# Developing New Models of Care in Dudley

Dr Steve Mann, Clinical Executive
Dudley CCG

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# OUR PRINCIPLES OF MUTUALITY

***1. Shared ownership*** – the NHS is owned by the public. Each patient registered with a Dudley practice is therefore a member of Dudley CCG. All public services are similarly owned by UK citizens.

***2. Shared responsibility*** – all service users and all staff have a shared responsibility to work together to co-create the best healthcare and well-being provision.

We also we want to shift responsibility from 'the system' providing care to dependant individuals, to instead achieve mutual responsibility whereby health, social care and wellbeing are co-produced with people.

***3. Shared benefits***- the benefits of the Council, NHS and other public services are mutually shared between stakeholders.

We aim to achieve defined outcomes – both for the whole community in improving overall health and wellbeing; and for individuals in their personalised care and wellbeing.

**Maximising the potential of:**

- The individual (in their community)
- Our staff in supporting the individual
- Our staff working effectively with each other

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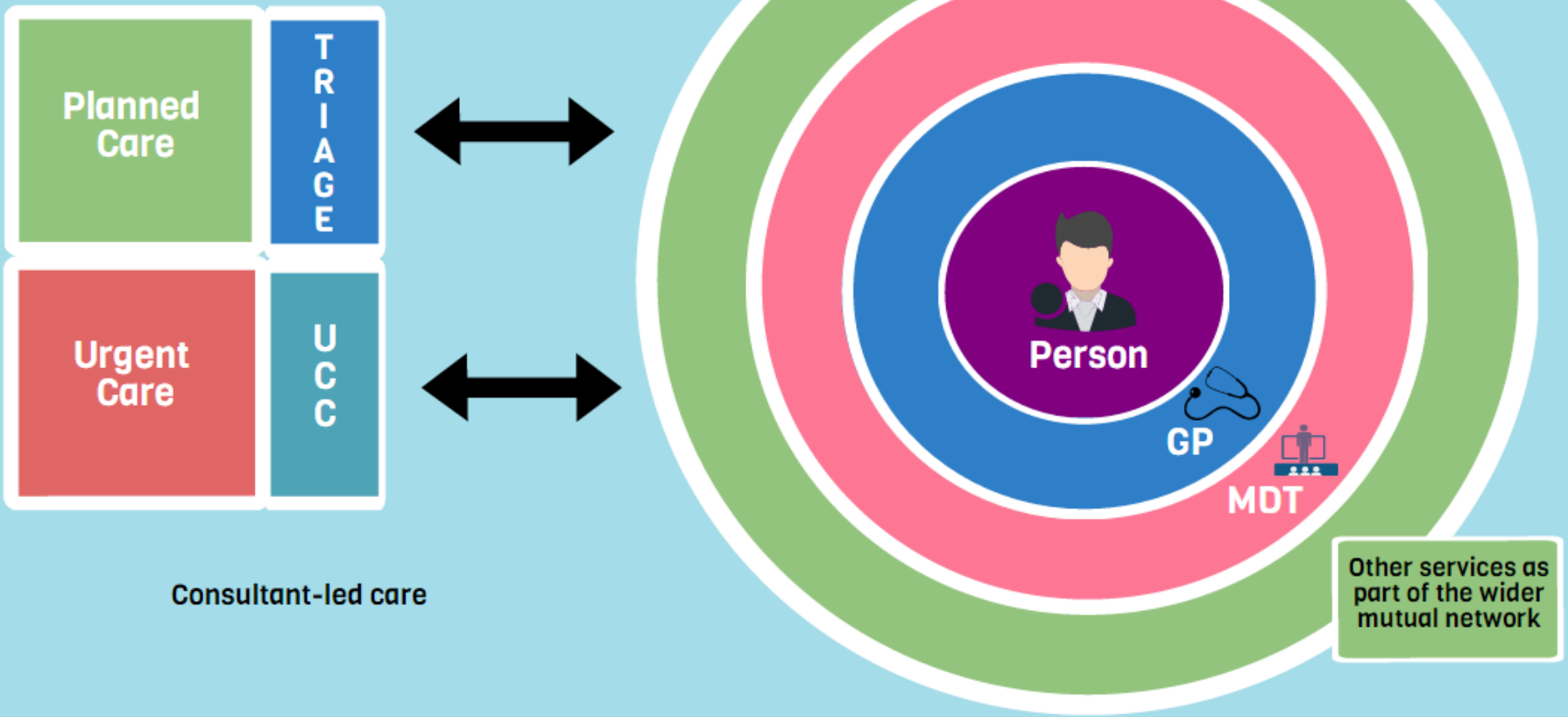
# Our Model

