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Demand & capacity modelling for the Berkshire West health & social care economy – Document 1

Final Report – 16th April 2013

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Content

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Section 1 – Introduction

Executive summary

Section 2 – Summary of Findings

We maintain our opinion from the interim report that by most standards the Berkshire West health and social care economy (the economy) is performing well. We continue to categorise the economy as High Potential whilst fully understanding the pressures many elements of the economy are experiencing. Unlike more distressed economies Berkshire West has the opportunity for planned and strategic innovation as you are not preoccupied with fire-fighting. There is however a pressing case for change and the 'Do Nothing' position is simply not tenable.

The 5 areas of demand pressure currently being experienced by the economy continue and we confirm our view that these are a combination of demographic and system induced. These pressures do need to be addressed now.

Section 3 – Summary of Recommendations

The four most important recommendations that have informed our choice of options are:

- The 'Do Nothing' option is untenable with demographic pressures alone likely to account for >7.5% average increases across services
- Current Demand and Capacity pressures (many of which concern emergency and unplanned care) must be addressed although the long and short term solutions are not necessarily the same
- The cultural and behavioural pre-conditions exist for fairly advanced levels of collaboration within and across the economy
- The economy is in a position to adopt a Whole System approach to working if the will can be marshalled

With this in mind we have produced two types of options. Type 1 options address the current pressures which are largely being felt in Emergency and Unplanned Care. They are largely operational and tactical in nature. The type 2 recommendations deal with longer term strategic options including 4 early questions about what and where you should be focusing your efforts.

Executive summary

Section 4 – Options to address current pressures

The 5 evident pressures from the Interim report remain, namely:
- Increased A& E attendances
- Increased use of OOH provision
- Increased demand for Ambulances
- Pressure on A&E capacity
- Increased demand for non-elective procedures

17 mostly tactical and operational options are then offered which will deal with the existing pressures

Section 5 – Options on Future Strategic Direction of Travel

Options in this section cannot be viewed as simply bolt-ons but have to be viewed as part of an overall coherent approach. Based on the qualitative research , we believe that as an economy you have an appetite for integrated working. Currently we assess this appetite as being for high levels of co-ordination and partnership working but not full structural integration. The appetite was best summarised by one interviewee who suggested that there needed to be a number of steps to build confidence towards more integrated working.

The next step should be about working with one or more patient groups across the whole health and social care economy. Key to success in making this work will be agreeing and communicating a Joint Vision. Once that has been done outcomes should be designed for the patient group that will then inform the choice of operating models to realise those outcomes. The models will then need to be supported by a range of cultural, technical, contractual and education and workforce enablers.

Against all these elements we have then offered a range of options which could be employed in combinations and where the evidence base is sufficient (it is not in all circumstances) then individual impacts have been modelled.

Overall purpose of the work and the Final Report

Overall purpose of work

The overall purpose of Capita's work is to provide health and social care commissioners, as well as provider stakeholders, with a view of the demand projections for health and social care. Following this, it is to provide the evidence-based service response to this demand as well as identifying any immediate procedural and productivity opportunities to maximise capacity in the system.

The demand modelling is:

- To model the demand for health and social care over the next 5 years at Unitary Authority level
- To build on the modelling work undertaken by Berkshire Health Care Foundation Trust as part of the Tomorrow's Community Health programme
- To build on the work done by health commissioners as part of the Care for the Future programme
- To build on demand modelling undertaken by the 3 Unitary Authorities
- To build on the predictive modelling capability of South Central Ambulance Service
- Cognisant of RBHs own internal Demand modelling

The capacity modelling is:

- To present the evidence base and make recommendations for the health and social care responses that should be provided in response to the identified demand, including both elective and non elective acute capacity.
- To develop an understanding of the financial resources available to commission such services for CCGs and each Unitary Authority

Role of this Report

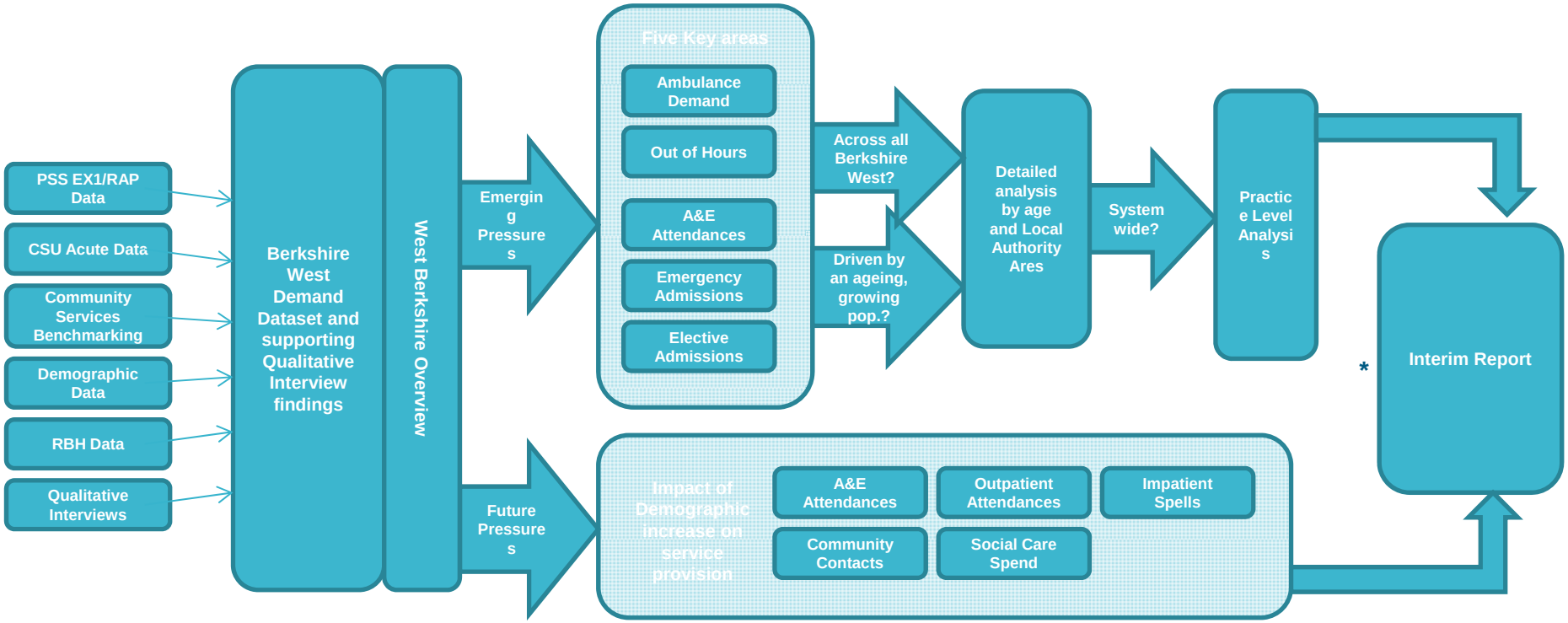
- This final report provides a 5 year view of demand in the economy building on February's Interim Report. It then provides evidence based strategic service redesign options for health and social care commissioners.
- The methodology used to produce this report is provided in the next slide. The report intentionally re- uses material from the Interim Report as it is intended to be read as a standalone document. This is particularly the case in the findings section

Out of Scope

At your request Mental Health and Continuing Health Care have excluded from the scope of this work.

Methodology

This methodology statement was included in the interim report.



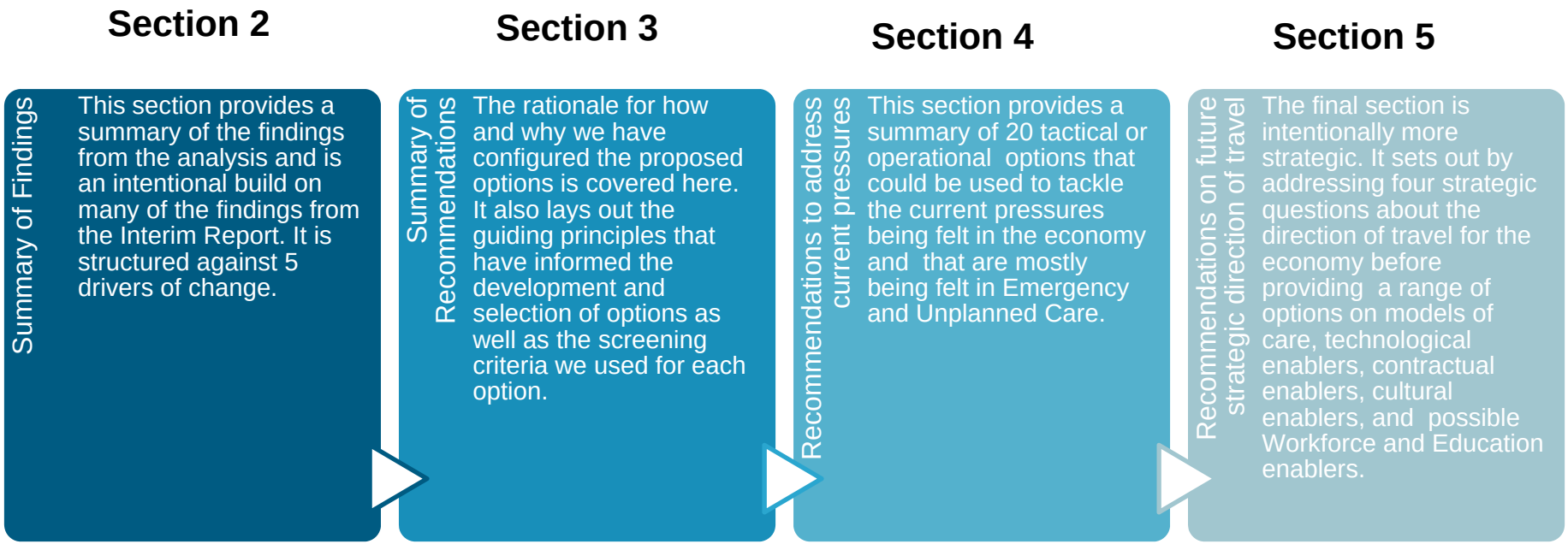
Following the production of the interim report the following work has been undertaken:

- Additional analysis undertaken of demand pressures and activity levels in West Berkshire
- Further discussion has taken place with each of the key organisations
- Further analysis of current and future needs and opportunities within West Berkshire has been undertaken
- Measures to address these needs and opportunities have been identified
- The potential impact of some of these initiatives has been modelled

Structure of the report

This report comprises two documents. This is document 1 and it contains both a summary of our findings and our recommendations. It is intended to be a standalone document. Document 2 is intended to be a supporting document and it contains much of the underpinning analysis that informed both the interim and the final report. It is intended to be a reference document.

Document 1 is structured as follows:



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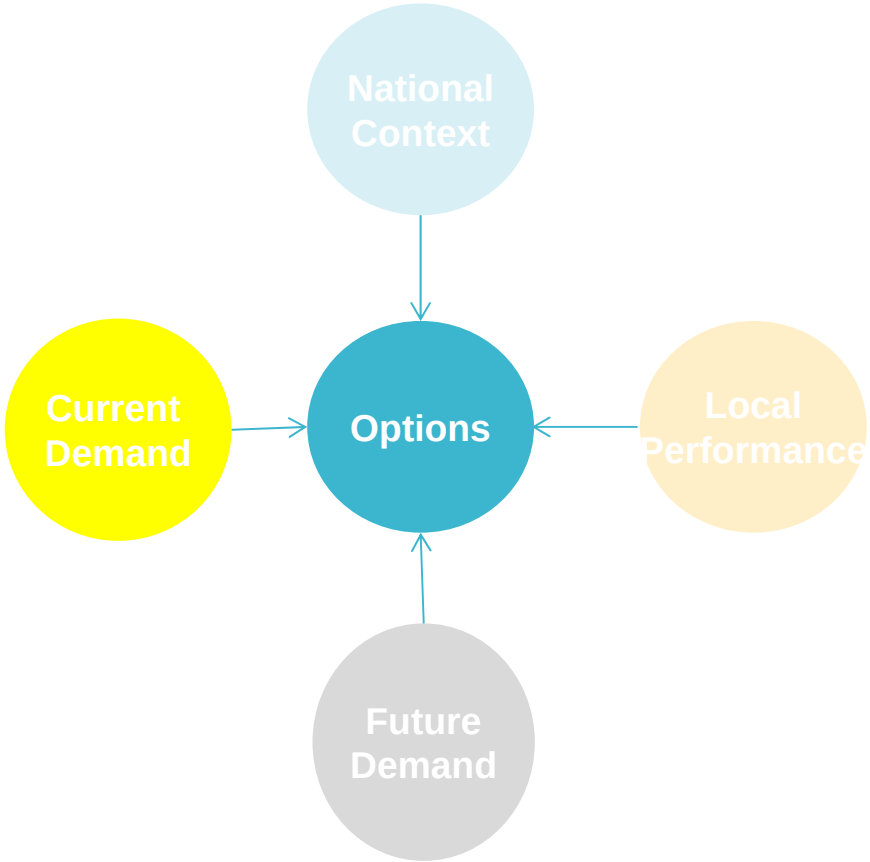
Section 2 – Summary of Findings

Summary of findings – Principal Drivers
The 4 Drivers

Collectively the qualitative and the quantitative analysis focused on a range of drivers that would inform not only the demand and capacity modelling but also the potential change options.

The 4 drivers were:

- **National Context** including the future policy and financial context.
- **Local Performance** and in particular the finances and performance of the local Health and Social Care economy
- **Current Demand** and activity including identifying pressure points
- **Future Demand** predictions based on demographic and other information



Summary of Findings – National Context

The broader national context the Berkshire West Health and Social Care Economy finds itself in

All Health and Social Care economies are about to enter a period of unparalleled challenge. Providing a free at point of delivery service in a time of austerity is going to stretch every organisation. In particular, flat line Health budgets, which are widely predicted to last a decade, will in practice be real terms cuts.

At the same time services will experience continuing and increasing demand pressures. Nationally, these demand pressures are coming from a range of sources including but not exclusively demographic and societally driven ones. The National population continues to age and the prevalence of long-term conditions continues to increase. The number of frail elderly patients with complex health and social care needs is already a mounting concern in the NHS and in health systems around the world.

Exacerbating the pressures on the system are the permanently raised expectations of patients whose recent memory is of continual increases in funding. This rise in expectation is more generally mirrored by an increased view of the citizen as a consumer who holds the state accountable for how their taxes are spent.

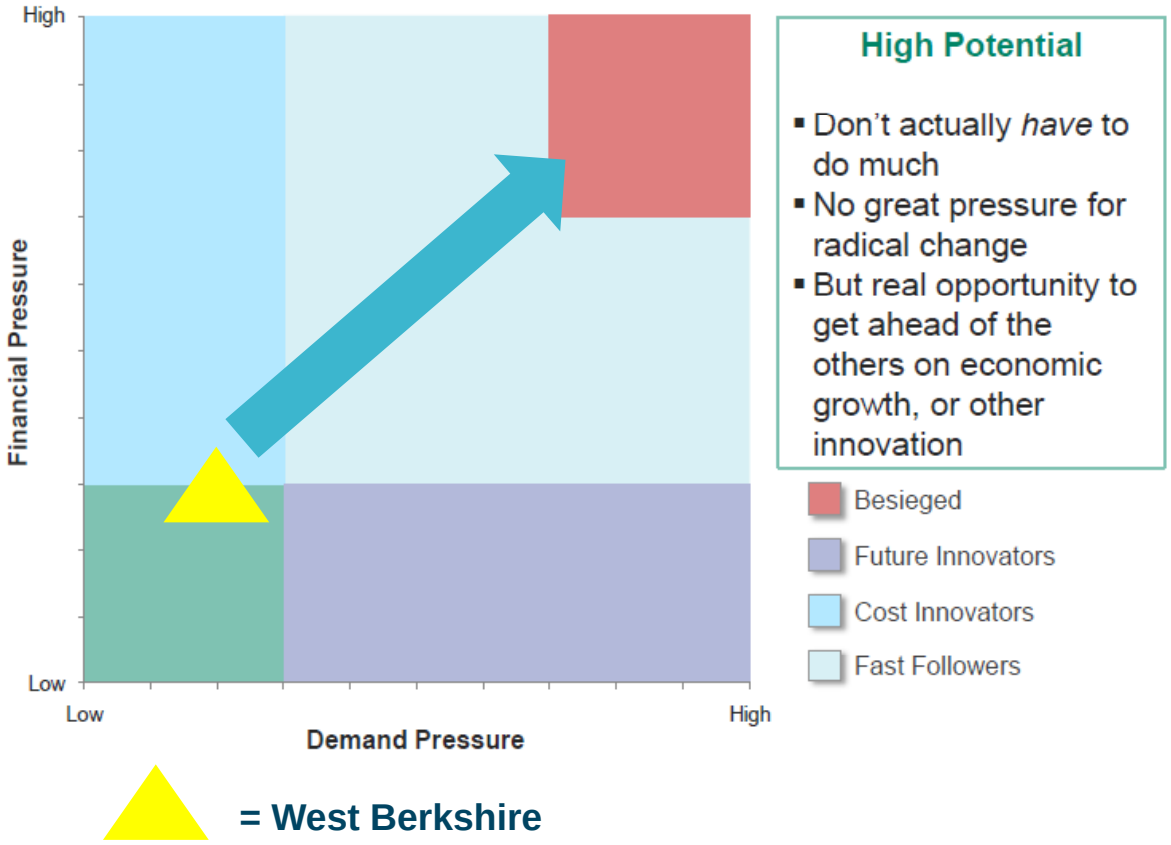
Against this backdrop, the challenges of maintaining and improving quality standards as well as improving the patient experience of care will loom large. The publication of the final Francis Report and HMGs response have brought these issues into sharp relief . However, embedding enduring approaches to increasing quality, improving patient safety, and increasing levels of customer satisfaction – putting compassion at the heart of it all – will become the principal leadership challenges of the next decade.

Many of the problems thrown up by these prevailing circumstances will be ‘wicked problems’ with no easy answers. To address some of the larger challenges, fundamental paradigm shifts will be required to achieve real behavioural change. All of which will require strong and motivated leadership at all levels and the levels of cross boundary working that have had to be adopted elsewhere in the Public Sector.

Image: Robert Francis QC

Summary of Findings – Local Performance
Overview of the West Berkshire Health and Social Care Economy

In the Interim report we concluded that by most standards West Berkshire was a well performing economy. Our view in the this final report has not changed. Our supporting evidence for this includes additional analysis since the Interim report and can found in Document 2 of this report.



For this reason, in the Interim Report we categorised West Berkshire as **High Potential** – the bottom left hand area of our 5 box model. We explained that this is due to West Berkshire neither suffering severe Demand nor severe Financial pressures. In practice this means there is less involvement in fire-fighting than other economies and as such have the opportunity for strategic and system wide innovation. **This categorisation remains.**

This categorisation has informed both the nature and the structure of our recommendations in Sections 3 to 5. Furthermore it should be re-iterated that this does not constitute a justification to do nothing. Both the current pressures in the economy and the future impact of demand make chance vital.

Summary of Findings – Current Demand Pressures
High Level Summary of Emerging Demand Pressures

Our analysis of the current pressures the economy is experiencing **remains largely unchanged** since the Interim Report. We would also continue to highlight the five specific areas of pressure the economy is experiencing. In our opinion these five areas collectively provide sufficient evidence of growing demand pressures in the economy. We also still contend they are early warning symptoms of greater problems ahead. The areas are:

- Increased A& E attendances
- Increased use of OOH provision
- Increased demand for Ambulances
- Pressure on A&E capacity
- Increased demand for non-elective procedures

Additional to these areas and based on qualitative interviews and qualitative data we also add the more general pressures on both Social Care and Community budgets.

