Hertfordshire Community NHS Trust

Health & Wellbeing Strategy

[Incorporating the Clinical and Quality Strategies]

(2017 – 2022)
**HEALTH AND WELLBEING STRATEGY 2017-2022**

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| Edition 2 | June 2017 | Version 1 updated to:  
• Reflect refreshed HCT strategy and to incorporate the Quality Strategy  
• Reflect feedback from external stakeholders  
• Reflect Hertfordshire Health and Wellbeing Board Strategy  
• Include EoL Strategy  
• Include delivery plans for key implementation projects  
• Reflect move to locality based services  
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1. EXECUTIVE SUMMARY

Hertfordshire Community NHS Trust (HCT) provides general and specialist adult and children’s community health services to local communities across Hertfordshire. Our services focus on health & wellbeing using a social model of health which combines physical, social and psychological components. We work in the context of people’s lives to provide safe and effective clinical expertise through:

- Improved health and wellbeing
- Self-management and prevention to enable independence
- Co-ordination of personalised care

Our vision is to maintain and improve the health and wellbeing of the people of Hertfordshire and other areas served by the Trust. We need to do this in the context of local and national drivers including increasing demand (increasing population and increasing morbidity), significant financial pressures and changing expectations of how, and where, services are delivered.

Our Health and Wellbeing Strategy provides the framework through which we will work with local communities to reduce health inequalities and improve people’s health whilst also ensuring the provision of high quality community health services which meet the needs of the local community and comply with regulatory frameworks, national and regional standards. It also describes how we will improve the safety and effectiveness of care, ensuring our patients receive safe, high quality care, and that we will stay focused on quality whilst continuing to develop our patient and customer care focus.

The Health and Wellbeing Strategy underpins the strategic direction for the Trust.. Reflecting a broad approach to population health and wellbeing, this strategy incorporates our previous Clinical and Quality strategies to provide a coherent basis on which HCT will deliver improved health outcomes and focus resources on quality, safety and patient experience. The Health and Wellbeing Strategy builds on notable successes HCT has already had in developing innovative approaches to service delivery and is recognised as a high performing trust.

Quality and safety is at the heart of the way we provide services and underpins the vision for the Health and Wellbeing Strategy which is to:

"Provide accessible, responsive, high quality, high value healthcare services and work with, for, and in local communities to reduce health inequalities and improve people's health."

This strategy aligns with the clinical strategies and commissioning intentions of our main commissioners and the Hertfordshire and West Essex Sustainability and Transformation Plan (STP)\(^1\) as well as with the NHS Five Year Forward View and the Hertfordshire Health and Wellbeing Board Strategy\(^2\).

Successful delivery of this Health and Wellbeing Strategy will deliver the following outcomes:

- Children are supported to get the best start in life and enabled to thrive and become healthy adults
- People achieve their individual health and wellbeing goals
- People with complex care needs receive well coordinated, personalised, multi-agency care
- Children with disability and / or life threatening disease and adults with long term conditions and disabilities are supported to manage their own care as far as possible

\(^1\) Hertfordshire and West Essex Sustainability and Transformation Plan 2015
\(^2\) Hertfordshire Health and Wellbeing Board Strategy 2016-2020
People at the end of their life are supported to live the life they wish to the best of their ability
Services are organised around individuals and local communities and provided as close to home as possible
Unnecessary stays in hospital are avoided
People receive safe and effective care from trained and skilled professionals

We aspire to provide services in the top decile for safety, efficiency and patient experience and will use national reporting and benchmarking data to monitor this.

Delivering our Health and Wellbeing Strategy

Many of the service changes we propose have been developed with our partners and will be taken forward with them, for example through the STP workstreams, Integrated Programme Boards and A&E Delivery Boards. We have established transformation programmes to take forward the significant service and operational delivery changes that are required by this strategy. As we work to transform our services we will:

- Work collaboratively and constructively with our stakeholders to ensure that services are responsive and seamless for our local population
- Actively seek user and carer input to developing our services to enhance patient experience and patient outcome
- Work in partnership with GPs and others to develop locality based services that enable more care to be provided in the community and people’s homes and that improve GPs experience of our services
- Ensure communication is timely and effective and available across Herts wide health and social care IT systems to support patient care no matter who is providing it
- Work differently with people and their carers, in a partnership to ensure they are in control of their health and supporting them to manage their conditions and help them achieve their goals
- Use national reporting and benchmarking data to monitor the standards of our performance against our peers and established best practice.

This strategy sets out a vision and plan for transforming the services we provide over a five year period. The pace at which we can do this will reflect both our organisational capability and capacity and that of the broader health economy in which we work. In this context our plans are necessarily more detailed for the early years of the strategy with ongoing planning required for the later stages of delivery.

The organisational capability and capacity to deliver our health and wellbeing strategy will be provided by enabling transformation programmes which are summarised in section 8.
2. ORGANISATIONAL VISION AND VALUES

HCT’s vision is:

“We will maintain and improve the health and wellbeing of the people of Hertfordshire and other areas served by the Trust”

To achieve this vision HCT has five strategic objectives:

1. We will support the people we serve to manage their own health and wellbeing
2. We will improve health outcomes and enhance patient safety
3. We will support the substantial expansion of community services through the delivery of excellent core services for adults and children and the development of ambulatory services
4. We will use resources efficiently to enhance our ability to improve services
5. We will develop the organisational capacity to deliver our vision and objectives.

Our overarching strategy for achieving these objectives is summarised below:

Figure 1. HCT Strategy
Underpinning HCT’s Strategy are five core values:

- **Care**: We put patients at the heart of everything we do
- **Respect**: We always respect patient privacy and confidentiality
- **Quality**: We strive for excellence and effectiveness at all times
- **Confidence**: We do what we say we will do
- **Improve**: We will improve through continuous learning and innovation.

HCT is committed to achieving excellence in the delivery of patient-centred care in an environment that promotes the safety, well-being and experience of our patients, staff and visitors, whilst safeguarding the continuity of services, assets and reputation of the Trust. HCT will, wherever feasible, adopt best practice in relation to quality based on national evidence and local and national benchmarks.

The Trust is committed to delivering ‘High Value Healthcare’ which we define as having four components:

- Excellent clinical outcomes
- An outstanding patient experience
- Consistent and improving patient safety
- Highly efficient and cost-effective services

Our approach to quality is based on a Quality Model (figure 1 below) which reflects the four key components of High Value Healthcare and aligns to the Triple Aim defined in the Five Year Forward View³.

**Figure 2. Quality Model**

³ Five Year Forward View, NHSE and NHSI 2014
3. CURRENT SITUATION – WHERE ARE WE NOW?

The Trust has an annual income of c£145m, employs around 3,000 staff and is the principal provider of community-based healthcare to the 1.1m residents of Hertfordshire\(^4\).

**Services Provided**

We provide community based services for adults and older people, children and young people, and young people transitioning to adulthood across a range of ambulatory and specialist services. We have around two million contacts with people every year and provide services for people from before birth until death. The Trust also provides prison health care services at HMP The Mount.