MCP : Commissioning Shared Outcomes

Value added treatments : Commissioning best practice pathways




Consultant-led care

GP - Led care

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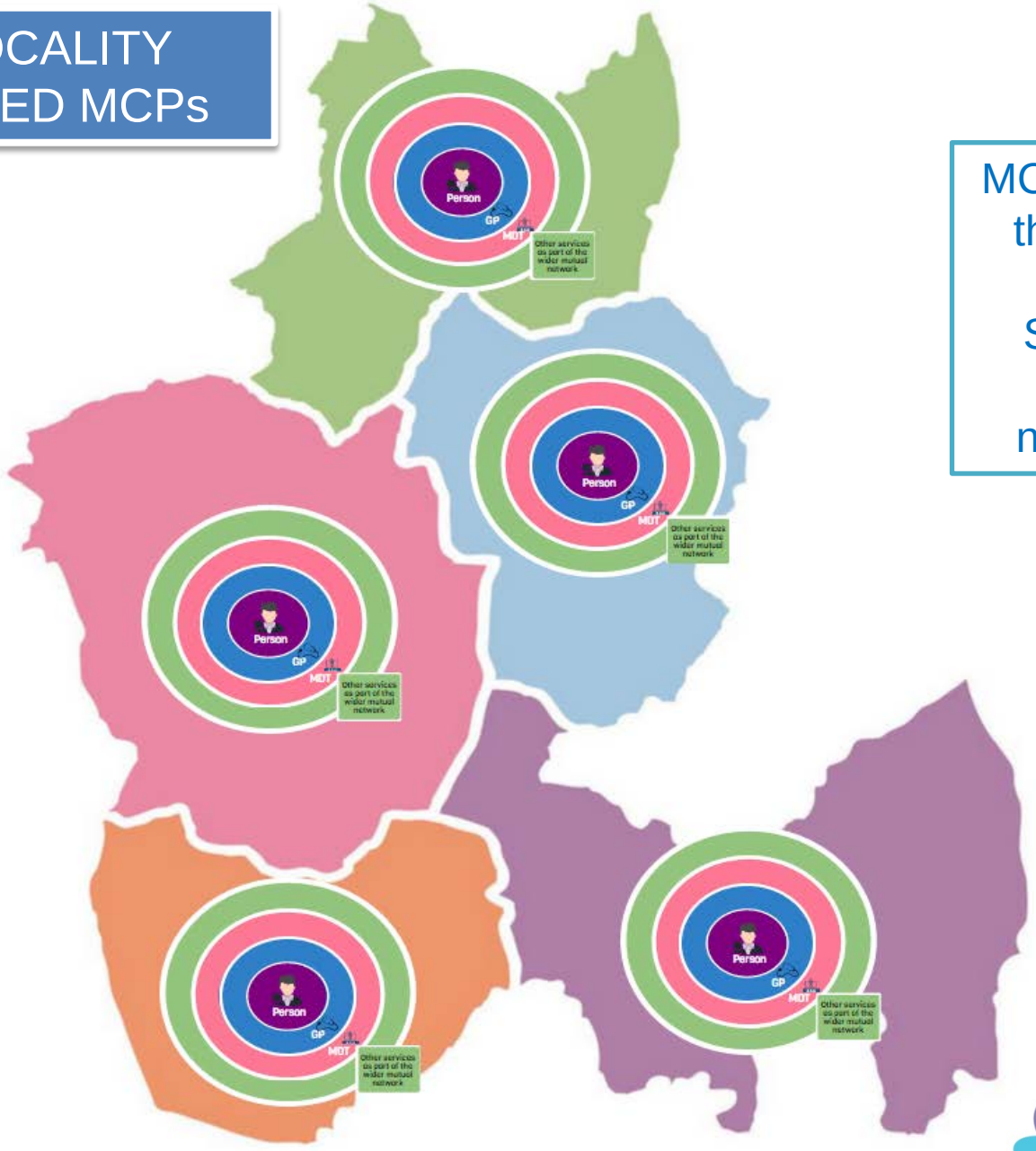
# LOCALITY BASED MCPs




MCPs connected to their community.

