AGENDA APPENDIX 6

NHS Herefordshire

Herefordshire Community Transformation Programme – "Living Well at Home" Clinical Case for Change

Case for change – summary of proposals

- The Herefordshire System is proposing to remodel the way it provides care to people in local communities through a phased development of primary care and community health and care services; an increase in capacity in “home based” settings, and a reduction in reliance on “bedded” capacity.
- The system has been working together to develop the clinical model that will achieve these changes. A provider Alliance (Integrated Care Alliance) has been formed to lead the development and implementation of the model

Understanding Herefordshire

Population distribution
Whole County: 187,200 (2014)

Hereford City – 60,000
Kington – 3,400
Leominster – 11,900
Bromyard – 4,600
Ledbury – 11,900
Ross-on-Wye – 10,900

Understanding Herefordshire

- **Rurality:** A predominantly rural county, with the 4th lowest population density in England (0.85 persons per hectare).
- **Poor transport infrastructure:** With only four railway stations, the transport network is mainly comprised of rural ‘C’ or unclassified roads leading off single carriageway ‘A’ roads.
- **Workforce challenges:** A relatively large proportion of employment in sectors that tend to attract lower wages such as ‘wholesale and retail’ and ‘agriculture’. Low wages and relatively high house prices mean that the affordability of housing is a key issue for the county – both to buy and rent. The health and care systems have significant challenges in attracting and retaining workforce.
- **An aging population:** the number of people aged 65+ living in England and Wales has increased by 24 per cent, in Herefordshire it has grown by 30 per cent. Most notably, the number of people aged 85+ in the county has increased by 48 per cent,. Nationally this rise has been 35 per cent. The number aged 65-84 is projected to grow at a similar rate as during the last decade (average of two per cent a year), but the number aged 85+ will rise even more rapidly (average of six per cent compared to just under four per cent a year since 2001).
- By 2034, there are projected to be 50,700 65-84 year-olds (33 per cent more than in 2015), whilst the number age 85+ will more than double to 12,800.

Why do we need to change?

- The “One Herefordshire” system recognises that the current models for delivering care are not sustainable into a future which includes an aging and geographically dispersed population.
- We are not delivering excellence in our clinical outcomes for patients.
- We have significant financial challenges that we need to address as a whole system and across the STP footprint. Our approach is to focus on areas where there is clear evidence of poor quality care driving inefficient use of resources.
- Benchmarking information suggests that the Herefordshire health and care system is failing some of our most vulnerable patients.
- Our system has under-development of locality based care provided in people’s own homes, both health and social care and over use of bedded healthcare environments
- Our engagement processes are telling us that people want more care at home and through their GP practice; better co-ordination of care; improved access to services; better communication, and support to care for themselves.

System Benchmarking information

Herefordshire System Metrics

1. **Emergency admissions (65+) per 100,000 65+ population = 2nd out of 152**
2. **90th percentile length of stay for emergency admissions (65+) = 147th**
3. **Total Delayed Days per day per 100,000 18+ population = 99th**
4. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services = 74th**
5. **Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation = 127th**
6. **Proportion of Discharges (following emergency admissions) which occur at the weekend = 129th**

Clinical Evidence – National

- There is now clear evidence that, particularly for older people, extended stays in a hospital bed can have an irreversible impact on mobility, confidence and therefore independence.
- Evidence shows that for every 10 days that someone over 85 spends in a hospital bed, their confidence and mobility can deteriorate by 10 years
- A National Audit Report 2013-15 highlighted that 85% of all people experiencing a delayed transfer of care were over the age of 65.
- Research has shown that 40% of all people who died in hospital did not have medical needs requiring hospitalisation.
- A national intermediate care audit for England suggested that a reduction by 50% of beds was possible if avoidable admissions were addressed.

