South Tees Hospitals NHS
NHS Foundation Trust

INTEGRATED CARE - BRIEFING (SEPTEMBER 2012)

1 Introduction

In April 2011 the community services across Middlesbrough, Redcar and Cleveland and The Hambleton and Richmondshire districts in North Yorkshire transferred to South Tees Hospitals NHS FT, as part of the government Transforming Community Services (TCS) policy.

The purpose of TCS was to;

a. Enable the separation of commissioning of services from the provision of services within Primary Care Trusts (PCTs)
b. Support the integration of secondary and community services within the NHS and closer working with social care.

The current government has continued to support a policy of integration of services, both within NHS and with local authorities.

Over the past 12 months health and social care agencies across South Tees have worked together as part of an agreed partnership to support the redesign of services to better able support people within the community. Emergency care and reduction in emergency admissions to hospital, particularly for those over age of 65 are strategic priorities for each Health and Wellbeing Boards. This work is supported by national and local evidence that areas that have well-developed, integrated services for older people have lower rates of hospital bed use and that areas with low bed use also deliver a good patient experience and have lower readmission rates (Kings Fund 2012).

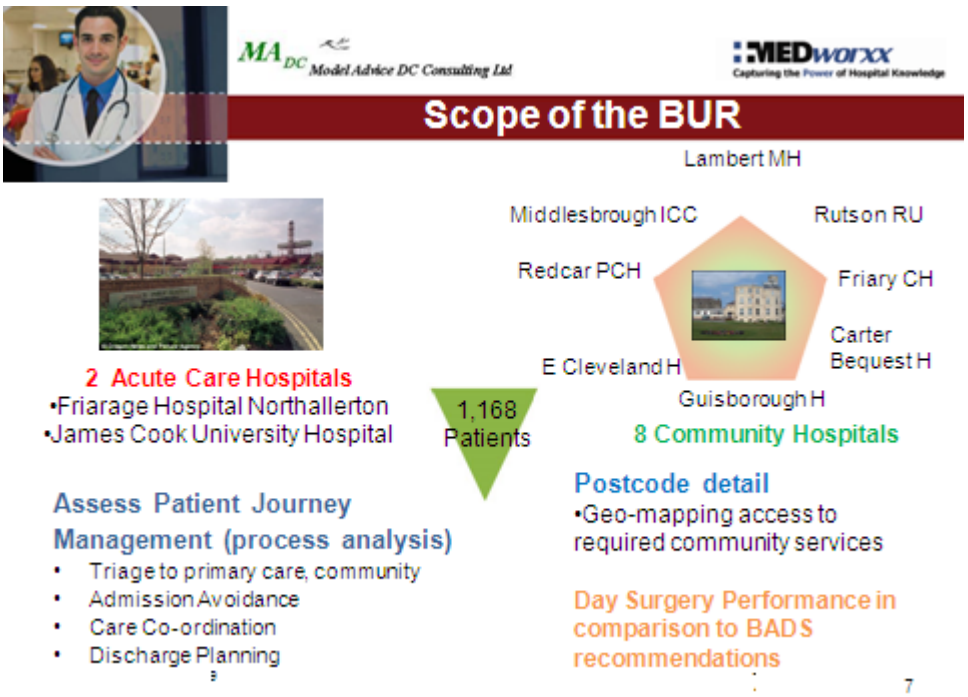
This paper provides an update on progress to date and plans for the future.

2 Background

Over the past 12 months we have undertaken a number of pieces of analysis looking at the way our systems are designed to deliver a smooth and efficient patient journey.

- The TCS work was formally launched in September 2011 at a major stakeholder visioning event that looked at the opportunities for improvement and efficiency across the Tees and North Yorkshire healthcare systems. The outputs of this event are outlined in **Appendix 1.**

- A Bed Utilisation Review (BUR) was commissioned in October 2011 and reported its findings back to the Trust in January 2012. The purpose of the review was to quantify how many patients in acute care and community hospitals require an alternative level of care and identify opportunities to restructure current resources to deliver what is required. This confirmed the suspicions of the initial TCS work that the health and social care system had inherent inefficiencies affecting the quality of the patient experience and our ability to see and treat them in the most appropriate location. The review looked at how we utilised the beds both with the acute hospitals and community hospitals within the Foundation Trust and Middlesbrough Intermediate Care Centre.



In addition to this review the Trust commissioned McKinseys to look at where there are opportunities to improve patient experience and operational efficiency. This identified that the Trust is a high performing organisation, when compared to others of a similar size and make up of services but that there are opportunities for us to perform better at an operational level which will in turn support better patient experience.

The potential impact of these three separate strands of work when considered together suggests that there are opportunities to release between 60-200 acute beds across the two hospital sites. This will be achieved by harnessing the opportunities created by the integration with the community services and, on Teesside, by the whole system redesign work being undertaken with the CCG/PCT (Clinical Commissioning Group (formerly Primary Care Trusts) and Local Authorities.

