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The Symphony Programme – an example from the UK of integrated working between primary and secondary care

Jeremy Martin, Symphony Programme Director

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About South Somerset

135,000 population, older age profile
30,000 with long term conditions
19 GP practices
2 community hospitals
Community mental health team
1 district general hospital
Poor public transport
Predominantly small market towns and villages

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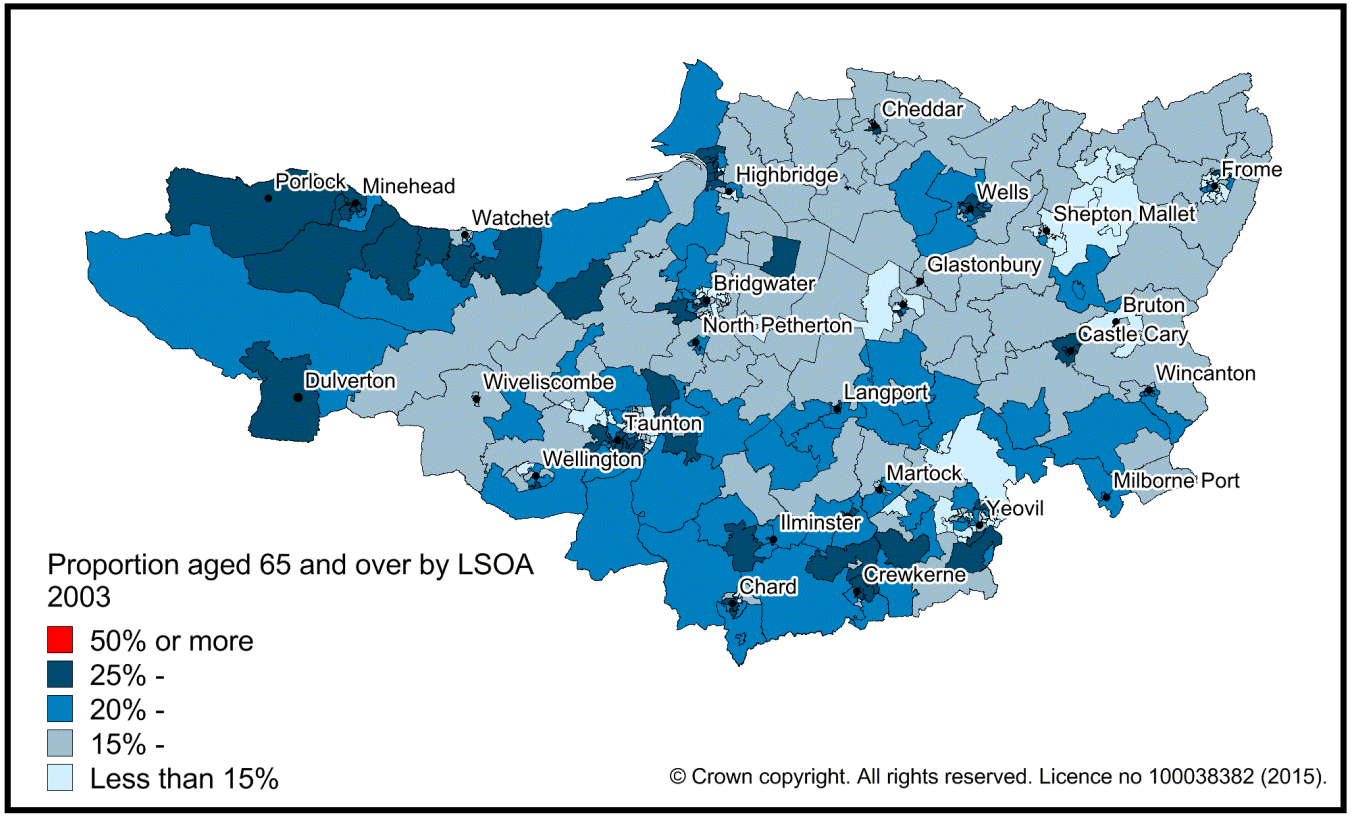
Proportion of the Somerset population aged 65+ by LSOA - 2003



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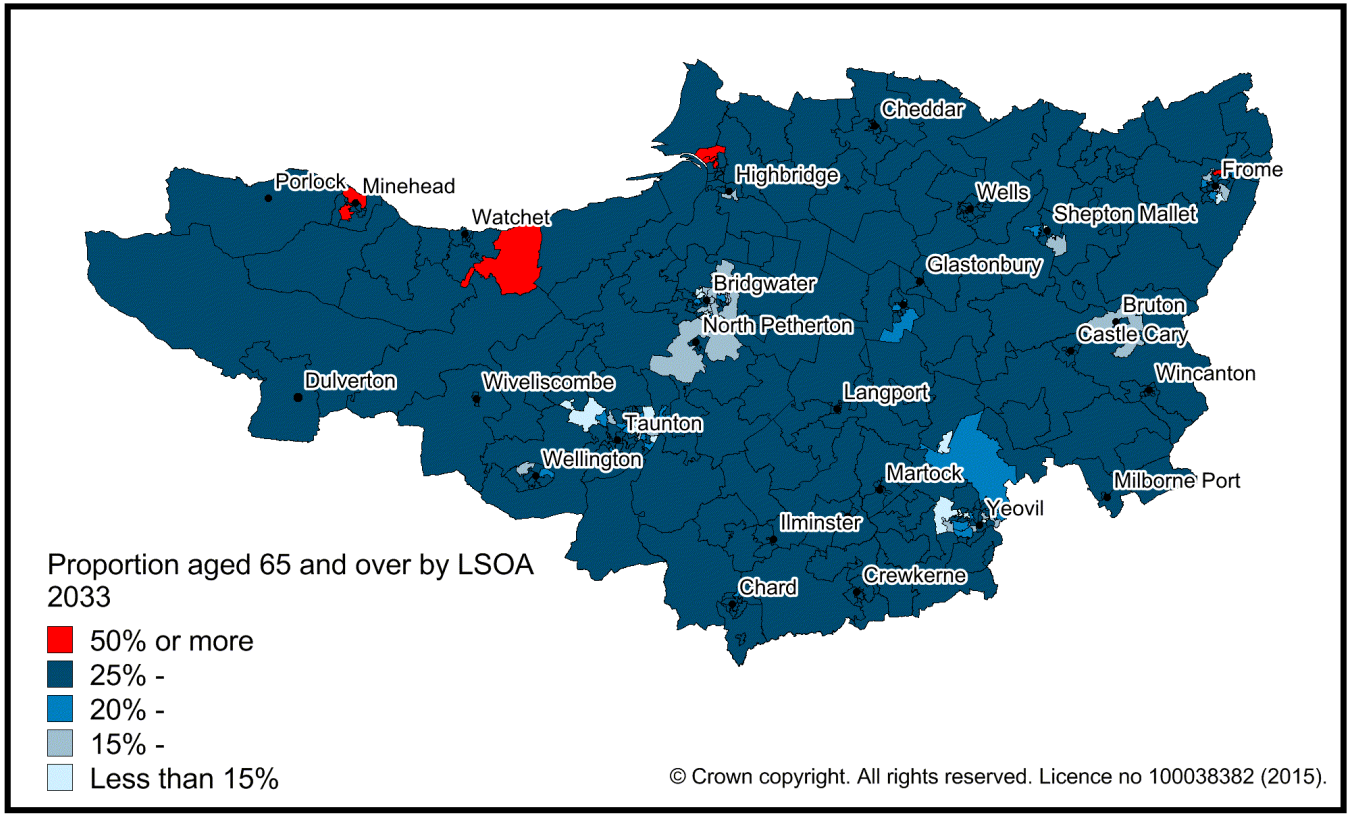
Proportion of the Somerset population aged 65+ by LSOA - 2033



How the NHS works…

- https://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

Key Challenges for Primary Care

- Patient demographics
- Proactive management of long term conditions
- Patient demand/expectations
- Immediate access vs. continuity of care
- Autonomy vs. scrutiny
- Unfunded transfer of work from other parts of the system
- Shortage of resources: time; finance; workforce

Key Challenges for Secondary Care

- Rapidly rising demand for unscheduled care
- Complex co-morbidities growing
- Discharge planning
- Generalised vs. specialist services
- Moving away from market economy
- Finding a new role supporting integrated care
- Shortage of resources: space; finance; time; workforce

Group discussion

- Which of these issues are relevant to the Austrian healthcare system?

- Which of these issues are relevant for rethinking secondary outpatient treatment in Austria?

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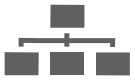
Core Logic



We need to create new integrated care models to organise care around patients' needs and enable much better joint working across the system

By doing the right thing, in the right place, at the right time we will reduce demand on secondary care and free up resources to invest in prevention and primary care

To enable that financial flow to take place, we need a single budget and decision making, and shared incentives

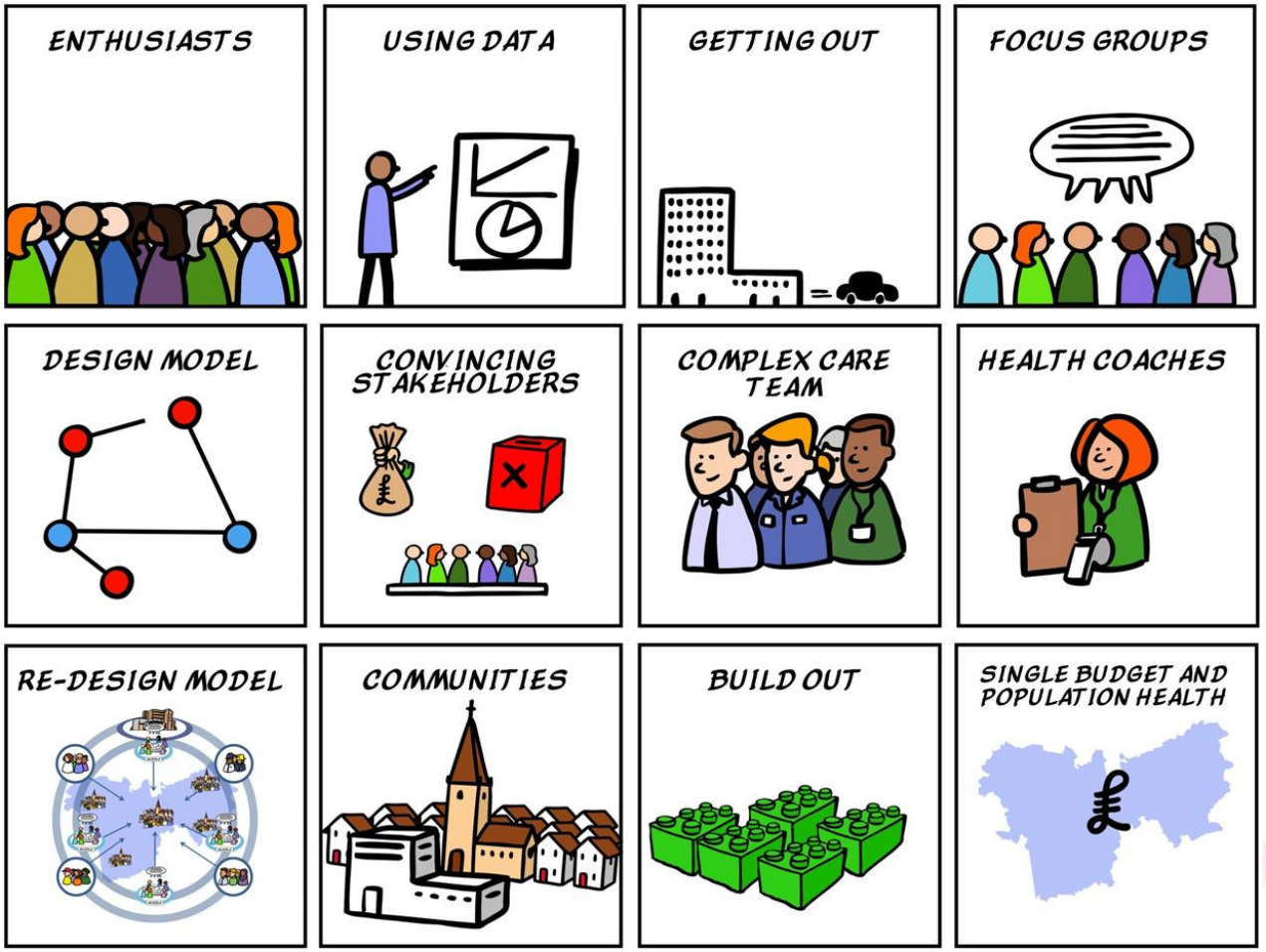
We also need shared control and decision making between all parts of the system, with primary care and secondary care as a core partners

