AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date: 14th March 2017**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/13/2017/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 our developing 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 Since the last report to the IJB on this topic in January 2017, IJB members attended a session exploring some of the issues in more depth (15th February), with a view to setting a robust foundation upon which to plan for future hospital bed usage. Alongside this work, the Chief Officers of the six HSCPs within the boundaries of NHS Greater Glasgow and Clyde have been working through the key conditions under which such transformational change can take place.

2.0 SUMMARY

2.1 This report sets out the agreements that need to be in place so that HSCPs and the Acute Sector can plan together effectively, creating a shift in care to the right place, at the right time and from the right professional.

3.0 RECOMMENDATION

3.1 That the Inverclyde Integration Joint Board members approve the proposed planning process, 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 As noted in the January 2017 report, 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;
- The Scottish Government's Health and Social Care Delivery Plan, and
- The Chief Medical Officer for Scotland's report, Realistic Medicine.

5.0 FEBRUARY IJB SESSION

5.1 At the IJB session on 15th February 2017, it was recognised that shifting the balance of care with the aim of reducing usage of hospital bed days will require a focused effort between both the acute sector and HSCPs. If joint planning is not robustly developed and implemented, there is a clear risk that any capacity that might be created in hospital will immediately be taken up by increased hospital activity.

5.2 It was noted at the session that there is a tension between reducing hospital bed usage, and funding alternative care from community-based services in the absence of a clear mechanism for releasing and transferring money and staff from the hospital. It was also noted that there would be a need to fund relocated care in advance of any resource transfer, and that in the current financial context, this would be extremely challenging.

5.3 IJB members noted that to effect a sustainable change in the balance of care, there needs to be a reduction in acute hospital bed usage, with a clear programme of bed closures alongside this reduced usage, so that staff and financial resources can be released into community services. This carries a risk to the future viability of the local hospital, so a clear strategic approach is required so that communities can be part of a process that redefines how and for what purpose the local hospital should be used, going into the future. It was acknowledged that there needs to be a transformational programme that ensures that those services that can be delivered safely in the community are transferred, and that the people of Inverclyde have confidence that we are effecting recalibrated health and care services rather than implementing reduction. The health inequalities that are evident in Inverclyde underscore the need for transformational change that delivers improved outcomes for local people.

5.4 Key transformation requirements noted within the January 2017 IJB paper included:

- 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.

6.0 ACUTE COMMISSIONING INTENTIONS

6.1 The requirements at 5.4 are still valid, but the six Chief Officers have also agreed a suite of Acute Commissioning Intentions, framed on the basis that there is a shared acknowledgement of the joint responsibilities across Acute Services, Primary Care and HSCPs to effect change. This suite of acute sector actions will be augmented by locally-defined HSCP-specific and proposed primary care actions. By working together to create a common set of directions, the Chief Officers recognise that the NHS Board needs to be supported to develop consistent and systemic change. The common directions to the NHS Board and acute sector are as follows.

6.1.1 Communication - acute and community services

- Establish mechanisms whereby GPs can access advice from senior acute medical staff pre-admission relating to the need for admission and/or options other than admission (e.g. potential hot clinics).
- Establish a consistent system whereby HSCPs are alerted by acute services, at the point of admission, of all patients already identified as at risk of unnecessary admission.

6.1.2 Unplanned admissions

- HSCPs and acute services will identify a joint scoring matrix for identifying patients at risk of unnecessary admission.
- Establish GP access to a range of options for patients at the point of pre-admission, for example urgent next day outpatient appointment by speciality and direct access to diagnostics.
- Review and optimise admissions pathways across acute sites with a view to reduce inappropriate variation.

6.1.3 Occupied bed days for unscheduled care

- Acute Services to demonstrate progress in working towards delivering the externally benchmarked upper quartile length of stay across all sites and specialties.
- Optimise discharge processes across all sites and specialties to create an earlier in the day discharge profile and increase weekend discharges.

6.1.4 A&E performance

- Create and implement redirection pathway back to minor injury units and primary care. (Note: recognise that HSCPs need to agree with GP Quality Clusters and/or LMC [via Primary Care Support] a process for seeing redirected patients).
- Review the balance of staffing in A&E departments to ensure that frail older patients have speedy access to appropriate clinical support and imaging and investigations.
- Establish a process whereby GPs are able to access agreed imaging investigations to support diagnosis and decision-making.

