# 5 year Forward View and New Models of Care

# Five Year Forward View

**NHS England: Five Year Forward View**

**Efficiencies** of 3% per year over next 5 years, but there *are* viable options for sustaining and improving the NHS based on new partnerships

**Prevention** still needs more serious backing if we are to avoid sharply rising burden of avoidable illness

**Focus on needs of aging population** and break down barriers between health and social care

**Greater control for patients** and carers over their own care

**'New deal' for GPs** with more investment in primary care, while stabilising core funding for general practice nationally

**Local flexibility** on small number of 'radical new care delivery options': **Multi-speciality community providers (MCPs) –** led by GPs, serving populations of 50,000, combining primary, social and community care (but not acute services)

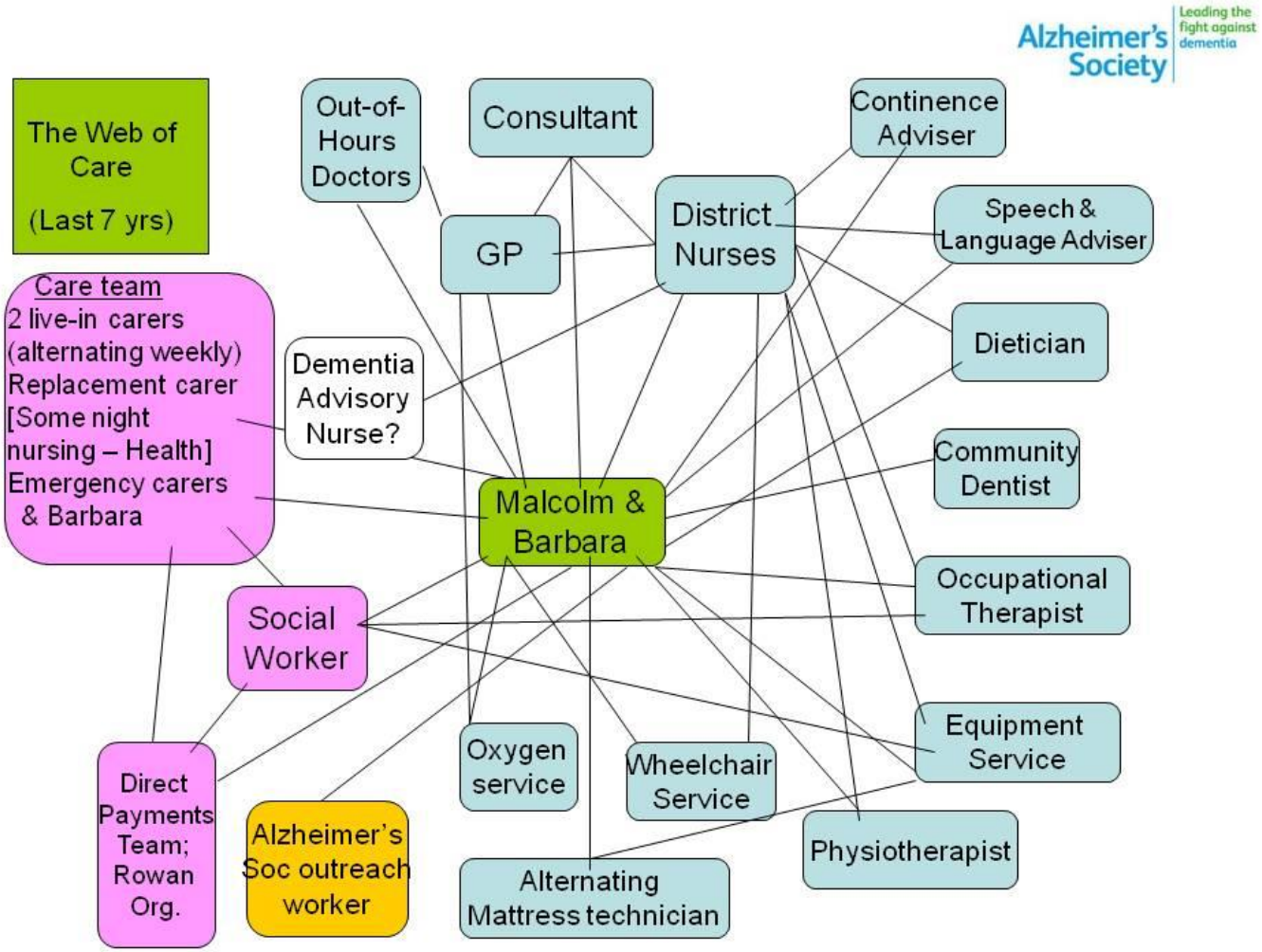
**Integrated Primary and Acute Systems (PACs) –** vertical integration of whole pathway from primary to acute care.

**Dalton Review** is proposing range of options for smaller hospitals to become 'vanguards' and implement these new models in 2015-16

# Five Year Forward View Models

| | |
|---|---|
| **Multispecialty Community Providers** | • Blending primary care and specialist services in one organisation<br>• Multidisciplinary teams providing services in the community<br>• Identifying the patients who will benefit most, across a population of at least 30,000 |
| **Integrated primary and acute care systems** | • Integrated primary, hospital and mental health services working as a single integrated network or organisation<br>• Sharing the risk for the health of a defined population<br>• Flexible use of workforce and wider community assets |
| **New approaches to smaller viable hospitals** | • Coordinated care for patients with long-term conditions<br>• Targeting specific areas of interest, such as elective surgery<br>• Considering new organisational forms and joint ventures |
| **Enhanced health in care homes** | • Multi-agency support for people in care homes and to help people stay at home<br>• Using new technologies and telemedicine for specialist input<br>• Support for patients to die in their place of choice |

