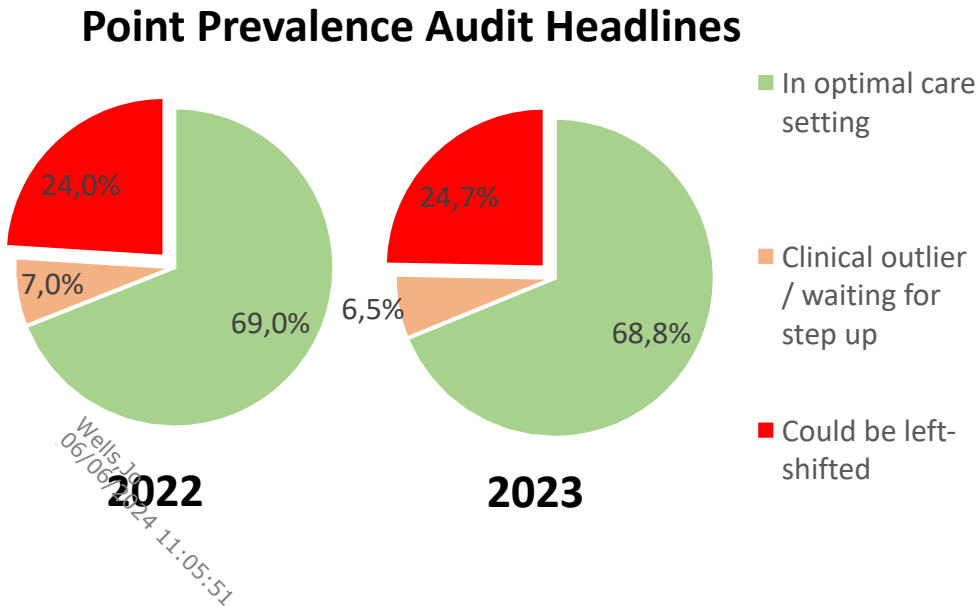


Understanding the issues and opportunities around “optimal care settings” – The Point Prevalence Audit

