Hertfordshire and West Essex
Sustainability and Transformation Plan

A Healthier Future

HERTFORDSHIRE HEALTH AND WELLBEING BOARD

14 December 2016

Aims for today

- Shared understanding of STP aims and process
- Understanding the context and challenges we face as a system
- What we can achieve by working together as a system

STP National Aims

- Close the health and wellbeing gap
- Drive transformation to close the care and quality gap
- Close the finance and efficiency gap

Our Ambitions

VISION: Local populations working with health and care providers to improve health and wellbeing, stay as independent as possible, and get the most effective treatment and care when they need it

- Support the population to live well and make the right choices
- For people who have long-term conditions, support to stay independent
  - Support self management with information, advice and technology
  - Single, personalised care plans
  - Integrated services delivered at home and the community
- People only go to acute hospital when they need acute hospital care, and only stay for as long as they require that level of care
- Right care, by the right person, in the right place, at the right time
- Bringing the system back into sustainable financial balance

Context

Financial pressures

- Current system spend is approximately £3.1bn
- Forecast deficit of £94m for 2016/17 rising to £401m (£552m Inc Social Care) by 2020/21 if we don't take action

Increasing demand

- Population expected to increase by over 10% from 2011 to 2021.
- Number of over 85s expected to increase by approximately 45% from 2011 to 2021

