SYSTEM WIDE BUSINESS CASE				Fit for the Future Working together to keep people well
Reference Number:				
Date:		**Version:**		
Business Case Title:	**Intermediate Care Tier including Discharge to Assess**			
Organisation(s) submitting business case:	Cambridgeshire and Peterborough CCG			
STP Work Stream / Directorate	Urgent and Emergency Care			
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Senior Finance Manager Comments:	*This is to be completed by the Senior Finance representative responsible for reviewing bids prior to submission to the Exec Team / relevant committee for approval*			
Executive Team / Committee Meeting Comments:	*This is to be completed by the Exec Team / relevant committee reviewing the Business Case to capture the outcome of the review.*			

Guide to complete (and submit) your business case:

This document provides a template for all Business Cases. Please complete every section using the guidance as highlighted.

Be clear and concise.

Where relevant, try to articulate the case in terms of three core areas; Clinical effectiveness, Patient Experience and Safety.

Where necessary, involve specialists e.g. from finance, and proposed project work-streams to provide business case information including costs, risks, benefits and assumptions.

Include a paragraph in the Conclusion and Recommendations section explaining the decisions the committee are being asked to make.

Once completed, arrange for the business case to be reviewed by a peer and agreed by the Executive Sponsor before submission to the relevant board. Allow enough time for key people to review drafts, to support getting the business case right before it goes through the formal approval process.

Section Guidance is given in italics

[A] EXECUTIVE SUMMARY:

A1 – Purpose

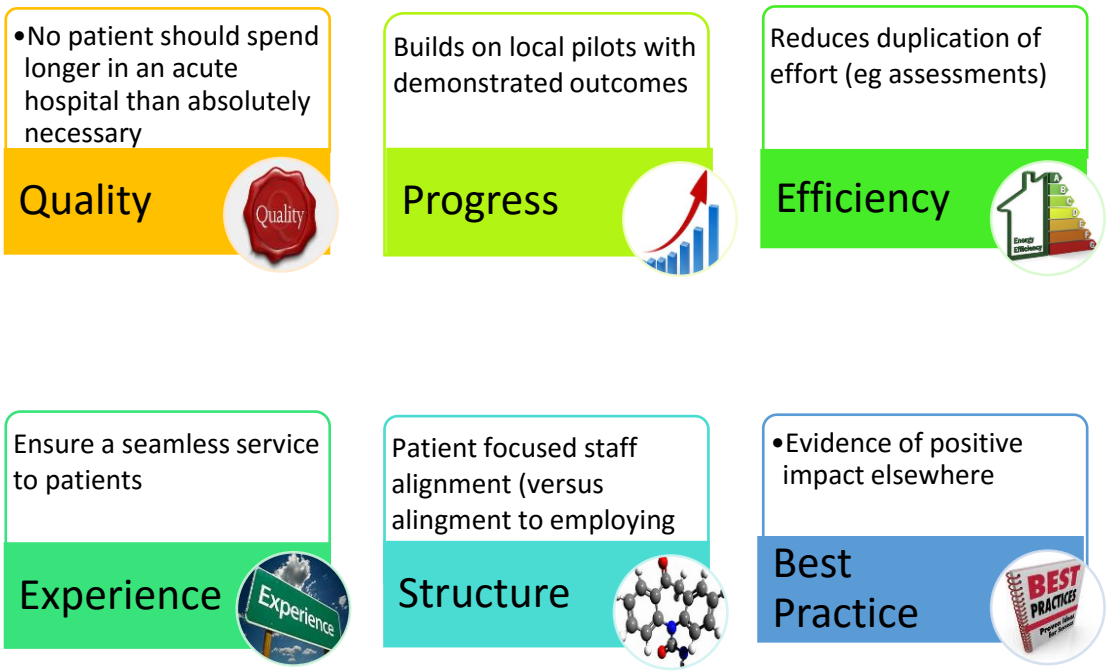
This proposal sets out how the local system can address the mismatch between patient need and demand and provision of community intermediate care services, with a particular emphasis on home support services.

Intermediate care comprises a number of services that is wider than solely community inpatient beds. Intermediate care was initially introduced to target elderly people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care or continuing in-patient care. It is understood as being time-limited.

The local system is currently heavily dependent on acute and community bed based solutions and therefore there are missed opportunities to meet the needs of patients with home support to the levels required, resulting in unnecessary delayed transfers of care, and subsequent impact on patients' potential for deconditioning further while waiting.

This imbalance can only be reduced by investing and developing a comprehensive intermediate care tier offer, strengthening home based services. The preference is for patients to go back to their own home, however it is recognised sometimes this may not be possible for a number of reasons and therefore it is key that going forward community pathways are simplified into three main care pathways that provide the right mix of home based services, community rehabilitation beds, and residential / nursing home care for more complex patients.

This is also an opportunity for the system to establish a more integrated discharge support service in community that delivers the following ambitions:



To achieve this, the work stream is seeking investment to allow for the establishment of an Intermediate care workforce which would support the delivery of Discharge to Assess pathways for patients that are medically fit. The benefits to the system are inclusive of:

- Reduction in Delayed Transfers of Care
- Improved Patient Flow.
- Improved clinical outcomes
- Improved Patient outcomes and experience
- Reduced hospital falls and Hospital born infections
- Reduction in elective sourcing in the private sector
- Reduction in elective cancellations and improved RTT

A2 – Driver for Change

The Starting Point

- **Population Growth:** Cambridgeshire and Peterborough is facing increasing demand for local health and care services. It has a rapidly growing and ethnically diverse population that will be 20% higher by 2031.

- **Insufficient community capacity:** there is insufficient resource in community for the system to support complex discharges from hospital at the rate that it should, with demand for health and social care services (including long term placements) currently outstripping supply.

- **Clinical evidence:** There is much evidence of the benefits of delivering care at or closer to home. A recent national audit (2014) reported that the average waiting time for a place in an intermediate care service is currently 6.5 days – higher than in previous years. A wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10% decline in muscle strength which is a disadvantage for people with frailty for whom muscle weakness is a defining characteristic.

- **Pressures on patient flow and performance:** Acute hospitals in Cambridgeshire and Peterborough are under considerable and continuing pressure to meet the demands of unplanned care. The hospitals are regularly prone to black alert without available beds, long A&E waits, high outliers, and high average lengths of stay (ALOS). The system is failing to meet national standards and at times the quality of patient care is at risk.

- **The current approach leads to duplication and pathway delays:** the system doesn't have a single point of exit for complex discharges. The current system is not working effectively, often consumed by paperwork and process of "transfer of care", facing many obstacles and barriers as patients transfer through different services and teams.

Evidence from Case Studies / Pilots

Discharge to Assess has been successfully implemented across the country in a number of sites and has also been successfully trialled locally to support discharges from hospital. A summary of findings from national and local pilots is included in **Appendix A.**

National Direction of Travel

In May 2016 the National Audit office (NAO) reported its findings on discharging older patients from hospital. It reported nearly two thirds of hospital bed days being occupied by people over 65 with an 18% rise in emergency admission for older people in the last four years. The NAO also reported 1.75 million hospital bed days being lost due to delays in transfer of care in 2015, with an estimated 4.2 million bed days occupied by people no longer in need of acute hospital care.

The NAO described older people stranded in hospital when they no longer need to be there. It has been estimated that 10 days of bed rest for healthy older people can equate to 10 years of muscle ageing with attendant loss of function.

Staying in hospital has negative consequences for patients, especially the frail elderly who will experience physical decline, loss of mobility, their ability to function as they did before admission as well as a loss in confidence. It also impacts on patients who are unable to access beds occupied by those medically fit for discharge. Therefore, we need to ensure people are in hospital only for as long as they need acute medical and nursing care. Assessment for longer -term care and support needs should be undertaken in the person's own home (where possible) or another community setting.

This means patients no longer wait in hospital for these assessments, which reduces delayed discharges and improves patient flow. This challenges the current model of OT and PT assessment within the acute hospital, which has traditionally been based around the 'Assess to Discharge' model.

A3 – Alignment with Organisation or System Priorities

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care
Together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 10. Using technology to modernise health

A4 – Brief Outline of Proposal

Our ambition is to provide a comprehensive suite of services that provide truly integrated intermediate care in community for patients in Cambridgeshire and Peterborough. In doing this we need to embed pathways that focus on supporting discharges from hospital to the patients' home when clinically appropriate. The proposed model of care therefore needs to encompass the full range of intermediate care services. It is widely understood that long stays in hospital for older people once they are medically fit can result in significant muscle loss, deconditioning, loss of independence and confidence, and increased risk of infection. The evidence points to the significant benefits to patients returning to the life they had before through a shorter stay in hospital followed by discharge to their own home when appropriate with the right support package to meet their needs.

At present the capacity to provide home based health services is not formally commissioned. It has grown ad hoc to build system resilience over the winter and respond to increases in demand to support discharges of older and frail patients. Home capacity is provided mainly by the independent sector which - although responsive and a good alternative to bridge gaps in provision- can be expensive. It is also harder to achieve effective integration across services if the provider landscape is too diverse, and capacity taken from the independent sector for intermediate care puts further pressure on the pool of capacity available to the system for long term placements.

There are also variations as to how Discharge to Assess is being applied in different localities, and hospitals often find the large plethora of services and community pathways confusing and difficult to navigate effectively.

