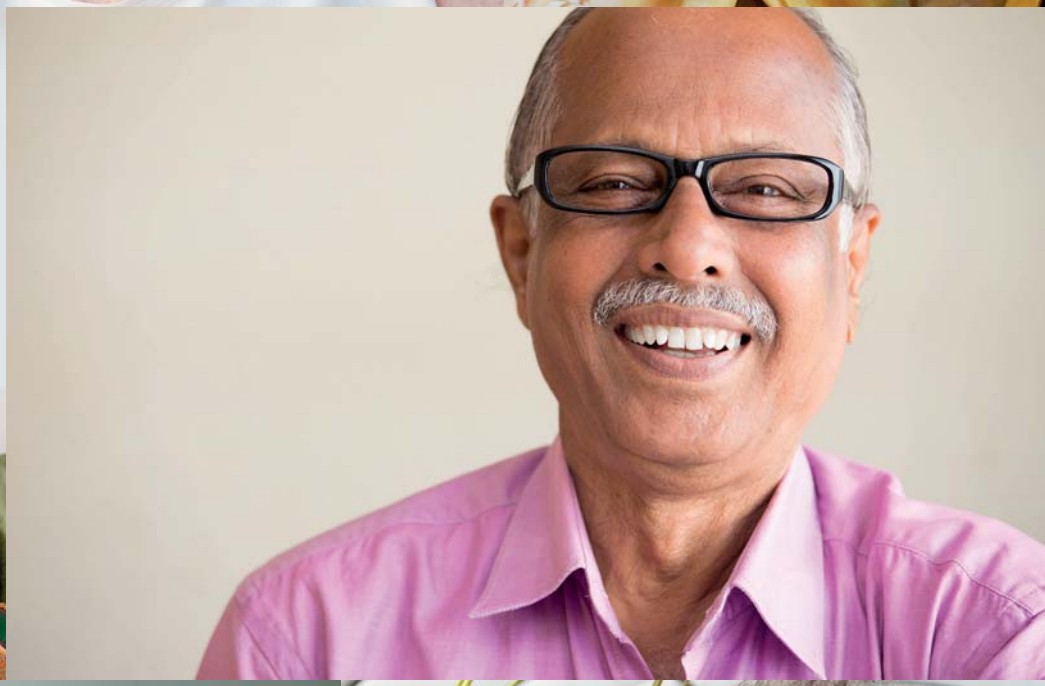
The Future of Out of Hospital Care in Coventry & Warwickshire







Overview

The way in which care is delivered across Coventry and Warwickshire both in hospitals and within the community is evolving.

An Out of Hospital Programme has been adopted by the health and care system as an important way to make change happen. The programme will put in place a new model of health and social care that will meet the changing needs of patients, capitalise on the opportunities presented by new technologies and treatments; and, to unleash system efficiencies more widely.

Through this programme of transformation, we will deliver the following benefits:

- **A healthier population** who are empowered to self-care and who receive the right treatment in the right setting when they need it.
- **Effective planning** of services to reduce demand on services and pressure on the health and care system.
- **Improved care and quality** when services do need to be provided.
- **A financially sustainable** health and social care system.

With the improvement in the way healthcare services are delivered over the next five years, you, as a patient, will therefore see changes in your day-to-day care. It will not take place overnight, and we will ensure that no patient's treatment is interrupted. However, integration between all the services will help and support you with whichever illness you may be facing, working together with shared information to create a cohesive journey of care. You will be able to make decisions on what type of care you receive as well as where you receive it, tailoring your treatment to you. This patient-focused approach will be enhanced by the preventative methods which will educate and support you to make even just little changes to your lifestyle for long-term health benefits.

With more education, care plans tailored to the person, and community-based care, you will be able to see the relevant clinician faster, and both waiting times and the current strain on hospitals will decrease. Not only is this more effective and convenient, something which you will notice on a day-to-day basis, but it will also fundamentally save more lives and increase overall life expectancy in Coventry and Warwickshire.

Introduction

Whoever we are and whatever we do, how health and social care is delivered in this country impacts us all.

In December 2015, the National Health Service (NHS) was asked to take a new approach to help ensure that health and care services are built on the evidence about the needs of local populations. Every health and care system in England was tasked to produce a five year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable. The aim is to deliver a vision of better health, better patient care and improved NHS efficiency.

Health and social care leaders within Coventry and Warwickshire agreed that the already established Out of Hospital Programme was critical for both the sustainability and transformation of the local health and care system and therefore agreed that it should form part of the overall plan.

This document explains the reasons for developing our Out of Hospital Programme, what we are doing and how it will affect you and your family.

Healthcare is evolving

The NHS was founded on a commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. Whilst our values haven't changed, our world has and so the NHS needs to adapt to new trends which are emerging in both health and social care. These trends are presenting new challenges in our society that have led to three gaps in the provision of healthcare across the country. Closing these emerging gaps is known as the 'Triple Aim'.