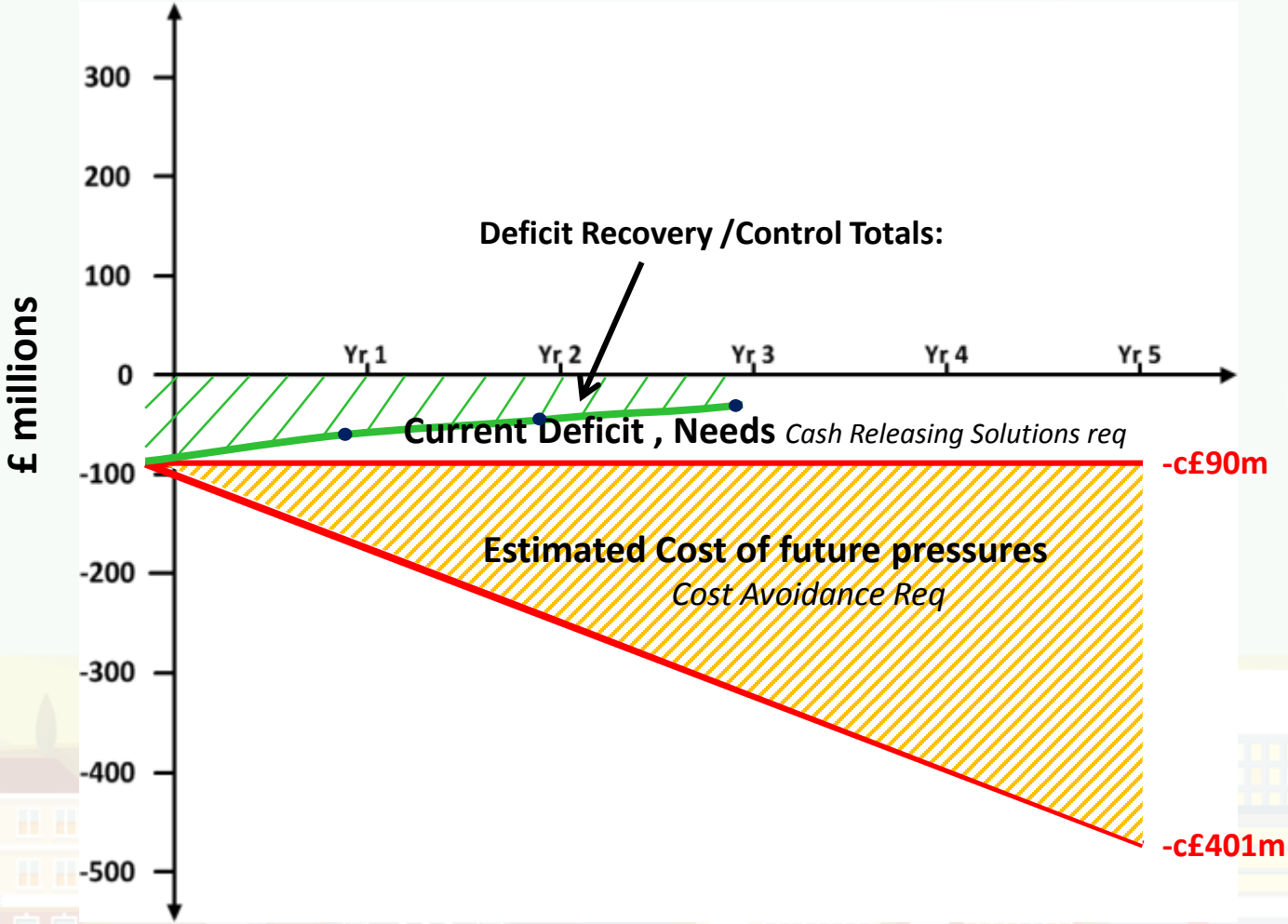
Pressure on the health and care system

- Primary care capacity
- Acute care performance and quality challenges
- Social care funding

National drivers

- NHS Five Year Forward View
- NHS Constitution commitments
- National service strategies, e.g. mental health, cancer and maternity

Herts and West Essex Financial Overview



Solutions

Solution(s)	Impact £m
Demand reductions/management	57.5
CCG QIPP requirements - estimated activity reduction	21.2
Social Care Savings	49.8
CCG 20% running cost savings	6.7
CCG other	11.1
Specialist commissioning savings	39.5
Provider back office	13.3
Provider estates efficiencies	4.3
Provider other Carter savings	36.1
Agency costs	16.7
Clinical workforce review	8.3
Other provider productivity/staff changes	86.7
SUBTOTAL	351.1
NHS STF Allocation	100.0
Total Solutions	451

Workstreams

Prevention

- Improve health and wellbeing by supporting communities to make the right choices
- Keep people with long term conditions as well as possible for as long as possible
- Reduce demand for services

Integrated Primary and Community services

- Keeping people as independent as possible
- Services located close to where people live
- Deliver Mental Health and Primary Care 5YFVs
- Reduce demand for hospitals, relocate services from hospitals

Acute Hospital services

- Partnerships – ENHT/PAH, WHHT/RFH
- Reducing variation
- Standardised protocols and pathways
- Back office

Finance and Activity

- Develop the financial bridge and align finance and activity
- Support other workstreams

Enablers

Collaborative Commissioning

- 3 CCGs and 2 County Councils
- Uniform criteria and protocols
- New ways of contracting
- Reduce transactions and back office

Technology

- Interoperability
- Shared information
- Single care records
- Assistive technology

Workforce

- Solutions to current challenges
- Transformation to the new workforce
- OD programme

Estates

- Fit for purpose community & primary care estate to support transformation
- Best value by looking across organisations

Comms and Engagement

- Engaging stakeholders in process
- Engaging communities in health and wellbeing initiatives
- Engaging the workforce to achieve transformation

