1.0 Developing the Integrated Community Enablement model to support frail elderly people with complex needs

2.0 Purpose

2.1 This paper highlights that the current approach to meet the needs of frail elderly with complex needs is not sustainable for the future. It sets out:

- An integrated model to meet the needs of the population including this group.
- The clinical and financial benefits of the proposed model.

2.2 Previous papers to Board (September 2012, February and July 2013) have highlighted the work originally steered by the Pan Shropshire Urgent Care Board to develop a new model of care for ‘Frail and Complex’ patients.

2.3 The Urgent Care Strategy had recognised that the current model of treatment, care and support for frail elderly patients tended to be hospital bed-based and fragmented.

2.4 A strong hypothesis had been developed that with the appropriate community based care, admissions could be avoided, and earlier discharges facilitated. Similarly within the acute sector, better multi-disciplinary assessments and ‘tracking’ of patients would improve the speed of interventions and flow through the hospital.

2.5 The Urgent Care Board had recommended that the solution to these problems was to redesign urgent care services by creating, what was then called, a ‘Frail and Complex’ model. While this was not completely defined, the intention was to redesign elements of both the acute and community services supporting frail elderly patients with complex needs.

2.6 The respective providers had been invited to collaborate to design the model, and suggest ways of delivering this. Unfortunately progress stalled during the challenging winter last year (2012/13).

2.7 There was also some confusion about what a ‘Frail and Complex’ service was – particularly given the different starting points in Shropshire (where there are four Community Hospitals) and Telford & Wrekin where there is an effective community Intermediate Care service – The ‘Enablement Team’.

2.8 In early 2013 the CCGs commissioned the ATOS Management Group to complete an audit of the local urgent care system. Their analysis demonstrated, (along with other related findings), that the health economy could do more to ‘optimise capacity’. This would facilitate alternatives to
admission and speed up discharges.

2.9 One of the 5 project groups set up to implement the ATOS recommendations was the ‘Optimising Capacity to Support Discharge Group’. This group includes representatives from both Shropshire and Telford & Wrekin Councils, both CCGs and provider leads. It has built on the earlier concepts for a ‘Frail and Complex model’, and produced a series of proposals that were supported by the Chief Officer group and the Pan Shropshire Transformation Board.

2.10 The Optimising Capacity Group commissioned a further analytical exercise from the clinically led ‘Oak Group’. This was designed to clarify which patients really needed acute care and which did not. For the latter group of patients it would identify what alternative clinical capacity would have more effectively met their needs in the community. The exercise was completed in August 2013 and the report received in September confirmed much of the earlier hypotheses. The full report available from Michael.Bennett@Telfordccg.nhs.uk

2.11 The key recommendation emerging from the Optimising Capacity group is for Telford & Wrekin to build on the integrated community based ‘Enablement’ model which already includes health and social care staff. An expanded service would provide more capacity to support rapid access to alternatives to admission and ensure timely discharge when patients are ready to go home.

2.12 This model is in alignment with the CCGs proposed commissioning intentions for 2014/15.

3.0 Reasons for the proposal

3.1 The rationale for the integrated model of care includes:

- National focus for integration of services
- Meet the requirements of the Integrated Transformation Fund (ITF) including:
  - 7 day health and social care services
  - Joint approach to assessments and care planning
  - Joint funding for integrated care packages
  - Protection of social care services
- National focus on the poor care for frail, elderly patients
- Implication of the Social Care Bill for eligibility to access services; better information and prevention services
- Patient experience, e.g. the Urgent Care Strategy has been built on patient messages:
  - Be joined up and responsible for my care
  - Help me understand my (urgent care) needs
  - Assess and treat me promptly and in the right place
  - Admit me to hospital only when necessary
  - Try to care for me at home, even when I am ill
• Quality and safety issues
• Demographic changes
• Findings from ATOS, and the Oak Group Audit August 2013.

3.2 The Oak Group audit reviewed 299 patients in SaTH. 70% were over 70 years of age. The audit found;

“There is a significant proportion of patients residing on non-elective in-patient beds when their care could be provided in lower levels of care. This applies to both acute and community hospitals. 48% of acute patients and 65% of community hospital patients audited could have been supported with lower levels of care in a community setting.”

3.3 It is essential that changes are planned now as continuing to commission the same model of care is unsustainable in the future. The 2011 census indicated that T&W had a population of 164,400, with a younger age profile than nationally. The population is forecast to increase to 196,300 by 2026 (over 15%).

