Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 4

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 24 October 2013**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/51/2013/HW**
Contact Officer:	**Helen Watson Head of Planning, Health Improvement & Commissioning**	**Contact No: 01475 715369**
Subject:	**NHSGGC CLINICAL SERVICES FIT FOR THE FUTURE - UPDATE**	

1.0 PURPOSE

1.1 To provide an update to CHCP Sub-Committee on the current NHSGGC Clinical Services Review, following the earlier report in January 2013. The NHSGGC Board has produced a paper setting progress so far in a bid to describe a clearer direction of travel.

2.0 SUMMARY

2.1 NHS Greater Glasgow & Clyde's Clinical Services Review programme aims to reconfigure the shape of clinical services beyond 2015 to ensure that the NHS can adapt to future changes, challenges and opportunities. The Clinical Services Review aims to reshape the provision of clinical services across the whole of NHSGGC to ensure that patients have equitable access to high quality, safe, consistent and cohesive health services.

2.2 The emerging service models have been developed by the seven clinically led groups, who have taken account of outputs from the engagement work, feedback from local authority partners, other commentators and the Scottish Health Council. Prior to publication of the models paper an integrated impact assessment was carried out taking account of equalities, health and human rights. Recommendations from that assessment prompted revisions to the models being proposed.

2.3 The ethos underpinning the Review is that a coherent and consistent approach to health services delivery across the whole of NHSGGC should achieve a shift in the balance of care to support the provision of more care at home and in the community, reducing the number of inpatient hospital beds required. This shift in emphasis should release resources to support investment in primary care and community infrastructure to provide better alternatives to hospital care, and needs to take account of the full range of community supports required including health services, social care services and hosing needs.

2.4 The system of care envisaged aims to provide care where it is most appropriate to the patient, based on strengthened 24/7 community services (potentially both health and social care) and with acute services focused on assessing and managing acute episodes. This would be underpinned by developing a range of services at the interface including shared management of high risk patients and a range of alternatives to having to visit hospital. The principles of this proposal in many ways mirror the current arrangements that Inverclyde has in place for mental health

services, with most of the care being delivered in the community; inpatient services used for acute episodes, and smooth transition of care back into community services once the acute episode has abated. As an integrated CHCP, we are well placed to take this more inclusive model forward in Inverclyde.

2.5 The report recognises that the main thrust of the next stage will be to consider and develop the range of services and supports that need to be in place at the interface between acute and primary care/ community services. Inverclyde CHCP and our Public Partnership Forum (PPF) will be very much involved in that process. We will be developing a programme of communication and engagement locally.

3.0 RECOMMENDATION

3.1 Members are asked to note the emerging service models paper and comment as required to the Corporate Director, Inverclyde CHCP.

Brian Moore
Corporate Director
Inverclyde Community Health & Care
Partnership

4.0 BACKGROUND

4.1 NHS Greater Glasgow & Clyde's Clinical Services Review programme aims to reconfigure the shape of clinical services beyond 2015 to ensure that the NHS can adapt to future changes, challenges and opportunities. The Clinical Services Review aims to modernise the provision of clinical services across the whole of NHSGGC to ensure that patients have equitable access to high quality, safe, consistent and cohesive health services.

4.2 The Clinical Review Board paper outlines the process the review has taken to date, including detailed reporting of engagement and feedback, and reiterates a summary of the case for change. The ethos underpinning the Review is that a coherent and consistent approach to health services delivery across the whole of NHSGGC should achieve a shift in the balance of care to support the provision of more care at home and in the community, reducing the number of inpatient hospital beds required. This shift in emphasis should release resources to support investment in primary care and community infrastructure to provide better alternatives to hospital care.