# Services designed around the people that need them?



**Financial background**

- 3.8% efficiency challenge-currently under challenge-expected that savings of 3% plus required year on year
- Analysis of Monitors considerations shows that this is not deliverable through current organisational forms
- Additional funding used to close allocation gap-North East lose out
- Overall deficit across provider sector about £1bn
- Forecasts for 2015/16 that this will deteriorate
- Most North East providers forecasting a deficit in 2015/16
- Local Authorities continue to forecast significant reductions in social care spending of up to 33% over the next four years
- And don't forget..forward view talks about £30bn gap over next five years, excluding social care-the ask for funding is only £8bn

# At the Same Time…

Mid-staffs

Baby P

Winterbourne


Public Accounts Committee

Daniel Pelka

Keogh

# Better Care Fund-National Summary

- £200m for Local Authorities in 2014/15
- £3.8bn pooled budget in 2015/16 (Section 75 of the NHS Act 2006)
- £1bn of £3.8bn 'payment by performance' in 2015/16
- Final submission must be signed off by Health and Wellbeing Board

**Plans must deliver on national conditions:**

- Protecting social care services
- 7-day service to support discharge
- Data sharing and the use of NHS number
- Joint assessments and accountable lead professional

**Pay for performance is based on:**

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service-user experience
- Locally determined metric

# Dalton Review of Provider Models

***Thesis***

**Providers need wider range of organisational forms to meet current & future challenges**

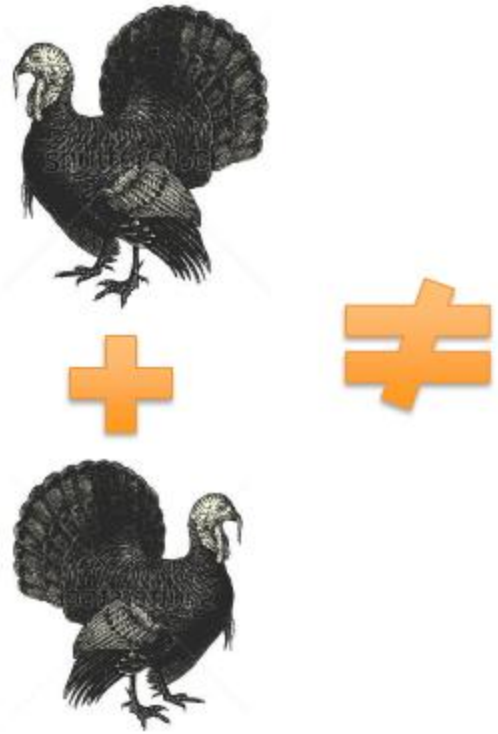
***Four key messages***

- **Excessive variation in care quality unacceptable**
- **Existing way of doing things no longer sustainable**
- **Use of a wider range of provider organisational forms can be one way of meeting provider challenges**
- **Providers and NHS system leaders need to systematically work through how we can get wider take up of these models**

# Potential Impact of Dalton Review


- Greater use of wider range of ownership models at enterprise and single service / groups of services levels
- Transaction approvals process speeding up
- JVs beyond pathology e.g. SWLEOC
- Vertical integration (e.g. Tameside)
- Greater use of management franchise model post election??
- More mergers / emergence of chains???

# But organisational ownership is not a panacaea



Merging two turkeys doesn't make a phoenix

Sustainability issues in provider sector likely to make acquisition / merger / chains a less attractive proposition

- There are four pillars to the DH response to 5YFV
  - A strong NHS needs a strong economy
  - Make a reality of integrated care closer to home
  - Unleash efficiency
  - Getting culture right for dignity and respect
- Focus on accountability – e.g. named clinicians, hospital coordinators, taking responsibility for the patient as a whole
- Focus on new approach to performance management – from targets & money to outcomes and a learning culture that builds on the desire deep down inside every staff member to deliver high quality care.
- Move from a culture of Stalin to Gandhi. From a culture of compliance to a culture of commitment.
- Extra £2bn for 2015/16 in response to 5YFV
- Continue status quo, steady progress to integrate health and social care

Jeremy Hunt,
Health Secretary

**Service Transformation Panel Recommendations**

- More pooling of resource and integration around people with multiple, complex needs – ‘deals on cohorts’
- Integrated inspection regimes to encourage collaborative service provision
- Aligning transformation funds as part of creating £5 bn fund, with funding matched to risk
- Firm commitment to multi-year budget allocations
- Further financial decentralisation and accountability for places that are ready
- A Bill to ensure better information sharing for shared outcomes
- Better use of digital technology and data analysis
- Commitment of Whitehall capacity to co-design transformation in places
- ‘What Works Centre’ for transformation
- Smarter use of assets across a place
- Stronger, more collaborative leadership - both nationally and locally