3.4 Residents aged 65 and over are an increasing proportion with the fastest increase since 2001 in the 85+ age group (27.3%). The 65+ population is expected to increase by 9,200, an increase of 37%. This age group currently represents 14.5% of the total population. By 2026 this will 17.3%.

3.5 This rise in the population indicates a significant increase of people who will be frail elderly with complex needs; at risk of falls; have dementia and LTCs. Delivering services within the current configuration is not sustainable to manage the predicted increase in the population and subsequent demand on services.

3.6 In addition to the Oak Group analysis, it has been already established as a CCG that the predicted increase of costs due to falls shows a £350,000 increase by 2020 and £935,000 by 2035 unless the model of delivery is changed.

4.0 The proposal

4.1 The proposal is to create an Enhanced Integrated Enablement Team for Telford & Wrekin which will focus on frail elderly people at risk of and/or suffering as a result of:

• Complex needs
• Falls
• Dementia
• LTCs /End of Life
• High risk of admission
• Discharged with a need for health or support care interventions

4.2 The proposal sits in the third quadrant set out in the Commissioning
Windscreen as broadly defined:

- **A Team around the Community** – to strengthen communities, develop greater capacity for patients to ‘self-care’, and to offer support to families and carers.
- **A Team around the GP Practice** – to strengthen primary care with a multi-disciplinary approach to proactive support of vulnerable patients.
- **Enhanced Integrated Enablement Team** – to build on the existing Home from Hospital and Enablement Services and to broaden the remit to include a community based Falls Service, all admission avoidance; all discharge of rehabilitation and reablement and End of Life Care.
- **Team around the Hospital** – ensuring acute hospital services have effective processes from ED attendance, admission, treatment pathway to discharge to ensure quality and efficiency.

4.3 The existing integrated Enablement Team already includes Social Workers, Domiciliary Carers, Nurses and Therapists. The proposal is to enhance the service with additional capacity from:

- Shropshire Community Trust Community Teams – District Nurses, Rapid Response Nurses, Occupational Therapists, Physiotherapists
- Early Supported Discharge Team for Stroke
- Neuro-Rehabilitation Team (formerly SET)
- SaTH embryonic Frail and Complex team; and other clinical/therapeutic staff providing care and rehabilitation including nurses, medical staff and therapists
- Falls Prevention and Rehabilitation staff currently delivered in the Paul Brown Unit
- Additional nurses and therapists based on MCAP audit data
- Additional social workers and domiciliary carers based on MCAP audit data
- Additional District Nurses based on Benchmarking data

4.4 The Optimising Capacity working group recommended that for Telford & Wrekin, the service would be delivered, as now, through one integrated team covering the whole population with a single management structure and deliver:

- Single Point of Access/ Referral
- 2 hour rapid response for community referrals to support admission avoidance
- ‘Discharge Home to Assess’ as the default position with home being the patients’ usual place of residence.
- An extended hours 7 day provision
- Stroke rehabilitation in the community
- Community based Falls Service
- Rehabilitation within the community rather than hospital setting
- Community based End of Life care
4.5 The diagram below gives a pictorial representation of how existing teams would be included in the Integrated Team.

Creating Integrated Community Independence Service – Transition from Existing Provision

4.6 Additional staff for the Enhanced Integrated Enablement Team would become part of the team through vertical integration as identified in paragraph 4.3

5.0 Benefits Expected

5.1 Patient benefits

5.2 The benefits expected from the Enhanced Integrated Enablement team relate to those within national guidance and early adopters of this type of model:

- More people are supported in the community
- More people are enabled to recover and regain their independence
- Improved patient experience
- Improved feedback of patient experience and the quality of care received
- Improved end of life care outside hospital
- Reductions in admissions due to falls and long term implications of falls
- Reduction in the number of patients leaving acute hospital whose destination is nursing home

The indicators above identified will be included within the new service specification as part of the performance framework.
5.3 **Financial benefits**

5.4 The financial benefits relate to reduced acute activity

- Reductions in hospital admissions
- Increases in zero length of stay
- Reductions in 1-5 day length of stay
- Reductions in excess bed days in acute hospitals
- Reductions in admissions to care/nursing homes from hospital
- Reductions in admissions due to falls

These are set out in the Costs section and Appendix 1 below.