Clinical Evidence – Local

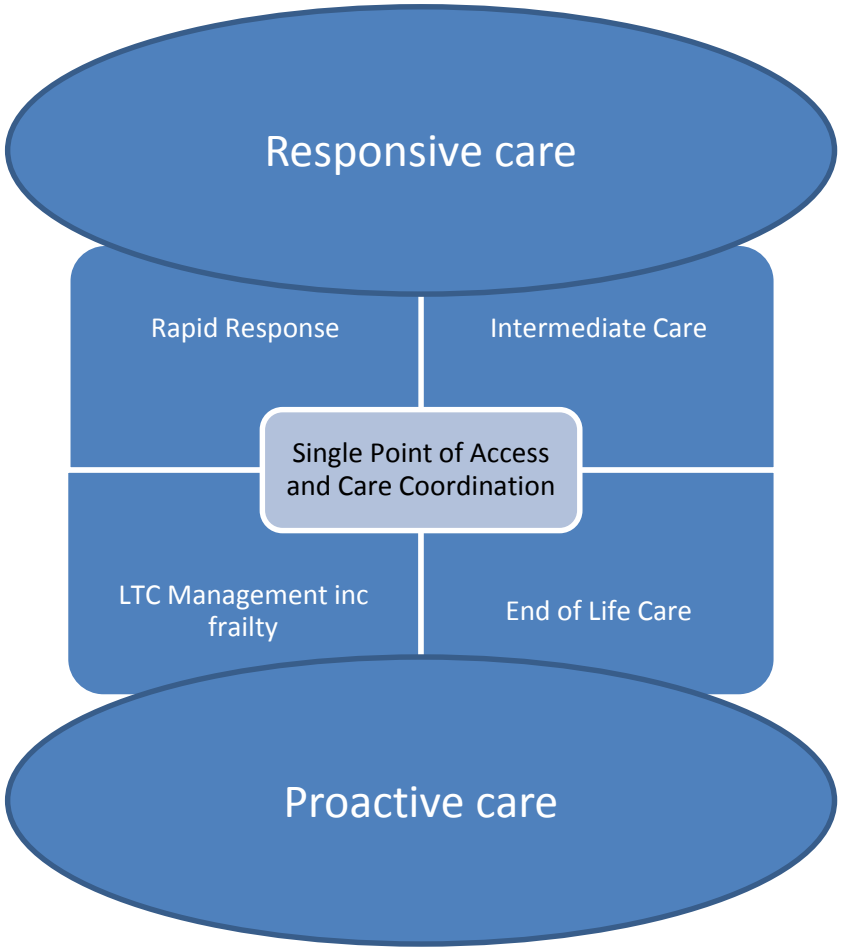
- Benchmarking information (above) suggests that Herefordshire is good at supporting people in their own homes and communities to avoid an emergency admission, but that we are failing to provide the support that is required to return them to their own homes in a timely manner.
- Delayed transfers of care are highest for patients awaiting a further health intervention.
- Indicative bed modelling suggested that, with appropriate alternatives in place, we could achieve a significant reduction in the community bed base. Any reduction is reliant on alternatives being in place and a managed transition.
- Local investments in End of Life care, including Hospice at Home and Anticipatory Care Plans, have enhanced quality of care as well as offering choice and reducing hospital admissions.
- Investment in an Early Supported Discharge team for Stroke has reduced length of stay and improved quality of care for stroke patients
- Community initiatives such as Hospital at Home, Virtual Wards, Dementia care nurses and a 24/7 Falls Response service are in place supporting people to remain at home. However our community health services often work in isolation from each other and from primary and social care.
- Our home care market is challenged with very few large providers and difficulties in recruiting staff in the most rural areas of the county. We have a relatively small re-ablement service and have struggled to develop local providers. This has led to the Local Authority recently having to "in-house" this service in order to grow capacity and capability in the provision.
- Snapshot audits have consistently demonstrated that many patients are being delayed in leaving hospitals to receive care at home. Most recently, in March 2017, 52 patients in a total bed base of 354 could have been supported at home whilst others could have been supported in alternative provision (see next slide)

