Breaking down barriers to better health and care

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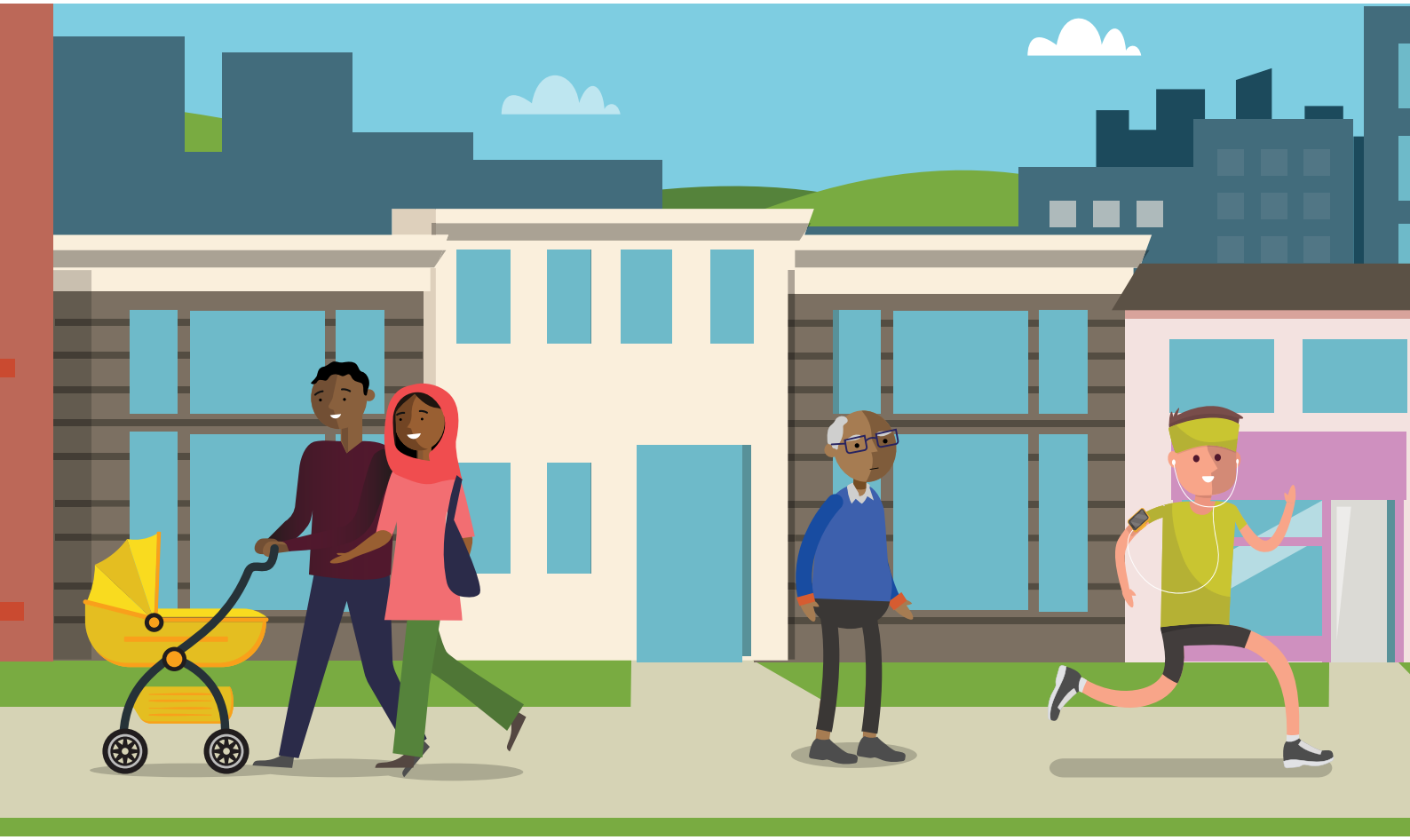

How health and care improve when the NHS, councils and communities all work together

Changing health and care needs

The NHS is one of Britain's proudest achievements and staff do a superb job treating record numbers of patients.

