South Somerset: creating an enhanced team around GPs

Summary

An integrated care model involving an acute hospital, GPs, adult social care, and the voluntary and community sector with activity driven by analysis of a linked dataset. For people with multiple conditions there are more than 40 health coaches and complex care teams that work from three hubs.

Main points

- South Somerset was part of NHS England's vanguard programme to test new ways of working
- Hospitals, social care, the CCG and 19 GP practices involved
- Complex care teams recruited to support individuals with complex health needs
- More than 40 health coaches appointed and embedded in GP practices to work with patients
- Hospital-based staff also started offering support via virtual clinics and community appointments

Context

Somerset is a county in south west England, covering a largely rural geography of 1,600 square miles. It is home to 550,000 people – a third of whom live in south Somerset.

Overall Somerset is generally healthy – life expectancy is above the national average - and has low rates of deprivation. But that masks the pockets of ill-health and deprivation that do exist and are increasing, particularly in rural areas.

Between 2010 and 2015 the number of local neighbourhoods falling into the most deprived fifth of areas rose from 14 to 25.

What was done?

In 2015 NHS England launched its vanguard programme to test new ways of working in the health service.

In Somerset a partnership between GPs, the council and local NHS put forward an application to become part of the pilot, leading to the creation of the Symphony Programme.

It covers the 19 practices in the South Somerset GP Federation, Yeovil District Hospital, Somerset Partnership NHS Foundation Trust and Somerset County Council.

The partnership is chaired by a GP and involves representatives from primary care, the local hospital, adult social care, the voluntary sector and Somerset CCG.

The vanguard was overseen through a programme board, chaired by a GP and including representatives from across health and care as well as the voluntary sector. In 2016 it led to the creation of a new organisation, Symphony Healthcare Services, to manage the new service.

The board worked with consultancy Iora Health, drawing lessons on changes made by other health systems across the world, and the University of York, which carried out an analysis on the health of the local population using hospital, primary care and social care data. It identified the presence of multiple conditions was a key driver of health service use rather than age.

The work led to the creation of a new integrated care model focusing on supporting people to understand and manage their own conditions and navigate health care, while linking together the system and patients.

One of the key steps was the introduction of health coaches – there are now more than 40 coaches in place, one for every 3,000 patients.

These are embedded in the GP practices and work with the GPs as well as the wider practice team. The coaches help patients to develop confidence to manage their conditions as well as ensuring that any liaison with other services is effective and coordinated.

Patients can contact the health coaches directly and will often see a coach or another member of the team instead of a GP, freeing up the GPs to focus on the most complex patients.

Meanwhile, the complex care team that had already been established was expanded. It went from a hospital-based team that worked with practices to being located in the community in three bases in South Petherton, Wincanton and Yeovil alongside community nursing teams.

The complex care teams work with patients, supporting them to better self-manage their conditions. They now have 12 full-time equivalent posts in total and include GPs, complex care nurses and key workers.

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>
> *- DR STEVE EDGAR, GP*

Essential to the coordinate of care, are the regular 'huddles' at GP practices - sometimes happening daily - where the whole team discusses the patients they are most concerned about, agree what actions are needed and who will do what, whether the patient is at home or Hospital.

The complex care team join the huddle normally once a week and provide updates on patients they are already involved with and are allocated new patients where appropriate. This allows all the staff involved in the care of the most complex cases to share information, collaborate and spot problems early.

Yeovil Primary Care Network clinical director Kat Dalby-Welsh said it is the combination of all the measures that is the key to the success of Symphony.

"It is the sum of all parts. By looking at where we have had success we have been able to share this and replicate with similar patients or teams, which in turn grew our success"

What has been achieved?

The work in south Somerset has been widely recognised. In 2018 the programme was named primary care team of the year in the British Medical Journal awards.

Over the last two years around 11,000 patients have received support from health coaches, while hospital admissions have been reduced by 7.5%, emergency bed days by 15% and non-elective admissions from nursing homes by 50% in 12 months.

Symphony chair Dr Steve Edgar said: "Teams across the partnership have worked incredibly hard together to design and develop new ways of supporting patients' healthcare needs.

"The benefits have not only been experienced by patients and carers, but also GPs like myself who are now more able to use their time to care for the most complex long-term healthcare needs – helping to manage workloads."

What challenges have been overcome?

Complex care clinical lead Dr Deb Gompertz said there have been a number of lessons learnt over the course of the past four years.

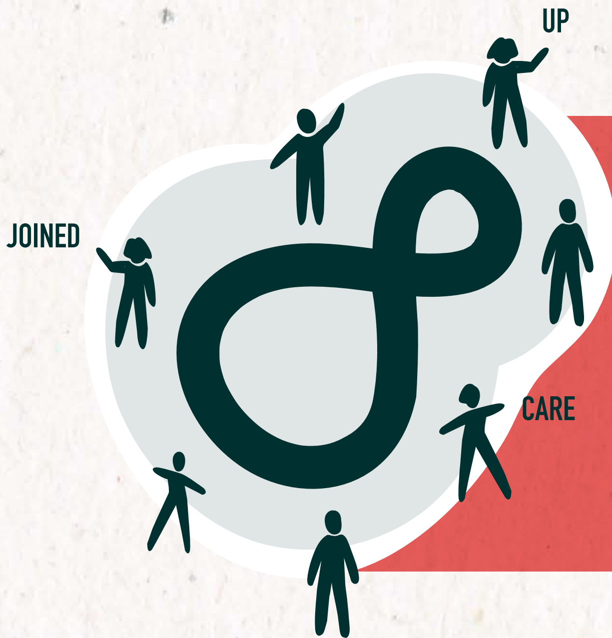
"Something like this takes time – and you certainly can't do it on your own. The way teams have come together has been great to see. But we have also worked with other services. For example, the health coaches have worked together with the social prescribing network that we have in place across Somerset."

This includes SPARK Somerset, which coordinates an online directory of local, low cost activities and services, and the community and village agents of Somerset Community Council, who are paid, part-time local residents who support vulnerable people in their communities.

"This has given patients access to a wealth of different groups and support services that have made a difference to their lives," added Dr Gompertz.

But Dr Gompertz said one challenge they are still coming to grips with is related to IT. There are different systems used by social care, community NHS teams and GPs, although there are plans to create a platform so that all the system are compatible.

"That will make a big difference, but in the meantime we have had to communicate between teams to make sure records and information is shared between the different teams."



"SYMPHONY HAS LED TO BETTER AND MORE JOINED UP CARE BEING DELIVERED TO PATIENTS AND WE EXPECT TO SEE THIS SUCCESS BE FURTHER BUILT ON IN THE FUTURE"

– JAMES RIMMER, CCG CHIEF EXECUTIVE

What is happening now?

Alongside the health coaches and complex care team, other measures have been taken too.

This has included virtual diabetes clinics where a consultant from the hospital discusses the most complex diabetes cases with a practice team in a virtual format. This has enabled changes to be made to medication and management to better manage patients' conditions, without the need for a hospital appointment.

Respiratory clinics have also been designed where practices can obtain an urgent opinion from a specialist nurse without attending an outpatient appointment.

The vanguard programme came to an end in 2018, but the success of the project convinced the CCG that local funding should be used to sustain the work. It has provided £1.7m of money to keep it running until 2021.

CCG chief executive James Rimmer said the work done by Symphony has been both "innovative and collaborative."

"Symphony has led to better and more joined up care being delivered to patents and we expect to see this success to be further built on in the future."

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