This will enable us to create a sustainable model which is a good place to work

Vanguard funding enables simultaneous development of new care models, while existing models are still in operation

Vanguard status brings national support to enable us to develop new approaches to commissioning, contracting, payment and provider forms

The Symphony Story



Data

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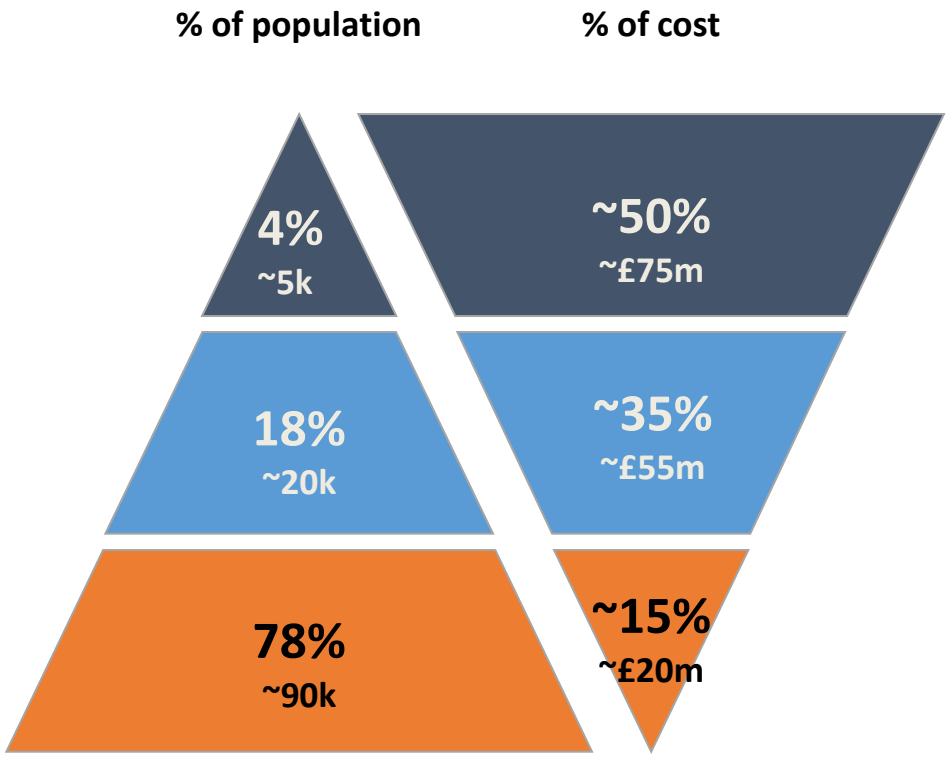
Population segmentation and new care models



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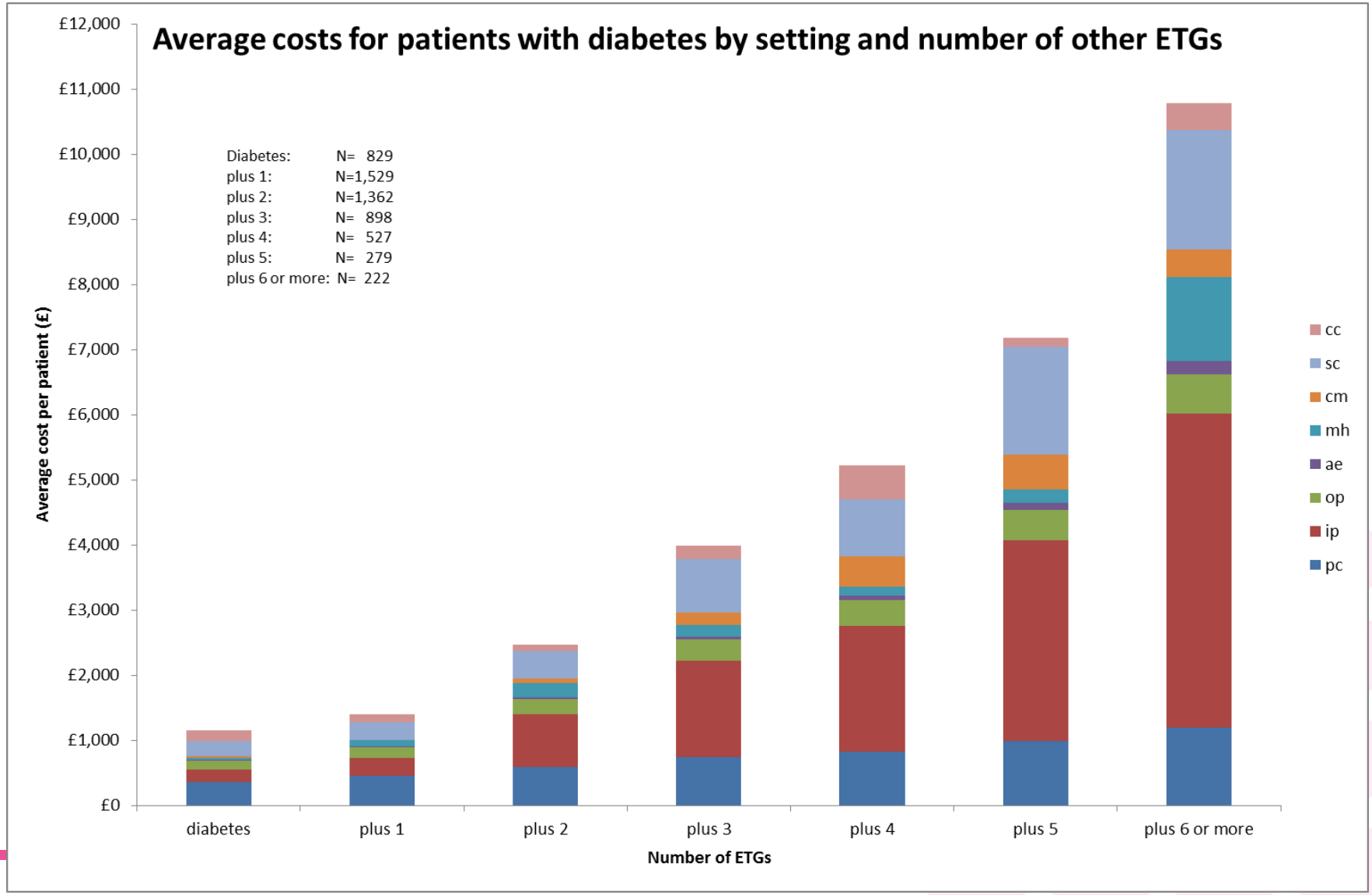

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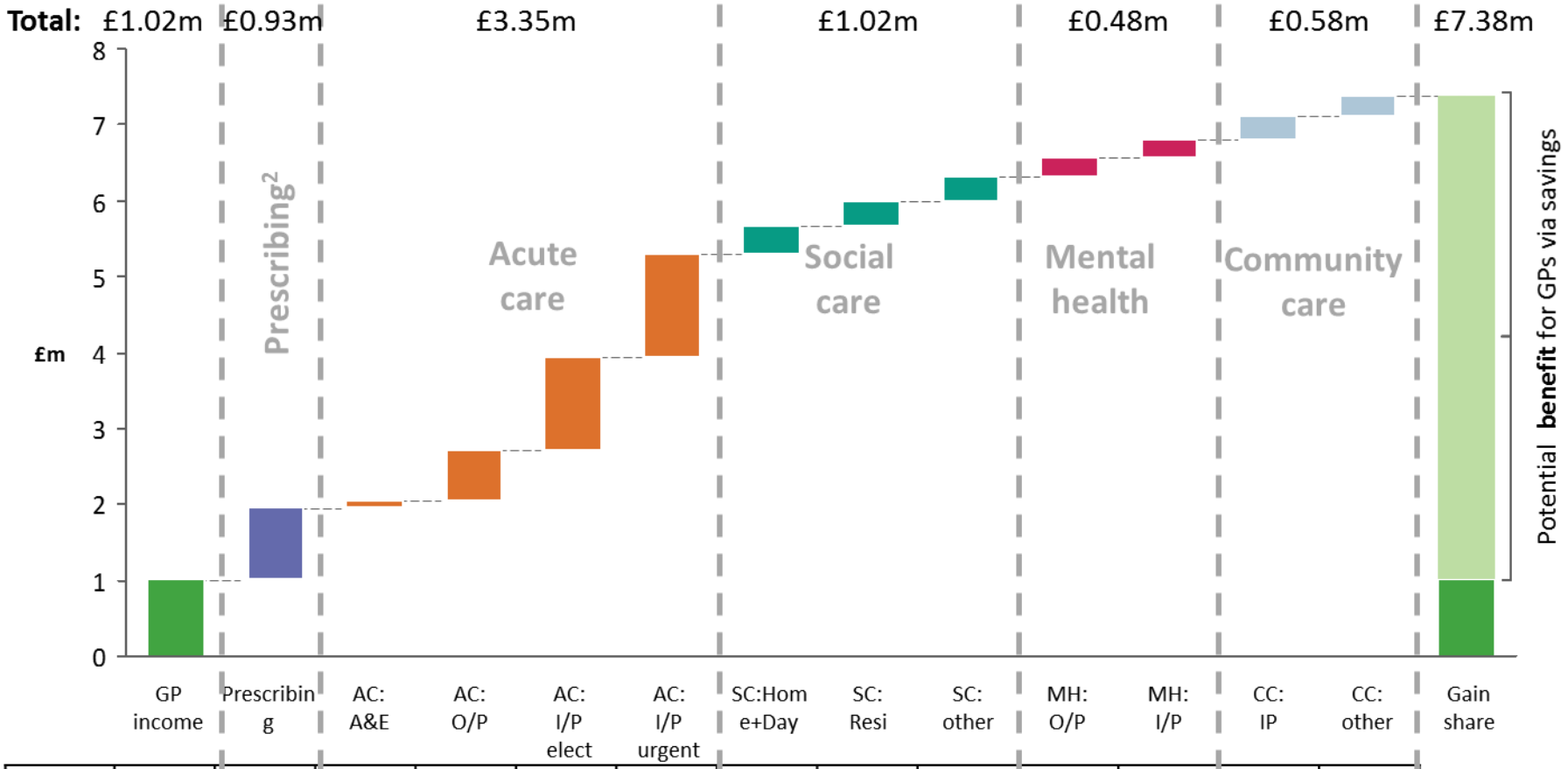
Potential impact on GP financials: average[1] South Somerset Practice



