

## Clinical Case for Change

### 1 Introduction

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Faced with increasing demand for services and financial pressures, it is even more important that the NHS continues to change the way it works, to innovate and to adopt 21<sup>st</sup> century best clinical practices which meet the needs of the local population.

We outline below the clinical arguments for building on past service changes and the evidence from home and abroad which underpins some of the consultation proposals. It brings together national NHS guidance, latest evidence, what people have told us at engagement events and local experience to set out the case for change in the way we support and provide care to people in the community.

### 2 Caring for People in the Right Place

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The NHS has never stood still. It has both driven and responded to change - in services, treatments, medicines and delivery. Many conditions which traditionally required a stay in hospital are today treated routinely at home or in a local setting. A report by the Independent Commission on Improving Urgent Care for Older People states that excellent care supports medical and non-medical care in the most appropriate setting<sup>1</sup>. This means patients only being admitted to hospital if they need treatment that cannot safely be provided in the community.

#### **Many patients in hospital beds do not need to be there**

Reviews show that between 50 and 60 percent of medical inpatient beds in UK hospitals are occupied by patients who could be cared for in an alternative setting (analysis by The Oak Group, cited in Edwards 2014<sup>2</sup>).

Over the last few years there has been considerable pressure on hospital beds and reports of delays in discharging patients into the most appropriate setting. Acuity audits were undertaken in 2010, 2011 and 2015 to assess the extent of the issue and to monitor the impact of service changes.

The Acuity Audit of Hospital Bed Occupancy in Devon report (October 2015) covered community hospitals in South Devon and Torbay but not Torbay Hospital. The report says that 42.3% of patients were fit to leave a community hospital bed in South Devon and Torbay and of these 31.8% had been fit to leave for 1-3 days and 49.3% for 4 days or more.

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<sup>1</sup> NHS Confederation, Growing Old Together – Sharing New Ways to Support Older People, 2016

<sup>2</sup> Edwards, N, (The King's fund), Community Services: How they can transform care, February 2014

The earlier acuity audits in May 2010 and 2011 were undertaken in the acute and community hospitals, as well as in homes where there were intermediate care in-patient beds.

Out of the 464 South Devon and Torbay clients in the 2011 audit, 187 (40%) were deemed medically fit to leave their current care setting:

- 25 % of those in an acute setting
- 52 % of those in a community hospital
- 66 % of those in a nursing intermediate care bed
- 82 % of those in a residential intermediate care bed

Being medically fit to leave a care setting does not necessarily mean being able to go home but rather, no longer requiring the level of current care. Being able to leave a care setting of course relies on the availability of another service (e.g. in a rehabilitation setting) or the availability of care provision at home.

### **Being in a hospital bed longer than clinically needed can be detrimental**

The 2013 Keogh Report 'Transforming urgent and emergency care services in England'<sup>3</sup> noted that:

*“Hospitals can be harmful to some people. Frail and elderly people may be made worse by hospital admission, which takes them from a familiar home environment to a confusing and noisy place where they are also at risk of harm from infection and falls. Very often their medical need is small and they just need a bit more care to help them through.”*

Whilst historically a hospital bed has been seen as a safe place to be we now know that:

- The longer an older person remains in a hospital bed, the harder it becomes to regain their independence and return home – a phenomenon known as functional decline, affecting 40 percent of the over-70s<sup>4</sup>.
- Usual aging is often associated with functional change, such as: a decline in muscle strength and aerobic capacity; vasomotor instability; reduced bone density; diminished pulmonary ventilation; altered sensory continence, appetite and thirst; and a tendency toward urinary incontinence. Hospitalisation and bed rest superimpose factors such as enforced immobilisation, reduction of plasma volume, accelerated bone loss, increased closing volume, and sensory deprivation. These factors can result in functional decline being irreversible<sup>5</sup>.
- Older people are more vulnerable to hospital-acquired infections which increase logarithmically with successive decades after the age of 50<sup>6</sup>.
- Older people admitted to hospital, generally stay longer and are more likely to be readmitted<sup>7</sup>.

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<sup>3</sup> NHS England, High quality care for all, now and for future generations: Transforming urgent and emergency care services in England – Urgent and Emergency Care Review End of Phase 1 Report, 2013

<sup>4</sup> BMJ 2015;350:h2389

<sup>5</sup> Ann Intern med 1993;118(3)219-23

<sup>6</sup> Infection control/volume4/issue03/May/June 1983, pp145-147

<sup>7</sup> Jocelyn Cornwell et al. (2012), “Continuity of care for older hospital patients: A call for action”, King’s Fund

A literature review by Monitor<sup>8</sup> found that patients could avoid harm and are generally happier, receiving equivalent healthcare in community based settings as appose to an acute hospital.