Services are provided primarily in peoples’ own homes but also from many clinics and GP surgeries. Inpatient services are managed by the Trust both in its own community hospitals and in local acute hospitals. Bed based services include stroke and neuro rehabilitation. A full list of services provided is included as Appendix 1.

**Approach to Quality Improvement**

In HCT we recognise that quality is everyone’s role and we encourage all staff to reflect on and think about their personal contribution to high value healthcare.

HCT has adopted the National Quality Board quality indicators\(^5\) incorporating them into our Integrated Business Performance Report and Business Unit Performance Reports so that quality forms an integral part of our delivery plan and performance monitoring (Figure 3 below).

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\(^4\) HCT Annual Report 2015  
\(^5\) Quality Indicators, National Quality Board 2011
Figure 3. National Quality Indicators Framework

Overview of the quality indicators framework

<table>
<thead>
<tr>
<th>Key purposes</th>
<th>Example product</th>
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<tbody>
<tr>
<td>• Improvement against national priorities</td>
<td>• NQB Quality Report</td>
</tr>
<tr>
<td>• Accountability to taxpayers</td>
<td>• Regional quality measures</td>
</tr>
<tr>
<td>• International benchmarking</td>
<td>• Services from Quality Observatory</td>
</tr>
<tr>
<td>• Improvement in quality within the region and progress against the region</td>
<td>• Provider quality account</td>
</tr>
<tr>
<td>• Enable benchmarking</td>
<td>• Clinical Team quality measure and dashboards</td>
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Sources of evidence-based indicators include Royal Colleges, specialist societies, NHS Information Centre, universities, commercial sector

We set our quality improvements through;

- The Quality Improvement Plan, linked to CQC compliance and our intended improvements
- CQUIN schemes in conjunction with our commissioners
- Annual quality priorities set by the Trust Board and monitored by the Healthcare Governance Committee
- Delivery of the NQB staffing levels to ensure the Right Care in the Right Place at the Right Time
- Prioritising the national quality improvements of End of Life, E Coli reduction, dementia care, pressure ulcer prevention and improving services for people with Learning Disability
- Establishing Trust wide strategic quality improvement priorities which help deliver our Trust strategy such as falls prevention and reduction, health coaching

This strategy sets out our intent to deliver, measure and demonstrate improvements on an agreed set of outcome measures, which will help us drive up our quality offer for the benefits of the people we serve.

Our aim is to ensure a continuous drive for quality improvement through;

- engaging, encouraging and inspiring our staff and celebrating success
- developing improvement skills and adopting our PDSA approach
- encouraging innovation, sharing best practice and embedding this into our daily work
- a focus on our agreed quality improvement projects supported and monitored through the Trust’s Healthcare Governance Committee.
We recognise this requires a change in the leadership behaviours and increased focus on distributed leadership. We also recognise the importance of embedding the organisation’s values and the workforce’ visible embodiment of the values to effect culture change.

We intend to increase our use of data to support effective decision making, to give staff time and space to solve complex problems, to increase our programme of Keeping in Touch visits by the Board and senior management team so that we listen more effectively to our staff, and to manage expectations.

We acknowledge that happy, engaged, staff deliver high quality services and to this end we will continue our focus on staff experience and engagement, building on the improved engagement demonstrated in our PULSE and annual staff surveys. A particular focus will be levels of staff health and wellbeing, staff satisfaction with the quality of work and patient care they are able to deliver, staff motivation to contribute to improvements at work and job satisfaction. Whilst the Trust’s overall staff engagement score of 3.83 in 2016 was average for Community Trusts nationally, we aim to be above average in this area by driving forward our plans to improve staff engagement and make HCT an employer of choice.

**Patient experience and patient outcomes**

The terms patient experience and patient reported outcomes are often used interchangeably but can be considered to represent different points on a spectrum of the degree to which they are generic or focussed on the patient’s individual goals:

![Generic vs Patient goal oriented](Generic_vs_Patient_goal_oriented)

Patient experience measures such as surveys, patient stories, complaints and compliments are already routinely used across the Trust. What is less well established is the routine use of goal oriented measures which ask the person receiving treatment to identify the two or three key things that matter most to them about the treatment they will receive and then include these as goals in the treatment plan. The impact of the treatment intervention is then reviewed at the end of treatment to assess the impact of the treatment on the individual’s personal goals. Whilst some of our adult therapy services are doing this, and others are planning to, adult nursing services currently only use patient experience measures. Children’s services have recently developed patient centred outcome measures aligned to the Hertfordshire County Council outcomes framework for children and these are being piloted currently prior to rolling out across all Children’s services.
4. STRATEGIC CONTEXT

The Health and Wellbeing Strategy is driven by a number of national, regional and local drivers including:

- Demographic changes
- Changing patterns of morbidity and patient acuity
- Changing expectations of how, and where, services are delivered as described in the NHS Five Year Forward View and local STP
- Quality and safety failures highlighted through national enquiries which resulted in National Quality and Safety recommendations including those from High Quality Care for All, Equity and Excellence: Liberating the NHS, and Leading Change, Adding Value.

Demographic Changes

The population of Hertfordshire is expected to grow by 23.9% between 2014 and 2039 due to longer life expectancy, a rising birth rate and inward migration.

Currently approximately 16% (196,000) of Hertfordshire’s population are aged 65 years and over and it is predicted this will increase by more than 60% to 321,000 by 2039. Over the same time period the number of people aged 0-19 is projected to increase by 18% to 342,000.

Changing Patterns of Morbidity and Patient Acuity

Public Health

For children advances in medicine mean there is increasing complexity of need as pre-term infants and children survive better with complex co-morbidity and there is increasing recognition of conditions such as Autism and Attention Deficit Hyperactive Disorder.

Life expectancy in Hertfordshire is improving and is better than the England average. The principal causes of death are heart disease and stroke, dementia and Alzheimers, cancers and respiratory diseases. These are also the major causes of disability and ill health amongst adults.

Whilst 85% of people describe themselves as being in good or very good health, lifestyle choices are driving increasing levels of obesity with more than 20% of children and 50% of adults considered overweight or obese.

Long Term Conditions

Nationally, £7 out of every £10 of health care spend is attributed to caring for people with long term conditions (LTCs) and they are the most intensive users of the most expensive services. Currently there are around 318,000 people living with a LTC condition in Hertfordshire of whom more than 42% have more than one LTC and 23% have more than two. Diabetes has the highest prevalence with 44,000 people on GP Quality and Outcomes Framework registers.

Whilst the number of people with one LTC is expected to remain relatively stable the number with multiple (2 or more) LTCs is rising sharply (nationally to 2.9m by 2018 from 1.9m in 2008).

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6 High Quality Care for all, DH 2008
7 Equity and Excellence: Liberating the NHS, DH 2010
8 Leading Change, Adding Value, NHSE 2016
9 Population projections 2014 www.hertslis.org
10 Hertfordshire Health profiles 2016
11 Needs Assessment: Enhancing quality of life for people with LTCs, HertLIS 2012
**Dementia**

In Hertfordshire, in 2015 there were approximately 14,329 people over 65 with dementia. This number is predicted to increase by 65% between 2014 and 2030, or an additional 8,316 people.

Approximately 72% of people with dementia also have another medical condition or disability which increases the complexity of their care needs.