List size	6,380	4,340	660	1,990	630	490	70	30	130	120	10	30	1,010
Cost per patient	£160	£210	£140	£340	£1,940	£2,770	£5,100	£12,500	£2,550	£2,230	£20,600	£9,790	£250

1. Mean figures averaging across 19 South Somerset GPs.
2. Prescribing cost is extrapolated from Mar 2015 (HSCIC), with prescribing list for 2013-14 (Symphony data)

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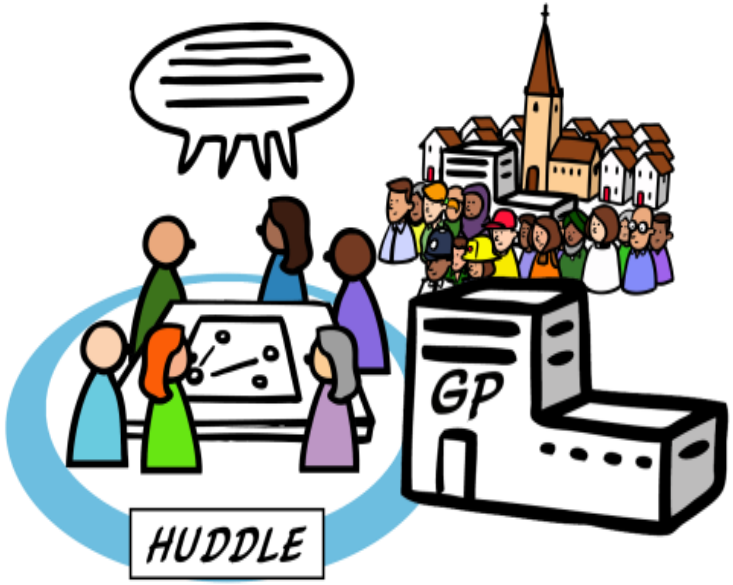
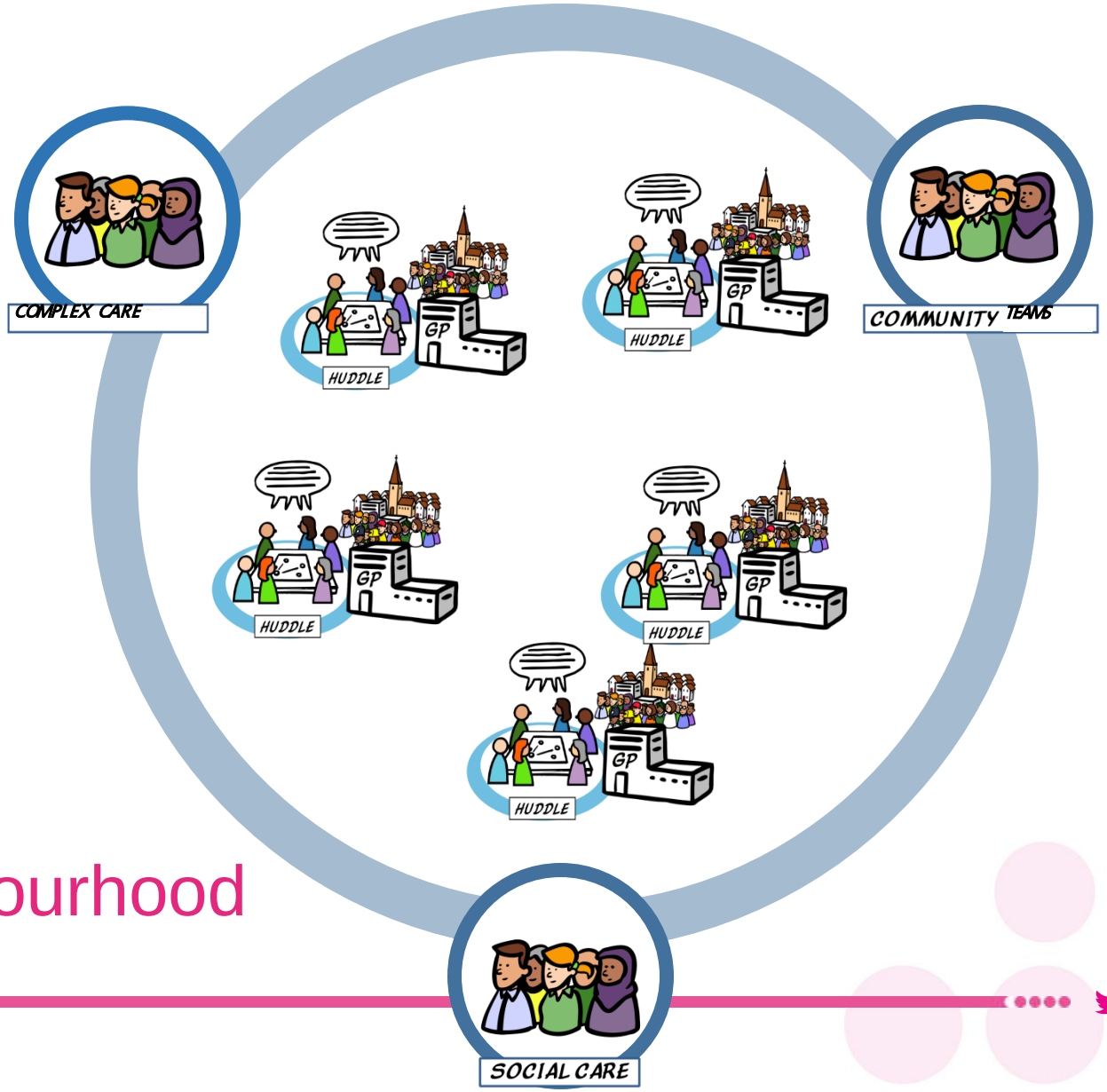
Core Care model



Town or village



Neighbourhood

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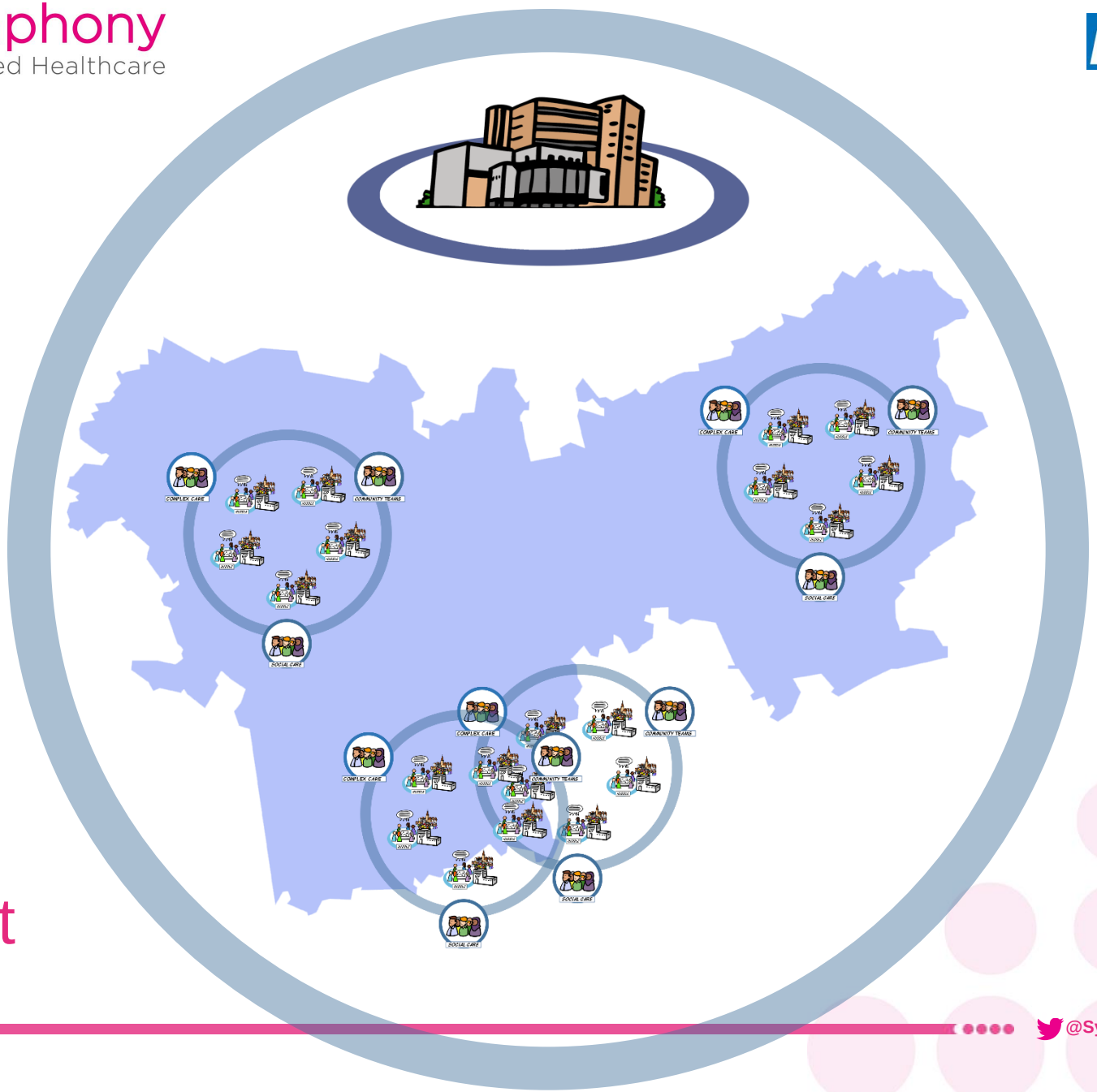