Our aim is to move the system from the current set up to a more effective and consistent approach, with a simplified number of community pathways to facilitate supported discharges from hospital. The figures below show a graphic representation of the current and proposed set ups:

Figure A: current pathways

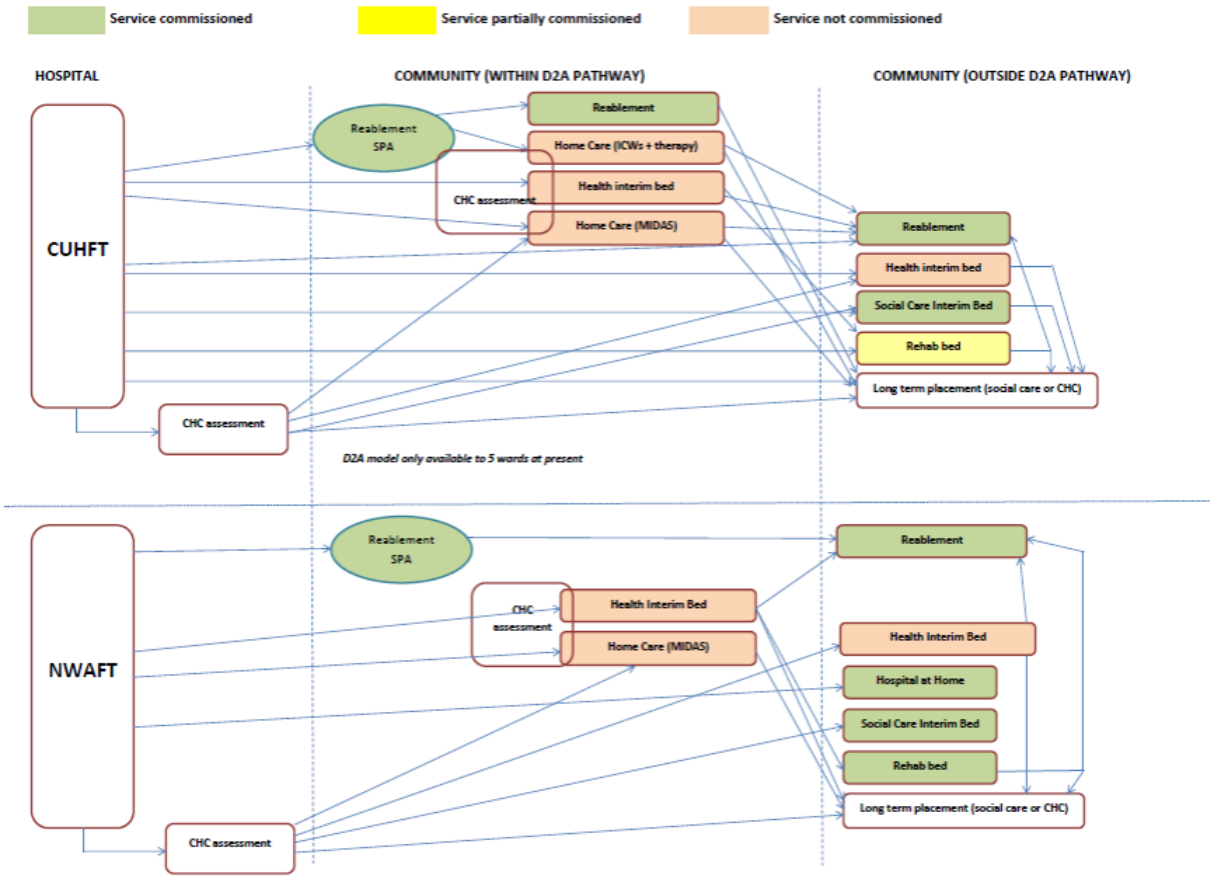
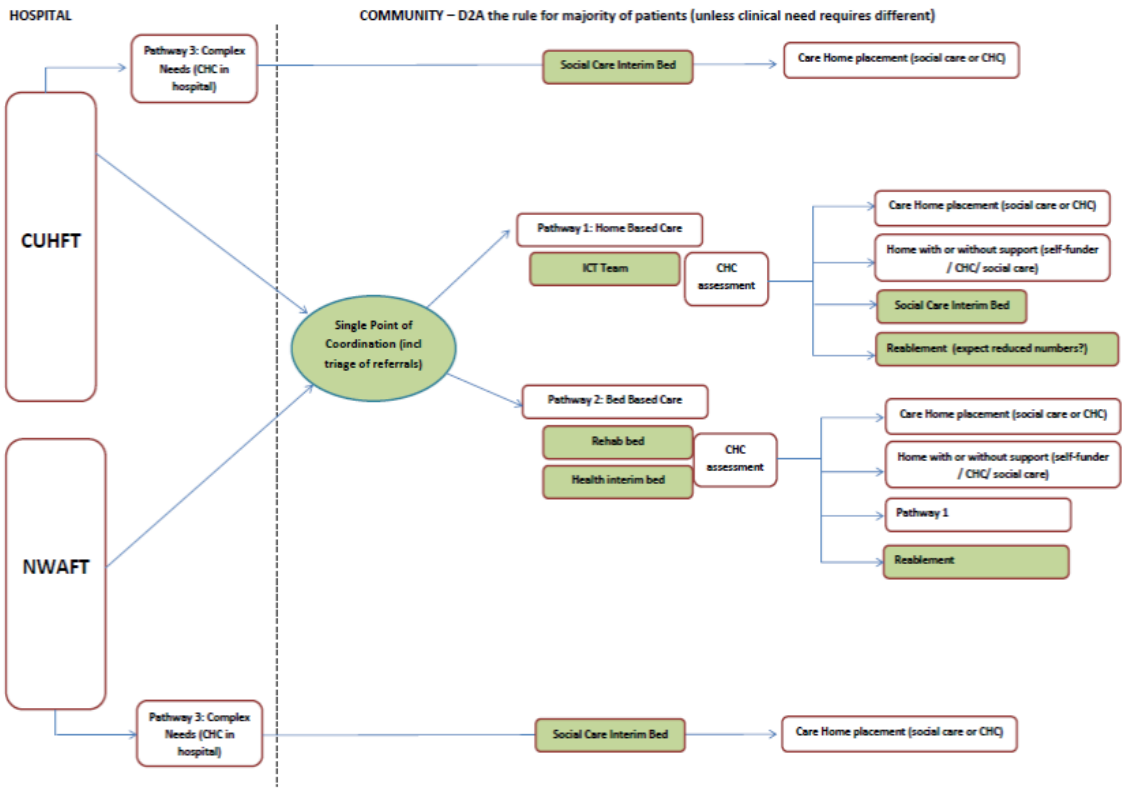


Figure B: Proposed Pathways



To make the transition from A to B as set out above, we need to deliver the following key elements:

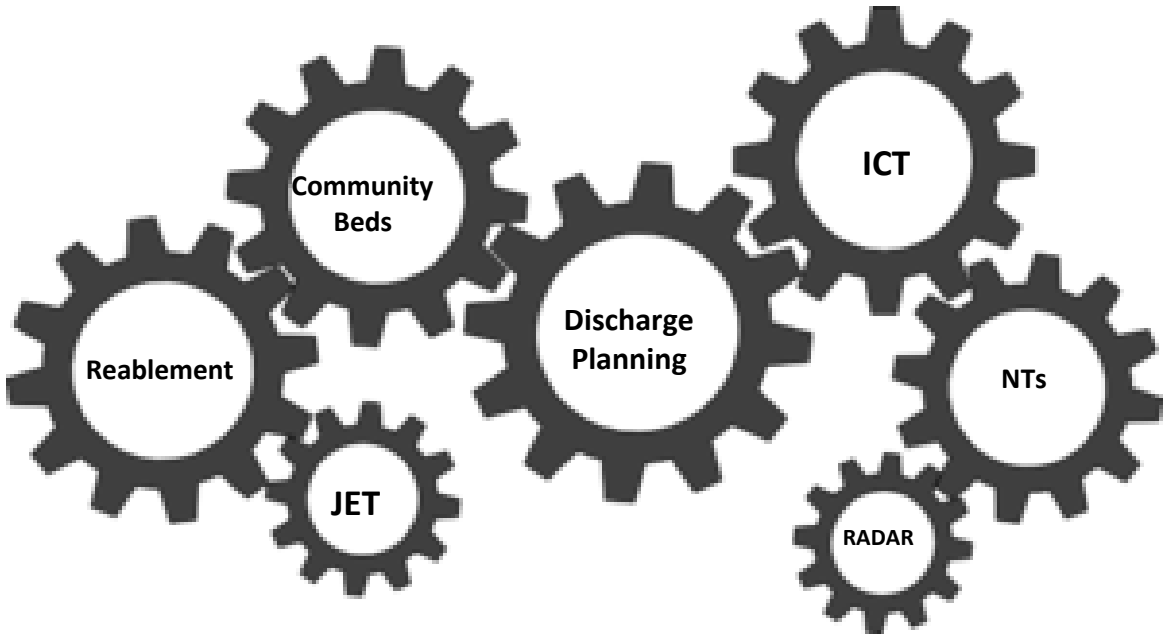
1. Development and implementation of a Single Point of Coordination (SPOC) to coordinate referrals into appropriate community services;
2. Development of a home based Intermediate Care Tier;
3. Improved utilisation and patient flow through existing bed based services;
4. Simplifying discharge pathways and implementing the full roll out of the Discharge to Assess approach across Cambridgeshire and Peterborough; and
5. Achieving greater integration across community services.

Services in Scope

- SPOC
- Intermediate Care Home Based Support (therapy & Integrated Care Workers)
- A proportion of reablement capacity (as part of the work in developing an integrated workforce)
- Community inpatient beds

Dependencies with other services – the full patient pathway

Intermediate care should be seen as a stage in overall care, not as an isolated service. It can help patients to stay independent for as long as possible and help identify the long term support needed after an accident or illness. It is a "cog" in a complex system of interconnected services in and out of hospital:



Recent work has been undertaken to reconfigure existing community services to develop multidisciplinary, locally-based community health and social care services, working closely with primary care. In addition a number of business cases have been put forth to expand capacity in other services with a particular focus in admission avoidance. We now need to take this to the next stage to establish a resilient intermediate care tier that can provide home-based services through Integrated Care Workers (ICW), and intensive rehabilitation services (therapy) better integrated to the robust reablement service provided by the local authorities to form the intermediate tier.

It is recognised that a number of health and care professionals are key to a number of services whether focused on admission avoidance or supported discharge (e.g. HCAs / Integrated Care Workers, therapists, OTs, nurses). Integrating teams around disciplines will enable the system to get greater economies of scale, and will support the provider of community services to manage workforce in a most effective manner. It will also avoid any potential duplication or double counting of workforce when developing proposals for future investment.

What will be different as a result?

Successful implementation of this proposal will deliver:

- Integrated ways of working in the community across health and social care
- Economies of scale through sharing workforce to support patient needs more effectively and appropriately
- Capacity agility to enable the system to flex capacity to reflect the demand of service
- Ownership of a complete patient pathway outside hospital and an objective overview of that collectively represents the patient
- A true Single Point of Coordination to access community services with clinical input to ensure patients' needs are matched to capacity
- Long term benefits to help us address social care and health capacity challenges

A5 – Financial Impact and Outcomes

The development of an Intermediate Care service including a single point of access to enable better coordination between agencies / services in providing a comprehensive approach to complex discharges will reduce bed days and Delayed Transfer of Care. The proposal will support the system to reduce length of stay in hospital and provide a safer, clinically effective pathway for patients.

A breakdown of expected financial savings resulting from implementation of the preferred option is provided in section E2 of this business case.

A6 – Sponsorship

The project team has engaged with the following internal and external stakeholders to secure sponsorship of the proposal:

- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridge University Hospitals NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Hinchingbrooke Health Care NHS Trust
- Papworth Hospital NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Cambridgeshire County Council
- Peterborough City Council

In addition, representatives from local general practices, East of England Ambulance Service NHS Trust, Hunts Forum, Peterborough Voluntary organisations, NHS Improvement, Emergency Care Improvement Programme (ECIP) and patient representatives have actively participated in developing solutions and are key partners for implementation.

