Quality Impact Assessment of the Transformation of Community Services as part of Safe Effective Care within a Budget

1. Introduction

NHS contracts for community services in the Northern and Eastern localities of NHS NEW Devon CCG are based on historic block (fixed) contract values that are not supported by up to date service specifications, particularly for the provision of inpatient beds.

2. The Case for Change

The strategic direction for both Northern and Eastern Localities approved by the CCG Governing Body in May and July 2015, confirms the transformation to greater home facing and person-centred services. This is completely aligned to the Northern Devon Healthcare Trust's vision of *"Delivering high quality services that support your health and wellbeing"*.

The compelling case for transforming community services starts with the premise that we can provide better care, safer care and higher quality care for patients.

The average length of stay (LoS) in a community hospital is approximately 21 days, 70% of patients are step-down and have had a superspell which includes an additional LoS in an acute hospital. It is nationally recognised that an inpatient LoS greater than 11 days places the patient at increased risk of incurring a complication e.g. UTI, pressure damage, fall or medication error.

It is also known that an increased LoS reduces the ability of the patient to return to the previous level of independence and well-being. We know that 40% of patients discharged from community hospitals are discharged to a care home.

Devon County Council's Public Health team has recently undertaken an acuity audit in May of this year which was applied to each of the acute providers and community providers within the CCG's boundaries. In North and East it confirmed that on any given day at least 30% (and up to 47%) of patients in our community hospitals could, and should, be cared for in a different way out of hospital, even if they had originally required admission to hospital. This fact is recognised in the Northern locality CCG's bed modelling paper.

The SRG reviewed the evidence when evaluating impact of last year's system resilience investment for winter. This compared the investment into rapid response services in the East against the additional community beds flexed up. This evaluation saw a far greater benefit from the rapid response than the beds, measured in terms of the reduction in emergency admissions.

Investment in Rapid Response was four times more cost effective on the wider system impact compared to investment in community hospital beds, as illustrated by the table below.

Scheme *(recurrent schemes would be more cost effective)*	£k cost	Expected acute bed equivalent	Actual approximate acute bed equivalent	Approximate expenditure £/ acute bed-day	Approximate actual £/ acute bed-day
22 Community Hospital Beds (3 mths)	£602k	11.8	7.9	£555	£832
Rapid Response (3 mths)	£150k	4.2	7.3	£388	£223
Block-booked care home beds (11 wks)	£11k	tbc	0.2	tbc	£733

Therefore the conclusion of the above is that there is compelling and growing evidence that the direction of travel to a home-based model of care delivers enhanced care to patients, and that this is more cost effective.

Services have been transformed by the Trust in line with this direction for a number of years. The Northern Devon Healthcare Trust has delivered this enhanced model of community services in five towns/areas across North and East Devon following the reduction of beds in Torrington, Ilfracombe, Moretonhampstead, Budleigh Salterton, Ottery and to a lesser extent Axminster.

The dataset to support the evaluation of this model of care is presented in appendix 1. The same data has been presented at both the North and East System Resilience Groups. It is minuted that all members of the SRG concluded that the service is at least as good as a bedded model.

3. The risk assessment of the current model of delivery in community hospital inpatient units

There is a fundamental lack of resilience of the current model of care in our community hospitals. The Trust has far greater difficulty in recruiting to vacancies in community hospitals than for community based roles, due in part to the national nursing shortage as well as the lack of certainty about the future of the inpatient beds, but also due to the nature of the role, and the responsibilities inherent within it. This leads to an increase in the use of agency personnel.

With the relatively small team rotas this leads to an unacceptably high percentage of agency staff relative to the substantive establishment which in its own right leads to patient safety issues. It also leads to immediacy of the risks due to the uncertainty about fill rates and the resultant pressure on existing staff.

With the assumption that this winter will be no different to last this is not a model we would wish to solely rely on as we head into winter.

4. What will the enhanced community service look like?

Northern Locality

Our plans for Community Services are to further improve continuity in care for our patients by making their health and social care more seamless and less transactional. This will mean that our services will be streamlined to prevent duplication in assessment and will operate in a single team manner.