**End of Life Care**

It is generally expected that around 1% of the population will die in any year and that the majority of these deaths could be predicted. Palliative care GP registers aim to improve the identification of people thought to be in the last year of life and drive up the quality of care they receive. However, the percentage of GP registered patients on the palliative care register across Hertfordshire is lower than the England average with significant variation between CCGs with fewest identified in East Herts and most in North Herts and Royston.

People dying in their preferred place is a measure of the quality of their end of life care. The PRISMA study found that 64% of people who live in England would prefer to die at home while 29% preferred hospices and palliative care facilities. Achieving this requires a step change in the way end of life care is provided as currently across England only 22% of people die at home. In Hertfordshire the picture is even worse with 19% in East and North Herts CCG and just 18% in Herts Valleys dying at home.

**Carers**

Hertfordshire’s ageing population, in conjunction with the rise in prevalence of long term conditions, is having an additional impact on the number of people with caring responsibilities. There are almost 110,000 carers in Hertfordshire (just under 10% of the population) and increasingly carers are older people themselves often with their own health problems although there are also significant numbers of much younger carers, including children. As people live longer and the number of people with more than one LTC increases so too will the demand for carers.

**Changing Expectations of how, and where, services are delivered**

The NHS Five Year Forward View and General Practice Forward View were clear that the way NHS services are provided has to change and that new models of care are required. Key messages include:

- Much more attention should be given to public health and prevention
- Patients should have far greater control of their own care
- Barriers in how care is provided should be broken down.

The Forward Views advocated that services should be integrated around the patient with community and home based services being a much larger part of what the NHS does.

In parallel with this, society’s expectations are changing as people become more consumer focussed and as digital technology radically changes the way people live and manage their lives. Increasingly people want to manage their own health as far as possible and expect technology to be available to enable them to do this. Advances in technology will also enable more care to be delivered safely, effectively and efficiently closer to, or in, the home.

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12 Needs assessment – living well with dementia HertsLIS 2015
13 Joint Strategic Needs assessment – End of Life Care, HertsLIS 2014
14 Hertfordshire Carers Joint Strategic Needs assessment 2015/16
15 General Practice Forward View, NHSE 2016
The Forward View recognised the significant financial pressures facing the NHS and summarised the challenge for the NHS in what has become known as the **Triple Aim** of:

- Improved health and wellbeing
- Improved quality of care
- Sustainable finances

**Sustainability and Transformation Plans** (STPs), and supporting Commissioning Intentions provide the framework for system-wide changes needed to deliver the Triple Aim. The Hertfordshire and West Essex STP has the ambition that by 2021

‘we will have integrated primary and community and social care services wrapped around local communities, alongside sustainable acute hospital services, which deliver the right care and the right time and at the right place within the financial resources available’

This aligns with the expectations of our local GPs who want greater integration and communication with practices, easier access to HCT services (along with social care) and a responsive district nursing and health visiting service.

Modelling of the demography and financial challenges that underpin the STP shows a ‘do nothing’ gap approaching £50m by 2020/21. To address this significant financial gap and realise the STP ambition the following draft priorities have been identified:

1. Deliver sustainable high quality acute care
2. Fully integrated community services across primary, community, mental health and social care with prevention and self-care
3. Whole system focus on preventing ill health and promoting wellbeing

Transformation schemes to deliver these priorities that are pertinent to HCT include:

- Integrated commissioning of health and social care for children’s services
- Engagement with communities on prevention and supported self-management
- Managing urgent / emergency demand by focussing on pathways for frailty and LTCs especially diabetes, respiratory and cardiovascular disease
- 7 day service across the whole integrated system
- Place-based ways of working based on integrated primary, community, mental health and social care services built on localities of c.50-100,000 population
- Integration of mental and physical health services to achieve parity of esteem

Capacity and staffing constraints mean there is very little capacity to transfer demand from acute hospitals to primary and community services without change in the way services are delivered and a shift in resources from acute to primary and community care.

**Quality and Safety**

The national context is one of quality and safety failures highlighted through national enquiries. A core aim of this strategy is to ensure the fundamentals of high value healthcare are embedded in all our services.

Lord Darzi defined three dimensions of quality in High Quality Care for All:

1. Safety (care that is clinically effective, personalised and safe);
2. Clinical Effectiveness (effective clinical procedures but also measured in terms of quality of life...
after treatment); and

3. With positive patient experience (ensuring that patients are treated with compassion, dignity and respect in a clean, safe and well managed environment)

These dimensions help patients and healthcare staff to understand the wide ranging elements within the scope of quality, whilst promoting the patient perspective. Although the financial environment for the NHS today is very different to 2008 these dimensions of quality remain just as important and national programmes such as Equity and Excellence and the NHS Outcomes Framework\(^\text{16}\) have focussed on putting patients at the heart of all NHS care, delivering improved healthcare outcomes and empowering local organisations and professionals to improve quality.

In 2012 ‘Compassion in Practice\(^\text{17}\) was launched as a strategy for those providing care based around six core values which became widely recognised as the 6Cs: Care, Compassion, Competence, Communication, Courage and Commitment. In 2016 a new framework ‘Leading Change, Adding Value’\(^\text{18}\) was published which builds on Compassion in Practice. It is directed at nursing, midwifery and care staff and is aligned to the Five Year Forward View and delivering the triple aim. It includes a new dimension of the need to constantly improve the quality of care, not least through removing unwarranted variation from the way that services are provided.

HCT currently employs c700 Allied Health Professionals (AHPs) including non-registered support staff working across eight distinct professions. AHP’s are autonomous practitioners whose unique skills include working across organisational boundaries and care pathways and who understand patient centred, co-ordinated care\(^\text{19}\).

In January 2017 ‘Allied Health Professionals into Action\(^\text{20}\) was launched as a blueprint for commissioners and strategic leaders to highlight the importance of harnessing this resource to meet the challenges faced by health care systems, and in supporting the STP’s in the delivery of the triple aim set out in the five year forward view.

AHP’s into Action describes the:
- Impact of the effective use of AHP’s for people and populations
- Commitment to the way services are delivered
- Priorities to meet the challenges of changing care needs

The NHS Patient Experience Framework\(^\text{21}\) and Compassion in Practice emphasise a number of requirements for a positive patient experience including:

- Involving patients and carers in shared decision-making about their treatment and care and empowering patients to be active participants and partners in their own care
- Managing expectations and providing emotional support and alleviation of fear and anxiety about issues such as clinical status, prognosis and the impact of illness on patients and their families (including on their finances)
- Helping patients care for themselves away from a clinical setting

\(^{16}\) NHS Outcomes Framework 2010
\(^{17}\) Compassion in Practice, DH and NHS Commissioning Board 2012
\(^{18}\) Leading Change, Adding Value, NHSE 2016
\(^{19}\) Quality Watch Focus on : Allied Health Professionals- Nuffield Trust Sept 2014
\(^{20}\) Allied Health Professionals into Action, NHSE 2017
\(^{21}\) The NHS Patient Experience Framework, NHS Quality Board, 2012
The recently published NICE Quality Standard on community engagement builds on this approach emphasising the potential to improve health and wellbeing through community engagement.

