INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date: 24th January 2017**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/08/2017/HW**
Contact Officer:	**Helen Watson Head of Service Strategy & Support Services**	**Contact No: 01475 715285**
Subject:	**Planning with Acute Sector**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Inverclyde Integration Joint Board members on developing our planning arrangements with the Acute Sector.

1.2 There is a statutory requirement for joint working between HSCPs and hospitals to plan for:

- Accident and Emergency services provided in a hospital;
- Inpatient hospital services relating to:
  - General medicine
  - Geriatric medicine
  - Rehabilitation medicine
  - Respiratory medicine
- Palliative care services provided in a hospital.

1.3 This requirement is challenging because:

- Integration Authorities are set up to deliver the nine national wellbeing indicators, and will have their performance judged against the 23 national wellbeing indicators, whereas hospital performance is still judged using the old HEAT targets. Additionally, the Scottish Government has commissioned Sir Harry Burns to develop indicators that will measure the implementation of the recommendations of the Christie Commission Report (2011). This means that both sectors (hospitals and HSCPs) will potentially be working to different drivers and priorities.
- Another challenging aspect is that the acute sector in NHS Greater Glasgow & Clyde spans the geographies of six Integration Authorities, each of which might have different priorities depending on the socio-economic structure of their communities, and the resultant manifestation of health needs and inequalities.
- Finally, the current financial constraints across all parts of the public sector mean that we are attempting to make transformational changes whilst at the same time, working to deliver significant cost savings.

2.0 SUMMARY

2.1 This report sets out the information that will be used to develop our acute sector planning, and the general direction that planning should lead to. The detail will be further developed at the scheduled IJB development session on 15th February 2017, with a view to bringing a more detailed paper to 14th March 2017 IJB meeting. That paper will also describe how we intend to meet the unscheduled care targets for 2017/18.

3.0 RECOMMENDATION

3.1 That the Inverclyde Integration Joint Board members note the proposed planning process and content, and comment to the Chief Officer as required.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 There is a statutory requirement for joint working between HSCPs and hospitals to plan for:

- Accident and Emergency services provided in a hospital;
- Inpatient hospital services relating to:
  - General medicine
  - Geriatric medicine
  - Rehabilitation medicine
  - Respiratory medicine
- Palliative care services provided in a hospital

4.2 Within this requirement there is also an expectation that we should set out how we will rebalance care with a view to reducing unnecessary use of hospital services, ensuring whenever possible that care is delivered in the right place, at the right time, and by the right people.

4.3 How we approach this is shaped by a number of policy statements including:

- The Inverclyde HSCP Strategic Plan;
- The Scottish Government Unscheduled Care Improvement Programme;
- The National Clinical Services Strategy;
- The NHS Greater Glasgow & Clyde Clinical Services Strategy;
- The emerging NHSGGC Strategy for Acute Services – Transforming the Delivery of Acute Services;
- The NHSGGC Unscheduled Care Performance Improvement Programme;
- New Ways of Working in Primary Care;
- IRH Weekly A & E Attendance Data;
- The Scottish Government's Health and Social Care Delivery Plan, and
- The Chief Medical Officer for Scotland's report, Realistic Medicine.

4.4 Although the policy context might seem complicated, it is important to recognise common themes amongst these drivers. Notable among these are that:

- The current configurations of community-based and hospital-based services are not financially sustainable, and
- The current configurations of community-based and hospital-based services are not always conducive to the best possible care or outcomes.

4.5 Transforming our current provision into a more effective and patient-centred system will be at the heart of our planning with the acute sector – particularly with regard to unscheduled care.

- We need to gain a better understanding of demand, and establish what can and should change;
- We need to clearly identify the improvements we want to make, and we need to know what these improvements will look like;
- We need a framework by which these improvements can be measured, and
- The financial framework that will support change needs to be clear, agreed and secure.