We anticipate that this approach will mean that Out of Hospital care will be much easier to understand and to navigate for patients and professionals. Core attributes of the service that we are providing as an alternative to Community Hospital inpatient care include:

- Increased rapid response where possible to provide an urgent response (KPI of response within 2 hours and visit within 4 hours) to enable people to remain at home - providing intensive and overnight care at home for short periods, working closely and case managed by the health and social care teams.
- Development of the Eastern and Northern Rapid Intervention Centres to be co-located with social care to provide a more streamlined and integrated response.
- Simplified referral systems for example e-referrals for planned nursing care from GPs, acute and community hospitals.
- Improved out of hours contingency planning with contingency plans agreed with individuals and their families held at the Rapid Intervention Centres for access by urgent care out of hours nurses and SWAST to prevent an avoidable admission where possible.
- Strengthened integrated multidisciplinary interventions and support providing wrap around care, including multidisciplinary weekly discussion at Core Group for people with most complex needs.
- Development of health and well-being services at the hospitals which lose beds offering increased clinics, for example: therapy and falls and balance classes within a social context so addressing needs of social isolation.
- Closer working with the local community to develop community model eg One Ilfracombe working with volunteer coordinators based within each of the community teams to refer to local groups.
- Piloting provision of health-led domiciliary care within Northern Devon to increase market capacity and closer working with personal care market.
- Development and expansion of care homes nursing team to provide support and training within care homes and safeguarding nurses to ensure quality and safety of care, as well as avoiding admissions where possible.
- Development of integrated health and social care teams at 'front door' of acute to prevent an admission and at 'back door' to facilitate timely complex discharges. Increased community led supported discharges by the community teams to proactively in reach and facilitate hospital discharge.

These services will be provided via a single point of co-ordination and are complimented with single referral/access points. Our evidence from existing service alternatives to Community Hospital beds such as Torrington and Ilfracombe have demonstrated that Out of Hospital services are able to manage a significant proportion of inpatient activity with improved outcomes, and we believe that this approach is consistent with the CCG's strategic direction.

Our findings are also supported by the recent Public Health Acuity Audit which confirms that a significant proportion of patients receiving hospital care can be managed in an out of the hospital setting. We do recognise however, that there are some patient cohorts where complexity means that patients are unable to be cared for within a home environment at present which means some level of inpatient provision will still be required, but which is lower than the current number of beds within the system.

Based on our experience of mitigating for bed reductions, often in far less favourable circumstances than the current, planned consultation, we have risk assessed our approach. A narrative of the key risks and mitigations follows below.

Any transition of the workforce from bedded to community care will occur simultaneously in order to mitigate a number of risks. In a climate where recruitment to the registered

workforce is difficult nationally, increasing a workforce through pump-priming, even if funding was available, would be challenging.

Effective use of the existing workforce is key in maintaining high quality effective care. As staff working in community hospital settings have high levels of transferable skills, such transition needs to be simultaneous to ensure continuity and resilient care. The cultural shift staff experience between settings of care is supported through transition with a period of guidance and input, enhance decision making skills and support individuals to adjust to the higher levels of autonomy afforded within community settings.

Significant amounts of work have been undertaken with the current workforce, in order to understand the challenges and skills gaps. This work has been undertaken with teams that have transitioned such as Ilfracombe, so that we fully understand the cultural challenges and adjustments staff need support with, as well as the focussed skills development. This has proven to be most effective if enacted simultaneously through transition.

We have considered double running but it is too high a risk. The advertising of new posts in the community home facing services would destabilise community hospital teams. Furthermore any additional recruitment would increase the potential risk of redundancy. Therefore, simultaneous transition would provide the best option in order to maintain safety and the effective skilled workforce.

<u>Eastern Locality</u>

We also recognise that within the Eastern Localities further work will need to be undertaken with partnering provider colleagues to improve the interface between acute and community services.

As part of our approach to enhance existing services we are engaged in a significant piece of work with the Royal Devon and Exeter Foundation Trust in exploring further opportunities to streamline discharge from acute to community services this winter as part of the ICE initiative and we feel there is scope and opportunity to expand these service innovations beyond Exeter to other localities which will again support Out of Hospital provision.

Inputs will be determined by the Trust to deliver the metrics outlined below, to the level equivalent to the reduction in beds, based on the historical service provision (and gaps) per locality.