6.0 **Risks**

6.1 A number of risks have been identified in developing the Integrated Community Enablement model. Mitigating actions are identified.

<table>
<thead>
<tr>
<th>Risks identified</th>
<th>Mitigating actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The financial analysis may not demonstrate the service redesign yields the financial benefits anticipated</td>
<td>Financial modelling identified potential savings of £1.38m Further detailed analysis being carried out to model further saving potential Further savings based on commissioned activity to be modelled for 2015/16 contract</td>
</tr>
<tr>
<td>The level of structural and personal change as staff move from existing work to new community based roles will be significant and the change process may be disruptive.</td>
<td>Formal commissioning intentions given to SaTH and Shropshire Community Trust Regular meetings in place with Providers considering the impact and benefits of the proposed model</td>
</tr>
<tr>
<td>Delays in the development may arise from contractual changes/commissioning planning and prioritisation timelines</td>
<td>Chief Officers agreement to work within planned timescales Regular meetings (as highlighted above)</td>
</tr>
<tr>
<td>Limited capacity to continue the focus on this development during the winter period</td>
<td>Separate meetings focusing on Winter planning and Integration in place.</td>
</tr>
<tr>
<td>Risks from the financial challenges in both the NHS and Local Authority</td>
<td>Financial modelling includes impact on CCG and Local Authority Development in line with Integrated Transformation Fund (ITF)</td>
</tr>
<tr>
<td>Risk of over-reliance on generic 'interventions rather than fully integrated</td>
<td>Clear principle established and outlined to Providers of ensuring specialist and</td>
</tr>
</tbody>
</table>
specialist rehabilitation and care interventions | generalist interventions. Detailed specification to be developed setting out need for specialist interventions including NICE and other guidance being delivered

7.0 **Costs and potential savings**

7.1 The section below summarises:

- The level of activity that would move to the community from SaTH
- The additional resources needed to support them within the community.
- Costs and how these would be funded
- Potential savings.

The detailed analysis to supporting the summary is Appendix 1
Cost and potential savings summary

<table>
<thead>
<tr>
<th>What do we currently commission?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current activity (20112/13) - admissions for over 65 years</td>
<td>5636 patients</td>
</tr>
<tr>
<td>Current cost (including (£1.4m excess beds days of 6+)</td>
<td>£14,376,809</td>
</tr>
</tbody>
</table>

What capacity is needed in alternative community services to provide equivalent level of 'Out of Hospital Care' 7 days/week for a proportion of 5636 patients?

<table>
<thead>
<tr>
<th>Diverted activity into the community</th>
<th>900 reduced admissions</th>
<th>Oak Group analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 earlier discharges</td>
<td>Oak group analysis</td>
<td></td>
</tr>
<tr>
<td>15-45 Fall admissions reduced</td>
<td>CCG Falls analysis</td>
<td></td>
</tr>
<tr>
<td>100-150 End of Life care admissions reduced</td>
<td>MHS Information Centre David Whiting/Karen Stringer analysis 2012</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1115-1195 reduced admissions</strong></td>
<td><strong>2000 early discharges</strong></td>
</tr>
</tbody>
</table>

What Healthcare capacity is needed to care for these patients?

<table>
<thead>
<tr>
<th>Activity needed</th>
<th>240-320 contacts per day</th>
<th>Average - including acute phase plus less intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff required</td>
<td>48-56 wte</td>
<td>Based on current caseload levels for acutely ill patients of 5-8 contacts/day</td>
</tr>
<tr>
<td>Cost of additional staff</td>
<td>£1.6m</td>
<td></td>
</tr>
<tr>
<td>What Social Care capacity is needed to care for these patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity needed</td>
<td>60-80 contacts per day</td>
<td>Current measure is based on Re-enablement episodes. These are separated into contacts based on MCAP data</td>
</tr>
<tr>
<td>Staff required</td>
<td>Tbc</td>
<td>Need to identify balance of in-house and domiciliary care</td>
</tr>
<tr>
<td>Cost of additional staff and care</td>
<td>£400,000</td>
<td>Based on additional staffing and £15-20/hour average cost for domiciliary care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How would this be funded?</th>
</tr>
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<tbody>
<tr>
<td>Integrated Transformation Fund requires a shift of £6m by 2015/16.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>What will this contribute to QIPP savings?</th>
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</thead>
<tbody>
<tr>
<td>Activity reductions in urgent care/acute contract</td>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>What is net financial impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer of resources from acute to be used to transform patient care</td>
</tr>
<tr>
<td>NB need to identify a further £1m for 14/15 to achieve target of £3m.</td>
</tr>
<tr>
<td>NB Staff included in the costing could be employed by SaTH and located in the community with the Integrated service.</td>
</tr>
<tr>
<td>The focus needs to be the transformation of pathways rather than structural change although that may be necessary either at the start or later in the programme.</td>
</tr>
<tr>
<td>QIPP saving</td>
</tr>
</tbody>
</table>