3 Improving Patient Pathway Programme

Within the Trust this work is being taken forward as a programme of work, known as the Improving Patient Pathway Programme. The projects within the programme report to the programme board, chaired by Hugh Laing (Non Executive Director).

In undertaking this work we will have a number of complementary objectives including:

- Improve the quality of care we offer to patients together with an improved experience in their stay with us
- Seek to operate at 85% occupancy
- Create headroom to support effective delivery of all clinical services
- Align acute services with community and social care (see TCS programme)
- Improve the working lives of clinical staff
- Support junior doctors to manage the care of non-elective patients effectively
- Create capacity for a winter ward
- Create capacity to increase our market share in some specialties
- Generate increased income or release financial savings

4 Transforming community services

The TCS programme continues to make progress towards the vision of :

- Care at home or as close to home as possible
- Equity of access and outcome
- Integration of core services with social care and specialist community services with acute services.

4.1 Middlesbrough and Redcar and Cleveland Localities

The South of Tees QIPP (Quality, Innovation, Productivity & Prevention) Board agreed with the vision presented and agreed to a whole system approach to the redesign and transformation of community services. The whole system redesign group has led this approach and development of the intermediate tier, previously agreed by the Trust Board. The whole system redesign group has developed :

- A partnership agreement based on a shared set of governance principles
- Scorecard approach to system level KPIs

In addition the TCS programme board, which has representatives from across the health and social care sector is now meeting monthly to monitor progress of all TCS projects and act as a problem solving forum to support the transformational change process. These projects include :

- Mapping of community services completed
- Realignment of community nursing teams to support locality team development
- Redesign of community therapy (this has started)
- Strategic service model for a rapid response team - the model is agreed and development has commenced.
- Procurement of a predictive risk tool (a way of identifying patients at risk of unplanned hospital admission giving them extra support which may prevent admission being required) commenced by the PCT
- Development of the medical model to support virtual ward (a way of providing support to people at home to prevent admission, using the same coordination of staff as happens in an inpatient hospital ward) - commenced
- Dementia workstream - commenced.
- Roll out of 'Systm one' (a clinical information system which gives primary and community staff access to patient information) and mobile working devices within community nursing – nearing completion
- Development of the telemedicine, telehealth and telecare strategy commenced in conjunction with local authorities.

In addition some actions to support changes have been put in place by the Trust :

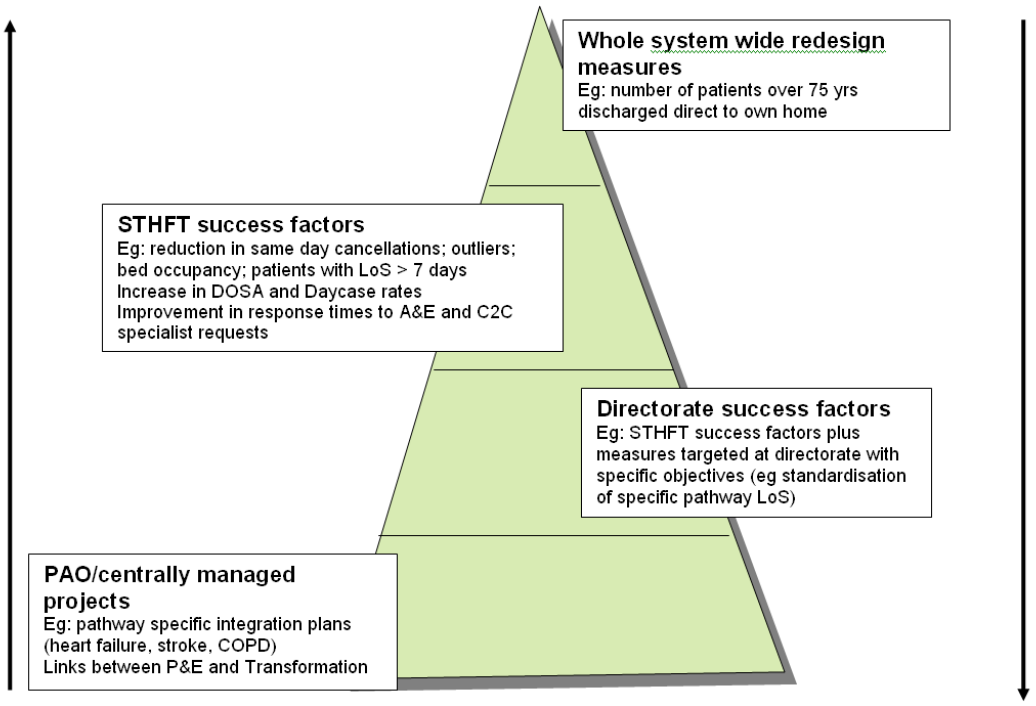
- restructuring of the Community Division from 1 April 2012;
- recruitment to various project management posts.

All projects are being monitored via a programme assurance office and the new developments are supported by £1.9 million pump priming funds.

The next phase of development is implementation of the intermediate tier services progress over the summer months with a go live date set for 1 October 2012. The CCG are now developing a strategic plan for the commissioning of the further transformation to community services s part of the clear and credible plan.