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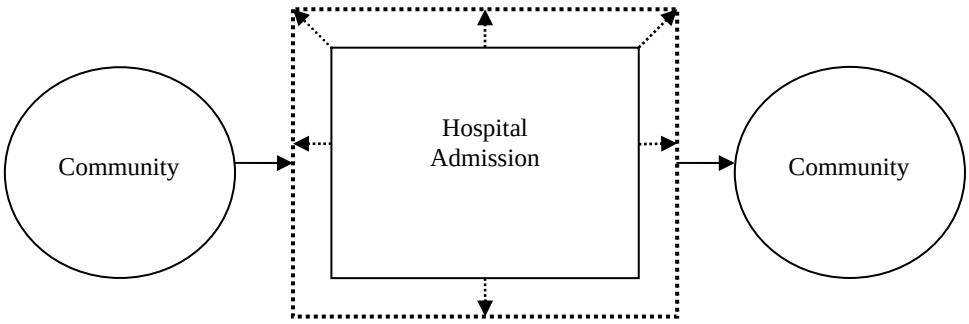
4.4 The service models have been developed by the seven clinically led groups as described in the January 2013 report to CHCP Sub-Committee, namely:

- Chronic Disease
- Emergency and Trauma
- Planned Care
- Children & Maternity
- Older People/ Frailty (including all age stroke)
- Mental Health
- Cancer

4.5 The diagrams below outline a simplified representation of current arrangements and then the sort of system that is envisaged for the future.

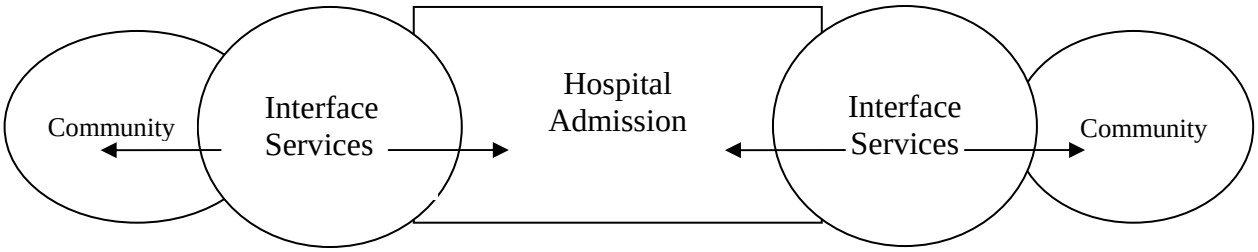
Figure 1



4.6 Figure 1 represents the current position from an NHS GGC perspective, where demand pressures are managed across a system in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and poor joint planning across the system. Within the diagram, "community" includes primary care and community health services. In

integrated CHCPs such as Inverclyde, community also includes social work services. Even in CHCP areas though, 'hospital' and 'community' are largely separate with integration focused across the community services that comprise the CHCP. The Review has identified that if the system continues as it is now, there would be a need for an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn would reduce our ability to support people at home, which is in most cases the preferred choice of those requiring support.

Figure 2



4.7 Figure 2 represents the system of care NHS Greater Glasgow & Clyde wants to move to, seeing a significant focus on providing care where it is most appropriate for the patient as outlined at 4.3 above. Working differently at the interface (represented by the overlap circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system. The future model aims to have a much stronger focus on the interface service that will be aimed at keeping people out of hospital if another alternative would be better, and supporting people back out of hospital where an admission has been necessary.

4.8 Anticipated Benefits: The Review anticipates a number of benefits as summarised.

- Patients will be in control of their care and empowered to share decisions about it.
- A system of care which is easier to navigate for patients and professionals.
- Clinicians and social work staff at all stages will have the necessary information about individuals, with care better tailored to needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- A reduction in health inequalities as the most vulnerable people receive better access to holistic person centred care.
- Care which is provided in the most appropriate setting, relative to the person's needs.
- More cost effective use of resources with care focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

4.9 The Review document provides some examples of how the proposed model will improve the patient experience.

Patient Story 1
A 58 year old woman with diabetes, hypertension, chronic kidney disease and rheumatoid arthritis, is overweight and smokes and is unable to work.

