Symphony Project, person-centred, co-ordinated care in South Somerset

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19 GP practices
4 community hospitals
Community mental health team
1 district general hospital
Poor public transport
Predominantly small market towns and villages
The Project Board

**Alliance Partners**

**Commissioners**
- Somerset CCG
- Somerset County Council
- Bristol, North Somerset, Somerset and South Gloucestershire Area Team

**Providers**
- Yeovil District Hospital NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Symphony Primary Care Group
- Adult Social Care

**Other Project Board Members**
- South Western Ambulance NHS Foundation Trust
- South West Commissioning Support Unit
- South Somerset District Council
- North Dorset CCG
Key Symphony Components

1. Evidence – individual level data set
2. Shared outcomes
3. Care model
Primary purpose of data analysis

• Identify people who might benefit from integrated financial arrangements
  – Those using care across multiple settings
  – Those with multi-morbidity profiles
  – Large enough group to form risk pool
  – Costs of the group offer potential scope for savings
Anonymised data at patient level (n=115k) for full year about their:

Utilisation of health and social care, with data linked across eight broad settings of care.

1. Costs according to type of care received in each setting.
2. Demographic characteristics, including age, gender, socio-economic status.
3. Indicators of morbidity.
Describing multi-morbidity

1. Constructed using United Health’s RISC tool
   • used to assess risk of unplanned hospital admissions
2. Uses diagnostic information in patient hospital and general practice records
   • ICD10 and Read codes
3. Summarised into 586 conditions
   • Episode Treatment Groups (ETGs)
4. We identified 49 ETGs as chronic conditions
5. GPs said 12 of these particularly important
Morbidity (number of ETGs) by age band

Number of conditions

0
1
2
3
4
5
6
7+

Age band (Years)

Patients (%)

0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
<table>
<thead>
<tr>
<th>Regression variables</th>
<th>Age</th>
<th>Number of chronic conditions</th>
<th>Age, Number of chronic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variation explained</td>
<td>3.36%</td>
<td>10.48%</td>
<td>10.66%</td>
</tr>
</tbody>
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<td>3.36%</td>
<td>19.80%</td>
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• Health and social care costs increase as people get older
• But as people get older, they have more co-morbidities
• Costs increase the more co-morbidities a person has
• Costs are explained more by the number of chronic co-morbidities (11%) than by age (3%)
Single and multi-morbidity

• Conditions vary in whether they are single or multi-morbidity
  – Hypertension: 30% single morbidity
  – Asthma: 50%
  – Diabetes: 15%
  – Stroke: 10%
  – COPD: 10%
Diabetes

• 5,676 people are recorded as having diabetes in South Somerset, their total costs amounting to £17m

• For those with this sole diagnosis, costs are around £1,000 on average

• Hypertension is the most common comorbidity for people with diabetes

• As people are recorded as having more diagnoses, average costs increase progressively faster
Average costs for patients with diabetes by setting and number of other ETGs

- Diabetes: N= 829
- plus 1: N= 1,529
- plus 2: N= 1,362
- plus 3: N= 898
- plus 4: N= 527
- plus 5: N= 279
- plus 6 or more: N= 222

Average cost per patient (£)

Number of ETGs

categories:
- cc
- sc
- cm
- mh
- ae
- op
- ip
- pc

Centre For Health Economics
Dementia

• 1,062 People with dementia - 0.92% of the South Somerset population
• Total costs amount to £13m – 11% total budget
• No obvious pattern between the number of conditions and average costs
• Costs predominantly social care and continuing care
Regression analysis

• Log-linear or two-part models
• Explanatory variables:
  – Age
  – Gender
  – Social deprivation
  – Whether patients died during the year
  – Whether patients or moved elsewhere
  – Number of chronic conditions
  – Twelve specific chronic conditions
<table>
<thead>
<tr>
<th>Variable</th>
<th>Diabetes</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.006***</td>
<td>0.01</td>
</tr>
<tr>
<td>Male</td>
<td>-0.100***</td>
<td>-0.10</td>
</tr>
<tr>
<td>Deprivation</td>
<td>0.003</td>
<td>0.02***</td>
</tr>
<tr>
<td>Number of co-morbidities</td>
<td>0.263***</td>
<td>0.14***</td>
</tr>
<tr>
<td>Died</td>
<td>1.188***</td>
<td>0.67***</td>
</tr>
<tr>
<td>Moved elsewhere</td>
<td>-0.095</td>
<td>0.07</td>
</tr>
<tr>
<td>Dementia / diabetes</td>
<td>0.937***</td>
<td>0.08</td>
</tr>
<tr>
<td>Mental health (exc dementia)</td>
<td>0.069</td>
<td>0.23</td>
</tr>
<tr>
<td>Cancer</td>
<td>0.176***</td>
<td>-0.18</td>
</tr>
<tr>
<td>Cardio-vascular disease</td>
<td>0.207***</td>
<td>-0.09</td>
</tr>
<tr>
<td>Stroke</td>
<td>0.163***</td>
<td>0.23*</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.562***</td>
<td>1.37</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>0.138**</td>
<td>0.30*</td>
</tr>
<tr>
<td>Gastric problems</td>
<td>0.134*</td>
<td>0.00</td>
</tr>
<tr>
<td>Trauma/burns/fractures</td>
<td>0.382***</td>
<td>0.61***</td>
</tr>
<tr>
<td>Arthritis</td>
<td>-0.030</td>
<td>-0.59</td>
</tr>
<tr>
<td>Renal problems</td>
<td>0.569***</td>
<td>0.54**</td>
</tr>
</tbody>
</table>
Calculate budget requirements