# King's Fund

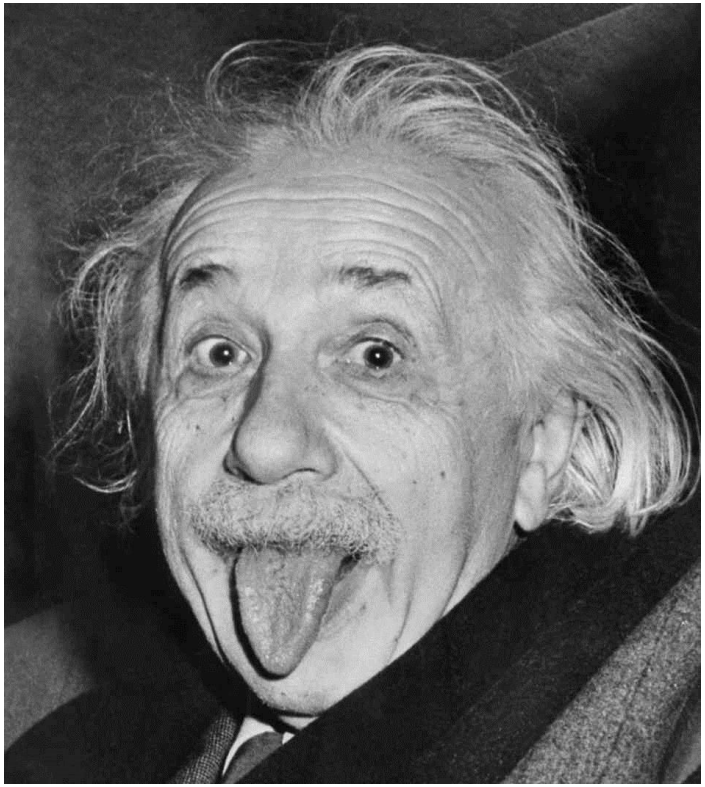
(Acute Hospitals and integrated Care 2015)

- Vision described in 5 year forward view highly ambitious-Developing PACS particularly challenging
- Where success had been achieved in this area it is over years of clearly focussed and consistent effort
- In many areas a blend of models will be appropriate
- Dangerous to simplify into primary care led or hospital led integration

# Are we going to go round the same loop?


Source: Gareth Morgan

# We might….



*“Insanity is doing the same things over and over, expecting to get a different result”*

*“Problems cannot be solved by the same level of thinking that created them”*

# Benefits and Opportunities of Integration

- Outcomes
  - 40% of people in secondary mental health services visit A and E each year (South of Tyne PCT 2010)
  - 12-18% of cost of long term care expenditure associated with mental health issues (Kings Fund)
  - Co-morbidity with mental illness increases cost of care for physical health conditions by 45-75% (Kings Fund)
  - People with SMI die 15-20 years earlier due to unassessed and untreated COPD, Diabetes, Cancer, High BP (National Audit of Schizophrenia)
  - Psychiatric crisis often associated with crisis in social care, welfare, housing
  - Cost effective/co-ordinated prevention and early interventions across health and social care deliver significant returns (Knapp et al 2011)
  - Recovery requires an individual to exert control over their lives, to self-manage, to be a part of shared decision making (IMROC). This requires a simpler, integrated system of care
- Systems
  - Simplified, understood access points, with clear signposting to the right care
  - Co-production of assessment and care planning (agencies, service user and carer) according to the needs of the service user
  - Standardised approach to interventions, pathways and supports, with agreed goals
  - Standard protocols and systems across organisations for the request and delivery of expert help (scaffolding), at the time it is needed by the service user
  - Effective transition planning, built into the assessment process and actively managed through the care pathway
- Organisation
  - Removal of waste
  - Long term sustainability of services

# Risks and organisational concerns

- Protectionism or failure of other parts of the system, leads to default de-funding of mental health and disability services
- Organisational structures change without defining benefits to the population, leading to focus on organisational design rather than care and support pathways
- Lack of capacity to change
- Failure to collectively manage the system leads to resource and service failure
- Lack of imagination, leadership and drive leads to the creation of more complex systems
- Many solutions are untested, and therefore evidence base needs to be created
- Timescales for delivering whole system change are significant and require consistency of purpose
- Changes will challenge professional, managerial and organisational interests
- Over focus on elderly frail, rather than complex needs and co-morbidity irrespective of age
- Over focus on complex solutions as pre-requisite for change rather than identifying simple solutions to address system problems (IT as example)