The **Triple Aim** is the term used to describe the three emerging gaps in the provision of healthcare across England which are being driven by a range of factors including changing population, trends in society and our economic situation, workforce challenges, sustainability of health and care organisations, and the ways in which organisations work.

The reasons for the need to close such gaps are:

1. **The health and wellbeing gap**: if prevention does not become more widespread, then recent progress in healthy life expectancies will stop, health inequalities will widen, and our ability to pay for beneficial new treatments will be put aside by the need to spend billions of pounds on avoidable illness.
2. **The care and quality gap**: unless we change the way in which care is delivered; make better use of technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in health outcomes will persist.
3. **The funding and efficiency gap**: if we fail to innovate how we deliver care and do more for patients within our existing tight financial parameters, the result will be worse services, fewer staff, and restrictions on new treatments.

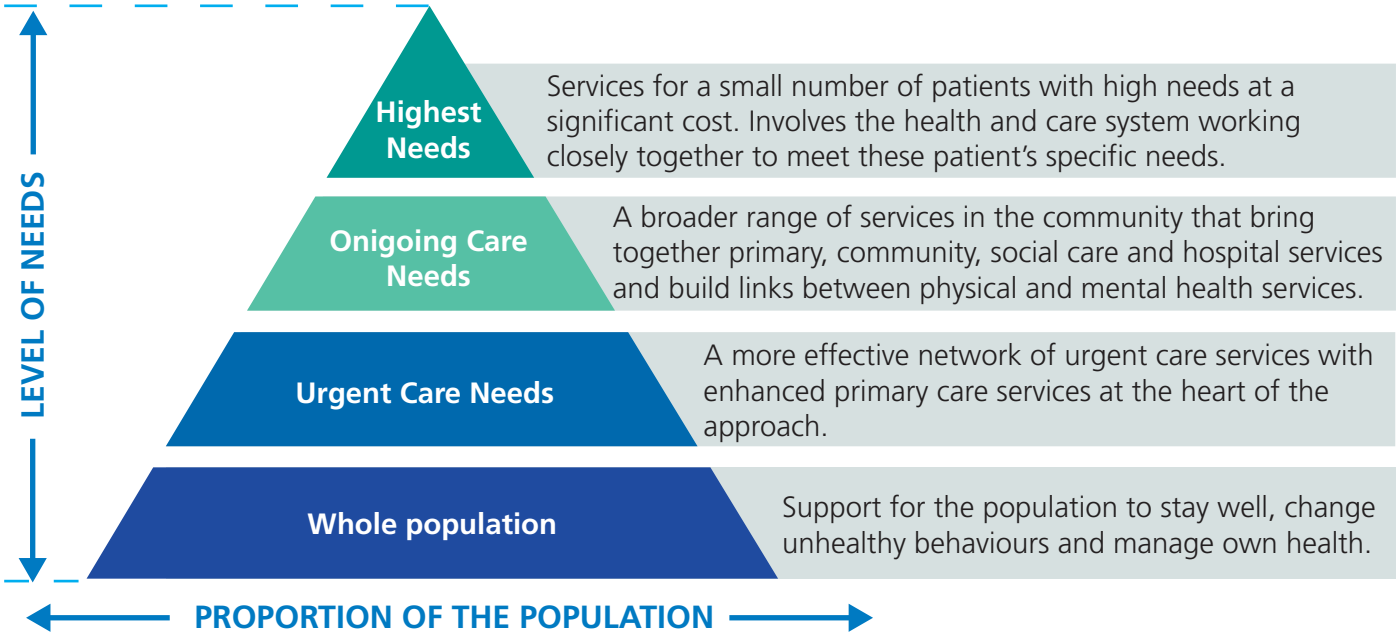
Closing these gaps to ensure the best delivery of care will require innovation and change in the provision of healthcare throughout the country.

New Model of Care

At the heart of the Out of Hospital Programme is the ambition to meet the changing needs of patients. Making better use of technology, capitalising on new treatments, and unleashing system efficiencies more widely, must be underpinned by the appropriate service delivery models.

Future services should be built on the following principles:

- A population health and care model focused on proactive and preventative care tailored around the needs of the individual;
- Empowering patients and local people to support each other and themselves in their health and care;
- Multi-disciplinary health care professionals working within a system that has accountability for the delivery of health and care services for their population;
- Contracting and payment systems that incentivise and enable the delivery of services for the population health.



How will we achieve this?

