Health and Adult Care Scrutiny Committee: 25 July 2017

Your Future Care

Report of the Director of Strategy (CCGs), Chief Operating Officer (CCG) and Deputy Chief Executive/Chief Nurse (Royal Devon and Exeter NHS Foundation Trust).

Purpose

The purpose of the following paper is to briefly outline the model of care in the Eastern Locality area and explain the implementation process followed.

Recommendations

That the Health and Adult Care Scrutiny Committee

(1) Notes the purpose and approach to change in the model of care
(2) Considers how it wishes to continue to scrutinise issues around 'Your Future Care'

Executive summary

The NHS in Devon is moving towards a model of care that focuses on community and home-based services – similar to that offered by Devon County Council.

The approach complements many of the services offered by Devon County Council's adult social services, such as social care, which work alongside the NHS multidisciplinary teams (MDTs) in communities throughout Devon. It brings 57 additional nursing, therapy, care workers and pharmacists to community services in the Eastern Locality.

Once patients are well enough to leave an acute setting, community services and staff available in their local community will ensure that they can return home safely and be as independent as they possibly can. Similarly when admission to hospital can be avoided, people will be supported earlier and receive care at home where necessary.

This is very different from the existing model of bed-based care which means many people who are well enough to return home with additional support are forced to remain in hospital - due to the lack of available services in the community. Prolonged and unnecessary stays in hospital have been proven to be bad for patients.

On average 875 inpatients a year will be affected by the change of model. This equates to average of about 3 people per week per site (see 3.2 over for detail).

The Your Future Care process will release resources through closing community inpatient beds, almost half of which will be re-invested in community services in the Eastern Locality, and will in turn reduce the need for bed-based care in community hospitals.

Under a changed model of care, there will be a tailored care plan for each and every patient, which addresses their individual needs and helps them to get back on their feet as quickly as possible.

Evidence from where the model is in place already shows that patients are healthy and independent enough to be discharged after an average of nine days, while the average length of stay in hospital for similar patients is 29 days. This is important because independent analysis by the National Audit Office shows that older people can lose as much as 5 per cent of their muscle strength for every additional day they spend unnecessarily in a hospital bed.

The same report shows that an average 67-year-old admitted to hospital in reasonably good health loses 14 per cent of their hip and muscle strength after just ten days. They lose 12 per cent of their lung capacity and the overall decline in their mobility and fitness is equivalent to losing ten years of life.

A significant amount of implementation planning has already been undertaken following engagement with the workforce, stakeholders and local communities.

1. The model of care

1.1 Over a number of years there has been an emphasis on changing the model of care, particularly for older people who are frail. The focus of this change is to personalise care, prevent a health crisis where possible through pro-active approaches and, where care and support are needed, to provide this at home where it is safe to do so.

1.2 To achieve this clinical advice and policy direction are clear that in the first instance resources and attention need to shift from the present over-reliance on hospital beds to create quality out of hospital services that meet people's needs, proactively manage risk and promote independence, health and wellbeing. This shift in emphasis is at the centre of the Your Future Care plans.

1.3 As previously reported to the Committee, three interventions have been identified by clinicians and the foundation of out of hospital care:

- Comprehensive assessment: This identifies people who are frail or becoming frail, and therefore are at risk of being admitted to hospital. It puts a care plan in place for them, owned by the individual.
- Single point of access: One phone number, which is now in place through a service known as Community Connect, will make getting additional support when it is needed as easy as possible. It will be connected to an Urgent Response service.
- Urgent Response (Care at Home): This service will help people to remain at home with support, rather than being admitted to hospital. Where hospital admission is unavoidable, it will provide the additional support at home that makes it safer to leave hospital.

1.4 For patients spending longer than necessary in hospital there is evidence that this can have a negative impact on their health and wellbeing. Independent analysis (published on 26th May 2016) by the National Audit Office shows that older people can lose as much as 5 per cent of their muscle strength for every additional day they spend unnecessarily in a hospital bed. Locally there is a clinical consensus that supports the move away from long term bed based care for patients.

1.5 The same report shows that an average 67-year-old admitted to hospital in reasonably good health loses 14 per cent of their hip and muscle strength after just ten days. They lose 12 per cent of their lung capacity and the overall decline in their mobility and fitness is equivalent to losing ten years of life. The current average length of stay in a community hospital bed is 29 days - and many patients will have already spent time in acute hospital bed before this.

1.6 Your future care in Eastern Devon reduces inpatient beds in Community Hospitals by 71, from 143 to 72. By directing this 'bed-based' investment towards home-based and community care when the patient is well enough to be out of hospital, the support and workforce will be better placed to help people remain at home or return to their homes, and the right care to be as independent as possible.

1.7 Those remaining beds in community hospitals will be used for intensive rehabilitation, shortening length of stay and ensuring patients are returned to independence more quickly.

