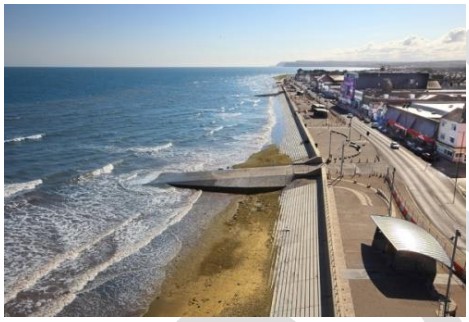
IMProVE – Integrated Management and Proactive Care for the Vulnerable and Elderly

Case for Change



March 2014

Contents

Case for Change - Integrated Management and Proactive Care for the Vulnerable and Elderly – Draft Work in Progress

1 Introduction

This case for change has been prepared by NHS South Tees Clinical Commissioning Group (CCG) in partnership with all stakeholders in health and social care across the area. It sets out a vision for the provision of a new enhanced care in the community model, which would involve a much more integrated approach than exists now and will be used to help inform proposals for formal public consultation.

Our intention to transform community services was included in our Clear and Credible Plan (published in the summer of 2012) and builds on work that was started by the former primary care trust. The focus will be the integration of services across primary, community, acute and social care with a move away from a more traditional bed-based model of care, and specifically aimed at older and vulnerable adults with one or more long term conditions.

We feel that the services we are currently providing for these patients could be much better and more focused on their actual needs. As they currently stand there is a very heavy reliance on hospital services. Generally, our services are reactive and result in too many older and vulnerable patients spending too much time in hospital when they don't need to.

The number of emergency hospital admissions is significantly higher than the national average, which we believe could be avoided if the right support was in the community to help people when their health deteriorates to reduce the risk of a crisis which requires a hospital admission.

Our community hospitals are being used mainly as step down facilities (where patients are transferred there following an unplanned admission in the James Cook University hospital) rather than step up (where patients are admitted when their condition deteriorates to prevent a crisis happening). The average length of stay for step down patients is 28 days, with over seven out of ten staying 14 days or more.

An assessment of bed usage in our community hospitals showed that almost half of the patients didn't need to be in a hospital bed but were there mainly due to insufficient home based health and social care services.

In addition, with the right community services, fewer people would also need to go into residential care. According to the National Adult Social Care Intelligence Service 2011-12 in Redcar and Cleveland there are 24 per cent more admissions of people over the age of 65 to residential care than authorities with similar populations and 59 per cent more than the England average.

We also feel that the level and frequency of rehabilitation that some patients receive in a community hospital could be improved.

By working with our partners and the public we want to bring about some changes which we strongly believe would provide better and more responsive care for older and vulnerable patients.

The model of care we are would like to achieve is based on the principles of "**right care, right place, at the right time**", with the overall aim being to provide care as close to home as possible, wherever this can be done safely and cost effectively, with an increased emphasis on patient choice, and empowering the patient to manage their own care where this is appropriate.

Importantly, the vision is to move away from the reactive care model described above to one which is more proactive and responsive in delivering a range of interventions aimed at preventing deterioration in a person's condition and an avoidable hospital admission. This includes early identification of those patients who may be at risk of their long term condition deteriorating; working with them and their carers or family to maintain their independence and if they do fall ill, return them to as near normal state of health as is possible.

To achieve this ambition there would need to be a truly integrated model of care which spans the entire spectrum of health and social care, 24/7 to provide the most appropriate levels of support whenever and wherever our service users require it. We will aim to move towards providing services which are co-located, making best use of our estate, to make it easier for service users to access them, with a real emphasis on prevention of disease and the promotion of healthy living. This is in line with the national vision for the integration and transformation of health and social care.

To take this work forward, we established the Integrated Management and proactive Care for the Vulnerable and Elderly (IMProVe) Advisory Group which comprises colleagues from the CCG, South Tees Hospital NHS Foundation Trust, Tees Esk and Wear Valleys NHS Foundation Trust, Middlesbrough and Redcar and Cleveland local authorities and the Durham, Darlington and Tees Area Team and more recently we were pleased to welcome representatives from Healthwatch Middlesbrough and Healthwatch Redcar and Cleveland to join our discussions.

Over the past year the group has been meeting to discuss what steps we need to take to realise this vision.

This case for change outlines some of the issues we have taken into consideration such as the drivers for change including national, regional and local strategies, clinical considerations and the health of our population. We have also looked at current community hospitals and community based intermediate care facilities and how these are being used and the economic factors which we need to consider. Last, but by no means least, we have considered what patients, particularly older people and those with long term conditions, told us during autumn 2013 when we carried out a substantial amount of engagement to understand better what is important to them when they need to use our services. The case for change also

sets out what a new service could look like and what would be some of the key enablers to achieving this.

2 What we would like to achieve

To meet the challenges now and in the future we want to provide care that is closer to home particularly for patients and service users who may have one or more long term condition, or who are simply frail and elderly. To achieve this, there will need to be much greater integration of health and care provision.

For the purpose of our vision integrated care is defined as:

> *A range of different services which delivered together work seamlessly to provide better quality patient care.*

The main aim is to shift the need for unplanned care in acute hospitals, as a result of an unpredicted health crisis, to a more proactive approach by forecasting individual patient needs for care and support which can be delivered in primary/community care and the service user's own home environment. By being more responsive and offering care in the most appropriate setting, we aim to improve clinical outcomes, improvements in measures of mental health and well being as well as the quality and experience of care we offer to our patients/service users.

Our key principles are:

- To provide and deliver sustainable, fully integrated, high quality care for all our patients / service users
- To proactively identify and effectively manage those people with the highest risk of future hospital admission
- To ensure better clinical outcomes for patients
- To facilitate, as far as possible, an environment where patients can self-manage their own condition and feel confident enough to do so
- To ensure that patients gain the best functionality as possible at the end of their health episode, and are returned to the best possible state.

A fully integrated approach across the entire health and social care system inclusive of partners from voluntary and independent sectors will ensure that we can offer the most appropriate interventions, in the right place, at the right time.

This will require extensive linkages with the developing urgent care strategy and the continued progression of the NHS 111 telephone access service. Within primary care, we will continue to support GP practices to make better use of telephone consultations and triage through the use of tools, such as Doctor First (a demand-led system that allows practices to effectively manage demand by clinicians talking to all patients, who are then assessed on a clinical priority basis) and Productive Practice

(a programme designed to help general practices continue to deliver high quality care while meeting increasing levels of demand and diverse expectations).

Our objectives are:

- To offer targeted and proactive **individualised case management** in a community setting with a range of additional support services for patients aimed at maintaining and improving their current health

- To **improve routine care for all patients with long term conditions** to prevent deterioration of their overall condition

- To **reduce avoidable unplanned hospital admissions** and readmissions for all patients following an exacerbation of their long term condition or deterioration of general health

- To **identify the need for and improve access to a range of integrated support services** on a 24/7 basis to allow them to better manage their own condition and remain as independent as possible

- To **improve outcomes** for elderly and frail patients and those with long term conditions

- To **identify early, via the use of a predictive risk tool, those patients at risk of a future admission**

- To **effectively deliver care and support for patients** through making the best use of our available resource.

3 The drivers for change

3.1 The NHS South Tees Clear and Credible Plan

The NHS South Tees CCG Clear and Credible Plan (CCP) published during summer 2012 sets out the commissioning vision for the CCG which is to Improve Health Together across South Tees. This means that we want to:

- Reduce health inequalities
- Reduce variable access to health care
- Continuously improve wellbeing
- Drive up the quality of services we commission

The plan focuses on the key priority areas from the Joint Strategic Needs Assessments for Middlesbrough and Redcar and Cleveland, specifically:

- Cardiovascular disease (including stroke)
- Cancer
- Smoking related illnesses e.g. chronic obstructive pulmonary disease (COPD)

- Alcohol related illness
- Health inequalities exacerbating the situation in the areas outlined above.

The CCP notes that detailed analysis of current hospital provision across South Tees shows a general picture of both strategic and operational developments that are the result of historical organisational forms, philosophy and where there was economic growth in the NHS. South Tees, and in particular Redcar and Cleveland, is quite unusual in having the number of community hospitals for its population size.

The opportunities for providing care outside of hospital, for example enhanced integrated community care provision and early supported discharge for stroke, and more innovative ways in which we commission is likely to see changes to the way in which beds need to be utilised in the community.

3.2 Local authority strategies

The South Tees community is served by two local authorities, Middlesbrough and Redcar and Cleveland, serving a population of 273,742 (138,744 in Middlesbrough and 134,998 in Redcar and Cleveland). Both authorities have an above average rate of deprivation and child poverty. Life expectancy is significantly lower than the national average and the gap is even more marked for those aged over 75.

The vision for adults living across the boroughs is for a sustainable social care system which prioritises supporting people to maximise their independence, remain safe in their own home and be part of the local community for as long as economically possible. There is recognition that effective strategic commissioning can drive transformation to deliver this vision for adult social care, as it will:

- Enable strategic investment
- Provide a rational resource allocation tool
- Focus on achieving outcomes
- Drive up quality
- Enable the design of more effective services
- Facilitate collaboration with providers
- Develop in house services

Both strategies set out the direction of travel and include practical steps that need to be taken to achieve desired objectives while seeking to fundamentally change the relationship between the council and the people of the borough and emphasise the role of commissioning to reshape service models and drive financial efficiencies.

The strategies also explain the context to commissioning services to support people with adult social care needs as well as the ways in which commissioning will make best use of resources to promote independence and choice for adults in the boroughs. Both long-term strategies are supported by more detailed commissioning plans.

There are some clear opportunities to further develop strategic commissioning, with partners, to take a whole system approach to improving outcomes for the local population.

