# Health and care system strategy development

# Summary presentation for the Health & Wellbeing Board, 13<sup>th</sup> June 2019





Oxford University Hospitals NHS Foundation Trust







Oxfordshire Clinical Commissioning Group The NHS Long Term Plan sets out ambitions and vision for the next 10 years, as shown below. NHS organisations will need to provide responses at organisational and wider levels, working in partnership with local government and engaging widely with stakeholders.

1. Integrated Care	2. Prevention & Inequalities	3. Care quality & outcomes		4. Workforce	5. Digital	6. Efficiency	7. Engagement & Partnerships
Out of hospital care, including primary care networks and helping people to age well & manage multiple long-term conditions	Smoking	Strong start in life for children & young people	Maternity & Neo-natal	Workforce planning	Empowering people	Financial balance	Public engagement
	Alcohol		CYP mental health	Recruitment	Supporting professionals	Cash-releasing productivity, inc. • Bank/agency • Procurement • Pathology • OOHC GIRFT • Prescribing • Admin • Estates • Inappropriate interventions • Reduce harm • Counter-fraud	Health and employment
	Obesity		Learning disabilities & autism	Supporting current staff	Supporting clinical care		Health and justice
Urgent and Emergency Care	Air pollution		CYP cancer	Productivity	Improving population health		Health and veterans/ armed forces
	Antimicrobial resistance		Other CYP	Leadership & Management			
Personalised	Health inequalities	Better care for major health conditions	Cancer	Volunteers	ers Improving efficiency/ safety	Reduce variation	Care leavers
care, inc. personal health			Cardiovascular				
budgets and social prescribing			Stroke				
			Diabetes			Responding to	Health and the environment
Digitally enabled primary care and outpatients Integrated care systems and population health			Respiratory			growing demand	Anchor
			Adult mental health			Capital	Institutions
	Better care		Short waits for planned care				
		ш	Research & Innovation				

# At each level we need to join up across organisations to provide personcentred care for the populations we serve.

#### 1. Independent Organisations

Commissioners, including CCGs and Local Authorities.

Providers, including Acute Trusts Community and Mental Health Trusts, General practices, Ambulance Trusts, 111 Providers, Care home providers, Voluntary and Community services 5. Collaboration with other providers to **provide services at** scale to achieve better outcomes and/or efficiencies e.g. some elective care, clinical support services, workforce issues

#### Regional/National

e.g. Thames Valley or England (5-10m+)

#### 6. Specialist provision of services

commissioned regionally or nationally - e.g. specialised cancer treatment; children's specialised services; genomics; learning disabilities; forensic mental health; dental

### Integrated Care System

Berkshire West, Oxfordshire & Buckinghamshire (BOB) (1m+; BOB is 1.86m)

#### **Integrated Care Partnership**

Oxfordshire (745k)

Oxford Health, Oxford University Hospitals, Oxfordshire CCG, Oxfordshire County Council, PCNs

#### **Districts/Localities/Federations**

e.g. Oxford City; arrangements agreed with PCNs and local communities

#### Primary Care Networks and Network areas

e.g. Bicester, Wantage (30k-50k+) Integrated primary health and community services 4. Health & Wellbeing Board strategy – formation of ICP for Oxfordshire. Recent system focus on Urgent & Emergency Care pathway; continued work on six care areas.

3. Application of the HWB population health planning framework. Possibility to move outpatients & diagnostics closer to home and online