Admission to an acute bed should be a last resort for those with an unstable or new medical condition requiring frequent interventions by senior clinicians alongside the need for diagnostic or therapeutic interventions that can only be provided in this acute care setting.

In practice, many patients are admitted unnecessarily and discharge is often delayed due to a shortage of community services. The King's Fund report on Torbay's development of an integrated health and social care system (2011) demonstrated that by properly integrating and enhancing community services, hospital bed use and patient satisfaction can be improved.

*"The results of integration include reduced use of hospital beds, low rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care. Use of residential and nursing homes has fallen and at the same time there has been an increase in the use of home care services. There has been increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission".<sup>9</sup>*

Similar experiments have proved successful, most notably in Canterbury, New Zealand<sup>10</sup>.

### **Falling demand for hospital beds**

The National Audit of Intermediate Care 2014<sup>11</sup> provides a summary of the number of commissioned community hospital beds per 100,000 weighted populations – with the average being 23.7 beds, a significant reduction of 2.6 beds on the previous year. If we were to follow that figure, we would need approximately 70 community beds across our footprint, significantly fewer than our current number (166).

Figures for acute beds show a similar trend. Between 1979 and 2012, beds used for acute care fell by 35 percent, for maternity by 58 percent, for geriatric care by 65 percent, for mental illness by 74 percent and for learning disability by 96 percent. If allowance is made for population increases, these bed reductions are proportionately higher – for example, a drop of 42 percent in the number of acute beds per 1,000 population. During the decade to 2009, the US and the UK experienced similar proportionate reductions in acute beds.<sup>12</sup>

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<sup>8</sup> Monitor, Moving healthcare closer to home: Literature review of clinical impacts, 2015

<sup>9</sup> Integrating health and social care in Torbay, Thistlethwaite, P, 2011

<sup>10</sup> The Kings Fund, The quest for integrated health and social care: A case study in Canterbury, New Zealand, 2013

<sup>11</sup> [www.nhsbenchmarking.nhs.uk/National-Audit-of-Intermediate-Care/year-three.php](http://www.nhsbenchmarking.nhs.uk/National-Audit-of-Intermediate-Care/year-three.php).

<sup>12</sup> The hospital bed: on its way out? (March 2013) BMJ 2013;346:f1563

### 3 More Services Closer to Home

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The 2013 Keogh Report ‘Transforming urgent and emergency care services in England’<sup>13</sup> noted that:

*“With improving technologies it is now possible to manage many problems in a patient’s own home or local community that would have required hospital admission 10 years ago. Innovative schemes have shown how early assessment, with good communication between primary and community health services and hospital specialists, can improve outcomes by keeping people out of hospital. These should be developed and expanded.”*

To deliver this in line with what people tell us they want, we need to invest more in preventative and home based care so that more people can enjoy the benefits of support in their communities, closer to or in the familiar surroundings of their own home.

The Five Year Forward View<sup>14</sup> sets out a clear direction for the NHS nationally – showing why change is needed and what it will look like. It requires the NHS to:

*“Take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases”.*

There is evidence that coordinated, person-centred care in a person’s own home or in the community, in partnership with health and social care and the voluntary sector, delivers outcomes that are better than bed-based care. For example:

- The International Journal of Integrated Care undertook a systematic literature review of studies on the reduction of bed use for frail older people<sup>15</sup>, reviewing 48 studies and found evidence for the effectiveness of care coordination, preventive health checks and care home liaison in the prevention of admission to hospital.
- There is robust evidence from three Cochrane Systematic reviews, and other supporting sources, that hospital at home patients have similar or reduced levels of mortality, similar levels of readmissions and fewer patients being in residential care at follow up than inpatient care. Hospital at home also significantly increased patient satisfaction.<sup>16</sup>
- Around half of all deaths in England occur in hospital<sup>17</sup> yet we know that most people would prefer to die at home. Palliative care services delivered in the community such as Midhurst Macmillan Community Specialist Palliative Care Service<sup>18</sup> can help people to

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<sup>13</sup> NHS England, High quality care for all, now and for future generations: Transforming urgent and emergency care services in England – Urgent and Emergency Care Review End of Phase 1 Report, 2013

<sup>14</sup> NHS England, Five Year Forward View, October 2014

<sup>15</sup> Reducing hospital bed use by frail older people: results from a systematic review of the literature Int J Integr Care. 2013 Oct-Dec; 13: e048.