6.1.5 Delayed discharges

- Establish a system whereby community staff, SSA and acute clinicians routinely use anticipatory care plans and the summary recorded on ekiss as part of assessment process to avoid admission and to expedite discharge.

- Strengthen discharge planning between acute discharge planning and community hospital teams including rehabilitation communication.

6.1.6 End of life care

- Establish a consistent system in place whereby HSCPs are given early notice by acute services of patients who require end of life care.

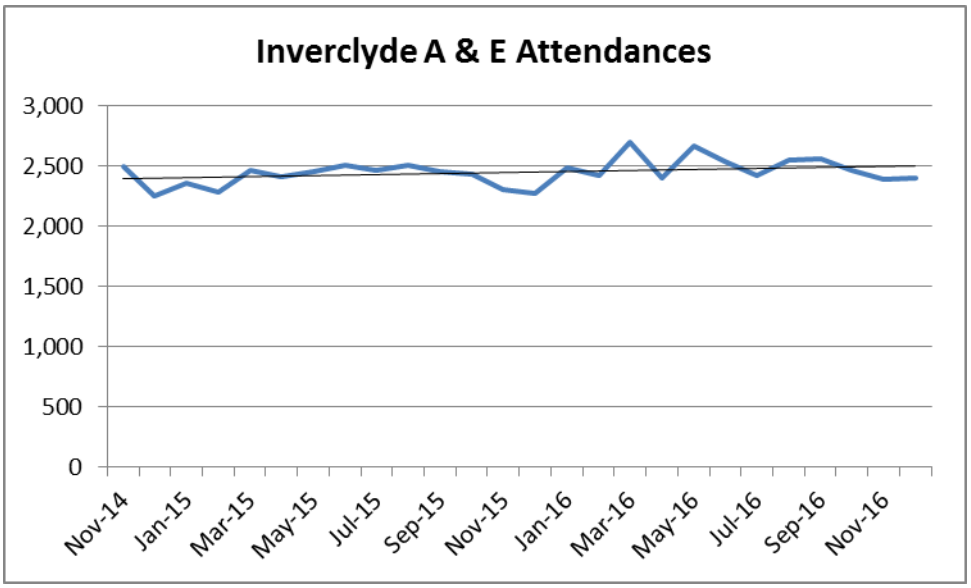
6.1.7 Balance of Spend - for both HSCP and Acute

- Acute services to review and ensure effective medicines management at point of admission and discharge.
- Agree a way of working between acute sites and all six HSCP community services through which a proportion of set aside budgets is used to support development of interface services out-with acute sites.

7.0 ACUTE BED USAGE CONTEXT

7.1 On 17th February 2017, the Scottish Government issued data to HSCP Chief Officers outlining unscheduled bed usage over a period of just over a year, from November 2014 to December 2016. During this period there were, on average, 2,446 A & E attendances by Inverclyde people per month. Graph 1 below shows that this figure is gradually increasing. The reasons for this are not clear, but will need to be explored as part of local joint planning with acute. The Inverclyde Royal Hospital A & E Department consistently meets the Government's waiting time target of 95% of A & E attendees being seen within 4 hours, so this might be driving demand upwards as an attractive 'drop-in' option.

We will work together to ascertain how to respond to demand at A & E that is neither accident-related nor an emergency, in a way that provides care in the right place at the right time, and importantly, demonstrates better value for public money that the current usage of hospital-based service.