Financial modelling has been verified by the Finance team and modelled on 30% marginal rate savings
Patients contacts used as consistent currency cross all professions and recognises needs for 1-3 daily contacts across 7 days and extended hours
Predicted savings assume effective admission avoidance and early discharge and increased admissions do not offset discharges
All calculations based on 2012/13 data except cancer. Cancer based on 2011/12 data
7.2 The proposed model meets the needs of the population more effectively than the current model and in line with the national direction of travel. Savings can be made by moving significant levels of activity from the hospital to the community:

- Reduced admissions
- Increasing early supported discharge
- Reducing Excess Bed Days
- Reducing Falls related admissions
- Reducing admissions and early discharge related to end of life
- Improved patient experience

7.3 Additional community resources are required to meet the increased activity. This has been consistently demonstrated by different exercises:-

- MCAP data highlighting the need for additional community staff
- NHS Benchmarking Club data identifies low levels of community resources in Telford & Wrekin compared to national norms
- The emerging model for transformation described above to shift care into the community

7.4 The model is financially affordable if we re-commission £3m of current SaTH contract. This is in line with the CCG Board’s commissioning intentions and identified potential savings highlighted above.

7.5 Reductions in admissions will contribute to QIPP savings. The modelled reductions would save £1.38m.

8.0 **Timescales**

8.1 The proposed timetable to address this is as follows:

<table>
<thead>
<tr>
<th>Key Action</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Business case to CCG Board</td>
<td>November</td>
</tr>
<tr>
<td>Development of an Implementation Plan</td>
<td>November</td>
</tr>
<tr>
<td>Development of ITF planning agreed with HWB Boards</td>
<td>Nov 2013-Feb 2014</td>
</tr>
<tr>
<td>Working within Integration Pioneer economies to learn lessons Planning for vertical integration of teams</td>
<td>Nov 2013-Jun 2014</td>
</tr>
<tr>
<td>Negotiation through contract for new service specification for 14/15</td>
<td>Jan/Feb 2014</td>
</tr>
<tr>
<td>Alignment of identified staff to the Integrated team</td>
<td>Feb- April 2014</td>
</tr>
<tr>
<td>Identification of additional SaTH staff to the Integrated team</td>
<td>April- Sep 2014</td>
</tr>
</tbody>
</table>
Recruitment of additional staff for the Integrated Team | April- Dec 2014
---|---
Review of capacity of TAC and TAP to ensure cost effective prevention and primary care services in place to reduce admissions | April- Sep 2014
Consider commissioning intentions for 2015/16 to move resources into the community and identify resources for the ITF | Sep-Dec 2014

8.2 In the Chief Officers meeting on 1st October they agreed to support two preliminary moves to locate the Rapid Response Nurses and the Early Supported Discharge staff with the Enhanced Integrated Enablement team in Telford. This would be implemented from November 2013.

9.0 Health Inequalities impact assessment

9.1 This will be undertaken as part of further development of the programme.

10.0 Equality & Diversity impact assessment

10.1 This has been completed. It highlights that the 65+ age group has a beneficial impact. No group has a detrimental impact from the proposals.

11.0 Financial Implications

11.1 Financial implications are identified within section 7 above and Appendix 1 (separate document).

12.0 Process by which the document has been developed, including consultation and engagement of patients and clinicians

12.1 CCG Clinicians led an audit of in patients in SaTH during April 2013 which also involved community and acute clinical colleagues. The findings concurred with those from ATOS and the Oak Group.

12.2 The Integrated model developed by the Optimising Capacity On Discharge Project Group was presented at a stakeholder group in August and supported. Stakeholders, including user and carer representation, felt strongly that the model is appropriate for admission avoidance and not just faster discharge.

13.0 Recommendations

13.1 The Board to asked to:
Support the proposed Enhanced Community Enablement model
Support the proposed timescales for the implementation to the new model