<sup>16</sup> Care Closer to Home Rapid Evidence Review, Public Health Devon, 2013

<sup>17</sup> Office for National Statistics (ONS) Mortality Statistics. Deaths registered in England and Wales 2014

<sup>18</sup> The Kings Fund, Midhurst Macmillan Community Specialist Palliative Care Service – Delivering end of life care in the community, 2013

achieve their preferred place of death and provide improved patient centred care coordination at the end of life.

- Community based interventions to preserve physical function and independence in older people have been shown to reduce the number of hospital admissions, falls and moves into long-term healthcare<sup>19</sup>
- Early supported discharge for stroke patients has been shown to reduce rates of illness and increase likelihood of survival<sup>20</sup>
- Hospital at home services for older patients with exacerbations of COPD in Italy has been shown to reduce hospital readmissions, depression and improve quality of life<sup>21</sup>

The literature review completed by Monitor<sup>22</sup> also found that many studies into community based health care reported the same clinical outcomes as patients treated in inpatient hospital care.

Our existing community services already deliver care at home, for example, our intermediate care service. The National Audit of Intermediate Care in 2014 and 2015<sup>23</sup> showed that models of intermediate care that include crisis response, home based care, bed based care and re-ablement all delivered good outcomes for patients. All outcome measures indicated that intermediate care successfully promotes and sustains the desirable outcome of functional independence. There was also strong evidence from the 2015 audit that intermediate care can also address the pernicious process of loneliness that affects a proportion of older people.

The King's Fund<sup>24</sup> also describes a number of alternatives to hospital care for older people and illustrates with examples of success which include:

- Hospital at home
- Community/virtual ward
- Tele-care for older people at risk
- Discharge-to-assess models
- Rapid access ambulatory care clinics
- Community and interface geriatrics

To fully implement successful alternatives to hospital, we will need to further shift the way services are delivered. We will need to promote to local people how to access these alternatives, explaining what they can expect and how these will enhance or improve the quality of care received. We must acknowledge the risks associated with moving treatment out of the hospital environment and into the community and in doing so, we must ensure that

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<sup>19</sup> Beswick et al, Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analyses, *Lancet* 371 (1): 725 – 735, 2008

<sup>20</sup> Laver et al, Organising health care services for people with an acquired brain injury: an overview of systematic reviews and randomised controlled trials, *BMC Health Services Research* 17 (14):397, 2014

<sup>21</sup> Riccauda et al, Substitutive "hospital at home" versus inpatient care for elderly patients with exacerbations of chronic obstructive pulmonary disease: a prospective randomized controlled trial, *Journal of the American Geriatrics Society* 56(3):493-500, 2008

<sup>22</sup> Monitor, *Moving healthcare closer to home: Literature review of clinical impacts*, 2015

<sup>23</sup> National Audit of Intermediate Care, 2014 and National Audit of Intermediate Care, 2015

<sup>24</sup> The Kings Fund, *Making our health and care systems fit for an ageing population* 2014

appropriate alternative services are put in place, that there is adequate investment into the community to meet the increase in demand and there are robust mechanisms for treating patients whose needs unexpectedly escalate.

## 4 Coping with Rising Demand

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Our existing services will not be able to cope with the forecast demand in the coming years. We want to help people to live the healthiest lives possible for as long as possible. This is not only what people want; it also eases the strain on the health and social care system.

### Prevention

Prevention and self-care requires a fundamental change to the way we view the relationship between patients and the healthcare system. It requires a move away from the traditional way of the expert clinician telling the patient what is best for them, towards a collaborative approach where the patient is involved in and takes control of their own health. It is more of a partnership with a clinician who listens to them and recognises them as the expert by experience.