5. Monitoring safety and quality of the new model and metrics

As a Trust we are responsible for providing at least equivalent service with regards to the health outcomes and patients experience. We believe this can be robustly evidenced through evaluations from implementing a number of agreed reductions in the number of community hospital beds and providing alternative home-facing services in a number of towns/clusters.

We currently care for approximately 7000 patients in their own homes at any one time across North and East Devon. The transformation to an out of hospital model will create a small increase in demand for community home-based services - approximately an additional 20 patients per month for every 16-beds reduction. This is a small number when considered in the context of the existing case loads.

Whilst actual outcome measures for patients will not be visible for some time, we plan to use a suite of robust and tested process measures to describe and monitor our journey to the new and better model of service delivery. These are the same as those

presented to and agreed by the System Resilience Group (SRG) and are described below:

Single point of access - colocation with Devon County Council Care Direct Plus rolled out across the Northern and Eastern patch.

Rapid response - times based on professional prioritisation;

- Urgent response to referral within 2 hours and visit within 4 hours.
- Increased contact time by fewer professionals – Increased efficiency, greater productivity and improved patient experience.

Patient experience – through Friends and Family Test, review of complaints and incidents.

6. The Financial Driver

In addition to the quality drivers described above, the outcome of the 2015/16 contract negotiation also introduced some significant financial drivers described below.

6.1 Negotiation of contract to arbitration

Separate 2015/16 contract negotiations were held specifically for the Northern and Eastern community contracts.

Approximately £1.4m of growth was agreed based on expected increases in demand on community based (home-facing) services that were subject to the shadow monitoring of activity against an Indicative Activity Plan, recognising in-year growth from the 2014/15 budget (district nursing, community physio etc).

Negotiations included discussing the potential impact on community services should the CCG implement its financial planning assumption regarding the full application of the national tariff deflator. The proposed contract settlement for 2015/16 using national planning assumptions required the delivery of £3.1m of cost reductions; however, similar to most areas of the country, national planning assumptions rarely hold true, and the actual level of CIP requirement driven by the application of the national tariff deflator to community services is £5.0m. As growth in community services was agreed, this meant that the majority of CIP delivery would have to focus on community hospital inpatient services.

There are no plans to reduce the number of sites providing inpatient services. There are currently 17 community hospital sites in North (5) and East Devon (12).

76% of the Trust's total cost base is either fixed or semi-fixed costs, e.g. staff and buildings that do not vary significantly if at all with activity volumes. It is a cost of providing capacity to treat patients.

24% of the Trust's total cost base is variable and costs incurred therefore vary in line with activity volumes.

The Trust was prepared to take responsibility for delivering £1.4m of savings against the national planning assumption through productivity and efficiency challenges with the remainder requiring recurrent service change.

The CCG maintained that Provider CIP was not a commissioner responsibility and the Trust should plan to deliver £3.1m of savings across community services.

The Trust and CCG were unable to agree on the issue and entered into formal arbitration on £1.7m of dispute.

6.2 Outlining the contract settlement following arbitration and the need to make efficiency saving

As a Trust when delivering CIP we are responsible for providing an at least equivalent service with regards to the outcomes and patients experience and this is evidenced through evaluations from implementing a number of agreed reductions in the number of community hospital beds and providing alternative home-facing services.

We know that we currently care for approximately 7000 patients in the community in their own homes at any one time. The changes described above will increase demand for community home based services by approximately an additional 24 patients per locality, which represents a small increase on existing caseloads.

Following an arbitration meeting on 23 April 2015, the panel found in favour of the CCG's position and the Trust was required to develop plans to ensure it operated within its financial budget by reducing the costs of delivering community services by £3.1m in 2015/16. The arbitration also confirmed that the CIP was the responsibility of the Trust as provider organisation.

It was confirmed by the Trust that the total CIP for the community services was greater than the national planning assumption and the bridge analysis confirmed a CIP for community services of £5.0m.

Safer staffing requirements, agency expenditure from recruitment difficulties due to uncertainty in the Eastern locality and the requirement to provide the current level of services across 17 Community hospitals results in a savings target for 2015/16 of £5.0m being £1.9m in excess of national planning assumptions.