District

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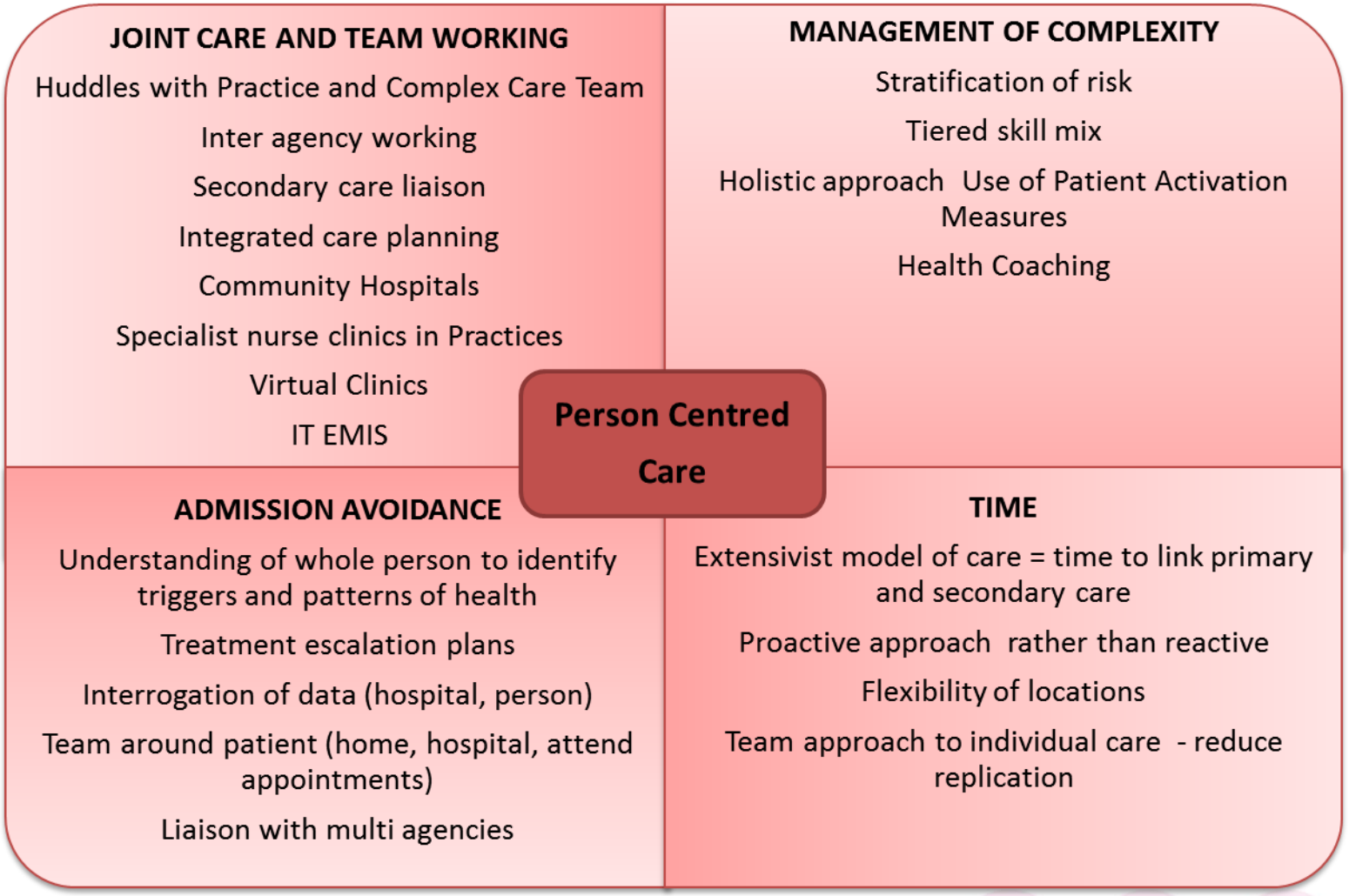
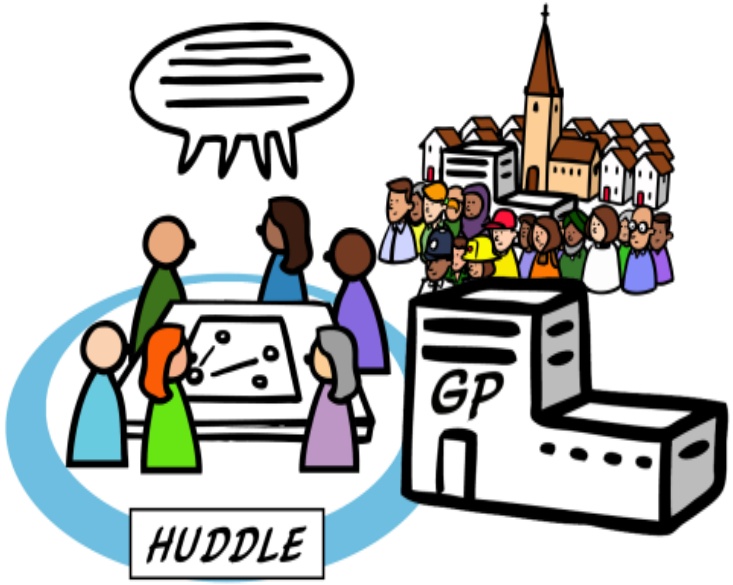
Framework for New Care Models





Town or village

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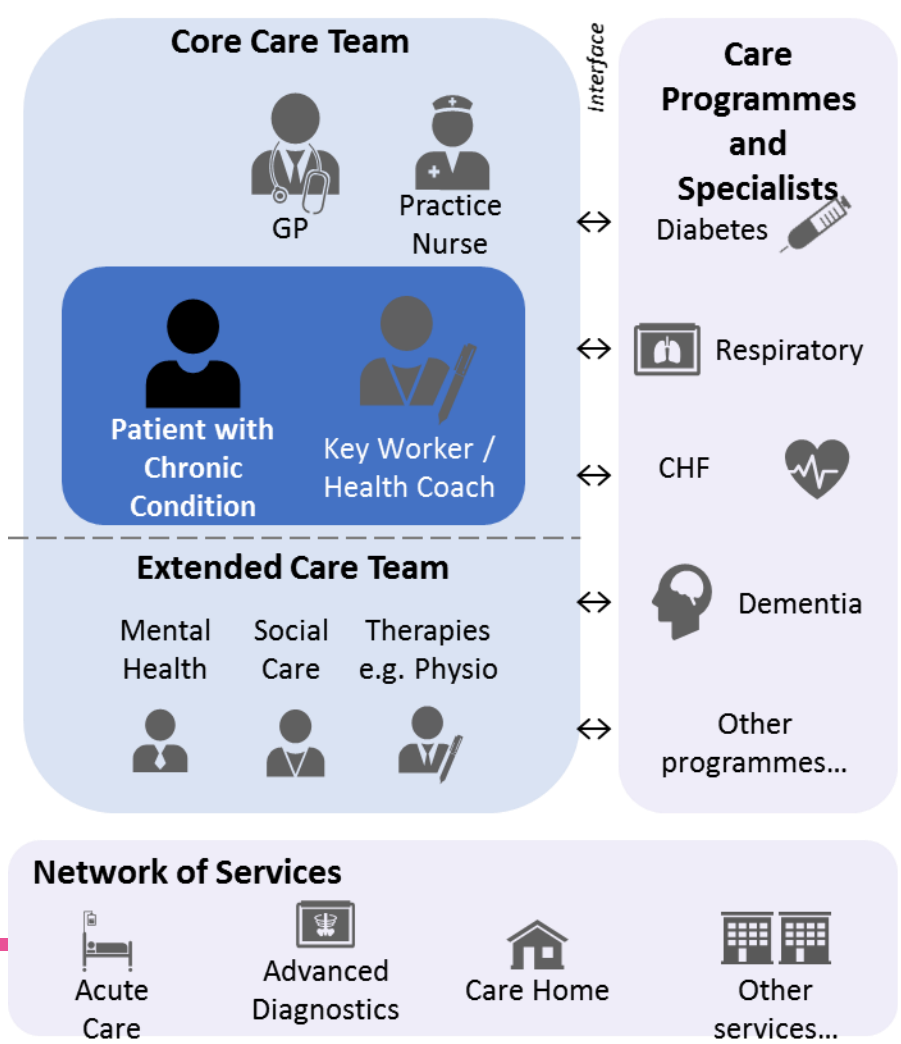
The GP Practice Model

The patient and health coach are supported by the wider care team and a number of care programmes and services.



Key Elements

- Team Working and Huddle
- Triage
- Stratification and Proactive Outreach
- Care Planning and Coordination
- Defined Workflows and Programme Integration
- Aligned Resources and Incentives
- Shared Clinical Data and Population Health Analytics

The Health Coach

- Acts as first point of contact for the patient and develops an agreed care plan, including health goals
- Develops close, trusting relationships with patients to understand potential health triggers
- Coordinates care across a range of healthcare and voluntary organisations
- Helps patients to understand and manage health conditions
- Empowers patients to live healthier lives through education, information and signposting
- Enables independence and self-care, reducing hospital admissions
- Supports effective discharge and reducing lengths of stay

