Breaking down barriers to better health and care

The journey from fragmented services to local partnerships and integrated care systems, designed to meet our needs today and tomorrow

Changing health and care needs

Our health and care needs today are different from those the current health and care system was designed to address. People are living longer and society is getting older overall. New technologies are being discovered and more people are living with long-term conditions such as diabetes and asthma. Health services set up in a different era must adapt to these changes.

Old divides between health and social care, between physical and mental health, and between GPs and hospitals mean that too many people experience disjointed care. For example, they may have to repeat the same details to several people in different parts of the system. This is bad for them and not a good use of staff's time. People also want more personalised care and greater support to live their lives independently.

How our health and care needs are changing

- The number of people aged over 65 in England rose by 21 per cent between 2005 and 2015, and is expected to do so again between 2015 and 2025. There are half a million more people aged over 75 than there were in 2010 – and there will be two million more in 10 years' time.
- People are living in ill health for longer – 65 per cent of people admitted to hospital today are 65 or older. Between 2015 and 2035, the number of older people with four or more diseases will double, and at least two-thirds of the extra time people live beyond 65 will be spent with four or more diseases.
- More and more people are living with more than one long-term condition – 15 million now and a further three million by 2025. Treating these conditions accounts for around £7 out of every £10 of total health and care spending in England, half of all GP appointments, almost two-thirds of outpatient appointments and seven out of ten inpatient bed days.
- Around 30 per cent of all people with a long-term physical condition in England also have a mental health concern such as anxiety or depression.
- In 2015, 58 per cent of women and 68 per cent of men were overweight or obese, with obesity rates increasing from 15 per cent in 1993 to 27 per cent in 2015.
- There is a nearly 20-year difference in healthy life expectancy between people living in the most deprived and the least deprived areas.

For these reasons, NHS organisations and local councils in England are joining forces to integrate services and to invest in ways to prevent illness and keep people out of hospital. Their aim is that people can live healthier lives and get the care and treatment they need, in the right place, at the right time. For people with multiple and long-term conditions, this means enhancing the care provided by GPs and community based services and helping people to manage their own health and to maintain their independence.

Working in partnership

To make this happen, all parts of local systems – such as GPs, care homes and home care, hospitals, community and mental health services – are working together more closely than ever before. They have come together to form local 'sustainability and transformation partnerships' in every part of England, to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health.

In some places the areas covered by these partnerships reflect established local government boundaries, although this is not always practical because of how people use health services. A large hospital may serve residents in several council areas, and centres of excellence for specialist services – such as cancer, trauma or stroke – often need to be planned on a wider scale.

> Every person will need support from health and care professionals that act as **one** team and work for organisations that behave as **one** system.

By ensuring decisions are made at the most appropriate level, and empowering local leaders to plan around the long-term needs of the people they serve, health and care systems can make simple, practical improvements for local communities. These could include ensuring that those who regularly rely on both NHS and home care services see a single team, or making it easier to access a range of services and treatments in one place.

Often, they will do this by incorporating and expanding ideas that worked well in one place, such as in the 50 'vanguard' sites that developed new models of care across England. These areas helped, for example, to expand the support given in care homes and supported living facilities, and reduced unnecessary trips to hospital.

Crucially, partnerships include people outside traditional care services whose work has an impact on day-to-day health and wellbeing. Services such as public health, housing and leisure can prevent or delay the onset of ill health and enable people to live longer, happier lives. The partnerships build on strategic plans to improve health and wellbeing that local councils have drawn up in every area.

Although partnerships published their initial proposals in 2016, these have substantially evolved to reflect views from people who use and provide services, elected representatives and local voluntary organisations. Each is at a different stage of its journey, and local priorities understandably vary.

The road to better coordinated health and care

- **2014:** the NHS Five Year Forward View set out a national vision for collaboration
- **2015:** 'vanguards' in 50 areas began to develop and test new models of integrated care
- **2016:** NHS organisations and many local councils came together to form partnerships covering all of England, to consider local health and care priorities and to plan services together
- **2017:** areas refined initial proposals, drawing on engagement with frontline staff, local residents and others in the community
- **2018:** some partnerships began to take on more responsibility by becoming 'integrated care systems'

Giving more power to local areas

From April 2018, a group of the most mature partnerships evolved to become 'integrated care systems'. In these areas, NHS organisations are taking shared responsibility for managing overall resources and using these to improve quality of care and health outcomes for their local population, working in close partnership with local government and others in the community. Other areas will follow in future, learning from the experience of the first group.

Integrated care systems will improve health and care by:

- supporting the coordination of services, with a particular focus on those at risk of developing acute illness and being hospitalised
- providing more care in a community- and home-based setting, including in partnership with council social care, and the voluntary and community sector
- ensuring a greater focus on population health and preventing ill health
- allowing systems to take collective responsibility for how they best use resources to improve health results and quality of care, including through agreed cross-system spending totals.

This group includes health and care systems in Manchester and Surrey that received new devolved health and care powers as part of wider devolution agreements. National regulators will further streamline their support for, and oversight of, these systems as they develop.