But society's health and care needs are changing. People are living longer, new medicines and technologies are being discovered and more of us are living with long-term conditions such as diabetes and asthma. We need services that understand these increasingly complex needs, and can treat us as individuals.

Yet old divides between hospitals and family doctors, between physical and mental health, and between NHS and council services, mean that too many people experience disjointed care. For example, they may have to repeat the same details to several people in different NHS organisations. This is bad for them and not a good use of staff's precious time.

Some of the changes we face

- The number of people aged over 65 (which includes nearly two-thirds of people admitted to hospital) 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 2 million more in 10 years' time.
- People are living in ill health for longer – 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 people are living with at least two long-term conditions – 15 million now and a further 3 million by 2025. Treating these conditions accounts for half of all GP appointments, 7 out of 10 overnight stays in an NHS hospital bed, and around £7 out of every £10 spent on health and care.
- Mental wellbeing should not be considered in isolation – around one-third of people with a long-term physical condition 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. Obesity, poor diet and lack of exercise are three of the biggest risk factors that contribute to early deaths.

Health and care services have always adapted, but they need to go further and faster as the world and our health needs change.

How partnerships are making a difference

To meet these challenges, local councils, care homes and different parts of the NHS – hospitals, family doctors, mental health teams and others – are working together more closely than ever before. In partnerships covering every part of England, they have begun to coordinate services better, spend more on keeping people healthy and out of hospital, and agree shared priorities for the future.

In some places the areas covered by these partnerships reflect 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 or stroke often need to be planned on a wider scale.

The partnerships have been making practical improvements. For example, ensuring that residents can get a wider range of services closer to where they live or work, at a time and place that is convenient for them. Or that someone who regularly uses different services sees just one team who talk to each other and make time to understand their full care needs and wider health goals.

They are making decisions as locally as possible, involving doctors, nurses and other staff who give care. They have learnt from and spread ideas that worked well in one place. This includes schemes that began in local government and in 50 'vanguard' areas that, for example, helped people in care homes and supported living facilities to get extra support, and avoided unnecessary trips to hospital.

Crucially, partnerships include people who do not provide care but whose work is linked to day-to-day health and wellbeing. Services such as public health, housing and leisure can prevent or delay the onset of ill health and support 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.

Partnerships published their initial proposals in 2017. These have since evolved substantially to reflect views from people who use and provide services, elected representatives and local community and voluntary organisations. In 2019, every partnership area began to set out their latest thinking for the next five years.

The road to better coordinated health and care

- **2014:** NHS and local government's national leaders set out a vision of more collaboration
- **2015:** 'vanguards' in 50 areas began to develop and test new models of care
- **2016:** NHS and local councils formed partnerships covering all of England, to consider local health and care priorities and to plan services together
- **2017:** areas refined initial proposals, drawing on conversations with frontline staff, local residents and others in the community
- **2018:** some partnerships began to take on more responsibility by becoming 'integrated care systems'
- **2019:** NHS Long-Term Plan confirms that every area will be served by an integrated care system by 2021, with primary and community services funded to do more

Strengthening the partnerships

From April 2018, a group of the most mature partnerships evolved to become 'integrated care systems'. In these areas, NHS organisations are taking collective responsibility for managing shared resources and using them to improve quality of care and health outcomes for local residents, working in close partnership with local government and others in the community.

Other areas have followed since, learning from the experience of the first group. In 2019, the NHS confirmed the aim that every part of England will be covered by one of these systems by 2021.

Integrated care systems are taking partnership to the next level, by:

- using a growing share of funding for primary and community services to help build 'primary care networks'. These GP-led partnerships mean people can see an expanded professional team in the local community, which could include therapists, nurses and mental health staff plus non-clinical support for concerns like social isolation or debt
- better understanding data and other intelligence about the health and wellbeing of all people in their area, so that they can improve day-to-day physical and mental health, and reduce health inequalities between different groups
- taking on shared responsibility for how they use their collective 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 health and care powers as part of wider devolution agreements.

Some examples of local improvements

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 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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