4.6 It is proposed that the HSCP develops a strategic commissioning plan for the delivery of the acute services that are within the scope of the IJB, covering the three-year timeframe of 2017/20, in line with other HSCPs within the NHSGGC area, and also within the timeframe of the NHS Greater Glasgow and Clyde Clinical Services Strategy.

5.0 BASIS OF THE COMMISSIONING STRATEGY AND KEY INFORMATION SOURCES

5.1 The Inverclyde HSCP Strategic Plan

Our own Strategic Plan outlines the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, our progress on these requirements by way of existing plans and strategies, and highlights new workstreams required of the HSCP, overseen by the IJB. A key dimension of that is our commitment to develop a framework that enables us to jointly plan the relevant hospital services along with acute sector colleagues. We acknowledged the challenges around this undertaking, in particular the financial challenge, but also the need to plan for local people within an acute sector that spans six Integration Authorities and need to think strategically across its entirety.

Notwithstanding these challenges, we have recognised that the Clinical Services Strategy needs to apply across the whole system, and our own Strategic Needs Assessment demonstrates that moving forward, all health and social care services will have to work together in a co-ordinated way if we are to achieve the best possible outcomes for the people most in need of these services.

5.2 The Scottish Government Unscheduled Care Improvement Programme

This programme seeks to share best practice and engage partners across Scotland, focusing on six Essential Actions to deliver unscheduled care.

Essential Action 1 – Clinically Focused and Empowered Hospital Management**.** This action is about the Clinical Leadership and operational management of hospitals, for example, determining appropriate staffing levels linked to hospital activity.

Essential Action 2 – Hospital Capacity Patient Flow Realignment. This will establish appropriate trend data to ensure that the correct resources are applied at the right time, right place and in the right format.

Essential Action 3 – Patient, Rather than Bed Management. This will examine processes that follow and facilitate the patient journey (flow) rather than about bed management. A key focus will be coordinated planning and implementation of appropriate discharge without delay.

This workstream is basically all about effective patient-tracking through the pathway and is about operational management, from an unscheduled and scheduled care point of view, and from a patient-centred point of view. These aspects should be coordinated to ensure optimum focus on effective discharge.

Essential Action 4 – Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway. This will ensure that internal hospital departments are geared with appropriate links to pull patients from the Emergency Department (for example, assessment units and acute receiving wards). This action should ensure that there is prompt access to appropriate assessment and clinical intervention from specialists in the appropriate environment to enhance patient experience and establish care management plans promptly, minimising unnecessary waits and delays.

Essential Action 5 - Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working. The priority will be to reduce evening, weekday and weekend variation in access to assessment, diagnostics and support services.

Essential Action 6 – Ensuring Patients are Optimally Cared for in their Own Homes or in a Homely Setting. This action will consider how someone who has an unscheduled care episode can be optimally cared for, or discharged to their own home, as soon as possible.

5.3 **The National Clinical Services Strategy and The NHS Greater Glasgow & Clyde Clinical Services Strategy** – These documents both focus on the need to be clear about what is (and what is not) appropriate use of acute hospital services. Essentially they propose that the functions of all clinical services need to be clearly defined and rigorously applied, reinforcing the need for the right care to be delivered at the right time, in the right place, and by the right professional. In defining the appropriate uses of all services, both strategies acknowledge that some gaps in provision might become visible. These gaps should be addressed through developing 'intermediate' services at the interface between hospitals and communities.

5.4 **The emerging NHSGGC Strategy for Acute Services – Transforming the Delivery of Acute Services**

In line with the Scottish Government's Health and Social Care Delivery Plan (see 5.6 below), the emerging NHSGGC Strategy outlines a vision for focusing 'hyper-acute' activity within three centres of excellence. The system of care NHSGGC wants to move to will entail a significant change – focusing on providing care where it is most appropriate for the patient. In practice, this will mean strengthened 24/7 community services, with hospital services focused on assessment and management of acute episodes. The strategy proposes that there will be a range of services developed at the interface, including shared management of high risk patients so that they can remain in the community if at all possible. This new approach will be supported by focusing on patient pathway and needs at each stage; changing the provision and accessibility of community services, and creating different ways of working at the interface. Co-ordinated care at crisis and transition points will be essential, so that individuals can move smoothly from acute care to community-based services at the right point in their own particular journey.