Supported by a wider mutual network of care.

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# PUBLIC VIEWS


Healthcare Forum
5th March 2015

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# PUBLIC VIEWS

**Access**

- More flexibility in booking GP appointments
- Easier access 7 days a week

**Continuity**

- Continuity of person for engaging in my condition- recent access survey showed a significantly higher proportion of Dudley registrants having a preferred GP than national averages
- Recognising that carers are patients and have needs to – we need more support

**Coordination**

- A more integrated and person centred approach to health and social would be a great positive move forward
- We like the fact the CCG are trying to improve quality and the way it works by more integration with the people in the borough

**Communication**

- Communication between agencies is vital
- We want joined up services with no delays in care or treatment
- Poor communication between GP and hospital or delays between the both leading to unnecessary waiting and anxiety

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# DEVELOPMENT OF THE MODEL

| | General | Long-term Conditions | Frailty and EOL |
|---|---|---|---|
| System | New Urgent Care Centre; specialist triage services; real-time access to consultant opinion | Consultants providing advice / support working in the community to the same outcome basis | Geriatricians supporting MDT-led frailty pathway, removing all transfers of care |
| Locality | Developing community-hubs to improve accessibility 7 days a week | Telehealth; direct access to services; Connecting to other public services and the voluntary sector | Lead GP co-ordinating locality approach; Falls prevention; telecare; dementia gateways, integration plus, care homes |
| Practice | Near patient testing; Avatar system for enabling access | Named primary point of contact | MDT as the locus of coordination |
| GP | GMS + | LTC framework, outcome based, prioritising hypertension and depression | GP as Lead co-ordinator of care |
| **Person** | **Accessibility** | **Continuity** | **Coordination** |
| Outcomes | Improved patient experience, More efficient and effective utilisation, healthier lifestyles | Stable management of conditions, reducing risk, reducing variation and the health inequalities gap | Reduced social isolation, Enabling individuals to remain in their home and connected to their community |

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# DRIVERS FOR CHANGE

**Dudley Population Health Status & Health Inequalities**

**Long-term Conditions**

- 20% of our population have a limiting long term illness
- Widening life expectancy gap due to CHD,COPD and Lung Cancer in men
- Gap in life expectancy across Dudley of 8.2 years
- A quarter of deaths in 40 – 59 age band are due to CVD, smoking, obesity, cardiovascular disease and lack of physical activity
- Recorded disease prevalence rates are lower than modelled prevalence rates

**Frailty and social isolation**

- In two decades time there will be, 25,100 more people 65+ & 9,900 85+
- 20% of single person households are in 60+ age group
- An increasing number of older people are carers of older people

