Surrey Heartlands

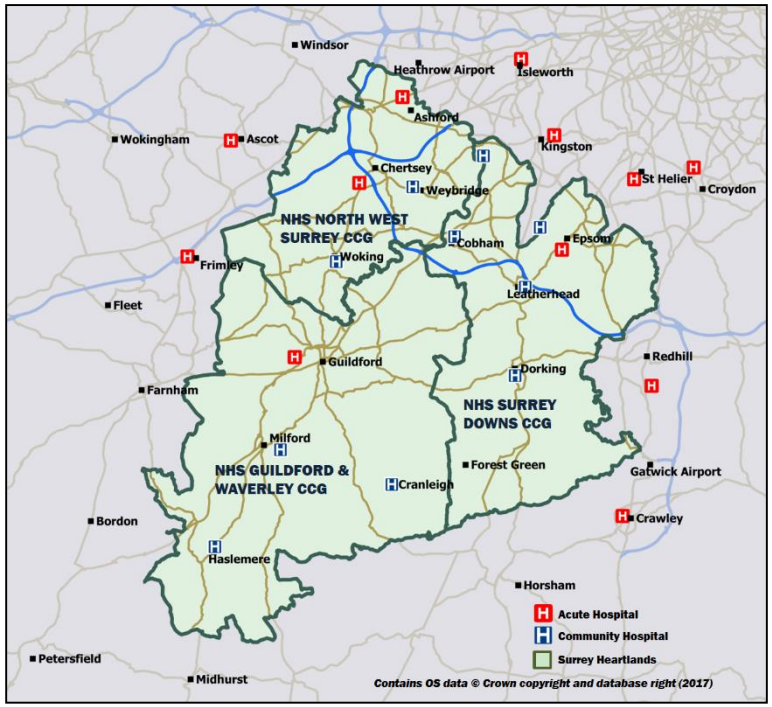
The role of the DPH in an integrated care system

Helen Atkinson, Executive Director of Public Health,
Surrey County Council and
Surrey Heartlands Health and Care Partnership

Overview

- The role of the DPH in an ICS
  - Prevention & prevention in clinical work streams
  - Wider Determinants of Health
  - Population Health Management
  - Business Intelligence and Evidence
  - Measuring success

Surrey Heartlands serves 850,000 people across 9 boroughs with combined health funding in 2016/17 of £1bn and combined social care and public health budget of £328m



- 3 CCGs working through eight GP-led localities
- 684 GPs in 95 practices

H 4 acute hospital sites

H 11 community hospital sites

- 1 community services provider
- 1 mental health provider working from 4 in-patient sites and delivering community services from 22 sites
- 1 upper tier local authority (Surrey County Council) operating adult & children's social services and public health
- 9 District/Borough Councils

Prevention - Objectives

Healthy Places (Wider Determinants)	• Shape the environment in which people live and work to improve and protect the health and wellbeing of communities
Healthy Lifestyles	• Address the major causes of ill health to prevent the future development of long term conditions
Staying independent	• Empower citizens to remain independent in their own homes
Staying Well (Delivery through clinical workstreams)	• Improve health and social outcomes for people with existing long term conditions
Healthy Workforce	• Support our staff to be happy and healthy through the creation of a healthy workplace environment and access to healthy lifestyle support.

Surrey Heartlands Prevention & Wider Determinants of Health Workstream

Workstream – Outline Strategy:

To enhance the health and well being of the population of Surrey Heartlands, to reduce the usage of costly health and social care services and empower the public in proactive care, behavioural change and appropriate self management.

Projects

1. Making Every Contact Count (MECC)

A system wide Workforce Development Programme to enable and empower staff to deliver opportunistic 'healthy conversations' when coming into contact with people, patients and their families.

Aiming to change the culture of organisations to focus on prevention to foster a workforce that provides people with opportunities & support to make informed choices to improve health outcomes.

2. Alcohol Prevention – DrinkCoach

Development of DrinkCoach - an online coaching service for people who want support to reduce their alcohol consumption. The service employs an evidence based extended brief intervention approach involving 'brief treatment' delivered by an alcohol specialist.

Aiming to deliver 1100 DrinkCoach Sessions in Surrey Heartlands and Surrey Heath.

3. Social Prescribing

Linking patients in primary care with sources of support within the community.

Enabling individuals to move between professional sectors and their community to fully address all the factors affecting their health and wellbeing before they escalate. Promoting self-care and encouraging residents to take more responsibility for their own healthcare.

