Supporting people with *High Impact Use of Services* through Personalised Care approaches

Cambridgeshire and Peterborough – Tier 1

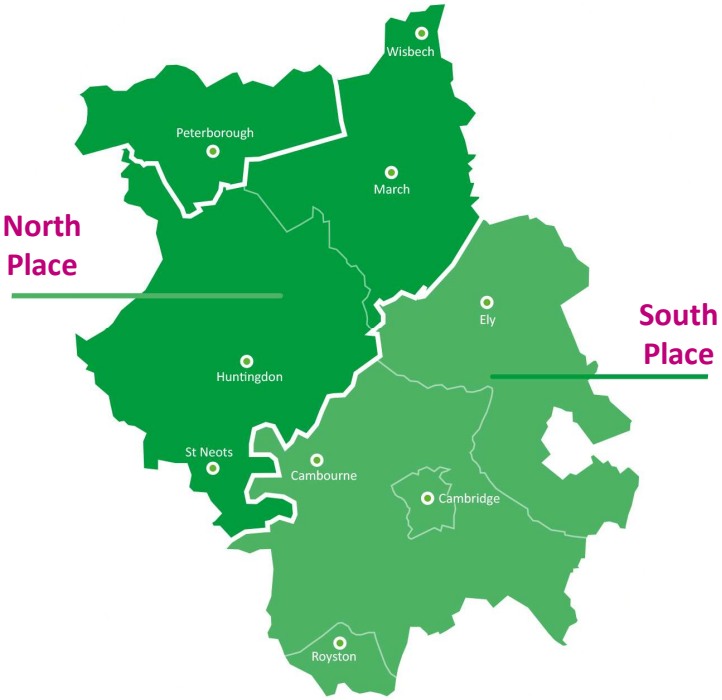
Cambridgeshire South Care Partnership

Cambridgeshire County Council

North Cambridgeshire & Peterborough Care Partnership

Cambridgeshire and Peterborough Integrated Care System

- Population circa **one million people** who live in **diverse communities**, from more deprived areas in Peterborough city and rural Fenland, to more affluent areas of the University city of Cambridge and Royston .Across our area, 112,000 people live in the 20% most deprived quintile nationally; 95% of these people live in the North of our system.
- Our diverse population includes **Asian/Asian British**, making up **5.9% of our population**, with **9.1% of the population using English as a second language** (the most common other languages are European).
- The population is estimated to **grow by 1.5% and 1.8% per year**, with considerable growth in our **older population anticipated to have grown by 128% by 2041**
- There are significant levels of need and health inequalities. Our Population and Person Insight Dashboard shows that 27% of patients are living with a chronic condition, 30% in North and 24% in South. There is a **10-year life expectancy gap** between those living in the most deprived areas compared to those living in the least deprived, which is driven predominantly by conditions such as cardiovascular disease, respiratory conditions and cancer.
- It is important to note that although deprivation is more widespread in the North compared to the South of our area, there are **pockets of deprivation throughout**, e.g. Cambridge and Huntingdon have lower super output areas (LSOAs) in the top 20% most deprived across our ICS



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Background: HIU and the need for a more proactive and personalised approach

Our Staff talking about: ***"people who keep us up at night"*** and ***"people who need us to work differently together"***

NHSE Data/local analysis which showed that in 2022/23 we spent an estimated £28million on emergency care for the 4,500 people attending ED 5-10 times per year

- Learning from North and South Integrated Neighbourhood Winter Projects
- Insights from our Personalised Care Leads
- The County Council's Changing Futures Programme describing people's negative experience of using urgent and emergency services in this way
- *And more!*

- People are using lots of unplanned services and showing up frequently but no one partner can solve their problems
- We were not always taking a personalised or proactive approach to address root causes of these problems
- We had an opportunity and buy in from partners to build on great work already happening and try this new way of working at greater scale
- We secured funding for 18 months to enable partners to identify those high users of NHS care and support and work together to support people as close to home as possible, including when specialist input is required

Context: Opportunities through a partnership approach

- As a system, we recognise the opportunity to work in partnership to address health inequalities for people who frequently make use of acute and emergency services within the NHS and services in other settings and sectors
- Last year, we spent an estimated £28million on emergency care for the 4,500 people attending ED (+/- admission) 5-10 times per year (average £6,200 per person).
- The impact of high intensity service use has not yet been quantified in the same way for other organisations and services, so these values are clearly an under-representation of the total resource and capacity the ICS is using to support this group of people.
- Proposed a model that offers a more proactive and personalised approach to addressing high or increasing use of services. Having a Tier 1 supporting high users of urgent and emergency NHS services. And Tier 2, identifying people at a Neighbourhood level and not solely identified due to NHS service use.
- Through this work we will work with partners to understand the gaps in service use, current gaps in care and support, and explore opportunities for care and support to be better coordinated through pathway transformation and personalised care approaches.