2. What this means for people

2.1 First and foremost, the support will be available outside of hospital to enable people to receive consistent and quality services at home. These span from identifying their needs earlier, before a health crises, to a range of skills including nursing, therapy and other support to care at home when this is needed. These out of hospital services will be available 7 days a week, 365 days a year.

2.2 An illustration of the model in action is provided for John, an example created from what will be the typical patient experience in East Devon.

Helping John to get back on his feet and into his own home, after an illness that led to him being admitted to an acute hospital.

Day 2 – The Therapy Assistant arrives to complete a functional (or basic) wash and dress assessment, and this assistant will continue to work with John to help him with his goals. Enabling care will be provided for John twice daily and the therapy assistant provides John with his third care visit. John is now progressing well enough for the night sitter to be stepped down.

Day 3 – John is visited by the Therapy Assistant who continues to support him in progressing his mobility and function. John receives enabling care twice a day.

Day 4 – The Occupational Therapist completes John's review, and confirms that John is now progressing well enough that enabling care will now take place only once a day - in the evening in addition to support from the Therapy Assistant.

Day 5 – The Therapy Assistant calls John at home and agrees to step down enabling care and review John's goals and progress at day 7.

Day 6 – The Therapy Assistant visits John to measure his progress and abilities to be independent.

Day 7 – The Therapy Assistant completes another visit with John and agrees that he has progressed well, and is now safely able to be independent in his home.

It is agreed with John that on-going befriending support from Neighbourhood Friends would be helpful.

The Therapy Assistant makes the referral to Neighbourhood Friends and in agreement with John discharges him.

2.3 An illustration of the challenges faced by the patient with the existing model of bed-based care.

Challenges faced by John with the existing model of bed-based care.

John is placed on a busy ward, and is well treated by the caring staff.

There are not enough services in the community to support John in his own home, so the doctors choose to send John to a community hospital which is approximately 10 minutes' drive from John's house.

John is given therapy three times a week, but begins to lose independence as drinks and food are generally brought direct to his bed.

Being confined to a ward setting John means he is less active and less independent than he normally would be at home.

John reads books and newspapers and chats to the other patients, but the lack of stimulation and independent activity is making his progress slow.

After 28 days John is pleased to return home close to his friends and neighbours, but his physical and mental condition have deteriorated, making him less safe in his own home, and more likely to have a fall or accident resulting in another prolonged spell in hospital.

2.4 Already steps have been taken to improve services - with Community Connect being established throughout the Eastern Locality **on 24th March 2017** and a 'discharge to assess' pilot in Exeter to avoid people staying in hospital longer than they need to but ensuring an assessment of what is needed at home.

2.5 The following table provides a comparison between the existing and new model:

Community Hospital	Out of Hospital Model
Average length of stay = 29 days	Patient independent and healthy enough to be discharged after an average of 9 days
MDT available on ward	Wrap around MDT support available
Average Therapy input 3 times weekly	Therapy input can be daily as required
Busy ward based setting	Familiar and quiet environment

Aim to be flexible on visiting times	Personal space and flexibility on visitors
Assessing and re-assessing people's function using ward kitchens, wide stairs	Give people time to settle home and assess them in their own environment; "my bed, chair and kitchen taps"
Mainly GP led	Patch Geriatrician support available
11% re-admission rate	Appropriate readmission rate of 7%

3. How change will look in practice

3.1 A key feature of implementation is the level of additional investment into the community health and social care teams, with additional nursing, therapy, care workers and pharmacists in each locality cluster. There are consultant geriatricians to support people in their own homes supporting GPs to provide the very best medical care where this is required.

3.2 Further recent modelling of impact of the changes and workforce allocations are set out below. This represents 57.23 additional whole time equivalent staff.

Community	Modelled impact	Workforce
Crediton, Moretonhampstead and Okehampton	2.19 patients per week	8.91 wte
Exeter	5.22 patients per week	13.81 wte
Woodbury, Exmouth, Budleigh	1.96 patients per week	7.93 wte
Tiverton and Cullompton	3.12 patients per week	11.23 wte
Honiton and Ottery St Mary	1.98 patients per week	5.65 wte
Seaton, Axminster, Sidmouth	2.28 patients per week	9.70 wte

3.3 Over the course of a year, recent modelling shows that the total number of people affected by the change to inpatient services is 875 people which equates to a very low number of people in each locality cluster as shown in the table above.

3.4 A further audit conducted by RD&E showed that of all 125 people in community hospital beds in seven Eastern hospitals during a week in March 2017, only 17% required community bed based care, 53% could go home with support and 11% did not require further support.

3.5 Closing the inpatient beds will both save money and increase staffing and support for people in the community. Through detailed work on the funding by RD&E, whilst higher than the original 20-40% re-investment estimates, it still saves over 50% of the resource spent on beds and invests the remainder in the community to bring about enhanced out of hospital services.