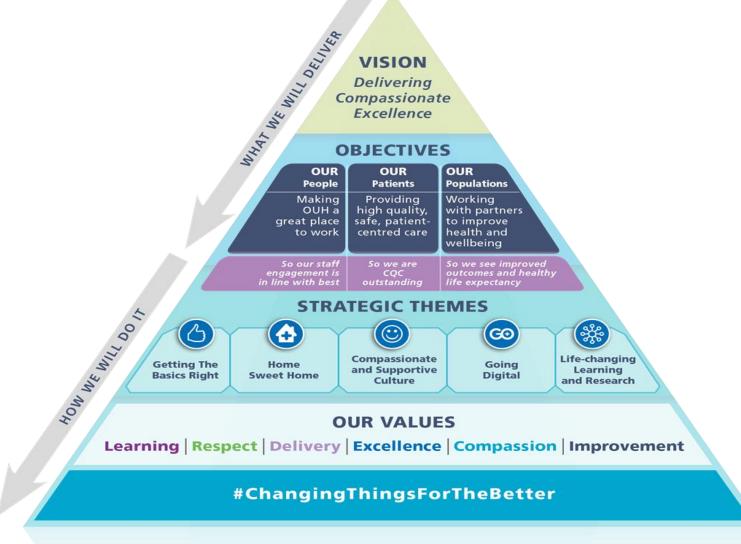
#### 2. Proactive and preventative approaches to supporting better health and wellbeing; and managing long-term conditions

Our Health & Wellbeing Strategy and priorities set out the shared vision for Oxfordshire, which is well-aligned with national as well as local priorities. All organisations need to ensure that their strategies are contributing to achieving these priorities.

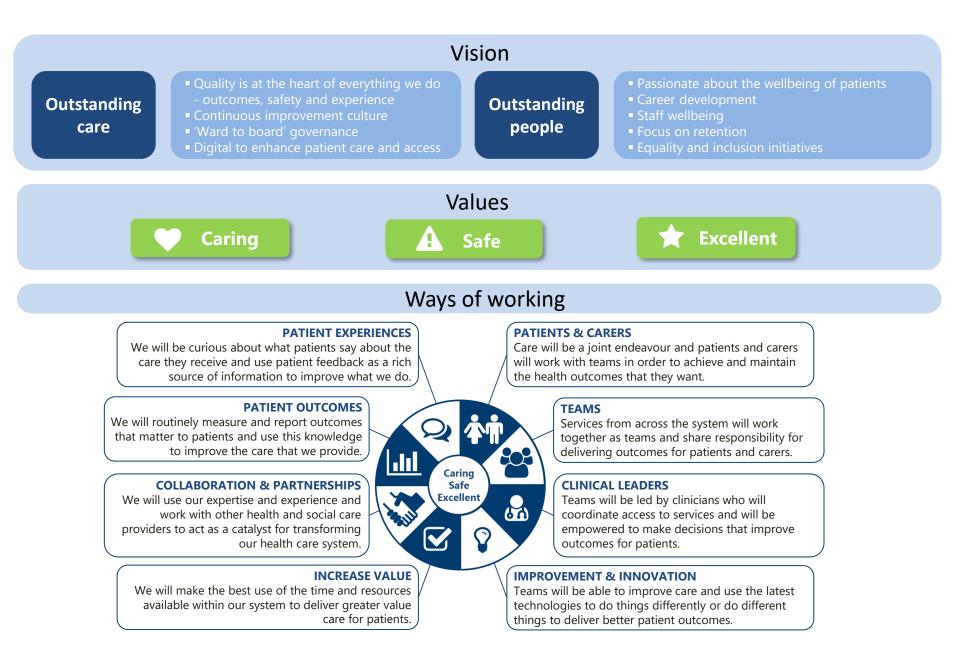


# Organisational strategies

OUH and OH are both refreshing their Trust strategies in the next few months and will be engaging with the community to help shape priorities. OUH's draft strategy framework is below.



# **Oxford Health NHS FT – strategic framework**

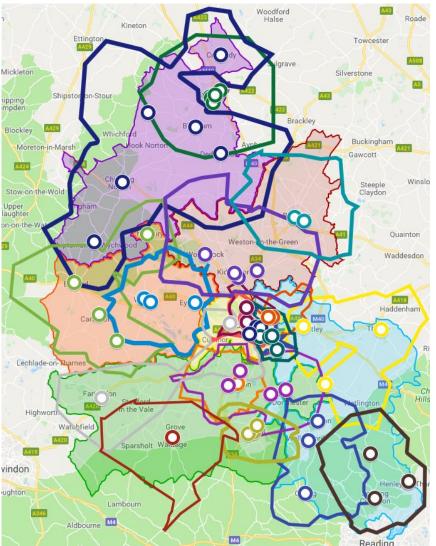


Priority areas and strategic themes under consideration							
Sustainable mental health services		Delivering care at home and in communities inc. PCNs		Improving the lives of people with Learning Disabilities & Autism		New Care Models e.g. Eating Disorders, CAMHS	
	Workforce – leadership, development, wellbeing & retention		Digital by advice, acc off	ess & care	Focus on QI, effective governance & financial stability		