A7 – Quality Outcomes

The implementation of the model will improve the experience of patients and carers as follows:

- Putting patients first with decisions about their long term care made within an environment familiar to the patient, it is 'context specific' and the patient's immediate and longer term needs can be more appropriately evaluated.
- Patients will see faster response times to care needs, as well as wider choice of alternative services to cater to their needs.

- Seamless care provision. Patients will benefit from greater availability of assessment services in the community leading to reduced dependency over time.
- Services targeted at encouraging self-care, promoting healthier living and providing activities in a home or community setting will dramatically improve the wellbeing of patients.
- Patients' outcomes will improve as more people will be able to live at home for longer. Length of stay in hospital will decrease thus reducing risk of deconditioning

It will also deliver the following benefits:

- Facilitating better integration across teams and providers, and breaking-down demarcation lines between professionals and multi-skilling to improve care.
- Releasing time to care with less time spent by referrers navigating services in an urgent care situation.
- Common outcomes to referral eligibility criteria and access to care.
- Prompt and appropriate professional advice to referrals from healthcare professionals / clinicians within the community.
- Removal of unnecessary steps, processes and delays in the discharge process with consume valuable resources and do not add value to the patient.
- Reduction in length of stay and Delayed Transfers of Care.
- Improvement in patient flow through hospital, thus enabling other patients to access acute care at the time they need it.
- Sharing responsibility, risks and skills across partners will lead to innovative and creative solutions that deliver safe, effective care and support.

A8 – Recommendation

Partner organisations are asked to approve investment as set out in section E of this business case from 1st April 2017.

[B] DRIVER(S) FOR CHANGE:

B1 – Risk or Opportunity

Cambridgeshire and Peterborough system partners have an opportunity to redress the current imbalance between investment in community capacity (particularly home based support) and patient demand. This business case puts forth a proposal that will restore that balance whilst enabling the delivery of the vision set out in our Sustainability and Transformation Plan (STP). We can do this by:

1) Increasing the ability of community services to respond to demand for care and support for patients in their own home / place of residence;
2) Optimising the utilisation of our existing community inpatient bed stock; and
3) Improving the speed with which people are safely discharged from hospital.

B2 – Strategic Context

Background and Strategic Ambition

The demand for health and care services is growing, associated with the rising age profile of the population and the increasing number of people living with long term conditions. The number of people aged 85 and over is expected to double over the next two decades.

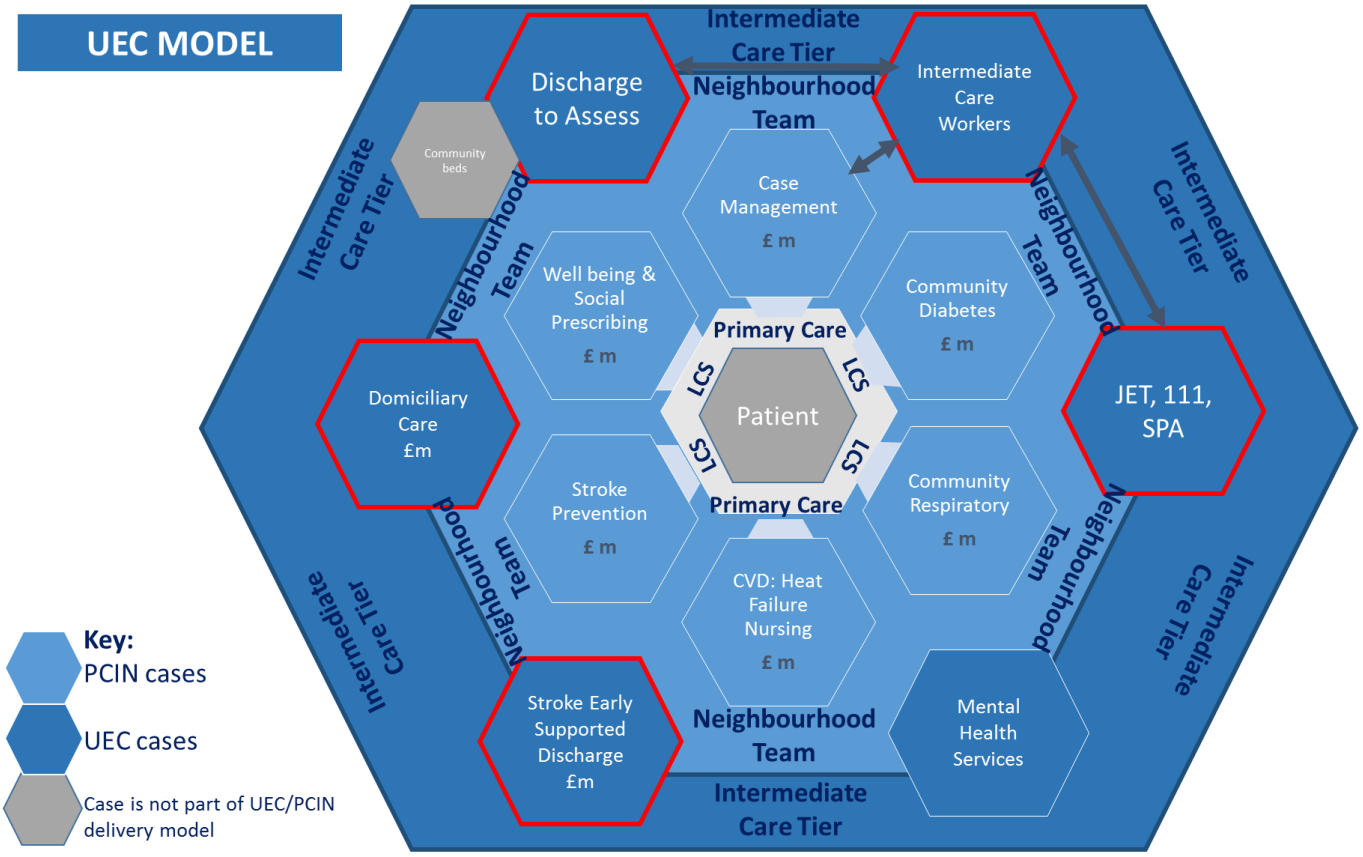
Between 2013 and 2031, the Cambridgeshire population is forecast to grow by 22.7% and Peterborough by 24.3%. In terms of the elderly population, there is expected to be substantially higher growth: 55.5% in Peterborough, and over 60% in Cambridgeshire. As elderly people are more likely to have chronic, long-term conditions, their needs from the services will change. It has been reported that older people with multiple

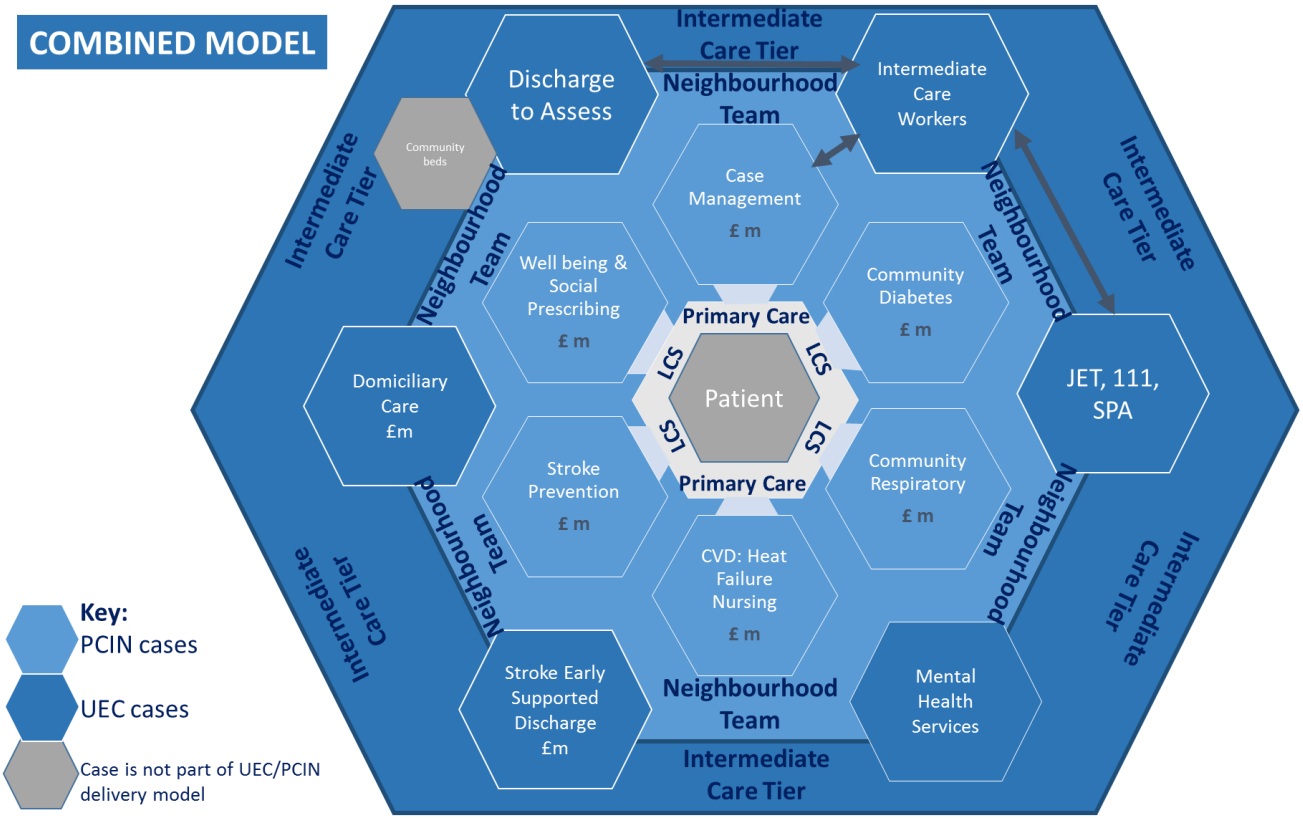
conditions, frailty or dementia, requiring complex and coordinated health and social care, currently account for 50% of NHS resources.

We need to transform our approach to providing intermediate care services in a community setting if we are to provide high quality services that are both clinically and financially sustainable. The system also faces significant financial challenges. Our ability to deal with the full scope of demand for health and social care services is limited and we need to radically change existing pathways of care to place a much stronger emphasis on:

1) Strengthening the capacity of our community services to support patients in their own place of residence;
2) Reducing the length of the stay patients spend in an acute setting when they no longer require acute care; and
3) Improving the outcomes for patients who can enjoy a longer period of independent living through front loaded rehabilitation and support interventions in their own home / place of residence whenever possible.

