Manchester
Integrated Care Partnership

Manchester Partnership Board	
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Date of paper:	01 November 2023
Item number:	4
Subject:	Prevention and Admission Avoidance
Recommendations:	MPB is asked to: • Note the elements of the work being undertaken across the Manchester system on prevention and admission avoidance; • Consider the initial feedback from Newton Europe's diagnostic work, and consider the further steps that follow from this; and • Endorse the continued work on the admissions avoidance component of the Keeping Well at Home Programme, and the further rollout of Hospital at Home.

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1. Strategic Context

1.1 Over the past five years, the development of integrated health and social care working in neighbourhoods has been a key strategic goal to support prevention and care closer to home. The Local Care Organisation (LCO) was established by all the partners in Manchester to create operational Integrated Neighbourhood Teams to design and deliver a co-ordinated health and social care prevention approaches in place. There is more to do to integrate the work of the neighbourhood teams across place, and this work is progressing as a priority.

1.2 This approach aligns closely to the work being undertaken across GM on prevention and the development of a Strategic Financial Framework. The long-term financial sustainability of the system relies on an increasing emphasis on avoiding ill health and keeping people healthier for longer. The challenge will be to continue to scale up investment in these areas, whilst recognising the immediate financial and operational pressures being felt across the system. We need to address these tensions head on and navigate a common route forward.

2. Key elements of our approach

2.1 The LCO neighbourhood teams use a **Public Health Management** methodology to upscale targeted prevention work in neighbourhoods. This is a core part of Making Manchester Fairer. This year, the first comparable datasets on targeted improvement work on diabetes prevention, increasing the uptake of bowel screening and preventing heart disease will be available. A full update on our population health management work is going to the Provider Collaborative in November.

2.2 The **Better Outcomes Better Lives** (BOBL) programme has seen a more stable, strength-based approach taken to assessing care needs, and has put adult social care on a more sustainable financial footing (albeit demand is increasing).

2.3 **Keeping Well at Home** is our adult admission avoidance programme. The first priority of this programme was to develop a 'hospital at home' service across the City, with the underpinning infrastructure to manage more complex illness in community settings. This programme also responds to an NHS England mandate to create 320 'virtual beds' across Manchester and Trafford by the end of 2023/24. Further detail around progress on hospital at home is below.

2.4 As part of Keeping People Well at Home, we have adopted a '**Back to Basics**' approach within MFT, which is being rolled out across an increasing number of wards. This is focused on a strength-based need assessment when a person is medically fit, creating a more resilient approach to discharge at a system level. This work is receiving external scrutiny through Newton Europe's Tier 1 work outlined above. The learning from this will enable us to continue to improve our approach to discharge and target key actions to improve flow.

2.5 Finally, MRI has been placed into **Tier 1 for Urgent and Emergency Care** (UEC). This designation has seen additional support provided from NHS England around electronic bed management, Getting it Right First Time (GIRFT) support, and a diagnostic led by Newton Europe, which seeks to map the patient journey through the system and to assess demand and capacity, identifying areas of stress within the system and suggest interventions to alleviate this stress. The Newton Europe work is developing at pace, and they will share their initial feedback at the Partnership Board meeting.

2.6 This remainder of this paper focuses on the admission avoidance element of the Keeping People Well at Home programme.

3. Admission avoidance programme

3.1 There has been significant progress in rolling out our admission avoidance model since the paper presented to the Partnership Board in July. Evidence from the pilot has been reviewed and has been incorporated into a high-level outline business case to secure funding so that a City-wide Hospital at Home offer can be in place for Christmas 2023. MFT Executive Director Team (EDT) have supported the funding request and the winter roll out plan.

3.2 The Hospital at Home roll out will bring together existing virtual wards with the community-based pilot in central Manchester, creating a consistent city-wide offer. These existing services typically aim at preventing readmissions following a spell in hospital by using remote monitoring technology to enable a proactive response when a patient is at risk of an acute emergency. The existing services create on average 96 virtual beds per day, based on the snapshot data reported back to NHS England

Site	Total patients on daily snapshots	% share
MRI	564	23%
NMGH	555	23%
Wythenshawe	853	35%
Crisis overperformance	309	13%
H@H pilot (central)	178	7%

Table 1: a summary of current virtual ward daily snapshots 23/03-07/09

3.3 In addition to the existing virtual ward offers the city-wide Crisis Response services (part of the Manchester Community Response suite of services) prevents an average of 300 admissions per month. An element of this activity is recorded in the virtual ward daily snapshot because Crisis exceeds its commissioned volumes of activity and so it is included in the virtual ward submission so that the full activity is recorded.