The five year forward view argues that “the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade **in prevention and public health.**” [emphasis in the original]

It is estimated that 80 percent of cases of heart disease, stroke and type 2 diabetes and 40 percent of cases of cancer could be avoided if common lifestyle risk factors were eliminated<sup>25</sup>

There are many examples of successful studies using targeted prevention approaches to reduce incidents of chronic diseases. For example the Finnish Diabetes Prevention Study and the Diabetes Prevention Program in the USA both showed that intensive lifestyle modification slowed progression to diabetes by 58% over 3-4 years.<sup>26</sup>

Many of the key health behaviours significant to the development of chronic disease follow the social gradient for example, smoking, obesity, lack of physical activity and unhealthy nutrition<sup>27</sup>. Modelling by the Department of Health has shown that systematic and scaled-up secondary prevention is a cost-effective, clinically significant and fast way to tackle inequalities in health in local areas<sup>28</sup>

### Self-Care

Self-care and self-management involves people taking responsibility for their own health, developing an understanding of how their health condition affects their lives and learning

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<sup>25</sup> World Health Organisation, Preventing Chronic Diseases: A vital investment, 2005

<sup>26</sup> Lifestyle interventions to prevent type 2 diabetes, The Lancet 368 (9548) 1635-1636, 2006

<sup>27</sup> Fair Society, Healthy Lives, The Marmot Review, Strategic Review of health inequalities in England post 2010, 2010

<sup>28</sup> Department of Health, Tackling Health Inequalities:2006-08 Policy and data update for the 2010 national target

how to cope with their symptoms. A report by the Health Foundation<sup>29</sup> suggests that *“Supporting self-management has the potential to alleviate the pressure on health and social services caused by workforce shortages, rising demand for services, population increases and budgetary constraints.”*

The Health Foundation’s evidence review found that proactively supporting self-management and focusing on a person’s confidence to self-manage and behaviour change can have an impact on clinical outcomes, crises and unplanned admissions or other emergency service use.

A summary of evidence conducted by the Kings Fund found that self-care and self-management was effective in reducing admissions.<sup>30</sup> A Cochrane review of 29 studies found that self-management training for patients with chronic obstructive pulmonary disease improves quality of life and reduced the number of patients with at least one hospital admission related to lung disease and other causes.<sup>31</sup>

### **Wellbeing Coordinators**

Our proposals include the use of Wellbeing Coordinators who will use a strengths-based approach to practice including the use of guided conversations and self-management support tools. They will provide a more holistic approach acting as a link between a full range of statutory and non-statutory services.

Age UK’s Pathfinder project has developed a similar care coordination and navigation role to support older people identified as at risk of hospital admission. As well as developing a shared care plan with a multidisciplinary team based in primary care they look at a person’s social needs and the goals that are important to them. They encourage people to take the lead in their own care. The project has run since 2012 and early evaluation shows a significant increase in wellbeing, a 31 percent reduction in all hospital admissions and a 26 percent reduction in non-elective hospital admissions.<sup>32</sup>

The role of the wellbeing coordinator is also in line with NICE guidance for older people with social care needs and multiple long-term conditions<sup>33</sup>

## **5 Delivering Services that Meet Peoples Needs**

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### **Effective Minor Injuries Units**

In South Devon and Torbay, the urgent and emergency care pathway is being redesigned as part of the national Urgent and Emergency Care Vanguard initiative which sees different health and social care organisations (South Devon and Torbay Clinical Commissioning Group, Torbay and South Devon NHS Foundation Trust, Torbay Council, South Western

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<sup>29</sup> Helping people help themselves, a review of the evidence considering whether it is worthwhile to support self-management, The Health Foundation, 2011

<sup>30</sup> Purdy S, Avoiding Hospital Admissions, What does the research evidence say, 2010

<sup>31</sup> Zwerink M et al Cochrane Review, Self management for patients with chronic obstructive pulmonary disease, 2014

<sup>32</sup> NHS Confederation, Growing Old Together – sharing new ways to support older people, 2016

<sup>33</sup> National Institute for Health and Care Excellence, Older people with social care needs and multiple long-term conditions, 2015

Ambulance Services Foundation Trust, Devon Doctors Ltd and community pharmacy) working together to deliver a clear, streamlined and effective system. Healthwatch is also ensuring the input of patients and carers.

Minor Injuries Units (MIUs) were established to provide better care in the local community, filling a gap between GP services and A&E, reducing the number of patients going to the Emergency Department and reducing travel time for patients and families.

The importance of this was reinforced in a report ('Transforming urgent and emergency care services in England') by NHS England's medical director, Professor Sir Bruce Keogh who said:

*"for adults and children with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families..... helping people who need urgent care to get the right advice in the right place, first time.....providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments."*

We know that MIU attendances in South Devon and Torbay have been falling. Local research has provided us with valuable information on why this may be the case:

- SWASFT feedback at the MIU task group meetings was that the MIU service is not accessible at relevant times, is limited or not available. These inconsistencies result in guidance on their Directory of Services being unclear.
- In its 'Future of Community Hospital task group' report in 2012<sup>34</sup>, Devon Health and Wellbeing Overview and Scrutiny Committee visited a range of minor injuries units. Concern was expressed at the lack of a consistent level of service and irregular opening hours. It called for greater clarity about the range of services, clear communication with local communities and appropriate sign-posting to emergency services.