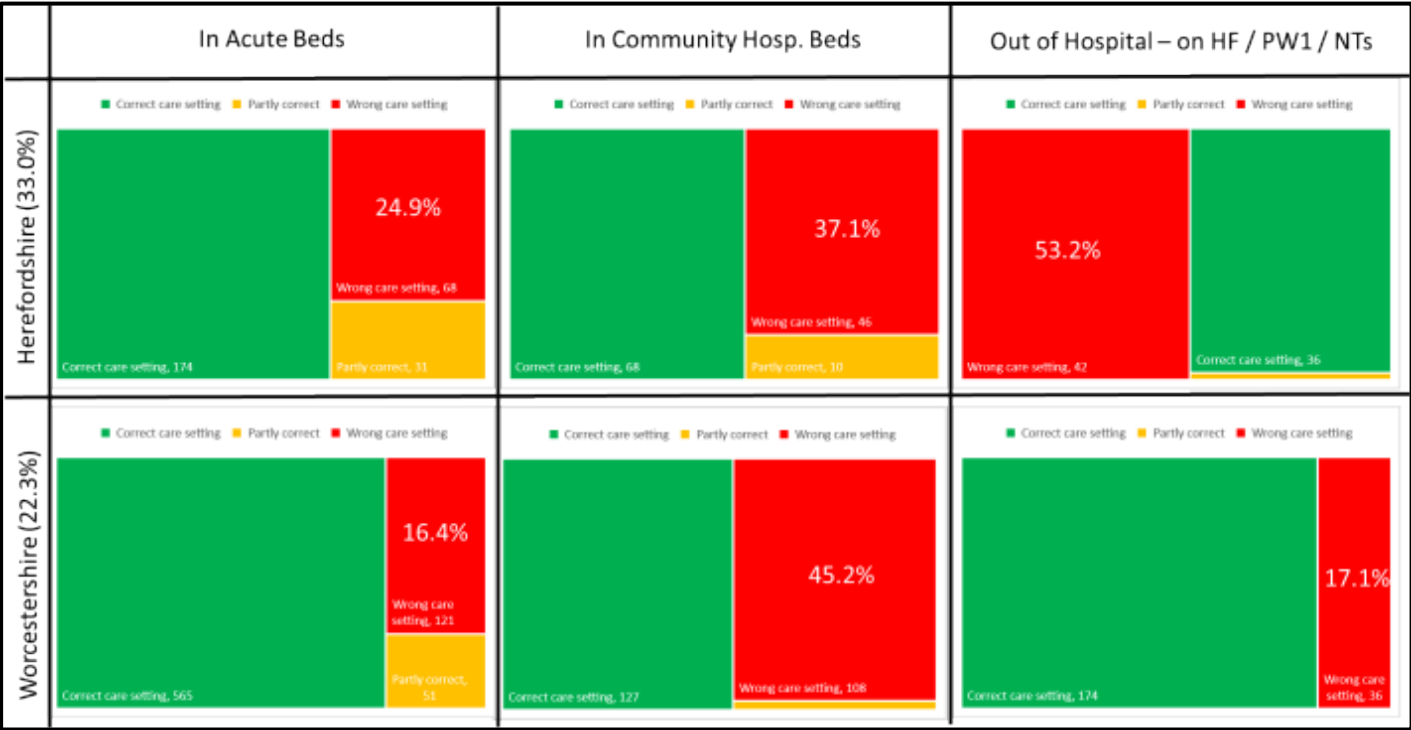
The Point Prevalence Audit

In September 2023 the system wide **Point Prevalence Audit** was conducted to assess the extent to which people in the health and care system are cared for in the most optimal care setting for their needs at the time. The audit, which replicated the method from a year before looked at 1,660 people across 88 care settings – including acute beds, community beds, discharge pathways and other home-based care such as community