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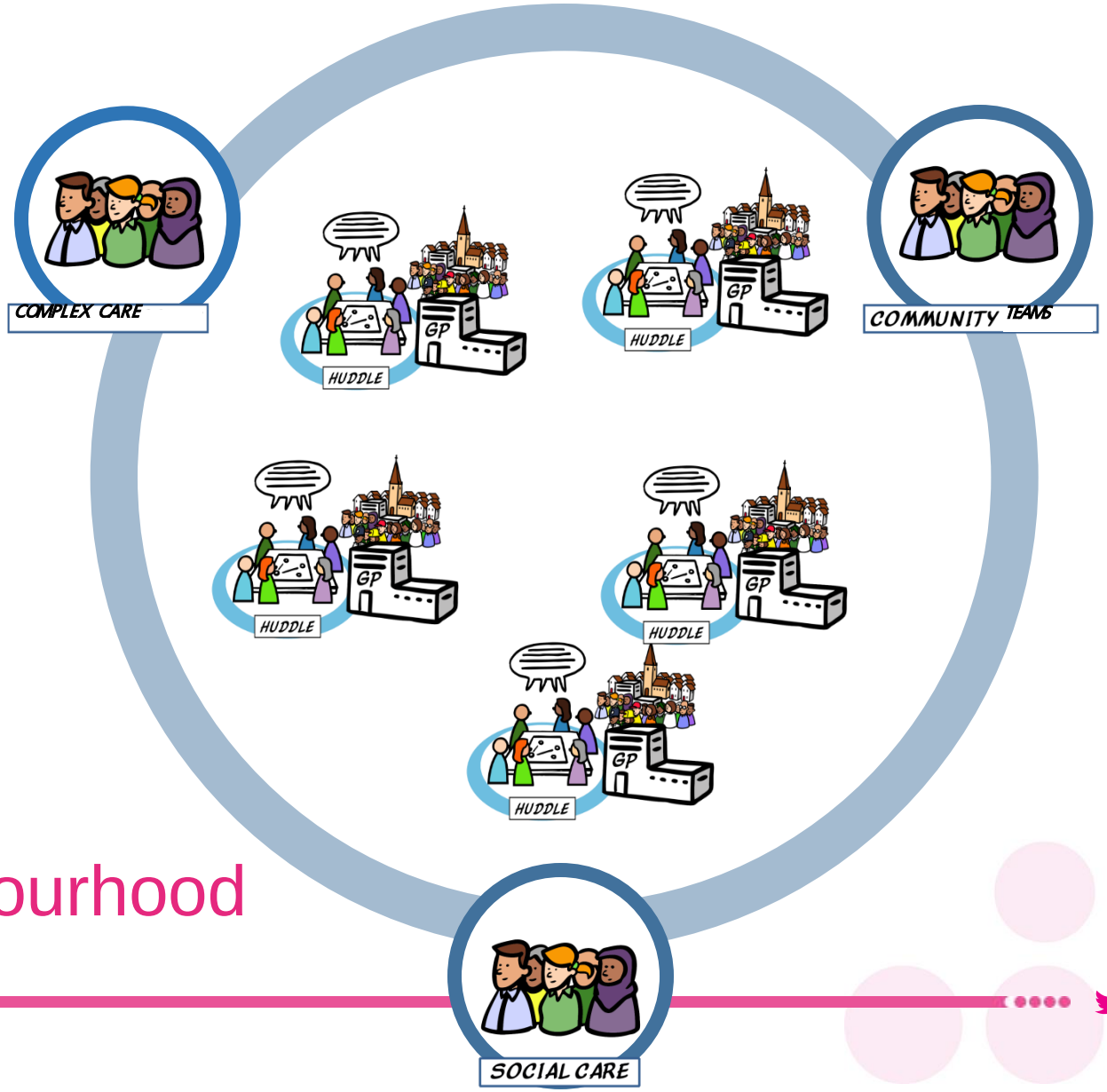
The Huddle


Assess risk
Patient - Centered
Bio-psycho-social approach
Core Team
Prevention of crisis
Educate and activate
Most appropriate intervention



Neighbourhood

Complex Care Team - core features

- Supports practices to deliver person centred care and move from a reactive to proactive model
- Works with most complex patients
- Works to promote patient activation (use of PAM scores)
- Staff work ‘to top of licence’
- Bridges gap between primary and secondary care
- Helps to avoid admission to hospital
- Embraces new roles and new tools

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Complex Care Team – new roles:

Keyworker

- An empathetic & motivational first point of contact for patients
- Aims to improve patients' self management skills and join up services

Complex Care Nurse

- Clinically trained senior nurses / therapists - prescribing & non prescribing
- Develops personalised care plan with patient and manages medical and social issues
- Aims to improve medical management of conditions and coordinate all care

Extensivist

- Experienced GPs with an interest in managing medical complexity
- Inputs into care and escalation plans and works to prevent hospital admissions
- Aims to maximise and 'tailor' medical care

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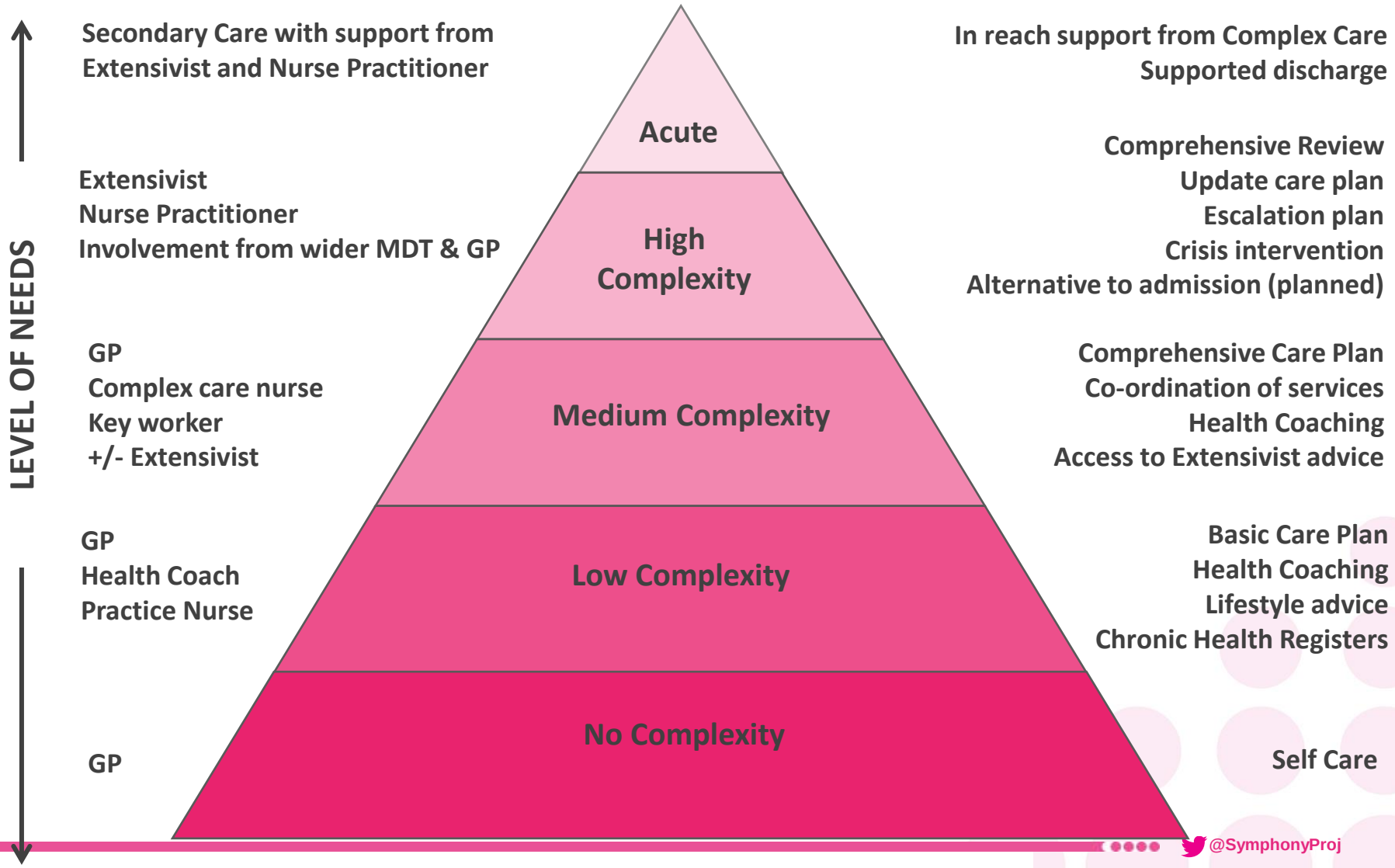
Model resource & provision



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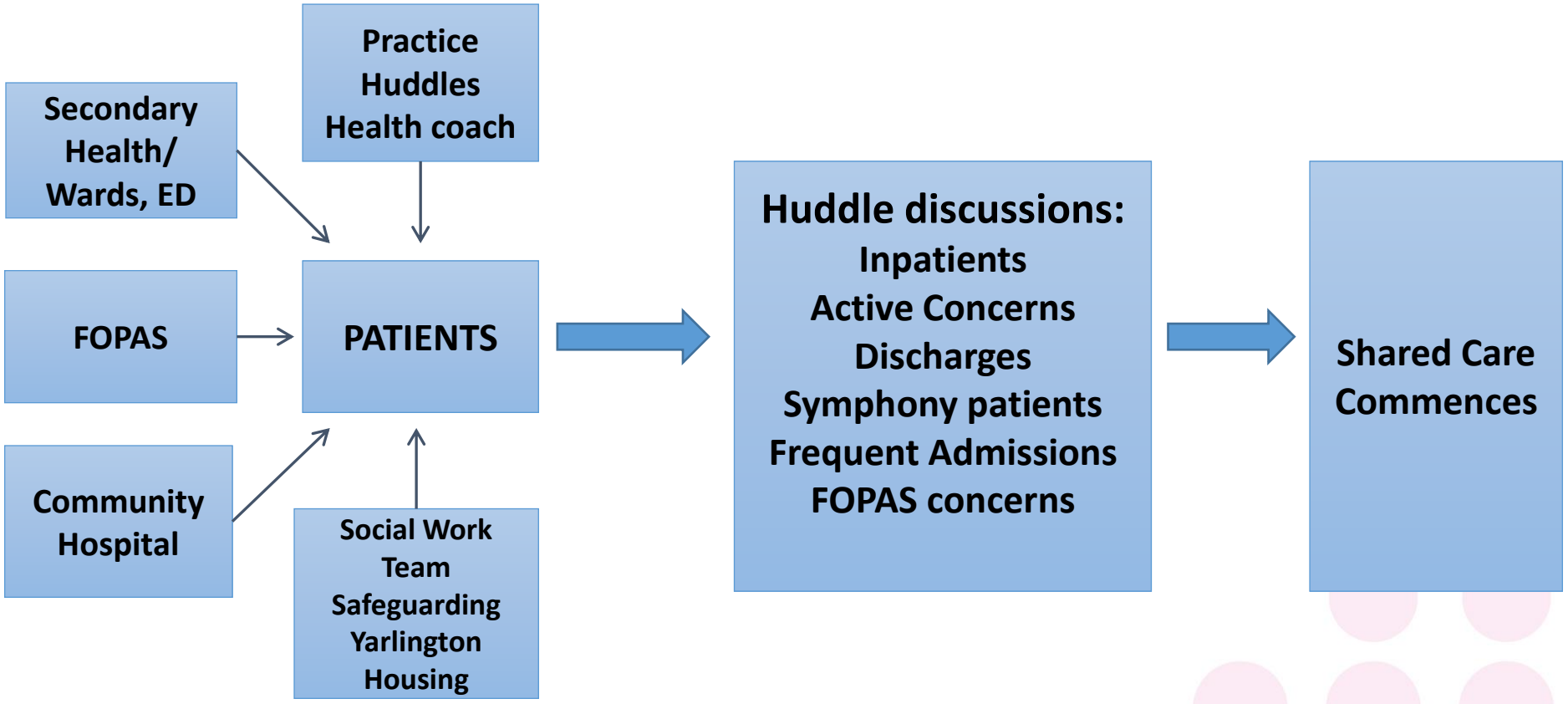
Process



Other new roles in primary care team

- Health coaches
- Physiotherapists
- Pharmacists
- Mental health support

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Prevention & community development

Prevention & community development

- Community Partnership Groups
- Death cafes
- Dementia friendly community work
- Mapping and connecting with community resources
- Health Coach/Social Care drop-in sessions
- Healthy eating initiative
- Community ambassadors
- Yeovil One Team – closer partnership working
- Yeovil Wellbeing Alliance
- South Somerset Loneliness strategy
- Training for parish councils
- Peer support networks
- Coordinating health coach involvement
- Empowering people and communities workstream

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Redesigning secondary outpatient treatment

Programmes

- 100 days programme: diabetes, gastroenterology and orthopaedics

- Integration Toolbox
  - Virtual clinics
  - Hot clinics
  - Consultant Connect
  - Visual 15s

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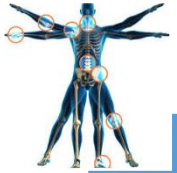
What benefits have been achieved locally *?