3.3 The regional strategic context

During the transition from primary care trusts to clinical commissioning groups, a series of legacy documents were produced to support the new organisations to undertake their new responsibilities.

One such document was produced as part of the County Durham and Tees Valley Acute Services Legacy project, which started in April 2012. The aim was to review the provision of health services across the region specifically with a focus on acute care, to determine if the best possible services were being delivered in terms of quality and efficiency for our patients.

A summary of the main contextual messages from this project, relevant to this case for change, are as follows:

- Following years of growth, demand for acute services is currently high for both elective and non-elective care.

- There will be a significant increase in prevalence across the major long term conditions over the next 10 years and a greater population will be over the age of 65.

- This will have an impact on the utilisation of acute services to a varying degree in the different services areas.

- This growth will put pressure on commissioners' allocations over the next 10 years as an older population with more co-morbidity will consume more health resource, unless effective demand and long term conditions management are implemented. This analysis does not take into account potential increased spend on high cost drugs and new medical technologies in the acute setting that may require further investment from commissioners.

- Forecasts show that providers can maintain a financially stable position over the next five years as long as cost improvement plans deliver to target. Failure to deliver these targets will have implications for trusts operating surplus / deficit position and ultimately the length of time they can rely on cash savings to keep them solvent.

3.4 The national strategic context

Following the last general election the coalition government produced a White Paper entitled "Equity and Excellence – Liberating the NHS". This described a series of sweeping reforms designed to put clinicians at the forefront of decision making in the NHS, and promised that the system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships.

The coalition government announced that it was to give priority to improving services for the elderly and those with long term conditions, stating that "by 2015, every health economy should be able to demonstrate high levels of care co-ordination or integrated care".

In July 2013 NHS England published 'The NHS belongs to the people: a call to action' which called on the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients. This was set against a backdrop of flat funding which, if services continue to be delivered in the same way, as now, will result in a funding gap which could grow to £30bn between 2013/14 to 2020/2021. For South Tees this equates £179m.

The document says that the NHS must change to meet these demands and make the use of new medicines and technology.

The then chief executive of NHS England, Sir David Nicholson, said that the focus needed to shift from buildings and onto patients and services.

This was a call for creativity, innovation and transformation. It will require a significant shift in activity and resource from the hospital sector to the community.

NHS England's planning guidance, 'Everyone counts: Planning for patients 2014/15 to 2018/19' calls for CCGs, working with key partners to lead the development and implementation of a 'modern' integrated model of care. The announcement of Integrated Care Funding in July 2013, now known as the 'Better Care Fund' aims to assist this integrated transformation, with a single pooled budget to support health and social care services to work more closely together in local areas.

This five year planning guidance advocates a number of key ambitions which include:

- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions

- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

- Increasing the proportion of older people living independently at home following discharge from hospital

- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

More recently in November 2013 NHS England's national medical director, Sir Bruce Keogh, published the first stage of his review of urgent and emergency care in England. This was developed after an extensive engagement exercise and it proposed a new blueprint for local services across the country that aims to make

services more responsive and personal for patients, as well as deliver even better clinical outcomes and enhanced safety.

He said the current system is under ‘intense, growing and unsustainable pressure’. This is driven by rising demand from a population that is getting older, a confusing and inconsistent array of services outside hospital, and high public trust in the A&E brand.

He advocated a system-wide transformation over the next three to five years, saying this is ‘the only way to create a sustainable solution and ensure future generations can have peace of mind that, when the unexpected happens, the NHS will still provide a rapid, high quality and responsive service free at the point of need’.

For those people with urgent but non-life threatening needs there must be highly responsive, effective and personalised services outside of hospital. He said these services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families. He said people with more serious and life threatening emergency needs should be treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

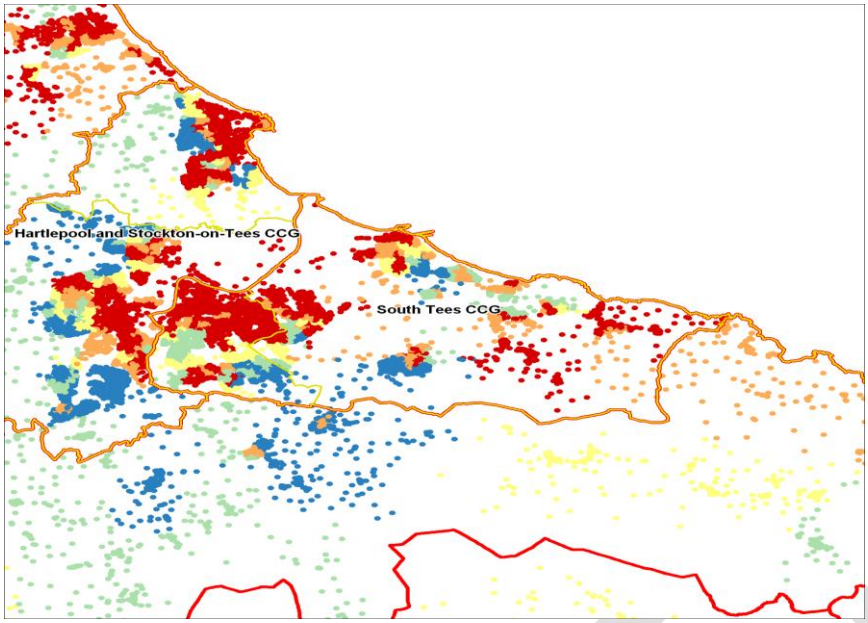
Highlighting opportunities to shift care closer to home he said 40 per cent of A&E patients are discharged requiring no treatment; up to one million emergency admissions were avoidable last year; and up to 50 per cent of 999 calls could be managed at the scene.

3.5 The health of our population

While the health of people in Tees is generally improving, it is still worse than the England average. Historically, our local area has been highly dependent on heavy industry for employment which has left a legacy of industrial illness and long term conditions. This, coupled with a more recent history of high unemployment as the traditional industries have declined, has led to significant levels of deprivation and health inequalities that rank amongst the highest in the country.

Within South Tees itself there are inequalities with regard to life expectancy, access to services and deprivation. The inequalities in life expectancy are evident in the most disadvantaged areas of Middlesbrough, where men can expect to live 14.8 years and women 11.3 years less than people in the least disadvantaged areas.

The map below shows the levels of deprivation within the area covered by our CCG, based on the Index of Multiple Deprivation 2010 (IMD2010), which shows that a significant proportion of our population live in the most disadvantaged areas:



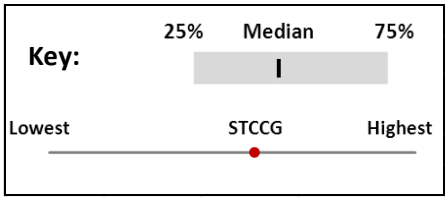
IMD score by quintile
- Quintile 5 (lowest)
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 (highest)

Over the last ten years, the death rate from all causes has fallen steadily for men, but has fluctuated for women. The early death rate from heart disease and stroke has fallen and the early death rate from cancer has also fallen, but has stabilised recently.

However, the table below shows that South Tees ranks higher than the England average for almost all disease prevalence. It shows the number and percentage of diseases recorded for the Quality Outcomes Framework (QOF) for the practices in this CCG in 2012/13. For all but one indicator, prevalence in South Tees is above average.

QoF 2012-13 Disease Prevalence Data: South Tees Clinical Commissioning Group			
QoF Disease Register	Number on Register	Prevalence (%)	Boxplot
Coronary Heart Disease	12,606	4.3%	
Stroke or Transient Ischaemic Attacks (TIA)	5,886	2.0%	
Hypertension	2.0	14.8%	
Chronic Obstructive Pulmonary Disease	7,747	2.7%	
Hypothyroidism	13,475	4.6%	
Cancer Prevalence	5,646	1.9%	
Mental Health	2,555	0.9%	
Asthma	17,425	6.0%	
Heart Failure	2,437	0.8%	
Heart Failure Due to LVD	1,538	0.5%	
Palliative Care	1,051	0.4%	
Dementia	1,864	0.6%	
Atrial Fibrillation	4,533	1.6%	
Cardiovascular Disease Primary Prevention	6,560	2.3%	
Peripheral Arterial Disease (PAD)	2,611	0.9%	

Vertical black line indicates England & Wales Average



In both Middlesbrough and Redcar and Cleveland we have continuing challenges in relation to the percentage of mothers smoking in pregnancy and breastfeeding initiation are worse than the England average.

The rate of hip fractures, sexually transmitted diseases, smoking related deaths and hospital stays for alcohol related harm are worse than the England average. Obesity levels are worse than the England average.

In terms of the older population, the demand for care and support, particularly residential care, continues to increase as people are generally living longer due to medical advances, and the transition into old age of the baby boom generation. There will be a significant increase in the number of people over 85, and an increase in the number of people living with dementia. These continued rises will not be matched by resources available to local authorities. Therefore, new and more cost effective approaches to supporting individuals are needed.

