New Models of Care

Proactive Complex Care Intervention
1. **WHAT IS COMPLEX CARE?**

Individuals with complex care needs often have social care needs that are not being met and/or medical conditions that are not managed optimally and are potentially exacerbated by known (or unknown) mental health issues. This results in them accessing health services more frequently. These will include frequent visits to a GP in and out of hours, ambulance call outs, Accident & Emergency attendances and unplanned admissions. Too often, people with complex care needs escalate upwards through the ‘Pyramid of Care’ (see Figure 1) to acute care.

The ‘Pyramid of Care’ represents the needs of different cohorts of individuals. Upwards movement through the pyramid reflects escalating care needs, complexity of care, and demand on health and social care services. Throughout their lives, individuals move between the tiers of the pyramid as determined by their needs at that point in time.

Transforming complex care services will enable individuals to remain, or return to, lower tiers in the pyramid as their needs are met and their demand for health and social care services reduces.

2. **WHY WE’RE FOCUSING ON PROACTIVE COMPLEX CARE INTERVENTION**

The underpinning principle of this Plan is that prevention is better than cure. Its primary focus is on pre-empting the escalation of individuals’ health and social care needs and the identification of scenarios where the current services provided do not sufficiently meet an individual’s needs. The intention is to provide holistic early intervention that prevents individuals rising up through the Pyramid of Care.

Local health and social care commissioners and providers recognise that we need to take a more preventative and proactive approach to reduce demand for services and a more innovative approach to service delivery based on the premise of integration. Current legislation and policies emphasise a system-wide approach, recognising the need for services to be designed around individuals rather than organisations. We consider that there are six key reasons why complex care is a priority for re-modelling in West Norfolk, as illustrated at Figure 2.
Ageing population more than England average

17% of the West Norfolk population are 70 years or older compared to 12% 70 years or older for England overall. The West Norfolk population is growing at around 0.6% a year overall, with the population aged 85 or older growing by 3.4% while 15-25 year olds are declining by 1.6% per annum (see Figure 3).

Evidence shows that an ageing population leads to higher dependency on out of hospital and in hospital care services, and greater demand on healthcare services due to frailty and multiple conditions. The impact of projected ageing on healthcare usage in West Norfolk, and therefore cost of providing healthcare, is 1.4% growth each year, which is just under £3 million increase in cost. This cost pressure will be compounded year on year, meaning a challenge of £15 million in 5 years.

Ageing population translates into a higher prevalence of long term conditions

The prevalence in West Norfolk of various long term conditions such as COPD, atrial fibrillation, coronary heart disease, hypertension, and diabetes are higher than for England overall, and are expected to increase.

For example, as a percentage of the total West Norfolk population, hypertension prevalence is 18% versus 14% prevalence for the England average (see Figure 4).

The cost of caring for people with one or more long term conditions is significant; patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. The available average spend per head of population for West Norfolk is approximately £1,300 per year, covering all but primary care (such as GP) expenditure.
Supporting the Delivery of Policy

The policy message is clear -

- Direct funding for clinical hubs and reformed urgent care
- A new voluntary Multispeciality Community Provider Contract supporting integrated primary and community services
- Acceleration of the design and implementation of new models of care in the NHS
- Integrated models of care for patients, especially older people and those with complex and long-term conditions
- An outcomes-focused approach
- No change is not an option
- A radical upgrade in prevention and public health
- Patients will gain far greater control of their own care and there will be a breakdown in barriers in how care is provided
- Different care models will be supported

NHS England: General Practice Forward View 2016

Health & Social Care Act (2012)

Department of Health: Care Act (2014)

Duty to promote integrated working

Overall wellbeing of the individual is at the forefront of their care and support

Integrated services in order to give individuals the care and support they require... across health and social care.

