NHS
South Worcestershire
Clinical Commissioning Group

A **New Model of Care** for South Worcestershire

Have your say

February 2016

Introduction

In 2014 NHS England published the Five Year Forward View which sets out the main challenges facing the NHS up to the year 2020. It gives a very clear message that the NHS, and the way people use the NHS, needs to change. This is because:

1. **People are living much longer with more complex long-term health conditions**
2. **Organisational boundaries between hospitals and primary care, and between health and social care, get in the way of how effective care is provided**
3. **There will be a funding gap because increases in health spending will not be able to keep up with increasing demands if services continue to be provided in the same way.**

These challenges will affect organisations across the country, not just those in South Worcestershire. However, we believe that if we organise services differently, and ensure that all parts of the health and social care system work together more closely, then we will be able to meet patients' health needs with the resources that will be available to us.

What needs to change?

We have worked with patients to identify which things need to change the most. One of the most important changes is to ensure that the various different health and social care services that some people use on a daily basis need to be coordinated better. Patients have told us that they don't want to be passed between teams. They only want to have to give basic information and tell their health story once. They also want people who are treating them to consider all their needs in one go, not just their individual health conditions in isolation.

The NHS does not currently do this very well. We treat patients' individual conditions, such as diabetes, effectively. However if a patient has diabetes along with a number of other health needs, we do not treat all of their needs in the most effective manner. Also, because different organisations treat different needs, patients are often passed between organisations for their care.

This is something we want to change for those patients that most need their care to be joined up.

If we can make these changes it will result in better care for patients. Care will be more coordinated between their local GP practice, hospitals, social workers, community nurses and ambulance crews. Information about patients' health will be shared more effectively between those who care for them. They will not have to repeat the same story to everybody that treats them and they will need to travel to hospital less because they will receive more care at home or close to home, such as at a community hospital or a GP surgery.

However, we know that this will require us to make some large changes to the way we work and it will require patients to get used to receiving services differently. These changes are known as a New Model of Care.

How will we make these changes?

The biggest change to our approach is based on a simple concept that organisations across the world use to run their businesses. It is known as segmentation, and it basically means that organisations provide services that are customised to specific groups. They do not provide the same type of service to everybody.

A good example of this is supermarkets. Today when people go shopping they can:

- Shop on-line for home delivery
- Click and collect
- Scan and shop
- Use a self checkout
  or
- Use a traditional checkout

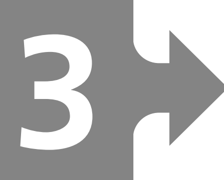
The basic principle is that customers have different needs and wants and the services provided to them are tailored to suit. There is not a single 'model' provided to everybody.

This is something that we believe we can learn from in the NHS. While we want to treat people as individuals, we can also group patients into different groups. For example:

1

People who are normally well or who effectively manage their own long-term conditions but have short-term health needs from which they either fully recover or which do not have a significant impact on their normal life. For example, women who have normal pregnancies and healthy babies, people who break an arm or a leg which requires an operation followed by physiotherapy, people who develop occasional illnesses that require medicines to be prescribed, or people who have a long term condition but manage their care needs without a great deal of external support

People who experience a significant illness from which they could recover, such as having a stroke or a heart attack. While their recovery might take quite a long time, a good recovery and a return to normal life is possible.



People who are normally unwell or who live with complex conditions that mean they have to rely on health and social care services every day or every week to be able meet their basic living requirements. This might include frail and elderly patients who require regular visits from GPs or district nurses, or younger patients who have very complex conditions that require them to attend hospital regularly for long periods of time.

People who have developed terminal illnesses or who are at the end of life stage and who will not recover from the condition which requires significant care and treatment for a period of time.

These are examples and not a definitive list. As we work with member practices, patients , carers and other stakeholders in the coming months we can add to this list to ensure that we target our efforts appropriately.

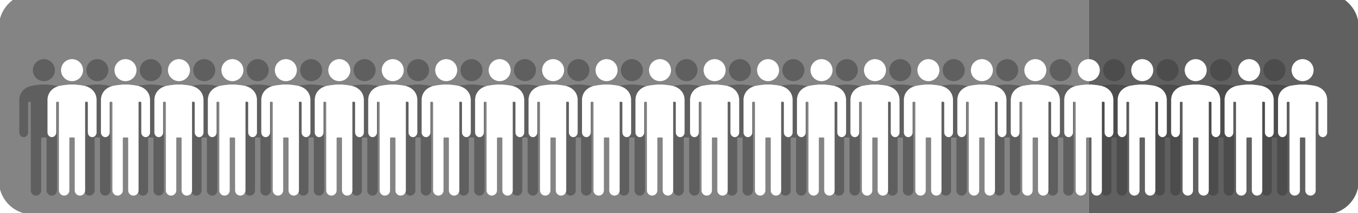
We believe that thinking about different patients' needs in this way will enable us to plan and provide services that treat those conditions better and at lower cost.