• Budget = Number of people × average cost
• What if people are more complex next year?
• Use model parameters to calculate “risk adjusted” budget
Model budget impact of change in service provision

• What are cost implications of (say) 5% reduction in hospital admissions?
  – Where is care delivered instead? Analyse provision across settings
  – Are those affected atypical? Model costs changing patient characteristics
  – Are providers able to realise cost savings?
Conclusions

• Multi-morbidity better than age at explaining costs
• Identify people who might benefit from integrated financial arrangements
• Calculate budget to support integrated care
• Model implications of change in service delivery
How the data analysis shaped the Symphony Project

• Changed focus from frail elderly to adults with several conditions
• Influenced decision to develop a multi-morbidity model of care
• Influenced choice of starting cohort
• Key enabler for a capitated budget
• Generated buy-in from clinical staff
• Attracted national interest and investment
Key Symphony Components

1. Evidence – individual level data set
2. Shared outcomes
3. Care model
What matters

Sought ideas from people with lived experience and current frontline staff.

- Reviewed national and local publications
- Held one-to-one interviews with people with long term conditions
- Facilitated event with people, carers and frontline staff.

Insights about what works well now, what people hope to see more/less of in the future

People and carers’ shared hopes:

- Patient-centred care
- Easy, timely access
- Easy, timely discharge
- Timely, supported discharges
- Support for carers
- Support to stay healthy
- Crisis support 24/7
- Care continuity
- Shared information
- Avoid admissions
- Single point of contact
- Improved transport
- Seamless services
- Complete picture of information
- Responsive process
- Clear pathways and signposting

Staff’s shared hopes:

- Increased patient commitment to their own care
- Reduced pressures
- Easy navigation
- Efficiency
- Know who to contact
- Patient focussed
- Staff feel valued
- Integrated IT
- Integrated services
- Real, sustainable change
- Seamless care/continuity
- Clear understanding of roles
- Fewer boundaries
- Single point of access/contact
- Communication & co-ordination
- Reliability
- Time
- Prevent/crisis
- Care delivered in setting for people
- Care delivered in setting for people
- Holistic approach
- Responsive services
- Know who is involved
- More value for shared care
- More value for shared care
## What matters

Insights used to guide design work and formulate the outcome set

<table>
<thead>
<tr>
<th>Focus</th>
<th>Me and my carer (s), taking account of all my conditions and our physical, mental, social and emotional needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>I am helped to manage my conditions and live in the way I want to the best of my ability</td>
</tr>
<tr>
<td>Features</td>
<td></td>
</tr>
<tr>
<td>ACTIVE INVOLVEMENT</td>
<td>I am listened to and involved in planning and making choices about my care in a way that suits me.</td>
</tr>
<tr>
<td>POSITIVE RELATIONSHIPS</td>
<td>I have one key person who takes ownership for coordinating all aspects of my care. They make me aware of all the options and keep me informed about what’s happening. They understand me and I trust them.</td>
</tr>
<tr>
<td>EASY ACCESS</td>
<td>I can contact my care coordinator when I need to. I am given access to information, education, advice and expertise to help manage my condition. Support and services are available as close to my home as possible and I know there is a 24/7 response available if I need it.</td>
</tr>
<tr>
<td>SEAMLESS COORDINATION</td>
<td>I receive seamless timely, coordinated care with easy, efficient transitions from one service to another. Professionals across all services have access to an up-to-date shared record of my condition, needs history and services and treatments I am receiving.</td>
</tr>
</tbody>
</table>

| Enablers                                   | • Caring, compassionate, competent and knowledgeable staff work in multi-disciplinary teams across organisational boundaries with up-to-date, shared records, facilitated and supported by organisations and systems. |
|                                            | • Patients and carers asked for feedback on services and see improvements happen as a result. |
Outcomes

Representatives from all parties worked through options
Modified Michael Porter’s hierarchy of health outcomes
Focus on:
• what people say matters about their care
• outcomes representing value to commissioners and providers
Link to project aims

Tier 1: Wellbeing status
Independence
Wellbeing
Health outcomes

Tier 2: Process of care
Right care
Right time, right place

Tier 3: Sustainability of services
Cost
Staff
Learning organisation
Key Symphony Components

1. Evidence – individual level data set
2. Shared outcomes
3. Care model
Symphony - Core functions

- Coordination
- Service user
- Self Management support
- Care provision
Key features of the model

- Cohort of patients
- Single care plan, single pathway
- Four hubs – GP clusters
- Expert generalist medical input
- One care-coordinator - manage transition from current pathways to single pathway
- Key workers to build relationships and act as health coaches
- Intelligent use of new technology
- Support to improve health through self-management
- Early detection of crisis – wrap around health + social care
- Hospital team part of Symphony
Publication:
goo.gl/3WvTN6

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