4. Workforce Wellbeing

Programme of work that aims to improve the health and wellbeing of the Surrey Heartlands Workforce and to enable and influence Surrey Businesses to focus on workforce health and wellbeing.

Lead by Workplace Health Steering Group , with implementation through Workplace Delivery Group, and collaboration between County Council, Boroughs and Districts, Health, LEP and Voluntary Sector.

5. Wider Determinants of Health

Programme of work to shape the environment in which people live and work to improve and protect the health and wellbeing of communities.

Framework developed to focus on 3 initial areas; planning (building health into planning), housing, and utilising existing community assets.

6. Developing a system-wide preventative approach

Supporting other 'business as usual' areas such as smoking , healthy weight and suicide prevention to promote a whole system approach across Surrey Heartlands.

Supporting other workstreams with the prevention element of their pathways, such as Women & Children (reducing smoking at time of deliver, contraceptive choices, preconception health), Planned care (CVD Prevention).

Prevention in Clinical Workstreams

Women and Children's

- First 1000 days – major focus on prevention
- Unicef Baby Friendly neonatal units
- Antenatal and post natal pathways including:
  - Reduce smoking at time of delivery
  - Contraceptive choices and access
  - Preconception health including healthy weight support
- Improving model of parenting support through universal and targeted approaches.
- Immunisations
- Social prescribing

Planned Care - CVD

- MECC and referral to services embedded in pathways.
- Secondary prevention through improved detection and mgmt. of hypertension and AF.

Cancer

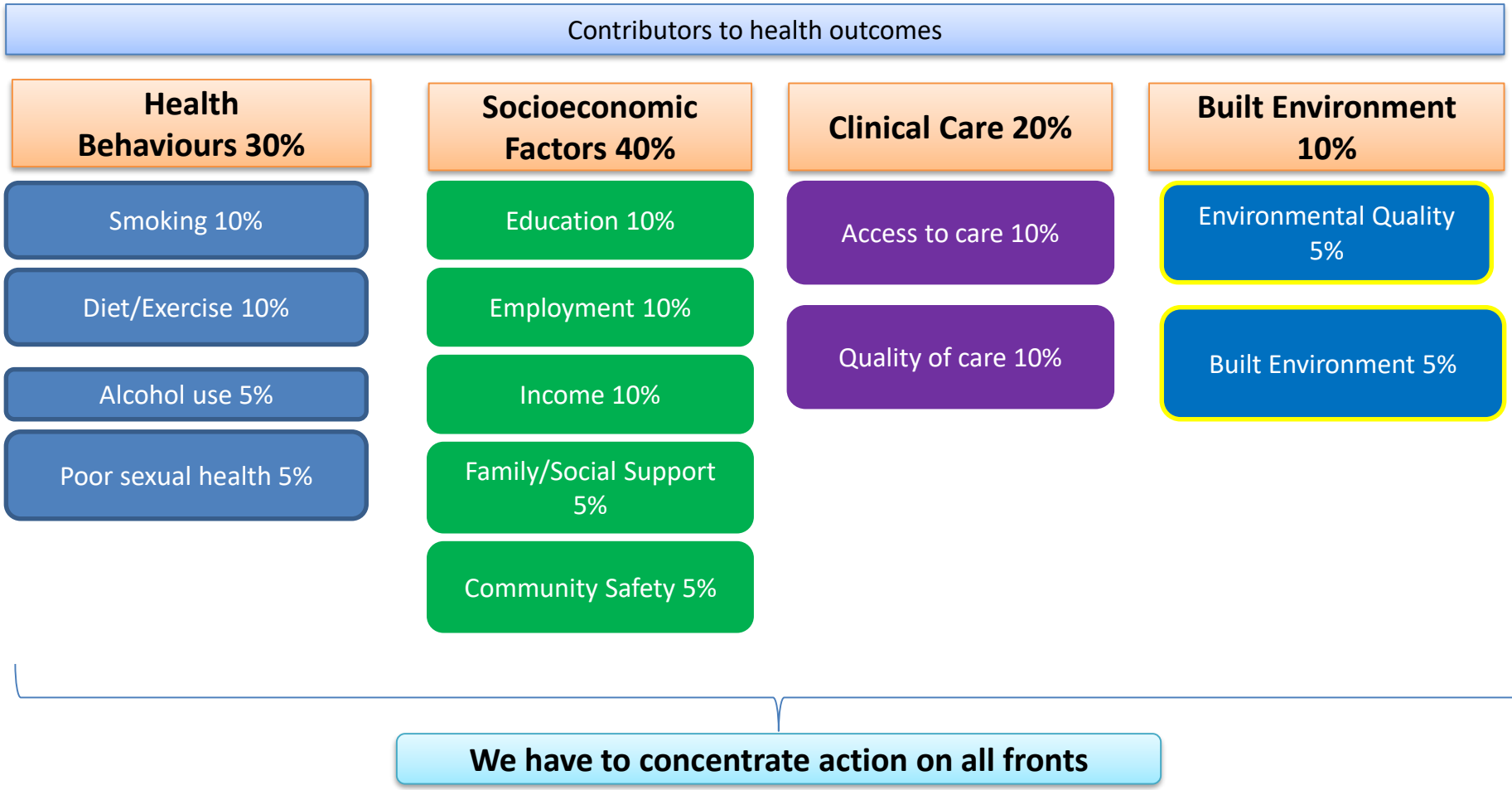
Via Cancer Alliance – Prevention plan to include:

- Early identification
- Healthy behaviours advice in those living beyond cancer
- Lung function testing and brief Smoking advice in workplaces and communities

Mental Health

- Healthy behaviours for people with SMI
- Perinatal mental health
- Suicide Prevention

Affected by a wide range of factors



1. Wider Determinants of Health

Shaping the environment in which people live and work to improve and protect the health and wellbeing of communities

- Housing
  - important for health
  - appropriate housing options can reduce demand for health and social care

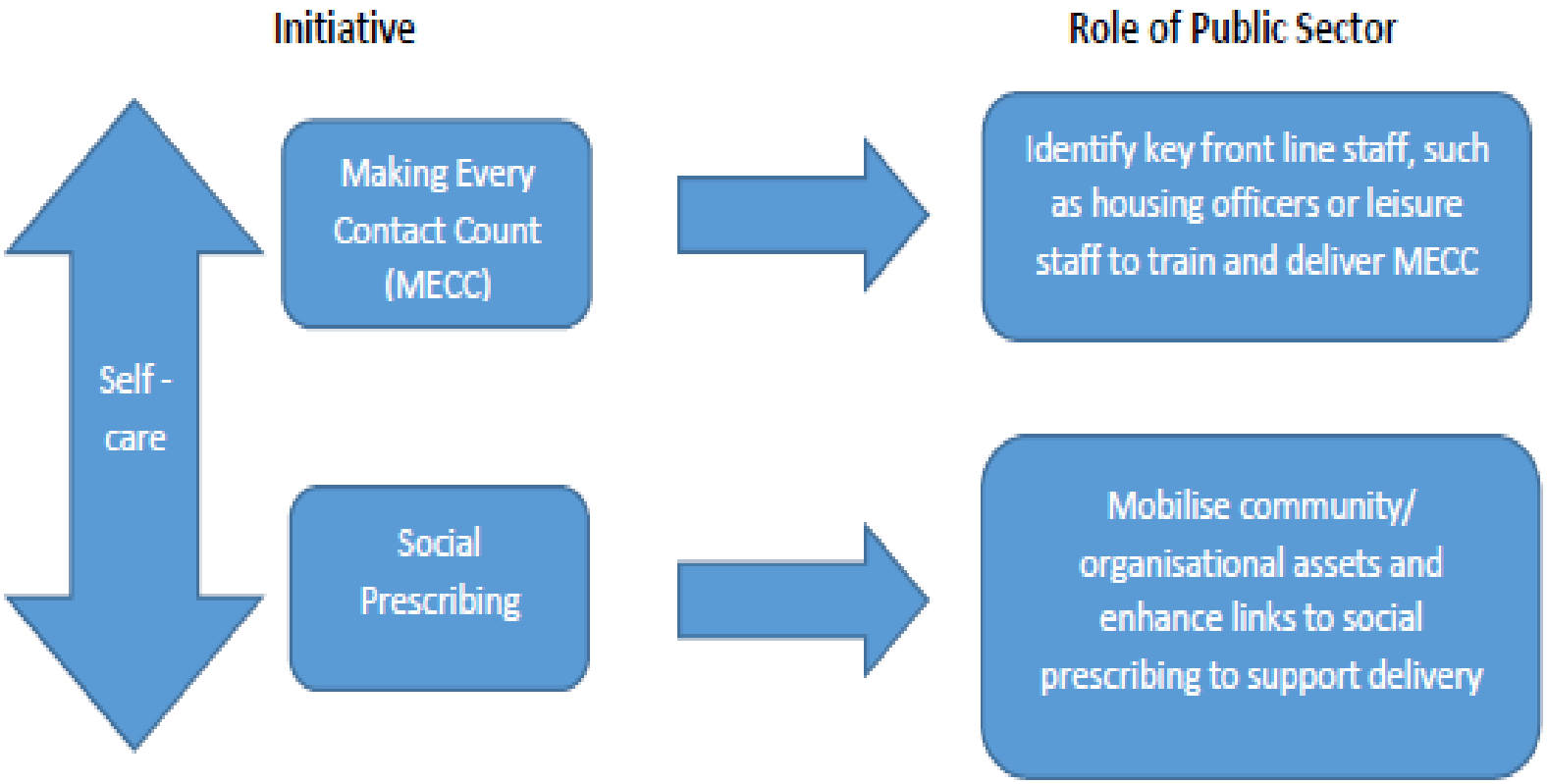
- Planning
  - influencing the wider determinants of health through the built and natural environments
  - developing channels to strengthen health and social care input into local infrastructure planning