teams and virtual wards. The study showed that around 69% were in the right care setting, 7% were clinical outliers or waiting for “step-up” care, but 24% could have been cared for in a lower level of care, that would have been more optimal for their needs.



- 1,660 patients audited over 88 care settings to answer the question
- *Is this the optimal care setting for the patient’s needs today?*

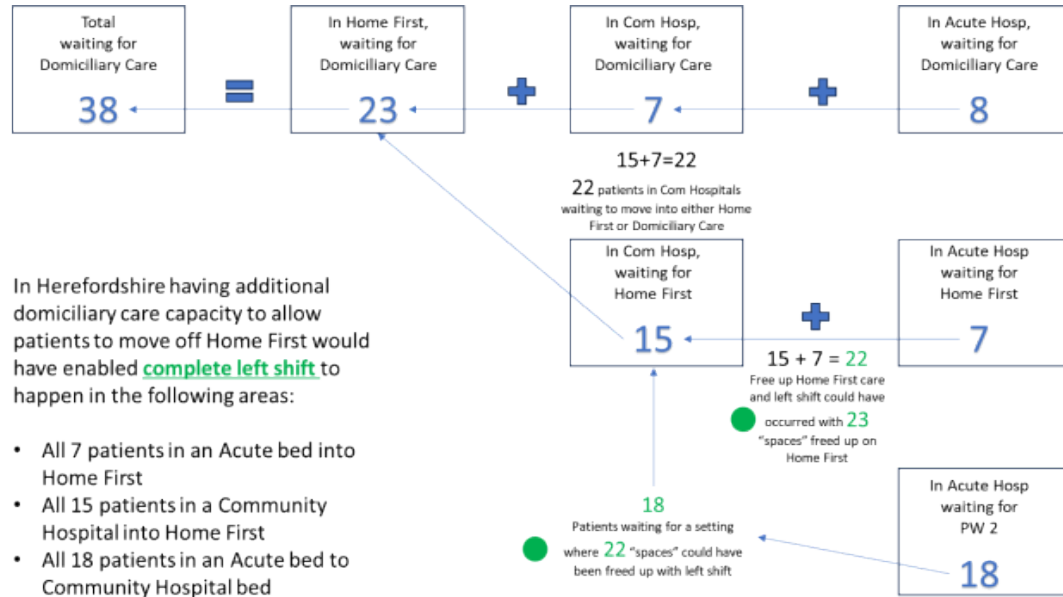
2023 Detailed results – analysis by setting