NHS England: New Models of Care Programme (Vanguard) (2014)

- Re-model to provide integrated, person-centred pro-active care to people with complex needs


Better Care Fund (2013)

NHS England: Five Year Forward View (2014)

A single pooled budget for health and social care services
The Local Health Economy is facing a significant financial challenge

The Contingency Planning Team concluded that Local Health Economy partners are not financially sustainable under current models of care. A significant financial gap is forecast by 2018/19 and which cannot be bridged through efficiency, transactional and cost reduction plans alone. Transformational re-modelling of services is required and a focus on those with complex care needs is required, not only to improve patient experience and outcomes, but also to support closing the financial gap.

5% of the West Norfolk population are in the top 2 risk strata (complex needs); these account for almost 40% of health and social care spend. Reducing avoidable activity and bed days for people with complex care needs, with the focus on frailty, will deliver significant savings to fund a complex care model and contribute to financial sustainability.

We cannot recruit and retain sufficient numbers of staff into current models of care which utilise traditional roles

West Norfolk is likely to lose a significant number of GPs to retirement in the next 5 years as one third of the workforce is 50+. It is also likely that it will be difficult to replace this loss of workforce with equivalent numbers of GPs, as West Norfolk is attracting comparatively lower numbers of younger GPs and registrars (see Figure 6).

There are a number of specialties in the QEHKL, due to the volume of demand and workload, where the number of full time consultants is one or less. Recruitment difficulties at QEHKL mean that it is harder to staff some clinical posts and there is a higher reliance on bank and agency staff. This means that additional money often needs to be spent to employ temporary workers, creating a cost pressure for the Trust. Nurse recruitment and retention is a significant challenge across all sectors including primary, community and secondary care.
People with complex care needs do not receive consistently good quality care

The current model and care pathways do not provide integrated, person-centred pro-active consistent high quality care to people with complex needs.

Too often, community care fails people with complex care needs leading to an unnecessary hospital attendance. There are too many unnecessary admissions and, too often, there are unnecessary delays in discharging patients.

Our definition of Transformation is to change a system that provides some quality of care to some people with complex needs some of the time to a reality of consistently high quality pro-active care for all those with complex care needs.
3. OUR VISION FOR 2021

In reality, right now, some people with complex care needs receive a degree of good quality care some of the time. We want to change this current paradigm.

Put simply, by 2021, all those people with complex care needs will always receive good quality of care all of the time.

This vision can best be illustrated by a case study:

**Vision of care**
By 2021, we will have transformed the on-going challenges of complex care management...

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**Introducing Harry**

Harry is a 78 year old retired plumber with multiple morbidities (Diabetes, COPD) living with his wife of similar health in rural West Norfolk. Harry had a recent hospital admission for treatment of COPD exacerbation. In hospital, Harry became disorientated and was assessed and diagnosed with dementia. Discharge from hospital was complicated by an infected leg ulcer with a need for daily dressings. At home, Harry had 5 different people visiting for health and social care. Harry and his wife feel anxious and unsupported.

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**Introducing Harry**

Harry, with multiple morbidities and polypharmacy living with his wife in rural West Norfolk, well supported in the community by GP and Complex Care Team. During an exacerbation of Harry's COPD, the matron liaised with the respiratory nurses specialist, GP and chest physician to maintain his with the right support at home. Night shifts are provided and equipment brought in. Harry's condition deteriorates, his advances care plan clearly states his wish to remain at home and the Home Support Team provide end of life care. Throughout their care, Harry and his wife remain involved, well supported and feel safe.

