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<b>Report To:</b>	<b>Community Health and Care Partnership Sub Committee</b>	<b>Date:</b>	<b>8<sup>th</sup> January 2015</b>
<b>Report By:</b>	<b>Brian Moore Corporate Director Inverclyde Community Health and Care Partnership</b>	<b>Report No:</b>	<b>CHCP/09/2014/BC</b>
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<b>Subject:</b>	<b>The Inverclyde Pilot: A Shared Approach to Shaping Demand and Design for Hospital Services</b>		

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## 1.0 PURPOSE

1.1 The purpose of this report is to update the Sub Committee on the work to date of the "Inverclyde Pilot".

## 2.0 SUMMARY

2.1 Working with NHS Greater Glasgow and Clyde, we established the Inverclyde Pilot in 2013 to develop a Board approach to ensure that partnerships focus on and change the use of acute services delivered for their population. The aim was to establish joint planning:-

- Ensuring partnerships have a full stake in the use of acute care;
- Influencing the reshaping of acute services to reflect population needs and priorities;
- Leading to a shift in the balance of resources between acute and partnership allocations to reflect agreed redesign and activity changes.

## 3.0 RECOMMENDATIONS

3.1 The Sub Committee is asked to note the progress of the work to date.

**Brian Moore  
Corporate Director  
Inverclyde CHCP**

## 4.0 BACKGROUND

### 4.1 Rationale

The Inverclyde locality was chosen to provide a useful test bed to begin exploring the potential of the new HSCPs to work in partnership with acute services to focus on, and change the use of, acute care delivered for their populations.

While there are already numerous examples of good practice in relation to joint working between acute and primary care, the creation of HSCPs as strategic commissioning organisations with responsibility for the strategic planning of acute services creates increased opportunities. Joint strategic planning will allow partnerships to have a full stake in the use of acute care and to influence the reshaping of acute services to reflect population needs and priorities.

The Inverclyde Pilot has been established to test this potential in both a planning/analytical context and in respect of local operational change to improve service efficiency for patients, service users and carers.

A shift in the balance of resources between acute and partnerships in line with the rebalancing of services will be required to support implementation and will provide an impetus to drive effective change.

This focus on acute services by Partnerships is key to the delivery of each of our five strategic priorities to improve the health of our population:

- Early intervention and preventing ill-health.
- Shifting the balance of care.
- Reshaping care for older people.
- Improving quality, efficiency and effectiveness of the care provided
- Tackling inequalities.

It is anticipated that the Inverclyde work will be a pathfinder for the rest of the board area to develop interface working and service integration across community, primary care and secondary care.

4.2 Inverclyde CHCP is coterminous with the catchment area of Inverclyde Royal Hospital. In excess of 70% of the local hospital's activity is from the local community of Inverclyde, with the remainder made up of patients from neighbouring health boards in North Ayrshire and the Cowal and Bute peninsula. There is a strong affiliation to the hospital amongst local people with limited use currently made of hospital services outwith the area, apart from maternity and inpatient services which are unavailable at Inverclyde with the Royal Alexandra Hospital, Paisley providing the shortfall. This dominance in service delivery has undoubtedly partially evolved as a result of Inverclyde Royal Hospital being more remote from any other hospital in NHS Greater Glasgow and Clyde.

4.3 The development seen since the inception of the Community Health and Care Partnership in 2010 has facilitated the commitment to joint working across community health services and social care.

## 5.0 PROPOSALS

5.1 There were guiding principles underpinning our work in respect of the Inverclyde Pilot which are consistent with the aspirations and intentions of a number of key strategic drivers articulated in our local plans and strategies such as our Directorate Improvement and Development Plans and overarching Commissioning Strategy. These principles include:-

- Care is provided in the most appropriate place by the most appropriate professionals.