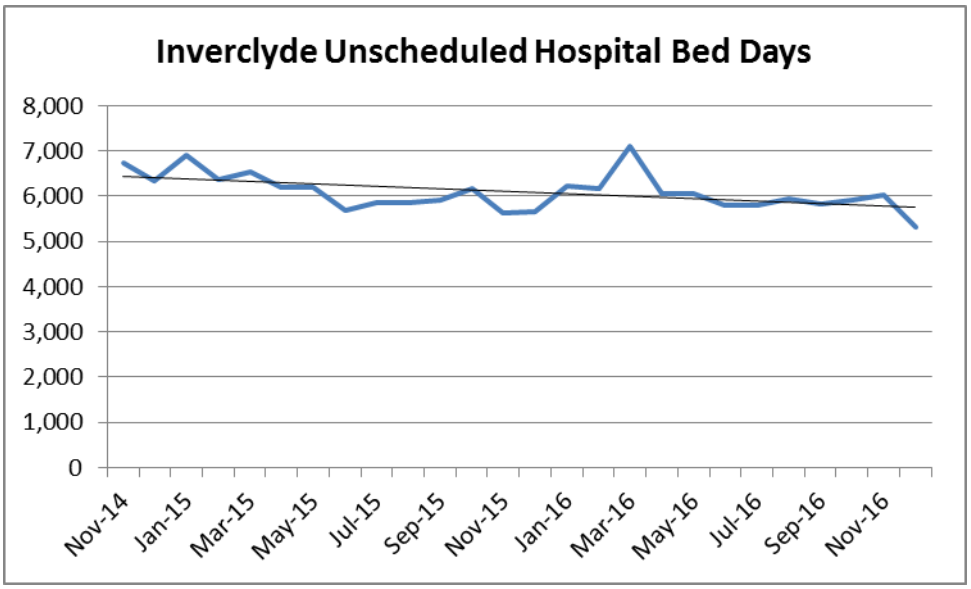


Graph 1: A & E Attendances relating to Inverclyde residents

7.2 During the same period, on average there were 637 admissions per month from A & E, in relation to Inverclyde residents. This equates to, on average, 26% of Inverclyde A & E attendances resulting in a hospital admission (which is the same as both the Scottish and NHS GGC averages). However the range in admission rates across Scotland goes from 11% in Angus to 40% in North Ayrshire (a proportion of which will be admitted to the IRH). The NHSGGC Unscheduled Care Performance Improvement Report of November 2016 highlights that the Greater Glasgow & Clyde unplanned admission rate is by far the highest in Scotland, so more work needs to be undertaken to understand this. Initial analysis suggests that there are no clear thresholds or

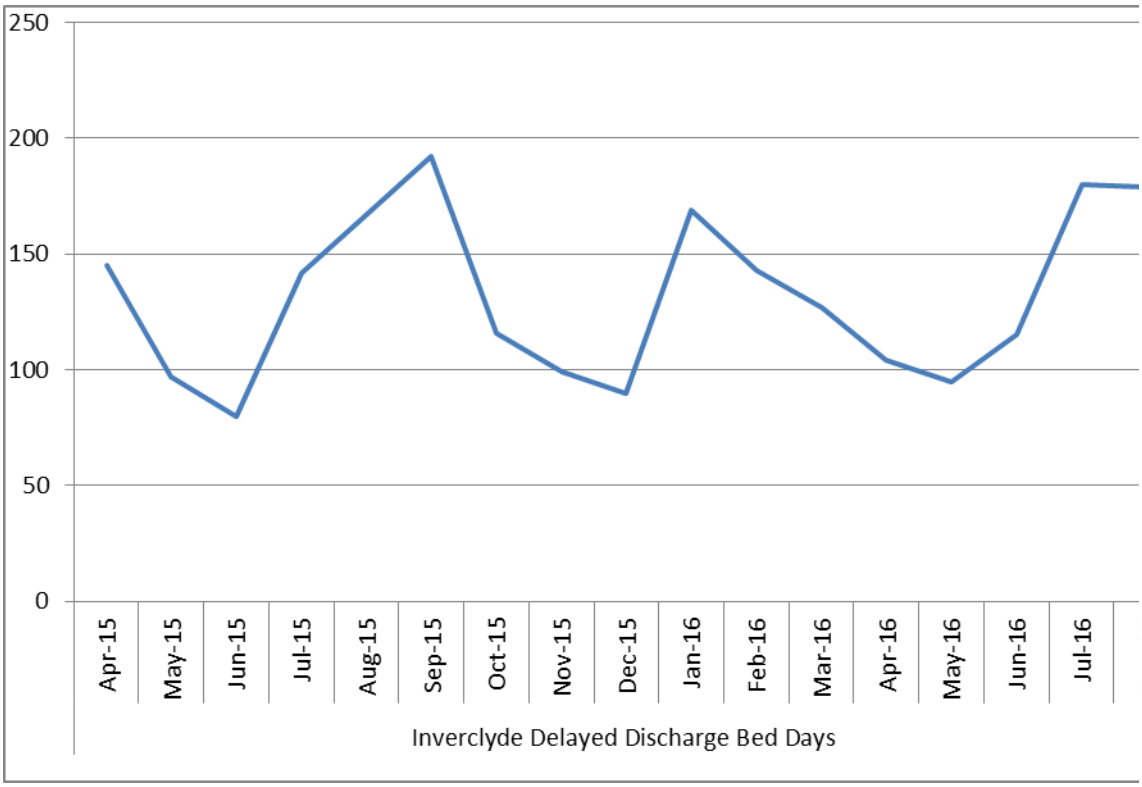
criteria for admission, which would ideally be linked to a robust understanding of levels of support that are available from community services. By developing and implementing such thresholds, it might be possible to reduce the number of unplanned admissions, with a view to bringing our performance closer to that of other Scottish Health Boards.