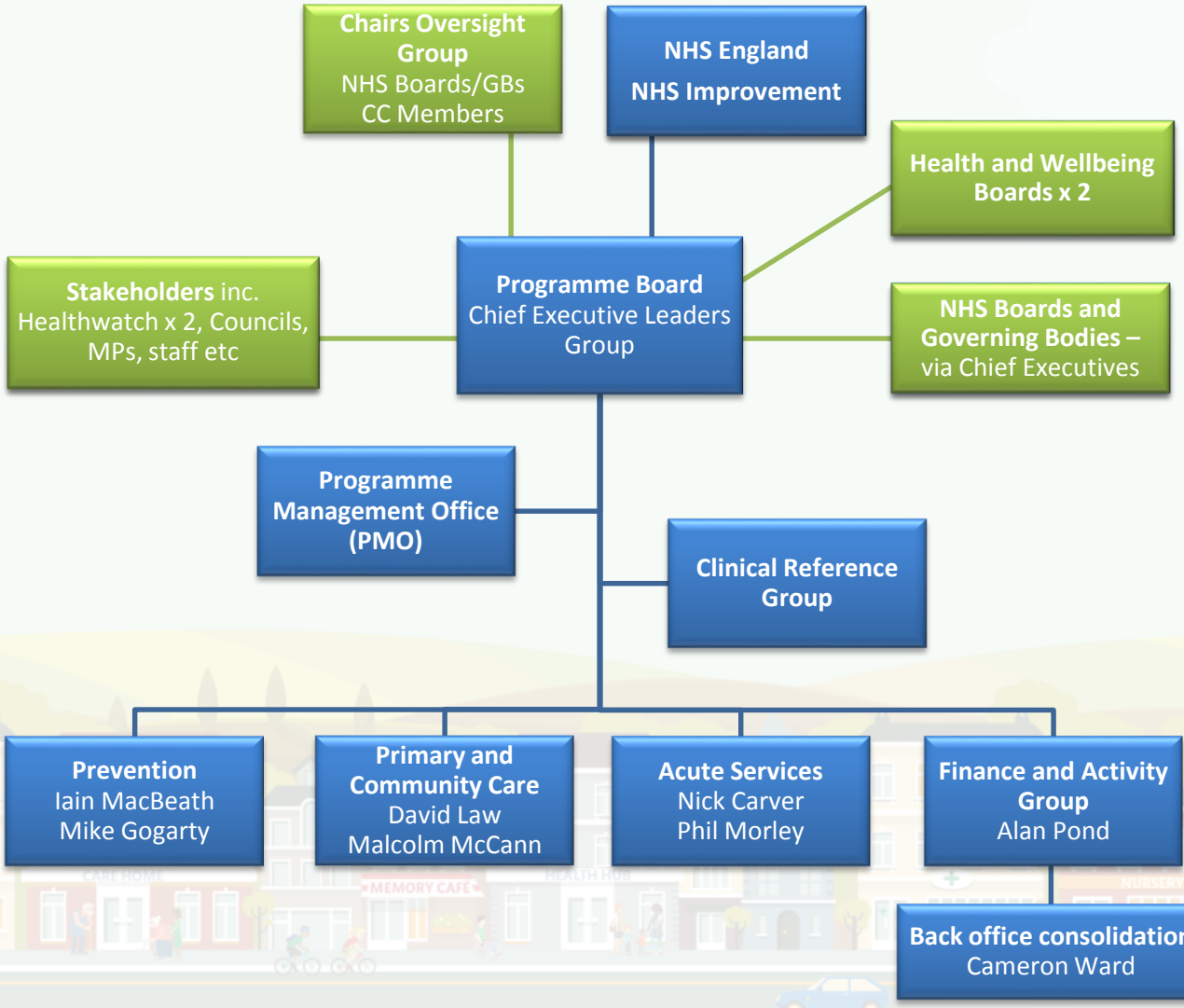
Key Risks and Issues

This is an ambitious plan, and there are therefore some significant risks associated with its achievement.

These are:

- The plans are in development phase and need to be tested to verify viability and give scale of challenge
- There is a risk that 2017/18 control totals cannot be achieved by all organisations
- There is significant uncertainty about the ability to maintain the planned year-end financial position for 2016/17
- The capacity and capability in the system is not sufficient to deliver the plan
- Insufficient engagement and buy-in from clinicians and practitioners, which impedes delivery
- The priorities of individual organisations may preclude the full commitment of all partners that is needed to achieve the plan.