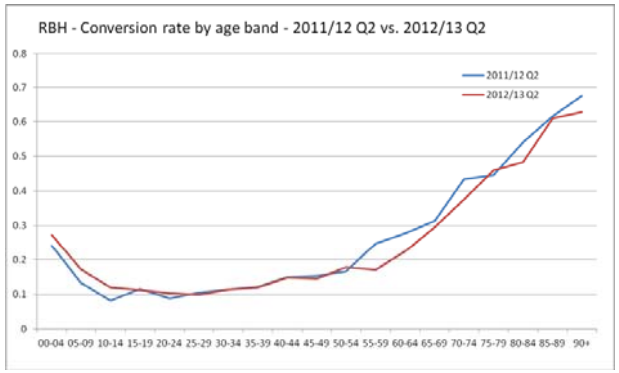
Since the Interim report we have conducted further analysis of the root causes of these pressures and we continue to support our Interim conclusions that these **pressures have both demographic and system induced demand pressures**. Our recommendations, particularly in Section 4, are designed to address both sorts of pressures.

Image: A classic pattern of stress fractures on a boiler

Summary of Findings – Current Demand Pressures
Some Root Cause Analysis on increasing A&E Attendance

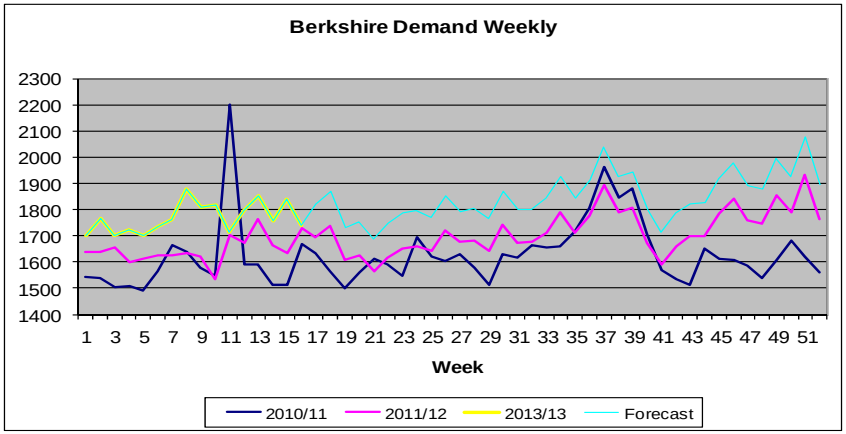
To explore the drivers of demand we began with A&E because of the insight it can provide. We reviewed all the A&E data that was available to us. A&E has seen a 20% growth in attendance in the last 18months. In our opinion it is this and the emergency admissions rate for adults that demonstrates a greater increase than can be explained by the rate of population increase and age change in Berkshire West, which led us to ask; **'Where is this A&E demand coming from?'**. To answer this we analysed A&E attendances over the last two years by age and home area . Overall, Q2 showed an increase in A&E attendances of 25% compared to same period last year. The largest proportional increases across the board was not in the eldest cohort (70+), rather it came from the 45 to 69 year old cohort . Furthermore the greatest year on year growth came from the 45 – 69 year old age bracket from Wokingham, a finding which was unexpected.

We then wanted an insight into the acuity in 45-69 year old cohort . As a proxy we took conversion rates. What we saw was that conversion rates fell both as a percentage and as an absolute number between the two years (see graph opposite). Whilst an explanation for this reduced conversion could be because of capacity constraints in Secondary Care or use of alternative settings of care, it could also indicate an increase of patients presenting inappropriately. If this were the case it opens the question as to why. In particular it could be a symptom of access issue or of blocks elsewhere in the system.

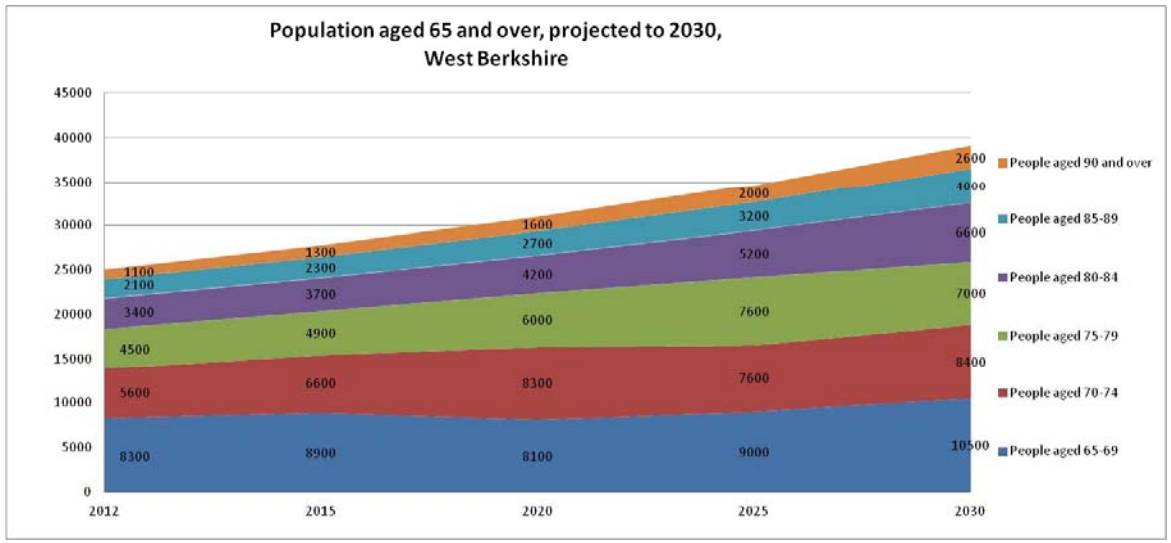


To continue this line of enquiry we then looked at ambulance data and the rise in demand for ambulances. A summary of the findings are that:

- There is a pattern of increasing demand for ambulance services with significant actions already taken to address this.
- Current resources are not sufficient to address the continued demand and 111 services are set to worsen the problem
- Peaks in ambulance activity are potentially leading to queuing at A&E and unnecessary admissions.
- These peaks link to the scheduling of home visits by GP practices which largely take place at the same time in the late morning or early afternoon
- There is some reason to believe that late arrival and treatment times are leading to unnecessary admissions as a result of failure to access diagnostic departments before they close.



Summary of Findings – Demographic Demand Pressures
Modelling the impact of demographic changes on demand in Berkshire West



POPPI Projections 65+ age range

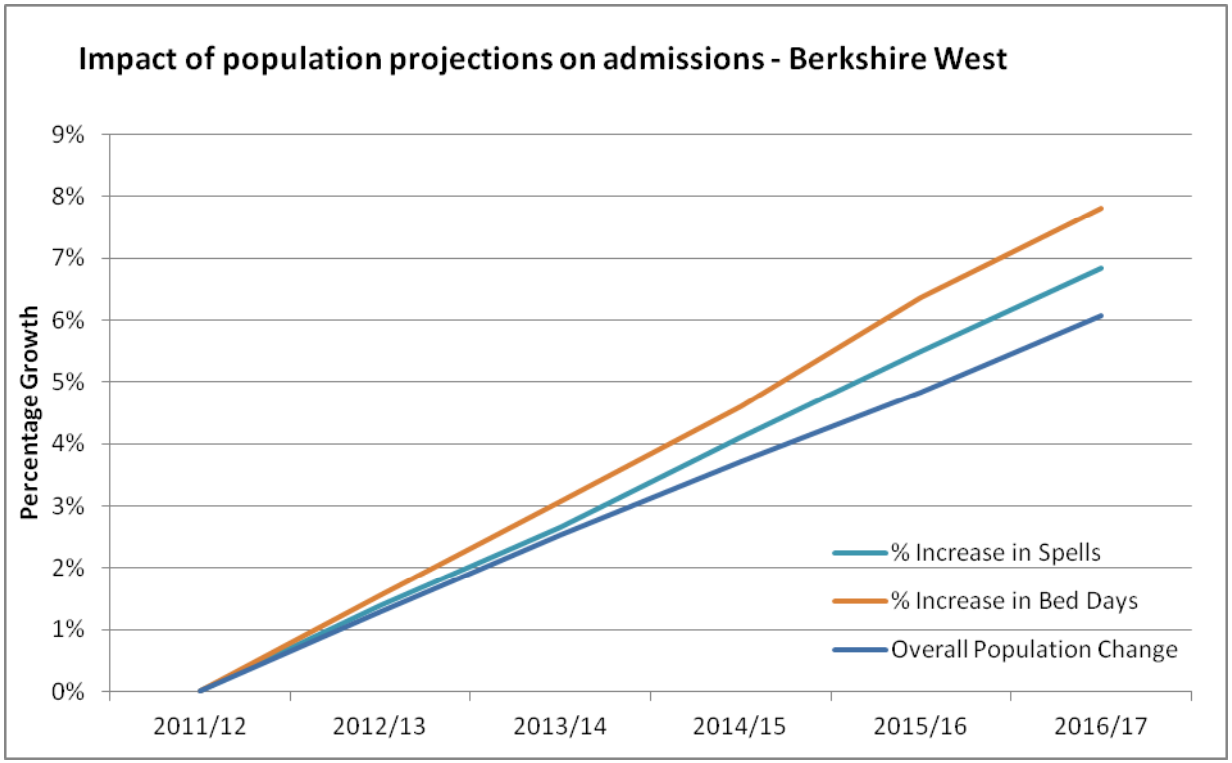
West Berkshire's population data showed not only a increase in overall population but also an increasingly ageing population.

In this section we model the impact of demographic changes on various services if nothing else changes – the 'Do Nothing' option.

To do this population forecasts have been taken from the latest ONS sub-regional population projections, and future rates applied to hospital activity on a record basis, with specific multipliers dependent on the 5-year age band, gender, and council area of the patient over the next five years.

The CCG impacted most by these projections is Wokingham CCG, seeing an increase in overall attendances of nearly 7%. It should be noted that this modelling is based on demographics alone and does not take into account some of the growths we have seen elsewhere that seem not to be directly attributable to demographic factors.

Summary of Findings – Demographic Demand Pressures
Impact of demographic changes on In-patient Admissions



Future Demand Pressures - Five Year 'Do nothing' Including £Projection for 2016/17

Using the approach described we first looked at inpatient admissions. The 'Do Nothing' project is summarised in the graph opposite and can be summarised as having the following features:

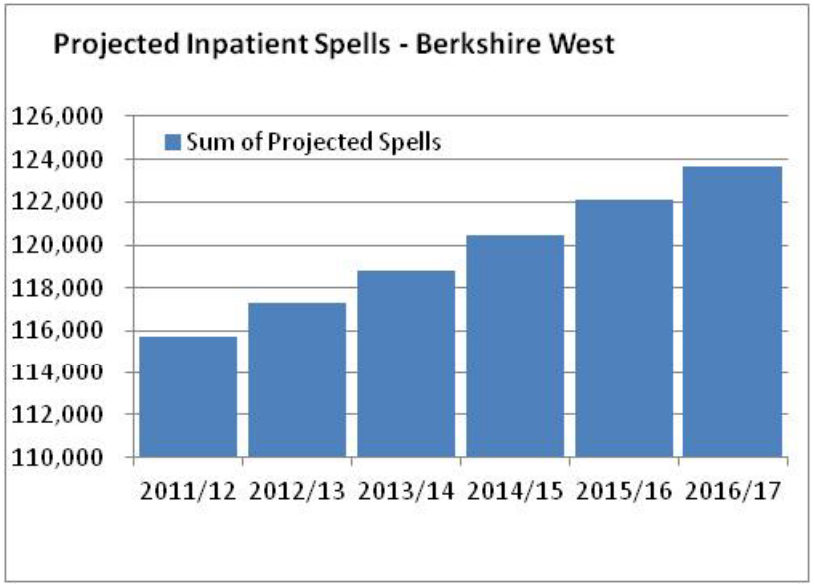
- An increase in spells by a total of 7% from the 11/12 position until 16/17

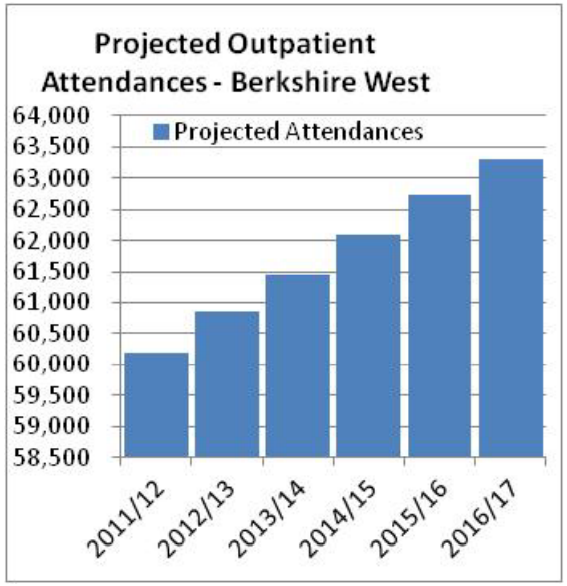
- An increase in the total number of bed days by almost 8% from the 11/12 position until 16/17

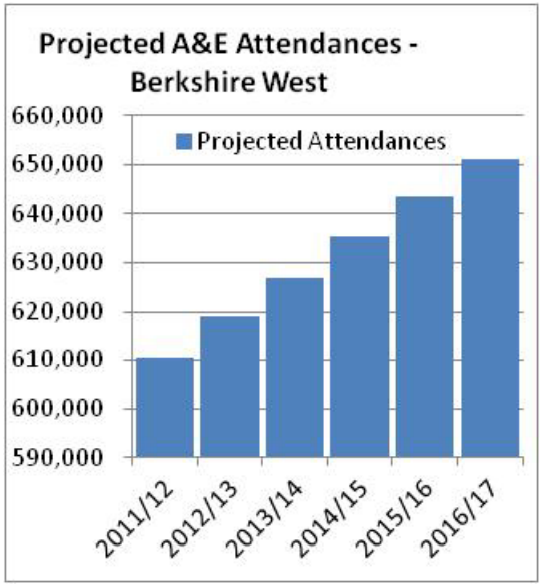
A further stage of the modelling is to look at what this means in terms of cost to Commissioners and resource for provider.

However in summary that for inpatients, the 'Do Nothing' option is not a possibility.

Summary of Findings – Demographic Demand Pressures
Impact of demographic changes across Secondary Care







In these three slides we look at the projected growth in:

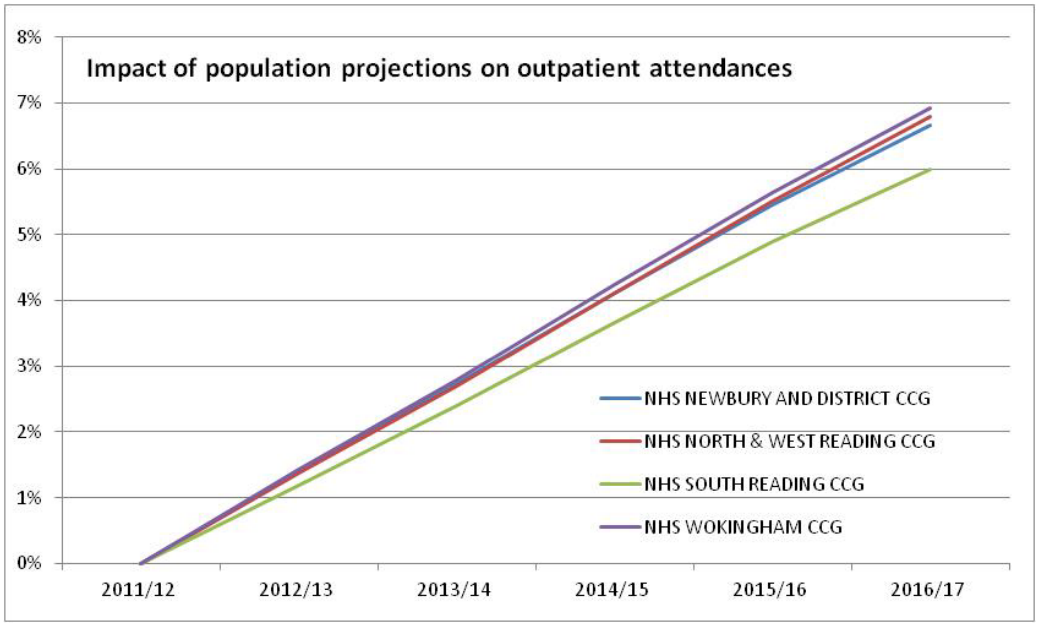
- In-Patient Spells,
- Outpatient Attendance
- A&E attendance

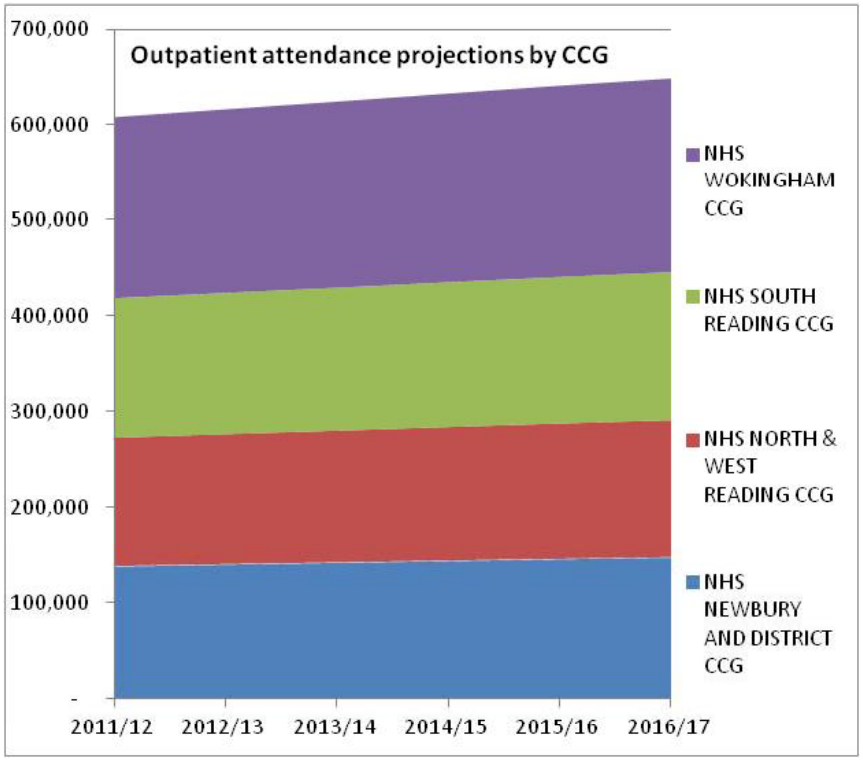
Based on these calculations, the expected increase in inpatient spells would mean an increase of 78 beds to cope with the additional demand. The next step is again to model cost. There may also be issues to cope with an increase in Outpatients of over nearly 3,500 patients per year.

Summary of Findings – Demographic Demand Pressures
Impact of demographic changes – on Outpatient Attendance by CCG

We have also begun to model the Demographic impact by CCG of the 'Do Nothing' option. The graphs below show the impact on outpatients alone.

