Integrated Care Value Case

North Devon, England




November 2013

This Value Case has been commissioned by the Local Government Association with support from the national partners on the integrated care and support collaborative

Local Government Association · adass directors of adult social services · Department of Health · NHS England · Public Health England · scie · Monitor Making the health sector work for patients · think local act personal · NHS Improving Quality

Produced by integrating care

Guiding principles for the value case:

The overall goal of this work is to develop value cases which are:

- Aimed at Health & Wellbeing Boards

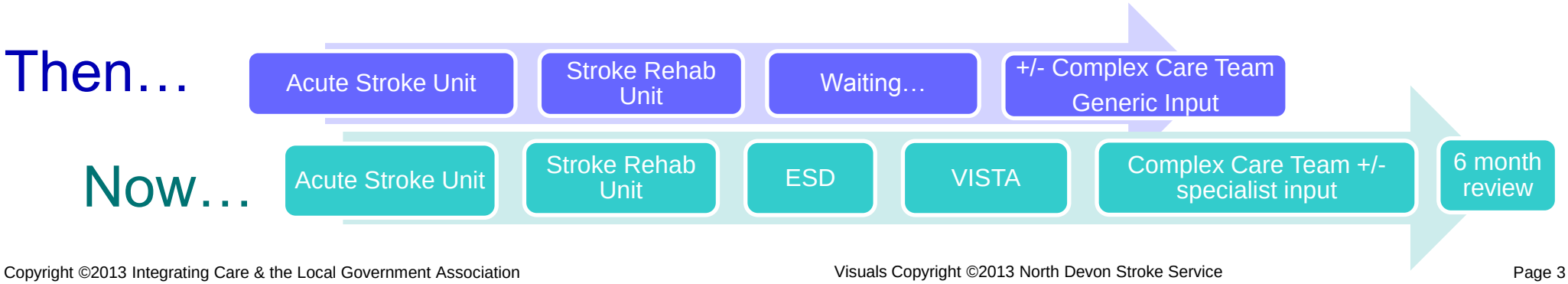
And incorporate:

- Service user stories, capturing changes to the service user's journey
- Features of the model, including enablers (e.g. technology initiatives to support the model)
- Costs of the model
- Evidence of benefit, including activity, spend and outcomes