### Supporting plans & programmes:

- Operational Plan
- Clinical plans (e.g. Dementia Strategy)
- Transformation programmes (e.g. Care Closer to Home)
- Enabling plans (e.g. Workforce Plan)

# **Developing primary care networks in Oxfordshire**



Primary Care Network	Number of practices	Registered Population	District/s
City - East Oxford	5	47,535	Oxford City
City - OX3+	2	43,391	Oxford City
Oxford Central	5	39,178	Oxford City
Oxford City North	4	42,990	Oxford City
SE Oxfordshire Health Alliance	4	40,824	Oxford City
Banbury Town	6	66,154	Cherwell
Bicester	3	49,523	Cherwell
Eynsham & Witney	4	51,273	West
KIWY (Kidlington, Islip, Woodstock, Yarnton)	4	35,229	Cherwell, West
NORA (North Oxfordshire Rural Alliance)	5	47,666	Cherwell, West
Rural West	4	31,457	West
Abingdon & District	4	30,043	Vale
Abingdon Central	2	33,657	Vale
Didcot	3	41,902	South
Henley SonNet	4	32,144	South
Thame	3	30,525	South
Wallingford & Surrounds	3	32,052	South
Wantage	2	30,070	Vale
White Horse Botley	2	31,366	Vale
Total		756,979	

Practice main locations and PCN network areas (shaded areas denote CCG localities)

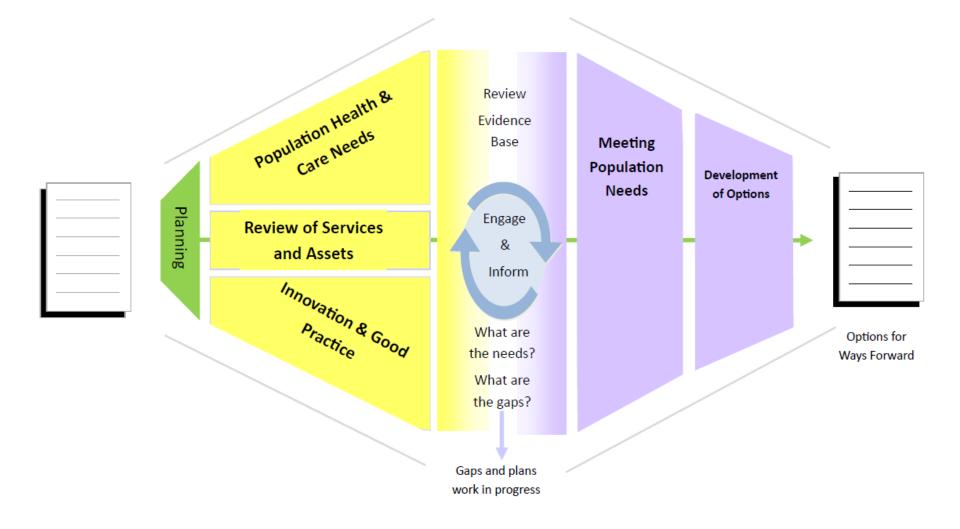
Practice registered list size as of 1 January 2019

# Applying our population health planning framework

- Approved by the Health and Wellbeing Board in November 2018
- Currently in use in the Wantage area
- Subject to a Joint HOSC Task and Finish Group
- Progress good but challenges around first time delivery
- About to start rolling out in Banbury and surrounding area including implementing strategic vision for the Horton now that the judicial review is completed (subject to findings of Joint HOSC on obstetrics)