7.3 The average number or unscheduled bed days per month in the same timeframe is reported as 6,088 per month, although graph 2 below shows that this is steadily reducing. This reduction appears in part to be due to improved communication about alternatives, and a sustained focus on delayed hospital discharge, however this will be accelerated through the implementation of the directions at 6.1.



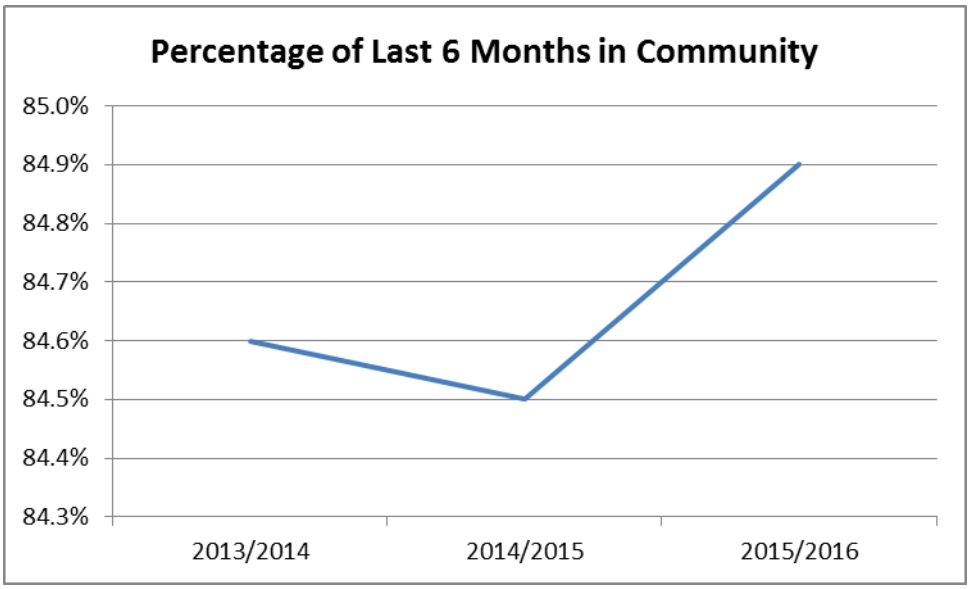
Graph 2: Inverclyde unscheduled hospital bed days

7.4 Delayed hospital discharge is often cited as a wasteful use of expensive hospital bed days, and indeed can have a negative influence on patients' outcomes. Inverclyde performs comparatively well in getting people out of hospital and into a more appropriate setting (ideally their own home). Graph 3 below shows bed days lost to delayed discharge between April 2015 and August 2016 average 132 beds days per month. We aim to reduce the average, with a combination of good community infrastructure and close joint working between acute and community-based services.