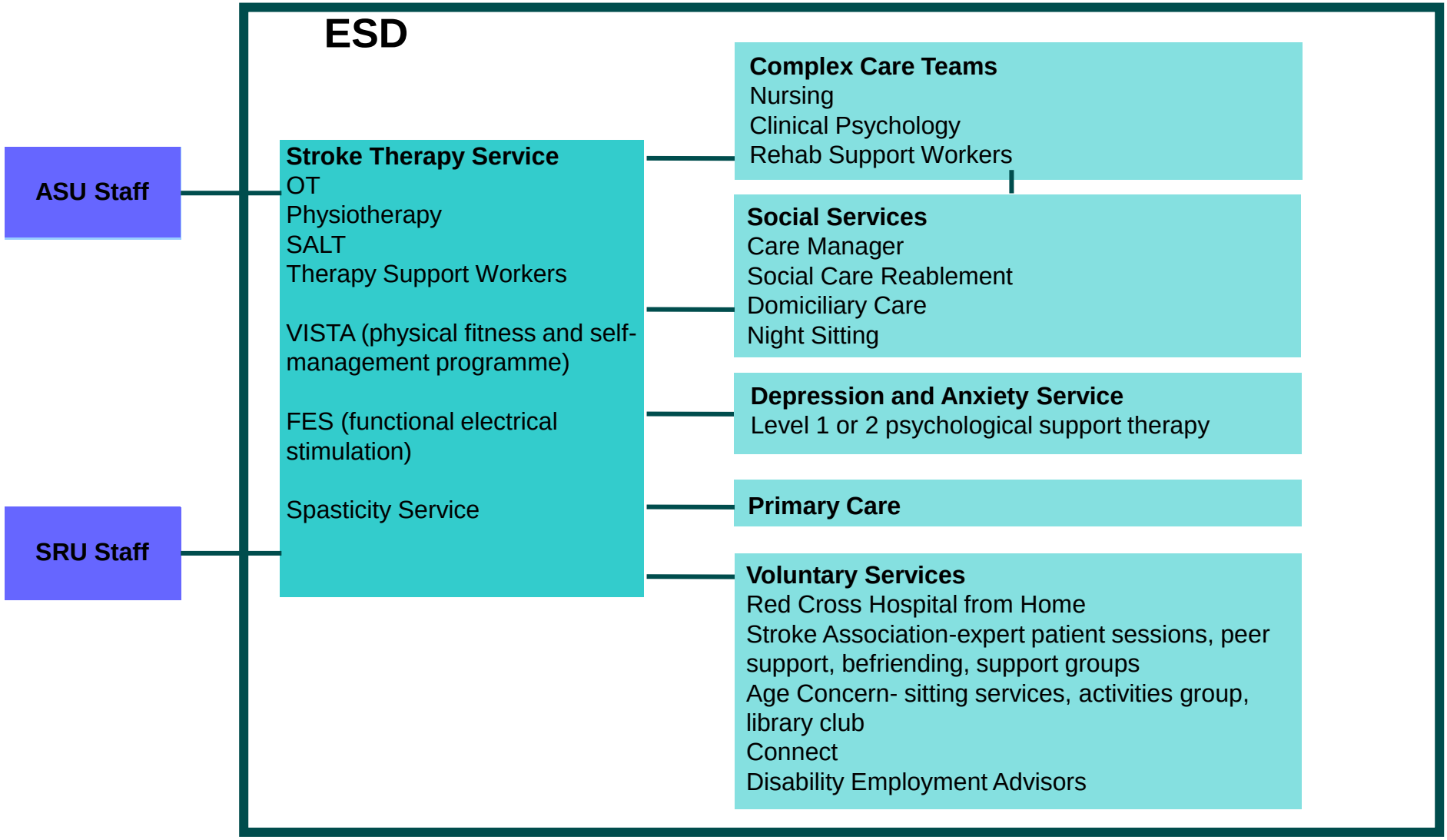
We recognise that the information contained in the value case may prompt further questions, in which case we recommend you use the contact details at the end of the value case to follow up with a direct contact.