Governance Structure



Enabling Work Streams

- **Collaborative Commissioning** Cameron Ward
- **Technology** Katie Fisher
- **Estates and Infrastructure** Debbie Fielding
- **Communication and Engagement** Beverley Flowers
- **Workforce** Jinjer Kandola

A population-based strategy to tackle the key health issues

Prevention work stream

PREVENTION

Wanless Report 2004

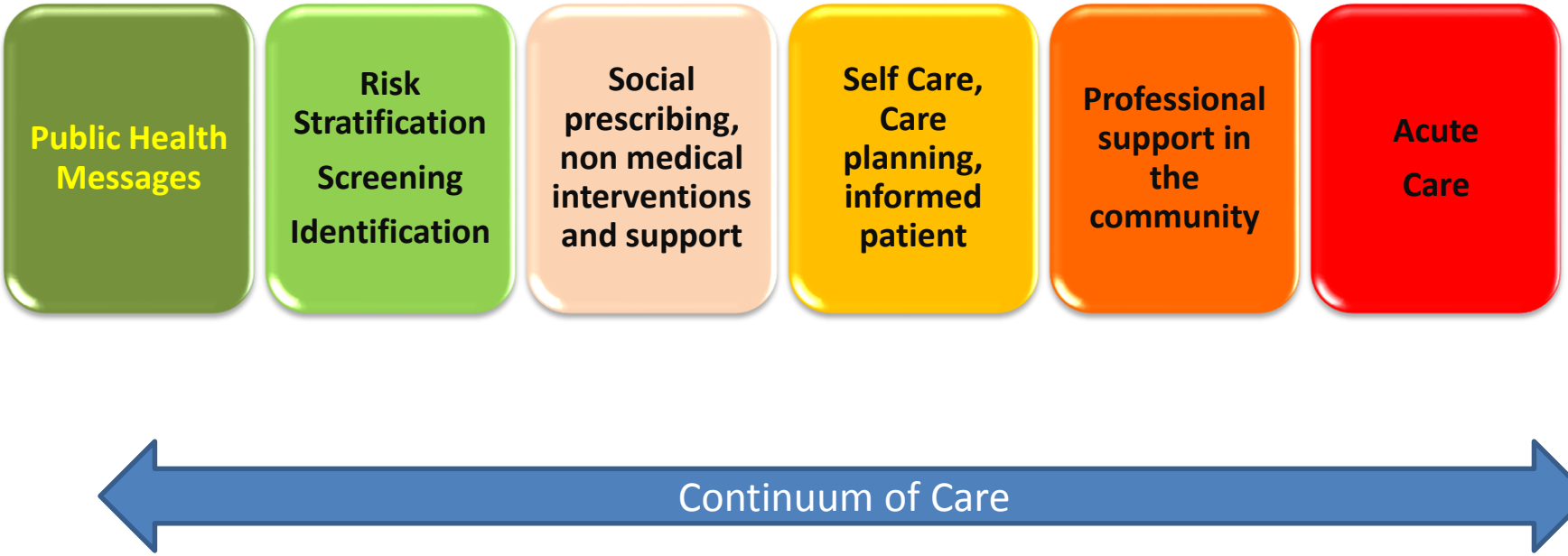
"If a nation fails to get serious about prevention then recent progress in healthy life experiences will stall, health inequalities will widen, and our ability to fund beneficial treatments will be crowded out by the need to spend billions of pounds on wholly avoidable illness"

Five Year Forward View – six principles reflecting commitment to promoting well being, preventing ill health and closing health and wellbeing gap

- Care & Support is person centred, personalised, coordinated and empowering
- Services are created in partnership with citizens and communities
- Focus on equality and narrowing the gap
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers

Our Ambitions

Support our patients and population to live well and stay well for as long as they can. Where they do have healthcare requirements, our aim is to provide them with the tools to manage their own health and wellbeing independently.