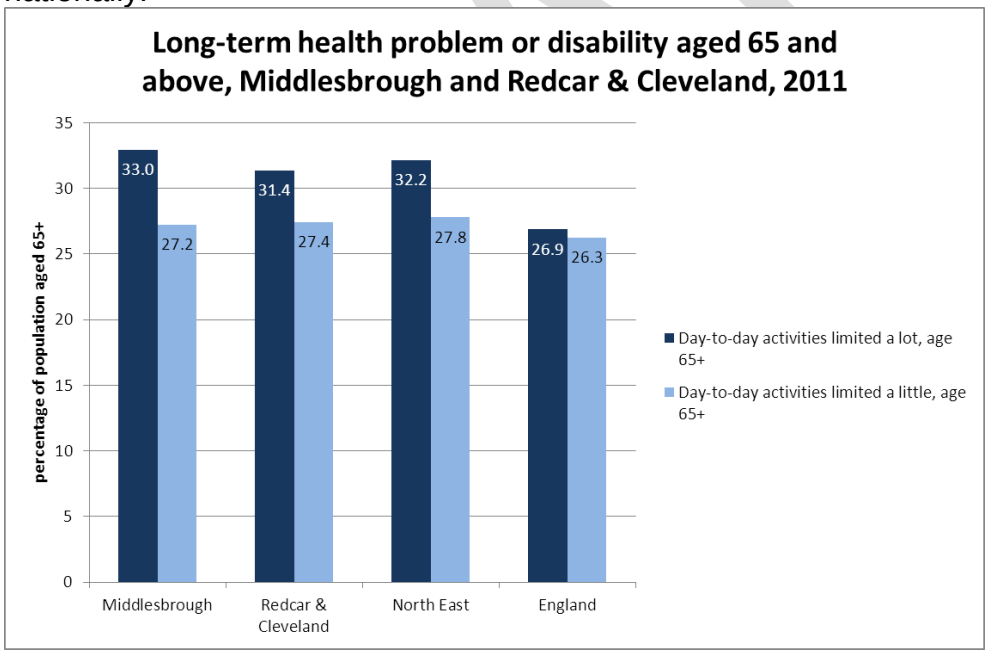
The total population of South Tees is 273,742 of which 48,689 are over the age of 65. This and the projected increase in the population are set out in the table below:

Authority	Mid-2012 population estimate			2021 population projection		
	Number	No. (%) aged 65 +	No.(%) aged 85 +	Number	% aged 65 +	% aged 85 +
Middlesbrough	138,744	21,293 (15.35%)	2,591 (1.87%)	144,275	24,997 (17.33%)	3,911 (2.71%)
Redcar & Cleveland	134,998	27,396 (20.29%)	3,259 (2.41%)	135,466	31,782 (23.46%)	4,540 (3.35%)
Total	**273,742**	**48,689 (17.7%)**	**5,850 (2.1%)**	**279,741**	**56,779 (20.2%)**	**8,451 (3.2%)**

Source: ONS mid-2012 population estimates and interim mid-2011 based population projection

This predicted increase in the number of retired people living in the area will have a major impact on health and care services. Older patients may be expected to present a greater disease burden due to long term conditions and higher GP consultation rates.

The graph below, although taken from 2011, shows that long term health and disability problems are greater in our area than the rest of the North East and nationally.



Patients aged 75+ have a disproportionate impact on acute hospitals: although only a quarter of patients with emergency admissions at James Cook University Hospital are aged 75 or over, these patients account for the majority of emergency bed days:

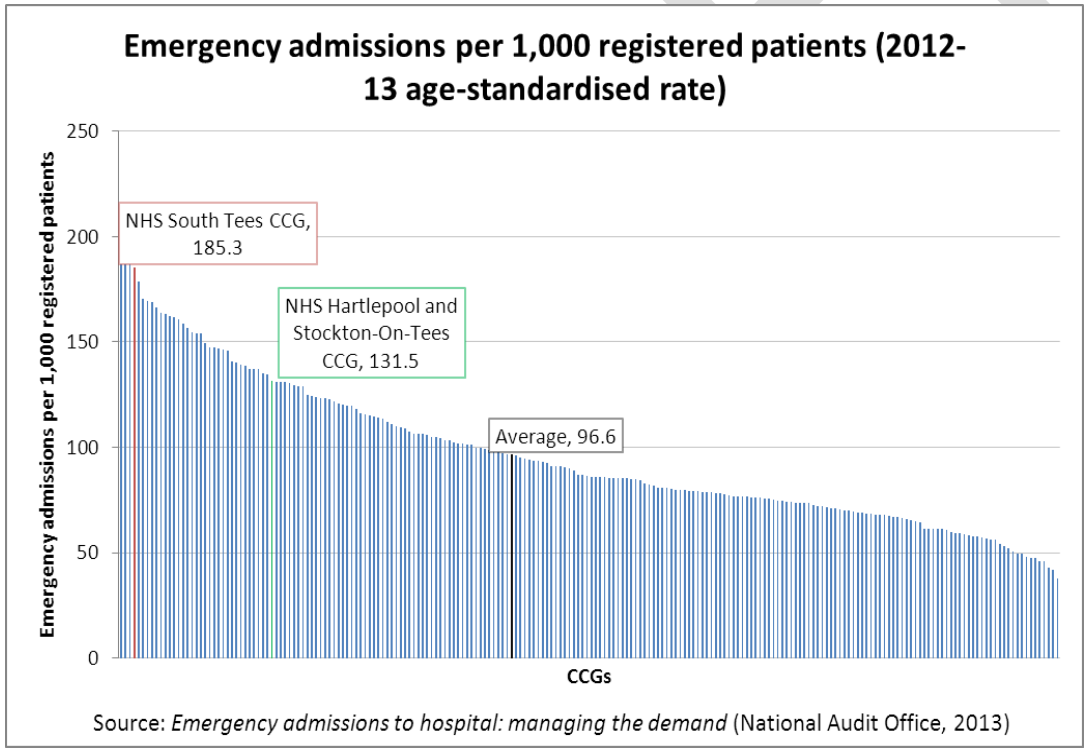
	0-74	75+
Number of Patients	18,093	6,044
Number of Spells	25,480	9,867
Total Length of Stay	69,966	86,713

Around 65% of service users aged 75+ with an emergency admission have a diagnosis for either chronic obstructive pulmonary disorder, coronary heart disease, stroke or diabetes, which may or may not be the primary reason for their hospital admission. Over a quarter of these have two or more of the above conditions. This analysis was done on James Cook University Hospital data from September 2012 to October 2013.

3.6 Level of unplanned hospital admissions

Against this background of social and economic disadvantage, ill-health and an increasing elderly population, as indicated in the previous section, we have an increasing number of unplanned hospital admissions which are well above the national average.

The chart below taken from Emergency admissions to hospital: managing the demand (National Audit Office, 2013) shows South Tees to be an outlier with 185.3 unplanned hospital admissions per 1,000 registered patients, which is significantly higher than NHS Hartlepool & Stockton on Tees which stands at 131.5. Both are significantly higher than the England average of 96.6.



Source: *Emergency admissions to hospital: managing the demand* (National Audit Office, 2013)

Furthermore, there is evidence that more is spent on emergency care in Middlesbrough than in Redcar and Cleveland. Between August 2012 and July 2013, Secondary Uses Service (SUS) data showed that patients registered with GP surgeries in Middlesbrough incurred £9.16 more per head than those in Redcar and Cleveland. In other words, if Redcar and Cleveland patients incurred the same emergency costs as Middlesbrough patients (in non-elective admissions and attendances at A&E, minor injuries units and walk-in centres), the cost to the NHS would rise by £1.2m per year.

	Total List Population	Emergency Activity Cost	Cost per capita
Middlesbrough	156,043	£42,501,961.75	£272.37
Redcar and Cleveland	135,027	£35,541,236.09	£263.22
		Difference	**£9.16**
		Difference * R&C Population	**£1,236,526.39**

There may be a number of reasons why variation exists between the two localities:

- There are more patients receiving community step-up care in Redcar and Cleveland than in Middlesbrough
    - There are more step-up beds available in Redcar and Cleveland
    - There are GP premises attached to step-up facilities which makes it more convenient/easier to manage these patients
- The population in Redcar and Cleveland is more rural than Middlesbrough which often brings inherent differences in accessing services, levels of self-management and resultant demands upon general practice
- James Cook University Hospital is more accessible to the Middlesbrough population.

3.7 Our community hospitals and community based intermediate care facilities

At South Tees we are in an unusual position compared with neighbouring CCGs in that we have four community hospitals and an intermediate care centre which between them have 152 beds (consultant/GP led). There are historical reasons around the location of the buildings which can reduce flexibility over how they are used and can be a barrier to improvement.

The community hospitals are as follows:

Hospital	Reason	No of beds
Carter Bequest Hospital	Stroke Rehab	10
	Other	34
East Cleveland Hospital	Stroke Rehab	0
	Other	30
Guisborough General Hospital	Stroke Rehab	8
	Other	18
Redcar Primary Care Hospital	Other	32
Grand Total		**132**

The above table excludes bed numbers (20) at the Middlesbrough Intermediate Care Centre. The number at Guisborough does not include ten beds that have been closed for over 12 months.

An independent survey of bed utilisation in 2011 for South Tees Hospitals NHS Foundation Trust indicated that almost half (around 49%) of patients were medically fit and did not need to be in hospital. The reasons for their hospital stay were mainly due to insufficient home based health and social care services.

Also, our community hospitals are under-utilised, with bed occupancy varying across the four hospital sites. Stroke bed utilisation is good but bed occupancy for patients with other conditions is as low as 32 per cent in Guisborough Hospital and 66 per cent in East Cleveland Hospital over an 18 month period (Community Hospitals Activity for South Tees – Bed Modelling) – see Appendix A. There is an uneven distribution of beds, clinical rooms and diagnostic equipment over the four hospital sites.

It is estimated that unused/unoccupied space in the community hospitals is costing us around £1.9 million a year.

The running and maintenance costs are high. The estimated maintenance costs over the next five years for the Carter Bequest Hospital, East Cleveland General Hospital and Guisborough General Hospital are around £2.7 million. These figures do not include Redcar Primary Care Hospital which is a private finance initiative (PFI) building and therefore the maintenance costs are included in overall costs. Redcar has a 35 year PFI lease.