We see that the CCG who will be impacted most will be Wokingham CCG who will see an increase in overall attendances of nearly 7%. It should also be noted that this modelling is based on demographics alone and does not take into account some of the growths we have seen elsewhere that seem not to be directly attributable to demographic factors.

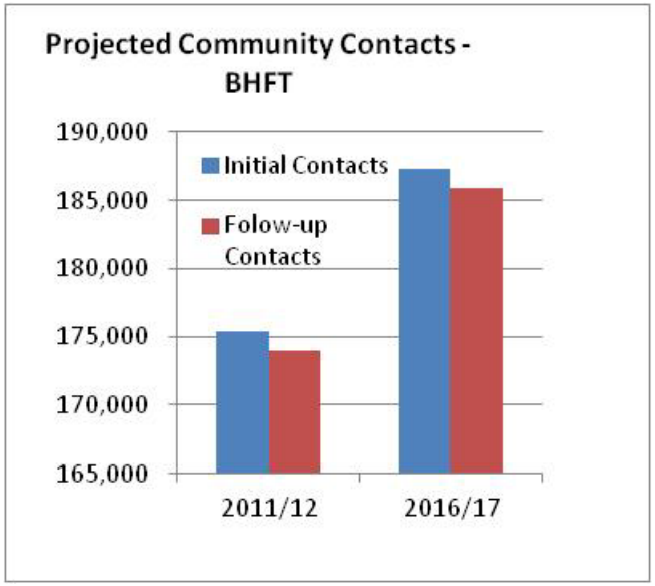


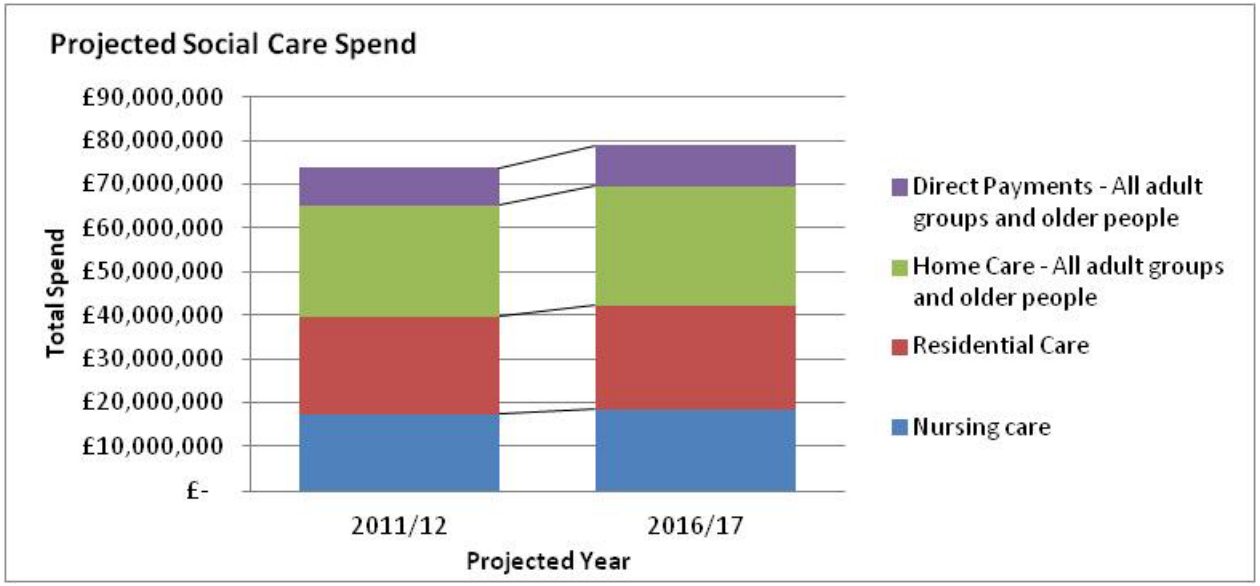


Summary of Findings – Demographic Demand Pressures
Impact of demographic changes on Community Contacts and Social Care Spend

We have also started to model the demographic impact on both Community Contacts and on projected Social Care spend. The methodology employed to create the projected community contacts is a simple estimation based on population growth impact on admissions.

The Social Care spend figure is a total figure across all three Unitary Authorities. This sees an increase in total spend up an additional £6m from the 11/12 position to the 16/17 position. In the same spirit as the Secondary Care slides though – it does indicate that a 'Do Nothing ' position is not really an option.





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Section 3 – Summary of Options

Section 3 – Summary of Options
How our findings informed our choice of options

The analysis element of this work provided the opportunity for insights into the overall state of the health and social care economy, the current pressures it is under, individual and organisational attitudes to change, and some of the pressures likely to emerge over the next 5 years. Additionally the very act of Commissioning this piece of work from Capita is indicative of a level of co-operation that is not present in many other Health and Social Economies. Based on all these findings we prioritised those which should most inform our recommendations.

Based on the prioritisation we believe the following findings were the most instrumental in informing our recommendations:

- The 'Do Nothing' option is untenable with demographic pressures alone likely to account for >7.5% average increases across services
- Current Demand and Capacity pressures (many of which concern emergency and unplanned care) must be addressed although the long and short term solutions are not necessarily the same
- The cultural and behavioural pre-conditions exist for fairly advanced levels of collaboration within and across the economy
- The economy is in a position to adopt a Whole System approach to working if the political will (capitalised and non-capitalised) could be marshalled

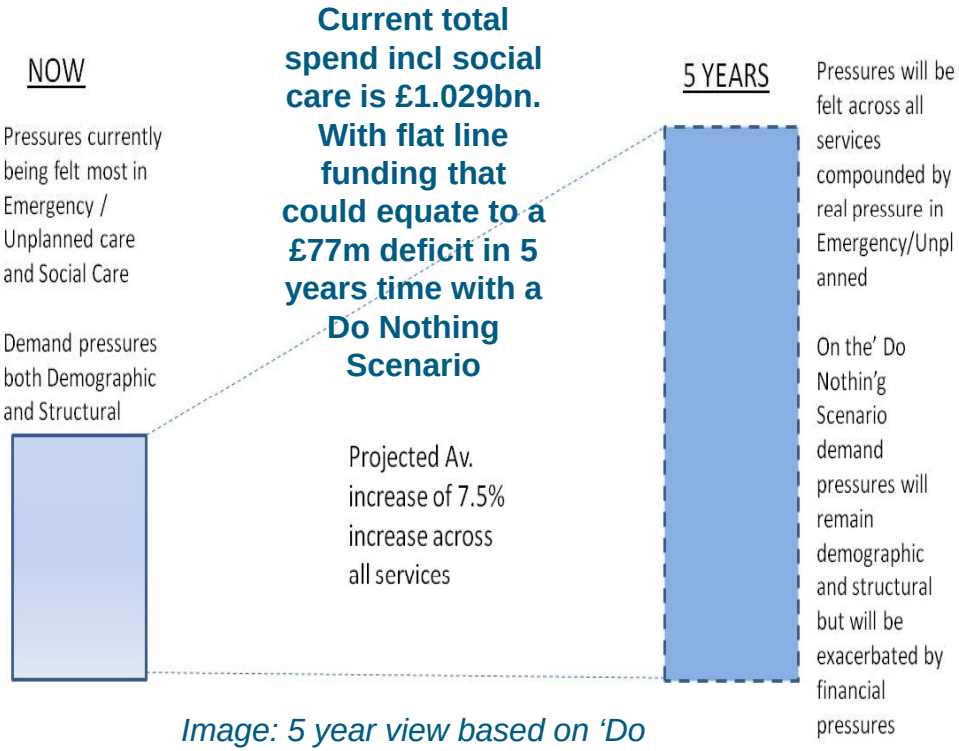


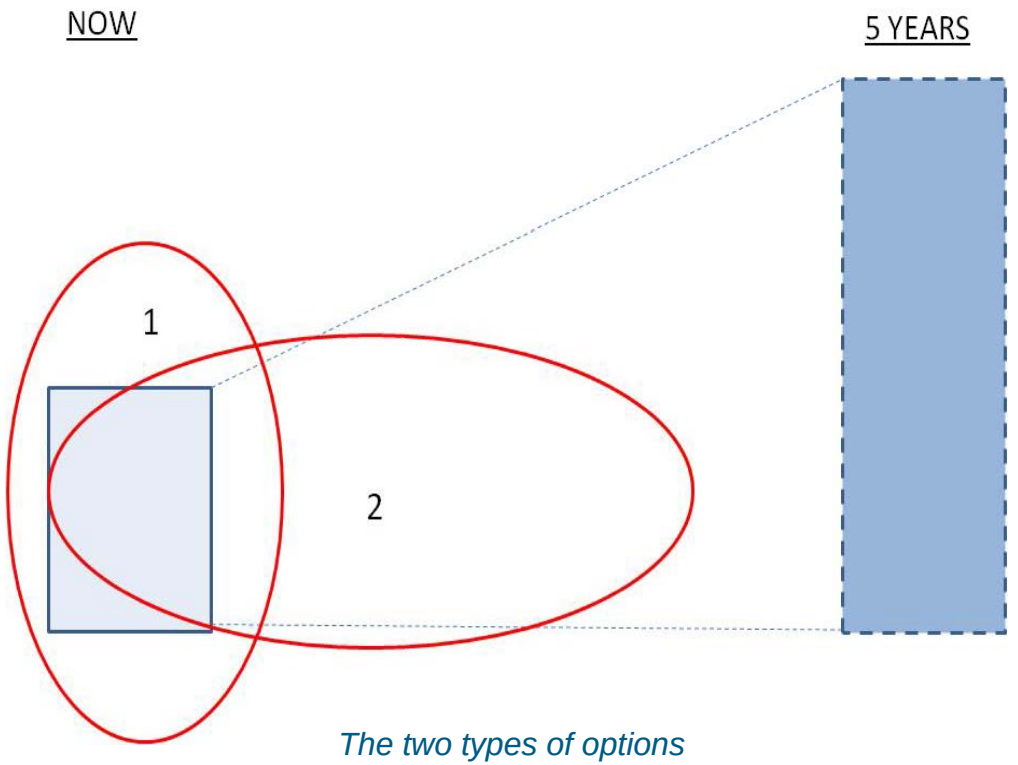
Image: 5 year view based on 'Do Nothing' Scenario

Section 3 – Summary of options
High level overview of our approach to creating recommendations

Based on the analysis of the prevailing conditions in West Berkshire and the prioritisation of findings, we have generated two types of options:

Type 1 – Options that are *aimed at addressing the current pressures*. These may be implementable quickly and there may be an alternative longer term option. They are depicted in the vertical oval marked 1. Most are inherently tactical or operational in nature

Type 2 – Options *on the future strategic direction of travel*. These include overall approaches, models of care and enablers. Some of these could address the current pressures but should be introduced as part of a more deliberate approach and as such will have longer lead times. They are depicted in the horizontal oval marked 2.



The two types of options

Section 3 – Summary of Options
Guiding Principles for the development of options

When developing options we have established a number of guiding principles that have informed our choice of options. These guiding principles can be summarised as follows:

Principle	Description
Upstreaming	Intervening with the patient in a timely way in order to prevent them presenting too late
Activating Patients	Patients involved and taking responsibility for their own care
At Health and Social Care Level	Options should where possible take a whole Health and Social Care perspective (acknowledged that some of the Type 1 options are more localised)
Organisational responsibility in promoting a stable economy	An understanding that all organisations, individually and collectively, have a role in promoting a stable economy
Quality and Safety	Patient Safety should never be compromised nor should Quality
Best use of resources	Quality, Safety and best use of resources are three sides of the same triangle
Personalisation	Options should endeavour to support the personalisation agenda

Review of Options

All potential options were screened against a range of criteria :

Categorisation	Definition
Need	Which of the needs identified in the findings this measure would address
Originality	Is this an option that (a) the economy is already doing but could make more effective (b) is not currently doing but where there appears to be an appetite or (c) a new or bold step that would constitute a radical departure
Impact	Which area of the economy this would impact
Timeline to effect	The time it would take to implement or effect
Scale of the Saving	A modelled estimate where possible of the size of the saving
Implementation costs	Whether there are implementation costs and if known what they would be
Will	Capita's perceptions of the will to implement or adopt
Pros and Cons	Additional Pros and Cons where identified

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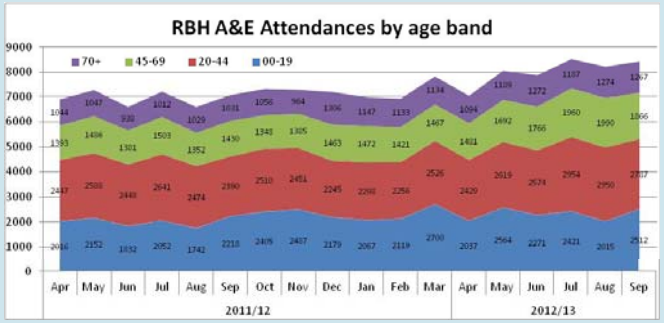
Section 4 - Options to address current pressures

Options to address current pressures
Attendance at A&E

Building on the work from the Interim report, the following slides identify the key demand pressures that are currently manifesting themselves - most of which are associated with Emergency or Unplanned Care

Increased attendance at A&E



There has been a significant increase in the levels of A&E activity at RBFT.

A&E activity for Berkshire West residents is up by 20% in the last 18 months (5,000 to 6,000 people).

The increased activity may in part be due to the closure of the A&E services in Wycombe and also anomalies related to the implementation of a new patient record system (EPR). However, it constitutes a very significant increase.

Overall demand for A&E services in Berkshire West is not only linked to Berkshire West commissioners but is also linked to patient increases from other CCGs.

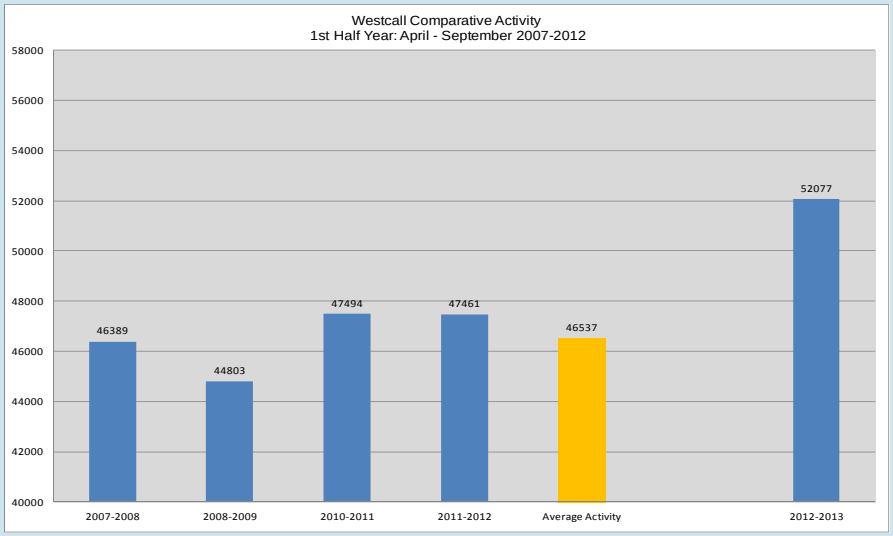
Significant numbers of patients are presenting at A&E by means other than ambulance with conditions not requiring investigation.
This suggests that the level of need of some of these patients was not significant enough to require A&E and that such patients could make more appropriate use of other services.

There were differing patterns of A&E usage across the four main CCGs which appear to be based on differing service provisions across the economy. The provision of a Minor Injuries Unit in Thatcham appears to have prevented a range of patients going to A&E. That said, Newbury CCGs attendance /1,000 population at all types of A&E (including minor injuries) is very similar (at 237/1,000) to both Wokingham (207/1,000) and N&W Reading (247/1,000). It is also very similar in the average cost / attendance (ex MFF) at £76/visit versus £83 and £79 respectively. This suggests the total volume and cost impact of the Minor Injuries facility is marginal but it may act as an effective triage and reduce pressure on the door of A&E.

All but nine of the practices across Berkshire West have seen an increase in A&E attendances. The size of any increase in activity varies between practices, with individual practices demonstrating up to a 20% increase in A&E activity. This suggests unwarranted variation in individual practice increases.

Options to address current pressures
Increased use of Out of Hours GP Services

Increased use of the out of hours service



The level of activity for the first half-year overall was very high. The recent Primary Care Foundation OOH Benchmark report listed Berkshire West as having the 2nd highest level of activity nationally with 200.5 cases per 1000 population compared to a national of average of 138 cases per 1000 population. Further detailed analysis on the nature of these calls may provide additional insights.

The average cost per head of OOH activity stands at £9.97, compared with a national average of £8.75. Due to the high number of cases the cost per case is actually lower than the national average.

The most common conditions treated during Q2 were urinary tract infections, acute abdominal pain and upper respiratory tract infections.

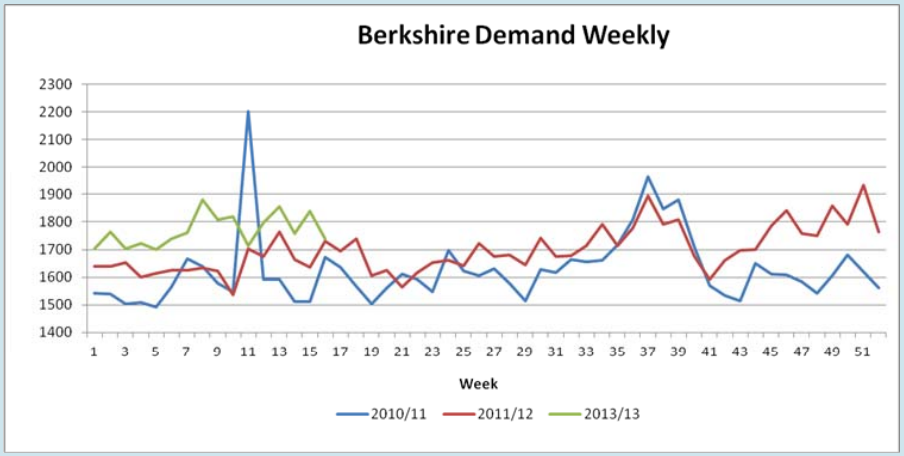
There were a high number of requests for medication recorded (4.2%) given the nature of the service i.e. That medication should only be issued when the condition would seriously deteriorate should the patient not be treated before their GP service opened the next morning.

Management of clinical cases was broadly in line with national averages for providing advice on self-management and home visits.

The OOH service in West Berkshire had higher than average levels of patient satisfaction. This suggests that some patients may repeatedly use the service when other care channels may be more appropriate.

Options to address current pressures
Demand for Ambulances

Increased demand for Ambulances



Ambulance use is increasing year on year.

Distribution of demand is causing pinch points of pressures within the ambulance service. GPs typically visit patients at home after morning surgery, then ring for non-urgent transport which causes a surge of requests at the same time. This adds to the intensity to increase in demand on an operational basis.

Experience in Oxfordshire suggests an increase of 15% in 999 activity as a result of the move from OOH to 111 (8% of 111 calls result in an ambulance being called compared with 1% of OOH calls) which may exacerbate the difficulties being experienced in West Berkshire

There is little doubt that there has been a significant increase in demand for ambulance services. Demand in 2011-12 was consistently higher than in the previous year. In nearly all weeks of the year there were more call outs. 2012-13 has seen higher volumes of demand by quite some distances for all weeks.

