The Symphony Programme, South Somerset

Care Models: Supporting Patients for Healthier Lives

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Who we are

17 GP practices in South Somerset
135,000 population

Working collaboratively….

With our partners:
  • Yeovil District Hospital
  • Somerset Partnership Community and Mental Health Trust
  • Somerset County Council
  • Voluntary sector (SPARKS)
  • Our Community
The problem

• Population demographics (next set of slides!)
• Limited resources: time; finance; workforce
• NHS recruitment crisis
• Struggling GP practices
• Unsustainable pressures
• Patient dissatisfaction with quality of care
• The same problems for GPs, hospitals, CC.
Proportion of the Somerset population aged 65+ by LSOA - 2003

Proportion aged 65 and over by LSOA 2003

- 50% or more
- 25% -
- 20% -
- 15% -
- Less than 15%

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Proportion of the population aged 65+ by LSOA - 2013

Proportion aged 65 and over by LSOA 2013
- 50% or more
- 25% -
- 20% -
- 15% -
- Less than 15%

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Proportion of the population aged 65+ by LSOA - 2023

Proportion aged 65 and over by LSOA 2023

- 50% or more
- 25% -
- 20% -
- 15% -
- Less than 15%

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Proportion of the population aged 65+ by LSOA - 2033

Proportion aged 65 and over by LSOA 2033

- 50% or more
- 25% -
- 20% -
- 15% -
- Less than 15%

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Multi-morbidity is common at all ages, but becomes more prevalent the older you get.
Cost increases quickly with more conditions, mostly in hospital inpatients.
### Impact of General Practice on Health and Social Care System

**Typical South Somerset Practice**

<table>
<thead>
<tr>
<th>Category</th>
<th>List Size</th>
<th>Cost per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GP Funding</strong></td>
<td>6,380</td>
<td><strong>£160</strong></td>
</tr>
<tr>
<td><strong>Prescribing</strong></td>
<td>4,340</td>
<td><strong>£210</strong></td>
</tr>
<tr>
<td><strong>AC: A&amp;E</strong></td>
<td>660</td>
<td><strong>£140</strong></td>
</tr>
<tr>
<td><strong>AC: O/P</strong></td>
<td>1,990</td>
<td><strong>£340</strong></td>
</tr>
<tr>
<td><strong>AC: I/P elect</strong></td>
<td>630</td>
<td><strong>£1,940</strong></td>
</tr>
<tr>
<td><strong>AC: I/P urgent</strong></td>
<td>490</td>
<td><strong>£2,770</strong></td>
</tr>
<tr>
<td><strong>SC: Home+Day</strong></td>
<td>70</td>
<td><strong>£5,100</strong></td>
</tr>
<tr>
<td><strong>SC: Resi</strong></td>
<td>30</td>
<td><strong>£12,500</strong></td>
</tr>
<tr>
<td><strong>SC: other</strong></td>
<td>130</td>
<td><strong>£2,550</strong></td>
</tr>
<tr>
<td><strong>MH: O/P</strong></td>
<td>120</td>
<td><strong>£2,230</strong></td>
</tr>
<tr>
<td><strong>MH: I/P</strong></td>
<td>10</td>
<td><strong>£20,600</strong></td>
</tr>
<tr>
<td><strong>CC: IP</strong></td>
<td>30</td>
<td><strong>£9,790</strong></td>
</tr>
<tr>
<td><strong>CC: other</strong></td>
<td>1,010</td>
<td><strong>£250</strong></td>
</tr>
</tbody>
</table>

**Total:**
- **£1.02m**
- **£0.93m**
- **£3.35m**
- **£1.02m**
- **£0.48m**
- **£0.58m**
- **£7.38m**

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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).
Population segmentation leading to new care models

- **Complex patients with many conditions**
  - 4% of population (~5k)
  - ~50% of cost (~£75m)
  - Complex care hubs

- **Less complex patients with fewer conditions**
  - 18% of population (~20k)
  - ~35% of cost (~£55m)
  - Enhanced primary care

- **Mainly healthy patients**
  - 78% of population (~90k)
  - ~15% of cost (~£20m)
  - Proactive health and wellbeing support
Enhanced Primary Care (EPC) Model
Patients supported by health coaches and numerous 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

Network of Services
- Acute Care
- Advanced Diagnostics
- Care Home
- Other services...
Health Coaches: What they do?

• 52 HCs in 17 practices supporting 10,000 patients
• Patient Activation (PAM scores)
• First point of contact
• Patient support
• Patient advocacy
• Healthcare Navigation
• Link to community and social resources
• Care co-ordination
• Managing practice huddles
Complex Care (CC) Service Model

Patient assigned a care coordinator and offered intensive care, support and attention through a number of services

**Key Elements**

- Comprehensive assessment of physical, mental health and social care needs
- Support and coaching for patients and carers
- Co-ordination of integrated pathway
- Routine contact and monitoring of patient’s health and care needs
- Proactive development of personalised health and social care escalation plans
- Rapid crisis response

**Extended Care Team**

- Mental Health
- Social Care
- Therapies e.g. Physio
- FOPAS (Crisis Support)

**Care Programmes**

- Diabetes
- Respiratory
- CHF
- Dementia
- Other...

**Network of Services**

- Acute Care
- Advanced Diagnostics
- Care Home
- Other services...

**Core Care Team**

- GP
- GP Extensivist
- Complex Care Nurse

**Key Worker**

- Complex, Poly-chronic Patients
Symphony
Integrated Healthcare

Secondary Care with support from Extensivist and Nurse Practitioner

Extensivist
Nurse Practitioner
Involvement from wider MDT & GP

GP
Complex care nurse
Key worker
+/- Extensivist

GP
Health Coach
Practice Nurse

GP

LEVEL OF NEEDS

Acute
High Complexity
Medium Complexity
Low Complexity
No Complexity

In reach support from Complex Care
Supported discharge

Comprehensive Review
Update care plan
Escalation plan
Crisis intervention
Alternative to admission (planned)

Comprehensive Care Plan
Co-ordination of services
Health Coaching
Access to Extensivist advice

Basic Care Plan
Health Coaching
Lifestyle advice
Chronic Health Registers

Self Care

PROPORTION OF THE POPULATION
Changes to how care is delivered

- Physios, pharmacists, ECPs (paramedics), dieticians, and mental health workers working in practices
- Huddles involving practice team, CC, social services, DNs, Rehab. Team, CPNs, link workers
- Health Coaches focus on the whole patient and non-medical model of care
- Specialist Nurses and Consultants doing virtual clinics in practices
- Systematic care planning for all 75s beginning, initially focused on care homes and complex/frail patients
- Direct helpline and training programme available to care home staff
- Community hubs linking third sector to practices and community services
Community Development

• Community partnerships: Wincanton, Martock, South Petherton, Yeovil
• Click Into Activity Programme (CLIC Federation)
• Webinars on IBS led by dieticians
• Social prescribing/connecting (based on Mendip Health Connections model):
  • Wellbeing Directory
  • Community Signposting workshops
  • Peer Support Groups
  • Community Ambassadors
Activation improved in 71% of lowest activated patients
20% reduction in appointments done by GPs
11.5% reduction in hospital bed days (Vs historical annual increase of 6-8%)
The future

• Continuing development of neighbourhood teams covering 30-50,000 patients
• Expanding social prescribing and care planning
• Helping to spread similar models across Somerset
• Sharing our story, learning from others, helping other areas replicate the model if desired
• Empowering people to live healthier lives

Thank you for listening!