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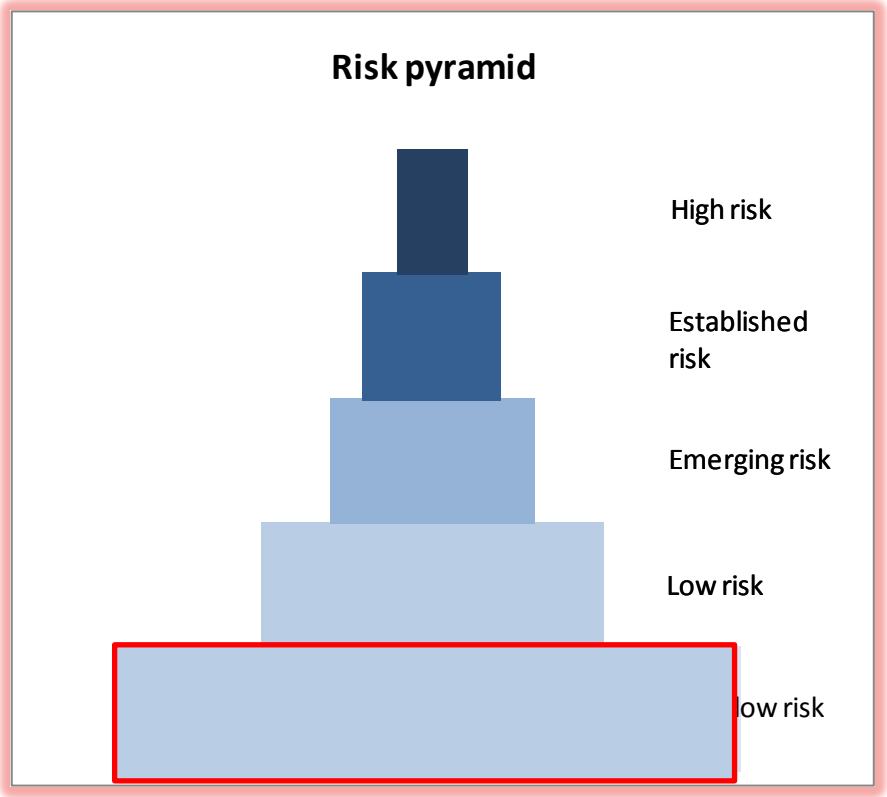
# Very low risk (n = 251,835)




**Key population characteristics:**

- Majority young people or early middle-age
- Virtually no sign of frailty
- Few or no chronic conditions detected
- Of those with morbidities majority are MSK, ENT and Skin diagnoses
- 88% of the total population, but only 50% of total resource utilised
- Low costs per head (£402), not predicted to rise or fall over next 12 months
- Low current levels of IP, OP and A&E usage
- Very small probabilities of acute activity and pharma costs in next 12 months.

**Intervention approaches:**

- Key health messages – 'Do it Right Dudley'
- Primary prevention CVD
- Lifestyle interventions – Health Champions in schools, Health Improvement for our staff, physical activity & sports action plan
- Accessibility to diagnosis – improving access, virtual access and near patient testing

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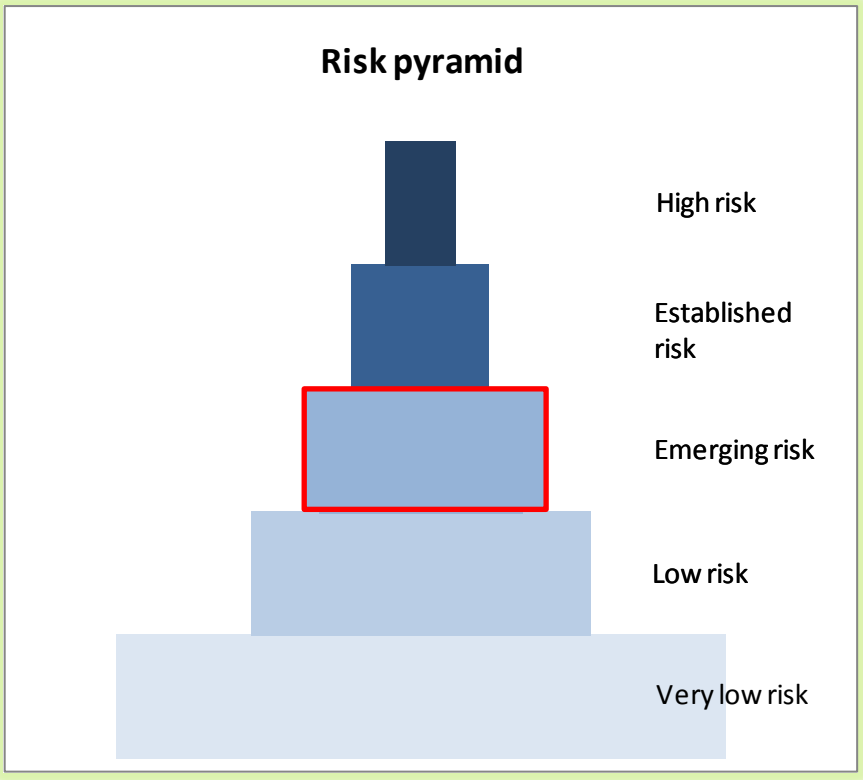
# Emerging risk (n = 6,273)




**Key population characteristics:**

- Vast majority 65+ years, more females
- 1 in 3 now have 1 or more frailties at this stage
- 50% now have 5+ morbidities
- Of those with morbidities majority are CVD, MSK and endocrine diagnoses
- 2.2% of the population but 11% of healthcare costs
- Costs per head £2,854, although predicted to rise by £195 in next 12 months
- Average 7 OP encounters per patient and 1+ IP spells. 1 in 2 will have A&E 'episode'
- Still relatively small probabilities of acute activity in next 12 months.