Focusing on our most frail patients

At first we want to start by focusing on those patients in group 3, but we are keen to quickly expand this to patients in groups 2 and 4. We will need to develop a different approach for patients who are in group 1, which will be worked on in more detail in the coming months. Initially, care for these patients is unlikely to change substantially for patients who are in these groups and as with the approach we have taken to date, we will seek involvement of patients to help us shape this approach.

We want to do this first because just 2 to 4% of people in groups 3 and 4 require services that account for about 35% to 40% of the money we spend on care. If we can organise services for this relatively small number of patients more effectively then we will be able to free up resources to improve services for everybody.

Least Frail | Most Frail



People in this group are either free from conditions that affect their daily living or manage them so effectively through self-care that they do not depend on NHS, council or voluntary sector services to maintain their daily living

They account for about 96% of the South Worcestershire population.

These patients are the most dependent on health and social care services.

They account for about 4% of the local population.

For patients in group 3 we want to create something that the NHS calls a 'Multispecialty Community Provider'. Basically this means that we want doctors, nurses, therapists and other staff who currently work in different organisations and from different teams to come together and provide care to those patients in a more joined up way. This team will aim to provide much more of the care each patient needs outside of hospital – ideally from the patient's own home.

The care provided by this team will also be paid for in a different way so teams will not have to pass a patient to other organisations to provide some of their care needs. At the moment, a patient experiencing a hospital admission for a condition that they have lived with for years could be treated by staff working for four or five different organisations working under six or more different contracts. While we recognise that how services are organised is not particularly important to patients, we know that the way in which services are organised can lead to the sorts of issues that frustrate patients the most. We are determined to change this.

In making these changes we believe that we will be able to focus more on the patient rather than the health and social care organisations that provide care to the patients.

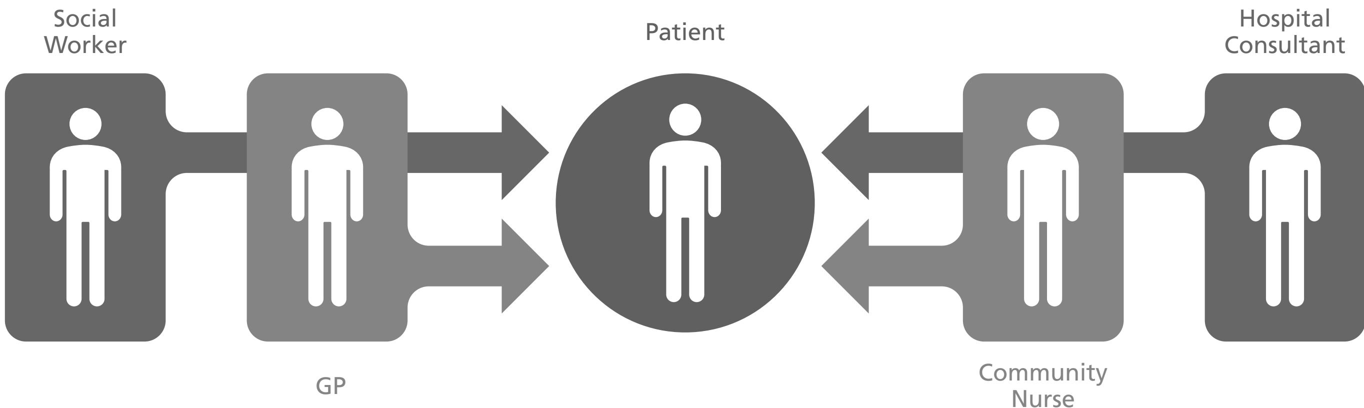
How will this model work?

We want to buy services through a smaller number of bigger contracts that encourage existing providers to work in a different way.

