Health and care services in Herefordshire & Worcestershire are changing

An update on a five year plan to provide safe, effective and sustainable care in our area

www.yourconversationhw.nhs.uk

Your Health & Wellbeing
#YourConversation

Worcestershire Acute Hospitals NHS Trust

NHS Herefordshire Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

Wye Valley NHS Trust

Worcestershire Health and Care NHS

2gether NHS Foundation Trust

Taurus Healthcare

worcestershire county council

Herefordshire Council

Why our health and care services need to change

Across Herefordshire and Worcestershire, health and care organisations are committed to providing safe and effective services, but the way some services are run may need to change.

This is because we have a growing population with people living longer than ever, but as we age our health needs change. This leads to rising demands on services, and we want to make sure we can provide safe and effective services with the resources available.

We are also experiencing some practical issues in our area:

- Recruiting and retaining staff is a challenge
- Our health, local authority and other care services are not always joined up, designed to meet people's individual needs and do not always balance physical health with mental health and wellbeing
- We spend too much of our time and resources treating illnesses which can be prevented or supported in different ways
- On current projections, we won't have enough funding to meet expected levels of demand

All of this means we have to make some really tough decisions about how we provide and access care, treatment and support in our local area. By working together as organisations and with our patients and communities we think we can do lots of things better, but we also have to be clear that we can't carry on doing what we've always done, and some hard choices are required which may mean some things being delivered differently, or not at all, over the coming few years.

#YourConversation

This update provides some thoughts on how health and care service could change to help us continue providing safe, effective and sustainable care and support. We won't make these tough choices without the views of patients and our wider communities and while there may be constraints on what is possible, there will be lots of opportunities to get involved in helping shape things moving forward. The information described in this update are some initial thoughts and concepts, they are not set in stone.

This is your health and wellbeing, and therefore #YourConversation so we want you to let us know what you think. Details of how you can do this are at the end of this document.

What you've told us is important

Over the last few years health and care organisations across Herefordshire and Worcestershire have been out and about listening to feedback on services and the way care has been organised. This has helped inform some of the thoughts described in this document.

We have heard that:

- You want to receive more care at home or as close to home as possible
- You want us to provide more care, including urgent care through GP practices
- You want better communication between teams/staff so you don't have to repeat your story over and over again
- You want to access the right service, first time but often it is not clear how to do this
- You and your family want to be part of developing your care plan, and you want easy access to help and support
- You want to be empowered to self-care aspects of your conditions where this is appropriate
- You want improvements in the range of mental health services and support so you can access help before things get too serious
- Transport needs to be key consideration in any proposals to change how services are provided.

Safe, effective and sustainable

Our vision:

Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people.

In reality this will mean:

- Organisations working better in partnership to make services easier to navigate and access
- We all need to do more to support healthy living, or to self-care and manage aspects of our conditions ourselves
- Improving parity of esteem between mental and physical health, so both types of conditions are viewed equally
- Providing more care in the place where you live or closer to home, reducing avoidable hospital admissions
- Making our current out-of-hospital system more efficient and effective
- Improving access to urgent care
- Ensuring our specialist services are safe and sustainable

We know there are lots of serious and long-term health conditions such as diabetes, stroke and heart disease which in lots of cases can be prevented.

We also recognise that if we can encourage healthy living within children and young people then they are likely to take their healthy life choices into adult hood, which will help prevent the kinds of illness which are influenced by lifestyle. We also want to encourage children and young people to get active and healthier now so avoidable health issues, for example those triggered by obesity, can be prevented.

We want to view prevention and healthy living as everyone's responsibility, and not just an issue for health and social care organisations. We want to work better with housing providers, schools, colleges and local businesses, and we also need to empower local communities, voluntary sector organisations and other community groups to help put physical and mental wellbeing at the heart of our communities.

When someone does get ill we want to be better equipped to support them and their families with tools to stay independent and in control which lots of people tell us is important. We want patients to become equal partners with those caring for them; make more decisions about their own treatment plans; ensure timely advice and support; and to enable them to become increasingly confident to manage their own conditions supported by useful and usable technology. For example, the number of people living with dementia is increasing,

but early diagnosis and support can help people to live as well as possible. We want to support people who notice that their own or a loved one's health is deteriorating, so that they can make timely decisions about the support they might need to live independently and safely and so that carers are supported and able to keep themselves well.