**Summary of what this means for HCT Health and Wellbeing Strategy and key assumptions**

The strategic context and key drivers mean that HCT needs to transform the way in which it delivers services, to be sustainable in the future and to meet the demands of those that pay for, use and refer to HCT services. Our Health and Wellbeing Strategy and the supporting transformation programmes are aimed at delivering HCT services in a way that effectively manages increasing demand and maximises the benefits (including quality and safety outcomes) of health spend in Hertfordshire within the available resources and aligned to the priorities of the Sustainability and Transformation Plan.

The key assumptions that underpin this strategy are:

1. The pressures of increasing demand and patient acuity in the context of limited financial growth mean new ways of providing services are required that reduce ill health and increase the ability of people to be as independent as possible managing or coordinating their own care
2. Where care services are required these will be provided in, or as close to, the patient’s home as possible – achieving this will require substantial changes in the locations from which services are provided and the way in which they are provided
3. People increasingly expect services to be easy to access, timely and integrated so that they are organised around the needs of the patient not the preferences of the organisation(s) providing the care
4. Where different organisations are responsible for different parts of the care pathway these organisational boundaries should be invisible to the patient – services will be locality based rather than organisation or service based
5. We will need to harness the opportunities of advances in technology to support self-management and the delivery of mobile services.

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22 Community engagement: improving health and wellbeing, NICE March 2017
5. HEALTH AND WELLBEING STRATEGY SWOT ANALYSIS

Our analysis of our Strengths, Weaknesses, Opportunities and Threats is summarised below.

Table 1. Health and Wellbeing Strategy SWOT Analysis

<table>
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<tr>
<th>Strengths to Build On</th>
<th>Weaknesses to Address</th>
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<tr>
<td>Commitment and leadership of the Board to achieve high value healthcare services</td>
<td>End of Life services rated by CQC as ‘requires improvement’</td>
</tr>
<tr>
<td>Overall CQC rating of Good with Dental Service rated as outstanding</td>
<td>Ability to operationalise innovations and to deliver change at scale and pace</td>
</tr>
<tr>
<td>Evidence of good, and improving, clinical quality throughout a substantial number of services.</td>
<td>Organisational culture does not adequately reflect quality as everyone’s business.</td>
</tr>
<tr>
<td>NHSI oversight segmentation of 1 and strong financial position</td>
<td>Poorly defined clinical outcomes and indicators of quality at all levels</td>
</tr>
<tr>
<td>Track record of achievement and innovation in service delivery e.g. Heart Failure, Clinical Navigators, Integrated services, Homefirst, FIRST</td>
<td>Absence of regular staff review on their team’s quality and financial performance</td>
</tr>
<tr>
<td>Reputation with GPs and service users for good quality services</td>
<td></td>
</tr>
<tr>
<td>Significant progress in seeking feedback from patients.</td>
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<tr>
<td>NHSLA Level One achieved.</td>
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<td>Sound clinical policies and underpinning Standard Operating Procedures in place</td>
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<table>
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<tr>
<th>Opportunities to Maximise</th>
<th>Threats to Mitigate</th>
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<tr>
<td>NHS Five Year Forward View and STP emphasis on providing more care in people’s homes and the community</td>
<td>Five Year Forward View proposals for alternative organisational forms.</td>
</tr>
<tr>
<td>Strategic Alliance with HPFT</td>
<td>Services being tendered or re-commissioned – resulting in either loss of service or reduction in quality as income is reduced for ostensibly same service</td>
</tr>
<tr>
<td>STP plans for community hubs - local networks of care</td>
<td>System wide financial challenges may adversely affect commissioning focus on quality improvements. Quality not always seen as the QIPP agenda, but as a cost increasing measure.</td>
</tr>
<tr>
<td>Tenders for provision of services outside of Hertfordshire or new services that complement our portfolio</td>
<td>Cost improvement programme negative impact on staffing and resources for quality support, enablement and assurance</td>
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Response to the SWOT

Analysis of the SWOT has directed us to the following actions and areas of focus for this strategy:

Build on our Strengths
- We will encourage commissioners and other providers to support the roll out integrated community services across Hertfordshire and be key players in developing PLACE based care through partnership with others by building on our experience
- We will use our clinicians to drive improvement and innovation
- We will use our reputation for the high quality of our services to underpin future service innovation and development
- We will use feedback from patients, carers and our members to inform service change and improvement and will include patients, carers and others in the design of new services
- We will introduce patient reported outcome measures.

Address Weaknesses
- Supported by MacMillan, our End of Life Network has launched an ambitious programme of transformation to deliver our refreshed Palliative and End of Life Care Strategy
- We will continue to use feedback from CQC and other inspections to address any gaps where services fall short of the high quality that we, our regulators and people who use our services expect
- We are building our transformation capability and capacity to deliver service and quality improvement which will take forward our ambitious programmes for service change
- We will use a core suite of validated, outcomes measures, including patient reported outcome measures, to benchmark our services both within teams and localities and against our peers to ensure effort is focussed on making the biggest impact for the individual patient or the system. These are described further in the next section
- Performance against our outcome measures will be routinely shared with staff and made public.

Maximise Opportunities
- The STP is focussed on delivering more, and more complex, services in the community and in people’s homes and HCT is jointly leading the Primary and Community workstream with Hertfordshire Partnership NHS Foundation Trust (HPFT). Operationally we will continue to work closely with HPFT
- Our business development team will work closely with service managers to identify appropriate opportunities to tender for new contracts and work with commissioners to develop service specifications that deliver innovative community based models of care.

Mitigate Threats
- We aim to deliver services in the top decile of performance and to be the preferred provider of community health services for local commissioners
- We will continue to develop our organisational capability as a high performing Trust that has high regard from NHSI with earned autonomy (whether or not as an NHS Foundation Trust)
- We will continue to engage constructively with partners and stakeholders (including service users and our members) as we develop and deliver our plans
- The alignment of our priorities with those of the STP will ensure that effort is focussed on those things that will make the biggest difference to people who use our services
- Our approach to partnership working is based on delivering integrated services without the need for organisational change.
6. HEALTH AND WELLBEING STRATEGY - VISION

Our Health and Wellbeing Strategy reflects the key drivers and strategic context in which we operate and supports the delivery of the Trust’s vision and strategic objectives. Quality and safety is at the heart of the way we provide services and underpins our vision for the Health and Wellbeing Strategy which is to:

“Provide accessible, responsive, high quality, high value healthcare services and work with, for, and in local communities to reduce health inequalities and improve people’s health.”

This vision for the Health and Wellbeing Strategy aligns closely with the clinical strategies and commissioning intentions of our main commissioners and the Hertfordshire and West Essex STP, the NHS Five Year Forward View and the Hertfordshire Health and Wellbeing Board Strategy.

Key objectives and outcomes

Across all our services we will aim to provide services at the lowest level of provision through improved health and wellbeing and increasing levels of self-management that enables independence. Care coordination will support the relatively few people who have complex health needs.