5 Acute Services Redesign Agenda

The blueprint for the acute services redesign work programme was agreed by the Trust in April 2012 and outlines the principles and philosophy being adopted and identifies a number of measures that will ensure the delivery of the desired outcomes. To support this, the team has developed a performance framework intended to provide system wide measures for the health care community, internal measures of success for the trust and measures of performance and success for individual specialties.



It is anticipated that all projects, including directorate projects will be managed through the Programme Assurance Office. The business manager allocated to this work will liaise with divisional teams to ensure that plans are consistent across the programme.

5.1 Divisional Transformation plans

Discussions are currently taking place with divisional teams to agree the areas in which they will undertake transformational change projects, the measures their directorates will work to and the timescales that will be applied. It is expected that divisions will ensure resources within the teams are allocated to support this work. Once agreed, individual divisional performance will be tracked at performance review meetings.

It is proposed to set targets at directorate rather than divisional level to minimise the risk that variation in performance is not lost in aggregation.

5.2 Case Management

A key recommendation of the Bed Utilisation Review was that the Trust consider the introduction of in hospital case management. This approach, common in USA, Canada, Australia and New Zealand essentially introduces the role of case manager to the acute hospital environment. A validated tool is used to assess each patient to determine whether they are ready to move to an alternative level of care and seeks to arrange this as soon as possible, thereby ensuring that patients are cared for within the right environment for the right amount of time. Supported by non-recurrent transformation funds the Trust has agreed to commence a 12 month pilot of case management and we are currently in the process of recruiting nurses and Allied Health

professionals to undertake this role. Training is due to commence in September 2012 with a go live date in October 2012.

5.3 Other areas of work

There is an extensive range of work being undertaken as part of the Improving patient pathway work, which is very interdependent and together will support the overall objectives of the programme in improving patient flow and reducing/reallocating the bed base. These include:

- Rapid Improvement Audits – across a range of topics including waits for diagnostic procedures and assessments by AHPS. The audit of patients receiving IV antibiotics who could be cared for in a different environment has progressed to a project developing the OHPAT service and capacity to deliver IV drugs in the community as part of TCS.

- SHA Transformation Funds - The trust was successful in being allocated funding for 4 projects from the SHA's transformation fund. Of these 3 are directly relevant to this programme. These are:

    - Investment in therapy team in A&E – now incorporated into the case management approach
    - Investment in mobile devices for Community Division –
    - Investment in dementia management

Each project will require clear objectives to be defined that can be measured and accounted for to the SHA but which also show contribution to reducing bed occupancy on the acute sites.

6 Conclusion

There has been considerable activity undertaken across the organisation with internal and external stakeholders. The initial phase has been in mobilising energy and action and developing a better understanding about which projects will deliver sustainable change and the best methods for achieving this. The Trust divisional transformation plans and monitoring of these via the Trust Programme Assurance Office is key in identifying interdependencies both within the organisation but also across the health and social care system.

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07.09.12

Appendix 1 – Outcomes of Visioning Event, September 2011

The event held on 14 September 2011 provided a wide range of stakeholders from across the geographical areas served by South Tees Hospitals Foundation Trust with the opportunity to discuss and describe the desired future of services delivered in a community setting.

The following themes emerged from the day:

- Service transformation should be considered at system level to fully maximise the benefits of integration in terms of quality, productivity, effectiveness and efficiency.
- Services should be based around communities, on a locality basis
- We should seek to provide equity of access and equity of outcome for all communities served.
- The ways in which services are provided will differ across communities depending on population need, demography, geography and the resources available.
- Care should be organised on the basis of pathways which work across organisational and other boundaries to achieve patient centred services and minimise clinical variation.
- Planning should not be based on the existing infrastructure but the principles of
    - care at home or as close to home as possible
    - supporting individuals, families and carers to maintain independence and self-care as far as possible.
- Integration of services should support patient centred services and pathways of care in a number of ways and at different levels.
- Innovation via information and information technology in the forms of telehealth, telemedicine, telecare and mobile working solutions should be maximised.
- Strategies for the specific demographic challenges relating to the elderly should be developed.
- The amount and complexity of service transformation required over next few years will be matched by the amount of transformation required within the health and social care workforce
- Strategic alliances with the 3rd sector should be developed to support the theme of communities and services arranged on a locality basis.
- From the emergent themes and analysis of a range of hard and soft evidence across the system the following model is proposed as the strategic direction for services delivered in a community setting:
- To organise services on a locality basis, coterminous with local authority and clinical commissioning boundaries, with sub-locality teams that support practical alignment to primary care.
- To develop a robust intermediate tier of core services, e.g. community nursing and therapy which is integrated with social care and supports a step change in the number of vulnerable and/or elderly adults with one or more long term conditions in their own homes.
- To review the role, function and number of community hospital beds and services
- To integrate specialist services with acute specialist services that provide an outreach/in reach service and advice to primary care and locality teams as most clinically appropriate within an integrated pathway of care.