The system is already fully committed to greater integration as a key part of the future we envisage: which is for proactive, seamless care delivered through a person-centric care model, far from the disjointed, organisation-focused care which too many people currently receive. All the elements in the system are connected and rely on each other to operate successfully as an effective health and social care system.





B3 – Risk Assessment (only applicable if responding to a risk as identified in B1):

The proposal put forth is designed to redress the balance of community provision. The risk of not doing so is the system will continue to fail to meet levels of demand for support services outside an acute setting, potentially putting patient care at risk, putting further downward pressure on the performance of providers, and making it difficult for the system to maximise the outcomes and impact of investment in existing services.

[C] ALIGNMENT WITH ORGANISATION or SYSTEM PRIORITIES:

C1 - The proposed investment aligns to the following elements of the organisational or system priorities:

STP Priorities:

Priorities for change	**Commitment**
At home is best	• Community based rapid response to deteriorating patients • Introduction of home first discharge to assess model • Review of community bed-based and non bed-based provision.
Safe and effective hospital care, when needed	• Reduced delayed transfers of care • Consistent urgent and emergency care in right place

CCG Improvement and Assessment Framework:

Better Health	
Health inequalities	Inequality in avoidable emergency admissions
Better Care	
Urgent and emergency care	Achievement of milestones in the delivery of an

	integrated urgent care service
	% of patients admitted, transferred or discharged from A&E within 4 hours
	Delayed transfers of care attributable to the NHS per 100,000 population
	Population use of hospital beds following emergency admission
Sustainability	
Allocative efficiency	Outcomes in areas with identified scope for improvement
New models of care	Adoption of new models of care
Leadership	
Sustainability & Transformation Plan	Sustainability and Transformation Plan Delivery

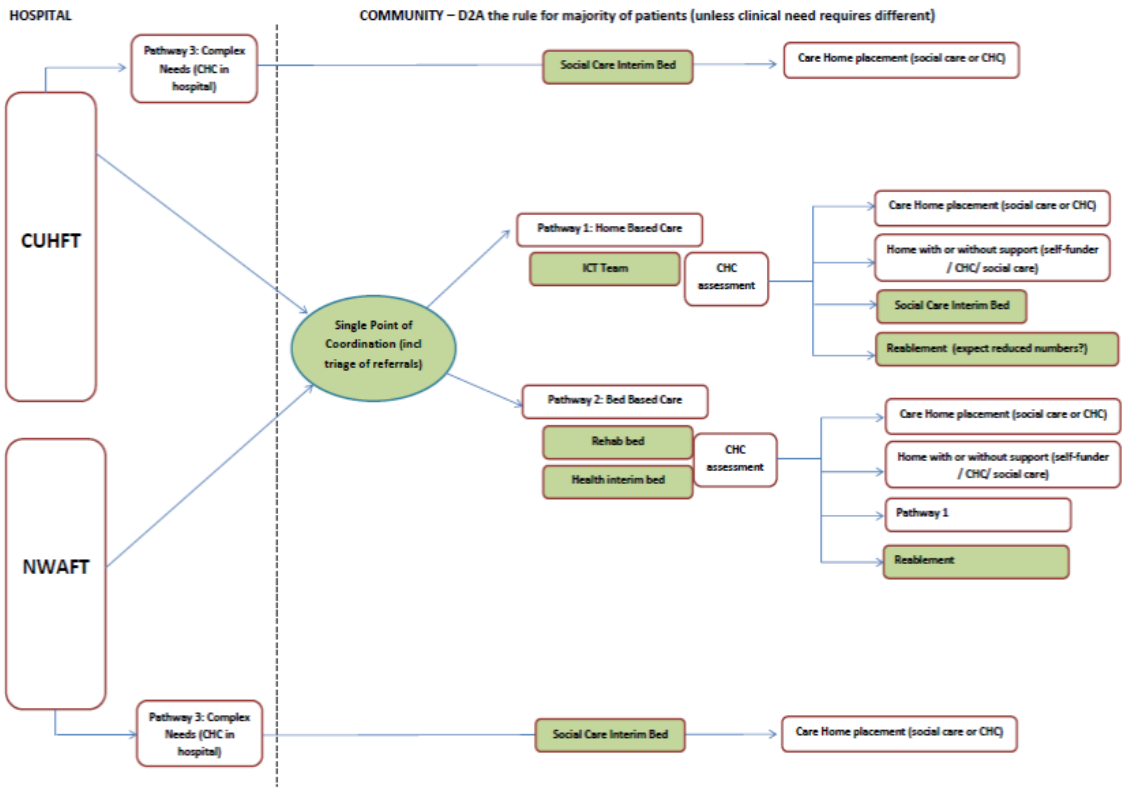
D] OUTLINE PROPOSAL

D1 - The Preferred Option

The preferred option is to set up a comprehensive and effective set of intermediate care services in the community, with effective overall coordination and pathway management. This requires the following:

- Development and implementation of a Single Point of Coordination (SPOC) to coordinate referrals into appropriate community services;
- Development of a home based Intermediate Care Tier;
- Improved utilisation and patient flow through existing bed based services;
- Simplifying discharge pathways and implementing the full roll out of the Discharge to Assess approach across Cambridgeshire and Peterborough;

Proposed Pathways



The Single Point of Coordination (SPOC)

To get economies of scale the proposal is to have a SPOC across the CCG, albeit some of the operational teams delivering intermediate care services will need to be split across the geography to be closely aligned to local services.

This SPOC will help professionals arrange the right care for referrals. It would operate as a "transfer of care bureau" supporting patients to receive appropriate care at home or as close as home as possible; and to prevent inappropriate hospital attendances and admissions through clinical navigation and integrated teams. The main functions will include:

- Act as the single point of access into the relevant community services;
- Triage referrals to the most appropriate service based on clinical review of information received from referrer;
- Respond to calls within clear and agreed timeframes working to agreed referral deadlines;
- Hold the knowledge of available community services and capacity levels;
- Hold and manage the overarching intermediate care tier patient flows and patient transfer list, proactively escalating delays in discharges from the relevant pathways;

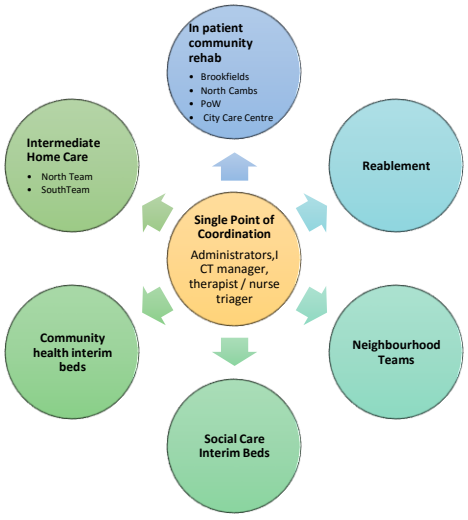
Referrals into the service will be accepted from a number of professionals as set out in the table below:

"Step Up" Care	**"Step Down" Care**
General Practitioners	Hospital Discharge Planning Teams
Community Matrons	A&E / Emergency Care Clinicians
Community Specialist Nurses / Teams*	
District Nurses*	
JET Practitioners*	
Social Care Services*	

**following consultation with GP or specialist consultant regarding patient condition and needs*

The SPOC will provide access into the following services[1]:

- Reablement
- Intermediate Home Care (ICWs and independent sector where appropriate)
- Community beds (rehabilitation, and interim)
- Social care interim beds
- Neighbourhood Teams



[1] Additional services can be added to the SPA if/where appropriate during future phases of service development if the system determines this to be the best approach

The Intermediate Care Tier

An effective model of care has to encompass a full range of intermediate care services to be able to support patients at home first but also offer alternatives for those patients for whom going back home is not an option right away. The proposed model of care for supported discharge will have three main community pathways supporting patients with different levels of dependency:

- Pathway 1: Home with support
- Pathway 2: Rehabilitation in a bedded facility
- Pathway 3 Long term care/ very complex care needs

The overarching principle of these pathways is that patients should always be cared for at home provided this pathway can meet their needs focusing on improving and maintaining their independence. All pathways should enable patients to rehabilitate fully (within their own potential) in the most appropriate setting. All assessments – including assessments for continuing health care needs - should be done in the community pathways rather than in hospital – with a very few exceptions. This would enable the system to have a consistent approach to **Discharge to Assess.**

Pathway 1: Home with Support

Patients that can go home with additional support are discharged home and receive ongoing support at home for a limited period. Support interventions can include nursing, therapy, care, or any service that will enable the patient's recovery to greater independence. The intensity of the service depends on the patients' needs.

Patients will be assessed at home following their discharge and will have therapy assessment within a 24 hour window to ensure the support package is tailored to the patient's needs.

This pathway is supported by therapies, social workers, integrated care workers (ICW's -Band 2/3) and discharge planning nurses, thus creating a rue intermediate care suite of health and/or social care services that can support early discharge from, or prevent unnecessarily prolonged stays in, hospital as well as supporting early discharge from community hospital rehabilitation units working alongside other community teams.

This service has to be integrated with the existing reablement services to form a truly integrated intermediate tier. It is envisaged that there will be co-ordination, co-location, and co-operation between the services to make the best use of the resources available.

The voluntary sector will also have a key role to play in this pathway as they offer key complementary services to support patients at home.

Pathway 2: Rehabilitation in a bedded facility

Patients who cannot be discharged home directly but will benefit from additional rehabilitation and have clear rehabilitation goals set out by therapists in the receiving unit. Care will be provided in community hospitals and/ or care homes with rehabilitation support dependent on need for up to 3 weeks (expected average length of stay; we recognise for some patients with complex needs the length of stay will exceed 3 weeks, but we expect this cohort to be a discrete number). The purpose of rehabilitation in a bedded facility is to stabilise the patients so that they can be safely discharged home (with our without home based support).

With an expectation that most patients will reable / rehabilitate at home under pathway 1, the community beds become the appropriate setting for those patients that need rehabilitation and that cannot go home because of the degree of medical and nursing need.

The system will need to sustain the current community bed provision at least until the new model of care is fully implemented and the system is able to evaluate the impact of increasing home care support through investment in a number of community services. However, there are opportunities to improve the performance and patient throughput of the existing bed stock by continued focus on the reduction of community DTOC in these units.