**Intervention approaches:**

- Regular Health checks across whole risk band
- Telehealth to support the person in the management of their long-term conditions
- An established main point of contact for each individual
- Consultant input into community delivery for key conditions

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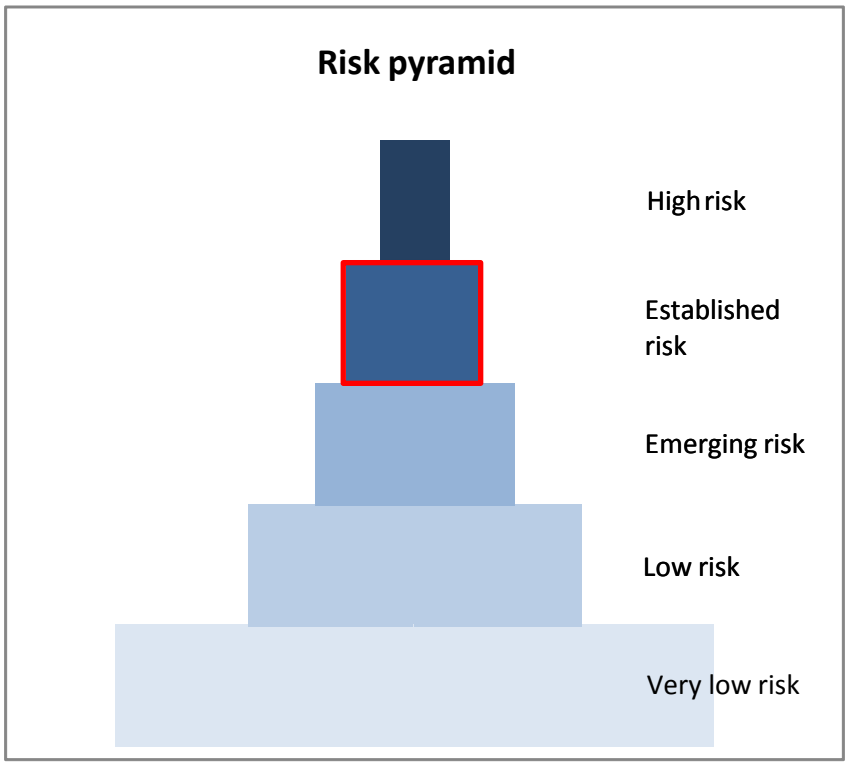
# Established risk (n = 4,278)




**Key population characteristics:**

- More even age distribution but most with several established chronic conditions
- 4 in 10 have at least one frailty marker
- Of those with morbidities majority are CV, MSK & endocrine although renal now prev.
- 1.5% of the total population, but 9% of healthcare costs utilised
- High avg. costs per head (£3,656), predicted to rise by 20% in next 12 months
- OP and IP spells now fairly regular, A&E usage approx 1 per patient during year.
- 1 in 3 likely to have IP spell < 6 mths and over half likely to have high pharma costs in next 12 months

**Intervention approaches:**

- Care Coordination provided by the MDT
- Telecare underpinning support provided by MDT
- Falls prevention
- Frail elderly pathway which brings physician support to MDT