We will continue to transform our services to focus on:

- Improved health and wellbeing
- Self-management and prevention to enable independence
- Co-ordination of personalised care

Successful delivery of this Health and Wellbeing Strategy will mean that:

- Children are supported to get the best start in life and are enabled to thrive and become healthy adults
- People achieve their individual health and wellbeing goals
- People with complex care needs receive well-coordinated, personalised, multi-agency care
- People of all ages with disability, long term conditions or life threatening disease are supported to manage their own health and care as far as possible
- People at the end of their life are supported to live the life they wish to the best of their ability and to die in their preferred place of death
- Services will be organised around individuals and local communities and provided as close to home as possible with unnecessary stays in hospital avoided
- People will receive safe and effective care from trained and skilled professionals

Underpinning these outcomes our approach to quality improvement is one where all clinical care is appropriately measured for its safety, effectiveness and patient experience; where we can increasingly measure the outcomes and benefits for patients; and where information on quality is acted upon rapidly and effectively to minimise variation in outcome and ensure service improvement is sustained.

Across all our services we aspire to provide services in the top decile for safety, efficiency and patient experience and will use national reporting and benchmarking data to monitor and demonstrate this.
Services will be **locality based** and will be organised around local communities and GP practices. This aligns with the NHS Five Year Forward View and the Hertfordshire and West Essex STP which proposes the significant shift of outpatient and ambulatory care out of hospital and in to the community and / or people’s homes. Whilst all localities will have a similar range of ‘core services’ there will be local variation where this reflects specific commissioner requirements for the needs of the local population.

We have significant estate which is underutilised, but which could be used to support the development of Community Hubs where health services are co-located with social care and voluntary sector services. Community Hubs may take a number of forms depending on the needs of the locality which could include:

- Ambulatory care for treatments such as intravenous antibiotics and blood transfusions
- Clinics for outreach specialist services that are traditionally provided in acute hospitals
- Onsite General Practice, mental health, social care and voluntary sector services
- Wellness services such as falls prevention and exercise classes
- Therapies such as physiotherapy, occupational therapy, speech and language therapy etc.
- Pharmacy services including pharmacist access for medication reviews
- Advice and information on access to social services and about public and personal health care benefits e.g. keeping warm and well
- Support for carers and carers’ assessments
- Making facilities available to community groups for social activities.

HCT is already working closely with our partners to develop health & wellbeing hubs that are planned for South Oxhey, Borehamwood, Hemel Hempstead and Harpenden.

**Improved health and wellbeing**

The majority of our population enjoy good health and have limited interaction with our services. For these people our focus will be on using those interactions we do have to support people to improve their health and wellbeing.

For healthy adults we will focus on health promotion and support to enable them to maximise their wellbeing through readily accessible sound, evidence based advice on maintaining and improving health and wellbeing and through the provision of early intervention services and weight management services.

For children, childhood is the time that habits for life are laid down and is a crucial time for supporting parents. With fifty per cent of illness due to lifestyle choices encouraging children and families to establish health promoting behaviours will lead to a reduction in illness later in life. With Hertfordshire County Council we are leading a multi-agency approach to develop a comprehensive, co-ordinated universal service with health visitors and school nurses working in an integrated way with other professionals such as children’s centres, GPs, schools, and voluntary organisations. Services will be co-ordinated around children and their families, targeting care at those who need it most and providing care at the lowest tier of provision feasible.

Improved health and wellbeing for children and young people will be targeted at:

- Improving physical and mental health in pregnancy and increasing rates of breastfeeding
- Improving the uptake of the immunisation programme
- Using screening programmes such as hearing, vision and bloodspot to identify developmental issues as early as possible and arrange appropriate support
• Improving readiness for school and good emotional and mental health support
• Reducing childhood obesity
• Reducing teenage pregnancy and increasing support for teenage parents to improve the life chances of their child.

Self-management and prevention to enable independence

Evidence shows that the more engaged people are in their healthcare the better their quality of life and disease outcomes. Self-management is a collaborative relationship between individual & clinician to enable the person to manage their health as effectively as possible and maintain their independence. It is not about people ‘going it alone’ and nor is it about staff having to do more. Rather it is about changing the way patients & staff work together and taps into patients’ expertise of their experience of their disease. We will support staff to develop a health coaching mind set to support people to take more responsibility for their health condition.

Care Co-ordination

Care coordination will ensure people with complex care needs receive well coordinated, personalised multi-agency care. The needs of people with complex care needs, especially children with disabilities or life threatening illnesses and the frail elderly will be assessed and coordinated. A single personalised plan of care, including a carers assessment will aim to maintain the patient in the community where they are in a familiar environment. Coordinating services across health, mental health, social care and the voluntary sector so that more people with complex needs can be cared for at home will reduce acute hospital admissions and / or need for long term residential or nursing care.

For adults, our core services will build on our existing highly regarded integrated community teams, and HomeFirst services which focus on the care and rehabilitation of people in their own home, care or residential home or within one of our community hospitals. Integrated community teams are multidisciplinary teams who manage care needs for people within their home or care setting. Each person will have a case manager / key worker to coordinate their care and a personalised single plan of care focussed on holistic care including their own goals and a carer’s assessment where appropriate. We will increasingly provide services seven days a week as there should be no difference in access to healthcare over the weekend although this will need to reflect commissioner requirements and any workforce constraints. Priorities will include services that respond to acute deterioration to prevent admission and support discharge or transfer in and out of acute/community beds.

For children, the expertise within our specialist services will be used to equip the wider children’s workforce to identify and work with children with additional needs as early as possible including Looked after Children. Early advice and intervention will reduce the need to access specialist services. Each child will have a case manager to coordinate services across health, social care and education and ensure the most appropriate clinician delivers each aspect of the services the child needs.

We will support children and their families to obtain the input they need physically, emotionally and spiritually when they have a child at the end of life, enabling them to live the life they wish to the best of their ability in their preferred place and to choose their preferred place of death.

Significant numbers of admissions to hospital, especially amongst the elderly, are related to the adverse consequences of the prescription of multiple drugs. Medicines Optimisation will ensure patients’ medicine is optimised to prevent side effects and complications due to drug interactions and will also reduce falls in the elderly. We will do this by providing pharmacists in community hospitals, community hubs and at HMP The Mount. We will also work to ensure that there is seamless
communication about medications when patients are transferred between organisations and within HCT including for example from acute hospital into a HCT community hospital or from a HCT community hospital into an Integrated Community Team.

Discharge planning will be enhanced to ensure seamless communication with acute providers, General Practitioners, social services and the voluntary sector to ensure patients move efficiently across the interfaces within health and social care system without delays. Supported discharge will reduce hospital length of stay especially for those with conditions such as cellulitis, pneumonia and urinary tract infections. Active rehabilitation and a focus on patient centred outcomes will enable faster recovery from illness and injury.

Our Palliative and End of Life Strategy sets out a person-centred approach that is aligned to patients’ needs, supporting them to live the life they wish to the best of their ability and supporting more people to die in the place of their choice. The End of Life Care pathway will be followed for all people identified as being in the last year of life with the Five Priorities for Care23 guiding all care in the last few days of life. We will work in partnership with the local hospice to maximise access to palliative care resources across Hertfordshire.