Team Diabetes

- Reduction in 75%of tier 2 & 3 referrals would lead to an income saving of £99k[1]
- If a 50% reduction achieved, then income saving will be £66k[1]
- Skype clinics have led to 14 saved clinic appointments leading to time savings for consultants



Team T&O

- 25% reduction in outpatient follow ups equates to £20k income reduction

Team Gastro

- 30% reduction in follow ups based on 16/17 referrals to gastro, gives annual saving of £43k
- Consultant Connect likely to result in 30 – 40% reduction in referrals over time[2]

- * - Savings are based on assumptions and subject to validation at the end of the 100 day challenge time period
- 1 - costs of staffing would remain the same so savings are income only
- 2 - based on an early view of 8 calls and 3 avoided referrals

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Specialist Services Integration Toolbox

The Symphony approach for Specialist Services in Secondary Care

Version 1 - July 2017

Prepared by:

Kate Brookman

Nurse Consultant for Integrated Care

Respiratory Nurse Specialist

@SymphonyProj

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Overview of the programme

The specialist services integration programme aims to…

- Improve current models of care
- Increase accessibility and availability of specialist nursing
- Create shared services and teams that are aligned to primary care
- Develop new models for delivering direct care, training and advice
- Improve patient outcomes
- Achieve high levels of patient satisfaction

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Variables identified in current ‘secondary care’ held services..

- Attitude and enthusiasm for the team to integrate new models of care
- Appropriateness for Integration
  - E.g. Respiratory/Pain Service = Yes, ICU -No!
- Most specialties will be somewhere in the middle. So which elements can be integrated safely and effectively?

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What to look at…

- Patient levels of secondary care attendance – emergency/planned?
- Length of stay
- Follow-up requirement
- Where follow-up and clinics are located and who does these
- What is done at those outpatient appointments
- What technology can be utilised.

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Why **our** speciality "can't" do integration

Things we may hear when discussing integration with colleagues:

- 'Daunting'
- 'Too big to even think about'
- 'Too busy'
- 'Our patients wouldn't like it'
- 'Specialist nurses are trained by us, therefore they stay with us'
- 'The hospital Trust would lose income'
- 'Just give us more GPs and Consultants'.

To address those views…

- Help the teams understand what methods of integration might be available for them
- No expectation of doing *everything at once* – this is a journey, not a take-off and arrival situation. Some of the changes *may* be fast but some will be small and incremental
- This is a direction of travel for every planning meeting or commissioning decision we make now
- There will be minimal or no new money – we have to make what we have work smarter and sharper
- There is limited/no pool of talented, trained NHS staff out there – we need to grow our own, and keep them with good work practices.

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Tools to achieve integration of specialist services

@SymphonyProj

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Virtual Clinics

Where a list of patients with a similar diagnosis or treatment problem (e.g. 16 pts) are discussed at a practice with as many of the healthcare team as possible. This includes a 'Visiting' Consultant Specialist , and/or the Clinical Nurse Specialist for that specialty. Takes a morning or afternoon:

- Initially pts from one practice, but once tested this can pull in from wider groups of practices.
- Specialist report template used and fed directly into EMIS System (Primary Care Patient Record). No hospital letter needed.
- Templates are designed to suit each specialty to pick up all correct EMIS Coding.
- Learning from these will feed into Treatment Escalation Plans, and application of best practice for many other patients
- Leading to best care for the patients, not having to attend an acute hospital setting, and brings specialist knowledge to the wider health setting.

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Hot Clinics

Patients seen by Clinical Nurse Specialist (CNS). Intermediate level of referral for patients starting to either spiral towards being admitted to secondary care, in a crisis, or who are having multiple contacts with primary care with sub-optimally controlled symptoms:

- Held in practice setting, initially one practice - but could be rolled out to see patients from several practices once tested and established
- Aim to see patients within two weeks of referral
- Patients have **Patient Activation Measure** pre-entered on EMIS
- Referral by email to CNS for vetting as suitable via email ,letter, FAX
- Escalation route for patients that need Consultant input
- CNS' will all be Independent Prescribers
- Patient survey completed

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Advice and guidance

Telephone contact to Specialties – Somerset is using Consultant and Urgent Connect to deliver this. Consultants on rotation take calls from primary care teams during the working day. Commissioned by CCG and in line with STP plans. This provides:

- Direct conversation between GP and Consultant but not adhoc as in previous trials when it involved interruption of ward rounds and clinics, with dissatisfaction and a lot of wasted time on all sides
- Frees up Consultant end clinic slots for more complex patients
- Delivers quicker advice for the GP and of course the patient requiring care
- Feedback can be gained post call to see if appointment or admissions were avoided.

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Visual 15s

These are 15 minute video updates delivered by the 25+ Clinical Nurse Specialists on new treatment choices, drug updates, application of best practice, problem solving and implementation of NICE guideline changes:

- Primary care teams can request topics.
- Accessed via Intranet, Jive / Kahoots (web sharing platform), GP Newsletter, Local Medical Council, 'Cornwall site' Practice Bulletins
- Building on skillset in primary care – keeps all up to date and gives some conformity of practice.

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Treatment Escalation Plans

Work specifically undertaken with Nursing Homes, Primary Care teams, Out of Hours, Complex Care team to identify patients that need forward planning. This can be via their care planning and Clinical Treatment Escalation Plans and allows for specialist input. This helps to:

- Avoids inappropriate hospital admission when patient has stated preference to be cared for elsewhere
- Avoids inappropriate testing and procedures that come into play once admitted and no advance plan is in place
- Helps guide Paramedic/Ambulance crews to make correct decision regarding optimal place of care
- **Turns Reactive care into Proactive care**.

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Other options for the toolkit

- Webinars – for groups of patients or for primary care teams

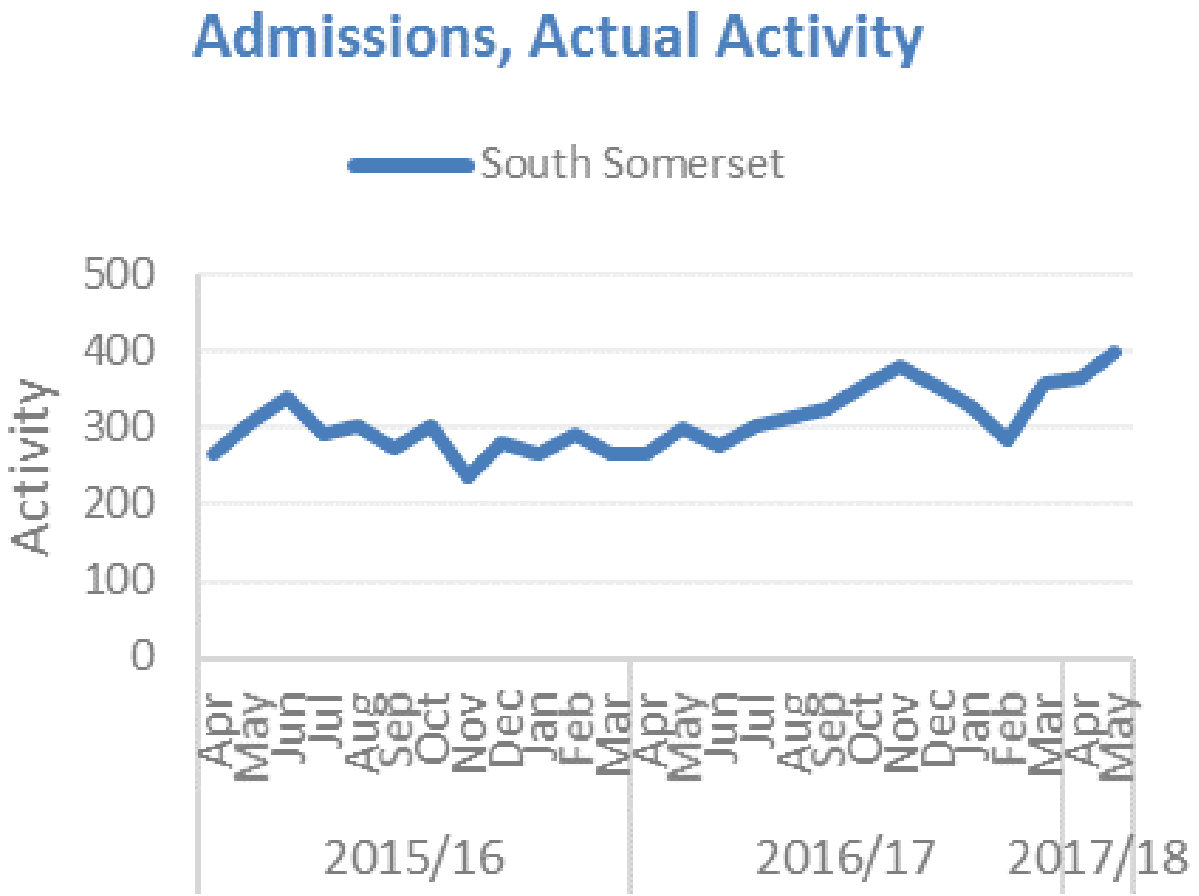
- Skype Consultations – for patients that require specialist input.

Group discussion

- Would these ideas help to tackle the issues in secondary outpatient treatment in Austria?
- What can the UK learn from Austria?