# System Barriers

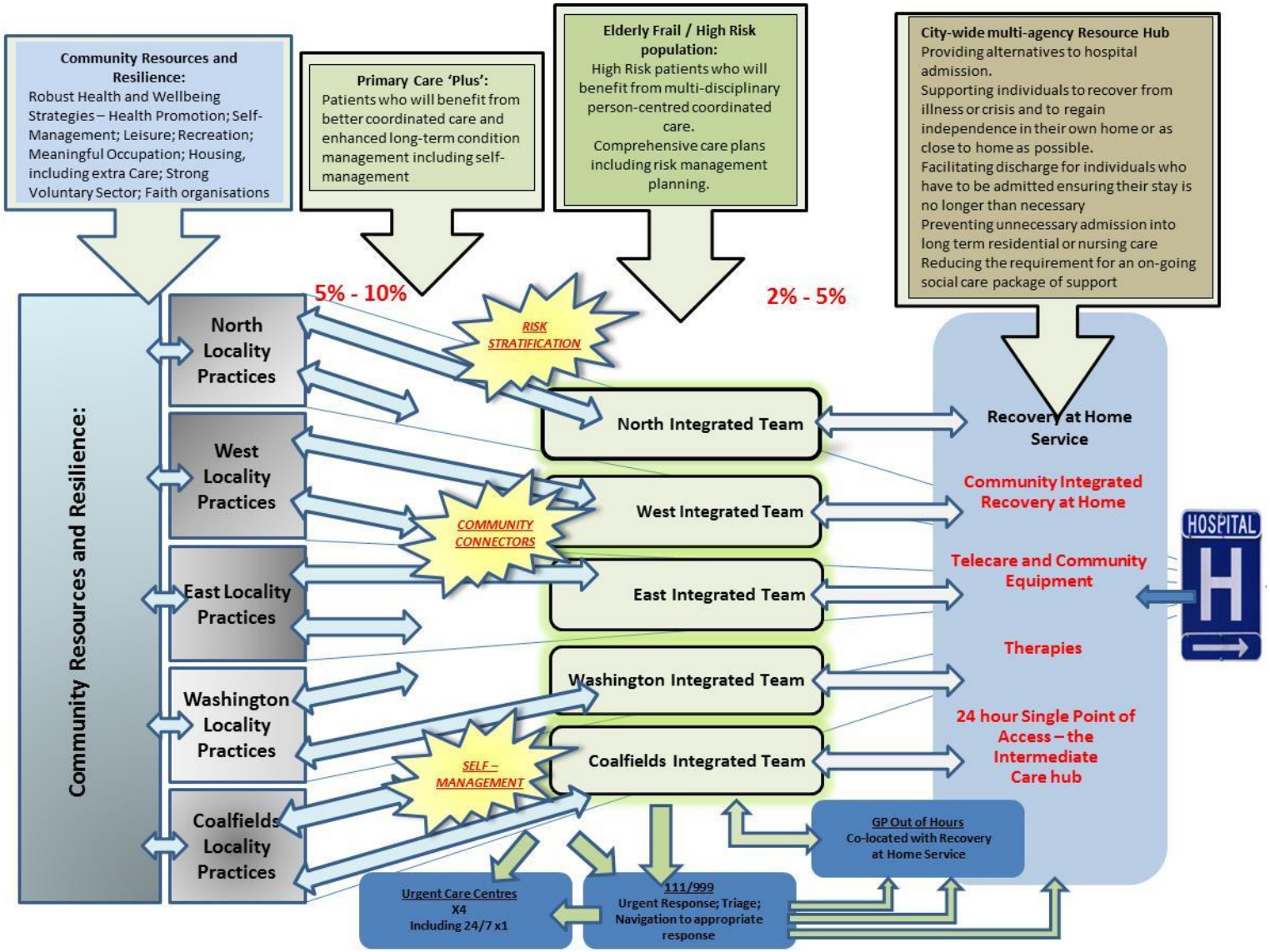
- Lack of alignment of incentives, penalties and targets
- Lack of focus on outcomes and health of local population
- Payment and reward systems
- Lack of alignment of national policy across health and social care
- Application of Competition law
- Lack of agreed process and methodology for delivering change
- Lack of clear system view of what is desired and deliverable state in 3-5 years
- Time to deliver vs timing of crisis
- Perceived organisational interest vs wider interests of system
- Capacity and effort to deliver
- Ability for system leaders to think out of organisational box

# System Enablers

- Agreed vision of future state including assessment and assumptions on impact on current capacity and methods of delivery
- Local payment, incentives and rewards system to incentivise delivery
- Locally agreed rules for commissioning and co-operation (management of whole system re-design v competition)
- Agreed methodology (*ies) for delivery with simple and clear governance and aligned resource and capacity
- Commitment to long term sustainability of vision and purpose by all organisations
- Workforce-commitment to gives and gets
- Genuine engagement and involvement-service users as experts in design of care
- Joined up approach to managing and influencing national government and agencies