The task group, which included doctors and Minor Injury Nurses, concluded that to be safe, sustainable and efficient, MIUs need to have x-ray available, be open seven days a week and see at least 7,000 patients a year.

- In 2013/14 the task group also found that *"The overwhelming feedback was that the patients were aware there was some form of service, but very little evidence of what they could expect from that service, the main points being:*
  - *Lack of understanding of the service available*
  - *Specific services not available at all times, e.g. lacking in x-ray facilities*
  - *Opening hours inconsistent, not convenient and not as good as A&E*
  - *Lack of consistent weekend access and the need for a seven day service*
  - *Frustrations around non-appropriate presentation to MIU and being sent to hospital anyway*
  - *Better links required to Community Hospitals*

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<sup>34</sup> Health and Wellbeing Scrutiny Committee: Future of Community Hospitals Task Group, September 2012  
[http://www.devon.gov.uk/community\\_hospital\\_tg\\_final.pdf](http://www.devon.gov.uk/community_hospital_tg_final.pdf)

*However, when patients reported using the services, they were pleased and deemed them important local services that should be better used.”*

From what you have told us, we know that offering a consistent, reliable MIU service with excellent facilities means that patients are more likely to use it. For MIUs to be seen as a real alternative to A&E, they therefore need to be easily accessible, provide a treatment service led by a specialist nurse, be open 12 hours a day, 7 days a week, supported by imaging services with access to medical imaging review and be delivered in an environment that can support quality care.

### **Safe Staffing Levels**

Optimum and safe staffing guidelines set out the national standards for numbers and skill mix that must be met. One trained nurse to eight patients is the minimum safety standard for a hospital. A minimum of two trained nursing staff must be on duty at any one time.<sup>35</sup> In order to meet these safe staffing standards the minimum number of beds therefore needs to be 16, and must increase by multiples of eight thereafter.

## **6 Supporting the Ageing Population**

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We are able to live longer than ever before with 1.5 million of the UK population now over 85. This is associated with an increase in the number of people living with one or more long term conditions<sup>36</sup>

As such, our proposals also include multi long term condition clinics in each clinical hub to provide a one stop shop approach to help people managing multiple long term conditions. This is in line with NICE guidance on caring for older people with social care needs and multiple long-term conditions<sup>37</sup> which suggests care that is person centred and integrated.

## **7 Conclusion**

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Our population is changing. We are living longer and consequentially developing more complex health needs - many of which are preventable - putting greater demands on a system with fewer available resources, not designed for the needs of today.

In Torbay and South Devon we have more hospital beds than we need. Improving technologies means we are now able to manage more health problems outside of hospital and best practice in care delivery is shifting away from bed based care. We have an ageing population who, in some cases are remaining in hospital longer than

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<sup>35</sup> Royal College of Nursing, Mandatory Safe Staffing Levels, 2012

<sup>36</sup> House of Commons Health Committee, Managing the Care of People with Long-term Conditions, second report of session 2014-15, 2014

<sup>37</sup> National Institute for Health and Care Excellence, Older people with social care needs and multiple long-term conditions, 2015

they need, due to a lack of resources in other parts of the system. There are risks associated with this and these risks increase with age. The evidence supports the need to keep people out of hospital wherever possible and when it *is* necessary to be admitted, to minimise the length of time they spend there. In order to do this we must ensure safe, effective and accessible alternatives in the community with the appropriate level of funding. The logical solution is to move resources out of the traditional bed based services in order to bolster community services that meet the needs of our current and future population, for example, intermediate care provision close to home, support for multi-long term conditions and safe and effective MIUs.

Nationally, there is a drive towards better integrated services, with more being delivered in a patient's own home or local community and there is evidence that for some health conditions this can result in outcomes that are as good, if not better than bed-based care. This should be in combination with an offer of better opportunities for prevention and self-care to support people to live healthier lives. This will in turn improve patient outcomes, address health inequalities and reduce demand on the system.

The evidence clearly indicates the need to think differently if we are going to develop and deliver quality services fit for our current and future population.