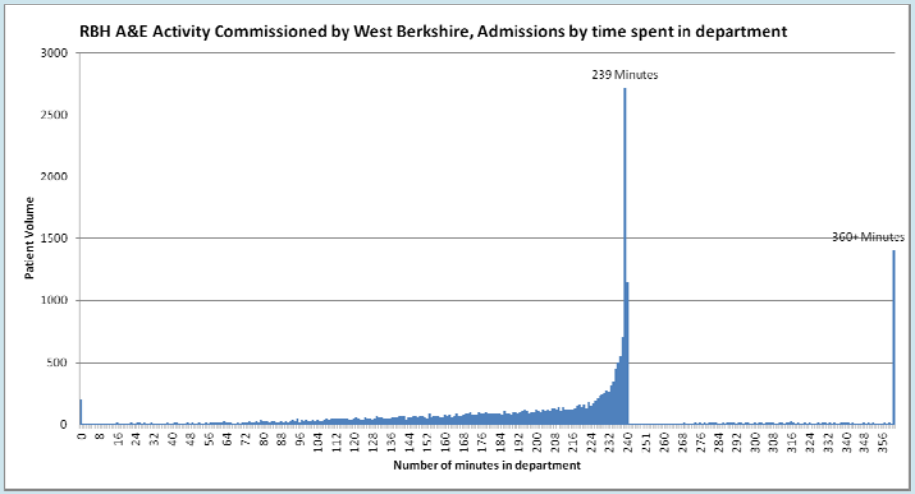
Several of the partners interviewed identified a significant problem with ambulances queuing at A&E. One interviewee quoted £3 million as the total amount of fines relating to such delays in a single year.

SCAS is about to become the provider of 111 services in Berkshire West. Their experience in Oxfordshire suggests an increase of 15% in 999 activity as a result of the move from Out Of Hours (OOH) to 111 (8% of 111 calls resulting in an ambulance being called). Previously 1% of OOH calls resulted in an ambulance being called. 111 is therefore set to increase the gap between demand and supply and demand further.

Current rota output has been carefully modelled to match current demand. However, we can see from the peaks of the graph that predicted demand will continue to outstrip rota supply at peak times (between 08:00 and 15:00). The gap between these two points increases significantly, by as much as 8 percentage points at 12:00, when the effect of the new NHS 111 service is taken into consideration.

Options to address current pressures
Pressures on A & E Capacity

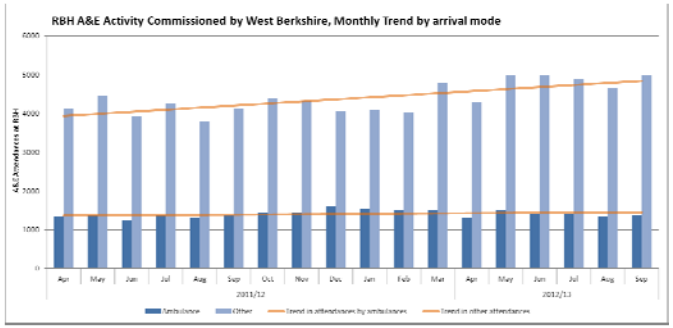
Pressure on A&E capacity



In terms of overall performance, Berkshire West has a 97.1% performance on 4 hour target (2011-12, plus early 12/13), in line with peer average. However, of the 23,323 admissions from A&E at RBFT, 7,277 (31%) were admitted within the last 10 minutes of the target. This would indicate a high degree of pressure being felt within A&E. 19% of admissions through A&E are subsequently discharged without an overnight stay although this percentage is showing signs of decreasing in recent months

Of those attending A&E there has been a significant increase in the number of people presenting by means other than ambulance

On a significantly higher proportion of occasions patients arriving at A&E by means other than ambulance received no investigations at all, 48%, compared with 16% for ambulance transferred patients. This applies across Berkshire West as a whole and in the case of patients from all four of the main CCGs considered.

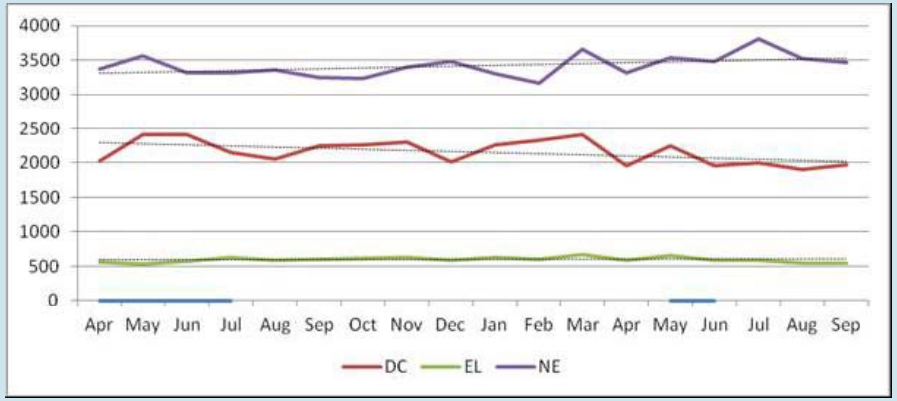


There has been a suggestion that daily peaks in ambulance activity are directly attributable to the scheduling of home visits by GP practices which tend to be largely at the same time in the late morning or early afternoon, a suggestion supported by evidence of a differing pattern at weekends when the main source of these referrals is the out of hours service.

Earlier in the day there is little difference between the time the ambulance is called, the time at which a vehicle is assigned and arrival at hospital. Later in the day peaks can clearly be seen.

Options to address current pressures
Increase in non-elective activity

Increase in non elective activity



There is a general increase in non elective admissions over the 18 months reviewed with two distinct spikes in March and July. Qualitative evidence has suggested that this is putting strain on the system.

Over the same period Elective admissions have remained static and elective day case admissions have decreased although some of the latter fall may have been caused by changes to coding practice of oncology regular attendees.

Whether there is a causal link between the increase in non-elective activity and the falls elsewhere is a potential subject for further investigation.

Whilst on the rise the increase in emergency admissions is relatively small when compared with the increase in A&E attendances.

There have been significant shifts in emergency admissions by HRG type and age range of patients.

There is no consistency across Berkshire West or across individual CCGs in terms of increases and decreases in number of referrals by individual practice.

The emergency length of stay at RBH is slightly longer than the national average for non-elective admissions.

Whilst the overall increase in numbers of emergency admissions across the 18 month period in question has been modest, data appears to show some significant shifts between different departments. It is not clear whether these are genuine changes in admission patterns of whether data entry or coding changes are giving the impression of shifting provision.

The diagnoses and procedures, both for elective and non-elective stays, with the longest Average Length of Stay (AvLOS) are for conditions associated with ageing and therefore the number of longer stays is likely to increase with an ageing population.

Social Care Activity and Expenditure

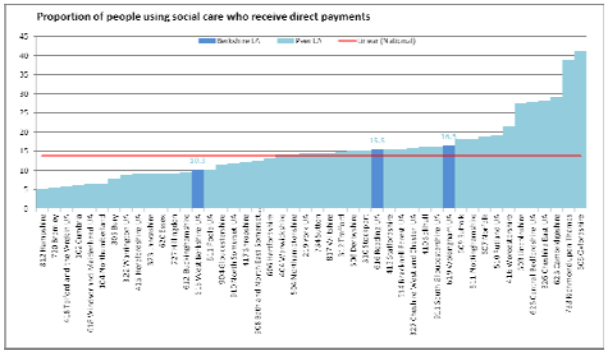
Social Care Activity and Expenditure

Both Wokingham Unitary Authority (UA) and Reading UA show levels of Delayed Transfer of Care (DTOC) below the national average and low in comparison to their peer group.

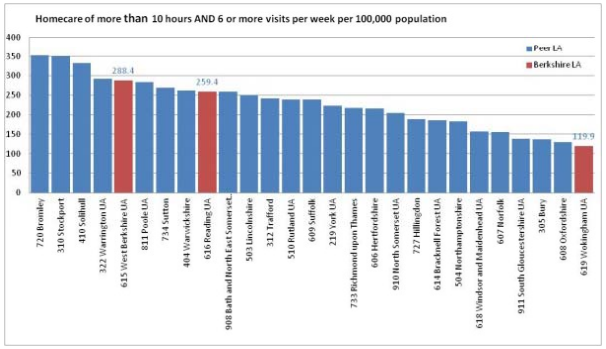
West Berkshire UA has one of the highest levels of DTOC, however the data for this analysis relates to the financial year 2011/12 when there were widely acknowledged issues with West Berkshire patients. Data from 2012/13 is expected to show significant improvements.

The proportion of DTOCs attributable to adult social care varies between the three UAs with the rate in West Berkshire very high, the rate in Reading in line with the national average and the rate in Wokingham notably below average.

Satisfaction levels were more closely aligned across all three UAs and were more closely in line with other members of their peer group. There are notable differences in the percentage of referrals to each of the UAs from primary and secondary care.



Reading Borough Council has an admission rate of older people into residential and nursing care higher than the national average whilst Wokingham has a rate just below the national average and West Berkshire has a rate significantly below the national average rate. Levels of provision are not merely a reflection of indices of deprivation (and hence requirement for statutory provision).



Community Services

Community Services

Demand for community services is generally more difficult to measure than acute services due to the variety of access routes and types of activity. Community providers do not tend to measure referrals in the same way as acute trusts, as the nature of community service delivery tends to be less episodic and less formal in terms of relationship between clinicians.

Nevertheless, the factors affecting demand for community services are not very different from other health services. Changes can result from several groups of factors:

•Organic change resulting from population changes including general growth, migration and changes in the age structure

•Change resulting from changes in professional practice and technological advance, as well as changes in models of care across the health economy

•Specific commissioning intentions not related to the above

•Supply-induced demand (introduction of a new specialist service or improved quality such as reduction in waiting lists may generate increased referrals)

•Change in market share, with referrers shifting activity between providers

Across intermediate care there have been a total of 5061 initial contacts with 23670 follow ups (a rate of 4.7) making a ration of 1:4.7

The number of contacts per whole time equivalents is lower in West Berkshire than the national average suggesting that there is potential to draw out additional capacity within the service, however this does depend on the exact nature of the service model for intermediate care.

The number of patient contacts per 100,000 population and activity per staff member is broadly lower across service lines compared against national benchmarked rates for Berkshire West, and Whole Time Equivalent (WTE) numbers are broadly in line for the population size covered. There may therefore be potential to draw out additional capacity within the service as contacts per WTE are lower than the national average. Further investigation into standard of service may be required to fully understand these figures.

The majority of community hospital beds are being used as a step-down facility.

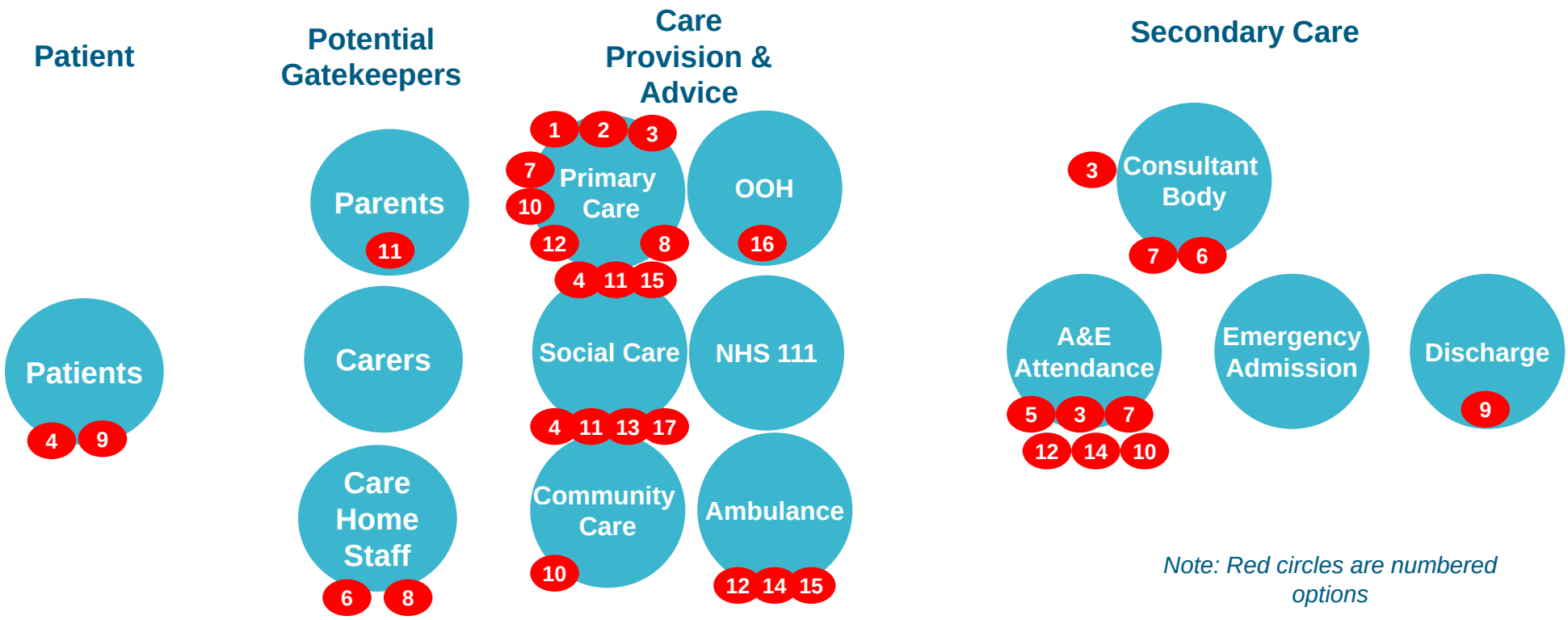
Over half of patients discharged from community hospitals are discharged back to their usual place of residence. However there is a possible concern in that 18% of patients once discharged are re-admitted to an NHS hospital provider. This may benefit from some further review.

Practical Limitations of some of the modelling

Every effort has been taken to ensure the modelling of options is as accurate as possible. The following limitations must however be acknowledged in the modelling:

- Some of the evidence base is derived from small sample sizes that in some cases are derived from pilots . To that end some conservative assumptions have had to applied about wholesale applicability
- Some of the evidence base is taken from outside the UK (including Scandinavian and US examples) with the associated limitations in direct applicability
- Some of the options provided are overlapping which means that if applied in parallel the sum of the impact may be less than that of each of the constituent parts
- Some of the evidence is taken from pilots which may mean that the true ROI of deployment at scale may not be fully reflected because of initial set up costs

Options to address current pressures – A&E attendance, Emergency Admissions , Ambulance &OOH
17 tactical or operational options for initiatives to reduce pressures in the short term



Note: Red circles are numbered options

The diagram above is a very simplified, nonlinear depiction of the 'upstream' elements between a patient and their potential A&E attendance and potential emergency admission. It does not attempt to reflect any particular patient journey. The numbered red dots however represent options for interventions that may prevent attendance or admission. The numbers relate to the descriptions in the following slides

Options to address current pressures – A&E attendance, Emergency Admissions , Ambulance &OOH Summary of Options

Option	Description
1	All Practices consistently ring fence same day emergency appointments daily
2	All Practices consistently ring fence same day children's appointments post school daily
3	Universal use of the advice and guidance function in Choose and Book
4	Enhanced use of risk stratification to support MDT working
5	Increased Senior Clinical Support at the door of A&E
6	Assistive video technologies to access Primary Care and specialist second opinions for nursing and Care Home patients
7	Secondary care Contact Lists in all Practices
8	Practices Routinely check the Care Plans and Medication prescriptions of Care and Nursing Home Staff

Option	Description
9	A&E frequent flyers with LTCs assessed for and supplied with Telehealth
10	Improved access Consultant Psychiatrists
11	Social Media campaign to parents of <5 on alternative options to A&E
12	Revised approach to GP Home visits
13	Creation of the Health and Social Care Co-ordinators
14	Analysis of Ambulance frequent flyers
15	Use of Third and Voluntary Sector to provide a place of safety in peoples own homes
16	Analysis of frequent flyers for the OOH service
17	Extension of Intermediate Rapid Response Team

Options to address current pressures
Options 1 and 2- All Practices Ring fencing Emergency and children's post school appointments daily

Option 1 – All Practices Consistently Ring fence same day emergency appointments daily

Need – inconsistency of rates of increase in A&E attendance by practice within CCGs suggesting potential patient access issues

Description – research by the Primary Care Foundation suggested that the right ratio of advance to same day bookings for a Practice is about two thirds to one third. The option here is to move towards greater consistency across practices and in particular to look at availability of same day appointments for Practices with high A&E attendance

Originality –this is good practice and is already happening in many practices but attendance figures suggest an inconsistency in application

Impact – while no definitive analysis of impact could be found, one of the pilot practices in the Primary Care Foundation Trial saw, when moving to the two thirds/one thirds ratio, a three week, like for like reduction in extras from 165 to 25 appointments suggesting demand was being met in Primary Care

References:
- 'Urgent Care: a practical guide for transforming same-day care in general practice'. Primary Care Foundation 2009.
- ' Introduction and User Guide – Urgent Care in General practice Toolkit' – NHSIMAS

Option 2 – All Practices Consistently Ring fence same day children's appointments post school daily

Need – inconsistency of rates of children's A&E by practice within CCGs suggesting inconsistency of access for children. In context attendance of under 19s between 3 and 6pm constituted nearly 7.5% (4,861 attendances) of all RBH A&E attendances in 11/12.

Description - The option is that all Practices across the CCG routinely keep available same days appointments for school age children at the end of the school day.

Originality - we suspect this is already happening in many practices but attendance figures suggest an inconsistency in application

Impact – while no definitive analysis exists to support this. The Primary Care Foundation found small amounts of change around same day appointments achieve 'significant' amounts of change.

Reference:
- 'Urgent Care: a practical guide for transforming same-day care in general practice'. Primary Care Foundation 2009.

Options to address current pressures
Options 3 and 4 – Universal use of the advice and guidance function in Choose and Book and use of risk stratification to support MDT working

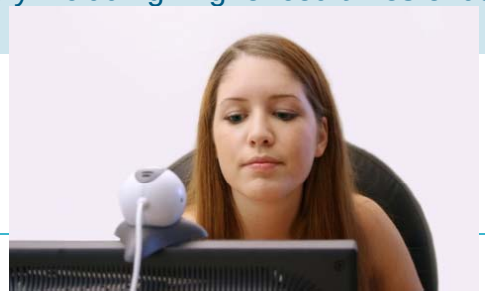
Option 3 – Universal use of the advice and guidance function in Choose and Book
Need – to ensure the correct streaming of patients and the Choose and Book system is optimised
Description – adoption of universal use of the advice and guidance function of Choose and Book
Originality – this is good practice and is already happening in most cases but some qualitative research suggests an inconsistency in application

Option 4 – Enhanced use of risk stratification to support MDT working
Need – Primary Care currently has risk stratification but there is reported erratic use. The development of the cluster teams, and the risk stratification co-ordinator seems the ideal opportunity to more comprehensively roll out risk stratification
Description - Build on the existing risk stratification tool available in Primary Care in order to target MDT interventions to high risk patients. This approach also strengthens the development of the developing Cluster teams
Originality - all elements of this already exist in the economy, the will is now needed to implement it in a consistent way
Impact.- the Birchwood Practice in Poole alone managed to effect an annual reduction in emergency hospital admissions of 10% just by the development of Integrated Team working
Pros/Cons – while the will and the tools largely exist to execute this, there appears to remain individual practice reluctance to data sharing and use. This will require both peer pressure and targeted communications to overcome. As such the *timelines* to implementation may be hindered
Reference: • Urgent Care: a practical guide for transforming same-day care in general practice'. Primary Care Foundation 2009.