In order to achieve these principles, community services and primary care will need to develop more integrated ways of working. Specialist and generalist clinicians will work together to deliver different types of care in the community:

- Core Community Care: this focuses on maintaining health, and includes services such as falls prevention and administration of medication.
- Rehabilitation and Re-ablement: enabling recovery after a period of ill health and supporting independent living for as long as clinically appropriate.
- Specialist Care: focusing on a specific aspect of a patient's condition in the community.

Maintaining independence and preventing unnecessary admission into hospital will be one of the fundamental goals of delivering effective care out of hospital. This will not only be more convenient for patients, but will reduce the current unnecessary pressure on hospitals.

Our objectives for Out of Hospital services

We have agreed a number of objectives for the Out Of Hospital Programme:

- To reduce the health and wellbeing inequalities;
- To address the care and quality gap by ensuring more services use evidence based best practice;
- Identify those in most need and co-ordinate their care more effectively, through commissioning and interdisciplinary working;
- To work within our tight financial parameters by transforming services around the needs of patients and carers, and reduce duplication and waste of resources.

Who will this affect?

Delivering this programme is the first of many steps in transforming our system and our initial focus will be on those individuals who have the most need. Those with:

- ✓ Long term conditions;
- ✓ Young adults with complex disabilities;
- ✓ People with high complex needs including physical and / or mental health illness – (known to a GP and/or a Health Practitioner within the community);
- ✓ People approaching the end of their life last 12 months;
- ✓ High users of health and social care services;
- ✓ People at risk of requiring health and social care services;
- ✓ People who are housebound.

By focusing on a defined population we will establish the most effective way of delivering the scale of change we want as both commissioners and providers.

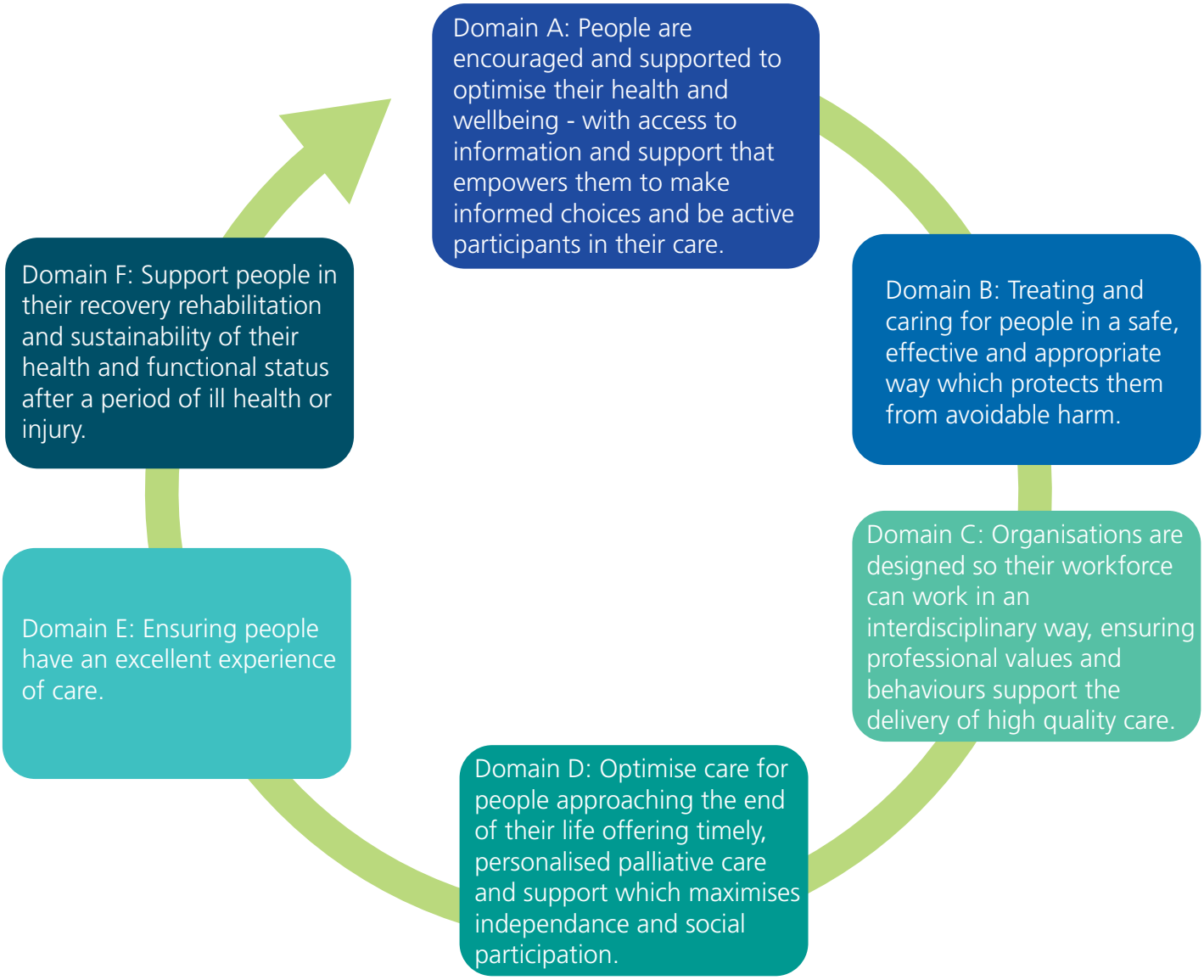
How we will deliver the Out of Hospital Programme

Outcome-based Contracting

Health and social care commissioners will come together to commission a service through a single approach to the contract.