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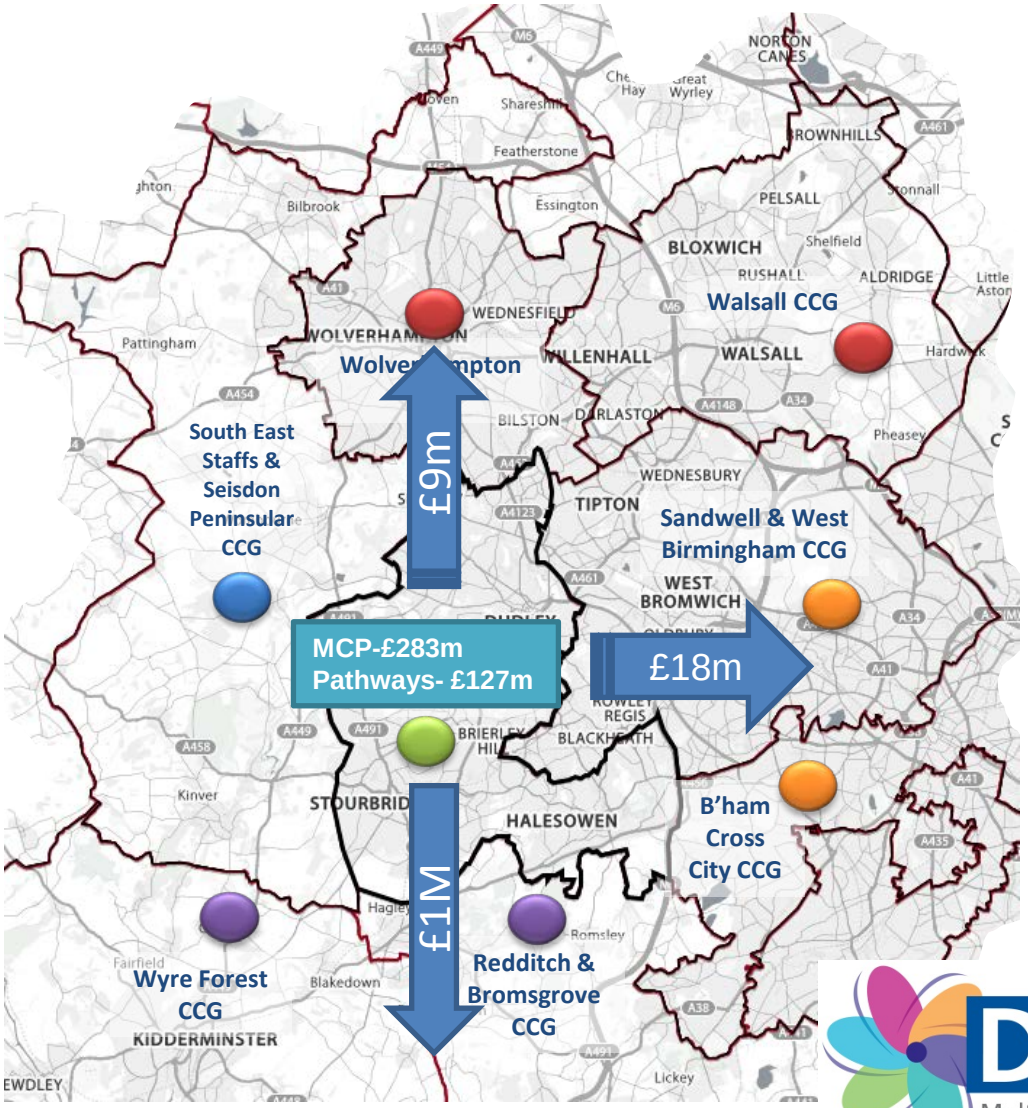
# WE ARE NOT A CLOSED SYSTEM - ACTIVITY OUTFLOWS