- Acute is acute only and interface/integration is much better.
- Ensuring the most acute and expensive care is used appropriately.
- Addressing the continuing pressures of growth in demand for acute care.
- Redesigning services to increase efficiency and effectiveness and identify opportunities to shift the balance of care.
- Addressing the disproportionately high use of hospital services by our population.
- Fewer people are cared for in settings which are inappropriate for their needs.
- There are agreed patient pathways across the system, with roles and capacity clearly defined including new ways of working for primary and community care.
- We offer increased support for self-care and self-management which reduces demand for other services.
- Increased use of anticipatory care planning which takes account of health and care needs, and home circumstances and support.
- Clearly defined, sustainable models of care for older people.
- More services in the community to support older people at home and to provide alternatives to admission where appropriate.
- More people are able to die at home or in their preferred place of care.

Key steps included:

1. High level analysis of Inverclyde CHCP's usage of secondary care services was undertaken in spring 2013. This provided the initial grounding of baseline data for review at an engagement event with the wider clinical and service reference group.
2. An event took place in June 2013 with representation from primary and secondary care both from a clinical and managerial perspective. Discussion focused on reaching a common understanding of any identified undue variation in activity. From this, priority areas were agreed around which joint work would be undertaken.
3. Cognisance was also taken of the areas of interest of the clinicians involved, allowing to a large extent, the front line clinicians, informed by the analysis, to decide on which areas to work on.
4. The feedback from this event allowed the local Implementation Group to create an action plan to determine the best way forward for the Inverclyde locality. Areas of focus within the action plan were agreed as follows:-
  - Orthopaedics referrals
  - Dermatology referrals
  - Diabetes admissions
  - COPD admissions
  - Diagnostics
  - A&E Attendances
  - Admissions from Care Homes
5. Once the broad areas of work were defined, a needs assessment was undertaken. This included an initial description of the demographic characteristics of the Inverclyde population compared with corresponding ones for NHS GGC.

The data was standardised to allow the identification of variation over and above that which is attributable to demographic factors, as this is the variation which is likely to be amenable to local intervention.

Data of the most recent financial year available was used where possible.

Ongoing provision of data analysis as required

6. Ongoing engagement between lead clinicians across primary and acute care, focused on the topic areas listed above, with support from the project team.

7. Regular reporting to the overarching steering group to ensure progress, alignment with original aims, and to retain the links required to ensure transferability to other Board areas.

## 5.2 Use of data and some early findings

Given the vast amount of data which could be analysed, the Board Support Group adopted a systematic approach to data analysis and interpretation, which could facilitate replication of the pilot if it is successful.

The data analysis focused on the acute activity generated by Inverclyde CHCP residents. It did not include activity generated in other NHS GGC CHCPs or from other NHS boards, conducted in Inverclyde Royal Hospital.

**A Needs Assessment** was conducted. Need may be defined as the potential to benefit from an intervention. Assessment of need is epidemiological in nature and consists fundamentally of assessment of prevalence or incidence of disease. In many cases, direct measures of incidence and prevalence may not be available and recourse must be made to proxy measures. These may include measures derived from mortality or morbidity data. The assessment of need in the population of Inverclyde CHCP has been a central part of the project.

**Indices of Population Health in Inverclyde:** In a needs-based health service, variations in service delivery would be accounted for by variations in population need. In practice, much variation in service delivery is related to other factors. Standardised Mortality Ratios (SMR) for important forms of mortality and prevalence rates for common chronic diseases are shown in Tables 1.1 and 1.2.

**Table 1.1: Standardised Mortality Ratios (%) in Inverclyde CHCP**

Cause of Mortality	Standardised Mortality Ratio (%)
All causes	98.3 (ns)
Colorectal cancer	128.3 (ns)
Lung cancer	65.8 (s)
Breast cancer	118.1 (ns)
Prostate cancer	135.4 (ns)
Ischaemic heart disease	101.6 (ns)
Stroke	115.3 (ns)
Pneumonia	53.3 (s)
Chronic pulmonary disease	87.6 (ns)
Hepatic disease	129.6 (ns)

The SMR for mortality from all causes was 98.3% and the result was not statistically significant. This means that the overall level of mortality was not significantly different in Inverclyde from the standard population, NHS GGC. The values of the SMR for the other major causes of mortality were either less than, or not significantly different from, the level in NHS GGC.