Patient supported to move to less interventional support

Prevention work across the STP

Risk Identification	Social Prescribing	Self-care – Living well	Professional support to avoid crisis	Avoidable disability & avoidable acute admissions
Screening Lifestyle Smoking Obesity Blood Pressure Carer Family History Frailty scores Social isolation Stress / Depression Perinatal Maternity Safeguarding / Families First Atrial Fibrillation	Carer support Befriending Walking groups Slimming World Money & benefit advice Healthy lifestyle advice Apps Planning & Housing Local Authority & District Restricting licenses Healthy schools	Tailored care plan – physical and mental health Patient education Diabetes advice & support Pharmacy advice Peer support Apps Postural stability/exercise Employee health & wellbeing advice & support	Specialist nurses & Multi disciplinary community support Timely access to primary care & support Shared records across system Tele health Family support teams Specialist social services End of life care	Stroke Secondary Falls Acute exacerbations Amputations due to diabetes Reduction in life expectancy in those with mental health conditions Frequent attendees with complex issues

Providing fully integrated community-based care

Primary and Community Services work stream

What are we aiming to do

- To maintain people in the community, living as independently as possible
- To support people to manage their own health and well-being
- To reduce the burden of disease…
- …to reduce the demand on health and social care and provide services at lower cost

What's the ask?

- Reduce/absorb activity to the tune of £100million
- Spend £35million in doing so
- Leaving a benefit of £65m savings – most of which comes from the avoidance of cost associated with growing demand
- BUT…. Where does the cash come from?

What is our approach?

- Build primary health and social care teams for neighbourhoods of around 50,000 people
- Develop leadership at locality level
- Focus on population health and wellbeing
- Set clear activity and financial performance parameters
- To reduce demand management of long term conditions avoid admissions to hospital or outpatients
- Engage extensively with the community

Priority areas/pathways

- Prevention of admission – across the system including mental health
- Frailty (including Falls/UTI/Dementia/Respiratory)
- Diabetes (including obesity)
- COPD (including smoking cessation)
- Stroke
- Parity of esteem for mental health
- Urgent care access across primary and community care

The scale

	3 years		5 years	
	ACTIVITY	REDUCED BED DAYS	ACTIVITY	REDUCED BED DAYS
In patients				
Frailty	11231	13584	24451	28222
Respiratory	1578	4263	3730	8637
CVD	1677	2544	3923	5228
Diabetes	164	205	386	407
MSK	282	418	674	856
Elective	1093	3520	2884	8524
	0	0	0	0
TOTAL	16025	24534	36048	51874
A&E attendances				
Well adults	44888	0	113050	0
Outpatients	140959	0	343095	0
TOTAL	**185847**	**0**	**456145**	
GRAND TOTAL	**201872**	**24534**	**492193**	**51874**

Priority areas/pathways

- Building a strong focus on: primary care; mental health; children's services
- Moving to clinical leadership
- Developing the workforce – upskilling
- Identifying/generating the cash to invest
- Using hubs effectively
- How we measure the right outcomes – triple aim
- Building a collaborative environment to make the best use of resources
- Creating the right incentives and commissioning arrangements

Delivering sustainable acute services

Acute Services work stream

Vision and key principles

Vision

We will support the provision of sustainable acute services across the STP by adopting a patient-centered, quality driven approach to optimising patient outcomes whilst reducing activity, optimising use of all resources and removing avoidable cost.