- Asset based approach to health, wellbeing and resilience

  - empower individuals and communities, enabling them to rely less on public services

WDH

Next steps – Asset Based Approach



A journey to population health as an ICS

Population Health is an approach aimed at improving the health of an entire population.

- It is about **improving the physical and mental health outcomes** and wellbeing of people…
- whilst **reducing health inequalities** within and across a defined population
- It includes action to reduce the occurrence of ill-health, including **addressing wider determinants of health**, and requires working with communities and partner agencies

Agreed definition of PHM

Population Health...

...is an approach aimed at **improving the health of an entire population**

It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population.

It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

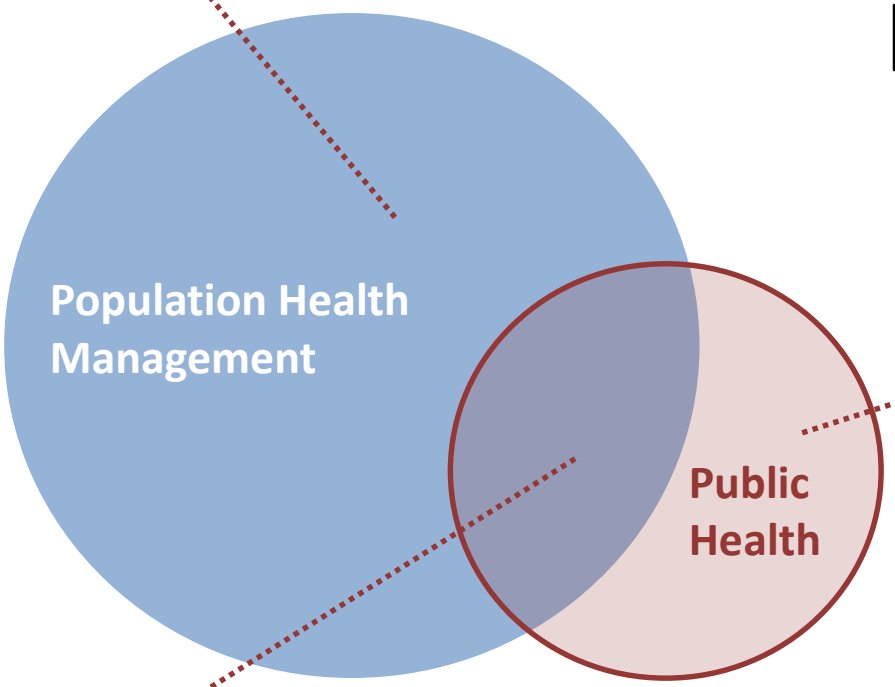
Population Health *Management*...