A previous survey of all community estate showed that Guisborough and Carter Bequest in particular have issues in terms of renovation and would need significant capital investment to make them fit for purpose, which in turn supports an urgent need to consider the use of these facilities in the longer term (see Estates Report Appendix B).

In addition, we have historically struggled to keep all beds open at all community hospital sites due to both the challenges of maintaining the necessary number of appropriately skilled staff and the need to undertake frequent essential maintenance. Guisborough Hospital has had reduced capacity on a number of occasions over the last 18 months due to staffing issues and maintenance work.

3.8 Economic considerations

There is a national drive to make significant cost savings while at the same time provide better patient care.

A recent evaluation of the interrelationships between the different providers of health care across South Tees has provided some interesting data to help us to determine what is required to improve patient care / pathways, and ultimately help manage resources in a more efficient and effective way.

We have also compared our information to NHS Hartlepool & Stockton-on-Tees CCG, which services a similar population, to help provide some further clarity on the best way forward. That CCG has a population of 283,818, around 10,000 more than South Tees. It does not have community hospitals but has in-patient community rehabilitation facilities, Rosedale in Stockton (44 beds) and West View Lodge in Hartlepool (22 beds), a total of 66 beds (compared with 152 in South Tees).

If we look at the key areas of spend and compare these across Tees, the overall cost is similar, although the actual way in which the services are delivered is different.

- NHS Hartlepool and Stockton CCG (HaST) spends £319,307 per 1000 weighted population

- NHS South Tees CCG spends £342,387 per 1000 weighted population

The key reason for the additional expenditure in South Tees is the use of community hospitals. However, HaST has more services that are closer to home and they spend more on continuing health care.

3.8.1 Consideration of community hospital activity

To understand more about our expenditure, particularly on community hospitals, we have considered information about activity which clearly shows that the vast majority of admissions are for step down care (ie rather than step up care to prevent a crisis when a patient's condition starts to deteriorate). Analysis shows that the vast majority of all occupied beds are the result of a transfer from the James Cook University Hospital following an unplanned admission. (See Appendix A Community Hospitals Activity for South Tees – Bed Modelling.)

Over seven out of ten of these transfers are for general rehabilitation for a range of conditions which relate to frail and elderly people. Under one in five (17 per cent) are for stroke rehabilitation.

The average length of stay in a community hospital for these patients is 28 days and over seven out of ten (71 per cent) stay for 14 days or more.

During 2012/13 the total transfer admissions to community hospitals was 1,044 (1,016) from the James Cook University Hospital and for six months in 2013/14 the figures were 565 and 533 respectively.

The number of step up admissions account for just under one in five (19 per cent) of all admissions. The total admissions for step up care during 2012/13 was 242 and for six months during 2013/14 was 102. In 2012/13 the average length of stay was 18 days and just over half (52 per cent) of patients stayed for 14 days or more.

More than nine out of ten of these patients (92 per cent for step down and 93 per cent for step up) were aged over 65.

When considering these figures an important point to remember is that an assessment of bed usage has shown that almost half (49 per cent) of patients in

community hospitals did not need to be in a hospital bed but were there because there was insufficient support available in the community. It is clinically recognised that delays of this nature are detrimental to the long term wellbeing of older people.

3.8.2 Consideration of secondary care urgent activity

In 2012/13 from the total number of James Cook University Hospital (JCUH) unplanned admissions, just over 43 per cent were over 61 years of age. The age split is as follows:

0-17	8638
18-30	7297
31-40	5194
41-60	13638
61-80	19407
81-100	6971
100+	18
Total	**61163**

There is a correlation between age and an increased length of stay. People aged 60-65 had an average length of stay of 2.3 days. This increases by age, so that for people aged 81-85 the average length of stay is 4.7 days and for people aged 91-95 it is 8 days.

3.9 Clinical considerations

3.9.1 Older frail people

The figures in section 3.8 tell us that we have many patients occupying hospital beds when they could be cared for at home with the right community support. An analysis of community beds showed that 49 per cent of patients didn't need to be in hospital and we know that the average length of stay for patients who are transferred to a community hospital after a period in an acute hospital is 28 days. More than half of those patients who go into community hospitals for step up care, when their condition is deteriorating ie to prevent a crisis, are there for 14 days or more.

Evidence also tells us that unnecessary time in hospital can be very harmful to frail older patients, exposing them to risks, such as hospital acquired infections, increasing the likelihood of depression and loss of confidence. (Jahnigen et al, 1982.)

3.9.2 Stroke

There are around 110,000 strokes and 20,000 transient ischemic attacks (TIAs) per year in England. Stroke is the leading cause of adult disability and costs the NHS over £3 billion a year. Around one in four people who have a stroke die of it and around half of stroke survivors are left dependent on others for everyday activities.

Stroke mortality rates in the UK have been falling steadily since the late 1960s. The development of stroke units and the re-organisation of services following the advent of thrombolysis (injection of clot-busting drugs into the brain suitable for some patients), have resulted in further significant improvements in mortality and morbidity from stroke (as documented in the National Sentinel Stroke Audit). However, the burden of stroke may increase in the future as a consequence of the ageing population.

The National Clinical Guidelines for Stroke (Royal College of Physicians, fourth edition, 2012) advocates that commissioning organisations should commission:

- An in-patient stroke unit capable of delivering stroke rehabilitation for all people with stroke admitted to hospital
- Supported discharge to deliver stroke specialist rehabilitation at home or in a care home in liaison with inpatient services
- Rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages

Current local Services

While the acute stroke facilities available in South Tees Hospitals NHS Foundation Trust are highly rated nationally, in terms of rehabilitation and discharge of stroke patients, there are areas where the trust's service provision falls short of best practice as defined by the Royal College of Physician's National Clinical Guidelines as quoted above.

Patients suffering from stroke are admitted to a dedicated stroke unit at the James Cook University Hospital. However, following this acute stage, most patients are transferred for rehabilitation to Carter's Bequest in Middlesbrough or Guisborough Hospital. Delivering stroke services on a number of sites is difficult to maintain, with staff spread more thinly, diluting the level of input from the specialist stroke team. In particular, there are difficulties sustaining the required levels of therapy to patients and not delivering those levels across a seven day period.

South Tees also lags behind other areas nationally and regionally in that we have no community stroke service which could support patients' early discharge from hospital with rehabilitation at home.

The Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) in 2012 collected data nationally and scored hospitals across eight domains:

As the table below shows, South Tees Hospitals NHS Foundation Trust achieves highly in several domains and performs well on a national comparison. However, in Domain 2 (organisation of care), the trust was scored 40/100 against a national median of 65.

	D1	D2	D3	D4	D5	D6	D7	D8	Total score 2012
South Tees Hospitals NHS Foundation Trust	94	40	90	78	100	68	92	88	**81**

(Source: SSNAP Acute Organisational Audit 2012)

The Royal College of Physicians standard against which trusts are measured for this domain states:

"Standard: All patients with suspected stroke should be admitted directly to a specialist acute stroke unit unless they need more intensive care for example on an intensive care unit.

Community-based stroke-specialist rehabilitation teams, such as early supported discharge teams, can provide better and potentially more cost-effective outcomes than exclusively hospital-based rehabilitation for stroke patients with moderate disabilities." (SSNAP Acute Organisational Summary, 2012). The trust was not compliant with three aspects of the standard:

- Presence and composition of a stroke/neurology specialist early supported discharge (ESD) multidisciplinary team
- Presence and composition of a stroke/neurology specialist community team for longer term management
- Access to at least one of physiotherapy, occupational therapy or speech and language therapy in specialist early supported discharge team within 48 hours.

Four other trusts in the North East which have early supported discharge and specialist community stroke care in place were rated 100 on this domain. If South Tees Hospitals NHS Foundation Trust had the same service provision and access and had been rated 100 in domain 2, it would have had an overall 2012 rating between 88 and 89. This would be higher than any other trust in the region with the exception of Newcastle Hospitals NHS Foundation Trust and place it in the top 15 trusts in England.

The SSNAP audit therefore demonstrates that South Tees Hospitals NHS Foundation Trust provides excellent stroke care in most aspects of its work, but that the current configuration of community services is not providing the best model of care for stroke rehabilitation.

The length of stay for stroke patients at North Tees and Hartlepool NHS Foundation Trust is similar to that for South Tees Hospitals NHS Foundation Trust: 10.758 days

in North Tees and Hartlepool, compared to 11.547 in South Tees, a difference of less than a day. However, when you exclude patients who died, South Tees Hospitals' length of stay is 1.82 days longer (Apr 2012- March 2013). Furthermore, the 12 per cent of South Tees patients who are transferred to a community hospital have a total length of stay of 34.27 days. This would indicate that their rehabilitation phase is less than satisfactory.

Based on these assumptions and taking into account future demographic changes it is anticipated that in future we would need 12 stroke beds rather than the 18 stroke beds we have currently and that by concentrating our stroke rehabilitation service in one area, patients outcomes are likely to improve.

3.9.3 Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) kills about 25,000 people a year in England and Wales (an Outcome Strategy for COPD and Asthma in England 2011). It is the fifth biggest killer disease in the UK. Numbers of deaths from COPD increase with age, as the lungs become more obstructed over time. In the UK, deaths from COPD are very low in the age range 0-40 (less than 500 per year) but much higher in the 75+ age range for both males and females (about 20,000 per year).

COPD is the second most common cause of emergency admission to hospital and one of the most costly inpatient conditions to be treated by the NHS. There are around 835,000 people currently diagnosed with COPD in the UK and an estimated 2,200,000 people with COPD who remain undiagnosed, which is equivalent to 13% of the population of England aged 35 and over. In South Tees the prevalence of COPD is much higher than the England average with 2.6% of the Tees population (2010/11) diagnosed with COPD.