Now: Has frequent appointments at hospital diabetic clinic, GP chronic disease reviews, podiatrist, renal clinic, hypertension clinic, rheumatology clinic. Frequent non-attendance at appointments because she forgets appointments, doesn't see the point or doesn't have the bus fare to get there. This results in several acute hospital admissions per year.

Future: Risk stratification flags up the patient as high risk due to multi-morbidity (a number of chronic diseases at the same time); case review highlights that multiple teams are involved in

her care. The case manager is identified to develop a co-ordinated care plan involving the GP and appropriate specialists. Routine outpatient review is minimised (reducing the number of times she has to attend hospital) and clear triggers are in place for when she should return. Targeted support is put in place and advice on diet and weight loss, smoking and benefits maximisation.

Patient Story 2
An 80 year old man with mild dementia and mobility problems lives alone and has daily home care visits. His daughter lives 10 miles away, works full time and has small children but tries to visit several evenings a week. She arrives one evening to find her father has an upset stomach and has been unable to get to the toilet quickly enough, and has fallen.

Now: Daughter unsure of where to get help, so phones NHS24. GP arrives, suggests admission to hospital, so the patient is admitted, investigated and treated for a stomach bug. His confusion increases in strange environment, and his mobility decreases as he stays in bed until his stomach is better. He stays in hospital for several weeks and now there is doubt about him being able to return home.

Future: Patient has been identified at risk due to his mobility issues, dementia and living alone and he has anticipatory care plan. This has been informed by a Comprehensive Geriatric Assessment, which sets out steps to take if he is ill or needs additional support. His daughter is able to see on the plan who to contact. The crisis team responds quickly, assesses father and helps to clean up and get him to bed. Arrangements are made for his own GP to visit in the morning. Additional support is put in place for a few days to ensure he is drinking enough and to support mobility until he is better. Care needs are reassessed and the patient is given an alarm and increased support, with planned ongoing review.

These examples highlight approaches to care that are more likely to deliver better health outcomes, and are more in line with what people tell us they would prefer.

4.10 Analysis of feedback suggests support for the direction of travel, and in particular, the whole-systems approach that has been taken. The approach is generally regarded to describe an appropriate response to the issues raised in the case for change. However some important points were raised in the feedback, including:

- The need to be clearer about what the interface services should be – this is recognised by the NHS Board as being central to the next stage of development.
- The need for more emphasis on the role and implications for primary care – Inverclyde CHCP is working on a pilot with the NHS Board to develop a planning process which will enable this action to be further progressed.
- The need for appropriate focus on multi-morbidity – in Inverclyde multi-morbidity is pervasive so we would also support this. Patient Story 1 (above) highlights some of the core issues for patients and our services when trying to support multi-morbidity.
- The need for age-appropriate responses where disease spans a number of life stages.
- An emphasis on the need for continued engagement.

4.11 The report recognises that the main thrust of the next stage will be to consider and develop the range of services and supports that need to be in place at the interface between acute and primary care/ community services. There is a commitment that these will be underpinned by the principles of:

- Patient-centred.
- Integrated between primary and secondary care.
- Efficient, making best use of resources.
- Affordable and provided within the funding available.
- Accessible and provided as locally as possible.
- Safe and sustainable.
- Adaptable, achieving change over time.

4.12 Whilst these principles are a useful foundation to map out the ethos of the review, the work to define the actual services needed will require detailed analysis of current and future patient pathways. This work will be required to ensure smooth transition between the main arena of day-to-day patient care (primary care and community health and social care services), and acute

care in what should in most cases be relatively short episodes of need. It should also be recognised that there will be a challenge in shaping the future in tandem with keeping current services going so that future change can be properly managed. The report recognises that defining interface services might involve new services; extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to communication and the ways in which information is shared across the system. Inverclyde CHCP and our Public Partnership Forum will be very much involved in that process locally. We will be developing a programme of communication and engagement locally.