3.4 The city-wide Hospital at Home offer goes beyond the scope and capacity of these existing services to prevent more admissions from more groups of Manchester citizens.

4. Learning from central pilot

4.1 The community-based pilot in central Manchester tested an enhanced Hospital at Home model. This model is based on creating a workforce and infrastructure in the community, which enables the safe care of frail patients who have not been medically optimised.

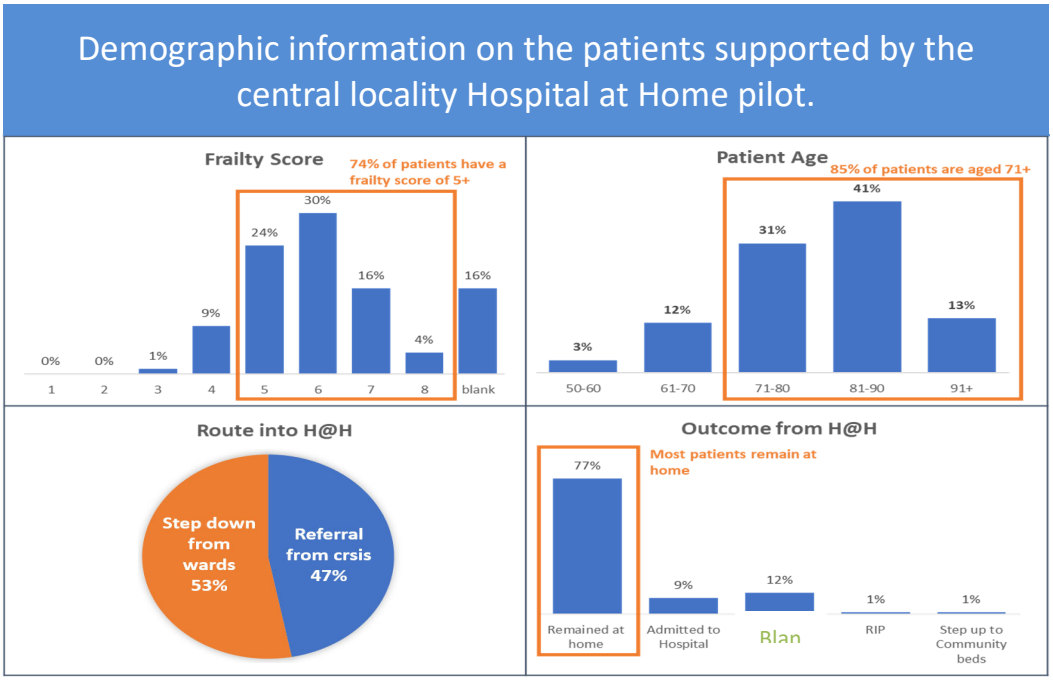
4.2 This pilot has run for twelve months and there has been significant learning from this period:

- The pilot has supported circa 300 patients.
- 85% of patients are aged 71 or older.
- 74% of patients have a frailty score of 5 or more (a score of 5 is ‘mildly frail’ on the Rockwood Frailty Score).
- 47% of patients in the model have been based on referrals from Crisis; this means that patients in the community were reviewed by Crisis and stepped up to the pilot to prevent

a hospital admission.

- 77% of patients in the pilot remained at home following their intervention.

4.3 This evidence suggests that the Hospital at Home model is capable of supporting frail and elderly people who can currently only be supported by admission to hospital and inpatient stay. This is because the Hospital at Home multi-disciplinary team includes oversight from a hospital consultant, and a GP, alongside nursing, therapy, and social care roles. This mix of staff means that there is a sufficient level of senior clinical decision making, alongside the skillsets required to manage the complexities of frailty.



4.4 There is also a Children's Virtual Ward established by the Royal Manchester Children's Hospital, which supports 20 children per day. This activity is not included within the *Keeping People Well at Home* programme or the Hospital at Home roll out because there is already an established and mature programme of work to oversee the development of the children's offer. The programme focused on adult patients will use opportunities through programme boards and symposiums to learn from the children's work.

4.5 The pilot in the central locality has created a template Hospital at Home team of c16 roles, creating a resilient multi-disciplinary team. North and south localities are also recruiting to their structures. The pilot showed that external recruitment took a long time. A recruitment sub-group has been established to help build community teams and combine external recruitment with options around deployment of existing staff. The biggest challenge has been in recruiting to Advanced Clinical Practitioner roles in south locality, which are critical for a safe go live.