# Developing thoughts across our patch

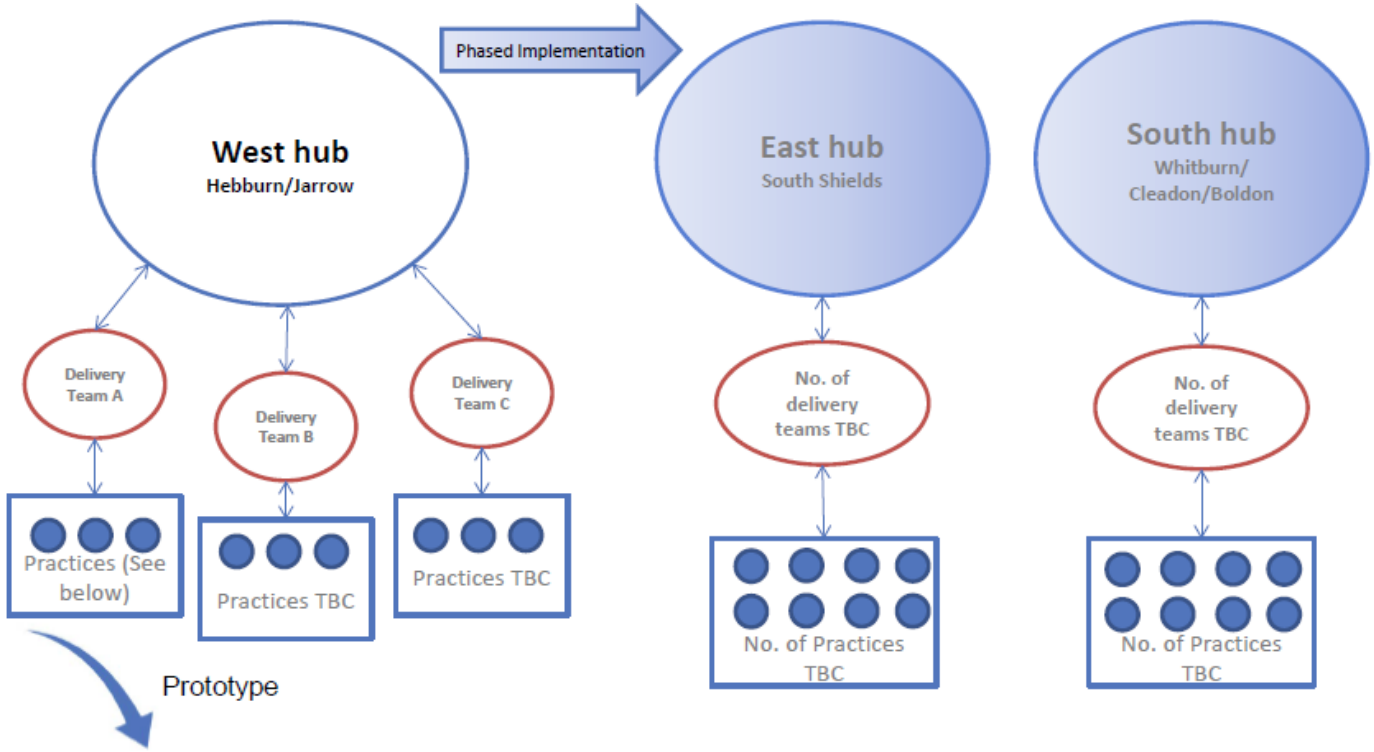
# Sunderland Vanguard Model



# Sunderland Vanguard progress

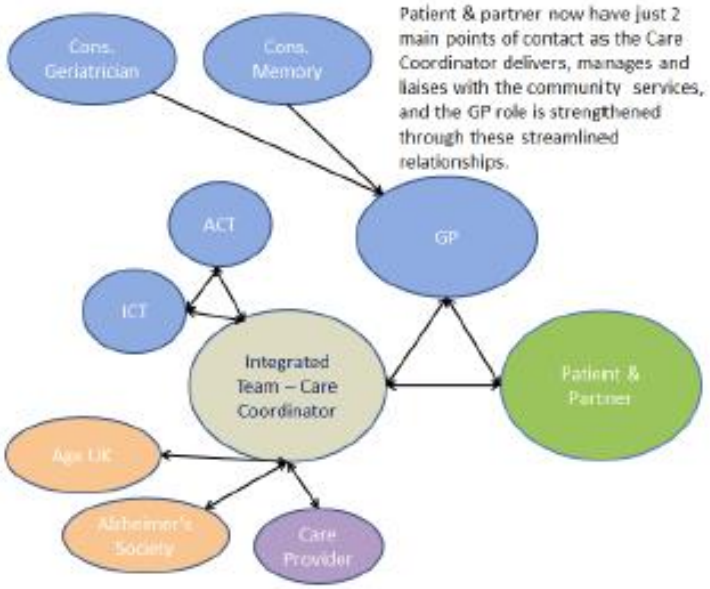
- Integrated commissioning and provision– 150m pooled budget
- Recovery @ Home
  - City wide step up
  - Single Point of Access
  - 24/7 availability
- Integrated Community Teams
- Establishment of 2 GP federations for 51 practices