...improves population health by **data driven planning and delivery of care to achieve maximum impact**

It includes segmentation, stratification and impactibilty modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

PHM and Public Health

Wider System Input:
Information governance
Integrated care pathway design and implementation
Analytical capacity
Clinical and professional input
Public engagement



Wider PH duties:
Core Local Authority Responsibilities
PHE

Public Health Input into PHM:

- Supporting the intelligence and evidence focus.
- Providing information and context related to Health Inequalities
- A focus on system wide prevention including the wider determinants of health
- Assessing population need
- Health economics and opportunity analyses expertise
- Providing expertise on evaluation

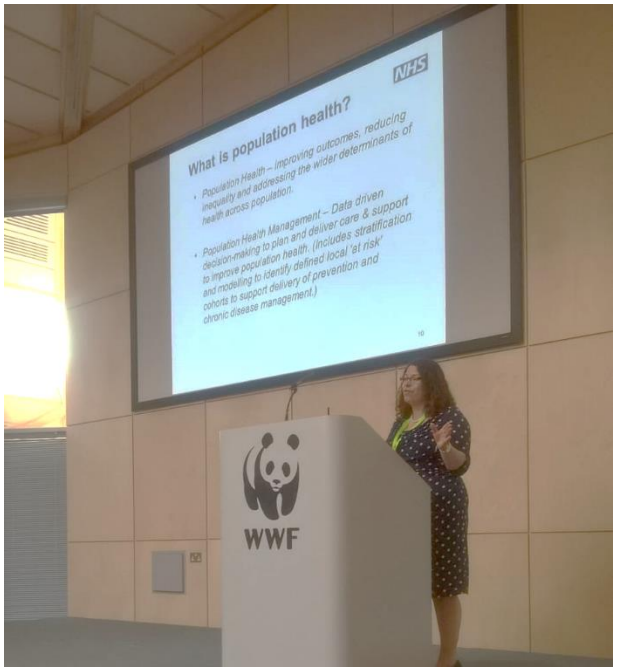
Public Health's role in Population Health Management

Potential mechanisms for public health input include:

- Public Health Consultants employed directly by the ICS – either with a remit for Public Health overall or with a specific Population Health Management remit.
- Directors of Public Health in Local Authorities with responsibilities including population health management.
- Local Authority Public Health Consultants delivering PHM in "places".
- PHE centre links with systems.
- Links with Academic Public Health to support the evidence base for PHM.
- In addition there are national links with public health through PHE and ADPH which influences work with systems.

Where have we been?

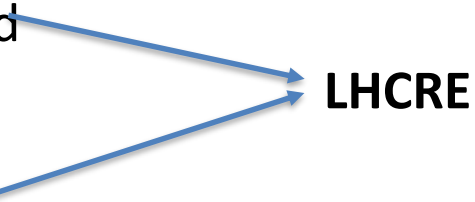
- System wide event
- Established working group
- Topic focused work, events and leadership
- Assessed system maturity
  - Infrastructure
  - Intelligence
  - Interventions



Where are we now and where are we going?

Infrastructure

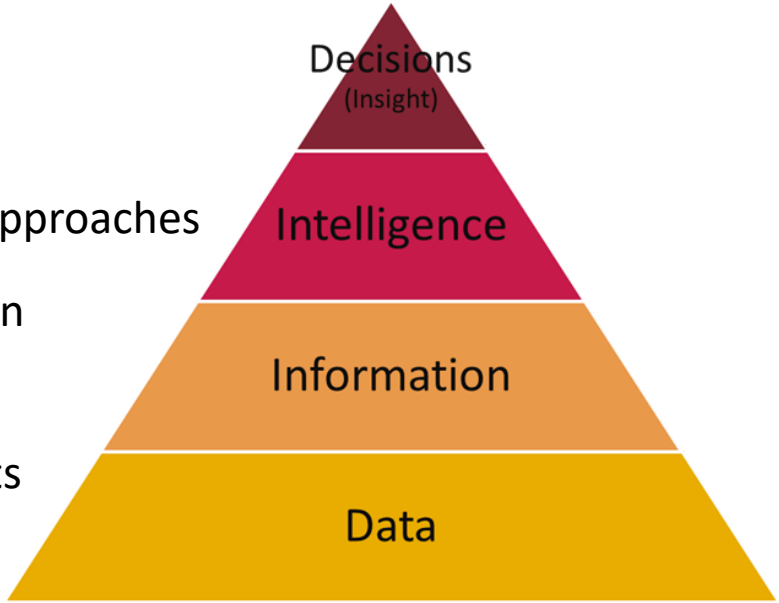
- Strong collaborative leadership
- Developing a system-wide information governance resource
- Establishing single digital care record
- Establishing common data platform



Where are we now and where are we going?

