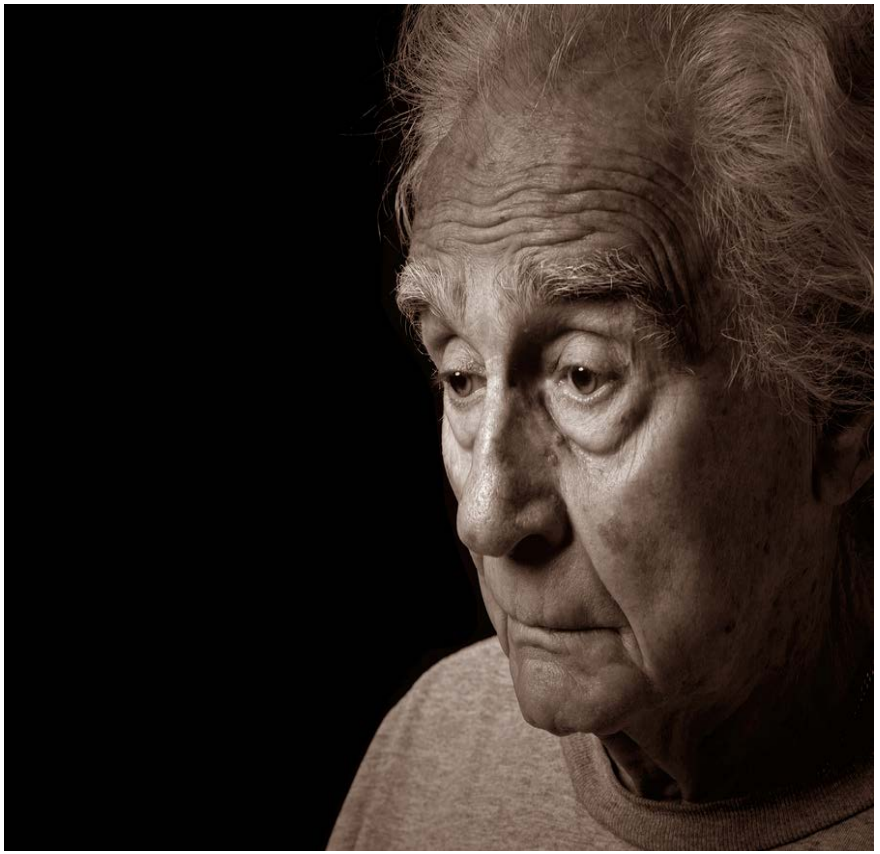
- Direct link to *Carers in Herts* in all practices
- Surgeries more 'carer-friendly'
- Reduction in risk of depression etc

- Incentivised by CCG
- Helps carers access flu jabs and health checks
- Helps clinicians 'identify' carers
- Gets carers social support

NHS
Herts Valleys
Clinical Commissioning Group

Community Navigator Case Study

- Bereaved older man
- Had stroke, urinary incontinence and deaf
- Presenting at A&E frequently
- Referred by GP to community navigator



No longer isolated

- Navigator focused on what mattered to him
- Helped to attend local lip- reading course
- Joined *Hertfordshire Health Walks* group – exercise ***and*** social life
- Reduced attendance at A&E and primary care

Impact on Primary Care

- 50% of referring GPs saw reduction in visits *(survey November 2016)*
- Increased ability to address clinical issues

"We were able to do the doctor bit, the pharmacist was able to do the pharmacy bit, everyone was able to do their own bit to help him improve in his life. These wider determinants of health had been faced and compassionately dealt with so then we could make progress." ***A GP***

Impact on the community

- Clients often turned into volunteers
- SP focuses integration and builds partnerships
- Improved local networking (community resilience)
- Ensuring addressing social determinants part of the ‘offer’ of local ‘hubs’
- *Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill* (Marmot, 2010).

Resilience

“After the intervention he came in a different man. I feel that the Navigator intervention was critical. If you are not looking after yourself then you don’t have any resilience when you are unwell. I’d say that I’ve seen positive results in almost everybody that I’ve referred.”

W Herts GP

Thank you

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