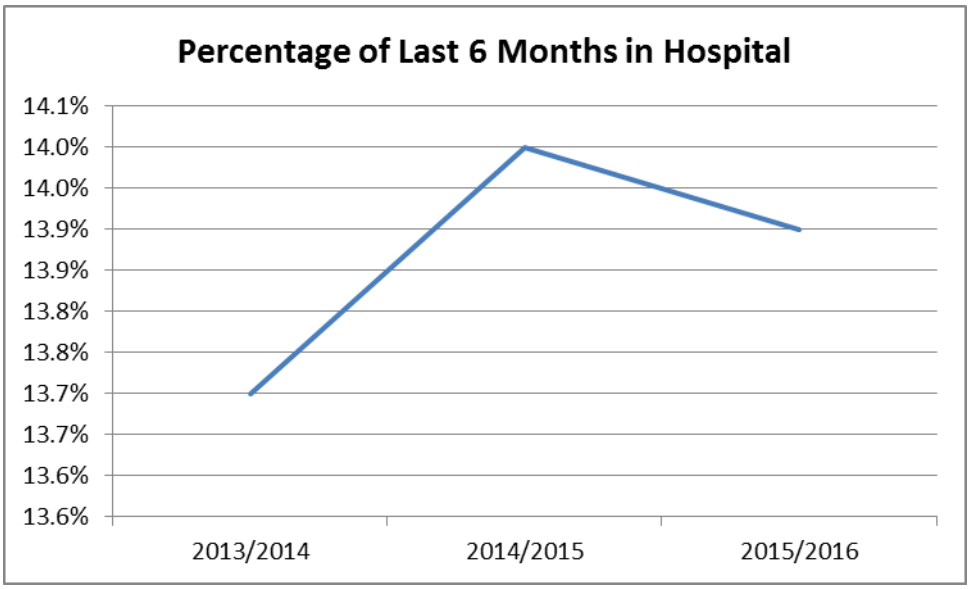


Graph 3: Inverclyde delayed discharge bed days

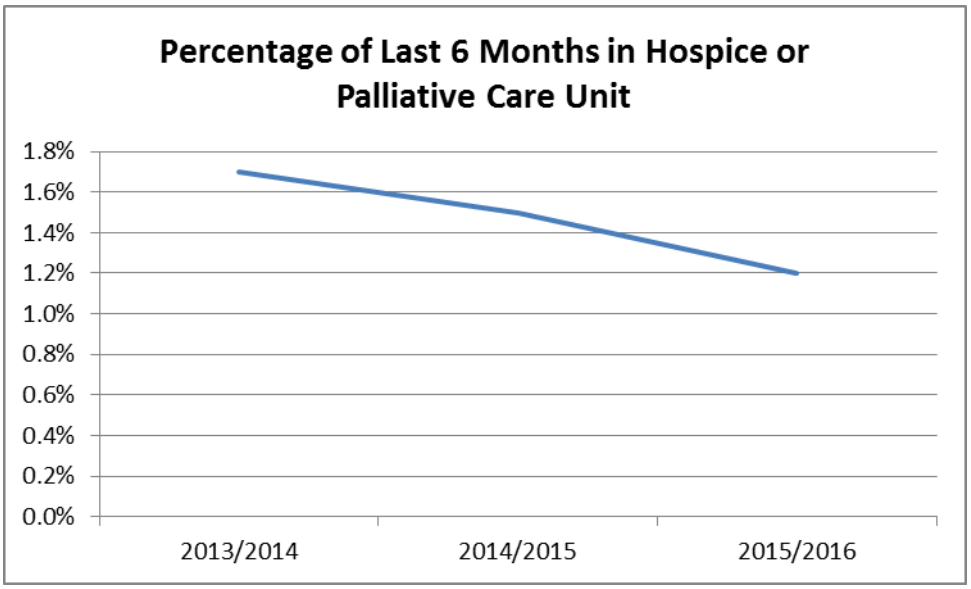
7.5 An important theme running through most of the policy drivers noted at 4.3 is the need for good quality end of life care, at home or in a homely setting. Graphs 4 – 9 below describe progress in improving end of life care through a data lens, but it should be noted that we do not currently have information about the patient's perceived experience. Graph 4 shows that for those people whose lives ended, there has been a small increase in the percentage of their last six months spent in the community (generally regarded as the best option). We might expect this to be mirrored by a small decrease in the percentage of the last six months of life being spent in hospital, however graph 5 shows that this has not been the case. There has also been a small increase in the percentage of the last 6 months of life spent in hospital. Graph 6 indicates that there has been a decrease in the percentage of the last six months of life spent in a hospice or palliative care unit. This perhaps demonstrates that the local hospice and palliative care unit have been more successful in getting people at the end of their lives back into their homes and communities.