The table below sets out potential bed days the system could gain (full year effect) if average LoS was reduced to 21 days across the 4 main community hospitals (21 day LoS applied to 75% of the patient

throughput in the understanding that 25% of patients going to a bed could have health interim needs and require a longer stay beyond 3 weeks):

	April 2016 to Jan 2017 Actuals			**75% focus for reduction LoS to 21 days**		**New bed days used if 75% of patients average 21 day LoS**	
	Bed Days	Patients discharged	Avg LoS	Bed Days	Patients	Bed Days	Discharges
Lord Byron Ward bed days	9873	336	29.38	7405	252	5292	252
Welney Ward bed days	3482	126	27.63	2612	95	1984.5	95
Trafford Ward bed days	4335	181	23.95	3251	136	2850.75	136
Intermediate Care Unit bed days	9573	500	19.15	N/A	N/A	N/A	N/A
Totals	27263	1143	23.85	13268	483	10127	483
Potential gain if average LoS reduced to 21 days for 75% of patient throughput - excluding ICU (full year effect)			***3141 bed days***				

Pathway 3: Long Term Care / Very Complex Care Needs

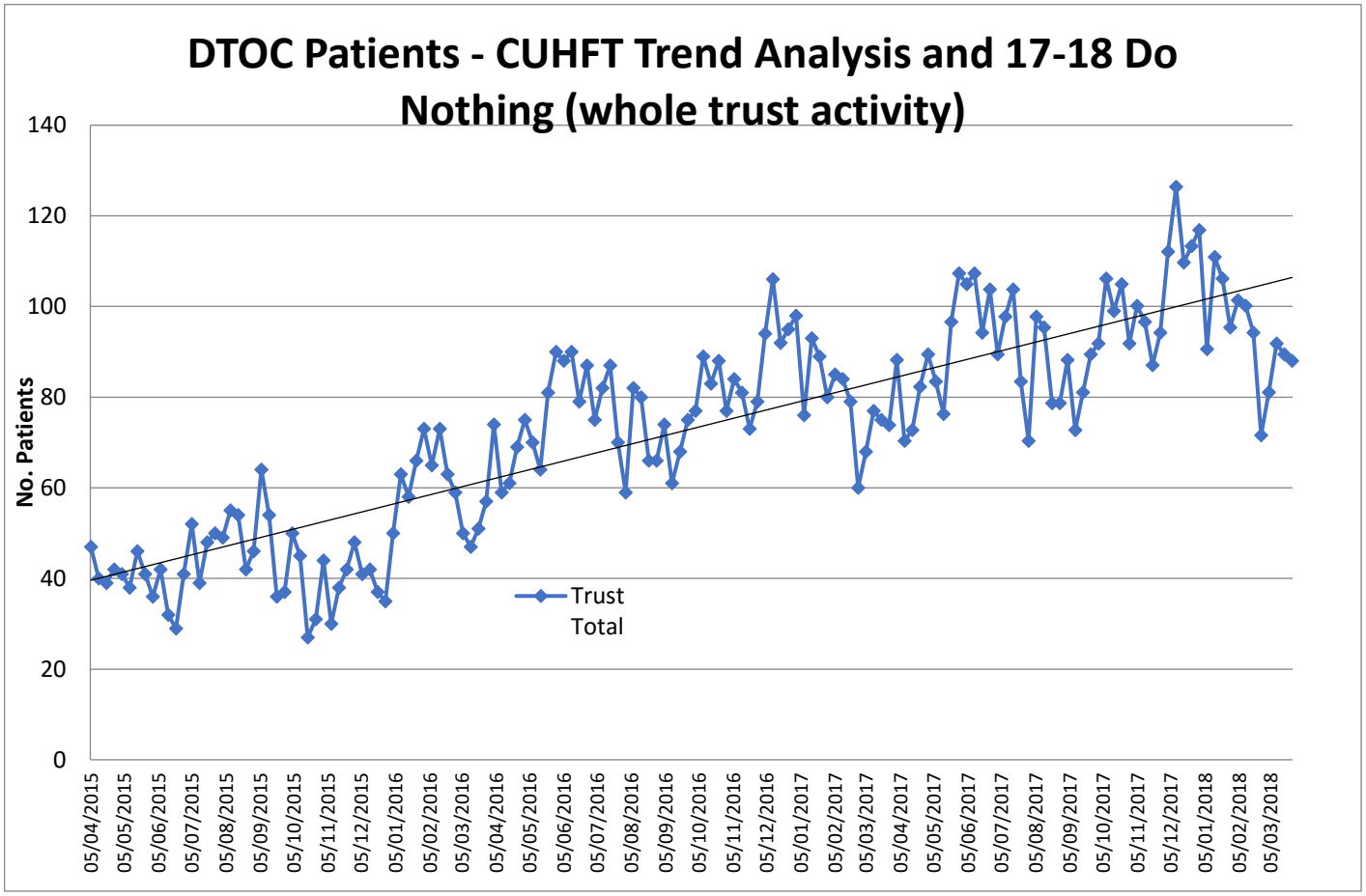
Patients that have likely long term care needs and require on going care in a residential setting. The hospital team would have identified these patients as having very complex care needs and are likely to require continued care in a care home setting for the rest of their lives. It is anticipated this will be a smaller cohort of patients for whom completing assessments in hospital will remain the best approach to provide the best quality of care.
Patients who can be discharged with a straight re-start of the care package in place before admission will be included under this pathway as they don't require new assessments if they can go home with same care package within 14 days of admission.

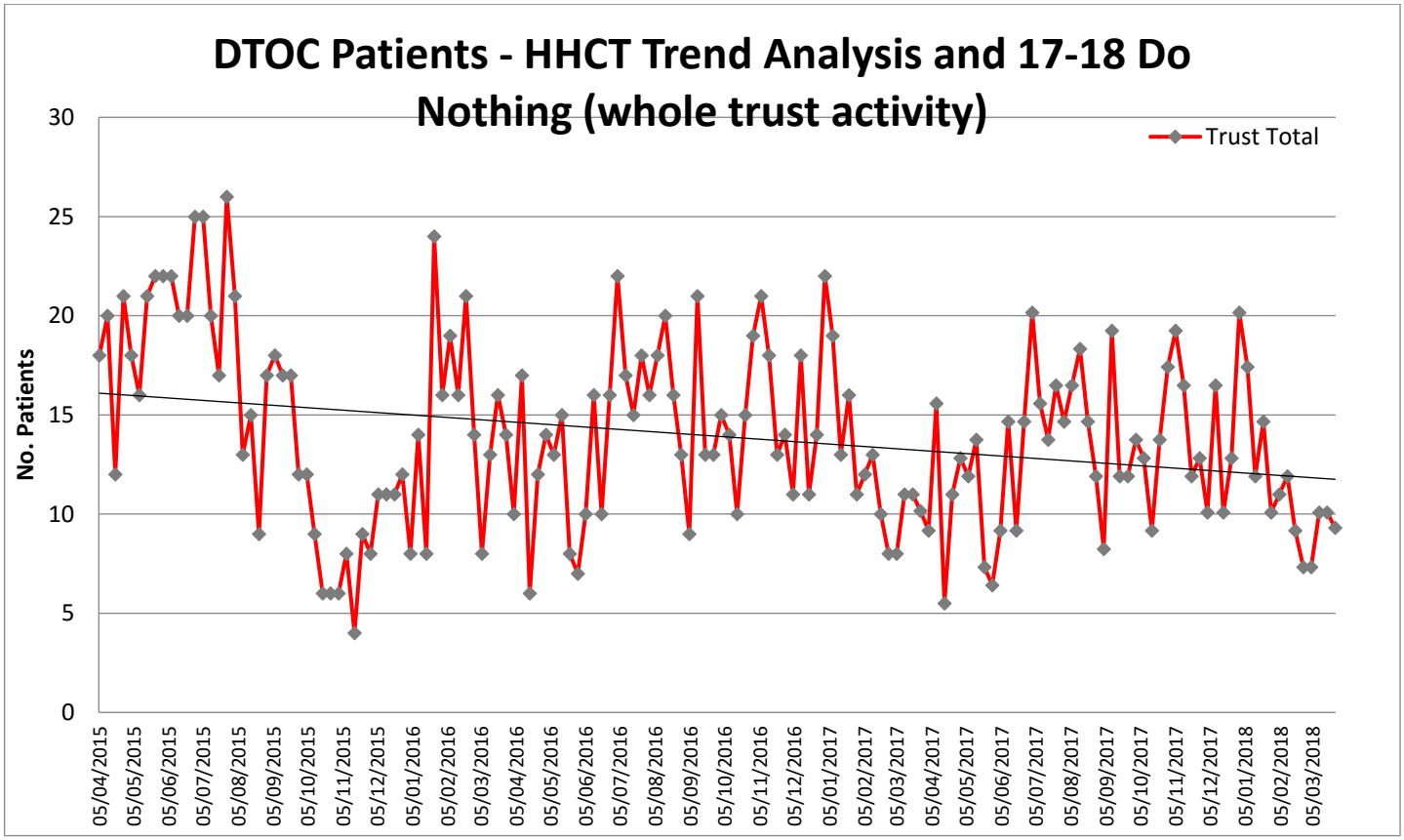
There can be movement between the 3 pathways if /when clinically appropriate; e.g. patient needs / abilities have changed (either improvement or deterioration)