Key principles

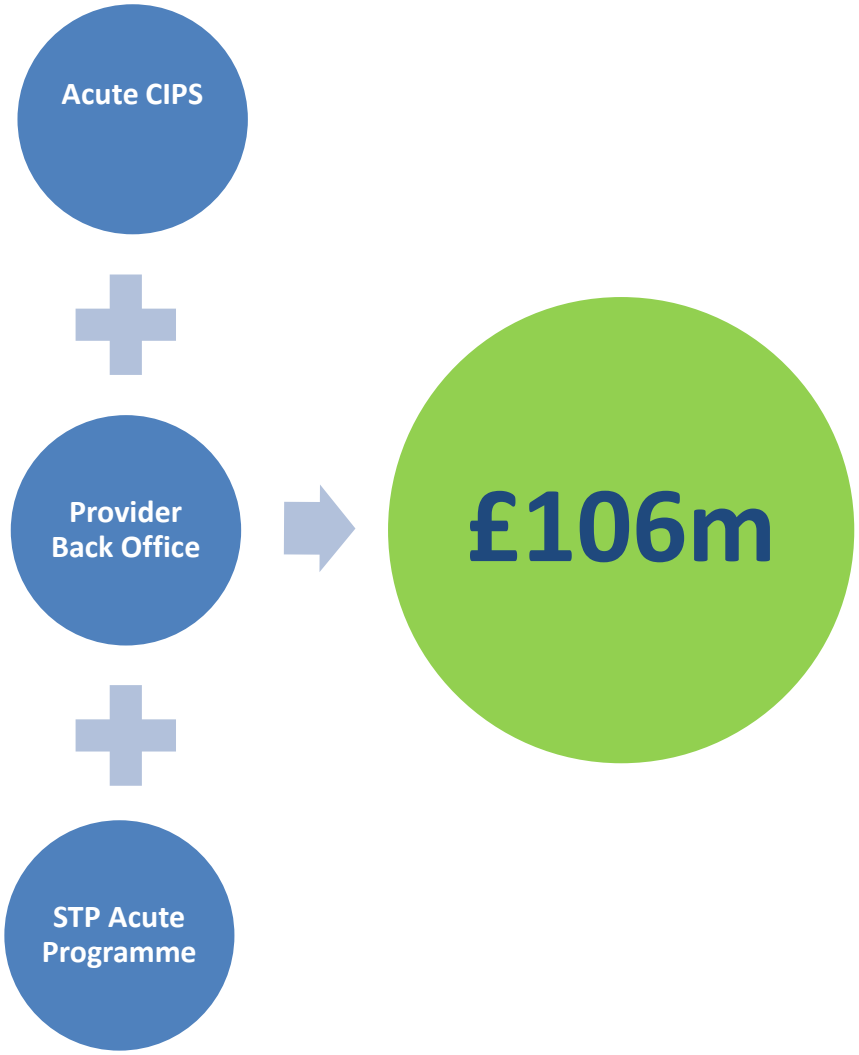
- Integrated clinical pathways
- Evidence-based clinical services and pathways
- Effective system demand management and co-designed pathways and services
- Shared services to reduce costs of non-clinical and back office functions
- Sustainable workforce
- Drive best value solutions for investment in estates development and backlog maintenance