Population Health Needs Framework Summary		S	tages can be run concurrently	Health and Wellbeing Board Approved November 2018		
	Planning and Co- design	Population Health and Care Needs	Review of Services and Assets	Innovation and Good Practice	Meeting Population Needs	Development of options
Key Activities	<ul> <li>Co-design the detailed approach with particular emphasis on local involvement</li> <li>Informed by JSNA and community profiles confirm the scope of the focus of the work - neighbourhood / Town / locality etc</li> <li>Establish a core project team</li> <li>Establish a stakeholder group</li> <li>Establish a stakeholder group</li> <li>Establish a clinical / professional group</li> <li>Develop involvement strategy and communications plan</li> <li>Hold a community event(s) to introduce and kick off the project</li> </ul>	<ul> <li>Start population health management approach</li> <li>Build on existing work to understand the current and future population needs</li> <li>Identify key leads to be engaged in development of specific aspect of the needs assessment work</li> <li>Segment the population to identify and consider need, use modelling to predict trends and changes</li> <li>Identify any urgent or immediate concerns that require action</li> <li>Plot out timescale for significant population changes linked to growth deal</li> </ul>	<ul> <li>Identify key individuals and organisations to undertake review</li> <li>Map what services are provided by whom, where and when</li> <li>Map which population accesses the services</li> <li>Identify physical assets and the services provided from those assets</li> <li>Capture any sustainability issues – workforce, physical condition of buildings, non recurrent funding etc</li> <li>Where possible highlight activity - what population segments access which services</li> </ul>	<ul> <li>Identification of innovative approaches to the future delivery of services</li> <li>Identify and understand the successes and impact that early adopter sites have achieved</li> <li>Consideration of latest ideas and clinical good practice</li> <li>Establish local views and ideas from those delivering services on how services could be provided differently in the future with innovation and integration</li> <li>Work to identify initiatives and programmes that will address wellbeing and prevention</li> </ul>	<ul> <li>Co-design a range of small solution building events or a significant accelerated event</li> <li>Draw up suggestions and proposals directly informed by the preceding stages that will meet the identified population needs</li> <li>Test whether or not all challenges or gaps can be addressed locally</li> <li>Considering population health management what impact and benefit could wellbeing and prevention initiatives have for the future</li> <li>Challenge – are emerging solutions / proposals affordable and deliverable</li> </ul>	<ul> <li>Further refine options informed by local engagement events</li> <li>Any additional detailed modelling and analysis to test proposals</li> <li>Present options tested against deliverability, operational sustainability, affordability</li> <li>Utilise a recognised Outline Business Case approach such as a 5 case model to summarise options for consideration</li> <li>Identify any quick wins</li> <li>Confirm any potential significant service changes</li> </ul>

# **Delivery flow of population health framework**



# **Developing an Oxfordshire Integrated Care Partnership**

The Oxfordshire Integrated Care Partnership (ICP) can be defined as the 'Place'-based alliance of providers, commissioners, local authorities and third sector providers that will work by collaboration not competition, with:

- An open book approach through a cost-based, system funding approach to managing the cost of care;
- Local Authority colleagues as important partners who have agreed to work with transparent and aligned budgets;
- A system Clinical and Care Forum to ensure we have coordinated, multidisciplinary clinical input into local decision making;
- A system Stakeholder Group to ensure we have a coordinated and proactive approach to public engagement.

The ICP is where providers work with commissioners using a population-based approach to ensure resources are targeted to the most appropriate need, aligned with our Health & Wellbeing Strategy.

## Year 1 Integrated Care Partnership priorities

- Support development of Primary Care Networks with wraparound, integrated community teams;
- Develop a **shared record** that these teams can use;
- Develop an information system and analytical capacity to enable PCNs to make progress on population health management;
- Apply results of work on care pathway redesign in areas of urgent and planned care; and
- Develop the roadmap to April 2021 that establishes the ICP accountability and governance arrangements needed for decision-making, safe care delivery and risk management.

With partners in Buckinghamshire and Berkshire West, we are working out a set of principles and priorities which determine where the BOB Integrated Care System can best add value.