STP	Cambridgeshire and Pete	Cambridgeshire and Peterborough				
Patients with 20+ A&E attendances	Minimum	Maximum	Average	Totals	Conversion Rate (%	Total Cost (Based on Tariff)
People				102		
Attendances	20	372	28.3	2891		£ 994,161.95
Emergency admissions via A&E *	0	34	7.6	771	27%	£ 392,054.00
11-19 Attends						
Patients with 11-19 A&E attendances	Minimum	Maximum	Average	Totals	Conversion Rate (%	Total Cost (Based on Tariff)
People				340		
Attendances	11	19	13.2	4503		£ 2,923,044.91
Emergency admissions via A&E *	0	18	4.2	1444	32%	£ 646,499.00
5-10 Attends						
Patients with 5-10 A&E attendances	Minimum	Maximum	Average	Totals	Conversion Rate (%	Total Cost (Based on Tariff)
People				4555		
Attendances	5	10	6.0	27437		£ 23,979,625.11
Emergency admissions via A&E *	0	10	2.1	9668	35%	£ 3,888,959.00

Age group	% Population	% Attendances for that Age group
Under 5	0.9%	2.1%
5 to 11	0.2%	0.7%
12 to 17	0.5%	1.4%
18 to 29	0.6%	4.7%
30 to 44	0.4%	4.1%
45 to 64	0.4%	5.3%
Over 65s	1.0%	7.9%
TOTAL	0.6%	26.4%

Total Cost of HIUs	£	32,824,343.97

Tier 1 – Model of Care for HIU (the team you are applying for)

Funding across ICS - £900k to recruit an operational team hosted by Cambridgeshire County Council

The aim of Tier 1 of the HIU model is to reduce the use of unplanned health & care services for those people with most high intensity use of NHS urgent and emergency services.

WHO:

- ✓ Identify people who are living, or registered with a GP in, North and South (all ages):
  - who have attended ED 10+ times in previous 12 months
  - who have attended ED and have increased social needs/vulnerability, but not (yet) chronic health needs
  - who have contacted 999 (Ambulance) or NHS111 frequently in the previous 12 months

  The total annual cohort is expected to grow to approximately 400 with an annual caseload of approximately 50 per worker.

HOW:

- ✓ Core teams established in/aligned to North and South with an HIU Lead, Personalised Care Staff, Clinical Leadership and, if required, additional clinical psychology capacity.
- ✓ Core team works collaboratively with personalised care teams in Neighbourhoods, Joint Emergency Team, Call Before You Convey, and existing MDTs and problem solving forums
- ✓ Clearly defined pathways for escalation or to access urgent specialist clinical or other support when required

WHAT:

- ✓ Having 'What Matters To You' conversations with each individual, co-designing a personalised care plan, and 'team around me' discussions to bring in local expertise in our care services, council services and community assets - this approach builds trust with the individual and ensures key partners are aware of and use the agreed personalised care plan.
- ✓ Further exploring use of Personalised Budgets to meet immediate needs