A publication by the Department of Health in 2011, An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England, suggests that delivery of services for people with COPD are effective where an integrated care model is developed using multidisciplinary teams, including:

- Early recognition of disease to minimise late diagnosis through opportunistic and systematic case finding and better recognition of signs and symptoms by healthcare professionals especially those in primary care and by the population itself

- Carers receiving disease specific education and training to become active partners in a systematic approach to care planning and management

- Proactive management by healthcare professionals starting with an accurate diagnosis and a disease register with monitoring and assessment of severity, co-morbidity and impact of disease. There should be regular review with specialist input depending on severity of condition, and early and specialist rehabilitation and social services support to prevent disability and improve quality of life. Access to community equipment and other support to promote independent living and activities of daily living and re-ablement should be readily available.

- Effective prevention and management of acute episodes with prompt identification and treatment (where possible in the community). Any care model should facilitate admission avoidance, early supported discharge and structured hospital with specialist intervention. Follow-up should be proactive with treatment review and optimisation.

- Treatment intervention using evidence based pharmacological and non pharmacological treatments and regular review to ensure optimisation as well as community provision of specialist interventions/devices to support treatment and monitoring of signs and symptoms

- Effective and equitable end of life care including palliation of symptoms, end of life care management, bereavement care and support for relatives.

Work has already begun to improve the current model of respiratory care across South Tees. Systematic screening for COPD by primary care, with a particular focus on those hard to reach groups was introduced last year. Predictive risk modelling will ensure that patients with COPD and at risk of admission are better managed and a new pathway of care to achieve this is reaching final stages of development. This new pathway will have a particular focus on education, increasing the capacity of our pulmonary rehabilitation services in the community and implementing home based diagnostics to avoid admission where possible.

3.9.4 Coronary heart disease/heart failure

Over the last ten years, the early death rate from heart disease has fallen. In recent years the Health Check programme has been established locally to identify people at risk of heart disease and it is hoped that this will result in further reductions in people dying early from the disease.

However, chronic heart failure (CHF) is rapidly becoming a priority as it results in a poor quality of life with high hospital readmission rates and high mortality rates. The condition affects 900,000 people in the UK, costing the NHS £625m a year (National Institute for Health and Clinical Excellence, 2010) and in 2012/13 South Tees had 2,437 patients registered with heart failure.

Examples of service models are given in the report ‘Managing chronic heart failure: learning from best practice'. (Royal College of Physicians, 2005) General examples include: heart failure specialist nurse service and community based nurse led clinics, rapid access and one stop diagnostic clinics, practitioner with a special interest in cardiology, and shared care with cardiologists and the specialist nursing team. We have been working closely with South Tees Hospitals over the last year to review and improve our heart failure pathway. We have a specialist GP practitioners working alongside hospital consultants to support diagnosis and review of patients, supported by specialist community nurses. Further work will be required to ensure that community staff work more seamlessly with specialist staff to improve the care of patients in their homes and to avoid unnecessary admission where possible.

3.10 What patients have told us

During autumn 2013, as part of the IMProVe work and to gain a better understanding of what is important to patients and carers in terms of the services they receive, we carried out an extensive process of engagement with key stakeholder organisations, the public, patients, carers and MPs.

This work focused on seeking views on services for the vulnerable and elderly and those living with long-term health conditions such as diabetes, heart disease or chronic obstructive pulmonary disease (COPD).

To assist with this activity we commissioned a local voluntary organisation, Carers Together, to conduct an in-depth survey seeking views and opinions from over 300 elderly patients and their carers.

This was in addition to seeking the views of local people who attended one of a series of public drop-in events or who completed the survey that we made publicly available.

Over 400 carers, patients, service providers and members of the general public responded to the engagement activity. The majority were over 65 years of age and included people who were elderly, vulnerable, housebound, had limited mobility or were living with a significant long-term condition. We also spoke to a number of carers. Respondents were drawn widely from the South Tees area including Redcar, Eston, Brotton, Middlesbrough and Guisborough.

A number of key themes emerged from the work which are outlined below. Full details of all the responses received are available separately on our website www.southteesccg.nhs.uk

Co-ordination of services
Overall, respondents felt that local services were organised well. However, there were a significant number of comments about the need for better collaboration and coordination across health and social care organisations and between different services. Many felt that information was not always passed from one service to another effectively, that there was poor communication between providers and silo working was common.

GP access
While many were happy with the support provided by their GP surgery, poor access to appointments was a recurring theme. Respondents were unhappy with the length of time they had to wait for a GP appointment and felt that GPs should spend more time visiting patients in their own home. There were also comments about continuity of care and the importance of being able to see the same GP on a regular basis.

Access to information
While most people said that they knew who to contact for advice, guidance or support in relation to their long-term condition, we don't know whether this was the right person. Over half felt that more information or guidance would be helpful. This

included the need better information about social care provision and more information about specific conditions such as dementia and arthritis. Some respondents were concerned about the consistency of information and whether it was up to date. The importance of ensuring that not only patients but also their carers/families understood the information being given was also raised.

Quality of care provided
Most respondents felt they had received sufficient support to manage their condition, although a range of potential improvements were identified. These are reflected in the comments provided throughout this paper.

Where should care be provided?
Overall, the majority felt that the location of care should be determined by the needs of the patient. Most felt that a mixture of home, community and hospital-based care should be available.

Care closer to home
There was considerable support for the suggestion that more care should be provided in the home or in a community setting. Respondents felt that this could aid recovery, prolong independence and keep hospital beds free for the seriously ill. However, many commented that for this vision to become a reality, community-based care would need to improve significantly.

Quality of community provision
The quality and extent of community-based services was a recurring theme. Respondents identified a number of areas for improvement including more frequent and longer home visits from both health professionals and home care providers, more rapid assessment of need and access to services and equipment, more practical support in the home, and on-call support available on weekends and in the evenings. There were a number of comments about hospital discharges being delayed because of lack of provision. Some respondents suggested drop-in or day facilities should be available locally.

Hospital beds
When asked to consider a reduction in the number of community beds, respondents were divided. There was some confusion about the difference between community and acute beds with a number commenting that beds were needed in case of a flu epidemic or major incident.

Those who were largely against any reduction in bed numbers felt that there was already a shortage of bed, evidenced by the length of time people had to wait for admission. The view that having too many beds was preferable to having too few was given by a number of respondents. Some disputed the case for a reduction in beds, citing the growing elderly population and suggesting that further analysis was needed.

Opinions differed on the impact of closing community beds with some reflecting that it would take pressure off the hospital system and others claiming it would increase demand for acute beds.

Around half supported the idea of closing beds and providing greater care in the community. Amongst other things, respondents felt that this would aid recuperation and promote independence.

Many qualified their support for the closure of beds with the need to improve community health and social care services first. Some questioned whether there was sufficient budget/staff to develop and improve community services in line with the CCG's vision.

Other issues

Physiotherapy and occupational therapy services - There were a number of comments about the length of time taken for assessments/access to services. Some commented that this was impacting upon recovery and hospital discharge.

Dementia services - The need for improvement in services was mentioned by a number of people. This ranged from better information for patients and their carers through to the extent of the services available locally.

Community hospitals -There was some support for local community hospitals. Respondents valued their proximity to home/relatives/friends, particularly where there was a reliance on public transport, while others felt that they took the strain off acute beds. A few felt there needed to be more local beds for recuperation/respite.

Cost of travel – Some respondents mentioned the difficulty/cost of travelling to GP appointments and other services using public transport/taxis. The lack of public transport was raised.

More staff, more money – There were a number of comments about the need for greater investment in health and social care services.

Care homes – A few respondents identified the need for good, local care homes. There were a few comments about the lack of staff training and the impact this had on the delivery of care closer to home.

Reliance on elderly relative for support/care – Many of the respondents were being cared for by elderly relatives or were elderly carers and felt that this needed to be recognised.

Keeping carers/family informed - There were several comments about the need to keep family members/carers informed in general about health conditions and how to deal with them. Some also mentioned wanting to be kept up to date with the specific requirements of those they were caring for.

Listening to patients – A few made comments about the need to listen to patients. Some made the point that carers needed to be included in discussions in cases where patients found it difficult to get their point across without assistance.

4 A new model of care

In attempting to define what a new service model for community care across South Tees would look like, it is important to ensure deliverability and pragmatic measures of success. It is also essential to build on areas of good practice from other areas in the UK where fully integrated services for elderly patients, and those with long term conditions, have been successfully rolled out, creating economic and quality improvements across the whole system.

There is extensive evidence from across the UK to support development of enhanced community based services for the frail elderly, those patients with one or more long term conditions, and those who are at risk of escalation of a chronic health condition.

4.1 Learning from elsewhere

In developing this case for change we have looked at relevant national reports and also at examples of good practice from other parts of the country.

These include a report published by the NHS Confederation supported by the Royal College of General Practitioners (RCGPs) in 2012 “Making Integrated Out of Hospital Care a Reality” which discusses the foundations for integrated care for adults, children and young people, with a focus on implementing out-of-hospital care, and connecting primary, community and social care. It highlights key evidence and draws on learning from partners across health and social care and sets out how a set of principles, each underpinned by a range of drivers and enablers at primary and secondary levels, can support the effective delivery of integrated out-of-hospital care.

This report outlines issues raised at a round-table event convened by the NHS Confederation and the RCGP in April 2012, involving stakeholders from across health and care. Participants endorsed a range of principles and drivers. Discussions were informed by learning from an integrated care model being developed in Southampton by Dr David Paynton, national clinical lead at the RCGP Centre for Commissioning. The principles and drivers build on previous work by the Association of Directors of Adult Social Services (ADASS) and the NHS Confederation.