Acute Services Programme – key streams of work

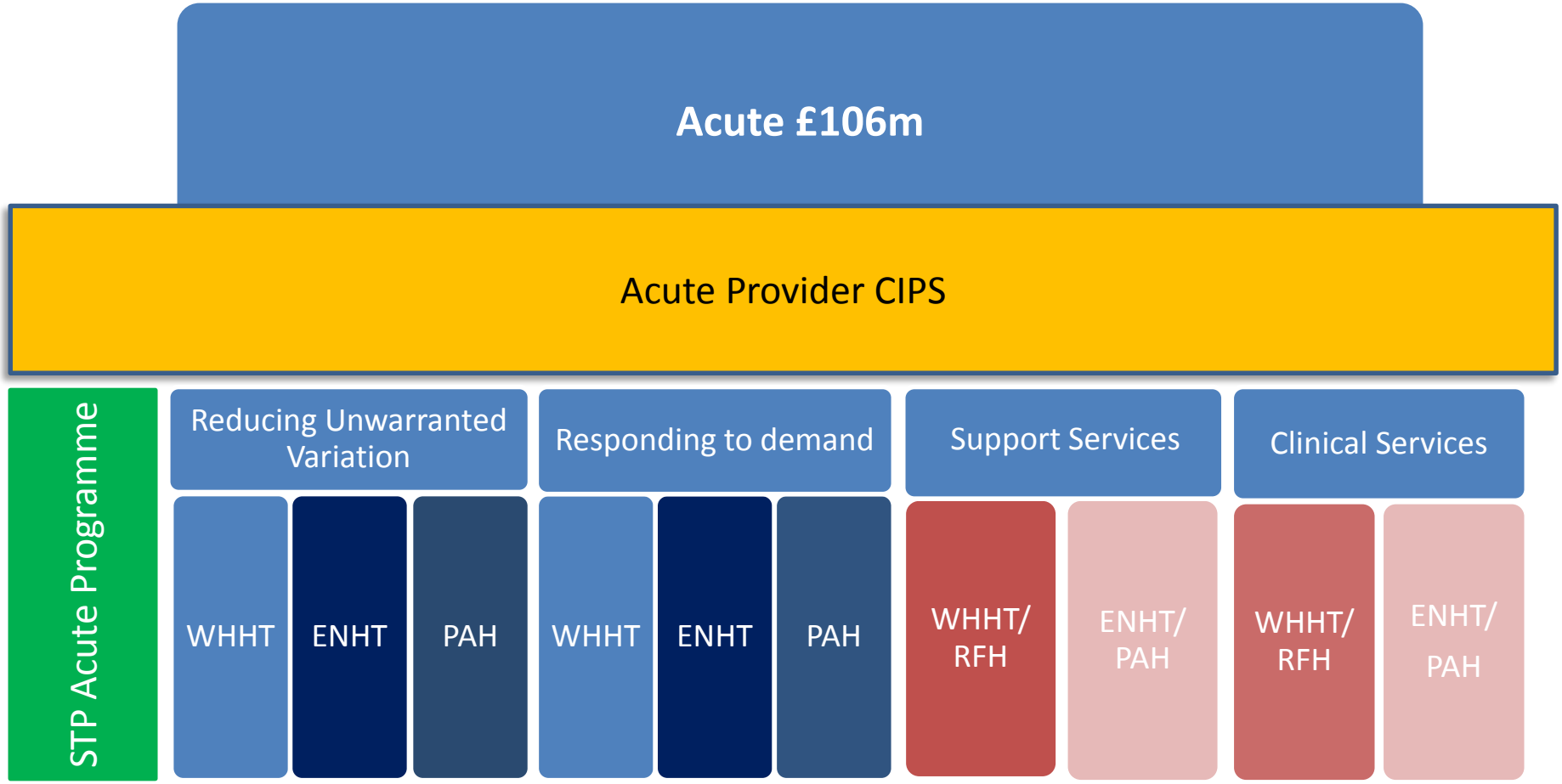
Focus	Priority Areas include
Elimination of unwarranted variation – appropriate standardisation of integrated clinical pathways across the STP in order to eliminate variation and optimise clinical effectiveness and efficiency	• Clinical pathways with greatest impact on acute bed and resource usage
Responding to demand for acute services – application of appropriate responses according to the acuity of patients presenting in acute care and working with STP partners to reduce and better manage demand for acute care by supporting their management of patients within primary and community services	• Developing models and pathways to support delivery of Primary & Community Work Stream priorities • Over 75s • People with ambulatory care sensitive conditions • Urgent Care • Elective demand
Harness benefits from sharing services at scale - sharing clinical support and back office functions to reduce service costs	• Pharmacy • Pathology • Finance incl Payroll • Human Resources • IM&T • Hard FM / Estates Management • Soft FM
Developing new pan-provider service models to enable fragile clinical services to continue to be provided sustainably and locally	• Vascular Surgery • Cancer • Interventional Radiology