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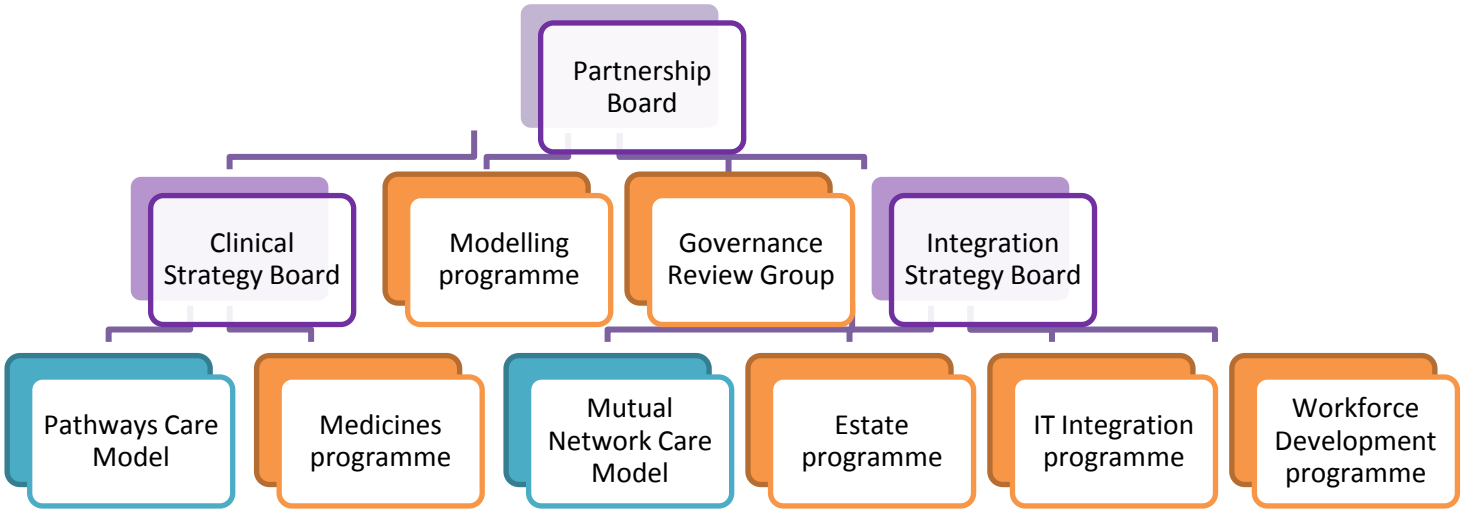
# Our Governance Structure

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Multi specialty Community Provider Group

1
2
3
4
5
Connected to community and person through locality MCPs

Clinical relationships, Information & Patient flow

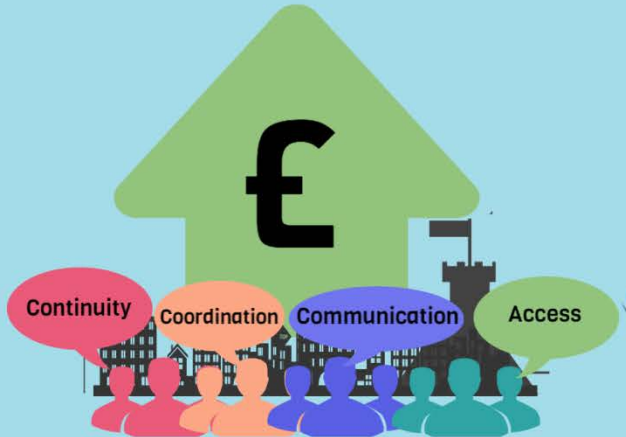
Planned Care
TRIAGE
Urgent Care
UCC

Delivery population based Health & Social Care

Funded on capitation based outcomes : Access, LTCs, Continuity & Coordinaation

Funded on best practice pathways with defined outcomes.

CCG
Local Authority

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# Describing Success – What People are saying

"Due to this disability I have had to give up work and I am now virtually housebound. The link officer has opened up a lot of possibilities for me by encouraging me to become involved with a number of activities which has been a massive help to me, she has done really well and it has made a huge difference to my life."

"I could have just stayed at home and given up. I wished I would have known about this five years ago. I've got what I really want, it's lifted me and I have a laugh. I can feel a change in myself – I feel more alive to be honest. If I hadn't have gone to the doctors and been referred to Integrated Plus none of this would have happened, its Jason's help that's got me here and I thank him very much".

"I feel safer now, really secure. The (Integrated Plus) service is fantastic – although my GP had tried to help I was getting nowhere. They are someone to turn to when you feel you have no one and I can't thank Terry enough. Since he came on the scene it's all gone one way, and that's up. He made me aware of places I didn't even know existed and I dread to think what my situation would be if he hadn't helped me. If I can give a mark to represent his support it would be 10 out of 10, he has given me a lot of backing. I'm really chuffed".

"(Link Officer) has helped me a lot, he has given me my confidence back. He is a very kind person. I am getting on well with people and beating everyone at pool. My life is getting better and I feel I will get back into work."

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