The service provider will be given a budget to cover the health and social care needs of a defined population given specific health outcomes for the population that they are expected to achieve. This will enable the provider to balance the risks they are expected to take on with the level of control and influence they have on outcomes.

The outcomes have been developed with providers, stakeholders clinicians, patients, carers, and the public, to achieve a clear and informed understanding of the requirements for out of hospital services. Each outcome sits within a domain, and providers will be managed against the delivery of the outcomes associated with each of the following domains:



Delivering the Triple Aim

By adopting this approach we are confident that we will make significant progress in addressing the triple aim.

We will address the Health and Wellbeing Gap through:

- ✓ Young adults with complex disabilities;
- ✓ People with high complex needs including physical and / or mental health illness – (known to a GP and/or a Health Practitioner within the community);
- ✓ People approaching the end of their life last 12 months;
- ✓ High users of health and social care services;
- ✓ People at risk of requiring health and social care services;
- ✓ People who are housebound.

We will address our Care and Quality Gap by:

- ✓ Better and more sustainable primary care services;
- ✓ Ensuring our community services are proactive, responsive and integrated community services;
- ✓ Breaking down boundaries between organisations and acting as one system that maximises the people, buildings and financial resources across our whole area;
- ✓ Reducing health inequalities by providing consistent, high quality access across the community.

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How will my family and I be affected?

With the improvement in the way healthcare services are delivered over the next five years, you, as a patient, will see changes in your day-to-day care provision.

It will not take place overnight, and we will ensure that no patient pathway is interrupted if you are currently undergoing treatment.

Health and care services working together will help and support you with whichever illness you may be facing, they will share information to create a cohesive journey of care. You will be able to make decisions on what type of care you receive as well as where you receive it, tailoring your treatment to you. This patient-focused approach will be enhanced by the preventative methods which will inform and support you to make even just little changes to your lifestyle for long-term health benefits.

With more education, streamlined care plans, and community-based care, you will be able to see the relevant clinician faster, and both waiting times and the current strain on hospitals will decrease. Not only is this more effective and convenient, something which you will notice on a day-to-day basis, but it will also fundamentally save more lives and increase overall life expectancy in Coventry and Warwickshire.

Differences in how care is delivered

To ensure a fast and easy consultation and, if necessary, treatment plan when you are ill, your GP will work with other care services to ensure you are seen by the right person at the right time. A system of care navigation will be developed to refer you to the right healthcare professional straight away, improving your experience and making best use of clinical time.

More appointments for onward referrals and follow-ups will take place in the community, meaning there is less need to attend hospital. This convenience is carried on into your journey as a patient; using secure technology with your consent, your healthcare record can be shared between clinicians. This means you will receive one seamless treatment, with all clinicians you see having access to your personal record and removing the risk of duplication and enabling a consistent care pathway.

With the higher level of community care and illnesses being both prevented and detected earlier, our Accident and Emergency departments will return to being solely for life-threatening cases. This means that, should you need to be admitted into hospital, waiting times will be much shorter, helping to improve quality of care and essentially save lives.

Prevention and self-care

With more emphasis being placed on preventative care; you will be given more information about health conditions and their causes. You will be empowered to make the simple changes to your lifestyle to prevent you from becoming ill. This will include having free health checks if you are of the right age, tailoring advice specifically to you and your lifestyle.

Furthermore, you will be more involved in decisions about your care. You will, where appropriate, be able to choose the type of care you receive in the community, or its location, for example. This will ensure the care you receive is the right type for you, and make it as convenient as possible. Receiving treatment and consultations will therefore be easier, with more availability due to care navigation preventing unnecessary or inappropriate appointments.

More help for carers

Unpaid carers are a key part of the community, supporting friends and family members through long-term conditions. As part of the more patient-focused, community-centred care model, we will ensure you, as a carer, are fully supported. Partner organisations will find new ways to support you, which will include work with voluntary organisations and GP practices to identify carers and provide better support. Flexible working arrangements for NHS staff with major unpaid caring responsibilities will also be explored.

The Out of Hospital Programme is being led by NHS South Warwickshire Clinical Commissioning Group on behalf of the health and social care system in Coventry and Warwickshire.

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