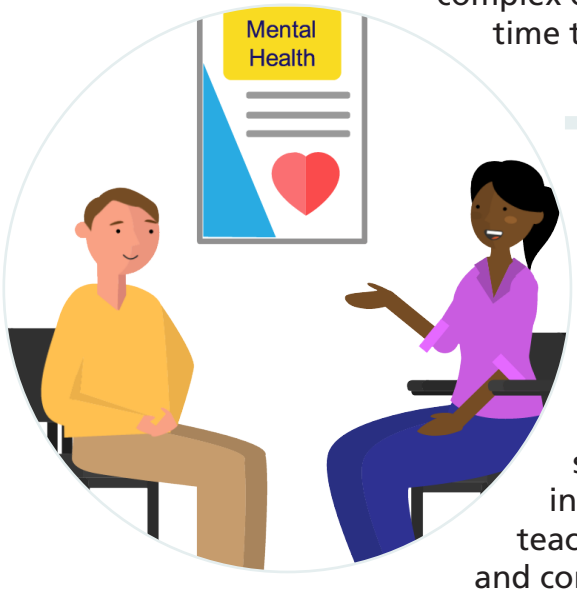
Some examples

Moving services closer to local communities

In Frimley (on the borders of Berkshire, Hampshire and Surrey), people are supported to manage their own care and to get more treatment in the local community instead of hospitals. For example, Aldershot residents with mental health needs now have an alternative to A&E if in crisis. They can visit the 'Time Out' café seven days a week, without an appointment, to get support from staff, learn self-management skills and use community resources such as peer support and advice on mental health and wellbeing.

People with urgent medical needs can also get same-day appointments at new centres that bring GPs, nurse practitioners, orthopaedic practitioners, paramedics and other relevant care professionals under one roof. GP practices are informed of all A&E attendances so they can help patients get the care and treatment they need more locally in future, reducing the risk of unnecessary hospital admissions.

Feedback shows that local residents value being able to access help when they need it. The changes have also helped to avoid trips to A&E where there is a better alternative, and cut the amount of time people unnecessarily spend in a hospital bed. Those with complex conditions have gained too as their GPs now have more time to dedicate to their care and treatment.



Improving day-to-day health and wellbeing

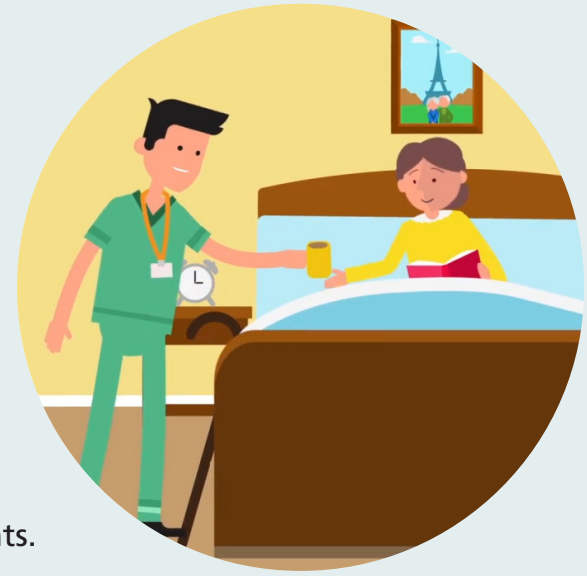
Health in Lancashire and South Cumbria is much worse than the national average, with higher rates of heart disease, high blood pressure, asthma and depression.

To address this, the local partnership has fostered schemes to improve day-to-day health and wellbeing, including the 'Run-a-Mile Challenge' in which children, teachers and others commit to run a mile a day regularly, and community-led creative activities that help to avoid social isolation and improve the local environment.

Technology is also helping people to become more able and confident to manage their health. NHS patients can record readings of their pulse, oxygen level and blood pressure, and receive text messages with tailored health advice and reminders. People over 60 with two or more long-term conditions may be referred by their GP to an 'extensivist' team with a range of clinical and support skills. They will develop a personalised care plan which is revisited at regular meetings with the same wellbeing support worker.

Doctors and nurses can see more patients overall, and residents receive continuity whether on the ward or at home. People are less likely to become acutely ill, and can avoid unnecessary hospital visits and stays. Emergency admissions among patients in Fylde Coast have fallen by up to 28 per cent.

Expanding and improving hospital services



Dorset's main hospitals provide many of the same services – for example, all three provide maternity and A&E – but they sometimes struggle to meet demand and quality varies. Dorset's clinicians want to have consultants available 24 hours a day, seven days a week, and significantly improve quality of care by ensuring each major hospital specialises in a particular area.

One aim is to provide more easily accessible local care by extending community-based services to all Dorset residents. Local centres bring together staff with different areas of expertise, allowing residents to see GPs, specialist doctors, nurses, physiotherapists, social care professionals and others in one place. They also offer blood tests, X-rays and screening, saving those in more rural parts of the county costly hospital trips.

If spread across Dorset, this model would mean less travel for 100,000 people, with outpatient appointments provided closer to home. The proposals for hospital services to specialise further received more than £100 million in 2017 and are expected to save 60 extra lives every year.

Find out more

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