Impact

Latest evaluation data: 0 LOS non-elective, adult admissions – ambulatorv care



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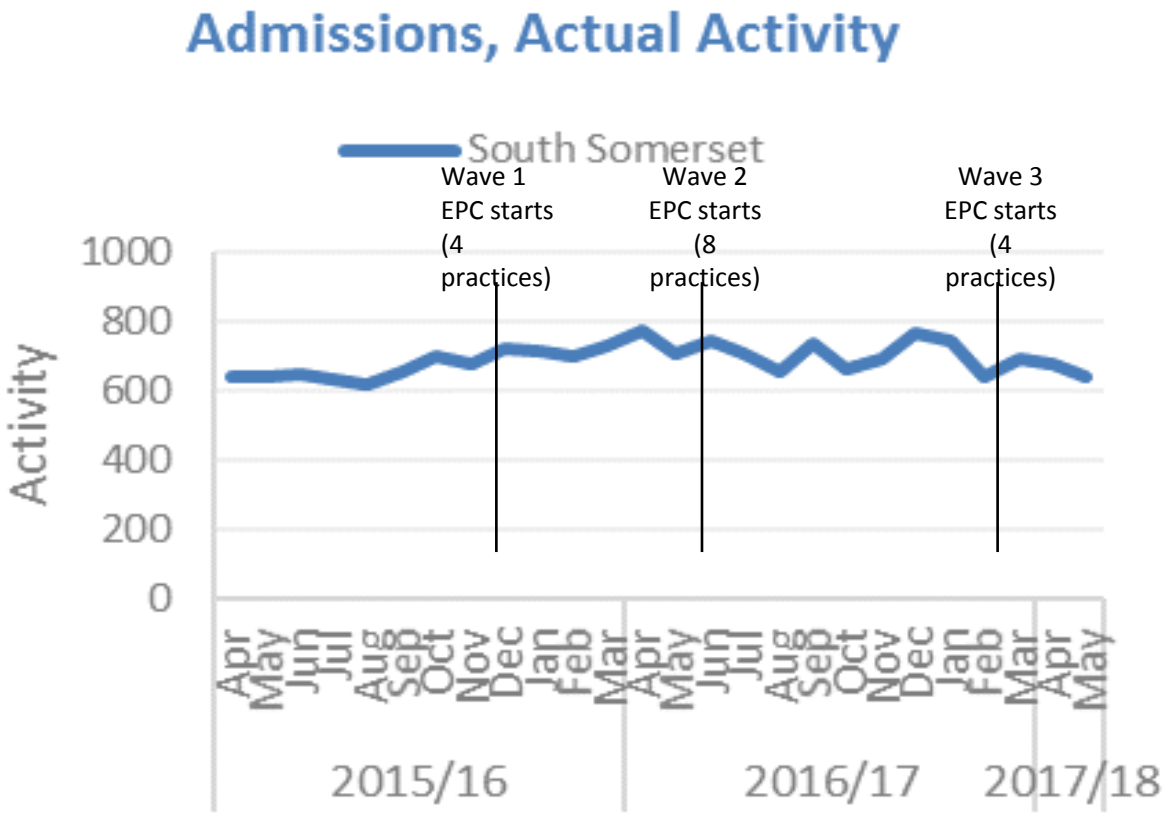
South Somerset population, all providers, adult, 1+ days length of stay



2016/17 Apr-May	2017/18 Apr-May
1482	1313
	-11.4%

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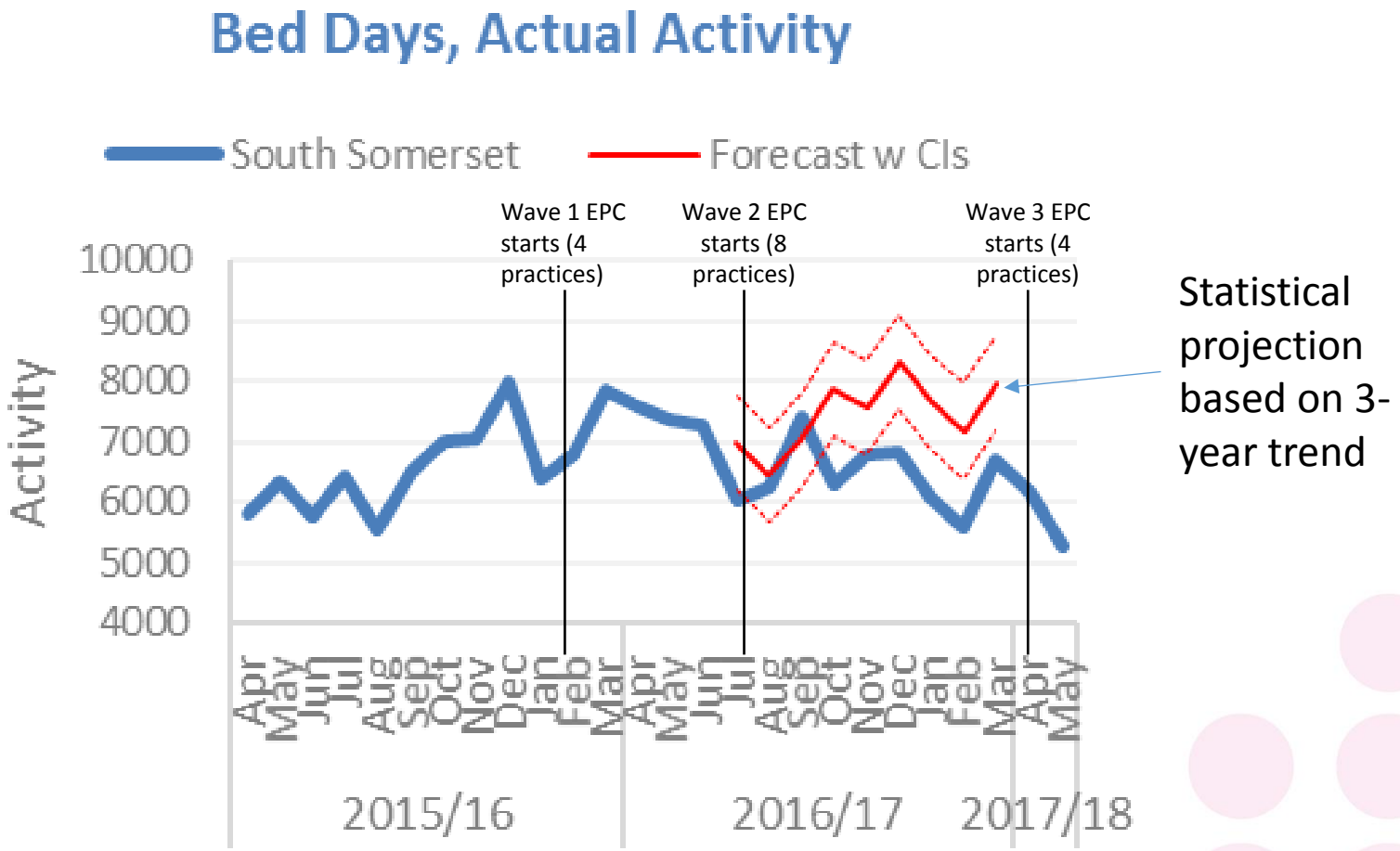
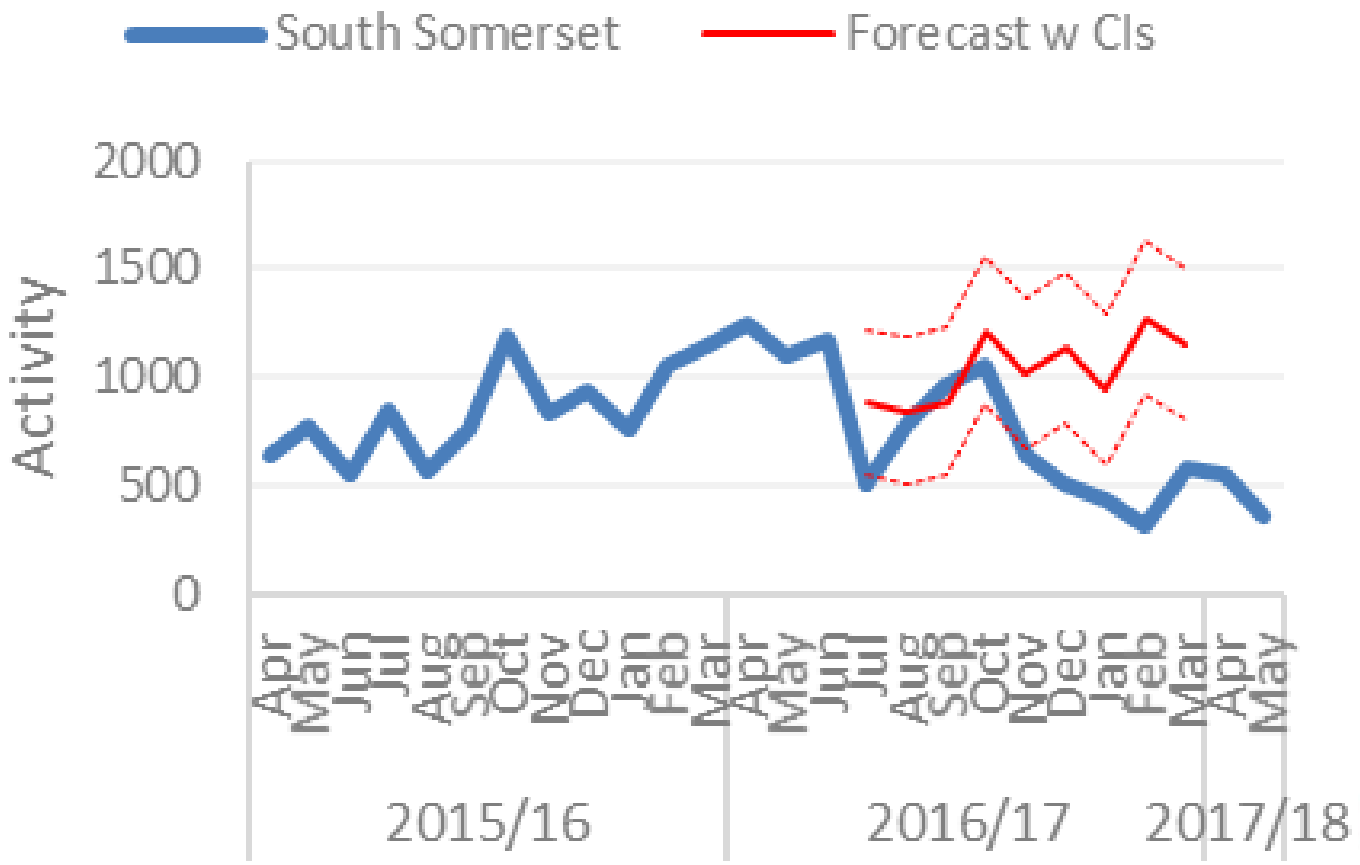
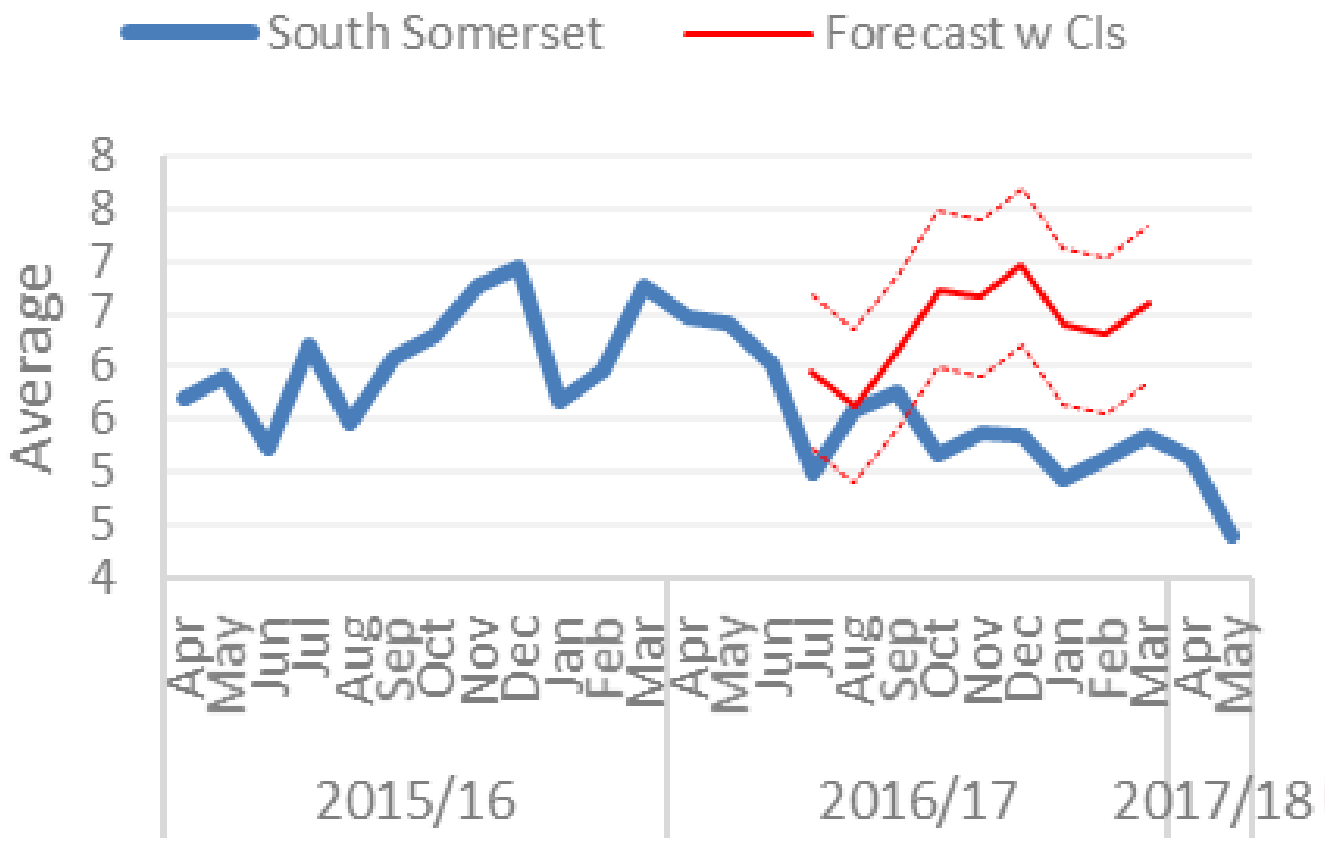
Non-elective bed days have been reducing for 17 months. Statistically significant reduction.