Options to address current pressures
Options 5 and 6 – Increased Senior Clinical Presence in A&E and assistive technology in nursing homes

Option 5 – Increased Senior Clinical Support at the door of A&E
Need – increasingly high volumes of emergency admissions which will, if not already, impact on the levels of elective activity
Description – Increased senior clinical presence in A&E to get opinions earlier and to avoid unnecessary emergency admissions
Originality – The provision for 2.8wte Consultants means this may be already train but the scale of the potential opportunity makes it also worth re-considering the execution
Impact – The Kings Fund analysis of increasing senior clinical presence in A&E can reduce emergency admissions by 10%. Applied to RBH alone that could equate to up to 3,000 admissions per year
Pros and Cons – while the potential impact is high it is acknowledged there is a compensating increase in staff costs and or commitments. To this end a range of alternative technology solutions are suggested elsewhere
References: • ‘’Avoiding Unnecessary Admissions’ –Kings Fund 2010

Option 6 – Assistive video technologies to access Primary Care and specialist second opinions for nursing and Care Home patients
Need – High volumes of elderly patients attending at A&E and having Emergency admissions are from nursing homes where clinical care standards are often low and staff are often risk averse
Description - As per option 7 but allowing Nursing and Care home staff to remotely access clinical advice and for clinicians to see the patient
Originality - As per option 7
Impact – The Birchwood Practice in Poole alone managed to effect an annual reduction in emergency hospital admissions just by the development of Integrated Team working
Pros/Cons – The benefits of reducing A&E attendances from Care homes is obvious however the same cost benefit analysis as per option 7 needs to take place and clear protocols about use, potentially including ring fenced times of day will need to be created



Options to address current pressures
Options 7 and 8 – Secondary Care Contact Lists in all Practices and Regular Care Plan checking for Nursing and Care Home Patients

Option 7 – Secondary care Contact Lists in all Practices

Need – The inconsistency in referring patterns between practices within the same CCG constitutes unwarranted variation

Description – CCGs and Secondary Care providers agree a list of contacts who are prepared to take calls from individual GPs for advice on patients and in particular over whether a patient needs an emergency referral

Originality – this may well be taking place with some practices however referral patterns would indicate this may be inconsistent

Option 8 – Practices Routinely check the Care Plans and Medication prescriptions of Care and Nursing Home Staff

Need – High volumes of elderly patients attending at A&E and having Emergency admissions are from nursing homes where clinical care standards are often low and staff are often risk adverse. These admissions are also often deleterious to their health.

Description - Practices routinely checking the Care Plans and Medication of their patients within nursing homes in order to reduce the risk of Emergency Admissions to Secondary Care.

Originality - – this may well be taking place within some practices however referral patterns would indicate this may be inconsistent

Impact - the research (RCT) by Caplan *et al* showed that Nursing and Care Home patients with advanced care plans were 25% less likely to be in a hospital intervention bed than those without. There was also some indication of increased life expectancy for these patients

Pros/Cons – this requires good relations between Practices and Care Homes, it also could be time consuming.

Reference:

• Advance Care Planning and hospital in the Nursing Home', Caplan *et al* – Oxford Journals, 2006

Options to address current pressures
Options 9 and 10 – Telehealth on Discharge and improved access to access Consultant Psychiatrists

Option 9 – A&E frequent flyers with LTCs assessed for and supplied with Telehealth
Need – There are frequent flyers to A&E many of whose attendance and subsequent admission could be avoided by monitoring
Description – This option proposes building on the work currently being undertaken by Kent and Medway Commissioning Support to identify frequent flyers to A&E, assess their suitability for Telehealth and fast track them onto it. They are particularly focusing on patients with LTCs. Multi-disciplinary interventions have then been designed to support the Tele-health results
Originality – we believe this would be a fresh approach for West Berkshire but that our qualitative research indicates collective support for this type of approach albeit with supporting funding flows
Impact – The Kent work has yet to report out but WSD findings which focused on 3 LTCs showed reductions of 15% in A&E attendances and 20% in Emergency admissions
Pros/Cons - capital investment would be required
References: • "'Its time for your screen test' HSJ Supplement 14th March 2013, p.2

Option 10 – Improved access Consultant Psychiatrists
Need - high volumes of patients with underlying mental health issues attending at A&E
Description -In a similar vein to options 7 & 8 , this approach could allow A&E staff to access Consultant Psychiatrists using video based assistive technology in order inform patient streaming and emergency admission decisions
Originality - this would follow on the existing Out of Hours access to Consultant Psychiatrists
Impact –This would build on the existing Rapid Assessment, Interface and Discharge (RAID) type approach already in place. The Birmingham experience of RAID saved 10,715 bed days across 3,540 patients in an 8 month month period. This equated to a Annual saving of £3m a year. The same trail also saw elderly MH re-admission rates fall by almost three quarters
Pros/Cons – a cost benefit analysis still needs to be done that looks at development costs, salary and likely impact. This would need to be owned and co-created with the clinical body.
Reference: • 'The Rapid Assessment Interface and Discharge Liaison Team, City Hospital Birmingham: Evaluation Report December 2009' Tadros *et a*l 2011

Options to address current pressures
Options 11 and 12 – Social Media Campaign to parents and revise approach to GP Home Visits

Option 11 –Social Media campaign to parents of <5 on alternative options to A&E

Need - in 2011/12 10,083 attendances at RBH A&E were aged under 5. This is approximately 15% of all attendances.

Description – Evidence across many sectors shows new mothers are heavy consumers of social media and in particular look at local issues. Proposal is to set up a Berkshire West Facebook page aimed at Mothers of <5s. The proposal is the use the medium to help them self-stream where they take their children and in particular to avoid A&E attendances

Originality Aware the Community Hospital already has a Facebook page but this is patient not organisation structured

Impact – in other sectors similar Facebook approaches have been highly effective streamers

Option 12– Revised approach to GP Home visits

Need – the qualitative research indicated that the timings of GP home visits may be affecting ambulance availability as well as creating demand spikes in A&E

Description - GP Home visits are staggered through the day. To minimise disruption to surgeries practices could consider sharing visiting doctor services so reducing the impact on overall availability of appointments

Originality - we believe this is something that may have been reviewed but requires a co-ordinated approach if adopted

Impact – The Primary Care Foundation reported that in the St Helen's Health Economy the effect of 9 small practices (4 of which were single handers) sharing visiting doctor services with access to an Acute Visiting Service, reduced emergency admissions by 30% and saved over £1m. The system made us of the local OOH infrastructure to ensure access to patient details. A side effect was that it freed up between 2 – 3 appointments /day/surgery

Reference:

•'Urgent Care: a practical guide for transforming same-day care in general practice'. Primary Care Foundation 2009.

Options to address current pressures

Options 13 and 14 – Creation of Health and Social Care Co-ordinators and analysis of ambulance frequent flyers

Option 13 – Creation of the Health and Social Care Co-ordinators
Need – Avoidable A&E attendances and emergency admissions need to be avoided.
Description – appointment of Health and Social Care Co-ordinators perhaps aligned to each Cluster to streamline and control referral processes
Originality – this would build on the existing Clustering and Service navigation work that is taking place
Impact – This suggestion is influenced by the Torbay whose achievements are widely acknowledged to be the product of some very specific circumstances. And while the Health and Social Care co-ordinators were but a part in the system – the overall impact included a 24% reduction in bed days for the 65+ population and a 32% reduction for the 75+ population. Emergency bed day use for was only 70% of the figure for its neighbouring comparator PCTs
Pros/Cons - requirement for funding of post, issues to be addressed around pay and grading, needs mandate to operate
References: • 'Integrating health and social care in Torbay: Improving Care for Mrs Smith' Kings Fund March 2011

Option 14 – Analysis of Ambulance frequent flyers
Need – increased pressure on ambulances needs to be addressed. Qualitative research indicates that the up skilling of crews has allowed them to deal with more patients. Given how precious a resource an ambulance is, what other options are there for some of the patients currently using ambulance time
Description - analysis of ambulance frequent flyers, identification of appropriateness of intervention, identification of alternatives, and training of staff to direct these individuals to those services.
Originality - this builds on the work already done around demand and capacity analysis by SCAS
Impact – San Diego Fire and Rescue Service developed a Resource Access Program (RAP) which is an EMS-based surveillance and case management system. It focused on frequent callers of 9-1-1 who had chaotic lifestyles. During the first two years the RAP demonstrated significant improvements for 51 clients, reducing the number of ambulance transports (736 to 459), task time (263 hours), miles (1,939) and charges ($314,306).
Pros/Cons – requires up front time in analysis, training in call handlers to identify frequent flyers, a clear directory of services to identify other options, and very probably a multi-disciplinary approach
Reference: • Elsevier Public Safety & Jems Magazine, March 2010

Options to address current pressures
Options 15 and 16 – Increased use of the Third sector to release Ambulance time

Option 15 – Use of Third and Voluntary Sector to provide a place of safety in peoples own homes

Need – increased pressure on ambulances needs to be addressed. Qualitative research indicates that the up skilling of crews has allowed them to deal with more patients. Given how precious a resource an ambulance is, what other options are there for some of the patients currently using ambulance time

Description – Options around the third sector being engaged to avoid the need for ambulances to either stay with patients in their home or bring to an alternative setting of care only because it provides a place of safety.

Originality - in effect an extension of an approach already being used in A&E where the Red Cross support discharge

Impact – detailed analysis not undertaken, the value is in the opportunity cost

Pros/Cons – there is an financial cost in engaging the Third and Voluntary Sector

Option 16 – Analysis of frequent flyers for the OOH service

Need – the OOH service (West Call) is stretched to capacity and exhibiting levels of demand considerably beyond what should be expected. To ease demand and increase capacity current volumes in the system need to be addressed

Description - a patient level analysis of OOH frequent flyers is undertaken in order to understand why they are using the system and are they using it in preference to other, more appropriate services. Potential educational interventions for both patients and the OOHs provider. This analysis could also be extended to cover prescribing to these patients.

Originality - builds on the existing analysis of OOH services but we don't believe this has been done at patient level

Impact – in our research we couldn't find evidence of this type of work being done elsewhere and us such we can't estimate the full impact.

Pros/Cons – the analysis alone will not necessarily deliver benefits, the nature of the follow up needs to address the underlying causes of the over usage. Some cultural change in the provider may also be required.

Options to address current pressures
Option 17 – Extension of Intermediate Care Rapid Response Team

Option 17 – Extension of Intermediate Rapid Response Team
Need – both qualitative and quantitative analysis suggest that more patients are seeking Emergency Care too late and hence raised Acuity levels at the door of A&E and settings of care.
Description - the option is an extension of the Intermediate Care Rapid Response Team. Obvious areas to address would include Community diagnostics and the development of Hospitals at Home (Virtual Wards).
Originality - this is building on strong existing Intermediate Rapid Response Team. In reality this should be done in conjunction with options 4, 14, 15 & 17.
Impact – the Virtual Wards work in Croydon provided a broad range of benefits but the most conservative figures suggest 10% reductions in A&E attendances & Emergency admissions
Pros/Cons - .This particular option may realistically fall within our type 2 options as a significant extension of the service will require the extension of a shared vision and may best be done as part of a broader Whole System approach. There will also have to be compensating reductions from elsewhere to fund the extension
References: • 'Developing Intermediate Care: A guide for Professionals' Kings Fund 2002 • Croydon Virtual Ward results 2009

CAPITA

Section 5 – Options on future strategic direction of travel

Options on future strategic direction of travel
The Context

“I think that.. there is a general feeling that technology brings opportunities but .. it is about people and patient empowerment. .. it has to be part of wider system redesign”

Dr Johnny Marshall in HSJ 14th March 2013

On Section 4

In the previous section we provided 17 options that can be implemented relatively quickly either individually or collectively. They are all intended to help reduce the demand pressures the economy is currently experiencing.

Those recommendations were intentionally either tactical or operational (with the possible exception of option 17) and could be effected easily. They were not designed to effect strategic change

On Section 5

In Section 3 we categorised the economy as High Potential because it has the opportunity for strategic and system wide innovation. This is the reason for the inclusion of the quote from Dr Johnny Marshall. Options here can’t simply be bolt-ons but have to be aligned to the strategic direction of travel . For that reason we have provided opinions on both the strategic decisions you need to address and then some of the enablers that will support them.

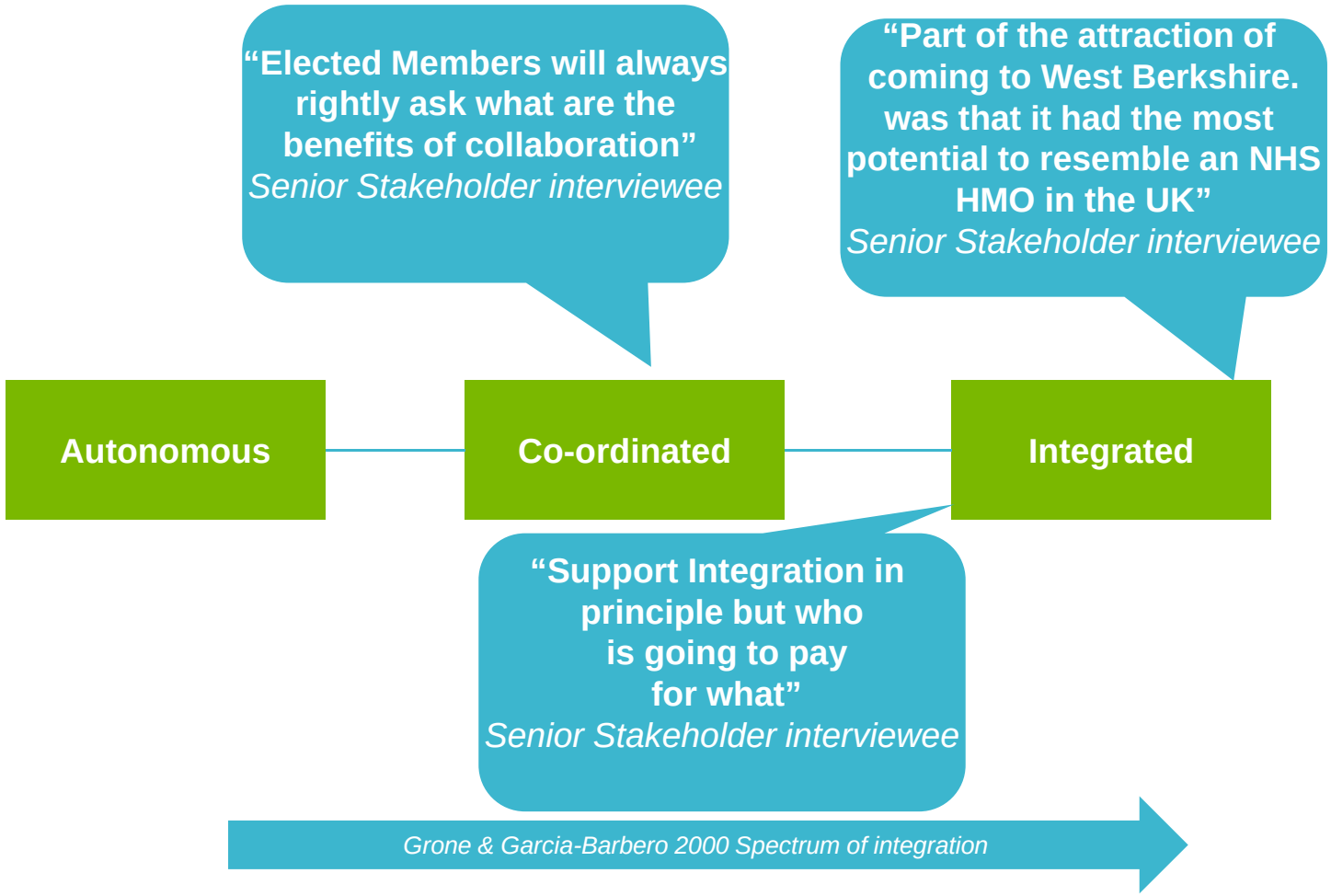
We have configured this section initially against a number of questions and then looked at options by service re-design element. They cover both planned and unplanned care.

Options on future strategic direction of travel
Question 1 - What sort of Health and Social Care Economy do you want to be?

Predicated on an appetite to work together, the first question that needs addressing is what sort of Health and Social Economy do you want to be?

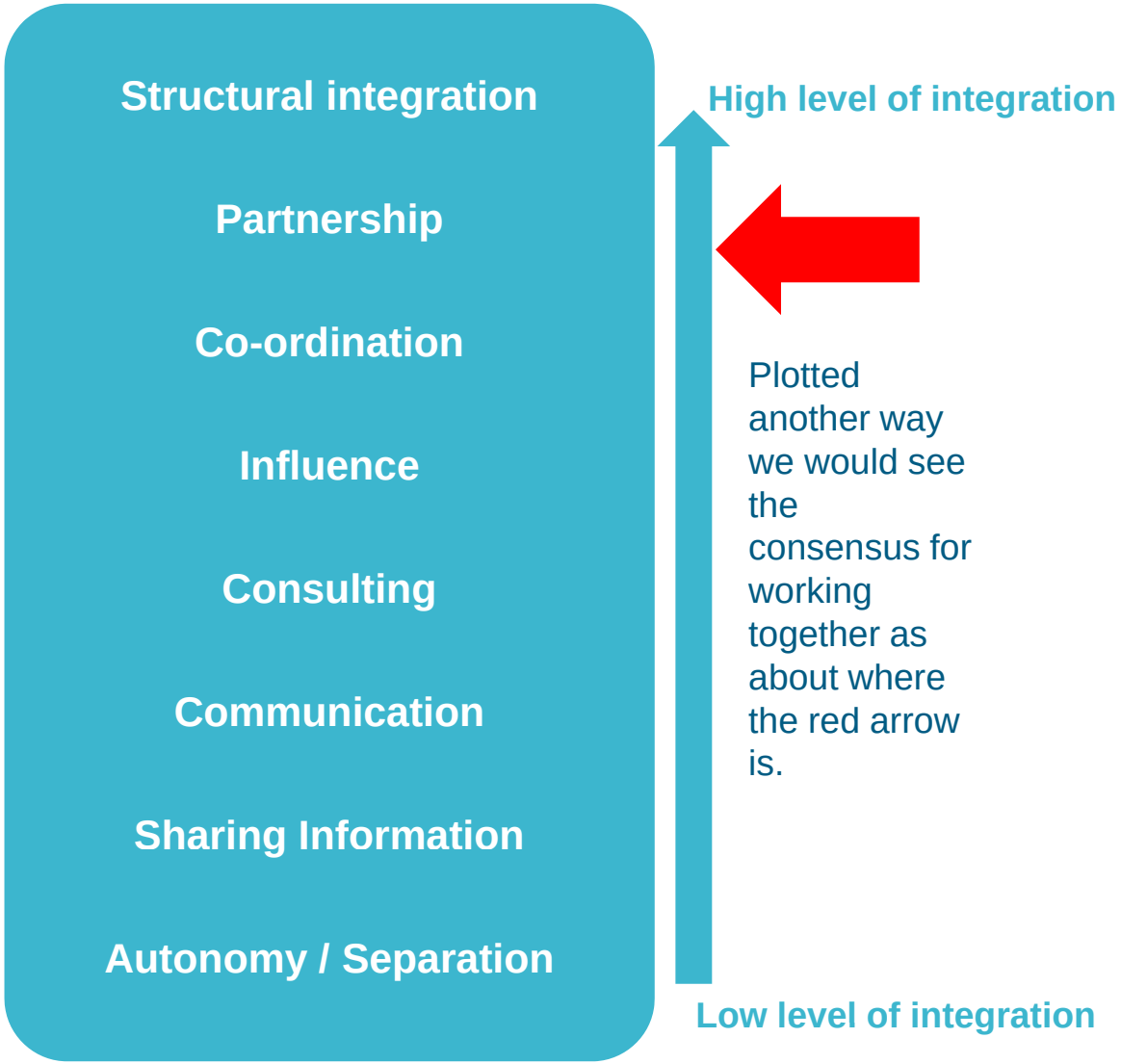
The Qualitative interviews highlighted a range of views, some verbatims of which are plotted against Grone and Garcia-Barbero's Spectrum of Integration.