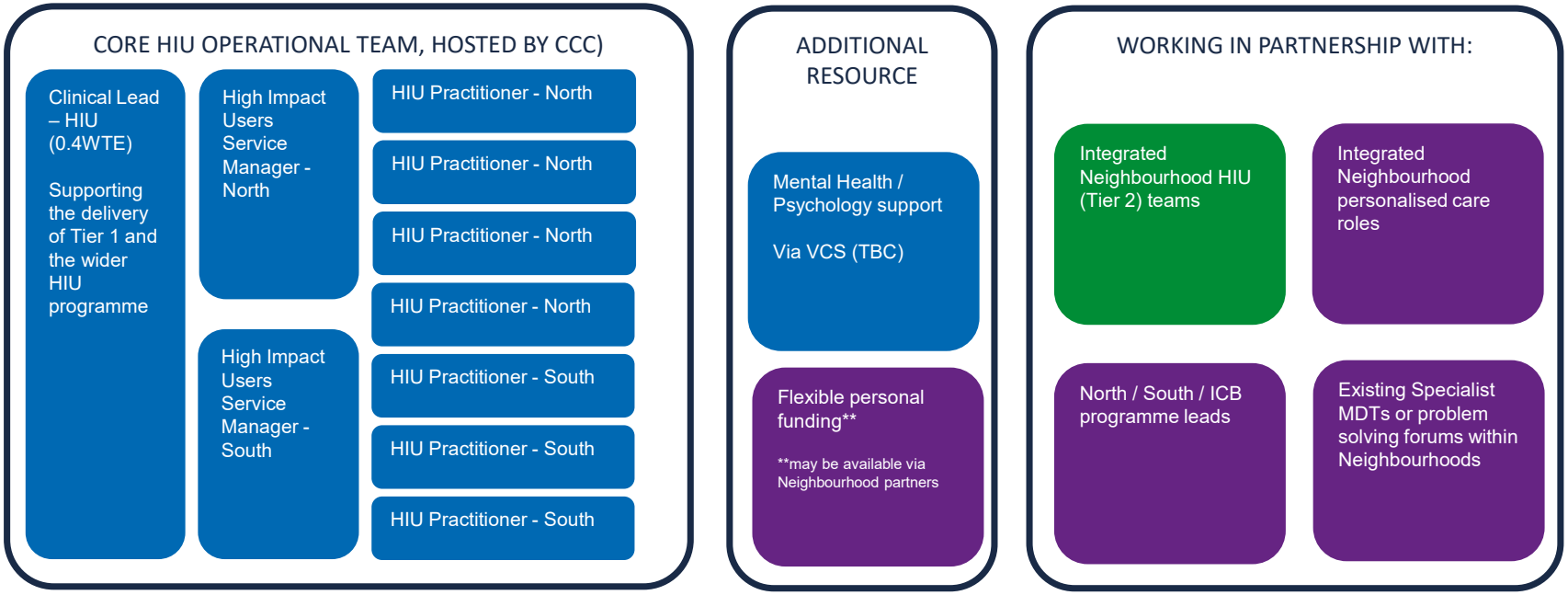
WHY:

- Improve proactive access to services to meet needs identified by patient
- Improve staff experience through multi-agency working
- Reduce use of unplanned urgent and emergency services by this cohort
- Reduce 'in crisis' presentations to all services by this cohort

Tier 1 – Workforce for delivering Model of Care

Workforce model:

- A single team covering Cambridgeshire and Peterborough with staff aligned to North and South
- Hosted by Cambridgeshire County Council
- Working closely in partnership with other organisations and colleagues to deliver this approach



Approach for HIU – covering both Tier 1 and Tier 2

Proactively identify and contact people starting with ED

Have a What Matters To You Conversation

Develop a personalised care and support plan

Partners work together to draw on the skills, services, expertise and assets where someone lives

Support person to step down from that more intensive support

Recording self-reported outcomes measures and concerns by using MYCAW

Sharing learning and taking a continuous improvement approach, building on what is already in place

Work closely with the external evaluation partner to evaluate how well the model is working and generate learning to inform how we work in the future

Tier 2 – Model of Care for HIU (Within Neighbourhoods)

Funding across ICS - £1,450,800 over 18 months

Allocated based on 50% population size + 25% IMD deprivation score + 25% rate of High Intensity Users of ED

Tier 2 uses this same personalised approach to reduce the use of unplanned health & care services for people identified by Neighbourhood colleagues and supported by a Neighbourhood workforce. Colleagues like GPs, District Councils, Social Care will be identifying those using lots of services through data analysis and referrals. Where Tier 1 will exclusively focus on high urgent and emergency NHS service use, Tier 2 is broader. Tier 1 will need to link into Neighbourhood meetings, pathways, processes and services to both avoid duplication and reaching out to the same people and to draw on local community assets and services to help people sustainably step down.

WHO:

- ✓ Identify people who are living, or registered with a GP in, North and South (all ages):
  - at increasing risk of using A&E services, health and care services or being admitted to a bed
- ✓ Exclusions: people receiving End of Life care, or nursing home care
- ✓ The total annual cohort is expected to grow to approximately 6000, based on 6/1000 registered population

HOW:

- ✓ Practices/Partners within Neighbourhoods define, find and contact cohort. They create a case load of people for personalised care
- ✓ Personalised Care Teams within Neighbourhoods, work collaboratively with partners e.g. Housing, Adult Social Care, JET, CB4UC, existing MDTs, etc
- ✓ Clearly defined pathways to access urgent specialist clinical or other support when required

WHAT:

- ✓ Having ‘what matters to you’ conversations with each individual, co-designing a personalised care plan, and ‘team around me’ discussions to bring in local expertise in our care services, council services and community assets - this approach builds trust with the individual and ensures key partners are aware of and use the agreed personalised care plan.
- ✓ Further exploring use of Personalised Budgets to meet immediate needs (this may be from other funding arrangements)

WHY:

- Improve proactive access to services to meet needs identified by individual
- Improve staff/volunteers experience through multi-agency working
- Reduce use of unplanned urgent and emergency services in any sector/setting by this cohort
- Reduce urgent or ‘in crisis’ presentations to all services by this cohort