# South Tyneside Approach- Pioneer and integration




South Tyneside Partnership

# South Tyneside Integrated Care Model

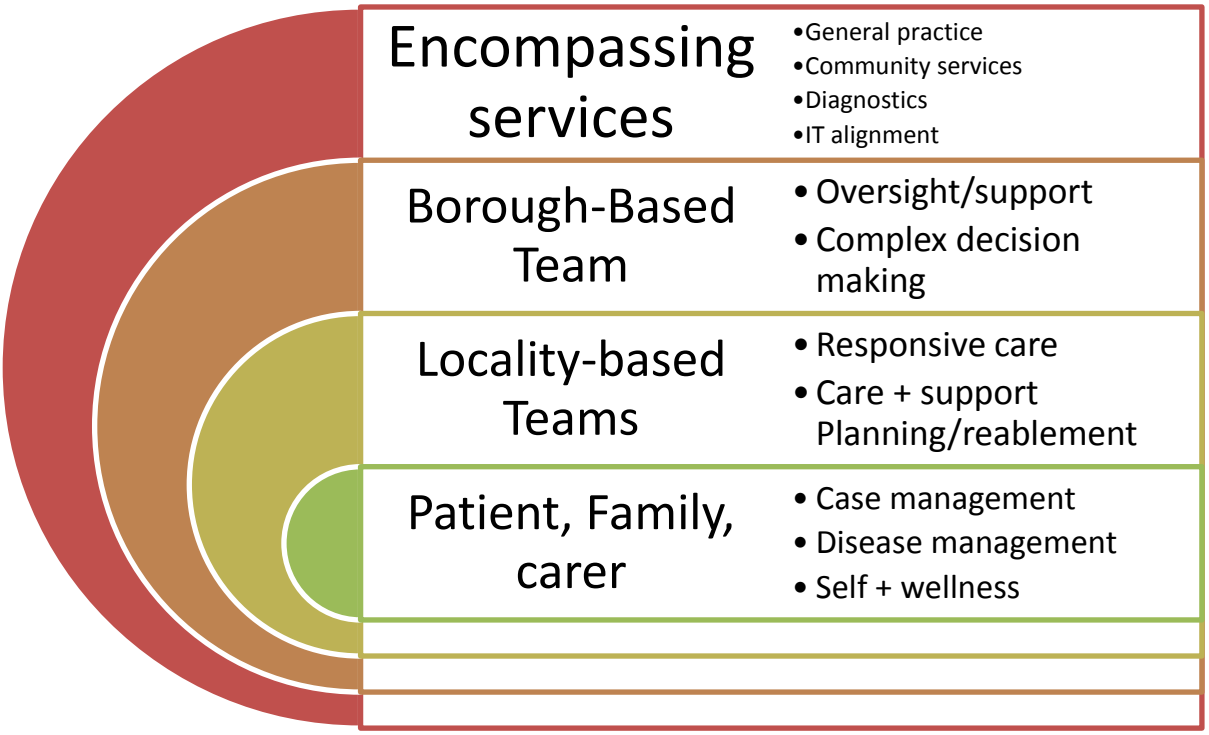



**BCF Scheme: Integrated Community teams**

**BCF Scheme Pioneer Programme:** Promoting self care

Gateshead's Integrated Community-bed and Home-based care Service

# Provider Alliance Network

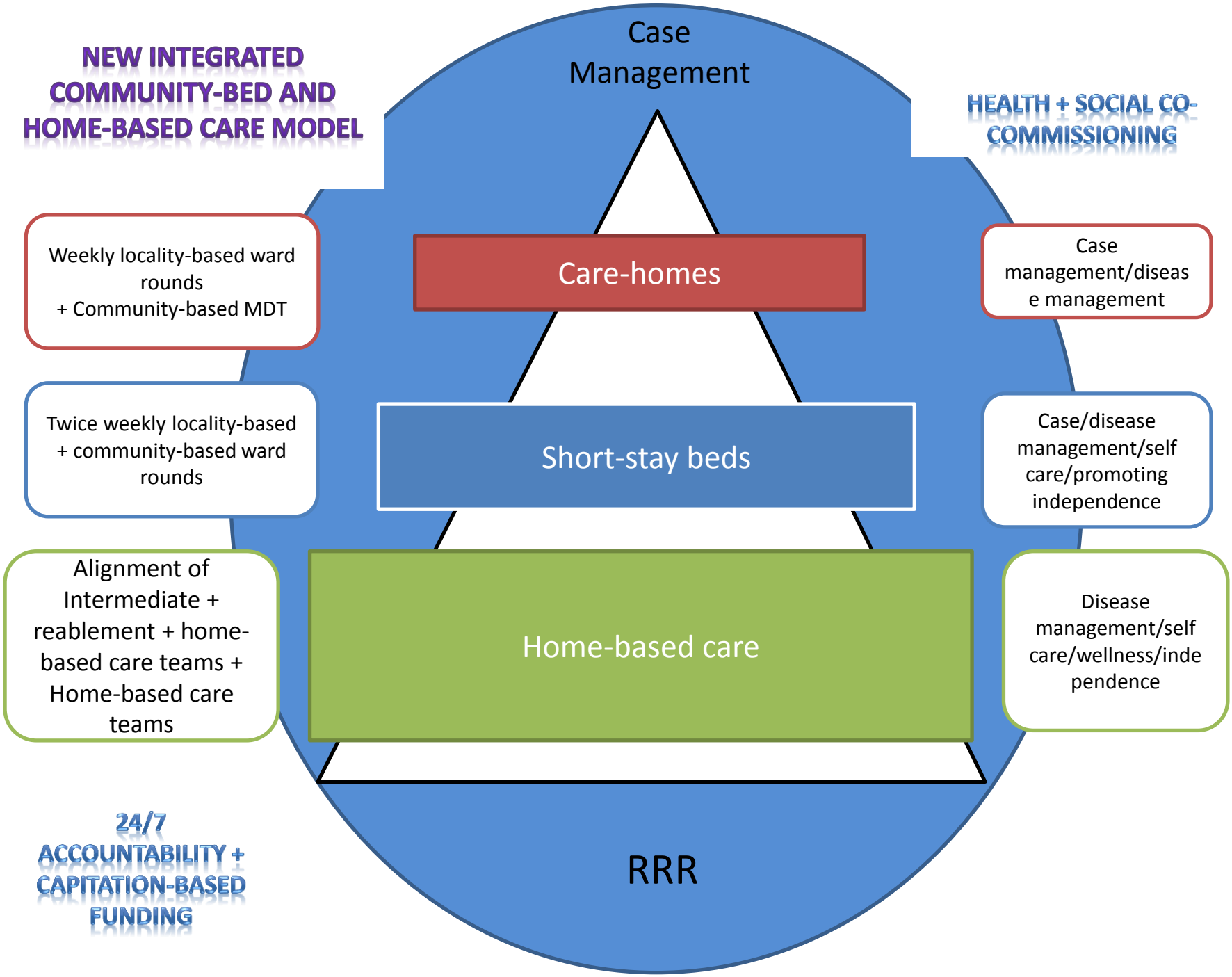



**Macro-integration (System)**

**Meso-integration (Organisational)**

**Micro-integration (Clinical)**

**Normative Integration**


NEW INTEGRATED COMMUNITY-BED AND HOME-BASED CARE MODEL
Case Management
HEALTH + SOCIAL CO-COMMISSIONING
Weekly locality-based ward rounds + Community-based MDT
Care-homes
Case management/disease management
Twice weekly locality-based + community-based ward rounds
Short-stay beds
Case/disease management/self care/promoting independence
Alignment of Intermediate + reablement + home-based care teams + Home-based care teams
Home-based care
Disease management/self care/wellness/independence
24/7 ACCOUNTABILITY + CAPITATION-BASED FUNDING
RRR

## Borough-based provision

- Core Health + Social care team across Gateshead
- MDTs + complex decision making
- Governance /leadership
- Establishing tools + care pathways + monitoring outcomes

## Locality-based provision

- Locality team of Health + Social care providers
- GPs, social workers, nurses, therapist, support workers, 3rd sector + voluntary
- Ward rounds in community-beds + MDTs + supporting discharge
- Collaborative working within clusters across practices and care home and neighbourhoods

## Home-based/bed-based provision

- Individuals providing care within community-beds, people 's homes and within the community

Prinicples of working

- Assessment of care
- Care planning (advanced planning)
- Coordinating care
- Supporting clients and carers/families
- Advocacy work
- Promoting independence/wellness