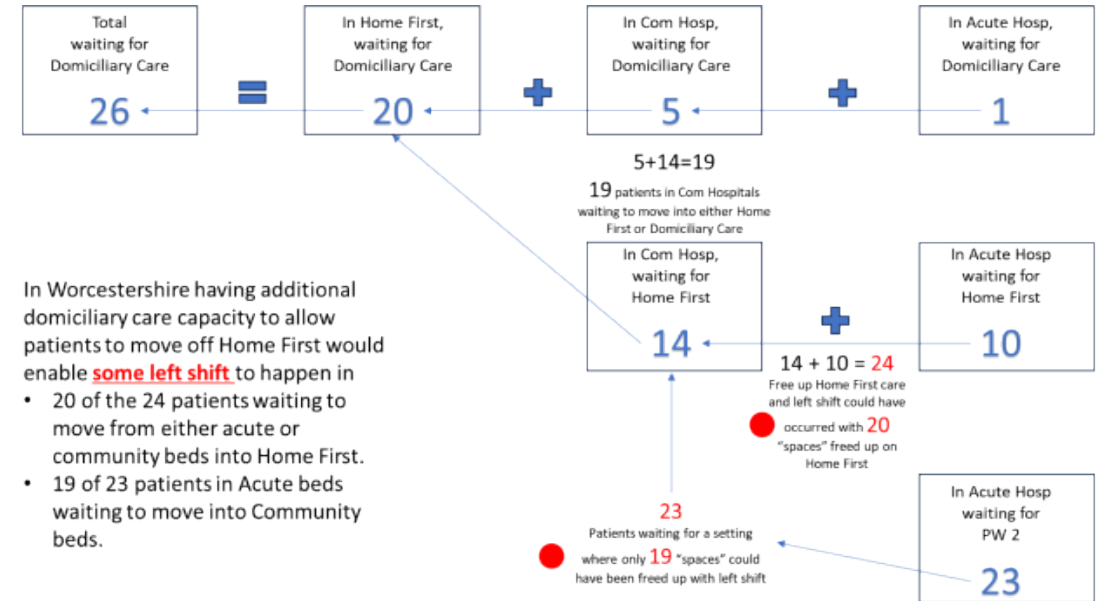
Whilst the overall percentages have not changed significantly between 2022 and 2023, the patterns across the two counties are very different. For 2023, in Herefordshire there was a significantly greater proportion of patients in acute settings deemed ready for step down and a particularly significant issue in out of hospital care. More than half of patients were deemed to be ready to move out of that care setting. This pattern was not replicated in Worcestershire. There was a significantly smaller proportion of patient in out of hospital settings waiting to move, but nearly half of patients in community hospitals were ready for step down.

What would it take to achieve “left shift” in the two counties

Left Shift in Herefordshire



Left Shift in Worcestershire



- On the day of the PPA, with 23 people in total waiting to depart out of hospital settings, but only 22 people waiting to enter on that day, **complete left shift** could have occurred if capacity in domiciliary care could have been accessed in a more timely way.
- Similarly, with 22 patients waiting to depart community hospital beds, but only 18 patients waiting to enter them, again **complete left shift** could have realistically been achieved if the right domiciliary care capacity was accessible.

- On the day of the PPA, with 20 people in total waiting to depart out of hospital settings, but 24 people waiting to enter on that day, **some left shift** could have occurred if capacity in domiciliary care could have been accessed in a more timely way.
- Similarly, with 19 patients waiting to depart community hospital beds, but 23 patients waiting to enter them, again **some left shift** could have realistically been achieved if the right domiciliary care capacity was accessible.