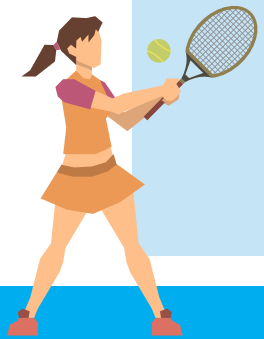
Carers

Carers are key to providing safe and effective out of hospital care however they don't always get the recognition and support they need to;

a) help and support the person they care for to safely manage their condition at home,

b) stay well themselves so they have the resilience to fulfil their caring role.

We need to work with carers to better understand the impact of any changes we make.



Patient story– Kate

Kate was a real sports fan but an injury stopped her playing for a few months and she struggled to get back in to it. By the age of 40 Kate did little exercise herself. She was stressed at work, and because she was putting in long hours she had become over reliant on fast food. On a regular check-up at her GP, Kate was told she was quite overweight and that there was a risk of developing diabetes as well as other health conditions if things didn't change. She was encouraged to change her lifestyle habits and was put in touch with a fitness coach who could recommend an exercise programme. She downloaded an app so she could access healthy food options, and was put in touch with primary care mental health teams which provided help to alleviate stress and anxiety. The fitness programme helped her get back into shape and when things do start getting too much at work, she has some self-help tools to keep things manageable. She's now thinking about re-joining her tennis club as well joining a local amateur running club to maintain her new found fitness.

Getting an appointment at my local GP

It can be really frustrating ringing for a routine GP appointment and being told you may have to wait two or three weeks. We also know that once you get one, the consultation with your GP is often restricted to just 10 minutes. This is because demand on GPs is increasing too, making it almost impossible to get same day appointments in some of our surgeries.

We think there are opportunities for local surgeries to pool their resources to more effectively share some of the demand. We also need to think, 'if I need an appointment, does it really need to be with my preferred GP'?

There may be times and circumstances when that is appropriate, but in lots of cases people have illnesses or conditions which can be just as effectively dealt with by a nurse who works in the local surgery.

This could help people get appointments much sooner, get the help and treatment needed, reduce demand on GPs, and ensure when someone really needs to see the GP they have a better chance of getting an appointment quicker. If this works we also want to increase the consultation time for those who need it.

We also want to develop our local community teams with input from local GPs to help maintain someone's health at home and reduce the risk of them being admitted to hospital unnecessarily.

Most admissions in people over 75 have bypassed GPs or out-of-hours services. Older people are more likely to call an ambulance, more likely to be conveyed to hospital, and once there, more likely to be admitted.

Providing more care at home or out of hospital

Wherever possible we should ensure that people do not get admitted to hospital unless they absolutely need to be there. Currently too many people are admitted to hospital for issues which could reasonably be treated at home or in the place where they live.

We also know that once admitted to a hospital bed, sometimes people stay there longer than necessary. This can actually have a bad effect on someone's health so we want to make sure they can leave hospital as soon as they are well enough. We have services which are equipped at providing care at home and reducing the risk of hospital admission; for example we have teams which support children with complex conditions at home; we have community nursing and therapy teams who help manage long-term issues at home or in care homes, including dressing wounds and support with medication; and we also have social care teams which provide domiciliary care at home, such as supporting someone preparing meals, dressing and washing.

However these services don't always work well together and the communication between the teams could be better. By working better in partnership we think there are real improvements to be made to the care we are able to give people at home.

GP Practice

Therapists

Nurses
(Physical & Mental health)

Social Workers

How could we do this?

More than 70% of hospital bed days are occupied by emergency admissions, so we want to reduce the risk of emergency. We will do this by developing multi-skilled teams who will work around a person at home, helping reduce unnecessary admission to hospital.

The physical and mental health nurses, therapists and social care professionals will all be part of one team who will get to know the person and their medical history. There will be one contact point which can be used whenever additional help is required. There will still be health issues, but wherever possible these can be dealt with at home by the local team who will work on the principle that 'your own bed is best'.

If someone does need to be taken to hospital, the team will know about it and will ensure they are able to leave and return home without delay. Delays in getting discharged from a hospital bed can be a real problem, often caused by challenges arranging social care or community support back home. But the local team will be able to sort this out much more quickly and easily, reducing the chance of any delay.

We could also support this by developing something called an 'integrated frailty pathway', which in simple terms is about ensuring those identified as being at greatest risk of being admitted to hospital have access to staff who can provide 24 hour care in their home. It is also about having real alternatives to hospital admission when someone needs more care than we can deliver at home.