Intelligence

- Good understanding of population – JSNA
- ICPs developing segmentation/risk stratification approaches
- System-wide performance monitoring/reporting in development
- Some collaboration of analysts – hackathon events
- Auditing analytic workforce skills and capacity
- Formalised collaboration – Surrey Office of Analytics



www.surreyi.gov.uk

Understand population need

1. Understand population need
2. Predictive system modelling
3. Opportunity analysis and targeting
4. Design and implement intervention
5. Active monitoring and improvement

Public Health England

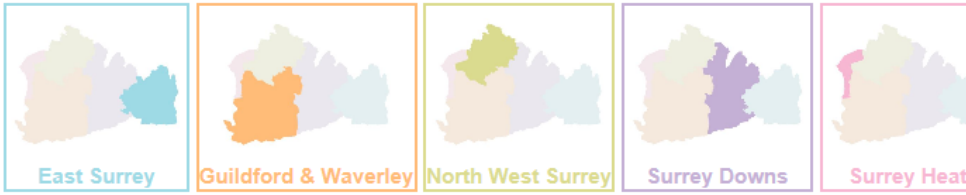
National Public Health Profiles

JOINT STRATEGIC NEEDS ASSESSMENT

NHS RightCare

Surrey-i

Place-based Health and Care profiles

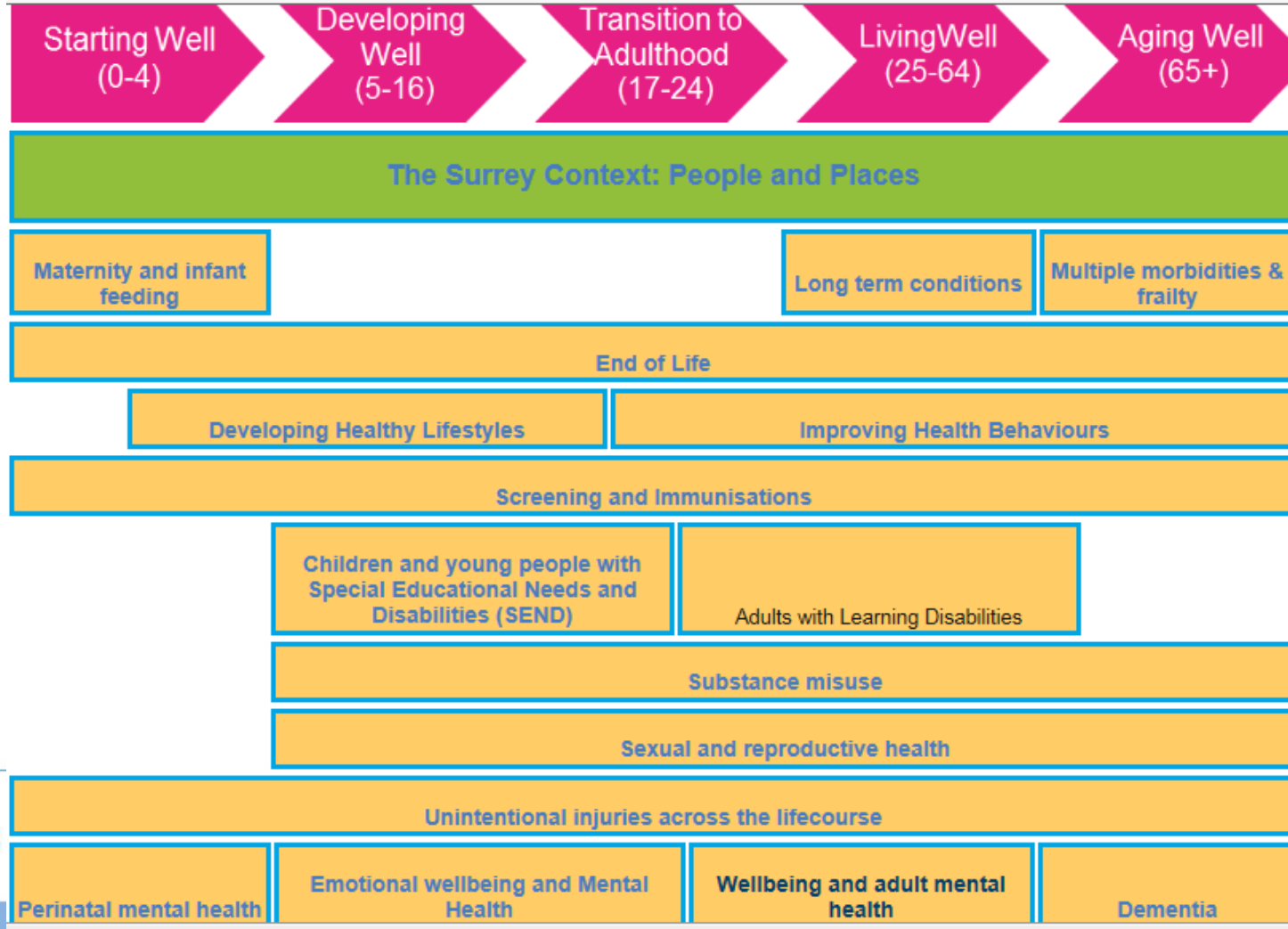


GIRFT
GETTING IT RIGHT FIRST TIME

2.Predictive system modelling

Joint Strategic Needs Assessment

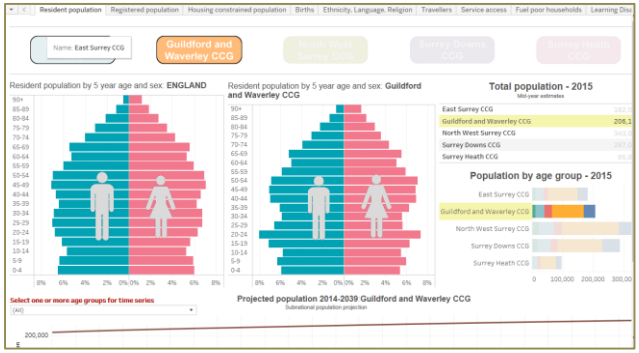
1. Understand population need
2. Predictive system modelling
3. Opportunity analysis and targeting
4. Design and implement intervention
5. Active monitoring and improvement