A set of principles to act as foundations for delivering integrated out-of-hospital care were agreed at the round-table event:

- Making best use of resources to improve health and wellbeing outcomes for the whole population
- Empowering patients to have more control over their care packages, strengthen prevention, self-care and wellbeing
- Targeting services – focusing integrated services on those patient groups most likely to derive the most benefit
- Collective leadership and joint working – health and social care leaders jointly deliver solutions appropriate to their own communities
- Incentivising integrated care – develop mechanisms to reward organisations and staff to deliver integrated care

- Ensuring openness and transparency – using an open-book approach towards all aspects of integrated care development

Also we have considered a recent publication in the Health Service Journal from South Warwickshire NHS Foundation Trust "The Principles Behind Integrated Care for Older People" which describes service transformation across a whole system with a health economy not dissimilar to that in South Tees, in that the acute trust is also the provider of community services. The paper describes the adoption of four principles for transforming community services:

- Get in early
- Invest in alternatives to acute hospital care
- Provide acute care by old age specialists
- Discharge to assess

The publication describes how these four principles have been adopted across a range of projects, and as a result outcomes have significantly improved for a number of measures, including reduction in acute hospital beds, improved throughput, reduction in length of stay, reduction in avoidable admissions, improved use of medication, reduction in the number of falls and increase in the number of referrals to the community emergency response team and so avoiding admissions to hospital. Quality based outcome measures around patient satisfaction, ease of use and overall response to the system redesign were also significantly increased.

A single, shared electronic assessment system – EASYcare - for health, social care and the third sector has been used in the assessment of older people, which provides a holistic assessment of the needs and priorities of this cohort of patients. This resonates with the approach we are taking in South Tees by rolling out the predictive risk modelling tool to GPs.

Importantly, the paper describes the model of community hospital provision as being changed to one which gives greater emphasis to step-up short stay care for patients not requiring the full diagnostic and treatment services of the acute hospital. They have reduced community hospital beds which has meant that more focused attention can be given to a smaller number of patients, releasing resources to invest in home-based community services. Given the desire and high priority in South Tees to realign our community health provision to one which moves away from a bed based model, there could be advantages to us in learning from this as an approach.

The South Warwickshire Trust also worked in partnership with adult social care services to align the work of intermediate care and reablement services, creating local teams with the capacity to provide a rapid (two hour) response to a frailty crisis with an older person and to meet the needs of patients who would benefit from early supported discharge from hospital.

Clear rules were established for the responsibility of patients with complex needs following acute care, and a key principle was that discharge from acute care should not be delayed to assess needs for further support. Community teams therefore accept patients for a support discharge package for community based assessment.

Pathways were agreed so that responsibility for care would transfer to social care after agreed periods for each pathway.

The paper ends by stating that the redesign of services to meet the needs of older people is complex, and recognises that integration is correctly seen as the right general approach; however, it is essential to build on relationships and trust through greater inter-agency work on strategy, operations, clinical care and information systems, and is not something which will be achieved overnight.

Clinicians and managers from South Tees CCG and James Cook hospital visited Sheffield Teaching Hospital NHS Trust who embarked upon a programme to improve the flow of older people through their hospital system. (The Health Foundation – Inspiring Improvement: Improving the flow of older people, April 2013) In the new system, consultants (geriatric medicine specialists) are available 'at the front door' to assess patients as soon as investigations have been done and enough clinical information is available. This is 10 to 20 hours sooner than in the previous system of post-take daily ward rounds. Faster turnaround for diagnostic tests and a clear plan of care devised by a multidisciplinary team, input from therapists and social care workers has increased the number of patients who can be discharged on the day of admission.

The National Audit of Intermediate Care Report 2013 produced by NHS England, reports that despite the benefits of a single point of access into intermediate care services having been advocated for quite some time, developments have been slow. However, good examples do exist with some well-established and developing systems such as Torbay, East Lincolnshire and Derbyshire. In Torbay a Single Point of Access (SPA) is only one element of integrated working across Health and Social Care. The SPA employs health and social care coordinators who provide a focal point for referrals from professionals and the general public. They are able to set up packages of care, refer complex cases to the multidisciplinary team. Torbays integrated approach to delivering integrated care has realized significant improvements which include the lowest percentage of hospital deaths in the country, lowest delayed discharges on record and lowest length of stay for older people in the country.

Derbyshire's single point of access provides three key services:

- Clinical Navigation - a healthcare professional led service which received calls from GP's and Community matrons to clinically navigate patients to the most appropriate service to avoid an unnecessary hospital admission.
- Service Navigation - a healthcare professional service who facilitates timely discharges for patients from the emergency units and assessment units in their Acute Trust who have been assessed as not requiring any further acute hospital inpatient services.
- In-Reach - a health care professional led service which received calls from GP's to facilitate timely discharges for patients admitted to inpatient wards

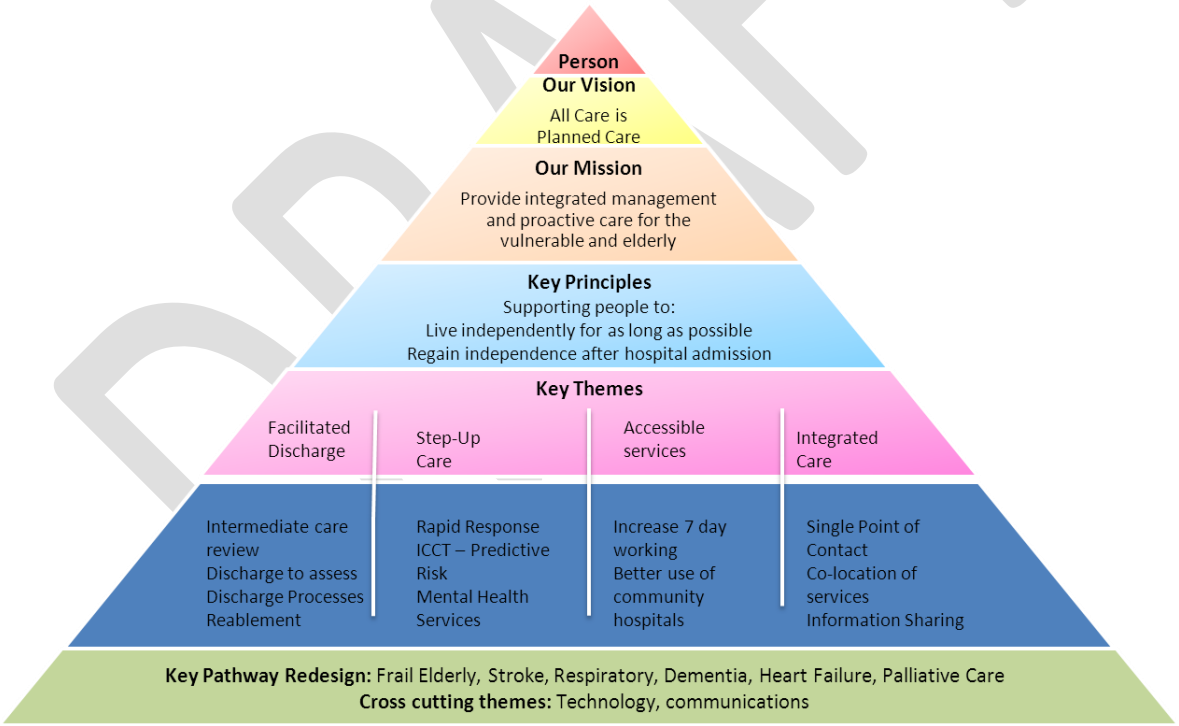
Derbyshire reported positive results in 2012 with the single point of access facilitating the right care at the right time and avoiding unnecessary admissions.

With the development of the Integrated Community Care Teams which incorporate predictive risk and rapid response services, South Tees is already moving the concept of integration forward but there is much to do before we start to realise the benefits of this approach.

On the basis of the extensive programme of work already started in South Tees, and real stakeholder engagement which has enhanced working relationships across the whole system, there is now a real motivation from all partners (both commissioning and provider) across the current health and social care landscape to build upon this concept of integration. The Better Care Fund from NHS England (a single pooled budget to help health and social care services to work more closely in local areas) with supportive planning will also hopefully hasten our progression to real integration.