Quality improvement and clinical effectiveness

High value healthcare drives the Trust’s business and is based on an understanding of what people value and their experience. We also know that a better experience can help achieve a better health outcome.

We will continue to focus quality improvement across all three dimensions of quality (safety, clinical effectiveness and patient experience) by listening and learning from the experiences of patients, their families and carers and will use their experiences as an arbiter of the quality of care which we deliver. The development, adoption and monitoring of Patient Reported Outcome Measures will provide an essential dimension to ensuring our services meet the needs identified by patients, and their carers, as being important to them.

Across all our services and in conjunction with our partners we aspire to provide services in the top decile for safety, efficiency and patient experience. Reducing variation in the quality of our services is a priority which will be achieved through standardising care pathways and adopting a norm of ‘protocolled care’ for all patients other than where a clear clinical need requires a different approach. We will support this by promoting a clinical environment where patient care is based on the best available evidence and embracing and nurturing a culture of open and honest communication where staff, patients and their carers will be confident to raise concerns about the quality of care. We will routinely monitor and take action to enable compliance with National Institute of Clinical Excellence guidance as well as commissioners’ contract and service specifications within the parameters of the contract.

We expect all our clinicians to have an active role in clinical audit and to participate in National Clinical Audit and National Confidential Enquiries programmes, to review the implications of these reports for HCT, make recommendations and implement actions as necessary. We will undertake self-assessments against all National Quality Standards applicable to our services and take action where change is required as a result.

23 One Chance to Get it Right, Leadership Alliance for the Care of Dying People 2014
Our Quality priorities include delivery of the national nursing priorities for improving clinical outcomes including:

- Supporting patients with complex needs to be involved in their personalised care planning
- Building upon Falls prevention, minimising harm and supporting independence
- End of Life care revised and developed in light of feedback
- Improving the safety of patients by reducing avoidable Pressure Ulcers, CAUTI and early detection of sepsis.
- Improving the clinical effectiveness of care we provide to patients with wounds by ensuring evidence based practice that is delivered by skilled and competent practitioners who monitor the effectiveness and healing time of interventions
- Infection Prevention and Control with a specific focus on the reduction of E. Coli
- Working with partners to identify frail elderly people in our communities and creating pathways of care to meet their needs in their own home and reduce unnecessary acute admissions
- Ensuring a mortality surveillance group is in place with robust systems to monitor deaths and improve services following any learning identified from avoidable deaths. We will summarise and publish all deaths in the annual Quality Accounts from 2018 as required in the Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care”.
- Improving our model of care for patients with learning disabilities by promoting the key objectives of Putting People First and High Quality Care for All; encouraging choice and control, personalisation, health and well-being, prevention, early intervention, enablement, and delivering services as locally as possible.
- Delivery of the NQB staffing levels to ensure the Right Care in the Right Place at the Right Time is available for patients in HCT.
- Standardising nursing practice to reduce unwarranted variation and ensure high quality care for all.
- Working with the Carter review programme to increase productivity and adopt clinically effective and cost efficient models to deliver improved care for our patients
- Recruitment and retention of nursing staff to maintain skilled, engaged and motivated nurses
- Investing in leadership training such as Mary Seacole to develop creative and confident leaders at all levels who can lead change and improve care

The HCT Healthcare Governance Committee will monitor delivery of the quality priorities and seek assurance of compliance or improvement.

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24 Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care”, NQB 2017
25 Putting People First, DH 2007
7. HOW WILL WE KNOW WE HAVE DELIVERED THE VISION AND THE STRATEGY’S OBJECTIVES?

The vision for this strategy is to

“Provide accessible, responsive, high quality, high value healthcare services and work with, for, and in local communities to reduce health inequalities and improve people’s health.”

.... and successful delivery of this strategy will provide the following outcomes for our patients, the local population and the wider health system:

- Children are supported to get the best start in life and are enabled to thrive and become healthy adults
- People achieve individual health and wellbeing goals
- People with complex care needs receive well-coordinated, personalised, multi-agency care
- Children with disability and / or life threatening disease and adults with long term conditions and disabilities are supported to manage their own care as far as possible
- People at the end of their life are supported to live the life they wish to the best of their ability
- Services are organised around individuals and local communities and provided as close to home as possible
- Unnecessary stays in hospital are avoided
- People receive safe and effective care from trained and skilled professionals
- Clinical outcomes are in the top 10% compared to our peers

Underpinning each of these high level outcomes will be clearly defined process improvements, or outputs, and outcome measures that include:

- Patient reported outcomes that identify what matters to the patient and their personal treatment goals
- Generic quality of life measures that assess overall improvements in individual health and wellbeing, and
- Outcomes that relate to clinical outcome and the health system.

Our expectation is that people we treat will each have a personalised treatment plan which is underpinned by an evidence based model of care or care pathway, and which also includes realistic patient reported outcome measures. The aim is to routinely ask all patients what matters to them and to identify their personal treatment goals which are then reflected in the treatment plan. The impact of the treatment intervention on the person’s goals is then re-assessed at the end of treatment. Many of our services have already introduced academically validated patient reported outcome measures (including Patient Functional Scale, East Kent Outcome Score and Goal Attainment Scoring) and others are planning to do so.

We also plan to use a generic Quality of Life Questionnaire to assess overall impact on health and wellbeing. A few services already use EQ-5D-5L but most services do not ask people to assess the quality of life.

In addition to patient reported outcome measures and quality of life questionnaires we will routinely use, and publish, simple, easy to use ‘system-focussed’ outcome measures of how the services we provide improve the health and well-being of our population and, where feasible, benchmarking of how our performance compares to our peers.
The table below provides an indicative overview of the process improvements / outputs and system outcome measures that will be used to monitor progress towards achievement of each of our health and wellbeing outcomes. Our work to develop and implement our outcomes framework is at an early stage and so the exact suite of measures is subject to refinement and change.

**Table 2. Indicative process improvements and outcomes measures**

<table>
<thead>
<tr>
<th>Process Improvements / Outputs</th>
<th>Outcome Measures (for defined population / patient cohorts)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children are supported to get the best start in life and are supported through their development to thrive and become healthy adults</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Co-ordinated universal children’s service Healthy Child Programme | Obesity rates in children – reception vs Yr 6 (TCS)*  
% Children who have had a 2yr review by 32 months (TCS)  
Teenage pregnancy rates  
Children with Type 2 diabetes – rate per 100,000 |
| Immunisation programme | % eligible children having routine immunisations at 12 and 24 months, 5 and 18years (TCS) |
| Breastfeeding | % infants being breastfed at 6-8 weeks (TCS)  
% compliance with UNICEF baby friendly award programme |
| **People achieve their individual health and wellbeing goals** |
| Sound, evidence based advice on maintaining and improving health and wellbeing is readily accessible | Reduction in risk factors eg. smoking and drug taking, alcohol consumption (STP intervention), obesity, teenage pregnancy |
| Early intervention services are provided | |
| Evidence based weight management services (STP intervention) | Reduction in obesity rate |
| Diabetes management programmes | Reduction in risk of diabetes related complications in adults with diabetes |
| Physiotherapy for all falls patients aged 60+ on caseload identified as having a clinical need (STP intervention) | Reduction in falls and harm from falls  
Number falls as % caseload (TCS) |
| **Children and young people with disability and / or life threatening disease and adults with long term health conditions and disabilities are supported to manage their own health and wellbeing and care needs as far as possible** |
| Long term care and therapy provided in partnership with children, parents and other providers (eg social services) | Reductions in ICT input, fewer hospital visits |
| Self-management is a component of all personalised plans of care | % Care plans including self-management and patient determined treatment goals |
| Access to advice, support and technology to enable people to manage their own conditions (Apps, telehealth, telecare) | % people confident to manage their own care with support (for defined patient cohorts) - patient activation measure |
### People with complex care needs receive well coordinated, personalised, multi-agency care