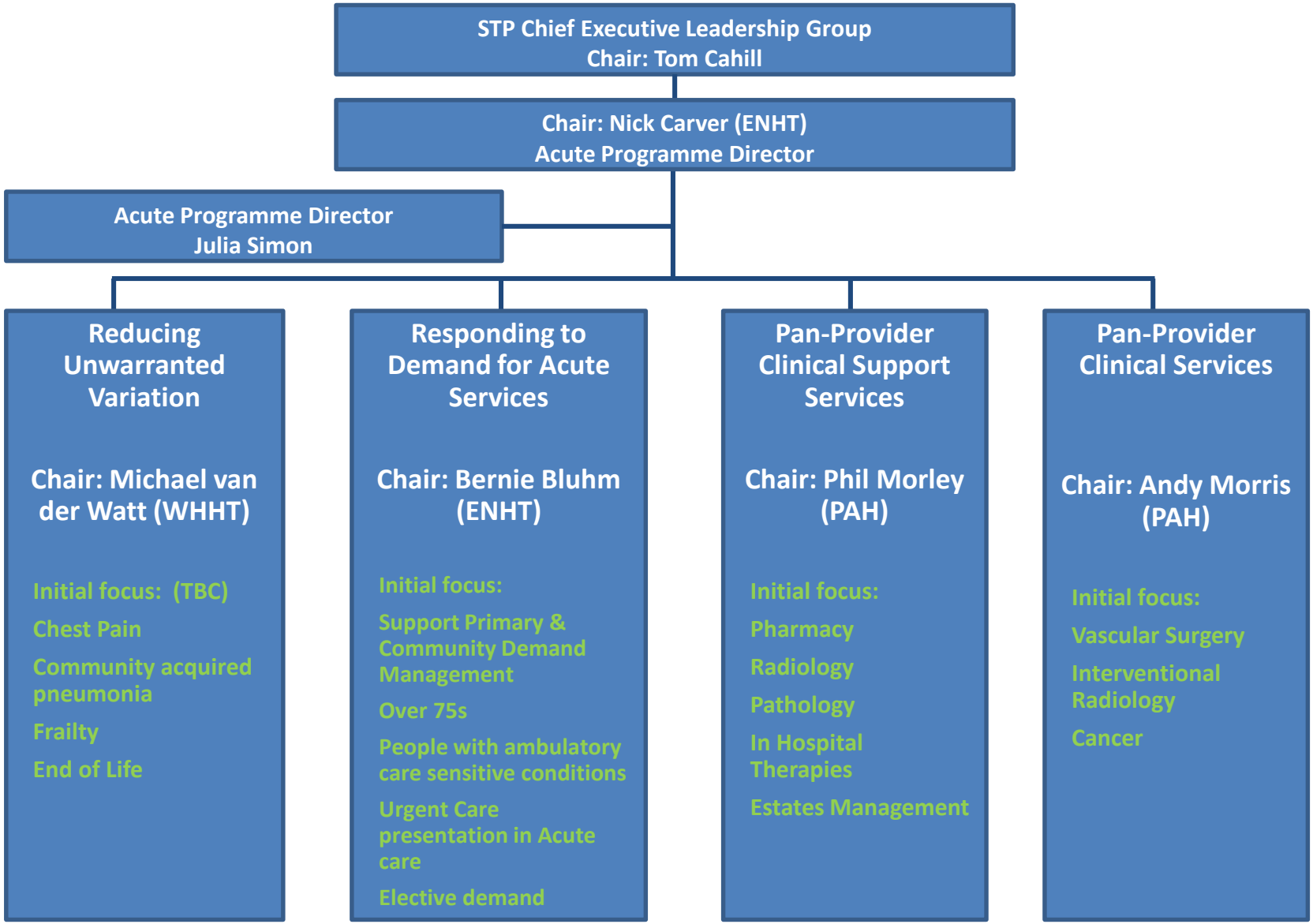

Acute Work Stream
Financial Contribution by 2020/21 Hypothesis



Total STP contribution from acute providers by 2020/21



STP Acute Work Stream Programme Structure



Next Steps

- External support to review and re-set plans
- Revised financial solutions – 'the bridge'
- Detailed implementation plans
- Delivery structures
- Engagement and partnership as a priority
  - New relationship with local people
  - Partnerships with local leaders – councils and 3rd sector
  - Clinicians and practitioners leading transformation
  - Effective health and social care integration and partnership