# Newcastle System Vision Statement

Accountable Officers - Based on Better Care Fund Plan

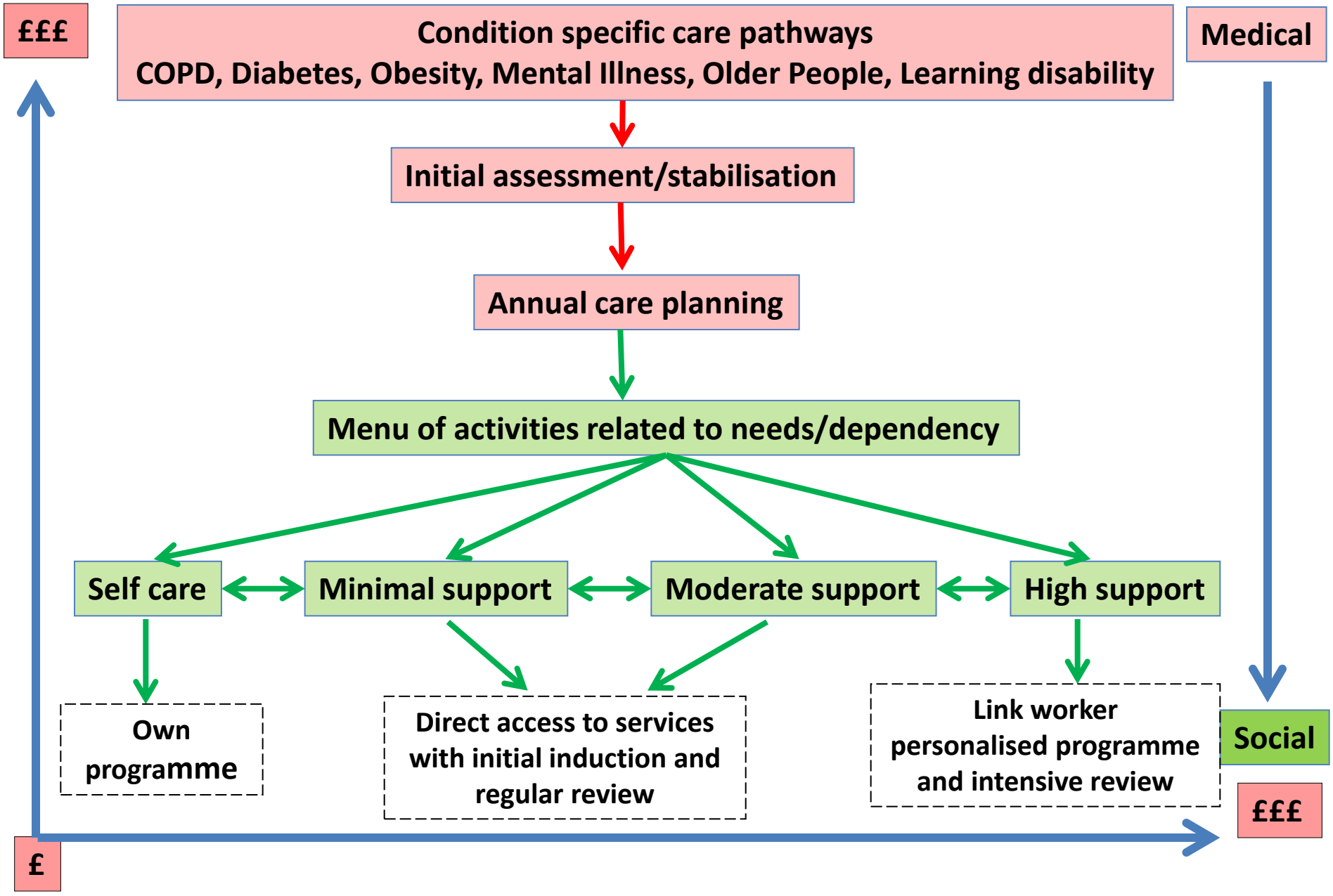
'Our vision for Newcastle in 2018/19 is a fully integrated health and care system designed to meet people's needs in a sustainable way.'

## Principles

- Primary care underpinned by innovative models, bringing together GP practices to work at scale and utilising strong partnerships to deliver increased range and scope of services which enable more pro-active care to be delivered outside of hospital.
- Communities fully engaged in shaping services, sharing ownership of health challenges they face.
- People adapting to the conditions they live with – confident and connected.
- Individual and community assets valued and fostered.
- Voluntary and community service sector fully engaged in the planning and where appropriate, the provision of services to our patients and public.
- Integrated working across primary, secondary, tertiary, community, voluntary and social care providers.
- High quality secondary care services for those who need to access them.
- World renowned specialist services locally accessible to our patients.
- Health and social care without walls, organisations without barriers.

# Characteristics of New Models of Care

- Redesign care across home and community based services, urgent and emergency care, elective care and specialised services.
- Be an integrated provider of out-of-hospital care, with separate governance structure.
- It combines core primary medical care services with wider community-based NHS services (including mental health) and, potentially, social care.
- Run expanded multi-disciplinary community-based teams, including for example pharmacists, social workers and nurse leaders.
- Incorporate some acute specialists e.g. consultant geriatricians, psychiatrists and paediatricians, to provide integrated specialist services in the community.
- Excel at both empowering patients and involving local communities, with strong voluntary sector input.