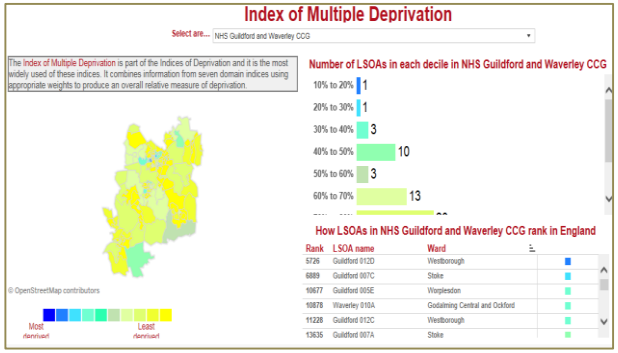


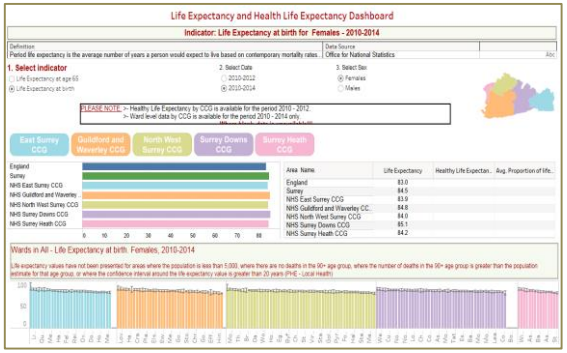
Surrey Heartlands

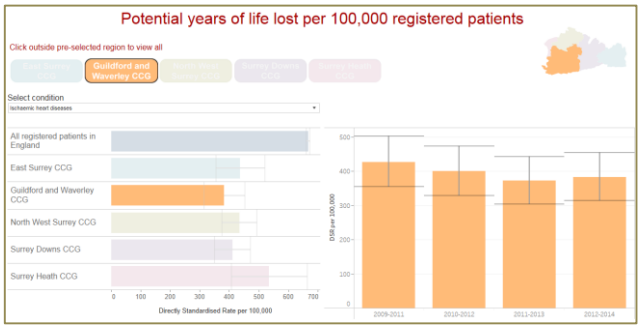
2. Predictive system modelling

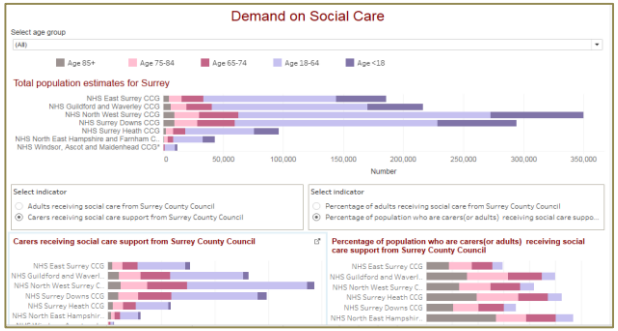
Place-based Health and Care Profiles

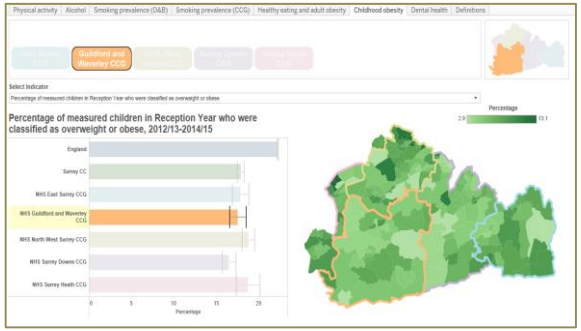


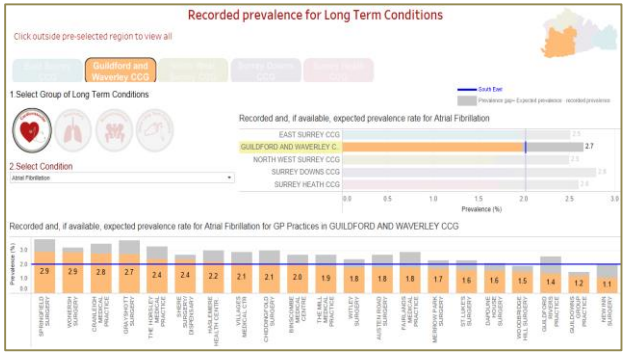


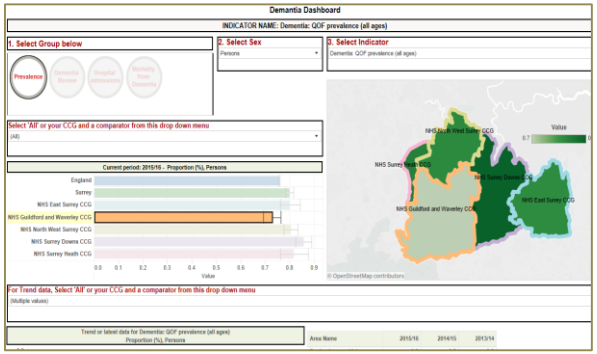


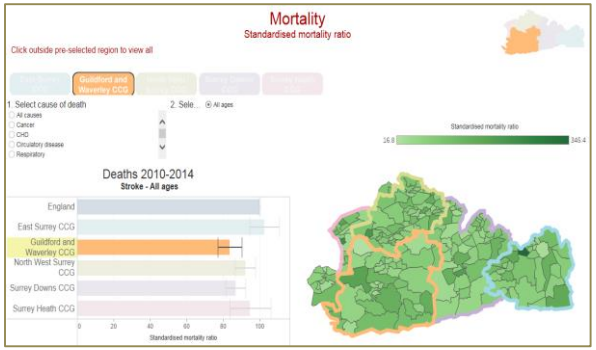












Measuring success

High level outcomes

33 outcome measures that provide an overview of how we are doing as a system on prevention

High Level ambitions

Whole system prevention targets where opportunities for improvement have been identified

Programme metrics

Outcomes and outputs to monitor and evaluate the success of prevention programmes

Keeping Well

Increase the hypertension diagnosis rate

59%

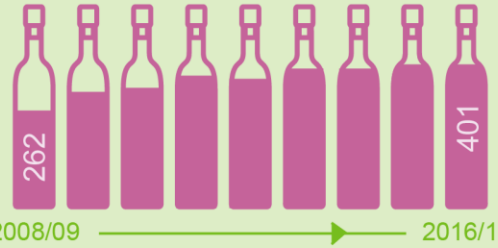
70%

2025

Healthy Lifestyles

Reduce rate of alcohol-specific hospital admissions

rate per 100,000



2025

Healthy Workplace

Reduce the percentage of employees who had at least one day off the previous week

1.8%

1%

2025

Staying Independent

Increase percentage of adults carers who have as much social contact as they would like

28%

40%

2025

Healthy Places

Increase the percentage of people using outdoor space for exercise

20.5%

24.4%

2025

Questions

- More information is available at: www.surreyheartlands.uk