<table>
<thead>
<tr>
<th>People who require complex care needs receive</th>
<th>Well coordinated, personalised, multi-agency care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care is provided at the lowest level of provision</td>
<td>Reduction in days spent in hospital / care homes</td>
</tr>
<tr>
<td>Integrated children’s services</td>
<td>Number of carers / parents reporting they are adequately supported in their caring role</td>
</tr>
<tr>
<td>Single personalised plan of care, including a carers assessment, for those who need it</td>
<td>% patients with complex needs with named case manager / key worker</td>
</tr>
<tr>
<td>Case manager / key worker</td>
<td></td>
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</tbody>
</table>

### People at the end of their life are supported to live the life they wish to the best of their ability

<table>
<thead>
<tr>
<th>People thought to be at the end of their life are offered</th>
<th>OACCS outcome measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>offered a holistic needs assessment, advanced care planning discussion and care plan if appropriate</td>
<td>Increase in amount of time patients at the end of their life are able to spend in their preferred place of care</td>
</tr>
<tr>
<td></td>
<td>% people identified as End of Life with Advanced Care Plan in place (TCS)</td>
</tr>
<tr>
<td></td>
<td>Increase in % people identified as End of Life dying in their preferred place of care (TCS)</td>
</tr>
</tbody>
</table>

### Services will be organised around individuals in local communities and provided as close to home as possible

<table>
<thead>
<tr>
<th>Services will be organised around individuals in local communities and provided as close to home as possible</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Locality teams co-ordinate multidisciplinary care and understand the services offered by each team</td>
<td>PROM – people reporting seamless / joined up multidisciplinary care</td>
</tr>
<tr>
<td>Increased use of community and voluntary sectors</td>
<td></td>
</tr>
<tr>
<td>Community hubs provide the focus for services in each locality</td>
<td>Reduction in unplanned hospital admission for ambulatory care sensitive conditions</td>
</tr>
<tr>
<td>Enhanced care for people living in care homes</td>
<td>% people referred to Rapid Response who subsequently have an unplanned hospital admission</td>
</tr>
<tr>
<td>Community bed bases provide inpatient facilities close to home</td>
<td>% community hospital in-patients who would otherwise require acute hospital admission</td>
</tr>
</tbody>
</table>

### Unnecessary stays in hospital are avoided

<table>
<thead>
<tr>
<th>Unnecessary stays in hospital are avoided</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Evening and weekend services reflect GP provision and support discharge or transfer in / out of acute / community beds</td>
<td>% people referred to Rapid Response who subsequently have an unplanned hospital admission</td>
</tr>
<tr>
<td>Risk stratification identifies those most at risk</td>
<td>% patients on Community caseload not admitted to hospital by day 90 following referral (TCS)</td>
</tr>
<tr>
<td>Enhanced care / Homefirst / virtual ward in all localities</td>
<td>A&amp;E case mix changes – reduction in % ambulatory care sensitive attendances eg UTIs attending A&amp;E</td>
</tr>
<tr>
<td>Rapid response for people in acute crisis / clinical navigators in acute providers</td>
<td>More older adults supported to remain at home</td>
</tr>
<tr>
<td></td>
<td>% A&amp;E attendances of people referred to Rapid Response</td>
</tr>
<tr>
<td></td>
<td>% unplanned admissions of people referred to Rapid Response</td>
</tr>
</tbody>
</table>
### Outcomes

| Supported discharge Stroke EDS | Reduction in length of stay (defined patient cohorts)  
| | % readmissions within 28 days for defined patient cohorts (TCS)  
| **People receive safe and effective care from trained and skilled professionals** |  
| Compliance with National Quality Standards | National Quality Indicators framework  
| Focus on health outcomes that are important to patients | Patient survey, complaints trends  
| | % Patients having individualised plan of care underpinned by evidence based model of care / care pathway (audit)  
| Standardised care pathways / Protocolised care | % reduction in variation in quality of service  
| | % increase in patients experiencing harm free care (Safety Thermometer)  
| | Incidence of pressure ulcers Grade 2&3 (TCS)  
| | % venous leg ulcers healed within 12-24 weeks from start of treatment (TCS)  
| **Clinical outcomes in top 10% compared to peers** |  
| Best practice is the norm | Published Clinical outcomes for each HCT service (Clinical audit)  
| | Outcomes benchmarked against peers where feasible  

*Measures annotated (TCS) have been taken from Transforming Community Services – Community Indicators for Quality Improvement 2011*

For each ‘system’ outcome measure baseline data and benchmarking comparison will be undertaken for a defined patient cohort to determine the level of improvement expected for each development over the period of the plan.
8. DELIVERY OF THE HEALTH AND WELLBEING STRATEGY

This strategy will be delivered through the Trust’s transformation programme and supporting quality improvement workstreams as summarised in Fig 1 HCT Strategy above.

Each workstream has a clearly set out project initiation document, or quality improvement plan, which makes explicit how the aim and objective will be delivered and the associated reporting and assurance arrangements to ensure delivery is monitored.

For every proposed change we ask three important questions:

1. Does it improve quality / outcome?
2. Does it improve the patient and carer experience?
3. Does it reduce the cost?

Routine monitoring of performance against our outcome measures will guide us in answering these questions and enable us to benchmark performance both between different localities or teams and between HCT and our peers.

The Trust’s strategy and resources committee monitors the overall delivery of this strategy, whilst the healthcare governance committee seeks assurance on the delivery of quality improvements and quality performance in HCT.

Developing and implementing our outcomes framework.

We will always put patients and their carers first and, through partnering with them to understand their priorities and goals, will develop and deliver personalised care plans that support them to achieve their own goals. A key element of our outcomes framework is to use patient outcome measures in all services. We will continue to use feedback from patient stories, complaints and patient surveys as measures of patient experience.