5. September Symposium

5.1 The second Hospital at Home symposium on 18 September brought system partners together to focus on the operational rollout of the programme. This set out the 'one team approach' that allows MFT staff to move between care settings and go to patients, meaning patients can benefit from the expertise and resources of acute hospitals in their own homes.

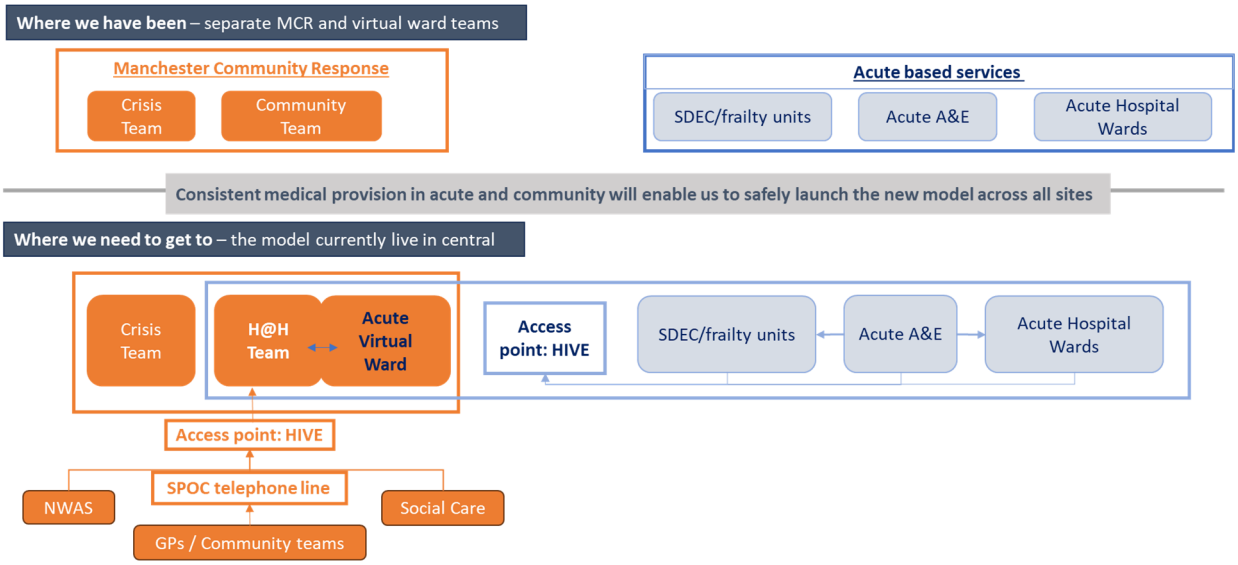


Fig 2: the future operational model of Hospital at Home

5.2 Each locality also fed back on progress. Clinical leaders discussed their work on Hospital at Home with one care of the elderly consultant saying this work was 'the highlight of [her] career' because it gives her the chance to offer really high-quality care, to very unwell patients, in their own homes.

5.3 A further symposium will be held in February 2024 and focus on the progress of operational roll out and the delivery of Hospital at Home activity against plans.

6. In year investment agreed by MFT to enable rollout

6.1 As outlined above, a high-level outline business case was submitted to MFT EDT to secure in-year funding to enable a City-wide roll out before Christmas. The was predicated on creating the infrastructure to manage frailty, and a critical part of this is securing hospital consultant time. To create a 'safe' go live position, EDT were asked to agree funding for five Direct Clinical Care (DCC) sessions per week, which means one session of consultant time per weekday.

Breakdown of phase one costs	North	Central	South	Total
Consultant sessions to enable new model to safely go live	£42,000	£50,000	£33,000	£125,000
Additional IV to enable HF go live		£60,500		£60,500
Additional High Intensity Users programme	£30,000	£30,000	£30,000	£90,000
Remote monitoring kit	£15,000	£10,000	£15,000	£40,000
MRI unfunded consultant post		£50,000		£50,000
			TOTAL	£365,000

Table 2: the linear investments supported by MFT EDT

6.2 In addition, EDT agreed to support:

- *Additional community IV* capacity which enables patients diagnosed with Heart Failure to be supported on Hospital at Home. This is being rolled out to central locality first because they have a community team established under the pilot, but it will also be rolled out to the other two localities.
- *Remote monitoring kit* so that there are sufficient devices to enable proactive monitoring of patients on the pathway (this is not suitable for all patients).
- *High intensity users programme* which is an NHS England sponsored programme which recruits staff to work with patients who attend A&E twenty times or more per year. There will be one staff member per hospital who will connect these individuals into community-based support (both formal and informal forms of support) so that they do not use A&E as a place of first recourse to manage their needs.