Current position – Snapshot audit, March17

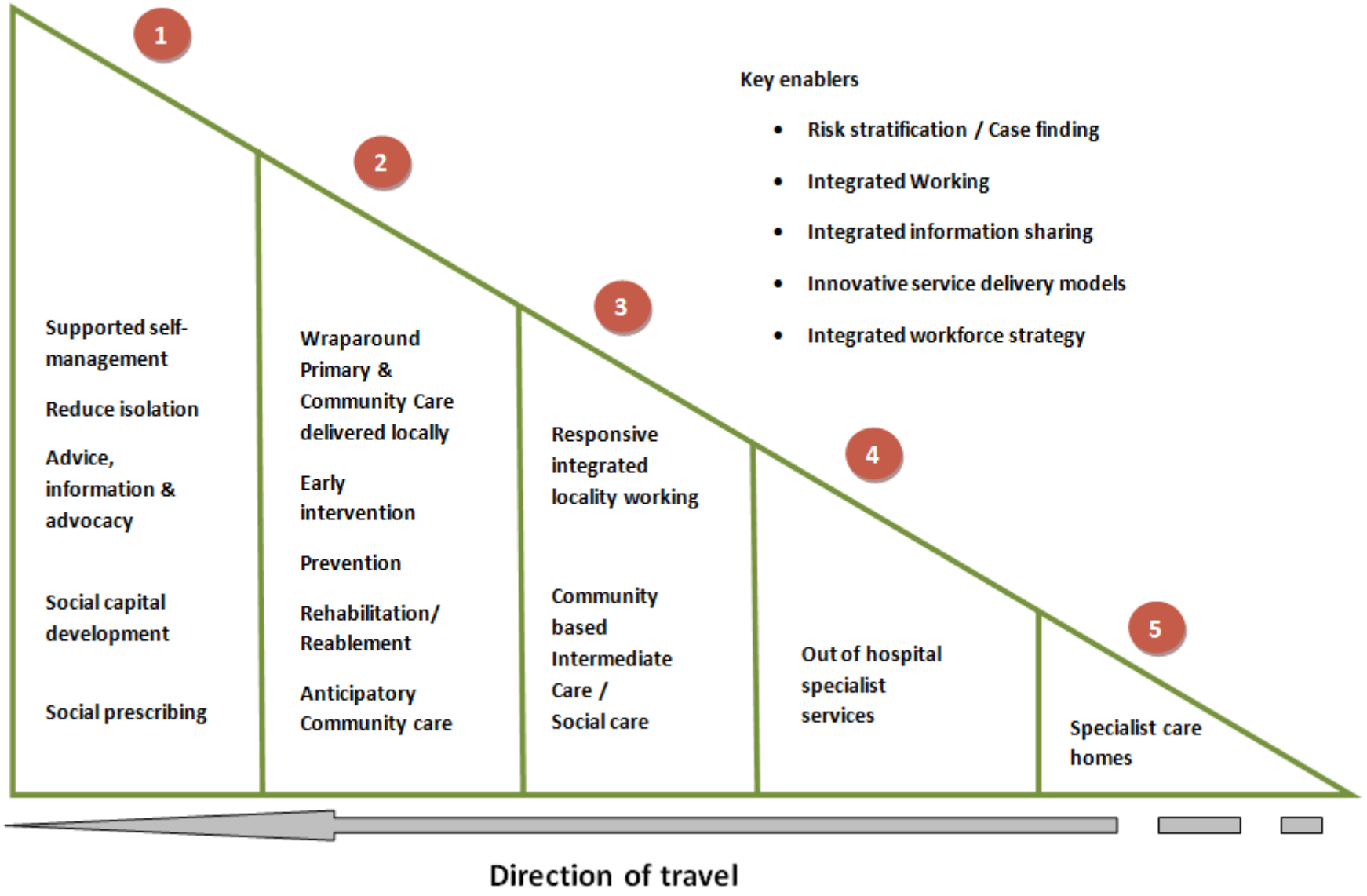
Service	Current provision	Required provision (on the day)
Hereford County Hospital	222	160
Community Hospitals – Ross, Leominster, Hillside, Bromyard	98	58
Ledbury Intermediate Care	14	12
Kington Intermediate Care	10	2
Rapid Access to Assessment and Care (Nursing Homes)	5	3
Intermediate Care Rehabilitation (Nursing Homes)	5	3
Discharge to Assess	0	36
TOTALS	**354**	**274**

Our Vision – Living well at home

- A multi-disciplinary, interagency service including supported self management
- Organised to deliver GP led wrap-around care and support to a population within a 30-50,000 population locality
- Using a standardised system of case management and care delivery
- Enabled by a single care plan and record
- Accessed through a single point of access with care co-ordination at the appropriate level
- Sufficient capacity to provide care at the time required for both reactive and proactive care.
- Supported by the **Primary Care Home** programme to ensure that primary care is at the forefront of developing and delivering our locality model