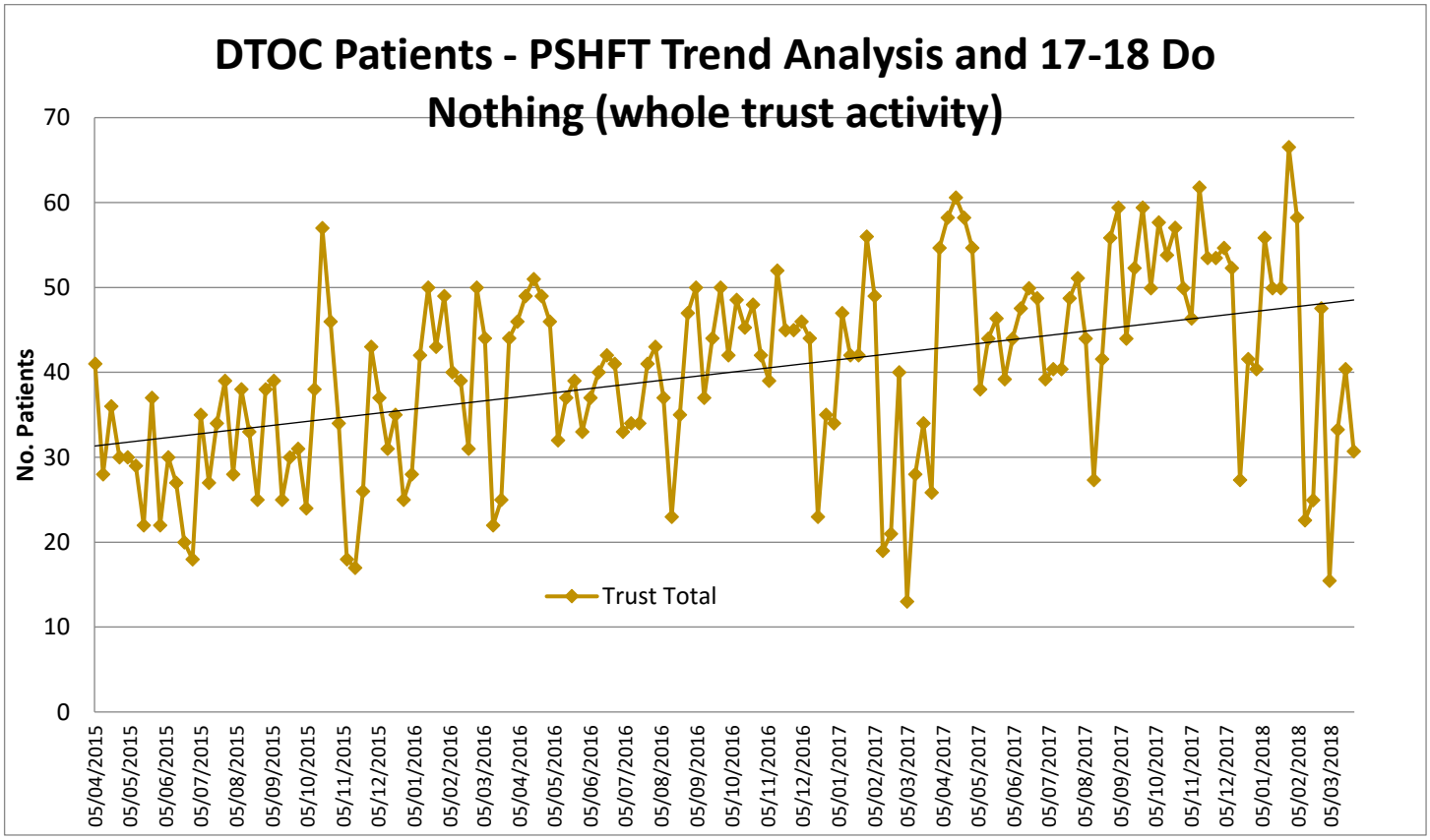
D2 - 'Do Nothing' Option

If the system doesn't make any changes and brings investment back to recurrent funding levels community capacity will be lost to include the existing intermediate care tier capacity (small number of ICWs and therapy to support existing pathways) and home care support for c.1200 patients per year delivered by the independent sector.

This would have a negative impact on the system's ability to facilitate supported discharges, increasing Delayed Transfers of Care. The tables below show the projected trend in DTOCs per Trust under this option:


DTOC Patients - CUHFT Trend Analysis and 17-18 Do Nothing (whole trust activity)
No. Patients
Trust Total


DTOC Patients - HHCT Trend Analysis and 17-18 Do Nothing (whole trust activity)
No. Patients
Trust Total



Data Source: Trust's SITREP reports

Most importantly, under the Do Nothing option patients in our system will not always have access to the best opportunities for a prompt discharge from hospital and speedy recovery at home, creating health and care inequalities and resulting in poorer patient experience. In the long term this would also be costly to the system through expected increased in long term dependency and high cost complex care packages for a greater number of people.

D3 - Alternative Option(s) Considered

In order to ensure there is capacity in community to deliver all three pathways under Discharge to Assess, the system could commission services with health home care provision delivered mainly by the independent sector. The current level of spend in home care (delivered by some ICW capacity plus independent sector packages) sits at circa £7.6m per year. This excludes comprehensive therapy input required to upscale D2A, nursing and social care support for assessments in community, and any clinical triage and pathway coordination (SPOC).

Under this option the system will not deliver an integrated care vision or realise full financial benefits as a more expensive and disjointed approach would be kept in place.

In addition, continued reliance on the independent sector to deliver home care will put further pressure on the pool of capacity available to the system for long term placements.

[E] FINANCIAL IMPACT:

E1 – Investment Required for Proposed Option

Different staffing scenarios have been modelled (see section H below on staffing). Of these, two preferred options have been highlighted and fully costed – options 4 and 6 - see attached below. The difference between them is whether patients stay in the pathway for 4 weeks or 3 weeks respectively. These two figures regarding length of stay are based on the current average length of stay for local reablement services

(average LoS of 3 weeks for Cambridgeshire and 4 weeks for Peterborough), which is the closest service model comparable to the proposed service. The system will need to determine which of the two is the preferred option.

D2A - Finance Schedule 6th April 17.

If the system is to continue to facilitate complex discharges from hospital until the new ICT team is in place, current levels of community capacity provided by the independent sector will have to be sustained as well as current levels of community in-patient beds. It is anticipated that the ICT tier builds proportionate independent sector capacity can be reduced in year.

The required investment for each option is put forth in the table below:

	Current Services	New Model	
		Option 4	Option 6
Expenditure	**£'000**	**£'000**	**£'000**
Home with Support			
Intermediate Care Tier (ICWs + Therapy already in place)	985	985	985
Independent Sector - Home Support	6,592	5,900	4,685
Non Recurrent transition costs		500	500
	7,577	**6,885**	**5,670**
Rehab in a bedded facility			
CPFT Lord Byron B	1,500	1,500	1,500
Independent sector - health interim beds	1,908	1,908	1,908
	3,408	**3,408**	**3,408**
Voluntary Sector	**248**	**248**	**248**
Total Cost	**11,233**	**11,041**	**9,826**
Funding Available			
CCG funding			
Operational Resilience	4,536	4,536	4,536
Better Care Fund	650	650	650
Re admissions	1,315	1,315	1,315
	6,501	**6,501**	**6,501**
Investment Committee			
MRET	935	935	935
Request from Invesptment pot	3,797	3,605	2,390
	4,732	**4,540**	**3,325**
Total Funding	**11,233**	**11,041**	**9,826**

E2 – Savings Delivered in the Proposed Option

There a number of benefits to the system from implementing the preferred option. Expected reduction in acute bed days has been modelled based on length of stay reductions achieved by other areas that have implemented this care model – see attached below. It is worth noting the potential benefits set out in the spreadsheet below will be realised by the providers:


D2A Modelling and Savings - by Provider

E3 – Source of Funding

It is anticipated that funding for the scheme for 17/18 will be provided by the STP investment pot in the first instance. This would allow mobilisation of the enhanced service. It is anticipated that the enhanced service would reach full potential by March 2018.

E5 – Contractual Considerations

Further consideration might be required for the long term commissioning of any new services going forward and whether procurement rules will apply.

E6 – Capital Risk (Capital Cases only)

N/A

[F] PATIENT EXPERIENCE:

In terms of the preferred option:

F1 – Impact on Patient Care

The new model of care will ensure patients:

1. Have enough information and support to allow him to look after himself as much as possible without having to rely on others

2. Have their care planned so that when they becomes ill they knows that they can get help quickly to manage their illness and to keep them out of hospital where possible

3. Know who to call when they need help and services know about them

4. If they need to go to hospital, they know that care and support will be put in place to allow them to come home as soon as possible

5. They know that everyone providing their care is well supported and the system helps them to learn from each other and develop better care for others

The new model of care will ensure patients:

G] OPERATIONAL IMPACT

In terms of the preferred option:

G1 – Capacity: post change, during implementation; Other areas:

To ensure there is no change to the current system which is already at a point of sub-optimal care being delivered, the Business case has taken account therefore for the current bedded provision to be maintained during this community mobilisation. As there is current bedded capacity funded non- recurrently the business case requires the support of this investment for 17-18. The bedded provision will then be reviewed in year, as the new care model is implemented.

G2 – Support Services, Physical and Equipment Capacity, IT and IG Compliant

There will be a requirement to review support services to be scoped at early implementation. This would add to the ongoing progress from the BCF funded projects, and the digital technology work streams of STP.

H] WORKFORCE/HR:

H1 – Staffing Numbers

This proposal has taken into account the patient journey across the full pathway resulting in a number of possible scenarios regarding possible staffing numbers. Each scenario is further shaped by a number of variables to include estimated length of stay and caseload. Options 4, 5 and 6 also take into account the anticipated impact on the patient cohort of the additional investment in further capacity and support across other services such as JET. This means that the capacity highlighted on these options is to focused on supported discharges only as the eligible patient base has been reduced based on assumptions around reductions in NEL admissions.

In addition, new pathway assumes reablement patients will go through the D2A pathway for a period of up to 3 or 4 weeks. This therefore will reduce demand for reablement services and a proportion of extra reablement staff numbers initially put forth in a previous business case have been “rationalised” into the intermediate care tier model.

From these, the work stream leads have put forth two preferred options (**Option 4 and Option 6**) which the Investment Committee may wish to discuss in relation to the other alternatives set out in the document attached below:

D2A Modelling v4 LE edits.xlsx

H2 – Staff Consultation

Consultation with existing staff may not be required in the first phases of delivery. If during deployment and delivery of the new model the system made a joint decision to change the arrangements for existing services (eg SPA centres, community beds) staff consultation may be required at a later time. The SRO and Project Manager will keep oversight of any potential implications on this aspect and will ensure early cross organisational HR input and advice is sought if / when required

H3 – Training

The proposal requires a system response to the current therapy and social care pathways to support the system change to assessment in the community and not in an acute hospital. There are major considerations to the training required to support this pathway move.

There is an interdependency with the workforce work stream of the STP which needs to be scoped further should the system support the realignment of current workforce.

H4 – Recruitment Considerations

Modelling has shown that a gold standard intermediate care tier able to provide intensive therapy and support to patients in their own home to optimise their chances of reablement and rehabilitation requires a significant number of health and care professionals.

The system however must take into account the capacity already in place that should be aligned to this pathway as not all the staff put forth in either of the preferred models will imply these are new posts that need to be recruited for.

There will be however a need to recruit significant numbers of care workers in particular and this could prove a challenge to the system and has been highlighted as a risk with mitigation actions identified.

In order to ensure the system has access to a flexible workforce the following factors have been considered as critical for success:

- Development of a national Trailblazer bid will allow the system to design apprenticeship standards tailored to the needs of our local system. The standards will provide generalist competencies but with the expectation of rotation and experience in a range of clinical settings, particularly for those seeking advancement in their role. By creating a large workforce which is agile, flexible, and competent in a range of areas to support our specialist staff and deliver basic care to our patients, we should be better equipped to manage changes in demand for care.

- Education and training programmes will incentivise staff into roles. This supports the cycle of progression, provides career enhancement opportunities, and increases the competency and capability of our workforce. Programmes have been costed for MSc level, in house competency packages, and will maximise levy opportunities.

