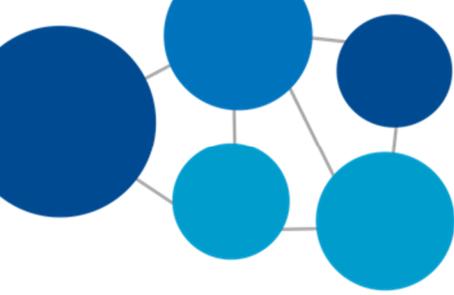


Modelling the Activity Implications of the Future Fit Clinical Model

Summary report for Programme Board, December 2014

1 Introduction

- 1.1. As part of the NHS Future Fit Programme the Strategy Unit were commissioned to support the health economy in Shropshire and Telford to develop a range of models to estimate future activity levels in the local health economy. This document provides a summary of the results of the second stage of the activity modelling process and assesses the activity consequences of the Future Fit Clinical Model. A detailed slidepack summarising the results is available on request. This report should be read in conjunction with the Models of Care report produced by the Clinical Design Workstream of NHS Future Fit.
- 1.2. This work builds upon an earlier phase of activity modelling that took place between November 2013 and May 2014. The phase 1 modelling estimated the levels of activity that Shropshire and Telford acute hospitals and the Shropshire community hospitals might be expected to manage in 2018/19 taking into account demographic change, a range of commissioner activity avoidance schemes and provider efficiency schemes. Whilst these activity models were produced by the Strategy Unit, the components of change and the change parameters were agreed by a reference group of clinical and managerial representatives from the local CCGs and provider trusts. The outputs of this first phase of activity modelling are summarised in two documents previously shared with the Future Fit Programme Board
- Modelling Future Activity Levels Shrewsbury & Telford Hospital NHS Trust
 - Modelling Future Community Hospital Provision in Shropshire and Telford
- 1.3. The NHS Future Fit Clinical Model, published in May 2014, sets out the clinical vision for locally sustainable acute and community hospital services for the next 20 years. The work is lead by Dr Bill Gowans (NHS Shropshire CCG), Dr Mike Innes (NHS Telford and Wrekin CCG), Dr Edwin Borman (Shrewsbury and Telford Hospital NHS Trust) and Dr Alastair Neale (Shropshire Community Health NHS Trust) in conjunction with a Clinical Reference Group of 90 local clinicians and the wider clinical community. Although the



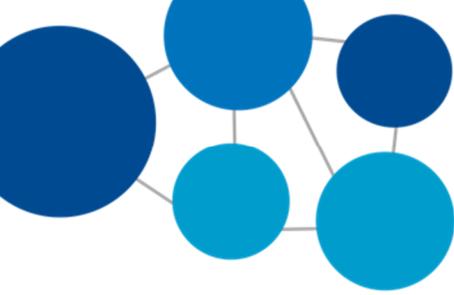
scope of the Future Fit programme is confined to the future of acute and community hospital services, the clinical design work stream was required to consider the health and social care economy as a whole and establish models of care which fully integrate all services within it. Subgroups were established to develop three complimentary aspects of the clinical model;

- acute and episodic care
- long term conditions and or frailty
- planned care

2 THE ACTIVITY MODELS

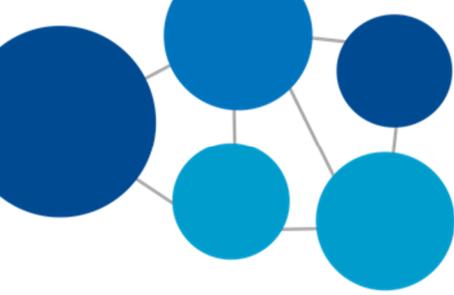
2.1. Three activity models were developed, one for each of the of the design subgroups, building on the phase 1 model outputs. The models included activity which the phase 1 models suggested would take place in Shrewsbury and Telford Hospital NHS Trust in 2018/19, but also incorporated relevant urgent care activity (e.g. WiC, MIU) and activity which the local health economy might expect to repatriate as part of the Future Fit programme (e.g. planned and primary PCI, low acuity attendances at neighbouring accident and emergency departments). The scope of the phase 2 models were also extended to include some non-PbR activity.

2.2. The planned care model sought to allocate outpatient attendances, and elective activity to one of three levels; local planned care centres, a diagnostic and treatment centre or an emergency centre. The acute and episodic care model allocated front door urgent and emergency activity to either urgent care centres or to an emergency centre. The long term conditions and frailty model estimated the number of emergency admissions that might be avoided through improved primary and secondary prevention and through integrated community services. In each case, the detailed rules and parameters that underpin these models were agreed with the clinical design workstreams and the activity and capacity subgroup.



3 The Results

- 3.1. The planned care model suggests that 67% of the planned care activity in 2018/19 would take place in Local Planned Care Centres, 29% at a diagnostic and treatment centre and 4% in an emergency centre. Approximately 35,000 follow-up outpatient attendances managed by the local planned care centres could take place virtually.
- 3.2. The acute and episodic care model suggests that 69% of front door urgent care activity (incorporating activity current managed in ED, direct GP admissions community hospital step-up admissions, MIU and WIC attendances, DAART assessments and GP OoH PCC contacts) could be managed at an urgent care centre, with the remaining 31% (c 68,000 attendances) requiring the emergency centre. 75% of the activity being managed by the urgent care centres will take the form of minor injuries or ailments, 12% as ambulatory emergency care, 8% as frailty management with 5% taking other forms.
- 3.3. There were approximately 10,000 emergency admissions associated with either frailty or long term conditions in 2012/13. The phase 1 models suggested these admissions could fall by 8% by 2018/19 largely as a consequence of improvements in primary care management and through better use of community hospitals. The phase 2 models suggests that a further 24% could be avoided by reducing the prevalence of the key risk factors that give rise to LTCs (e.g. smoking, cholesterol, blood pressure) and through greater integration of community and primary care.
- 3.4. Bringing the three models together, it is estimated that there would be approximately 66,000 admissions and 225,000 bed days used at the emergency centre 2018/19. Emergency admissions would make up the majority of the admissions (57%) and bed days (80%) at the emergency centre. 718 beds would be required to accommodate this activity assuming 85% occupancy rates. A further 20 beds would be required at a diagnostic and treatment centre.
- 3.5. The modelling for community beds suggests that about the same number of beds would be required in 2018/19 as exist today, but with a greater proportion of the beds being step up rather than step down. The work on apportioning emergency centre beds into acute and rehabilitation (see next steps), however, could have an impact on this conclusion.



4 Further Work and Next Steps

Further work is planned over the coming weeks to refine the model to ;

- Estimate the likely demand for diagnostics at each level of care
- Incorporate Telford and Wrekin Council's local population projections (the model currently uses the ONS 2012-nbased subnational population projections)
- refine the assumptions made about the impact of improvement primary prevention in Telford and Wrekin on the prevalence of LTCs
- Apportion beds and bed days within the emergency centre into those requiring acute care and those requiring intensive rehabilitation.

The provisional outputs of this modelling exercise will be used to guide the options appraisal (notably the drivetime analysis) and the financial planning components of the Future Fit work programme.