The financial modelling to calculate the annual cost of “getting it wrong” demonstrated an opportunity cost of **£21.1m**. Whilst this is theoretically realisable saving to the NHS, it is not a saving to the Integrated Care System as a whole because it would necessitate a significant increase in social care spending. Furthermore, the calculation represents a “perfect” scenario, where people can immediately be moved to the correct care settings. Rarely is it the case that optimization of this nature can be achieved so the total figure should be viewed as a theoretical opportunity cost, of which a proportion should be realizable as a financial saving.

Building system consensus towards driving the shift upstream to more prevention and best care in the right setting

Achieving this shift in focus cannot be achieved without system consensus. Practical implementation requires capacity to be shifted between different care settings and different providers. Typically, it involves building capacity in social, primary and community settings to free up resources in bedded facilities in community hospitals, acute hospitals and mental health inpatient facilities.

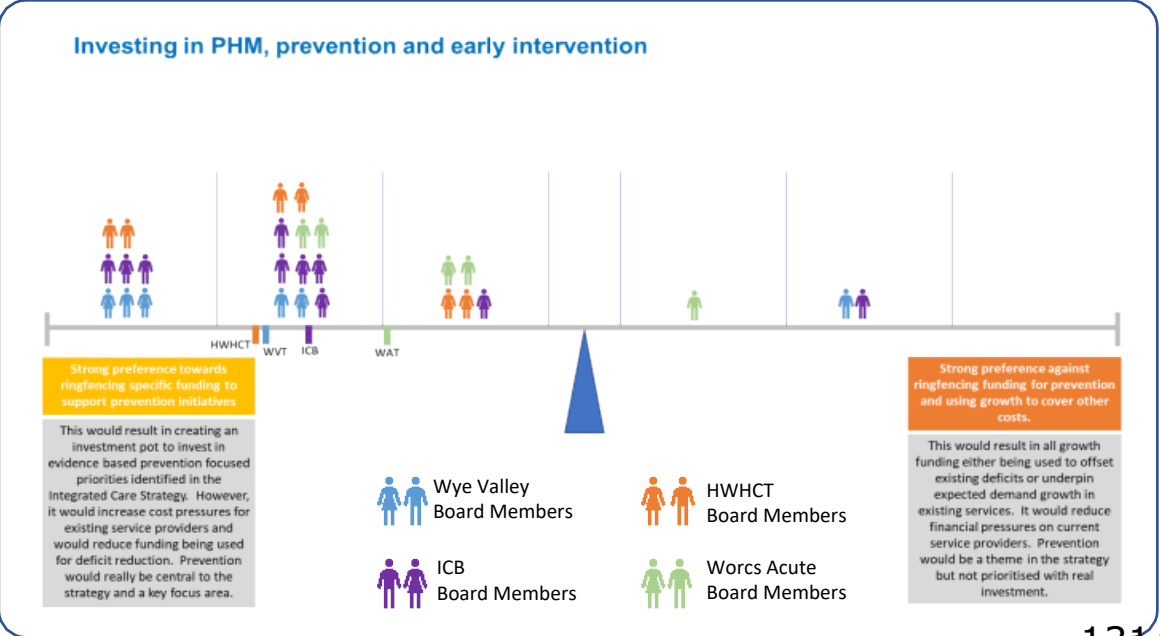
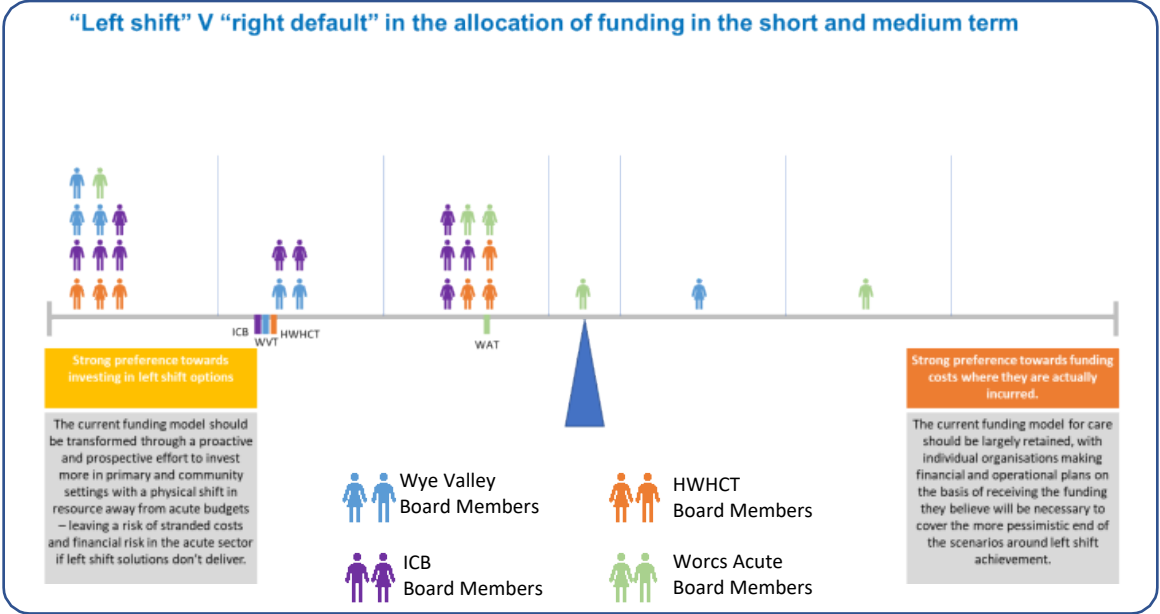
In order to test this consensus a **strategic choices** exercise was undertaken with the main board of the ICB and the non-executive directors of the three NHS Trusts. Individual Board Members were invited to review a briefing pack and complete a Mentimeter exercise to explore their individual perspectives on the shift in focus. For two questions, they were offered mutually exclusive options and asked to move a “slider” towards each option they thought was most desirable – the stronger the viewpoint, the further the slider should be moved. The results are shown the in charts to the right.