Our outcomes framework is described in section 7 above and our plan for doing this is summarised below:

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</thead>
<tbody>
<tr>
<td>Patient outcome measures</td>
<td>Agree HCT approach</td>
<td>100% services routinely using PROMs</td>
<td>100% services routinely using PROMs where this is feasible</td>
<td>100% services routinely using PROMs where this is feasible</td>
<td>100% services routinely using PROMs where this is feasible</td>
</tr>
<tr>
<td></td>
<td>25% services routinely using PROMs</td>
<td>100% services routinely using PROMs by March 2019 where this is feasible</td>
<td>100% services routinely using PROMs where this is feasible</td>
<td>100% services routinely using PROMs where this is feasible</td>
<td>100% services routinely using PROMs where this is feasible</td>
</tr>
<tr>
<td>System outcomes measures</td>
<td>Confirm suite of outcome measures</td>
<td>Routine reporting and monitoring of system Health and Wellbeing outcomes across all services</td>
<td>Routine reporting and monitoring of system Health and Wellbeing outcomes across all services</td>
<td>Routine reporting and monitoring of system Health and Wellbeing outcomes across all services</td>
<td>Routine reporting and monitoring of system Health and Wellbeing outcomes across all services</td>
</tr>
<tr>
<td></td>
<td>Initial analysis and benchmarking</td>
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</table>

Health & Wellbeing Strategy 2017 – 2022, V.2
<table>
<thead>
<tr>
<th></th>
<th>Develop Trust level outcomes dashboard / report</th>
<th>Service developments focussed on areas / services where outcomes not being achieved</th>
<th>Service developments focussed on areas / services where outcomes not being achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business Unit reporting (BUPR)</strong></td>
<td>Develop and pilot reporting template to include HWB outcome measures</td>
<td>100% BUPR reports include HWB outcome measures</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Audit – to ensure consistency of approach and assurance of outcomes being delivered</strong></td>
<td>Initial development of audit tool</td>
<td>Implement audit</td>
<td>Ongoing audit to ensure consistency of approach and assurance re achievement of outcomes</td>
</tr>
</tbody>
</table>

Further detail for the first two years is included in our Qualities Priorities for 2017/19.
9. IMPLICATIONS OF DELIVERING THE HEALTH AND WELLBEING STRATEGY

Our strategy is based on delivering a very different experience of community services for the population and for the organisations we work closely with, specifically carers, general practice, mental health, voluntary sector and social care.

It will ensure that responsive, seamless services are available within each locality, tailored to the needs of the population, with General Practice at the centre of patient care.

Our plans will:

- Enable a significant shift in services to the community for those with long term conditions and, in particular, older people with complex needs and multiple co-morbidities
- Deliver a systematic approach to managing people with complex needs across organisational boundaries
- Maintain delivery of the Healthy Child Programme whilst creating a wider system of care that will deal with all aspects of children’s health and wellbeing. This will include the significant challenges resulting from inequalities in early life and the specific needs of Children and Young People with additional needs.
- Develop further innovative models for providing more complex care closer to home
- Use increased skill-mix of workforce in the community to deliver cost effective services with better health outcomes
- Contribute to the wider development and use of clearly defined and validated outcome measures for community health services
10. DEPENDENCIES

The Health and Wellbeing Strategy is the central strategy of the Trust and has dependencies to a greater or lesser extent with all our other strategies. There is a golden thread of connection between the Health and Wellbeing Strategy and the following strategies, all of which are aligned to deliver our Health and Wellbeing Strategy:

Workforce and OD:
To ensure the workforce is fit for provision of care in the future, with a focus on skill mix and innovation which will recruit and retain suitable professionals who are values driven in the provision of high quality care for our patients.

Estates:
Develop facilities that are fit for purpose for care delivery over the next 5-10 years and beyond and that are responsive and flexible to accommodate:

i. Preventative services fit for the future
ii. Provision of Community Hubs to will enable increasingly complex care to be delivered closer to home
iii. Community bed bases which provide an appropriate therapeutic environment for the acuity of patients within them

IM&T:
To ensure robust data quality within HCT, wherever the service is provided. To work with partner organisations across Hertfordshire to enable data sharing between organisations for the benefit of patient care. To ensure data is provided for the use of HCT professionals to optimise quality performance across the organisation. Using technology to support self-management and innovative models of care.

Patient and Public Engagement

The HCT Communications and Engagement Strategy sets out the overarching approach to patient and public engagement. This is complemented by a toolkit which provides service managers and those managing the transformation programmes with practical advice and guidance for the effective engagement of our patients and the wider public served by the Trust.
<table>
<thead>
<tr>
<th>List of Services 2017/18</th>
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</thead>
<tbody>
<tr>
<td><strong>Adult Community Services</strong></td>
</tr>
<tr>
<td>Bladder &amp; Bowel Care Service</td>
</tr>
<tr>
<td>Community Neurological, including Early Supported Discharge</td>
</tr>
<tr>
<td>Diabetes Community Service</td>
</tr>
<tr>
<td>End of Life and Specialist Palliative Care</td>
</tr>
<tr>
<td>Foot Health Service (Podiatry)</td>
</tr>
<tr>
<td>Integrated Community Teams</td>
</tr>
<tr>
<td>Intermediate Care Bed-Bases (Community Hospitals)</td>
</tr>
<tr>
<td>Lymphoedema Services</td>
</tr>
<tr>
<td>Musculoskeletal Services</td>
</tr>
<tr>
<td>Neurological Bed-Bases</td>
</tr>
<tr>
<td>Nutrition and Dietetics Service</td>
</tr>
<tr>
<td>Pain Management and Chronic Fatigue Service</td>
</tr>
<tr>
<td>Speech and Language Service</td>
</tr>
<tr>
<td>Tissue Viability and Leg Ulcer Service</td>
</tr>
<tr>
<td>Acute Therapies Service</td>
</tr>
<tr>
<td>Hospital Day Service (Cheshunt)</td>
</tr>
<tr>
<td>Integrated Discharge Team (ENHT)</td>
</tr>
<tr>
<td>Minor Injuries Unit</td>
</tr>
<tr>
<td>Respiratory Service</td>
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<tr>
<td>Skin Health Services</td>
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<tr>
<td>Cardiology Services (including Cardiac Rehabilitation and Heart Failure)</td>
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<tr>
<td>Diabetic Retinopathy Service</td>
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<tr>
<td>Rapid Access Unit (RAU), St Albans</td>
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<tr>
<td>Rapid Response</td>
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<tr>
<td>HomeFirst (Rapid Response and Virtual Ward)</td>
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<tr>
<td>Prison Healthcare Services</td>
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<table>
<thead>
<tr>
<th><strong>Children And Young People’s Services</strong></th>
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<tbody>
<tr>
<td>Child Health Service</td>
</tr>
<tr>
<td>Dental Services</td>
</tr>
<tr>
<td>Health Visiting</td>
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<tr>
<td>Looked After Children Service</td>
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<tr>
<td>Occupational Therapy Service</td>
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<tr>
<td>PALMs (Positive Behaviour, Autism, Learning Disability and Mental Health Service)</td>
</tr>
<tr>
<td>Physiotherapy Service</td>
</tr>
<tr>
<td>School Nursing</td>
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<tr>
<td>Speech and Language Therapy Service</td>
</tr>
<tr>
<td>Specialist Nurse Co-ordinators (Transition and Sickle Cell)</td>
</tr>
<tr>
<td>Step2 Service</td>
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<tr>
<td>Children’s Eye Services</td>
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<tr>
<td>Children’s Hearing Service (Audiology)</td>
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<tr>
<td>Children’s Community Nursing</td>
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<tr>
<td>Community Medical Service</td>
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<tr>
<td>Continuing Care Service</td>
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<tr>
<td>Special School Nursing Service</td>
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