Once finalised, the Strategy will help local people to understand what care and expertise they should expect to receive from the whole acute system, as well as what will be provided locally and what they might need to travel for, but in the knowledge that they will be travelling for the best possible care, and will be repatriated to their own communities to continue with recovery as soon as it is clinically safe to do so.

5.5 **The NHSGGC Unscheduled Care Performance Improvement Programme**

This report has been developed by the Deputy Medical Director of NHS GGC, and provides data on emergency activity, demand and capacity, and analysis about what this means for the sustainability of hospital emergency services going forward. It also highlights the governance and programme management arrangements for the Unscheduled Care Collaborative, a group chaired by the NHS Chief Executive, and charged with ensuring leadership, guidance, engagement and communication at local levels and across the whole NHS Greater Glasgow & Clyde System.

It will be important for Inverclyde HSCP to interface effectively with this work, to ensure that local issues and priorities are represented. The work done so far offers a real opportunity to get some further depth to our understanding of how hospitals are currently used, and what needs to happen to support more appropriate usage in the future. Our local commissioning plans for acute services will be informed by a number of sources, but importantly these will include the information contained within the Programme Report.

5.6 **New Ways of Working in Primary Care**

The New Ways of Working in Primary Care Programme considers the current balance between available GP hours and the demand on General Practice. The programme is testing changes that aim to support the whole primary care team to be working to the extent of their qualifications for as much of the time as possible. This will mean that patients should only see a GP when that is what is needed, otherwise they might see a nurse, AHP or other professional, appropriate to the circumstances. This could have an impact on the transformation of the balance of care across the whole of patient pathways, as work diverted from acute into primary care might then need to be

redirected to the appropriate professional within primary care.

5.7 **IRH Weekly A & E Attendance Data**
The HSCP receives a weekly report from the IRH, showing A & E attendances; the number of these attendances that lead to hospital admission; the average length of stay for these admissions, etc. From this information it will become possible to track how A & E is being used, so that we can then begin to target efforts to help people to see the right professional, in the right place, and at the right time.

5.8 **The Scottish Government's Health and Social Care Delivery Plan**
This report outlines the key public health challenges and makes mention of the work currently underway, led by Sir Harry Burns, to develop performance measures that gauge improved outcomes for individuals and communities. It also refers to the need to plan and deliver some services on a regional basis, so that specialist expertise can be brought together and sustained through applying such expertise to as many people who need it as possible.

The direction proposed by this report is clear in that most care should be able to be delivered within communities, and that in cases where hospital care is required, this should only be for the acute phase of the disease, trauma or illness, and to be affordable and clinically sustainable, should be delivered out of a specialist, regionalised centre of excellence.

5.9 **The Chief Medical Officer for Scotland's Report, Realistic Medicine**
This report highlights the risks of 'over-medicalising', and how this can have adverse impacts on quality of life, particularly for those nearing the end of their lives. It highlights that doctors sometimes apply interventions on the basis of trying to prolong life, but if patients are supported to make informed choices, some will decide that the impact of side-effects of the intervention mean that they would prefer to have a shorter but better-quality time left, and be more in control of their own death. It is important to note that the report does not advocate denying treatment if that is the choice of the patient, but also notes that most doctors would not chose for themselves what they often choose for their patients.

The principles of the report are important for us moving forward, as they emphasise the need to support patients to be equal partners in their own care, if we are to develop truly person-centred approaches that deliver the wellbeing outcomes that underpin our strategic plan.

5.10 Informed by all of the above, our initial planning with acute sector colleagues will focus on a few high-impact areas:

- Unscheduled care;
- Complex care beds;
- Admissions to hospital from care homes, and
- End of life/ palliative care.