The scores were aggregated up to form the organisational score and the results were used in facilitated discussions at a series of face-to-face workshops. Participation in the exercise across each organisation is shown in the table below:

H&W Integrated Care Board	Wye Valley Trust	H&W Health and Care Trust	Worcestershire Acute NHS Trust
• Chair • Chief Executive • 5 Non-Executive Members • 2 Primary Care Partner Members • 1 Local Authority Partner Member	• Chair • Managing Director • 3 Non-Executive Directors	• Chair • Chief Executive • 4 Non-Executive Directors	• Chair • Chief Executive • 3 Non-Executive Directors

The charts show the results, both from an individual perspective (anonymized) and from the collective aggregate organizational view. There is clearly a preference across all organisations for setting a strategy that aspires towards the shift in focus (top chart) and supporting this with a funding regime that ringfences investment for prevention initiatives (bottom chart).

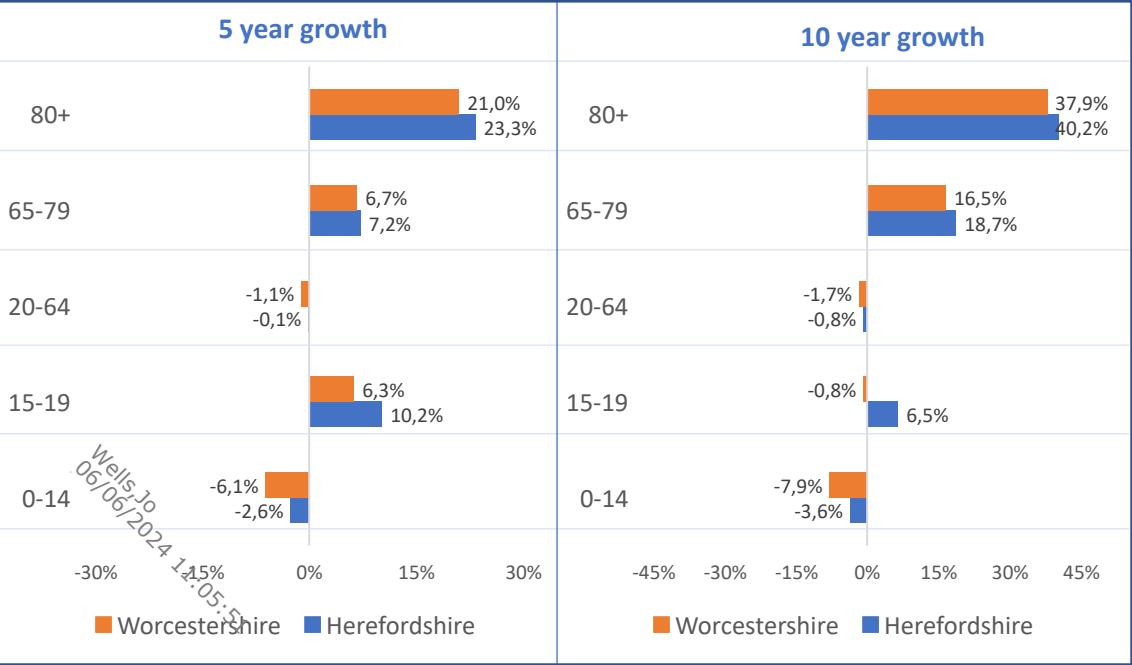
This strong degree of consensus provides a strong platform from which to drive the shift in focus as as the core foundation of the Joint Forward Plan.



Developing a better understanding of future demand and capacity requirements

The final element in the strategic planning work to support the development of the JFP has been the development of a system wide **strategic demand and capacity model**. The point prevalence audit results indicated that there is a mismatch between demand and capacity; which ultimately leads to people being treated in care settings that are not optimal for their needs, frequently at higher cost to the system. The first phase of the demand and capacity model work has been to quantify the future impact over 5 years of not optimizing the provision of care. The second phase of the work, to be conducted during the first 3-6 months of JFP implementation will be to model the potential solutions to mitigate that growth in demand.

Population growth: Population numbers are forecast to grow most in the older age groups in the population – more than 20% over 5 years and nearly 40% over 10 years for people aged 80 years or more.



Likely Impact on Frailty Demand: Whilst age alone is not an indicator of future health demand, it does provide a basis for calculating likely levels of frailty that services are likely to be responding to. Initial model projections suggest the following impact:

Frailty Risk Category	10 Yr impact – Herefordshire	10 Yr impact – Worcestershire
No frailty score	+21%	+21%
Low score	+19%	+17%
Moderately low score	+28%	+27%
Moderately high score	+33%	+32%
Highest score	+36%	+38%

Unmet demand: The model calculates the impact of unmet demand (such as people waiting in ambulances or on trollies in A&E that would be admitted if beds were available). However, they are often cared for in unconventional settings for their whole hospital stay.