The consensus seemed to be that there was an appetite for some form of Integrated working that fell considerably short of any form of structural integration



Options on future strategic direction of travel

Ouestion 2 – What sort of Integration does there appear to be an appetite for?



Plotted another way we would see the consensus for working together as about where the red arrow is.

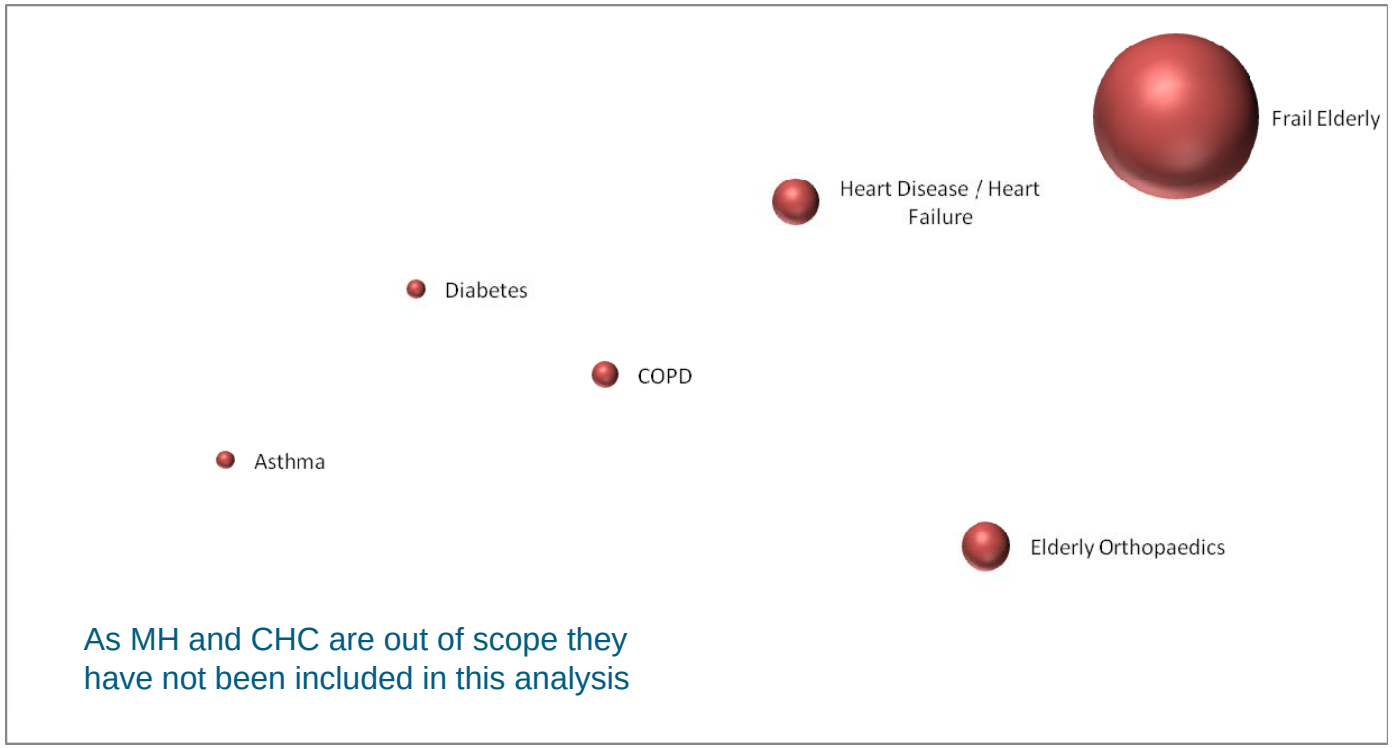
In our opinion there seems to be the appetite for greater co-ordination of effort in the spirit of Partnership working but without the structural elements of formal partnership working.

One of the Senior Stakeholders interviewed seemed to summarise the mood when they said:

"We need to go a journey of several steps together. The first steps are about consolidating strong relationships and Boards working together. The next step is about working together for a number of patient groups. Success there may lead to further steps".

We endorse this view and suggest collaborating over various patient groups it is the obvious way forward and for this reason we have not in the options covered HMOs or UK models of structural Integration like Torbay or Wye Valley

Options on future strategic direction of travel
Question 3 – What areas should we co-operate on?



As MH and CHC are out of scope they have not been included in this analysis

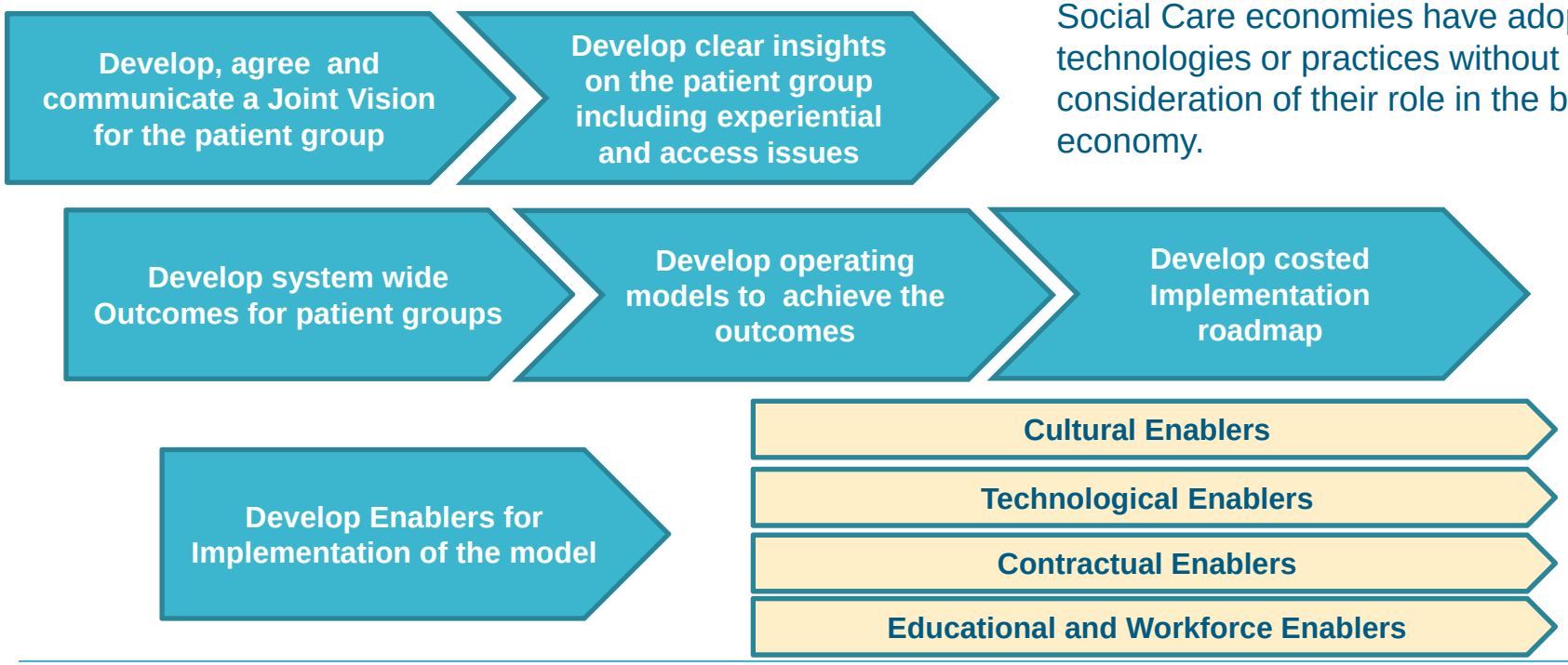
The bubble opportunity is an informed estimate of the total costs to the economy of certain cohorts of patients who would be suitable to the type of patient focused, Integrated working approach that was recommended in the previous slide.

The Frail elderly cohort seems to offer by far the largest opportunity with £44m of admitted tariff alone. When all Community and Social Care spend is attended to this figure it becomes considerably larger.

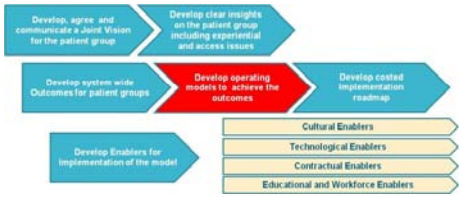
Options on future strategic direction of travel
Question 4 – How should we go about doing this?

The evidence base from both within and from outside health and social care is clear that the critical success factor to cross organisational working is to develop, agree and communicate a shared Vision. For instance there is a uniform consensus that the success of Torbay was predicated on a clear, shared Vision that was routinely referred back to. That Vision should then inform all the constituent elements of service redesign.

In our opinion too frequently Health and Social Care economies have adopted new technologies or practices without proper consideration of their role in the broader local economy.



Options on future strategic direction of travel
Operating Models not included as options



Health Maintenance Organisations

Given the perceived appetite for integration within Berkshire West we have not included the fully integrated options depicted in this slide**.**

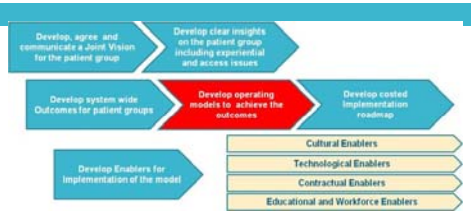
This is not ruling these out altogether, rather it is suggesting the time may not be right now.

Wye Valley NHS Trust

Structurally Integrated Trusts in England

The Sanitas 35 year contract to manage the whole population of the Manises district of Valencia

Options on future strategic direction of travel
Operating Models



Option 1 – Shared Decision Making (SDM)

Need – Patients to be actively involved in their own care and treatment choices. A SDM approach supports the personalisation agenda. It is also a key approach to managing unwarranted variation as well as a patient centric way to manage capacity around precious surgical intervention resources.

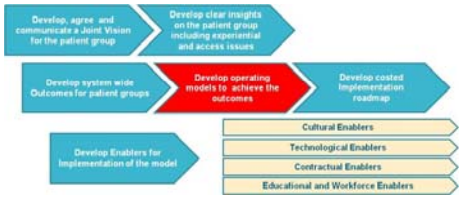
Description -

- SDM allows patients, carers and clinicians to equally engage in the decision making process when determining treatments. It recognises that whilst the clinician is the expert in the treatments, equally important are the patients' own choices. By clinician and patient communicating together, using evidence which explains all the treatment choices available combined with the wishes of the patient, the patient will arrive at an informed, satisfied decision.

- A key aspect of SDM is the use of decision aids. Decision aids have been defined as interventions designed to help people make specific and deliberate choices among options (including the status quo) by providing information on the options and outcomes relevant to that patients health status. These materials may contain information on probabilities of outcome, other patients experiences, costs and even recommendations based on the patients expressed preferences.

- SDM is particularly appropriate:
    - When people face major medical decisions where there is more than one feasible option
    - When people with long-term conditions want to plan their care, adopt healthier lifestyles, and enhance their ability to self-manage

Options on future strategic direction of travel
Operating Models



Option 1 – Shared Decision Making (cont.)

Timeline to Deliver –

• Like many of the models outlined, timescales to delivery are partly dependant on the scale of the ambition however simple SDM programmes could be launched within 3 to 6 months.

Impact

• The evidence base suggests that effective use of Shared Decision Making can reduce total levels of Elective Surgery and PSA tests by 20% and of HRT by 30%. Common Elective procedures that benefit from Angioplasty (PTCA), Back Surgery CABG, Carpal tunnel, Cataracts, Hernia Repair, Hip Replacement, Hysterectomy, Knee replacement Prostatectomy, Sterilisation and Tonsillectomy. The current spend on these procedures across Berkshire West is £15.013m. A saving of just 10% would save £1.5m. This would avoid 2,100 admissions per year. If 10% of these avoided admissions have required some rehab in the community in turn this could reduce between 4- 5,000 community contacts per year.

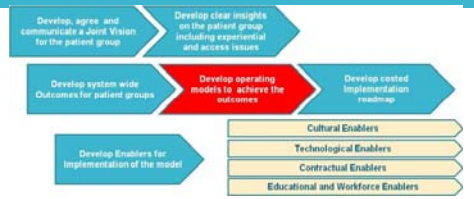
Pros and Cons

• The successful implementation of SDM is as much about effecting the cultural changes (particularly in terms of re-defining the Clinician/Patient relationship) as it is about the technical implementation of the approach.

Reference (UK)

• O'Connor et al. Cochrane Review 2009 (55 RCTs)

Options on future strategic direction of travel
Operating Models



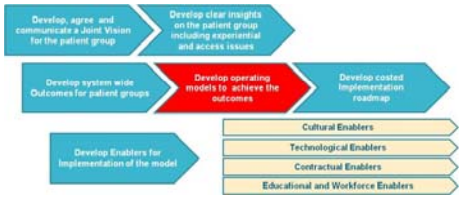
Option 2 – Locality Targeting

Need - Social and Demographic conditions may mean that certain high risk groups are concentrated in certain geographic locations. This is particularly true of patients with Long Term Conditions. Addressing the issues in these areas has both equality and health outcome benefits

Description -

- Johns Hopkins University have developed a community based care management delivery model to support self management. The goals of the approach are:
  - Identify health needs of practice populations and improve primary care, prevention and services for those with long term conditions
  - Engage and empower the practice population to achieve self management of chronic conditions
  - Align the aspirations of a neighbourhood with health system partners
  - Provide efficient care management services to improve outcomes, reduce emergency admissions, planned hospitalisations
- The delivery of care has 2 components: care delivered by a nurse led practice team and a community based social network comprised of mentors and patients. The Third Sector would have a clear role to play in the mentor element.
- The nurse led practice team is made up of professionals with experience in case management, outreach, behavioural health and social work. Community pharmacists are also members of the team, providing education in the use of medication and they also monitor usage. The targeted patients (mentees), tend to have multiple morbidity whereas mentors tend to have a single condition. This reflects the need for mentors to have a minimum level of fitness to fulfil their role.

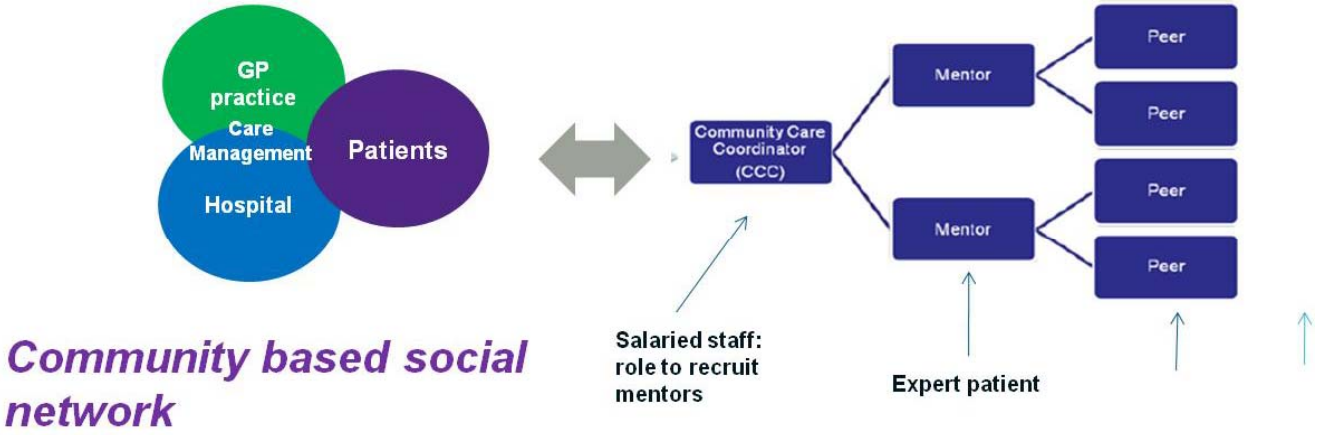
Options on future strategic direction of travel
Operating Models



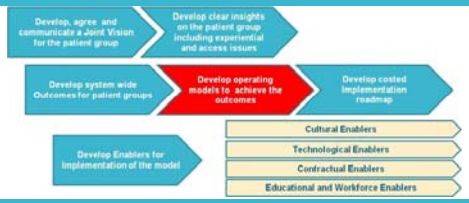
Option 2 – Locality Targeting (cont)

Description -

• The social networking component is managed by Community Care Co-ordinators (CCC). These are people who live in the neighbourhood, who typically do not have qualifications in nursing or social work. Their role is confined to recruiting and managing the mentors. The mentors receive no payment, however, they are given mobile phones, these can be used for personal calls and texts providing the mentors make a targeted number of contacts with mentees. Another benefit for mentors are social networking events sponsored by the primary care team.



Options on future strategic direction of travel
Operating Models



Option 2 – Locality Targeting (cont)

Impact

- A version of this approach was piloted in Smethwick Medical Practice Sandwell. They found the social networking dimension increased the uptake of practice services designed to reduce unplanned admissions. For example patients at high risk of A&E admission are offered telephone counselling. A GP commented:

"..*because of all of the community engagement we have a 75% uptake compared with 20% in the US where the model [telephone counselling] was developed, we have reduced EMAs by 200*"

If the Smethwick results were replicated across all Practices in West Berkshire you could save in excess of 5,000 Emergency Admissions per year. There could be a compensating increase in community contacts of approximately 20,000 community contacts some of which would come from the unpaid Mentors. The reduction in emergency admissions could save in excess of 3,000 Ambulance call-outs

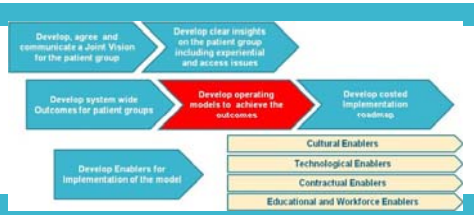
Pros and Cons

• These sorts of contracts force you to put the patient first and they also force co-operation and partnership working between providers. They are also explicitly outcome focused. They do however require detailed advance work both in setting the capitation total, defining the outcomes and in calculating the appropriate levels of incentives.

Reference (UK)

• Reference 1 HSJ 23/9/10 p.32

Options on future strategic direction of travel
Operating Models



Option 3 – Hospital at Homes (Virtual Wards)

Need – to prevent emergency admissions or re-admissions into secondary care so improving the well-being of the patient as well as reducing the capacity pressures on secondary care

Description –

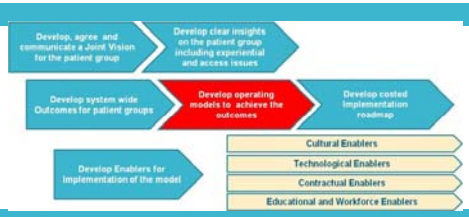
•.There are wide range of schemes that fall under the Hospital at Home or Virtual Ward umbrella. Most share a number of common features. The Hospital Home service in Oxfordshire is fairly representative. There, patients on Hospital at Home stay in their own homes but they receive extra care and attention from the Hospital at Home Team. The team work like a hospital ward team and have regular multi-disciplinary meetings where they discuss the patients they are looking after. The service is designed to give patients extra support so that they are not admitted to hospital or so that their admission is as short as possible.