**Table 1.2: Prevalence of Chronic Diseases in Inverclyde CHCP**

Disease	Number of cases (prevalent)	Inverclyde Prevalence (%)	NHS GGC Prevalence (%)
Diabetes	4,076	4.88	4.41
Epilepsy	786	0.94	0.82
Cardiac failure	701	0.84	0.86
Hypertension	11,993	14.36	12.82
Learning disabilities	469	0.56	0.46
Mental health problems	1,031	1.23	1.00
Obesity	7,933	9.5	7.84

Osteoporosis	156	0.19	0.14
Peripheral arterial disease	925	1.11	0.83
Stroke/TIA	2,222	2.66	2.07
Asthma	5,318	6.37	5.90
Ischaemic heart disease	4,545	5.44	4.23
Chronic renal disease	3,475	4.16	2.86
Chronic pulmonary disease	2,121	2.54	2.37

The prevalence rates (%) shown for chronic diseases in Table 1.2 are available as crude rates only. This means that no correction can be applied for demographic differences between Inverclyde and NHS GGC and this makes comparison between the populations difficult. For example, the prevalence of diabetes was 4.88% in Inverclyde and 4.41% in NHS GGC, but in the absence of standardised prevalence rates, it is not possible to conclude that the burden of diabetes was greater in Inverclyde than in the standard population.

In summary, there is no evidence of major differences in the overall health of the populations in Inverclyde and NHS GGC.

**General Aspects of Measures of Activity in Secondary Care:** A range of measures related to activity in secondary care is available, for example, elective and emergency admission rates. These measures reflect need in the population but are not direct measures of need because of the number of factors that mediate the relation between incidence of disease and admission to hospital. These factors are shown in Table 2.1.

**Table 2.2: Overall Activity (All Specialties) in Inverclyde Compared with NHS GGC (2012/2013)**

Activity	Inverclyde Number	Ratio (%)	Significantly Different	Comment
Day-case	9,917	95.4	Yes	Rate about 5% less than average in NHS GGC
Elective in-patient admission	2,993	101.8	No	Admission rate not significantly different from average in NHS GGC
Emergency in-patient admission	9,040	89.9	Yes	Admission rate about 10% less than average in NHS GGC
Total bed-days	90,997	95.1	Yes	Bed-day rate about 5% less than average in NHS GGC
New referrals to out-patients	25,596	97.7	Yes	Rate about 2% less than average in NHS GGC

This shows that for all specialties:-

- In total, residents of Inverclyde accounted for 9,917 day-cases in the year 2012/2013. The standardised day-case ratio was 95.4%. This means that the level of day-case activity in Inverclyde was about 5% less than in the population of NHS GGC and that this could not be attributed to demographic differences between the two populations.
- Residents of Inverclyde accounted for 2,993 elective admissions to hospital in the year 2012/2013. The standardised admission ratio was 101.8% and this was not significantly different from the rate in NHS GGC. This means that the elective admission rate was not significantly different from the overall level in the population of NHS GGC.
- Residents of Inverclyde accounted for 9,040 emergency admissions to hospital in the year 2012/2013. The standardised admission ratio was 89.9% and this difference was

significant. This means that the emergency admission rate was about ten percent less than in the population of NHS GGC, and that this could not be attributed to demographic differences between the two populations.

- Residents of Inverclyde accounted for 90,997 hospital bed-days in the year 2012/2013. The standardised bed-day ratio was 95.1% and this difference was significant. This means that the bed-day rate was about five percent less than in the population of NHS GGC, and that this could not be attributed to demographic differences between the two populations. The difference in bed-days overall corresponds to about 14 in-patient beds.

In summary, both the overall day-case rate and the in-patient bed-day rates can be considered as indicators of use of resources in secondary care in Inverclyde. Both indicators are less than the average levels in NHS GGC, although different patterns are evident in different specialties. This does not support the contention that the supply of secondary care is excessive compared to its population need.