About Northern Devon Stroke Service

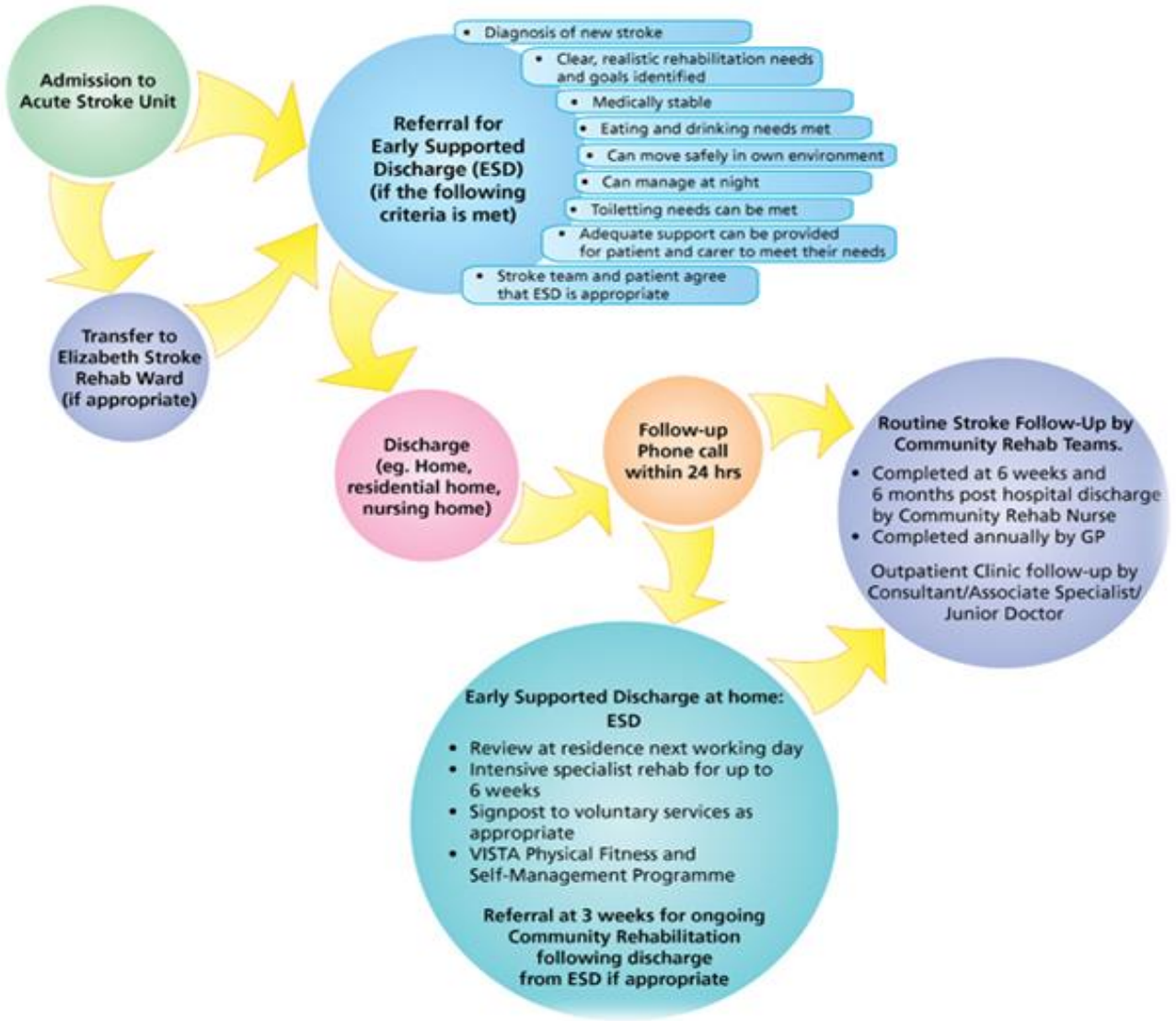
- North Devon Health Care services serve a population of 164,500 people covering 950 square miles.
- Around 150,000 people suffer stroke every year in the UK. Many die as a result, and many more suffer long-term disability. Around 400 of these people – nearly one every day – end up in North Devon District Hospital.
- Poor outcomes led to high long term costs for these individuals, their families and the health and social care system.
- The Northern Devon Stroke Service was introduced as a result. The service consists of the Acute Stroke Unit (ASU), a-10 bedded unit located at North Devon District Hospital, the 12-bedded Stroke Rehabilitation Unit located at Bideford Hospital, Early Supported Discharge (ESD) teams (consisting of physiotherapists, occupational therapists, therapy support workers and speech & language therapists) enabling appropriate stroke patients to return home sooner, and VISTA - a 12 week exercise, advice and support service.



North Devon Stroke Service visual model



A typical patient journey



"These services have been invaluable. It was fantastic to have the team visiting mum's home on a daily basis for several weeks; giving her physical, emotional and psychological support."

Outcomes evidenced by Northern Devon Stroke site: What difference does it make?

User experience

- Patient experience surveys and patient stories reveal high satisfaction with the service that patients have described as 'exemplary'

Frontline staff experience

- "It's incredibly motivating to work in such a dynamic, proactive and forward thinking interdisciplinary team that delivers real benefits to patients"
- "It's so valuable to be involved at every stage of the patient's journey"
- Minimal staff turnover

Health & wellbeing outcomes

- Improved physical and psychological wellbeing:
  - EuroQOL increased by 18%
  - Nottingham ADL scores increased by 24%
  - Self-Efficacy scores improved by 15%
- Reduced dependency – Barthel scores increased by 15%
- Improved function – VISTA: 28% increase in walking speed after 12 weeks and 26% increase in walking endurance 9 months after programme completion.
- 86% of participants had improved their diet, lost weight, stopped smoking and/or continued to exercise

Impact on institutional care

- Time on Acute Stroke Unit reduced by 4 days
- Time on Stroke Rehab Unit reduced by 7 days
- Autumn 2013 additional beds will enable direct admission targets to be delivered
- 13% more patients are returning home as opposed to a care home

Impact on cost

- Super-spell length of hospital stay for stroke patients last year fell by 6 days, resulting in £840,000 in bed day savings
- Largely delivered by reorganising use of existing staff and facilities to deliver specialist services. Reduced system costs for long-term support.