- Joint recruitment strategies across partner organisations resulting in a combined workforce plan that will mitigate against the current workforce shortages and the challenge and complexity associated with large scale workforce redesign and recruitment.

H5 – Tenure

To optimise recruitment opportunity and make the model sustainable staff should be recruited to posts on a substantive basis. We recognise however that until the full complement of staff is recruited across disciplines organisations may need to use agency / bank resources in the interim.

H6 – Job Plans

Should the system support the pathway move of therapy staff and discharge planning to the community, this will have a significant impact on Job plans for staff.

Should the system also support an integrated service as the preferred option to delivery an effective and efficient intermediate care tier then accountability structures will require significant realignment.

A full HR scoping of the agreed proposal will be central to the development of the model, to reduce efficient use of current resources in the system to support system change.

[I] IMPLEMENTATION:

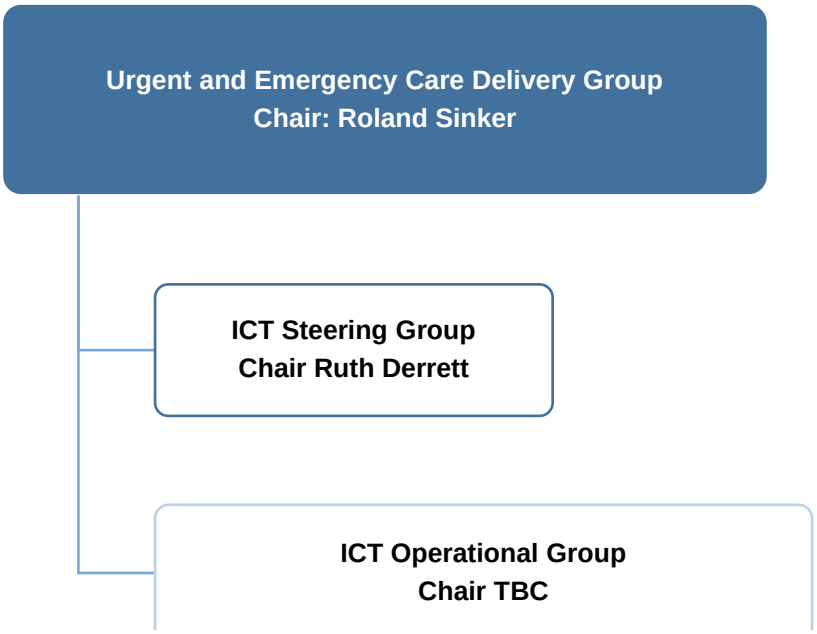
I1 – Timescales

Activity	No. Weeks	Dates Start - Finish
Scoping/Design		
Planning Consent		
Contracting/Advertising		
Delivery Lead-Time		
Works/Installation/Commissioning		
Practical Completion/"Go Live"		
Post-Project Evaluation		
TOTAL		

I2 – Implementation Governance Arrangements

SRO – Ruth Derrett

We will establish a programme management structure that reports formally to the UEC Delivery Group. There are project governance structures already in place with good clinical and senior management engagement and we wish to formalise these during the implementation phase. See figure below:



I3 – Support Services Resources

See E6

The delivery will require partnerships with all support services and support the STP priorities of change point 6 on use of services and estates.

I4 – Post-Project Evaluation (PPE)

Progress towards implementation will be continuously monitored by the ICT steering group; however it is proposed that a full evaluation of impact is also completed at 6 months and 12 months respectively

Timescale for PPE: (Please tick one box below)

3 months	☐	**6 months**	☒	**9 months**	☐

I5 – Deliverables: KPIs/Outcomes and systems for measuring performance of the scheme

KPIs/Outcomes	Target	Systems
Reduction in Non-Elective hospital Admissions (specified by CUHFT, HHCT and PSHFT respectively) – total and for over 65's	TBC	SUS data
NEL hospital admissions for falls for over 65's	TBC	SUS data
Reduction in Delayed Transfers of Care – total and specific categories (eg community rehab, reablement, assessment, patient choice)	TBC	Each Trust reporting for acutes CPFT reporting for community beds
Reduction in Length of Stay (acutes & community beds)	TBC	Each Trust reporting for acutes CPFT reporting for community beds
Reduction in excess bed days (acutes)	TBC	Each Trust reporting
Readmission to hospital following discharge into service (30 days)	TBC	Each relevant community service reporting
Patient & Carers satisfaction with care received	TBC	Patient surveys completed by each service
Reduction in dependency levels measured at admission to ICT service and discharge from ICT service	TBC	Community provider to establish mechanism to record and report on a regular basis
Staff satisfaction	TBC	Staff surveys by each provider organisation

(Please outline the specific KPIs that will be measured and the targets/outcomes this scheme is planned to meet. These should primarily align to improvements in Clinical Effectiveness, Patient Experience or Safety) Outline the systems in place that will monitor the respective KPI).

[J] RISKS & OPPORTUNITIES:

J1 – Implementation Risks & Opportunities

Risk Area	Mitigating Actions
Workforce: The new model requires the recruitment of a significant number of health care professionals and this may prove challenging	• Proactive recruitment campaign started early in the process pending approval of business case (end of February 2017) • Deployment of joint workforce strategies across provider organisations to increase appeal of roles to prospective applicants • Use of independent sector provider capacity in the interim to bridge gaps to provision during the recruitment process
Exit from the pathways might be affected by local market forces for domiciliary care and care home placements in particular	• Design processes (eg D2A) that enable system partners for early identification and planning of long term need to reduce risks of periods of excessive demand for long term assessment and care • Identify innovative solutions to delivery domiciliary care support (eg primary care support for patients at home, "grow your own workforce", etc) • Support the development of a "community pool" of capacity to support care for patients at home under the direct payment scheme (eg microbusinesses in community providing care in a given geography) • Promote use of direct payments as an alternative to social care support being arranged by the local authority

Financial implications to the system for the transition period	○ Ensure business case proposal takes account of the need to secure an interim period (up to 12 months maximum) of "double running" key community services until new models of care are sufficiently embedded and fully operational

J2 – Post-Implementation Risks & Opportunities:

All clinical safety and risks post Go Live will be managed by the relevant provider.

[K] STAKEHOLDER ENGAGEMENT:

K1 –Stakeholders Engaged During Business Case Development:

Name	Title	Representing	Internal / External
Roland Sinker			
Ruth Derrett			
Aidan Thomas			
Julie Frake Harris			
Ben Underwood			
Alex Gimson			
Charlotte Black			
Richard ODriscoll			
Phil Walmsley			
Neil Doverty			
Duncan Forsyth			

All of the above stakeholders have received and reviewed the latest version of this business case and have consented to its submission.

[L] RECOMMENDATION:

Partner organisations in the system across hospital, community and local authority sectors seek approval to invest a total of XXX from 1st April 2017. Of this total, XX is recurrent funding whilst XXX (for the community beds currently funded on a non-recurrent basis) could be reviewed at the 6 month evaluation point of the new service model.

[M] DUE REGARD SCREENING:

Impact (please indicate Yes or No for each question)	Race/Ethnicity	Sex	Religion or Belief	Gender Reassignment	Sexual Orientation	Age	Marriage & Civil Partnership	Pregnancy & Maternity	Disability
Do different groups have different	No	No	No	No	No	No	No	No	No

needs, experiences, issues and priorities in relation to the proposed change?									
Is there potential for or evidence that the proposed change will not promote equality of opportunity for all and promote good relations between different groups?	No	No	No	No	No	No	No	No	No
Is there potential for or evidence that the proposed change will affect different population groups differently (including possibly discriminating against certain groups)?	No	No	No	No	No	No	No	No	No
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular group or groups?	No	No	No	No	No	No	No	No	No

Note that if any box contains a 'Yes' then a full DUE REGARD assessment is required to be undertaken.

[N] REVISION HISTORY:

Version	Date	Amendments	Authored/Approved by
1	18/03/2017	Draft document created	Sara Rodriguez-Jimenez
2	24/03/2017	Inclusion of staffing models	Chris Gillings
3	24/03/2017	Inclusion of financial impact / benefits	Greg Lane
4	31/03/2017	Revision of staffing model and financials following discussions with health and local authority providers	Chris G / Louisa E / Sara RJ / Greg L
5	04/04/2017	Further revision of staffing model and financials following discussions with health and local authority providers	Chris G / Louisa E / Sara RJ / Greg L
6	06/01/2017	Further revision following discussions with health and local authority providers and following further clinical input / comments	Sara RJ

This template should be used for all investment bids (both Capital and Revenue), in accordance with relevant Organisation's SFIs.

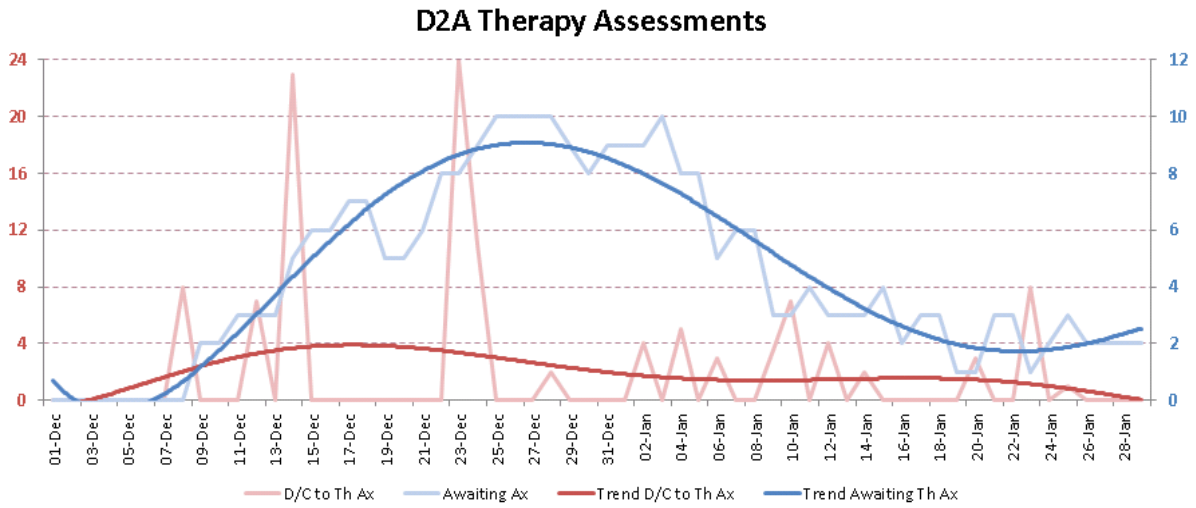
APPENDIX A

INTEGRATED CARE D2A PILOT: CAMBRIDGE SYSTEM (05/12/2016 TO PRESENT)