Excess Bed Days, Actual Activity



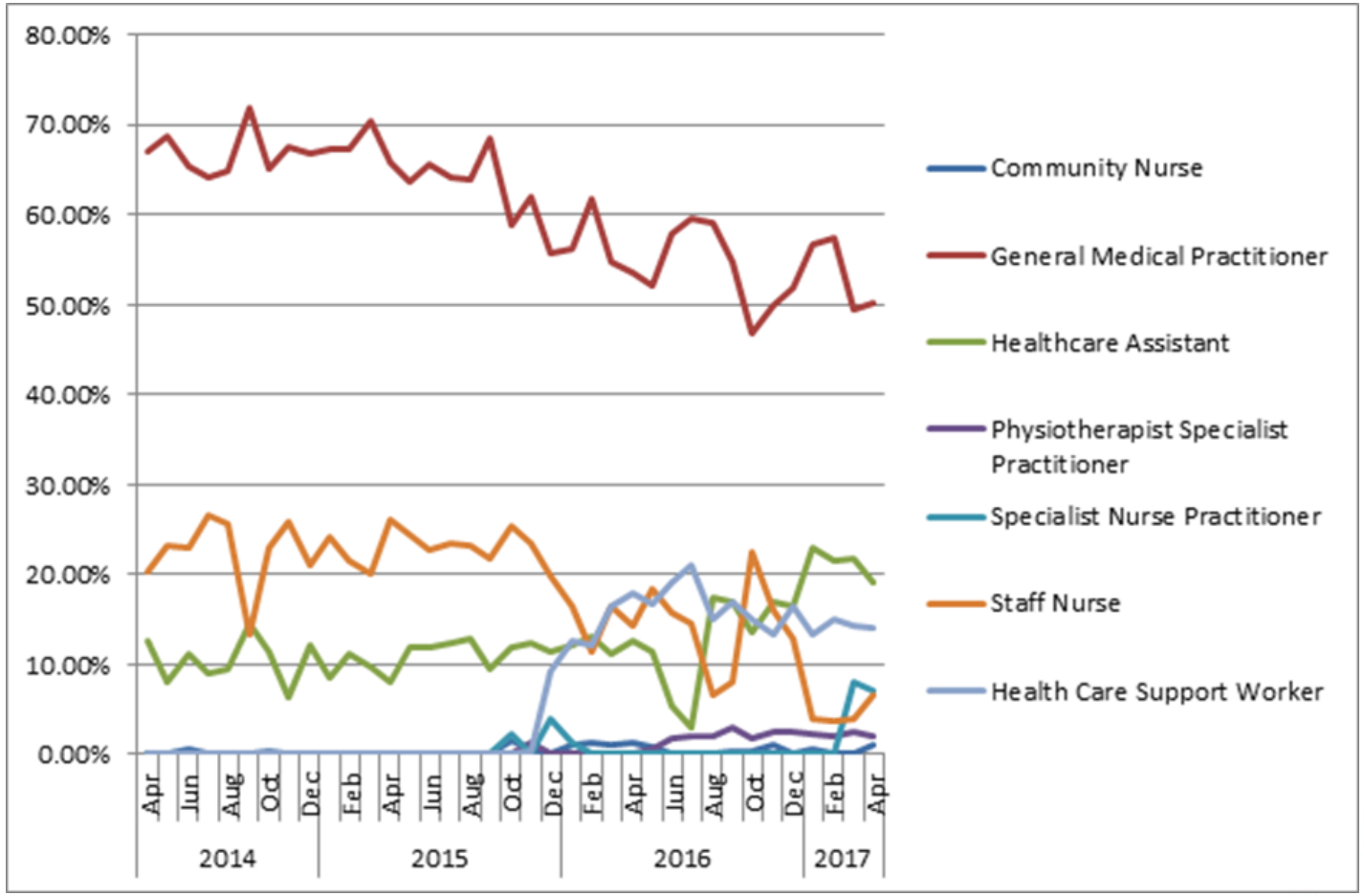
Average Length of Stay



Corroborating evidence

- System performance in South Somerset has improved significantly
- Pressure in hospital has eased – ward closed at Yeovil Hospital
- Yeovil Hospital consistently achieving waiting times targets since January 2017
- Delayed transfers out of hospital have reduced by 50%
- Consistently achieving diagnostics target

Impact on GP workload at Ryalls Park practice



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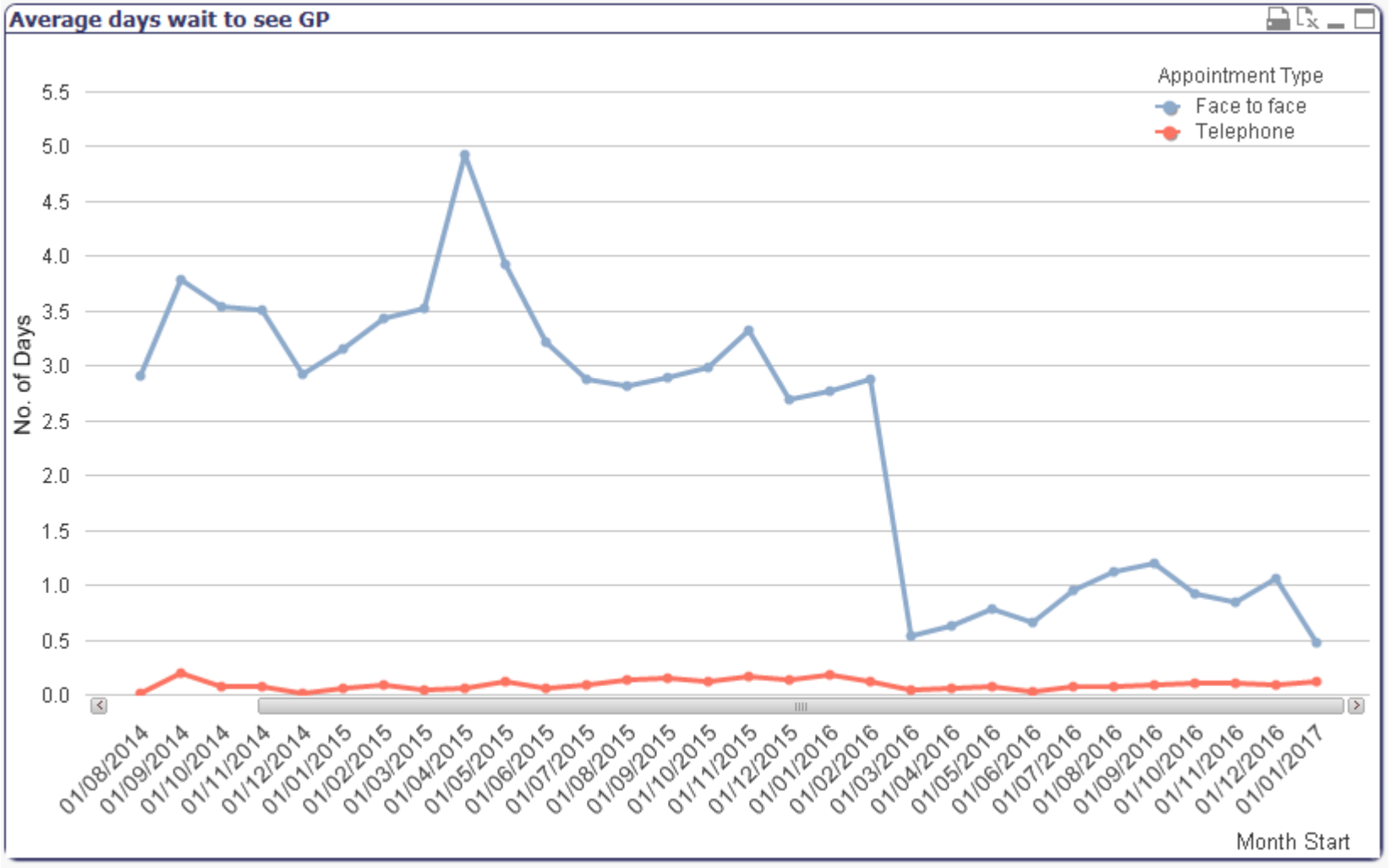
Impact on waiting times in Castle Cary practice



Video – A day in the life of a Symphony GP

https://www.youtube.com/watch?v=-YBNikPmEBM&feature=youtu.be

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For further information…

jeremy.martin@ydh.nhs.uk

www.symphonyintegratedhealthcare.com

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