Productivity

- 21% increase in patients being admitted to specialist Stroke Ward
- Access to thrombolysis and CT achieved
- 75% reduction in referrals to community therapy teams for ongoing rehabilitation
- Last year, 92% of all new stroke patients discharged from hospital were supported by the ESD service

"Mum trusted them and as the weeks progressed, she was encouraged and enabled to get 'out and about' again and resume her normal activities. They gave her great confidence and I am convinced that she would not have achieved so much without the team."

How we did it: key enablers

Governance

- Northern Devon Healthcare NHS Trust is an integrated organisation running acute hospitals
- Community hospital and services and social care services
- Stroke Services Strategy and Operational Group
- Measuring and monitoring progress – performance, SSNAP

Workforce development and OD

- Moved from all physicians, therapists and nurses looking after stroke patients to specialists including in-reach social care
- Stroke Team attended NHS Institute event re EBD and emotional mapping
- All stroke specialist staff complete stroke specific competency training

User and carer co-design

- Patient stories about their experience, patient experience surveys and patient ideas for service improvement are routinely collected and actioned
- Patient representatives form part of the membership of the Stroke Clinical Pathway Group, along with providers and commissioners

Legal and contracting Models

- Able as integrated provider Trust to support a shift to increased community delivery
- 2013/14 CQUIN payment framework for TIA (Transient ischaemic attack)

Financial enablers

- Investment in improved physical accommodation
- £320,000 investment from commissioners in Early Supported Discharge (Therapy and Neuropsychology)

"Prior to my stroke I was depressed and inactive. VISTA has given me a new lease of life! I now feel more positive and confident and ensure that I get out and about everyday"

What we did: integrated care design

Workforce

- Appointment of Stroke Unit Ward Manager and Stroke Therapy Service Lead
- Neuropsychologist to support patients across the whole pathway
- Stroke skilled specialist therapy staff work flexibly between the stroke units and ESD
- Development of Assistant Practitioner roles

Developed services

- Setting up TIA (Transient Ischaemic Attack) service
- Creation of Acute Stroke Unit (NDDH Site) followed by Rehab Stroke Unit (Bideford)
- 24/7 Thrombolysis Service and now post-thrombolysis care delivered on ASU
- Enabling access to social care support – reablement, domiciliary care, night sitting
- EDS service - mobile rehabilitation service, starts on admission to hospital and continues to discharge

Integration

- Specification for integration of ASU/SRU at NDDH developed, building work now underway
- Mobilising links to wide range of voluntary sector support
- Therapy staff managed as an integrated, interdisciplinary service with joint paperwork, assessments and working
- Access ESD nursing support from generic complex care teams
- Graded handover of care through joint working with complex care teams following period of specialist intervention

Protocols

- Direct admissions to ASU followed by ring-fencing of beds
- Revised protocol for requesting CT - diagnosed stroke patients have immediate access to CT
- Thrombolysis protocol
- Mood, cognitive screening and intervention protocols implemented, raising the standard of psychological care and support

Risk stratification

- Implemented IST3 using an individual patient risk based approach

"I have a very positive memory since my stroke and that is because of the great help I have had from the therapy team and how much encouragement they gave me to be able to walk again"

Who we did it for and why

Users and carers

- We want to ensure that living in rural North Devon does not lead to increased likelihood of delays to immediate diagnosis and treatment, variable access to rehabilitation and poor long term outcomes
- Voluntary sector support was out there but links for users and carers were patchy
- Unexploited social capital
- Self management and peer support help maximise long term recovery of function and well-being for those who suffer a stroke and their carers
- Patient outcomes and experiences were poor, with users experiencing:
    1. Non-specialist support
    2. Long waits
    3. Local inequality
    4. Low levels of psychological support
    5. Low levels of access to therapy

"The care I have received at home from the ESD team has been exemplary. I have been given the guidance to cope with my disabilities and this care has dramatically improved my physical problems and has given me the support to mentally cope"