In the case of Oxfordshire, The Hospital at Home Team will see patients for a time-banded period, but many other examples are not time-banded. The decision about when to discharge a patient from Hospital at Home is made in partnership between the patient, the team and the patient's GP.

Patients can be referred to the service through:

- District Nurses.
- Local Minor Injuries Units.
- Out of Hours services.
- Oxfordshire hospitals.
- GPs.
- The Emergency Multi-disciplinary Assessment Unit and Case Managers

Options on future strategic direction of travel
Operating Models



Option 3 – Hospital at Homes (Virtual Wards)

Timeline to Deliver –

• The time to deliver is somewhat dependant on the scale of the ambition. If funding and staffing issues can be agreed early we believe that a programme that did not need complex technology enablers could be set up within a quarter.

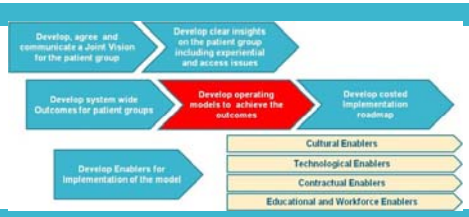
Impact

• The Croydon Virtual Ward initiative reported some impressive results for the target population including a 10% reduction in both A&E attendances and emergency admissions, a 20% reduction in LOS for those admitted, 29% reduction in Care Home Initiatives, and a 25% reduction in prescribing costs.

• The actual number of Emergency admissions or re-admissions avoided would be dependant on both the size of the Virtual Wards and the risk profile of the patients. This would also affect the Ambulance numbers. We would say however that for every patient in a Virtual ward there will be an additional 7 community contacts and approximately 85% of patients would need some form of social care (largely domiciliary).

• It must be said though that in the DHs' Intermediate Care – Halfway Home *Updated Guidance for the NHS and Local Authorities'* They did say about Hospitals at Home '*This area remains a gap in which rigorous evidence is still limited.'*

Options on future strategic direction of travel
Operating Models



Option 3 – Hospital at Homes (Virtual Wards)

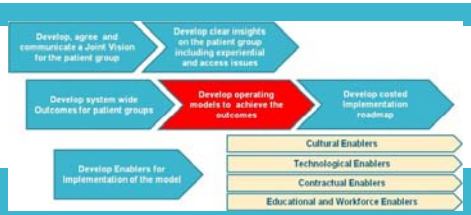
Pros and Cons

• For Hospitals at Home to be truly effective they need to be fully supported and in particular to have access to secondary care consultants and to a range of diagnostic services. In practice this will require collaborative working.

References

• http://www.oxfordhealth.nhs.uk
• Croydon Virtual Ward Pilot report
• Intermediate Care – Halfway Home *Updated Guidance for the NHS and Local Authorities' DH 2009*

Options on future strategic direction of travel
Operating Models



Option 4 – Chronic Care Management Model

Need – tackling the growing burden of patients with one or more LTC particularly in an ageing population

Description –

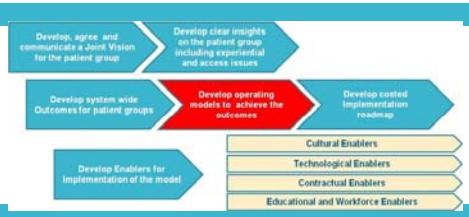
- Chronic Care Management was developed by Edward Wagner and colleagues at the MacColl Institute for Healthcare Innovation in the US. In a major review of evidence on primary care interventions, they found that variation in performance in managing LTCs was greater *within* than *between* primary care practices. This led to a shift away from benchmarking practices. Instead they focused on improving the management of long term conditions in all practices, to make delivery more systematic. *This approach is now being used by 3 Welsh Health Boards and has informed the Year of Care tariffs in England.*

- Wagner conducted a survey of published evidence on effective interventions for people with Long term conditions delivered from primary care. The evidence was grouped under 6 headings or domains: self management support, delivery system design, decision support, clinical information systems, effective use of community resources, and effective working in the wider health system

The key findings from the evidence were that:

- Interventions to improve the management of long term conditions that were confined to only one of the 6 domains were the least effective
- The larger the number of domains that were covered or packaged together in an intervention the more effective the initiative
- Patient self management was the most critical ingredient in any intervention, if this was not part of an intervention package it would have little impact

Options on future strategic direction of travel
Operating Models



Option 4 – Chronic Care Management Model

Description (cont)

• Wagner and the team at MacColl, drew on the evidence to develop the Chronic Care Management service model, which aims to deliver patient focused pro-active care from a primary care practice

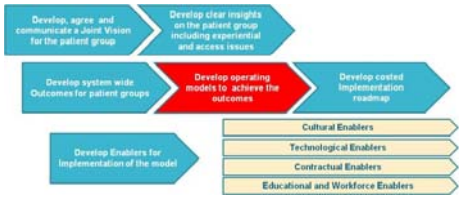
The six domains of the Chronic Care Management Model

The CCM model is applicable to all long term conditions and all levels of morbidity including prevention programmes for patients who are currently healthy e.g. Childhood obesity prevention

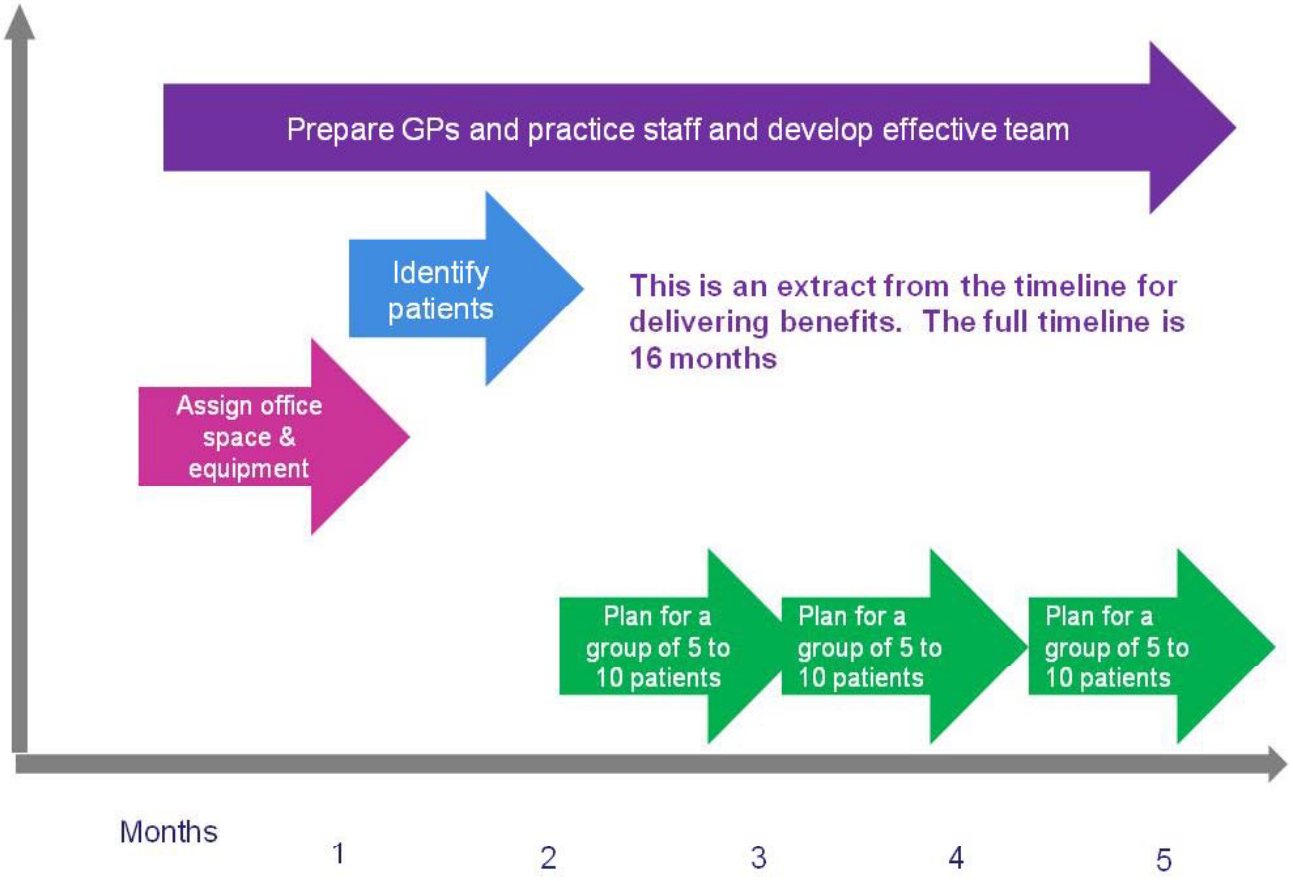
In addition a team at Johns Hopkins have incorporated CCM in a service called *Guided Care*. This is targeted at people at high risk of inappropriate admission.

In some ways it cold be viewed as an overarching model of care that brings together a number of strands under the title domain.

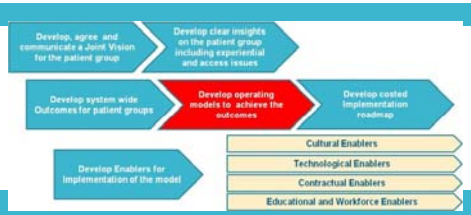
Options on future strategic direction of travel
Operating Models



Timeline for Integration of a Nurse into practice



Options on future strategic direction of travel
Operating Models



Option 4 – Chronic Care Management Model

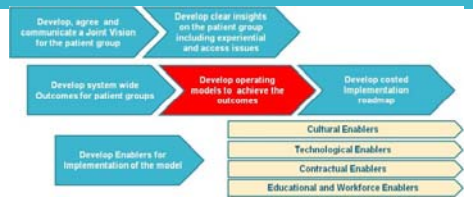
Timeline to Deliver –
- With piloting and preparation it is realistic to expect any form of comprehensive roll-out will take16 months. At practice level a roll-out could be effected in weeks.

Impact
- The evidence underpinning CCM suggests that packages of interventions that span all or a number of the six domains are more likely to succeed than those that rest on one or two of the enablers. In other words, the Chronic Care Management model is a way of drawing together enabling initiatives.
- Much of the evidence is for the USA and as such comes with a significant caveat (albeit with 150 RCTs on the model), however a RAND and the University of California at Berkeley undertook an evaluation of 51 CCRM participating sites and over 4,000 patients across the USA. They found patients in CCRM with CHF had 35% fewer hospital bed days and diabetic patients had reduced emergency admissions.
- Applied to West Berkshire, a reduction of 35% hospital bed days for patients with CHF would equate to about 700 admissions and an associated reduction in Ambulance call outs. With an average LOS of 3 days this is the equivalent of saving 6 beds. There would be a compensating increase in Community contacts around 5,000 community contacts for the CHF patients alone. The true cost of this model would be a significant rebalancing in terms of community and social care staff.

Pros and Cons
- CCM can begin with a limited number of practices and has the capacity to be launched even as a pilot.

Reference (UK)
- http://www.improvingchroniccare.org/index.php

Options on future strategic direction of travel
Operating Models



Option 5 – Enhanced Intermediate Care Services

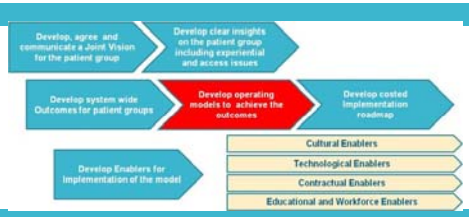
Need – We are aware that the level of Intermediate Care in West Berkshire is good and that the Rapid Re-ablement Service was something that received almost universal praise in the qualitative interviews. Amongst the other services we understand you have short term emergency care, community Geriatrician cover, hospital discharge support services and palliative care.

Description –

•.Our analysis of community contacts indicated there may still be further capacity to increase the scale of the Intermediate Care Services. Elsewhere we have proposed an option around a Hospital at Home model and so will not repeat that here. Rather we would postulate three further extensions of the service that are taking place elsewhere in the Country. They are:

- Extension of IV Antibiotic delivery in the Community and the inclusion of re-hydration services in an intermediate care environment
- The extension of diagnostic services in a Community setting in order to enhance the services available in an Intermediate Care setting.
- The extension of nursing home based IC is also limited. If the nursing homes have input from a multi-disciplinary team, including medical assessment they might be considered to be a special case community hospital and as such would have full IC services. It should be re-iterated that access to OT and Physiotherapy will be vital to the process.

Options on future strategic direction of travel
Operating Models



Option 5 – Enhanced Intermediate Care Services

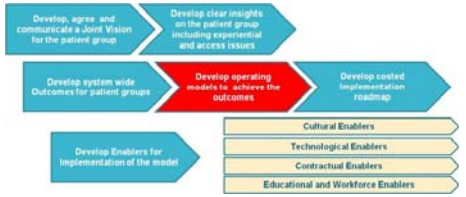
Timeline to Deliver –
- With appropriate agreements on funding these schemes could be introduced in between 3 – 6 months

Impact
- In 'Intermediate Care – Halfway Home *Updated Guidance for the NHS and Local Authorities' DH 2009*' it is said, when talking about evaluating the impact of Intermediate Care that:

"A small number of studies have attempted to evaluate entire intermediate care services. The services themselves were highly varied and some may not have been fully developed. In some cases the services were too small and too poorly organised to be expected to make a significant impact (Young and Stevenson, 2006)"

Reference
- Developing Intermediate Care: A guide for Professionals' Kings Fund 2002
- 'Intermediate Care – Halfway Home *Updated Guidance for the NHS and Local Authorities' DH 2009*

Options on future strategic direction of travel
Operating Models



Option 6 – Virtual Integrated Teams or Practices

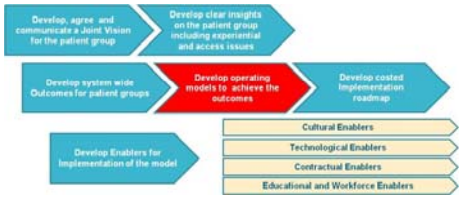
Need – to make best use of precious resources and to provide a seamless patient journey which maximises outcomes.

Description – There are a range of models for this type of approach nationally and internationally . Examples include:

The Virtual Practice - Rush University Medical Centre in Chicago implemented a pilot program known as Virtual Integrated Practice in which primary care physician practices recruit and organize their own offsite interdisciplinary teams consisting of social workers, dieticians, pharmacists, and other health care providers to manage and coordinate care for geriatric patients with chronic disease. These teams collaborate virtually using e-mail, phone, and fax to plan and deliver coordinated patient care. A comparison of patients in four practices using the virtual integrated practice model to four similar practices providing usual care found that the virtual integrated practice program reduced emergency department visits, enhanced patient satisfaction and understanding of their medical condition(s) and medications, increased physician knowledge, and boosted referrals to interdisciplinary team members. The work was primarily aimed at patients aged 75 and over.

Enhanced Clinical Networks – In Scotland managed clinical networks of multi-disciplinary teams of healthcare providers work together to provide appropriate and high-quality care irrespective of their organisational and professional boundaries. Building on this, in Sweden...

Options on future strategic direction of travel
Operating Models



Option 6 – Virtual Integrated Teams or Practices

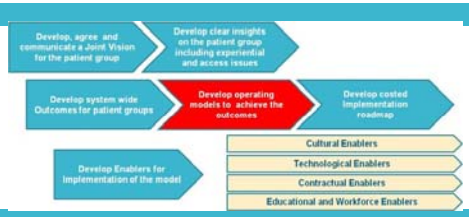
Description (cont)

the ‘chains of care’ model consists of a network of providers aiming to deliver high-quality, co-ordinated healthcare to patients. It differs from the Scottish networks in that there is a system of contractual relationships between purchasers and providers.

Thus, a purchaser would set up a contract using a chains of care-based agreement specifying volumes, costs and quality, with delivery overseen by a dedicated manager. One of the advantages of the Swedish model is that payments are based on the healthcare provided across a system. Therefore, incentives exist to develop integrated care and care pathways for patients. Although there is purported support among clinicians for the intended goals and outcomes of the chains of care, there have in fact been no significant changes in management systems and few changes to clinical services.

One of the key issues has been the difficulty of getting staff, both clinical and managerial, to embrace change by actually undertaking different roles and implementing new work practices. Ahgren argues that resistance is stronger among doctors than other healthcare professionals

Options on future strategic direction of travel
Operating Models



Option 6 – Virtual Integrated Teams

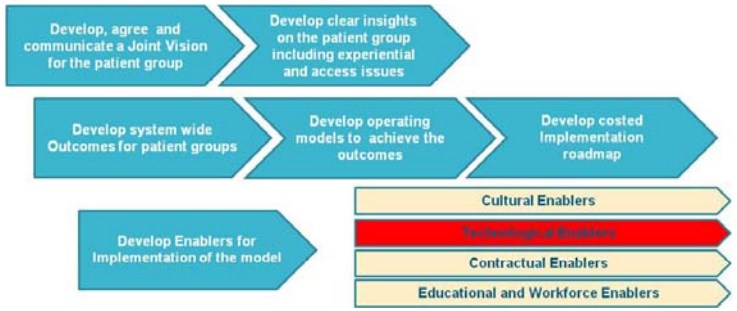
Timeline to Deliver –
- Virtual Practice – 3 -6 months

Impact
- Virtual Practice caveating that this was a US model, they saw in general patients 5% less to have an ED (A&E) attendance but patients with lower levels of functioning (as measured using an SF-36 score) being 42% less likely to have an ED attendance.
- A 5% reduction in A&E attendances in Berkshire could be as high as 5,000 attendances which if this were a direct replication of your current case mix would save £448,000 a year. There would however need to be a compensating increase of community contacts which could be as high as 4 per attendance avoided.

Pros and Cons
- As the descriptions explain there are some implementation issues around Virtual Integrated teams including overcoming clinical resistance. There are also some practical issues around accountability and responsibility that the Swedish Chain model goes some way to addressing.

References
- Virtual Practice - http://www.innovations.ahrq.gov/content.aspx?id=2459
- 'Building Integrated Care: The Lessons from UK and elsewhere' NHS Confederation

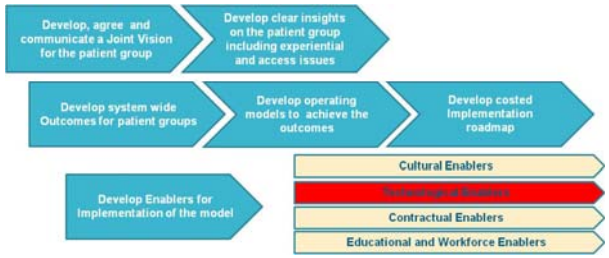
Options on future strategic direction of travel Technological Enablers – a high level overview



In section 4 a range of technological enablers were discussed. Many of the these platforms will have applicability to the models of care previously outlined. To avoid repetition, here they are again with a brief summary and a view on the strength of the evidence base.