Our Vision – shifting care



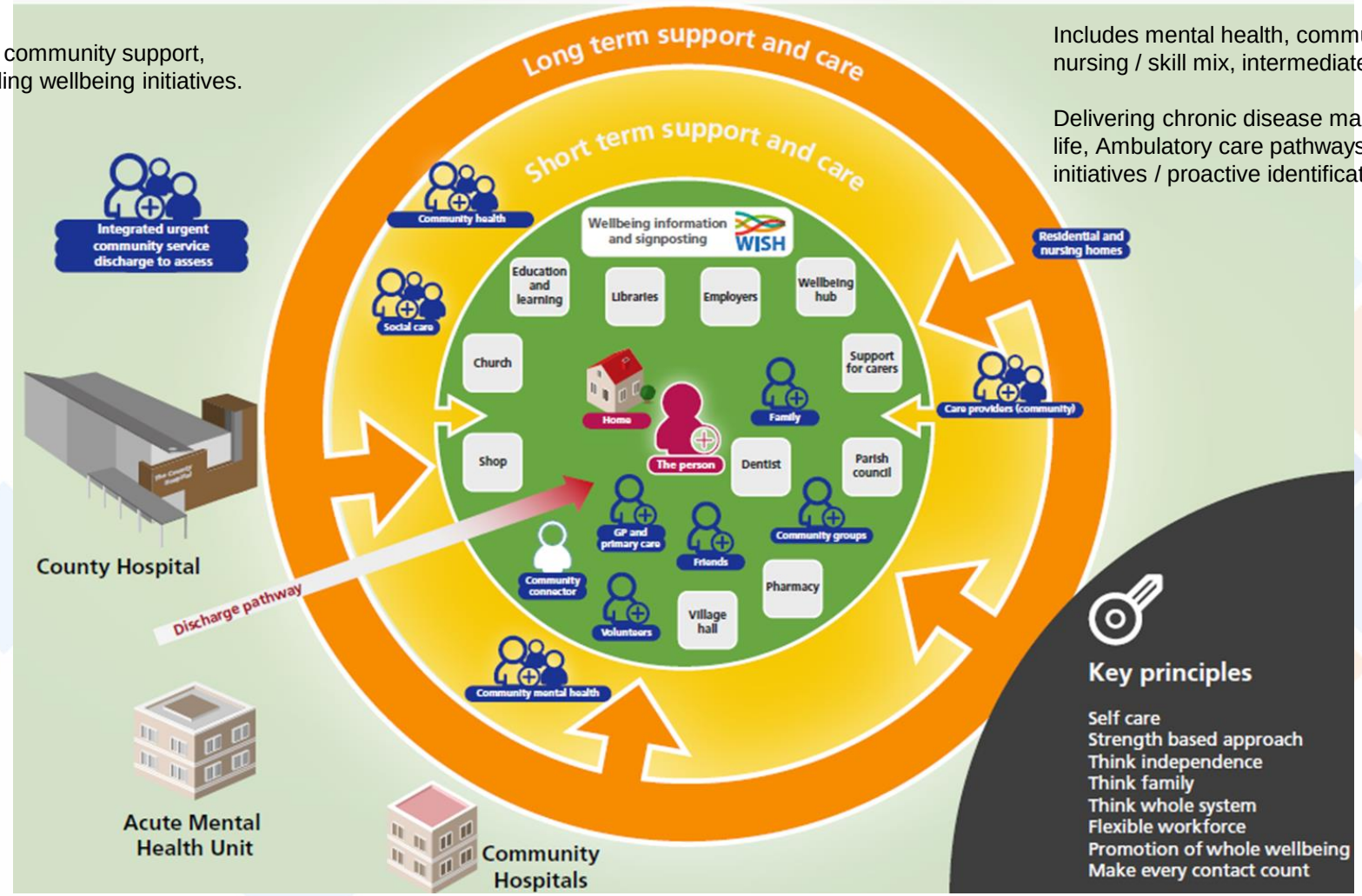
Our Vision – Living Well at Home

Wrap round person with primary care and access to specialist advice and support

Includes mental health, community nursing / skill mix, intermediate care

Delivering chronic disease management, End of life, Ambulatory care pathways and self-care initiatives / proactive identification.

Local community support, including wellbeing initiatives.



Benefits to patients

- A more responsive system focused on 4 localities bringing together mental health and community health care teams, primary care and social care
- More care provided in your local area, reducing the need for you and your relatives to travel to Hereford
- Better co-ordination of care with the MDT sharing information across teams and agencies.
- Improved provision of home care and reablement support in our most rural areas, a revitalised provider market
- Reduced need for an admission to hospital with teams that have the capacity and capability to support you at home
- Improved information for you to be able to make choices about the care you receive
- Improved support to volunteers and carers in your local area