The implication of this decision is that a similar level of savings should be assumed in future years requiring further review and service change to community services across both localities.

7. Consultation Timeline: Safe and effective care within our budget

The Trust's consultation on delivering safe and effective care within its budget in Northern Devon started on 18 August 2015 and is due to end on 29 September 2015.

The options are:

Option A community inpatient beds at two community hospitals
Option B all community inpatient beds at NDDH
Option C community inpatient beds at NDDH and one community hospital

There are no preferred options and the consultation is using nine of the non-financial decision-making criteria which came from the CCG's Care Closer to Home consultation. These criteria were reviewed, agreed, scored and weighted by the Stakeholder Review Group in August 2015.

Within the consultation, we have convened a full meeting of our clinical and service leads across acute and community to operationally risk assess the preferred option in the consultation. This risk assessment and mitigation report will be available to the Trust Board to aid its decision-making process.

A Trust Board meeting is planned for the 6 October 2015 at which the Trust Board will make a decision on the distribution of the reduced number of inpatient beds across Northern Devon. Implementation will follow at a safe pace following this decision to ensure that services are in place just prior or at the point at which the inpatient beds reduce.

In terms of CCG engagement with our consultation we are making the following points clear:

- We respect the CCG's decision to separate its Care Closer to Home consultation from the Trust's Safe Care Within Budget consultation
- Any change that we implement as a result of the safe and effective care within budget consultation will be fully reversible, meaning the CCG can still consider all options at the point at which you are ready to recommence Care Closer to Home

The changes will be implemented through October to be in place by the start of winter.

<u>East</u>

The same consultation process and scope is being considered for our Eastern community services given they fall under the same type and size of contract settlement. This will be approached on basis of risk, and meetings between the Trust and the CCG, and will continue to try to establish the most pragmatic solution.

8. Metrics for on-going monitoring

A Quality Impact Assessment is only valid at a point in time and needs active monitoring to ensure that patient safety effectiveness or experience is not compromised.

Monthly performance monitoring reports will be reviewed by the NDHT Board. We would also propose that the SRG receives this data on a monthly basis. The dataset for on-going monitoring is outlined below:

- Better Care Fund metrics
- Permanent admissions to care home for people over 65 years
- Emergency admissions avoided
- Delayed transfer of care
- Re-admissions after 91 days following Reablement
- CHC standards (possibly pick up Rob's comments about whether we can see any impact on CHC referrals?
- Assessment within 28 days from Checklist
- Quarterly and annual reviews of the rate of Emergency Admissions Number of contacts with Out of Hours
- Readmission rates Superspell Average Length of Stay
- Contacts in the community
- Contact time per contact

Appendix 1- Localised Data Evidence as at 1.9.15

	4 Towns		Ilfracombe		Moreton'head		Torrington		Axminster	
All Statistics Apply to Local Residents ONLY	% Change	Wider Comparator	% Change	Wider Comparator	% Change	Wider Comparator	% Change	Wider Comparator	% Change	Wider Comparator*
Acute A&E Attendances	tbc		-4%	4%	tbc		3%	3%	13%	13%
Acute Non-EL Admissions	3%	6%	-4%	2%	-4%	5%**	-6%	9%	15%	13%
Average Length of Stay at Acute	2%	9%	18%	11%	7%	6%**	2%	5%	1%	7%
Community Hospital Admissions	-17%		-79%		-52%		-62%		-52%	
Individuals Visited	34%		2%		34%		9%		0%	
Total Visits	7%	5%	9%	5%	34%	5%	34%	7%	0%	*-3%**
Urgent Visits	25%		60%	7%	49%	7%	46%	10%		
Hours face-to-face with patients	8%	7%	28%	7%	40%	7%	33%	10%	-70%	*7%**
Face-to-face time with patients (urgent visits)	25%		71%	10%	56%	10%	52%	12%		
Volume	5 mths, 4 towns		5 mths, 1 town		6 mths, 1 town		18 mths, 1 town		5 mths, 1 town	

** Please note that as a comparison "control group", these statistics do not always represent a static baseline, due to system change in particular for home-based care - e.g. some areas have seen similar bed change/ mitigation changes.*

*** Full data not available at this time from RDE - statistics quoted use best available data*