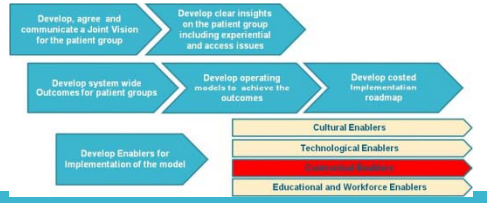
Enabler	Comment	Quality of evidence base
Risk Stratification	Ideally blending all data sets to identify patients at risk of a secondary care admission or potentially of developing a range of conditions	Evidence suggests that it can't be used as a stand alone asset
Video Platforms	Secure, high quality video platforms that have been developed to remotely access Consultants in order to rapidly access specialist opinions	Widely used in other sectors
Social Media	Use of one or a range of social media platforms to advise, inform, and direct patients and carers as well as to garner insight	Widely used in other sectors

Options on future strategic direction of travel
Technological Enablers – a high level overview



Enabler	Comment	Quality of evidence base
Monitoring Hubs	The approach currently being employed in Airedale Foundation Trust is to put a staffed 24 hour a day telehealth hub within the hospital. The hub provides clinical support to patients around the clock by using high quality, secure video links. The hub is staffed by high-band nurses who are empowered to make clinical decisions. Patients are also free to call into the Hub for advice and re-assurance.	Much is promised from this approach although stand alone hard evidence is difficult to find
Telehealth	The term “telehealth” encompasses both “telemonitoring” and telephone support. With telemonitoring, patients transmit data on their vital signs for real time monitoring, for instance, via video link or by store and forward systems (where data is submitted by the patient and transmitted to the health professional for later assessment)	WSD suggested strong evidence as have early trials in N Yorkshire however a recent BMJ review of 55 trials failed to identify positive results
Telemedicine	High cost drug compliance has proved one of the most used areas of Telemedicine in the UK	Some evidence of success

Options on future strategic direction of travel
Contractual Enablers



Option 1 – Adoption of Capitated Outcomes Based Incentivised Contracts

Need - To find a contractual mechanism to encourage and incentivise cross provider working and to support the creation of seamless patient journeys

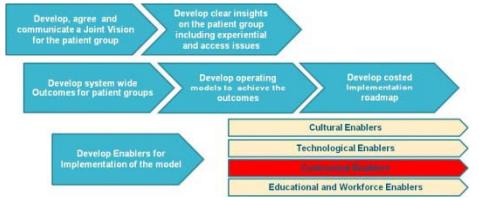
Description -

- Capitation Outcome based Incentive Contracts (COBICs) are a tool for commissioners to improve value for money and quality with a focus on restructuring the delivery of health services to make them more integrated. Central to COBIC is achieving a better alignment between financial incentives and outcomes. COBICs require development of accountable providers across the care delivery spectrum.

- COBICs require commissioners and providers to focus on and to define the outcomes that really matter to patients and deliver value for money. A COBIC pays for those outcomes, rather than processes or medical activities that may or may not improve health. The only way to achieve better outcomes is to require closer integration of health and social care.

- A COBIC starts with a category of people in mind about whom to develop health care provision – for example frail elderly. The budget is based upon an understanding of the needs of that population and would include financial rewards for achieving specified outcome measures. To deliver those outcomes and make the efficiency savings necessary to stay within the allocated budget, providers of currently poorly coordinated care must collaborate to provide much more integrated care.

Options on future strategic direction of travel
Contractual Enablers



Option 1 – Adoption of Capitated Outcomes Based Incentivised Contracts (cont.)

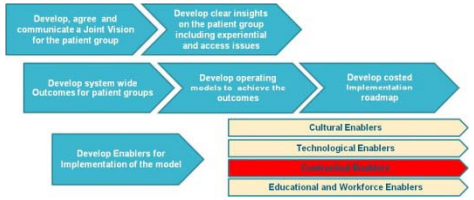
Description (cont) -
• The principle of the COBIC is that it can be developed over time, to offer a step change in the scale of incentives offered. For example, outcomes might start with at least 5% of the contract offered to be specifically concerning outcomes, and this would grow every year. An incentive of this size focuses the provider's attention on both outcomes and value and allows clinicians and other staff to use their expert knowledge to innovate and improve care.

Timeline to Deliver –
• Based on experience elsewhere 18 months from idea to implementation of first contract

Impact
• Early pilots of COBIC contracts in Milton Keynes for both Sexual Health and Substance Abuse showed savings of up to 20% where achievable. This approach is applicable to broader patient groups and could be applicable to larger cohorts of patient such as to frail elderly who currently cost the economy in excess of £40m annually

Pros and Cons
• These sorts of contracts force you to put the patient first and they also force co-operation and partnership working between providers. They are also explicitly outcome focused. They do however require detailed advance work both in setting the capitation total, defining the outcomes and in calculating the appropriate levels of incentives.

Options on future strategic direction of travel
Contractual Enablers



Option 2 – Prime Provider Model

Need - To find a contractual mechanism to encourage and Incentivise cross provider working and to support the creation of seamless patient journeys

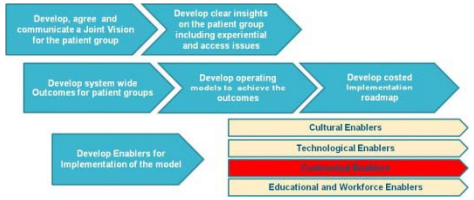
Description –

• The Prime Provider Model of Contracting is a variant of COBIC that need not necessarily have the emphasis on either outcomes or incentives of COBIC contracts. Prime Provider contracts were used extensively by the New York authorities in the 1990s to transform Public Services. In the UK other elements of the Public Sector have used Provider Contracts with the DWP at the vanguard.

• In practice the Prime Provider takes full responsibility for the delivery of the service which will include both delivery itself and managing a range of sub-contractor providers. As such they will also take on aspects of Quality and Performance Management for its sub-contractor base. The Prime will in practice have to take the lead in the Integration of Services and the associated hand-offs and co-ordinations.

• For tariff based activities there can be challenges to overcome and there will be detailed planning and negotiation on the nature and size of any incentives, the contracting arrangements between parties, indemnity and responsibility and the outcomes the Prime is asking from its sub-contractors.

Options on future strategic direction of travel Contractual Enablers



Option 2 – Prime Provider Contracts

Timeline to Deliver –

• Based on experience from other sectors the lead time will be between 12 - 18 months from idea to implementation

Impact

• While evidence was provided for the success of COBIC contracts it should be noted that many of these were undertaken for non-tariff based activity within Health

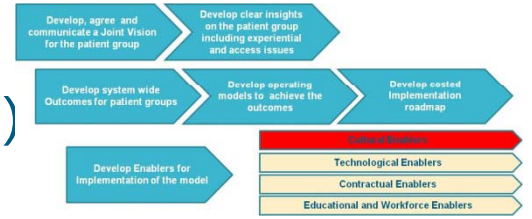
Pros and Cons

• For tariffed services there are issues to be addressed if savings are to be made, there is also a cultural change about prime/Sub-contractor relationships as well as issues over accountability. The potential benefits are however considerable. The best option is probably the COBIC one or a variant of it.

References

•. *'The Accountable Lead Provider. Developing a powerful disruptive innovator to create integrated and accountable programmes of care'.* Right Care Casebook. Professor Paul Corrigan and Dr Steven Laitner. July 2012.

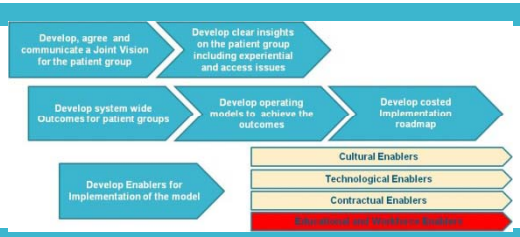
Options on future strategic direction of travel
Cultural Enablers (beyond development of a shared Vision)



The development of a shared Vision across the economy for the patient groups, and the related development of system wide outcomes measures are vital to develop to underpin the cultural change required. Other options to affect the culture are:

Option	Comment
The development and monitoring of system wide KPIs	This option is made cognisant of the work on system wide KPIs that is already being conducted. However if the change options are likely to underpinned by COBIC or Prime Provider model of contracting then performance. management of the prime contractor will require system wide KPIs. The transparency this will bring will also be vital for patient safety.
Becoming Digital by default	This would involve actively aligning to last years Government Digital Strategy ambition so that services will be re-designed to make them "so straightforward and convenient that all those who can use them will choose to do so whilst those who can't are not excluded“ in order to optimise the use of resources
Alignment of values and standards	To ensure that the patient receives a seamless service across provider boundaries there will be a requirement to align certain values and standards. This is both a workforce and training change as well as a cultural one because of the requirement for peers to hold each to account irrespective of tribe.

Options on future strategic direction of travel Workforce and Educational Enablers



Option 1 – MDT Staff Training and engagement Training

Need – The evidence of Integration suggests that training and preparing staff in working together are as important as the processes put in place. The benefit of this training manifests itself in both staff satisfaction and in clinical outcomes.

Description –

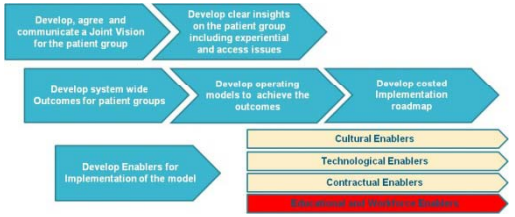
. NHS Greenwich has driven the development of integrated community teams, as well as integration of intermediate and adult social care, through a recognition of the importance of people management. This was born out of an acknowledgement that the performance of an integrated model will be heightened through a range of bespoke approaches including: talent management; engagement; skills development; enabling employees to assume ownership of programmes; and widespread participation.
In December 2011, 61 per cent of service users who completed their re-ablement needed no additional support. There has also been a 19 per cent decline in intensive care packages.

Impact – NHS Greenwich saw a 19% reduction in Intensive Community Care packages as a result of undertaking this sort of initiative.

References

- 'Making Integrated Care Out of Hospital a reality' NHS Confederation. NHS Greenwich's 2011 HSJ award winning imitative

Options on future strategic direction of travel Workforce and Educational Enablers



Option 2 – Implementing Health and Social Care Co-ordinators

Need – Avoidable A&E attendances and emergency admissions need to be avoided.

Description – Appointment of Health and Social Care Co-ordinators perhaps aligned to each Cluster to streamline and control referral processes

Originality – This would build on the existing Clustering work that is taking place

Impact – This suggestion is influenced by the Torbay whose achievements are widely acknowledged to be the product of some very specific circumstances. And while the Health and Social Care co-ordinators were but a part in the system – the overall impact included a 24% reduction in bed days for the 65+ population and a 32% reduction for the 75+ population. Emergency bed day use for was only 70% of the figure for its neighbouring comparator PCTs

Pros/Cons - Requirement for funding of post, issues to be addressed around pay and grading, needs mandate to operate

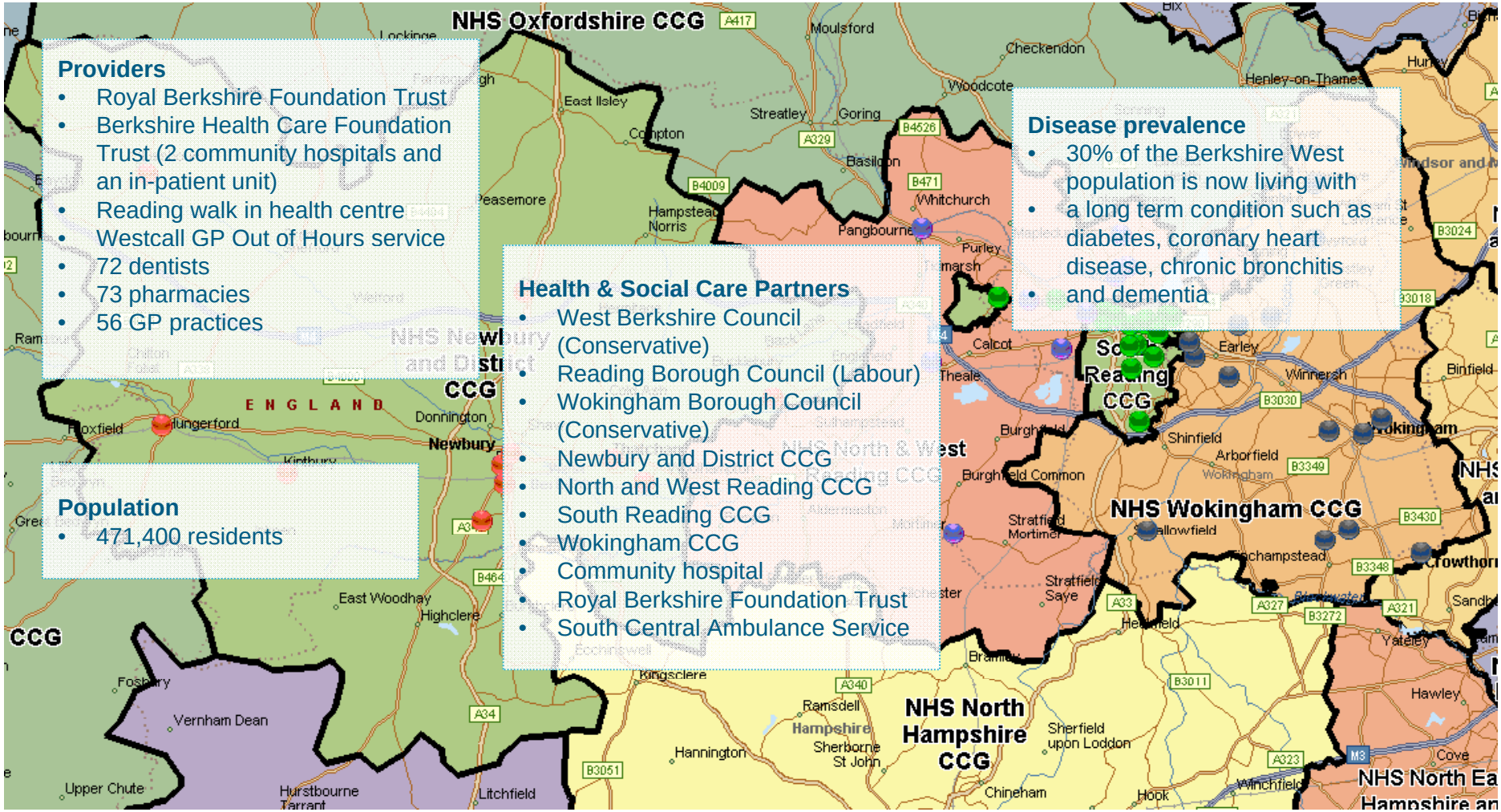
References:

- 'Integrating health and social care in Torbay: Improving Care for Mrs Smith' Kings Fund March 2011

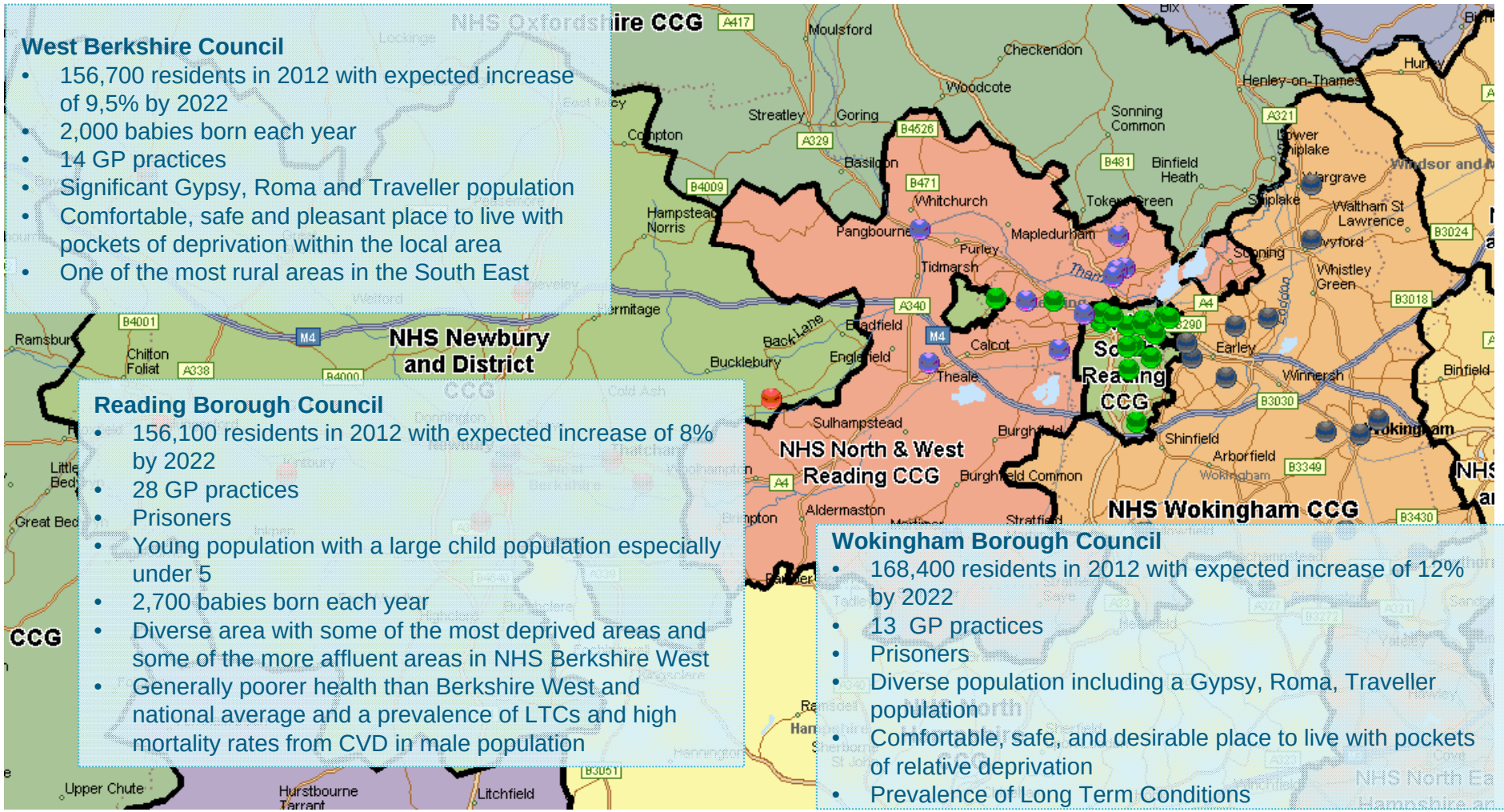
CAPITA

APPENDIX

Berkshire West – High Level Overview



Berkshire West – Socio-Demographic Overview by Unitary Authority



West Berkshire Council

- 156,700 residents in 2012 with expected increase of 9,5% by 2022
- 2,000 babies born each year
- 14 GP practices
- Significant Gypsy, Roma and Traveller population
- Comfortable, safe and pleasant place to live with pockets of deprivation within the local area
- One of the most rural areas in the South East

Reading Borough Council

- 156,100 residents in 2012 with expected increase of 8% by 2022
- 28 GP practices
- Prisoners
- Young population with a large child population especially under 5
- 2,700 babies born each year
- Diverse area with some of the most deprived areas and some of the more affluent areas in NHS Berkshire West
- Generally poorer health than Berkshire West and national average and a prevalence of LTCs and high mortality rates from CVD in male population

Wokingham Borough Council

- 168,400 residents in 2012 with expected increase of 12% by 2022
- 13 GP practices
- Prisoners
- Diverse population including a Gypsy, Roma, Traveller population
- Comfortable, safe, and desirable place to live with pockets of relative deprivation
- Prevalence of Long Term Conditions