4 Ensuring readiness for implementation

4.1 A key message from the public and clinicians alike has been the importance of safe and quality implementation. A series of 30 gateway questions were developed and a panel involving GP, consultant geriatrician, lay community representatives (members of the public), public health, social care and commissioning input was been established to check readiness implementation.

4.2 The work of this panel is in addition to the responsibility of Royal Devon and Exeter NHS Foundation Trust to deliver safe and quality services and is designed to provide added assurance and confidence in the out of hospital model of care as well as the in-hospital care that will take place in fewer overall beds. Members of the Committee have observed one panel meeting and the invitation is extended to future meetings.

4.3 Chaired by a GP the panel has met and received and reviewed presentations and evidence from RD&E NHS Foundation Trust spanning the following parameters and questions:

Parameter	Question
The model of care	• Does the new model of care align with the overriding ambition to promote independence? • Is there clinical and operational consensus in place on the functions of the model and configuration of community health and care teams incorporating primary care, personal care providers and the voluntary care sector? • Is there a short term offer that promotes independence and community resilience? • Is there a method for identifying people at highest risk based on risk stratification tool? • Are the needs of people requiring palliative and terminal care identified and planned for? • Are the needs of people with dementia identified and planned for? • Is support to care homes and personal care providers built into the community services specification? • Is support for carers enhanced through community sector development support in each community? • Has the health and care role of each part of the

	system been described? • Have key performance indicators been identified, and is performance being tracked now to support post-implementation evaluation, including impact on primary care and social care?
Workforce	• Is there a clear understanding of the capacity and gaps in the locality and a baseline agreed for current levels and required levels to meet the expected outputs of the changed model of care? • Is there a clear understanding of and plan for any changes required in ways of working: Thinking, behaviours, risk tolerance, promotion of independence, personal goal orientation. • Have the training needs of people undertaking new roles been identified, including ensuring they are able to meet the needs of patients with dementia? • Is there detailed knowledge with regards to investment, WTE and skill mix across the locality and a plan for achieving this? • Are system-wide staff recruitment and retention issues adequately addressed with a comprehensive plan, and where there are known or expected difficulties have innovative staffing models been explored?
Governance communication and engagement	• Is there a robust operational managerial model and leadership to support the implementation? • Has council member engagement and appropriate scrutiny taken place? • Is there an oversight and steering group in place and the process for readiness assessment agreed? • Have providers, commissioners and service users and carers or their representative groups such as Healthwatch agreed a set of key outcome measures and described how these will be recorded and monitored? • Is there a shared dashboard which describes outcomes, activity and productivity measures

	and provides evaluation measures?
Implementation	• Is there a clinical and operational consensus on the roles of each sector during the implementation phase including acute care, community health and care teams, mental health, primary care, social care, the voluntary care sector and independent sector care providers? • Is there an implementation plan at individual patient level describing their new pathway, mapping affected patients into new services? • Are the operational conditions necessary for safe implementation met? • Have the risks of not implementing the change at this point been described and balanced against any residual risk of doing so?
Post implementation	• Is there a description of the outcomes for individuals, their carers and communities? • Are the mechanisms for engagement with staff, users of services and carers in place and any findings being addressed appropriately? • Is there a process in place for immediate post-implementation tracking of service performance, including financial impact to all organisations? • Is longer-term performance and impact being tracked for comparison against pre-implementation performance? • Has user experience been captured as part of the process, and have findings been addressed and recorded to inform the planning of future changes? • Are there unintended consequences or impacts (e.g. on primary care or social care) which need to be addressed before any further change occurs? • Is there a clear communication plan for providers and the public describing the new system and retaining their involvement in community development?

4.4 In addition the panel has had feedback from a working group of medical, nursing, therapy and pharmacy leads and operational managers of the services (Clinical/professional reference group) and the GP chair of this group has confirmed the group's support indicating they were now very close to being satisfied that it is safe to close the community hospital inpatient beds. The panel is preparing its final recommendations, including the updated Quality and Equality Impact Assessment and the outcome and evaluation metrics to be used.

4.5 Royal Devon and Exeter NHS Foundation Trust has completed consultation with staff and whilst change of this nature brings concern and uncertainty it also brings opportunities and many staff are now getting ready to take on new roles and training and support will be offered as required. There is further recruitment to be completed and this is underway.

5. Post implementation

5.1 Following implementation of the changes the model will continue to be monitored and evaluated to ensure it delivers the benefits of improved experiences and outcomes for patients; improved experiences for staff and clinical and financial sustainability of services.

5.2 The clinical professional reference group will continue to work on service development and the assurance panel will review and report at intervals on the outcomes and metrics and scrutiny member continued observation with and future engagement in these processes is invited.

6. More information

Technical supporting information has already been provided to the Committee and can be made available again on request.