Patient story – Margaret and Len

After she turned 80, Margaret found her health deteriorating. She was diagnosed with diabetes and emphysema (COPD), as well as early stage dementia. She lives with her husband, Len, who is also in his 80s, and who has his own health issues.

Margaret's GP said she needed to be supported by the local community nursing team. Angela, a member of the community team, is her care coordinator and following an initial visit, quickly arranged what support Margaret needs from the rest of the team. Margaret is visited a few times a week, once by a nurse, then a therapist and finally from a mental health professional to support her with her dementia. A social worker will also visit to help with any domiciliary care needs. As each of them are part of the same team they each have up to date notes on Margaret's condition and she gets familiar with all of them, building up a rapport and an understanding. There is a contact number which she or Len can use if there is a problem. They have only used it a couple of times but on each occasion someone from the team have been out to check on them, and have been able to provide additional support without them needing to go to hospital.

There are volunteers from a local carers charity who are also part of the team and they contact Len regularly to check he's coping well too. They also give him support to maintain his own health.

Mental health and well-being

We believe 'there is no health without mental health' and so through partnership with other public services, local business and communities we will support people to understand how to keep themselves well, and how to access support and guidance if they need it.

Sometimes people will need expert care and at the moment, particularly for children and young people, this might mean travelling to another part of the country. We want to be able to provide specialist care in our two counties so that people can stay connected to their families and friends whilst they recover.

Having a baby is often a joyful event but sometimes it can affect people's mental as well as physical wellbeing. We are committed to ensuring that staff supporting women and their families through pregnancy childbirth have the skills to support women's mental and physical health needs.

Living with complex mental health problems can also affect some people's physical health. We will prioritise how we use our resources so to reduce the impact this has on people's quality and length of life.

We want to support more people with mental health issues early to prevent issues escalating, and then at home or in the community when more care is needed. This is what people tell us is important.

When admission to a mental health ward is required this should be more recovery focused and designed to help people get back home quicker so they can regain control and independence over their lives.

Patient story – Adam

Following a family bereavement Adam had become increasingly isolated and had withdrawn from his social circle. He had even told a colleague at work that he couldn't continue with things the way they were. He was persuaded to seek help and after the GP referred him to the local mental health team he was diagnosed with severe depression. He was in the care of the community mental health team who visited him regularly at home to check he was doing ok; Adam had a contact number he could use if he felt really unwell. Adam's depression meant he had to give up work, but through the support of his mental health nurse he was put on a work placement programme which provides opportunities for those recovering from a mental health problem to get back into employment. He really benefitted from this and is now starting to apply for part-time work. Because he's made so much progress he's been discharged from the community mental health team, but he has lots of self-help resources which he can refer too, and he also has contact details for primary care services which can help those with more common mental health illnesses.

Community Hospitals

These alleviate pressure on the acute hospital sites and traditionally provide short-term in-patient support for someone who can't stay at home, but neither are they too poorly that they require the specialist expertise of an acute bed.

Community hospitals will play a key role in our local system, and we believe there is potential for some of them to do even more than they currently do.

This would mean even more services provided in the local community, closer to home.

As we provide more responsive local support in people's homes, we do think the use of community hospitals might change.

We will be working with stakeholders to understand how many beds we may need and how community hospitals could offer a broader range of services such as more outpatient or day case activities.

Urgent Care

Sometimes we all need urgent care for an emergency or life threatening condition and we want to make sure that the right care is available across our two counties, 24 hours a day. This is about getting someone in this position the right care they need when they need it and in the most appropriate place without unnecessary delays.

But we also know that many people go to A&E when they could have been treated elsewhere. This overloads the services and leads to long waiting times and too many people waiting on trolleys in corridors.

To help understand the pressures in A&E we have been looking at A&E attendance, performance and staffing levels to ensure that people who really need it are getting the best service possible in the right place, from the right professionals who have the skills to meet people's physical and mental health needs.

We also need to strengthen the range of 7-day services and support for both physical and mental health issues, to prevent people getting in crisis and requiring urgent care services. This links back to the improvements we want to make to our out of hospital services.

In Herefordshire we have already worked with the public and local clinicians to identify what outcomes are important to people, and how we can best meet their urgent care needs through local services. We have used this to look at what changes we might need to make and we will be consulting on this in the coming months.