6.3 The total quantum of funding will put in place the resources to enable a city-wide roll out. Achieving roll out is subject to the roles being recruited to and team infrastructure being in place.

7. Roll out plans per locality

7.1 Patient safety will guide the roll out and expansion of Hospital at Home. The process will be cautious so that system partners can learn from and understand the full implications of the model before taking further steps. The roll out plan for each locality is as follows:

Date	Pathway to switch on
16/10/23	**Central locality** will start to increase delivery of ***frailty*** to achieve maximum activity
06/11/23	**North** locality will commence delivery of ***frailty***
04/12/23	**South** locality will commence delivery of ***frailty*** **Central locality** will commence delivery of ***heart failure***
The impact of achieving phase one will be to create between **80 to 100 additional Hospital at Home virtual beds per day** (from the baseline position of 100 beds per day in August 2023).	

7.2 An update against the roll out plan:

- *Central locality* is increasing its capacity to deliver frailty step down. The Manchester Royal Infirmary (MRI) have identified consultants to make up the 5 DCCs per week. During the week commencing 16 October the team increased their capacity by five patients per day.
- *North locality* is planning a soft go-live throughout November and will aim to support five patients per day by the week commencing 20 November. All staff are in place or will be in place during November.
- *South locality* is the biggest risk area because they have not been able to recruit to Advanced Clinical Practitioner (ACP) posts in their model. These posts are critical for creating the capability for managing frailty in the community. The MFT Group Executive Director of Nursing is working with the Wythenshawe Hospital Director of Nursing and the

Local Care Organisation Director of Nursing to identify ACP resource who can be deployed into these posts to enable go-live.

7.3 There will be specific communications to GPs in each locality as Hospital at Home rolls out to their localities. For example, there will be webinars so that GPs can meet their local Hospital at Home team, understand the routes of referral into the service, and ask questions of the sorts of patients in scope for support. The first of these webinars took place on 1 November in central locality. In the first instance, GPs will be able to access Hospital at Home by making referrals as per usual practice to crisis response. The crisis response team will stabilise the patient and can then decide on onward referral to Hospital at Home if appropriate.

8. Next steps beyond winter

8.1 This paper has so far focused on Phase 1 of the Hospital at Home rollout. Phase 2 will focus on establishing in reach to cardiac and respiratory specialisms in acute sites. These are two of the national Hospital at Home pathways so will be prioritised once the frailty pathways have been switched on.

	Phase 1	Phase 2	Phase 3
Timeframe	Q3 23/24	Q4 23/24	24/25 onwards
Pathways	Frailty all localities and heart failure in central	Heart failure and respiratory in all localities	Maximise delivery on all pathways
Target additional capacity	**80-110 additional virtual beds** (total target for 2023/24 of 180-210)		**110 additional virtual beds** (total target of 300-320)
Additional resources required	• 5 DCCs per locality • Additional IV capacity in central locality • Funding for High Intensity Users programme (to reduce ED pressure) • *MRI pilot pressure (unfunded consultant time)*	• Additional IV capacity in south and north localities • Ongoing build-up of community teams • Funding for remote monitoring kits	• 10 DCCs per locality • Community teams to be fully established in all localities • Permanent consultants in each team • Funding solutions to be made recurrent

Table 3: the future phases of Hospital at Home roll out

8.2 Phase 3 in the next financial year will focus on driving up and maximising the utilisation of Hospital at Home capacity. Achieving phase 3 will meet the NHS England target of 320 virtual beds across Manchester and Trafford.

8.3 During 2024/25 Hospital at Home capacity will be built into the MFT's annual plan so that the capacity can be used to offset demand for hospital beds in the acute sites. Incorporating Hospital at Home into the planning process will mean that there is an opportunity to create a sustainable funding mechanism for the service. The implications of this will be worked through as part of the annual planning process.

9. Recommendations

9.1 MPB is asked to:

- Note the elements of the work being undertaken across the Manchester system on prevention and admission avoidance;
- Consider the initial feedback from Newton Europe's diagnostic work, and consider the further steps that follow from this; and
- Endorse the continued work on the admissions avoidance component of the Keeping Well at

Home Programme, and the further rollout of Hospital at Home.