BOB has a place-based focus, recognising that system working at a county level is a key driver of much of the transformation across the BOB footprint.

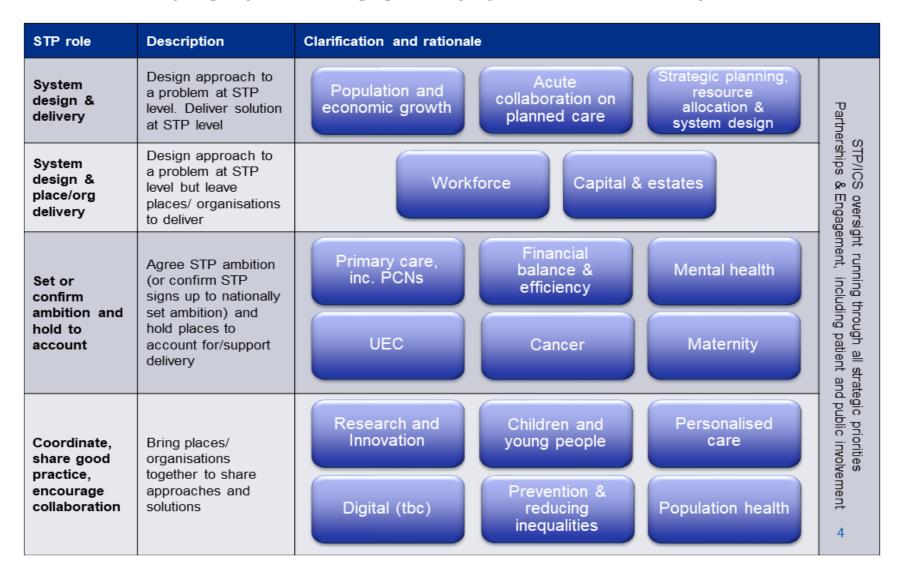
These principles are to help us to achieve the best possible outcomes and the best value for the population we serve.

 Activities and decisions will occur as
 locally as they can, keeping close to patients and services. 2. Focus effort at the level where it will be most efficient and effective at achieving optimum outcomes. 3. Reduce unwarranted variation in outcomes and value.

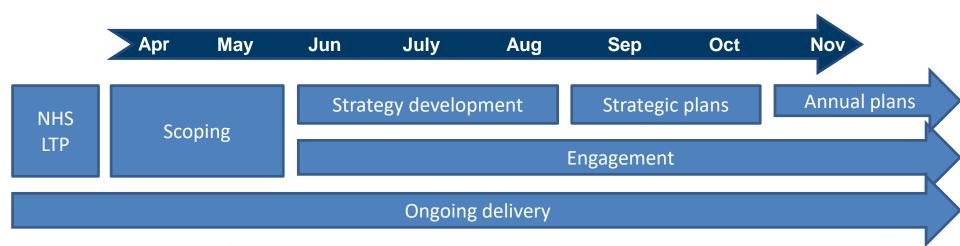
**4.** Avoid wasted effortby reducingduplication within thesystem.

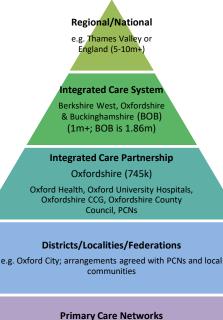
**5. Drive consistency** of intent, approach and outcome.

6. Align decisions with our long term population health outcome goals and our long term plans and strategy. 7. Deliver services in a way that is well understood by our populations and those who deliver care. With partners in Buckinghamshire and Berkshire West, we are working out which priorities the Integrated Care System can best add value on. We are developing a plan to engage our populations on these priorities.



# **Next steps**





e.g. Bicester, Wantage (30-50k+) Integrated primary health and community services

# Aims:

- Strategies to support achieving agreed priorities in the HWB strategy, as well as national plan
- Aligned approach across organisations
- Coherent strategies that link priorities across different geographies and populations
- Developed in line with Health & Wellbeing Board approach to engagement open and transparent
- Focus on improving outcomes and services for the people we all serve