4.2 Building the new service model across the South Tees health economy

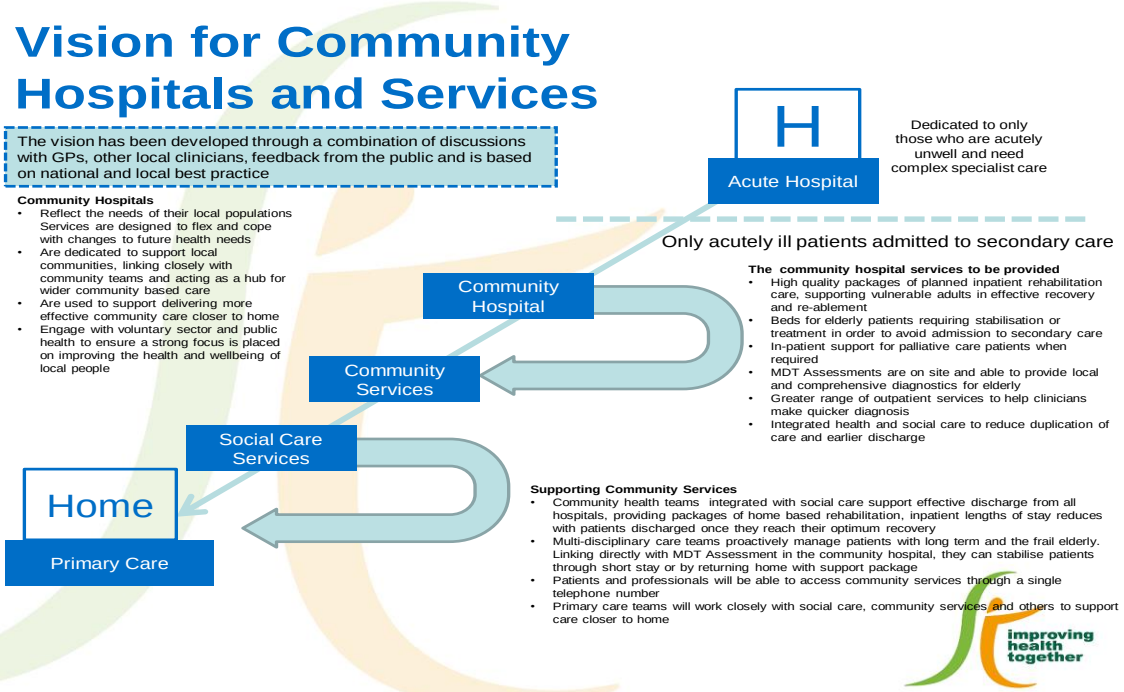
With strategic partners in the IMProVE advisory group, we have been working with our providers using a series of principles to build a new service model for integrated care which fully reflects national strategy and requirements and meets the needs of the patients and service users in South Tees. This is outlined in the diagram below:



An important part of this model will be the proposed development of a single point of contact, one telephone number for community service provision. Not unlike the Derbyshire model, the single point of contact would enable appropriate health and social care to support timely discharge or provide support services to avoid an unnecessary hospital admission. Sitting within this single point of contact will be a health and social care assessment 'hub' enabling rapid diagnostics and management planning for elderly patients which will be fundamental to achieving our

vision that all care is planned care and the concept of 'right care, right place, at the right time'. It is hoped that this can be developed using money from the Better Care Fund.

The following also illustrates what we would like to achieve:



In order to maintain a focus on improving outcomes for patients with one or more long term conditions, pathways of care for the most common conditions will be reviewed and improved to support the principles and philosophy of this strategy; providing the most appropriate care, in the right setting, at the right time. These pathways will focus on keeping patients as fit as they can be in their own home environment through proactively identifying their health and social care needs. This will be supported by providing a range of interventions and services which are able to respond quickly and appropriately should their condition deteriorate. We also want to ensure that when patients are admitted to hospital, they receive a timely and efficient discharge from a hospital bed into a more appropriate community setting – or their own home – as quickly as is medically appropriate.

Some of the actions that could be adopted in taking this forward the model include:

- Accessible services 24/7 – where appropriate, and to ensure equity right across the South Tees locality.
- Early supported discharge for stroke patients, and community respiratory disease management.
- Improved continuity of care through better use of technologies, information sharing across health and social care teams, and reduction in the number of times a patient must give routine information to a health or social care professional.

- A real drive to include health promotion and prevention of escalation of disease as part of the eventual solution.
- Better use of voluntary, independent and third sectors.
- Every GP practice undertaking proactive management of patients to identify those at risk of escalation of their condition. *Some of this work has already begun. A risk process has already been implemented across South Tees to identify those patients at higher risk of their chronic health issues escalating to a point where they need acute hospital intervention. One of the main objectives of this work is to ensure that this group of patients are offered individualised case management in a community setting with a range of additional support services aimed at maintaining and improving their current health, through integrated care teams.*
- Supportive training for primary care and community staff in collaboration with elderly care and medical physicians
- Reduction in the current bed base across four primary care hospitals, with consequent reinvestment in community based teams to provide enhanced care and support in patients own homes or community clinics.

4.3 Key points to consider

In developing the new service model, the following are key points we would expect our providers to consider:

- Avoid transfers of patients from one hospital to another, unless dictated by clinical need or to benefit from different types of service provision on a pathway of care.

- Introduce a step up (GP led direct admissions) model – reducing the number of patients admitted to an acute bed. The criteria for step up will need to be developed, and will utilise community hospitals / teams, rapid response and a fully integrated approach to care.

- Rationalise the stroke pathway so that the rehabilitation element is delivered on a dedicated site in line with national guidance.

- Significantly reduce the length of stay for those patients in community hospitals and improve quality of care. Provide seven day multi-disciplinary team ward rounds.

- Provide more urgent assessments for the elderly with appropriate diagnostics to aid diagnosis and manage.

- Provision of appropriate medical day care treatments in the community.

- Deliver appropriate out-patient clinics closer to home, improving the use of community hospital estate and providing better access for patients.

4.4 Enhancing intermediate care services and making better and more appropriate use of community hospital beds

Intermediate care provides a range of services based on three main areas:

- Prevention of people being inappropriately admitted to hospital
- Assisting timely hospital discharge, when admission has been necessary
- Promotion of good health, enabling people to make informed choices to remain as independent as possible, within their own homes.

It is clear that enhanced intermediate care services will be required to support the emerging community services model in South Tees, and this must be based on the principles and philosophy around supporting care closer to home wherever possible in the patient's own home surroundings. This means moving away from the traditional bed based model of care, with increased community based teams who can provide high quality care and therapies in patients' own homes, or usual living environments.

It is recognised that a small community bed base will be required, to provide step up and step down care for those patients who simply cannot remain at home for means of clinical safety, or who require a short period of intermediate care following discharge from an acute hospital bed.

This means working very differently in the future. We know that a bed utilisation review showed that almost half of patients in those beds at that point did not need to be there. Also, as indicated in section 3.7, bed usage at Guisborough Hospital was high for stoke rehabilitation but as low as 32 per cent for other conditions and at East Cleveland Hospital it was 66 per cent over an 18 month period.

Work has already taken place to understand future needs. A report following the South Tees Intermediate Care Services Systems Modelling Project (published June 2013) summarises findings and recommendations from work undertaken to explore future capacity requirements and system design for intermediate care services in South Tees. This work was commissioned by South Tees Hospitals NHS Foundation Trust and Middlesbrough and Redcar and Cleveland local authorities, as part of a whole systems partnership.

The review consisted of:

- An analysis of the current system and services for intermediate care locally
- Compilation of information on needs, service activity and patient flows to inform the development of a simulation modelling tool to analyse and communicate the current key issues
- Application of a simulation modelling tool to test out the impact of alternative scenarios for the future for intermediate tier services and hospital (acute and community) activity.

Three scenarios were modelled and there was consensus from stakeholders attending project workshops that a whole system approach needed to be adopted.

The scenarios tested demonstrated the relationship between changes in bed occupancy (acute, community and social care) and the growth in domiciliary (care at home) caseloads. It also took into account demographic changes and the increasing elderly population.

The scenarios described different levels to the use of rapid response and intermediate care in the home and also use of community hospitals to avoid admissions to James Cook University Hospital.

The recommendations from this work have been used to support further bed analysis and projected bed needs in the future.

Data Source	Currently:	Middlesbrough (34 beds)		Redcar & Cleveland (80 beds)		Total (114 beds)	
	Beds required at:	Beds Required	Beds Spare	Beds Required	Beds Spare	Beds Required	Beds Spare
Past data (excludes IC beds)	85% utilisation based on 12/13 actuals	28	6	62	18	90	24
	85% utilisation based on Oct 12 to Sep 13 actuals	30	4	59	21	88	26
IC Model (predictive model, includes 20 IC beds)	Baseline start in the IC model	23	11	61	19	83	31
	Baseline end, i.e. after demographic changes	24	10	64	16	88	26
	End of IC model Scenario 2	14	20	42	38	56	58
	End of IC model Scenario 3	8	26	28	52	36	78

(Figures for the top 2 lines taken from the Target Utilisation worksheet. Other figures derived from the Intermediate Care Modelling Tool.)
(Figures are rounded up to the nearest bed, hence the totals may not fully tally)

The above table demonstrates how two different approaches were taken to bed modelling in order to determine past demand for community beds and project what future demand might look like. It should be noted that these figures do not include the 18 stroke beds (which are anticipated to be reduced to 12).

The top two rows are based on past community hospital activity (and do not include the 20 MICC Intermediate Care beds). They show that even when making better use of our community beds (having a target of 85% utilization), only 88-90 beds would be required based on past activity levels and service provision, meaning on average 24-26 beds are spare.

The second approach, shown in the lower four rows on the table, comes from the Intermediate Care Modelling Tool. This is a predictive model rather than an analysis

of past experience. Similarly to the past data, the model also indicates that there is currently a surplus of beds, particularly in Redcar and Cleveland. Several scenarios were worked up in the model; both Scenarios 2 and 3 contain the same components of service change, but Scenario 3 goes further in making bigger cultural and practical changes in the system, and for that reason Scenario 2 is the more realistic. Scenario 2 predicts that after a change process has taken place, only 56 non-stroke beds (community and intermediate care) would be required.

The data differs slightly for two reasons: firstly, because it is a predictive model rather than a description of past experience, and secondly because it includes intermediate care. However, both approaches to the data clearly demonstrate that there is already spare capacity in the community bed base, and that moving more long-stay patients into domiciliary intermediate care will further reduce demand for community/intermediate care beds.

4.5 Benefits realisation

We can therefore describe the main benefits to be gained from the proposed service change to include:

- Improvements in quality of care offered to our patients and service users
- Improved clinical and functional outcomes to patients and service users
- Improved experience to both patients and their carers / families
- Improved access to services both in terms of times available, location and consolidation
- Improved efficiencies to the system by means of potential cost savings achieved through integrated commissioning and provision
- Better use of our workforce through integrated provision of care across the whole system
- Improved channels of communication across the whole system which will support the integrated care model
- Resultant better management of more acutely ill patients in secondary care, by more appropriately managing demand of other less ill patients into a wider range of services
- Greater staff satisfaction through more innovative ways of working across the whole system.