Clinical Commissioning Groups

- National standards and advice from the Stroke Improvement Team made it clear to the whole system what should be commissioned but funding constraints meant that commissioners needed those improvements to be delivered with little or no extra funding
- Commissioning strategy supports service users' preference to have more care delivered at home or close to home

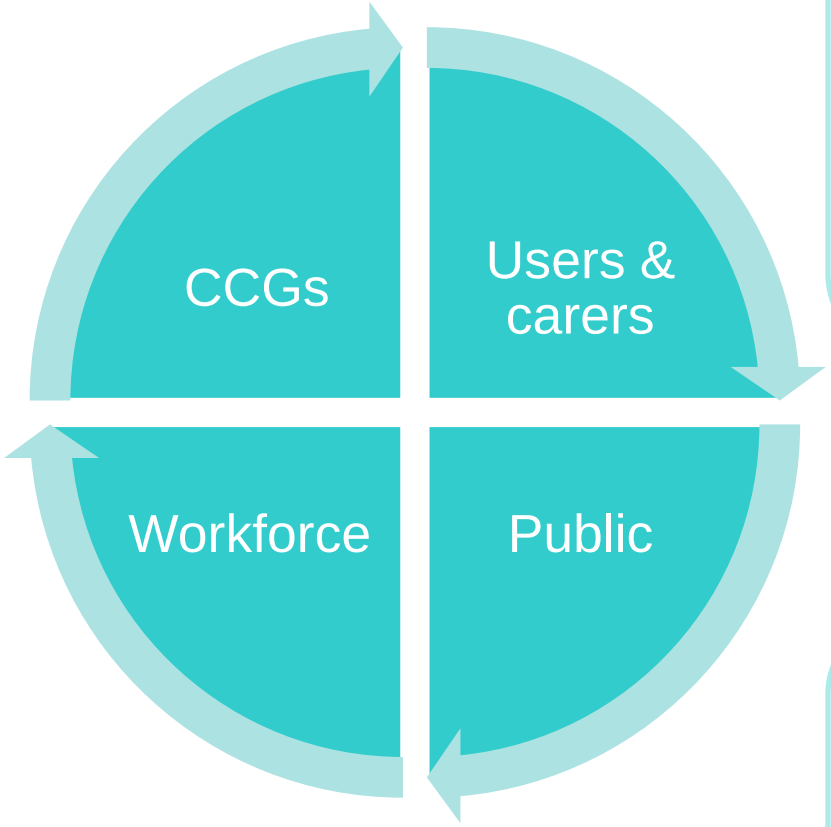
Workforce

- Committed, dedicated proactive and highly capable team have driven forward the improvements in performance and achieved measurable outcome benefits

Benefits

Benefits
- Delivered targets and measurable improvement in outcomes
- Reduced system costs for long-term support
- More care delivered at home or close to home

Benefits
- Seamless transition of care between hospital and home
- Enhanced patient experience
- Improved physical and psychological well-being for users and carers
- Peer support for users and carers



Benefits
- Greater staff satisfaction resulting in minimal turnover
- Increased staff motivation
- Improving outcomes for the users they work for

Benefits
- Equity of access to services for stroke patients across a dispersed largely rural community
- Better links with local voluntary sector support/increased access to local support networks

Lessons learned

Users and carers

- Supporting individuals and their carers to be fully engaged in their recovery and rehabilitation pays dividends.

CCG / Council support

- Joint commissioning/outcome measures would need to be explicit to deliver some of these improvements where responsibility rests with a number of different providers.

National standards and support

- The National Stroke Improvement Team visits have been a helpful catalyst and supports local teams to maintain momentum. It would be helpful to have more whole system measures as well as a focus on acute interventions e.g. Improved function or self perceived health status at 6 or 12 months.

Leadership and relationships

- Local clinical leaders with drive and determination to improve outcome for service users will find solutions – empower them to get on with it!

Workforce

- Moving to specialist teams delivering integrated care across the patch has worked because they have linked service users into 'generalist' support in localities.

"We have been very happy with all aspects of the service, especially the encouragement at each step along the way. We are delighted with the physical progress that has been made and the confidence gained. Thank you all!"

Contact details

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