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**Vision of care**
By 2021, we will have transformed the on-going challenges of complex care management...
The core principles underpinning our vision aim to:

1. Proactively identify individuals appropriate for complex care services;
2. Identifying the holistic needs of the individual through a single assessment;
3. Developing a person-centred plan that addresses all needs and delivers in a coordinated way;
4. Provides co-ordination to simplify care across multiple care providers in different care settings;
5. Provides a Single Point of Access (SPoA) accessible for extended hours, 7 days a week, 365 days a year;
6. Supports & assist individuals with navigating the care system, bridging the gap between the person, health professionals and social workers; and
7. Supports active self-management and encourages the use of community capacity
4. HOW WE WILL ACHIEVE OUR VISION

4.1 Implementing an (Extensivist) Complex Care Model

4.1.1 What is an ‘Extensivist’?

Extensivist Medicine is a relatively new area of medicine focusing on patients with complex care needs. An Extensivist leads a team that provides comprehensive and coordinated care to patients with multiple complex medical issues across multiple settings, and whenever appropriate, strives to simplify patient care by delivering comprehensive care.

We use the term ‘Extensivist’ because:

- The aim is to provide extensive care that:
  - is holistic;
  - addresses all needs - physical, mental and social; and
  - focuses on both the patient and carer
- The lead clinicians are generalists or “Extensivists”
- The team is extensive, with a broad skill mix:
  - potential for training in core generic skills; and
  - reduces duplication
- The hours are extended – evenings & weekend day
- Extended reach – working with secondary care to optimise the patient journey and plan supported discharge

4.1.2 What we’ve learned from elsewhere about this model

Many areas of England & Wales are implementing models to proactively manage complex care patients. In most areas where the Extensivist approach is being employed, the model is still in development or in the early stages of implementation and, therefore, without measurable outcomes data. Most Extensivist models, however, have similar aims:
• reducing admissions, A&E attendances, outpatient & GP attendances;
• supporting patients to manage conditions at home; and
• comprehensive, holistic, addressing social & mental health needs, as well as physical needs.

Most of the Extensivist models report high levels of patient & primary care satisfaction and where outcomes evidence exists, early indications are proving positive:
4.2 Integrating Community Services and Teams

The core principles (see Section 3 above) provide that the Complex Care Model must work in a proactive, holistic, coordinated manner through a Single Point of Access for patients and carers.

The Complex Care Team will consist of two elements (see Figure 13), namely:

- a Core Team including, amongst others, the Extensivist Physician, the Key Worker (Care Navigator), Advanced Nurse Practitioner, Mental Health Practitioner and Pharmacist;
- an Extended Team including, amongst others, Community Matrons, Rapid Assessment Team and Virtual Ward.

Much of the Core Team will be recruited, including the Extensivists, as these roles do not currently exist locally.

However, the resources and capacity for the Extended Team will come from the services and initiatives already in place to support admission avoidance and effective discharge management e.g. Rapid Assessment Team and Community Matrons.
What will be different?

- Co-located community staff from different organisations;
- Shared assessments and care plans;
- Decide jointly who ‘case manages’ and coordinates input from others;
- Improved communication between community teams and GPs;
- Strengthened partnership with Care Homes;
- Greater involvement of Voluntary Sector;
- Improved hospital and community coordination
4.3 Defining and building the cohort of patients

Critical to success of the Complex Care Model is defining the cohort of patients to be targeted. Questions we have asked ourselves include:

- Which cohort of patients would gain the greatest benefit from the service?
- Where should we deploy our resources to have the greatest impact on local system financial sustainability?
- Where should the balance be between targeting cohorts of patients where interventions maintain quality of life and care versus cohorts of patients where interventions can improve patient outcomes and return patients to lower tiers in the Pyramid of Care (see Figure 1)?

We have undertaken an extensive literature review of risk stratification tools including reviewing the work by the NICE Multimorbidity Guideline Group. We have also reviewed the approaches taken by other Complex Care models across England and Wales. Our key conclusions are:

- Most tools have limitations, with low sensitivity and specificity;
- Few tools are in development nationally;
- Clinicians (primary care and acute assessment) are well placed to identify patients who would benefit from an Extensivist approach;
- Clinical description is useful; and
- There is no ready-to-hand tool that we can use.

Therefore, we will need to implement a local approach that adapts what we have learned from elsewhere, is multifaceted, and can be tested via pilots.