5.0 CORE COMPONENTS OF THE FUTURE SYSTEM

5.1 The Emerging Service Models paper aims to describe a balanced system of care where people get care in the right place, from practitioners with the right skills, and working across the artificial boundary of hospital and community services. Detailed analysis of need at population level has underscored a reliance on a strong emphasis on prevention, noting that around 80% of the current Long Term Conditions disease burden is a result of lifestyle choices in modifiable behaviours. On that basis there is strong emphasis on the responsibility of all staff to promote healthier lifestyles and appropriately support individuals to take responsibility for doing what they can to improve their own health. The key characteristics of the clinical services required to support this approach are described as:

- Timely access to high quality primary care that deals with the whole person in the context of their socio-economic environment.
- A comprehensive range of community services integrated across health and social care, and working with the third sector to provide increased support at home.
- Co-ordinated care at crisis and transition points, especially for those most at risk.
- Hospital admission that focuses on early and comprehensive assessment to ensure that patients are directed to the right place and the right practitioner.
- Planned care that is locally accessible on an out-patient or ambulatory care basis where possible.
- Low volume and high complexity care is provided in defined units equipped to meet needs.

5.2 The cultural shift required is recognised, and the paper proposes a structured change-management programme that includes leadership development; clinical engagement and improved IT systems that support easier information sharing. All of these areas will require development to ensure that the anticipated benefits are realised. The need for care pathways development is also recognised, along with appropriate targeting for prevention and anticipatory care. Governance and performance management are also recognised as important change enablers as well as ensuring that contractual arrangements with Independent Contractors support the change programme.

A further important core component recognised in the paper is the need to develop approaches that promote personal outcomes for service users and carers. This represents a move away from a prescriptive or directive approach towards patients being central to defining recovery goals or ways of managing or living well with their condition(s).

6.0 CHANGES REQUIRED TO DELIVER THE MODEL

6.1 A number of changes in practice or delivery are suggested, including:

- Cease age-based exclusions (e.g. psychological interventions and liaison psychiatry).
- Shift from age-based configuration of adult and older people's mental health services.
- Address service gaps in the dementia care pathway (e.g. memory assessment services; post-diagnostic support services).

6.2 These examples highlight an overall drive to streamline services so that people get what they need, when they need it, where they need it, and from the right practitioner. They also represent a shift in thinking from configuring services to suit the system and its professionals, towards configuring to suit the needs of patients and carers.

7.0 NEXT STEPS

7.1 Clearly there is still considerable work to be done, however it is important to recognise the positive shifts represented in the paper. It sets out a future direction of travel and recognises the significant changes required to develop a person-centred care system that meets a vast and diverse range of needs and complexities. Importantly it provides a framework for future decision-making and describes the parameters for more detailed development.

7.2 The next stage will be to start developing specific options, and the NHS Board has given a commitment that this will be done within a clear process of engagement. Options appraisals will then be undertaken and brought back to the NHS Board, and we would anticipate that these should be brought to the CHCP Sub-Committee as well. There will also be a development programme to test out the whole-system approach and effectiveness of the interface models, including the impact of change.

8.0 IMPLICATIONS

8.1 Legal: None

8.2 Finance: None from the current paper, however there may be implications depending on the interface service options that are developed. It is not possible to quantify at this stage.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

8.3 Personnel: It is not possible to quantify at this stage.

8.4 Equalities: It is not possible to quantify at this stage, however the integrated impact assessment identified some possible issues that have been addressed, and also identified some benefits that should support more equal health outcomes.

8.5 Repopulation: It is not possible to quantify at this stage, however improved clinical services and pathways in Inverclyde could potentially have a positive impact on repopulation.

9.0 CONSULTATION

9.1 The PPF Advisory Group and Involvement Network have been given routine updates on progress (such as after the large scale events at Hampden Park) and have had newsletters/ briefings etc shared with them. An open meeting took place within the Your Voice premises on Wednesday 18th September, which was attended by the Board's lead officer for the programme, who gave a presentation and fielded questions. Some local involvement network members also attend patient panel sessions and are patients representatives on the Clinical Services Review reference fora.

10.0 LIST OF BACKGROUND PAPERS

10.1 Clinical Services Fit for the Future – Service Models