£££
Condition specific care pathways
COPD, Diabetes, Obesity, Mental Illness, Older People, Learning disability
Medical
Initial assessment/stabilisation
Annual care planning
Menu of activities related to needs/dependency
Self care
Minimal support
Moderate support
High support
Own programme
Direct access to services with initial induction and regular review
Link worker personalised programme and intensive review
Social
£
£££

**Providing seamless high quality care for the people of Northumberland**
**Empowering our communities to live long and healthy lives at home**

# Health and Care in Northumberland: The 7 Elements of Care

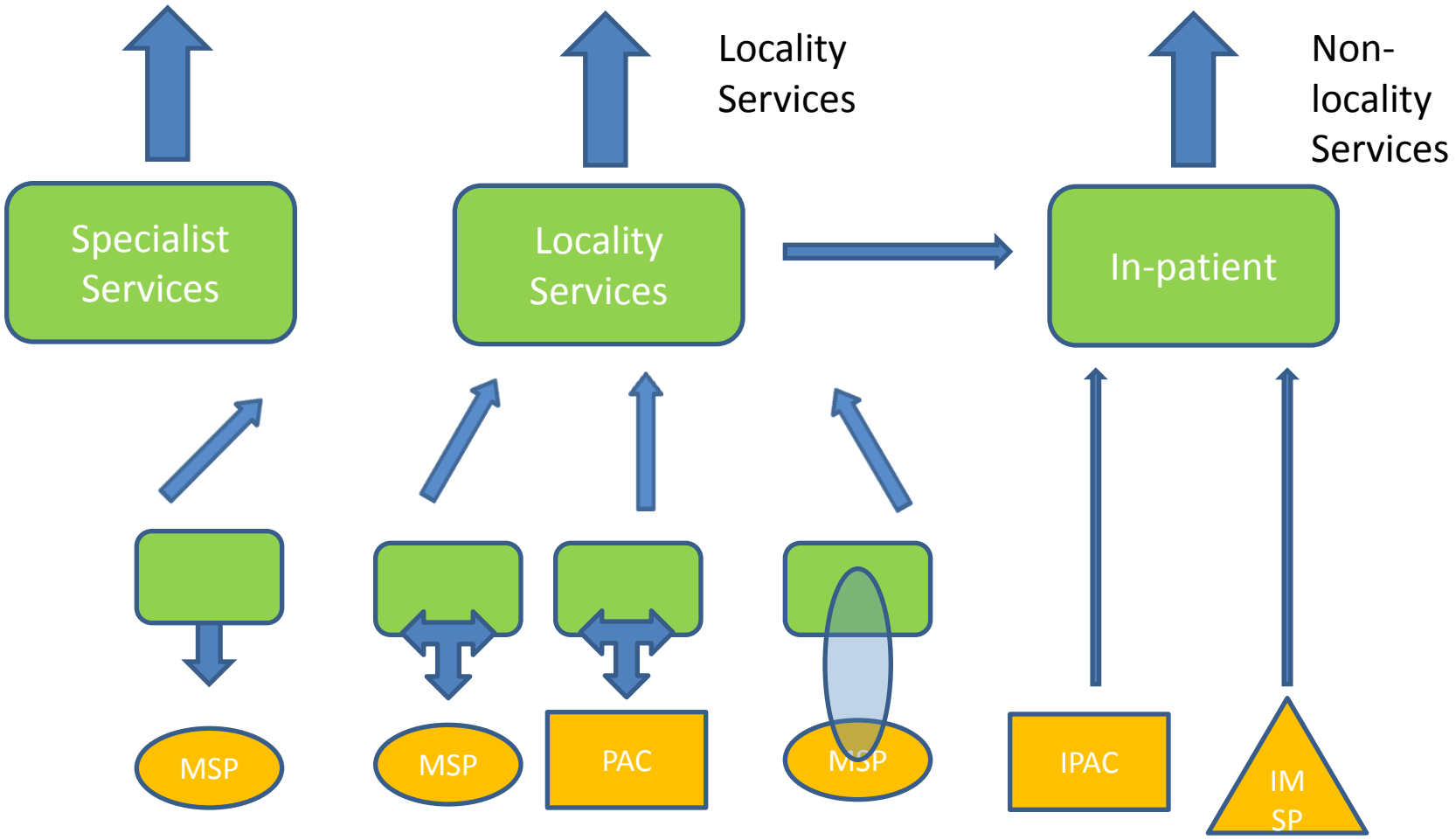
| Building a Caring Future | Building Care in Our Community | Care Closer to Home | Care Without Walls | Blurring the Boundaries | Patient at the Centre | Personal care led by the patient |
|---|---|---|---|---|---|---|
| Providing the best care delivered by the best people to achieve the best outcomes<br><br>We already have the plans for our local hospital settings | We now need to focus on building capacity in primary care and in our communities | Turning our services to face ands become embedded in the community: Including base hospitals, mental health and learning disabilities | Care is delivered in an integrated way where needed and is not limited by buildings or professional boundaries<br><br>Transformation | Between secondary care and primary care, physical and mental health and social and health care<br><br>Parity of esteem | Single point of access, easy navigation of the system, focus on full life course and a reduction of variation.<br><br>Doing things once | People are fully engaged and truly empowered to make decisions and take control of their own health and care<br><br>Self Care |




# Development of Northumberland PACs Model

- Stage 1 2015 Opening of specialist emergency care centre incorporating mental health services
- Stage 2015-Primary Care at scale, 7 day primary care operating from 8 hubs, co-location with hospitals and joint posts across primary and secondary care
- Stage 3 2015-Community and acute care service redesign “care without walls” ensuring care delivered within local communities
- Stage 4 2016-Transitional Year for Commissioning arrangements, transferring the commissioning of all primary, community and acute hospital care to Northumbria FT
- Stage 5 PACS 2017 – Delivery of integrated coherent care system leadership, demonstrating the delivery of  better health and care outcomes to the local population

# And back to us



# What integration means to people

National Voices
People shaping health and social care

**Integrated care: what do patients, service users and carers want?**

People want **co-ordination**. Not necessarily (organisational) integration.
People want **care**. Where it comes from is secondary.

There were no big gaps between seeing the doctor, going for tests and getting the results. I was always kept informed about what the next steps would be. The professionals involved with me talked to each other. I could see that they worked as a team.

I always knew who was the main person in charge of my care.
I had one first point of contact. They understood both me and my condition. I could go to them with questions at any time.
That person helped me to get other services and help, and to put everything together.

# And a last thought…