KEY SUCESSES

Clear improvements in patient outcomes:

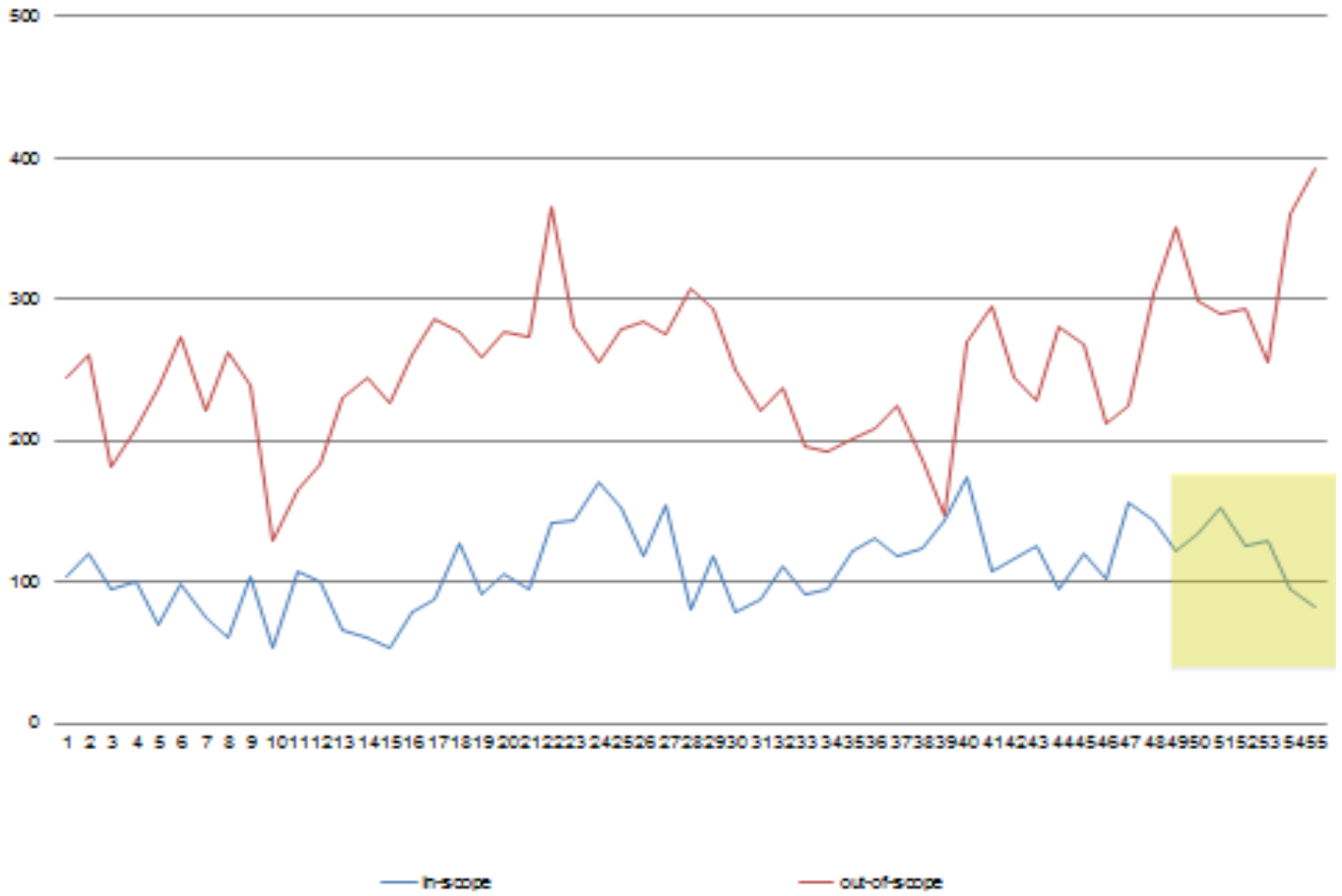
- A significant proportion of patients are going home and are remaining at home;
- Additional community therapy capacity has resulted in a significant reduction in wait times for patients to have a therapy assessment completed in the community (within 24 hours of discharge home). The table below shows the trend:



- Analysis of a sample of patients going through the pathway shows 7.5% of patients experienced functional improvement with need for therapy calls reducing by 75% from discharge into the pathway; a further 7.5% showed 100% reduction in need of therapy calls; and 14% showed 50% reduction.

- Readmission rates for patients in the 5 wards run at 10%, which is lower than the Trust average of 20%

- We have seen that for the 5 pilot wards the number of lost bed days has reduced whereas the rest of the hospital shows a general upward trend. Taking the week before the trial started as a baseline, there has been a reduction of 166 bed days in the first 7 weeks of the pathway since go live (compared to the LoS in the same five wards before the D2A pilot started). The figure below shows the Cambridgeshire validated lost bed days by ward for the last year. Blue is the line for the 5 wards in the pilot, and red is all other wards.



- Patient flow in reablement has improved, with a reduction in delays through the reablement pathway
- We have seen a clear commitment across teams to work differently, with high health and care professional buy in and engagement
- Improved communication between discharge planning, SPA, reablement, Intermediate Care teams
- 49% of patients have been discharged from CUH within 3 days of the Community Support Referral (CSR) being submitted; 44% of patients have been discharged within 3 days of their Clinically Fit Date (CFD).
- Released time to care for ward staff through reduction of phone calls to SPA /other services to facilitate discharge of individual patients

LEARNING POINTS TO TAKE FORWARD

- An overarching coordinating role to manage and “own” patient flow throughout the whole pathway is key to the success of this model.
- It is essential we continue to move forward the integration of pathways in the community and realise economies of scale through sharing of workforce to support patient needs more effectively (reablement / IC).
- Role of the SPA needs to be clearly defined to set out professional disciplines that need to be integrated / aligned into the single point of access / coordination (CPFT, reablement / social care, Discharge Planning teams); include clinical advice and expertise; and set out functions / responsibilities of the SPA going forward. All community pathways should also be routed through this single point – including community bed capacity

INTEGRATED D2A PILOT: NORTH BRISTOL NHS TRUST (began October 2015)

KEY SUCESSES

- There have been reductions in LoS for both the acute phase of treatment and the LHPD phase
- The total average stay is now 3.4 days shorter than the same period last year
- Stock (number of patients on LHPD at any time) has reduced due to the reduced LOS
- This has resulted in a reduction in bed days per annum which would equate to 29 beds across a full year
- As changes were not implemented as soon as demand & capacity model was completed the full saving has not been achieve during 2015/16
- Full saving could be achieved in 16/17

Measure	Impower Model (Jan 15)	Refreshed Model (Dec 15 to Feb 16)	Difference
Average LOS before LHPD	16	15.1	-0.9
Average LOS on LHPD	16.7	14.2	-2.5
Total LOS	32.7	29.3	-3.4
New Patients per Day subject to LHPD	13	13.4	0.4
LHPD Stock	218	190	-28
Bed days per annum	79242	69452	-9789.3
Equivalent beds at 92% occupancy			-29.2

INTEGRATED D2A PILOT: SHEFFIELD

KEY SUCESSES

- A study concluded from the Royal College of Physicians (2017) showed that two significant reductions in the weekly average wait for patients between hospital referral and being at home with community based support services (data from April 2012 to June 2015)
- The first reduction corresponds with the establishment of integrated community intermediate care service and demonstrates a reduction in average wait from 5.5 to 3.6 days. The second step change was driven by the more formal reconfiguration into a single service – Active Recovery (see figure below)

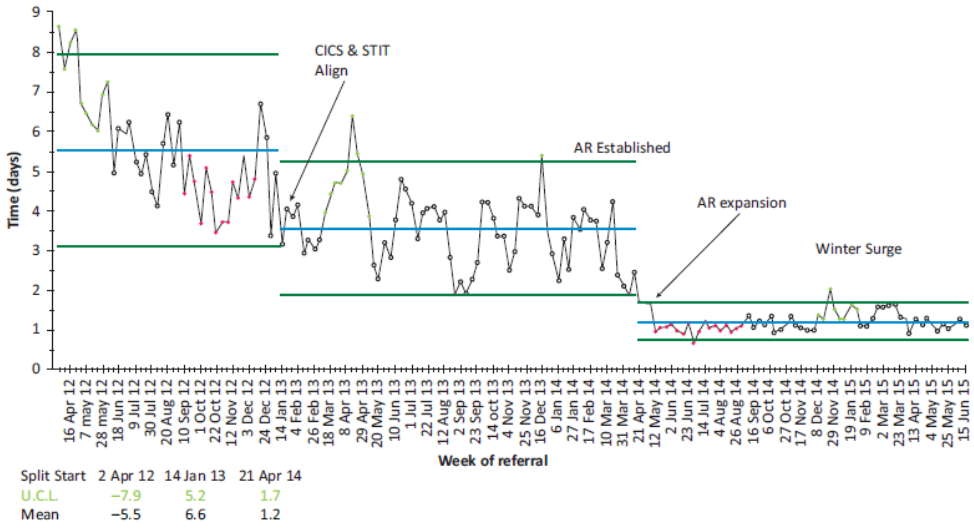


Fig 2. Reducing patient wait for active recovery from a hospital bed. AR = Active Recovery; CICS = Community Intermediate Care Service; STIT = Short Term Intervention Team

- Vertical integration between hospital and community healthcare systems further enabled and accelerated benefits.

- Further investment into the model in 2014 resulted in a more stable system with a mean transfer time from hospital to support at home of 1.2 days (therefore total reduction of average 4 hospital bed days per patient being saved as a result of implementing the new model of care at scale)

DISCHARGE TO ASSESS: SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

KEY SUCESSES

- The Discharge to Assess service enables patient discharge from acute into nursing or residential homes, community hospitals, or their own homes with care and rehabilitation support for up to six weeks (average length of stay in the pathway is reported at 21 days)

- The patients' assessment for ongoing care needs are done outside of the hospital. Services are provided via three pathways for three distinct cohorts of patients. On average about 60% of patients a week are discharged home with support to reable/ rehabilitate.

- From 2011 to 2014 the trust reports that this work has supported improvements in A&E performance, reduction in length of stay for emergency inpatient adults, and reductions in length of stay for patients aged 75 and older with fewer emergency readmissions and fewer patients affected by several ward moves

- The Trust also reports that 2014/15 data shows the proportion of patients going to long term care home placements receiving CHC funds has fallen from 40% of eligible patients to 20% in year when compared to patients who refused to go on the D2A pathway.