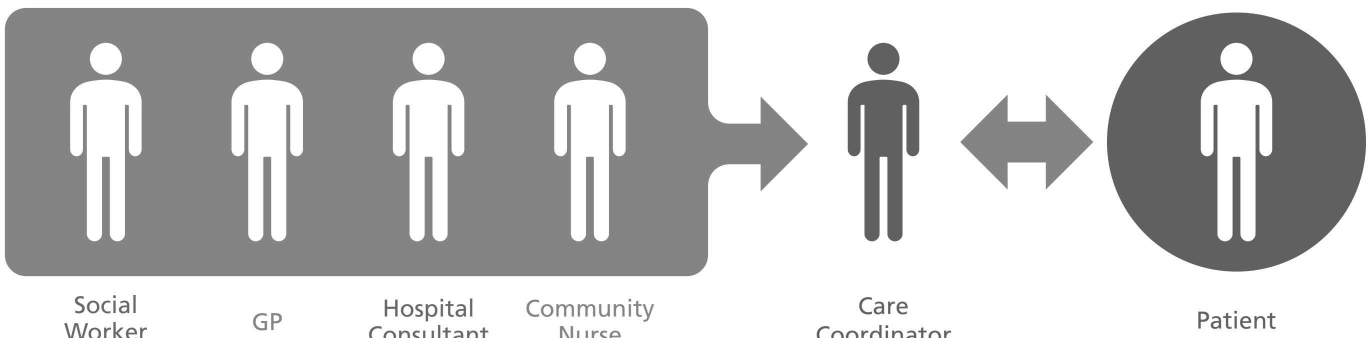
To achieve this we will work with doctors and nurses to identify the patients that will most benefit from this new approach and then identify how much we currently spend on services provided to these patients to develop a total budget for their care. We will then ask the organisations that provide the care to these patients to identify how they will provide the care in a better and more cost effective way.

Under this approach the care for these patients will be co-ordinated and overseen by one person in the team who is always the first point of contact for the patient.

Existing Model:



Going Forward:



What do we aim to achieve?

One aim will be to reduce the number of avoidable emergency hospital admissions, which are typically the most expensive forms of care that the NHS provides. Better care planning, more regular support and faster responses to situations when people start to become ill should help us to achieve this aim.

Another aim will be to reduce unnecessary duplication such as multiple home visits to provide different aspect of a patient's care needs when a different approach or additional training might enable one person to support a number of different needs in a single visit.

How will this benefit you?

From…	To…
…having difficulty making an appointment to see a GP who knows your health needs best, or not having enough time with your GP to discuss all your needs in one visit.	…having a specific phone line that is only available to patients like yourself. Through that phone line you will be able to book an appointment with one of a small number of GPs that work in a team and who know your health needs well.
… attending multiple hospital appointments for different health conditions and having several different visits at home.	… all appointments and home visits being coordinated and having a single key contact who provides your basic health and social care support.
… being passed from one organisation to another when dealing with each of your conditions and feeling like nobody is really interested in you as a person.	… seeing the same nurse, whether through a home visit or a trip to the surgery, and seeing the same GP who may work with the hospital consultant and be involved in your treatment when in hospital.
… telling many different people the same basic information and feeling that this information is not being shared.	… taking part in a single assessment and that information being shared with everyone who needs to know.
… spending many hours waiting in Accident and Emergency for a bed when you need hospital treatment.	… being admitted directly to a specialist ward where you are looked after by a team of people, including those who normally care for you when you are not in hospital.
… spending longer in hospital than you need to because people are trying to organise the care you need for when you leave.	… being able to leave hospital as soon as possible because the people looking after you will have already planned your care for when you leave.

We want to hear from you

Although we are only at an early stage of developing this model and there are still a lot of details to resolve, we are currently asking people who provide care and the patients who receive care what they think of this suggested approach. In particular it would be helpful to know what you think about the following:

1. **On page 1 we talk about what we want to achieve for patients. Do you agree? Is there anything important to you that we have missed?**
2. **On pages 2 and 3 we talk about grouping patients and focusing on the most complex patients to begin with. What do you think of this approach?**
3. **On pages 3 and 4 we talk about asking organisations who provide care to work differently and more closely together to improve care for patients. What do you think about this?**
4. **From what you have read so far, what other important things do you think we need to consider which we may have overlooked?**

How can I have my say?

You can let us know your thoughts by:

Completing the short questionnaire on our website at:

www.southworcsccg.nhs.uk/about-us/strategy/new-model-of-care/

Sending an email to:

ccgcomms@worcestershire.nhs.uk

Writing to us using the following Freepost address:

Freepost Plus RTCU-KZKZ-EJZZ, NHS South Worcestershire CCG, The Coach House, John Comyn Drive, Worcester, WR3 7NS

Please submit your responses before Monday 9th May 2016. When responding please let us know whether you are a professional, patient or carer.

If you would like to be kept up-to-date with further developments please make sure that you also provide your email address.

Where can I find out more?

You can find more information, including the full South Worcestershire Model of Care Strategy, on our website at:

www.southworcsccg.nhs.uk/about-us/strategy/new-model-of-care/

A New Model of Care
for South Worcestershire

Published FEB2016