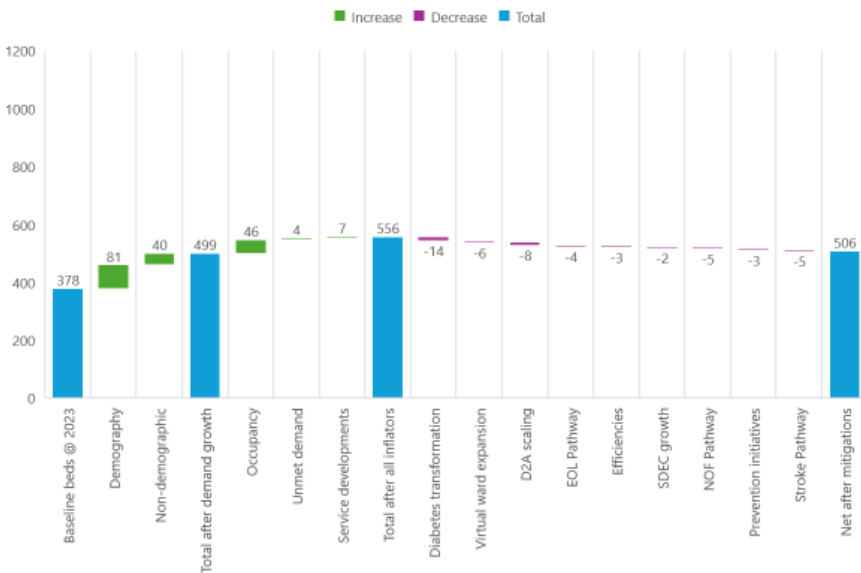
Sub-optimal flow: The model also calculates the impact sub-optimal flow on projected future bed numbers. There are two main mitigations to this, one of which is increasing the size of the bed pool to enable better flow, the other is to optimize practice to ensure that patients are only admitted when necessary and don't have any delays to their discharge.

Initial aggregate demand impact: Bringing together all aspects of growth, the draft model indicates future demand growth that will need to be mitigated by actions to be delivered under the JFP is an additional 274 beds.

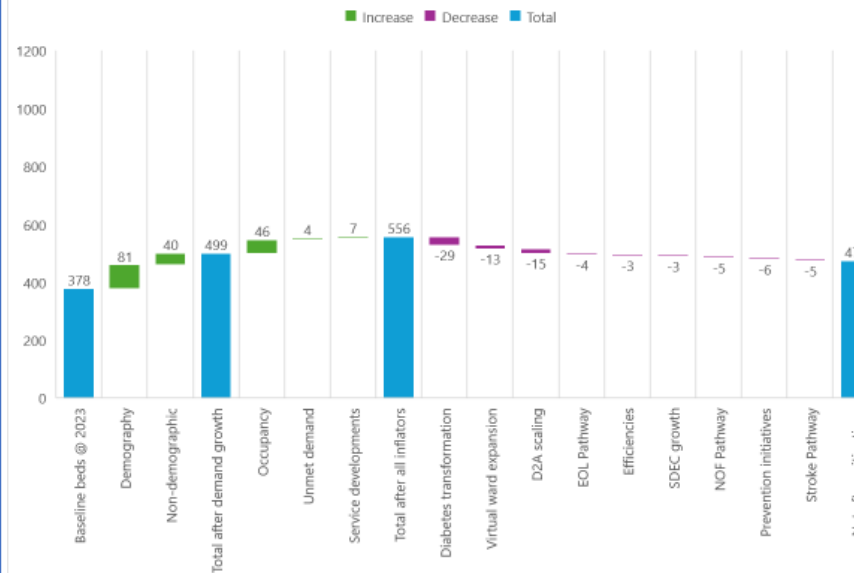
Aggregate acute bed requirement in 10 years under the do nothing scenario	Acute Bed Impact
Baseline beds	1,229
Demographic growth	+236
Non-demographic growth	+129
Measure of un-met demand	+8
Impact of sub optimal flow	+83
New service developments	+28
Mitigations, efficiencies and transformation programmes	-123
Net ten year bed requirement for acute care	1,540

Developing a better understanding of future demand and capacity requirements – modelling the mitigations