Acute Hospitals

By preventing the risk of avoidable hospital admissions and by moving some activity into the community, this will help ensure that only those with an acute medical condition need to access an acute hospital, and when that is required they don't have to stay any longer than required.

Given some of the challenges we have recruiting to certain specialist roles, we want to ensure they are sustainable so we aren't spreading our resources too thinly which is a risk. We need to make sure we have the right staff equipped and skilled to provide the specialise care needed. This might mean having to travel further in some cases in order to get the safest and most effective care possible.

Some services are already delivered in a specialist 'centre' which is safer and more clinically appropriate, for example:

- **Major trauma** – if you are in a car accident and suffer a head injury you are taken straight to a major trauma centre out of county
- **Stroke** – anyone who has a stroke in Worcestershire is treated at the Worcestershire Royal where a specialist stroke team is available to provide the highest level of care
- **Heart attacks** – if you have a heart attack because your arteries are clogged up you are likely to need a stent (a small tube) to re-open them. This is done in a specialist centre in Worcester where there are highly trained staff capable of carrying out this life saving procedure.

Ten days in a hospital bed for someone over 75 leads to a 10% loss of aerobic capacity and 14% loss of muscle strength – **equivalent to 10 years of life**

Using our land and buildings better:

We want to bring all our NHS and local government sites up to modern standards. We want to make better use of our out of hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

We want to explore how we can work together to get more value from our land and buildings.

Using technology to modernise health:

Good information and advice helps people take control of their health. Shared information will help hospital clinicians, GP practices, local community teams, which include health and social care, to work together more effectively. Technology will help us to provide more rapid and reliable information for patients, and our clinicians will make sure technology is built into new services, with support provided for those who might need it.

The amount we currently receive **£1.17 billion**

The amount we will receive **£1.37 billion**

But with demand increasing it's expected that we'll need an additional **£230m unless we act now**

Finances

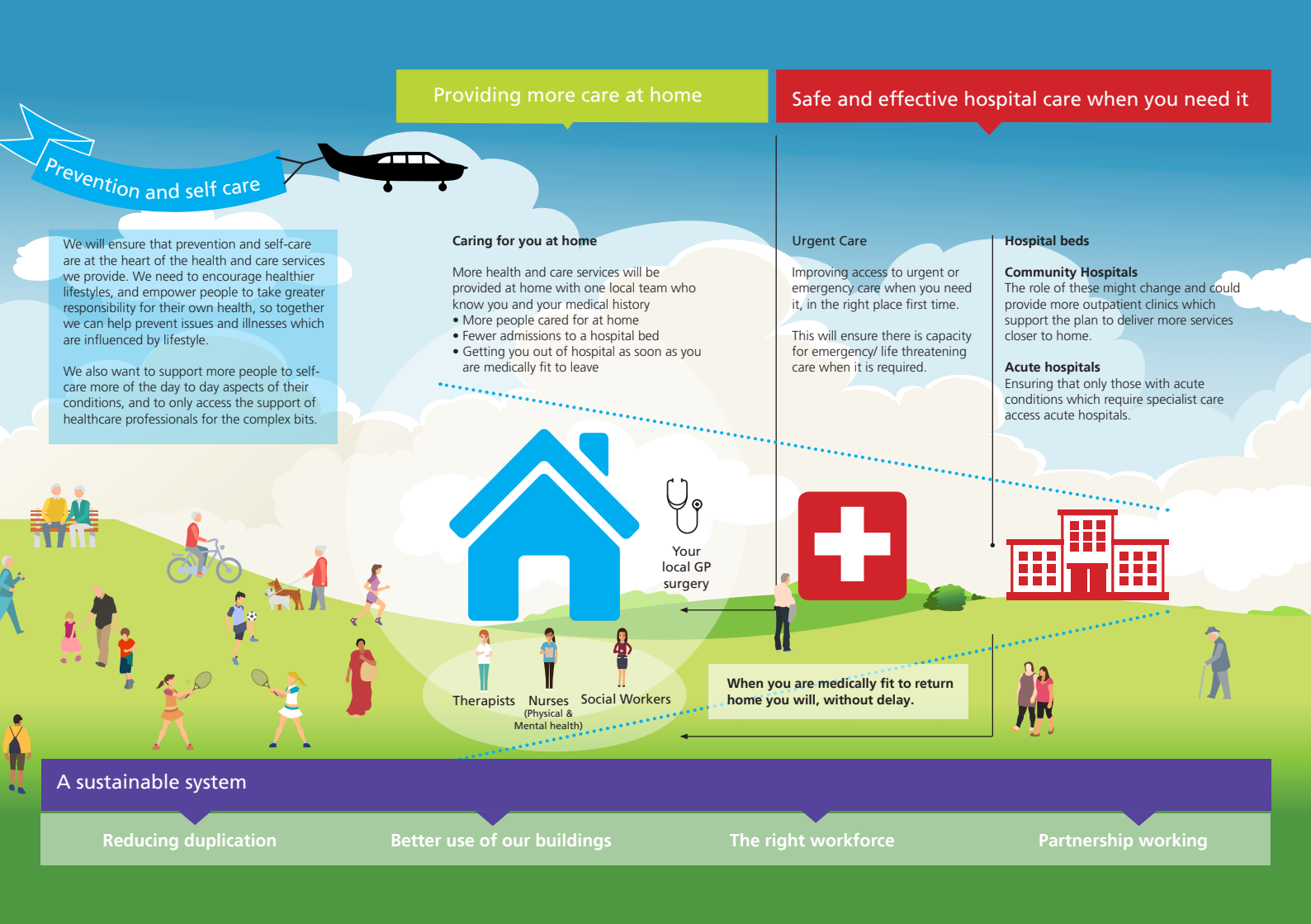
We will receive more money over the next five years but on current projections it won't be enough to meet the continual rise in demand. Even with the increase in funding, if we do nothing the gap between what we receive and what we would need to meet that demand will be around £230million.