**Trends in Activity in Secondary Care:** Analysis of trends in activity rates provides information about patterns of change in different clinical specialties. Information about trends in overall activity in secondary care and in the core medical and surgical specialties is shown in the tables below.

In general, patterns of growth in activity rates may be considered to reflect changes in a range of different factors. These include demographic change, epidemiological change, changes in supply factors, developments in services, changes in admission rates or criteria or changes in referral criteria (Table 2.1). The significance of demographic change for the trends in activity rates may be isolated relatively easily. This is shown in the tables as the proportion of the trend that is attributable to demographic change alone.

**Table 3.1: Trends in Overall Activity in Inverclyde, 2003 to 2013**

Activity	Trend	Comment	Demographic component
Day-case	Positive trend	Growth in rate from 92.4 per 1,000 to 125.9 per 1,000 between 2003 and 2013	Demographic change accounted for -2.6% of trend
Elective in-patient admission	Negative trend	Decline in rate from 47.6 per 1,000 to 38.0 per 1,000 between 2003 and 2013	Demographic change accounted for -0.8% of trend
Emergency in-patient admission	Positive trend	Growth in rate from 101.7 per 1,000 to 114.8 per 1,000 between 2003 and 2013	Demographic change accounted for -26.0% of trend
Total bed-days	No trend		

Information about trends in overall activity rates is shown in Table 3.1. The main results are as follows:-

- The overall day-case rate increased from 92.4 per 1,000 in 2003 to 125.9 per 1,000 in 2012. Demographic change accounted for -2.6% of the increase in rate. This reflects the fact that demographic change alone would have led to a decline in the day-case rate. This means that the increase was entirely accounted for by other factors including a policy to increase the amount of elective surgery carried out as day-surgery.
- The overall elective in-patient admission rate declined from 47.6 per 1,000 in 2003 to 38.0 per 1,000 in 2012. Demographic change accounted for -0.8% of this decline in rate.
- The overall emergency in-patient admission rate increased from 101.7 per 1,000 in 2003 to 114.8 per 1,000 in 2012. Demographic change accounted for -26.0% of this decline in rate.

- There was no significant trend in overall bed-day rate.

Tables 3.2 to 3.8 reflect the changing trends by specialty.

### 5.3 Method

Following analysis of the data and taking into account the anecdotal areas of interest highlighted by the clinicians who attended the open event in June 2013, 3 areas were selected to undergo further analysis. The 3 areas reflected apparent significant variations in activity as well as a level of clinical engagement to pragmatically explore further clinical focus groups consisting of multi-disciplinary teams including primary and secondary care clinicians nursing staff, allied health professionals, public health colleagues, planners and managers met to consider the evidence and devise interventions to address the issues.

As this is a pilot of a process, a small number of examples were “worked through” using this approach to assess its utility locally and to provide an output in the timescale of the project. The rest of the analysis was agreed to be undertaken thereafter. The agreed three areas of initial focus are as follows:

1. Orthopaedic
2. Dermatology
3. Diabetes

Action Plans were created, providing an output from each focus group session. This allowed local priorities to be set and leads assigned to drive forward the required changes.

Orthopaedics was highlighted as the main area that further intervention would have the biggest impact on referral behaviours. It was decided that this topic would be the main focus for progressing actions and evaluating the outcomes, providing a model for further work streams to be progressed.

It was agreed that a cycle of Clinical Focus Groups would be the route for bringing primary and secondary care clinicians to focus on these three identified specific areas.

It was agreed that there may be some interventions which can be implemented without going through this Clinical Focus Group process as they are measures which will improve the quality of the service irrespective of the effects of activity.

## 6.0 IMPLICATIONS

### Finance

6.1 None.

#### Financial Implications:

##### One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

##### Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

**Legal**

6.2 None.

**Human Resources**

6.3 None.

**Equalities**

6.4 None at this time, although recognition will be given to the wider and associate equalities agenda.

Has an Equality Impact Assessment been carried out?

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YES (see attached appendix)

NO - This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

**Repopulation**

6.5 None.

**7.0 CONSULTATIONS**

7.1 None.