Herefordshire - Mid Range Scenario



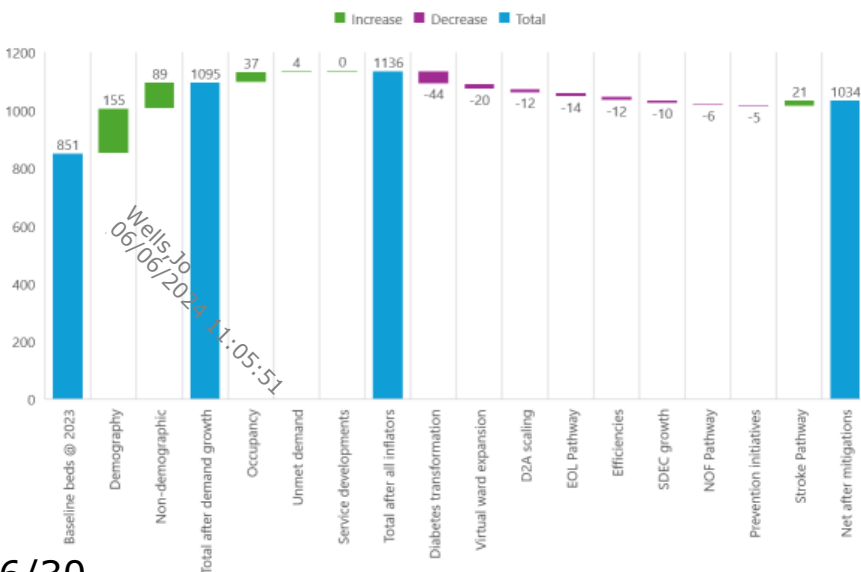
Herefordshire - Optimistic Scenario



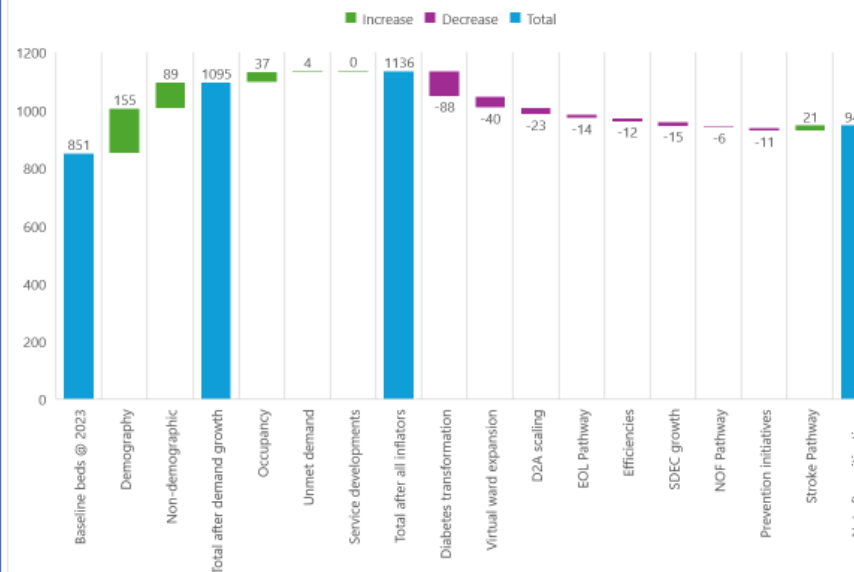
Herefordshire

- **Mid-range scenario** bed requirement by 2033 grows from 378 beds to 506 beds (+128).
- **Optimistic scenario** bed requirement by 2033 grows from 378 beds to 473 beds (+95).
- **Occupancy improvement** calculation is equivalent to 46 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations:** The biggest mitigation opportunities are diabetes transformation and D2A pathways.

Worcestershire - Mid Range Scenario



Worcestershire - Optimistic Scenario



Worcestershire

- **Mid-range scenario** bed requirement by 2033 grows from 851 beds to 1034 beds (+183).
- **Optimistic scenario** bed requirement by 2033 grows from 851 beds to 948 beds (+97).
- **Occupancy improvement** calculation is equivalent to 37 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations:** The biggest mitigation opportunities are diabetes transformation and virtual ward scaling.