The CCG and our partners in social care already have a series of benchmark measures in place which will help us to assess the success of our new model. These key outcomes/performance indicators are outlined in appendix C.

5 The key enablers

5.1 Relationships and partnership working

Pivotal to the delivery of our vision will be maintaining the ongoing strong relationships with our partner commissioners in Middlesbrough and Redcar and Cleveland local authorities, neighbouring CCGs in the North East and all of our providers, including NHS, independent sector and voluntary and community sector. We will continue to build on the existing true partnership approach.

Governance will be maintained by means of the South Tees CCG- led IMProVE Advisory Group with membership from all stakeholders, that meets monthly to oversee progress and make recommendations for ongoing change. This advisory group also provides regular progress reports to the health and wellbeing boards via appropriate sub-committees and the overview and scrutiny committees.

In August 2013 the government announced new funding arrangements, the Better Care Fund, to be used to drive closer integration between health and social care and therefore improve outcomes for patients. In 2015/16 the fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities.

A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements. Local authorities and CCGs are being asked to develop these plans now for submission in February 2015.

5.2 Estate

We are unusual in the number of community hospitals we have across our geographical locality – there are four, including a newly built PFI primary care hospital at Redcar. In addition, South Tees is fortunate to be able to provide primary care from a number of custom built and new premises. Making best and economic use of this estate to support pathway redesign and delivery of community based services will be a key part of our vision and redesign work.

5.3 Workforce

Progressing our vision gives us an excellent opportunity to review and develop our existing workforce as a health and social care system and create new posts, which support the concept of integrated care.

We have already begun to expand the number of community based clinical teams by recruitment of additional nursing staff to support integrated care and rapid response nursing services. New and innovative ways of working across health and social care, and the co-location of services will give us an opportunity to develop and maintain a workforce which has greater variety in job role thus strengthening and supporting recruitment and retention of those staff.

We know there are potential shortfalls in occupational therapy, speech and language therapy and physiotherapy to meet patient needs. However, there are no major concerns regarding the supply of suitably competent staff to meet any increase in demand. What we will need to ensure is that there is suitable training and development to equip our workforce to work differently, delivering more care in patient's own homes and community settings rather than in hospital. Our main challenges will be in culture and the change management that will be required.

5.4 Information and technology

Advances in medical and information technology particularly around the concept of telehealth / telemedicine / telecare fully supports the vision of this programme by giving us the opportunity of providing care to our patients / service users where they most need it – mainly in their own homes or place of residence. Opportunities around remote consultations, simple monitoring and improved communications all strengthen and underpin the planned changes to the way we deliver services. We will be reviewing the level and type of information we currently use to facilitate this, particularly where we can take a more integrated approach across health and social care. This will enable better and more efficient data sharing promoting better management of our patients.

5.5 Clinical engagement and leadership

The philosophy of having clinical leaders at the forefront of progressing our vision is providing a powerful means for us to take forward service redesign by ensuring that any potential change is evidence based and fully reflects the clinical needs of our population. Our planning process is based on targeting the best possible outcomes for all our patients and service users. The identification of clinical leads from both commissioning and provider organisations has enabled us to give a depth of insight into the whole commissioning process which, combined with a supporting management presence, makes a powerful team to lead and implement this programme.

5.6 Service user engagement

The CCG seeks to engage with the public to inform commissioning, which includes any proposals for service redesign or development. As indicated in Section 3.10 we have already carried out extensive engagement activity over the autumn 2013 to inform the IMProVe work. To take this forward, our communications and engagement team is working with us to develop a strategy which will support the continued engagement of service users in progressing our vision. This will ensure that their views are taken into account and that the resultant service changes are fully inclusive, representative and in line with our statutory requirements around the duties to involve and consult.

We will work closely with the health and wellbeing boards and joint overview and scrutiny committee as part of the planning and implementation process to ensure

that they are fully engaged with our vision, as well as providing regular reports to the boards of all partner organisations involved in the process.

6 Conclusion

The work we have been engaged in is absolutely in line with national, regional and local strategies which are aimed at providing the best possible care for people, as close to home as possible and to reduce avoidable hospital admissions, which are higher than in other parts of the country.

It is also in line with the health needs of our population which has greater than average levels of ill-health therefore requiring greater levels of health and care support. We can expect that demands will increase as our elderly population grows.

Although we are already identifying those patients who are older and vulnerable due to long term conditions so that we can provide timely interventions at home to reduce the likelihood of their condition deteriorating to such a point where they need an emergency hospital admission, we know we could do more. But to do more and to achieve our vision of 'all care is planned care', we will need to change the way that we provide services.

During our recent engagement exercise we heard from patients and carers that while overall they felt local services were organised well, a significant number made comments about the need for better collaboration and coordination across health and social care services and between different services.

The majority of people said they felt that the location of care should be determined by the needs of the patient and most felt that a mixture of home, community and hospital-based care should be available.

There was considerable support for the suggestion that more care should be provided in the home or in a community setting. Respondents felt that this could aid recovery, prolong independence and keep hospital beds free for the seriously ill. However, many commented that for this to become a reality, community based care would need to improve significantly.

Indeed the quality and extent of community-based services was a recurring theme during our engagement activity. Respondents identified a number of areas for improvement including more frequent and longer home visits from both health professionals and home care providers, more rapid assessment of need and access to services and equipment, more practical support in the home, and on-call support available on weekends and in the evenings. There were a number of comments about hospital discharges being delayed because of lack of provision. Some respondents suggested drop-in or day facilities should be available locally.

Against this background we know we have more community hospital beds than neighbouring CCGs and that the cost of these reduces the amount of money we have to invest in improvements to community services. Two of the buildings are in need of significant improvement and to do so would require significant investment. Added to this, bed utilisation is not what we would expect.

We also know that an assessment showed that almost half of the patients in those beds did not need to be in hospital but were there due to insufficient home based health and social care services. It is clinically recognised that delays in discharge of this nature are detrimental to the long term wellbeing of elderly people.

In addition, we know that the vast majority of patients in our community hospitals are classed as step down in that they transfer there after an unplanned admission in an acute hospital. A much smaller number are known as step up, which means they are admitted to a community hospital when their condition deteriorates to avoid a crisis.

We appreciate that during the public engagement there were some mixed views about whether we should reduce community beds. We need to reassure people that under a new model of care there would be sufficient beds should they be needed. Our current situation is that we have significantly more community beds than exist in areas with a similar population. These beds are not being used to optimum effect and the cost of running them means we have less to spend on community services which provide more support at home or closer to home and help older and vulnerable people to remain as independent as possible.

National guidance around the care of people who have had a stroke suggests that as a national average, 40% of stroke patients would benefit from the interventions of a stroke early supported discharge service.

Chronic obstructive pulmonary disease (COPD) is the second most common cause of emergency admission to hospital and one of the most costly inpatient conditions to be treated by the NHS. Meanwhile, evidence suggests that delivery of services for people with COPD are effective where an integrated care model is developed using multidisciplinary teams (NICE commissioning guide, Services for people with chronic pulmonary disease).

In Section 4 we have set out ideas about what a new service model might look like and how this might benefit patients. What we need to do now is to develop a set of proposals, on which we will formally consult the public, to help achieve our vision.

7 References

The following documents have been referred to in the preparation of this report:

NHS South Tees Clinical Commissioning Group's Clear and Credible Plan (summer 2012) – www.southteesccg.nhs.uk/publications/

National Adult Social Care Intelligence Service 2011-12

Joint Strategic Needs Assessments doe Middlesbrough and Redcar and Cleveland – www.southteesccg.nhs.uk/publications/

Middlesbrough and Redcar and Cleveland strategies

County Durham and Tees Valley Acute Services Legacy Project –

www.southteesccg.nhs.uk/publications/

Equity and Excellence – liberating the NHS (Department of Health 2012) –

https://www.gov.uk/government/publications/liberating-the-nhs-white-paper

The NHS belongs to the people: a call to action (NHS England July 2013)
www.england.nhs.uk/2013/07/11call-to-action/

Everyone Counts: planning for patients 2014/15 to 2018/19 (NHS England)

Emergency Admissions to Hospital: managing the demand (National Audit Office, 2013)
www.nao.org.uk/report/emergency-admissions-hospitals-managing-demand/

Jahnigen D, Hannon C, Laxson L, LaForce FM. Iatrogenic disease in hospitalized elderly veterans. Journal of the American Geriatric Society. 1982;30(6):387–390.

National Sentinel Stroke Audit
http://www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme

National Clinical Guidelines for Stroke, Royal College of Physicians, fourth edition 2012

Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) 2012

Managing Chronic Heart Failure: learning from best practice (Royal College of Physicians 2005)
www.rcplondon.ac.uk/publications/managing-chronic-heart-failure-best-practice-0

An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England (Department of Health 2011)

NICE commissioning guide, Services for people with chronic obstructive pulmonary disease

Making integrated out of hospital care a reality
Royal College of General Practitioners, NHS Confederation, 2012

The principles behind integrated care for older people (South Warwickshire Hospitals NHS Foundation Trust), Health Service Journal

The Health Foundation – Inspiring Improvement: Improving the flow of older people, April 2013

The National Audit of Intermediate Care Report 2013

South Tees Intermediate Care Services Systems Modelling Project (June 2013)

8 Appendices

Appendix A Community Hospitals Activity for south Tees – Bed Modelling

Appendix B Estates Report

Appendix C Outcome Measures/Key performance indicators