We have thoroughly reviewed our finances, including making comparisons with national figures, looking for opportunities to secure savings and ways to organise services more efficiently. We continue to look at the demands on services and our costs.

We think the types of changes described in this update will help us save money and ensure we have sustainable services long-term. We cannot continue overspending as it puts services at greater risk so while the quality of care will always be our priority, we will also have to make sure we are using our resources the best we can.

In summary, we will...

- Maximise efficiency and effectiveness across clinical, service and support functions
- Put prevention at the heart of what we do, and create an environment where people stay healthy supported by resilient communities
- Improve our services which care for people at home or closer to home, supported by GPs working alongside community teams
- Ensure acute sites have the capacity to provide the care the staff are trained to provide
- Ensure our specialist services are safe and sustainable
- Involve and engage our communities before any significant changes to services.


Providing more care at home
Safe and effective hospital care when you need it
Prevention and self care
We will ensure that prevention and self-care are at the heart of the health and care services we provide. We need to encourage healthier lifestyles, and empower people to take greater responsibility for their own health, so together we can help prevent issues and illnesses which are influenced by lifestyle.
We also want to support more people to self-care more of the day to day aspects of their conditions, and to only access the support of healthcare professionals for the complex bits.
Caring for you at home
More health and care services will be provided at home with one local team who know you and your medical history
• More people cared for at home
• Fewer admissions to a hospital bed
• Getting you out of hospital as soon as you are medically fit to leave
Urgent Care
Improving access to urgent or emergency care when you need it, in the right place first time.
This will ensure there is capacity for emergency/ life threatening care when it is required.
Hospital beds
Community Hospitals
The role of these might change and could provide more outpatient clinics which support the plan to deliver more services closer to home.
Acute hospitals
Ensuring that only those with acute conditions which require specialist care access acute hospitals.
Your local GP surgery
Therapists
Nurses (Physical & Mental health)
Social Workers
When you are medically fit to return home you will, without delay.
A sustainable system
Reducing duplication
Better use of our buildings
The right workforce
Partnership working

#YOURCONVERSATION

YOUR HEALTH AND WELLBEING IN HEREFORDSHIRE AND WORCESTERSHIRE

Your Health & Wellbeing
#**Your**Conversation

We want your views on the information in this update which provides some thoughts for how health and care services may change over the next five years.

There will be more details to follow and we won't make any significant changes until we have carried out full engagement and consultation work with our patients, staff and the wider community.

You can join in the conversation online at: **www.yourconversationhw.nhs.uk** or by following the organisations on social media.

We will be getting out and engaging our patients and local communities on this update over the next few months and we will be publicising events and engagement activity at **www.yourconversationhw.nhs.uk**

Produced by Herefordshire and Worcestershire Sustainability and Transformation Programme. November 2016