By focusing on these key areas, we will aim to shift some care out of hospital and into community settings. This is in line with best practice, but importantly also reflects the preferences of most people who need care. The longer term ambition will be to reduce reliance on hospital services to an extent whereby some beds can either close or be reassigned into community pathway uses, with their costs then being transferred to HSCP budgets to further develop community infrastructure.

6.0 PROPOSAL

6.1 The IJB is required by the legislation to oversee the development of joint planning for the service areas noted at 4.1, with a view to shifting the balance of care away from hospitals and towards communities. It is proposed that this planning is based on the information outlined within this report.

7.0 IMPLICATIONS

7.1 **Finance**

There are no direct financial implications arising from this report, however, the work undertaken as a result of the report may lead to changes in set aside budgets longer term. Any such change would come to the IJB for approval prior to implementation.

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					

7.2 **Legal**

There are no legal implications in respect of this report.

Human Resources

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

7.4 Has an Equality Impact Assessment been carried out?

	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

7.4.1 **How does this report address our Equality Outcomes?**

By ensuring that people get the right care, in the right place and from the right professional, we anticipate that they will experience more equal health outcomes**.**

7.4.1.1 **People, including individuals from the protected characteristic groups, can access HSCP services.**

Improved access to services will be achieved for all Inverclyde residents, including those with protected characteristics.

7.4.1.2 **Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.**

Not applicable.

7.4.1.3 **People with protected characteristics feel safe within their communities.**

Not applicable

7.4.1.4 **People with protected characteristics feel included in the planning and developing of services.**

Planning will be led by the Strategic Planning Group and overseen by the Integration Joint Board (IJB). There is carer and service user/ public partner representation on both of these groups ensuring that people with protected characteristics are represented.

7.4.1.5 **HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.**

Not applicable.

7.4.1.6 **Opportunities to support Learning Disability service users experiencing gender based violence are maximised.**

Not applicable.

7.4.1.7 **Positive attitudes towards the resettled refugee community in Inverclyde are promoted.**

Not applicable.

7.5 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

As we start to shift usage patterns, clinical and care outcomes will be monitored by the Clinical and Care Governance Group.

7.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

7.6.1 **People are able to look after and improve their own health and wellbeing and live in good health for longer.**

Through people accessing the right care, in the right place, at the right time and from the right professional, illnesses will be detected and treated at an earlier stage, thereby mitigating their deleterious effects and offering greater scope for supported self-management.

7.6.2 **People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

Through people accessing the right care, in the right place, at the right time and from the right professional, illnesses will be detected and treated at an earlier stage, thereby mitigating their deleterious effects and offering greater scope for sustaining people in their own homes for longer.

7.6.3 **People who use health and social care services have positive experiences of those services, and have their dignity respected.**

We will ask service users about their experience of services, and report their responses to the IJB.

7.6.4 **Health and social care services are centred on helping to maintain or improve**

the quality of life of people who use those services.

By placing emphasis on the right care, in the right place, at the right time and from the right professional, we will support a culture of person-centredness.

7.6.5 **Health and social care services contribute to reducing health inequalities.**

A focus on person-centredness and more appropriate access will contribute to reducing unequal outcomes.

7.6.6 **People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.**

Carers will have greater clarity about where and when they should take the cared-for person for health or social care. This in turn will help inform them about what services they themselves should have access to, and how to access these.

7.6.7 **People using health and social care services are safe from harm.**

Quality and safety are central to clinical and care governance processes, and this will remain the case as we work to transform local provision. The Clinical and Care Governance Group will continue to operate, ensuring that any significant incidents are reviewed and learning from them is disseminated.

7.6.8 **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

Staff will have greater opportunities to diversify their careers and develop their skills and knowledge base.

8.0 CONSULTATION

8.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with relevant senior officers in the HSCP, and colleagues in the Acute Sector.

9.0 LIST OF BACKGROUND PAPERS

9.1 As detailed at 4.3 – available on request.