Graph 4: Percentage of last 6 months spent in the community

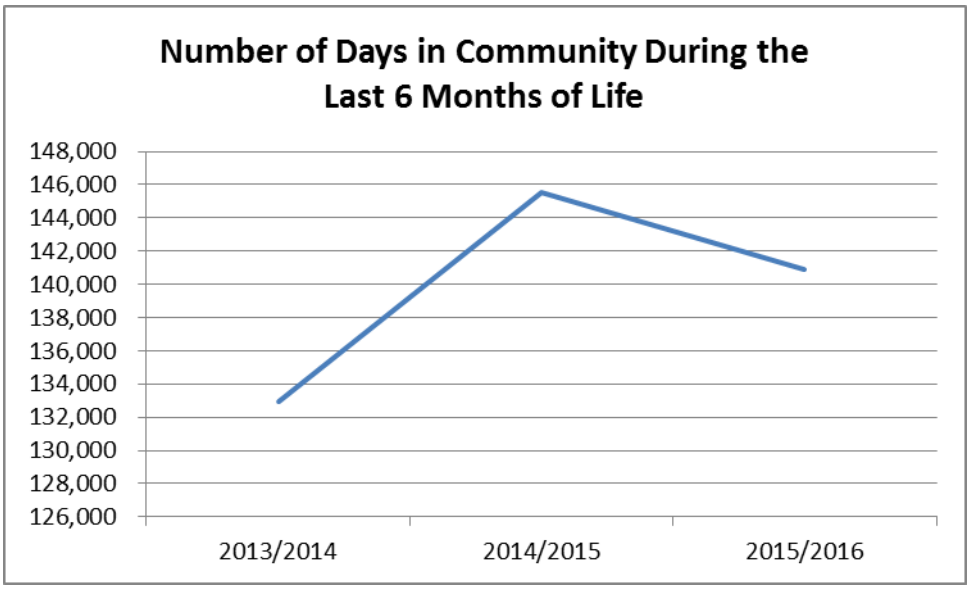


Graph 5: Percentage of last 6 months spent in hospital

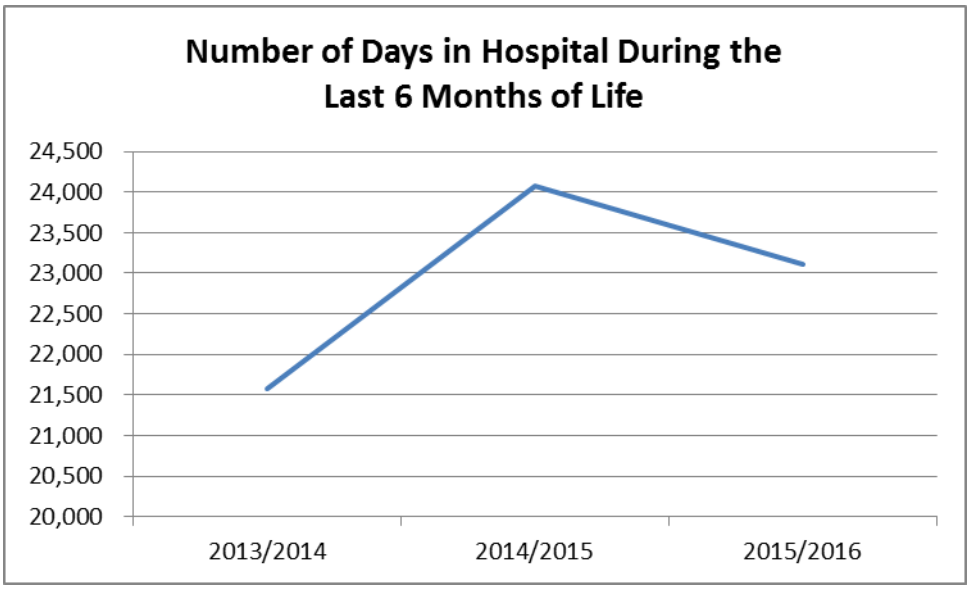


Graph 6: Percentage of last 6 months spent in a hospice or palliative care unit

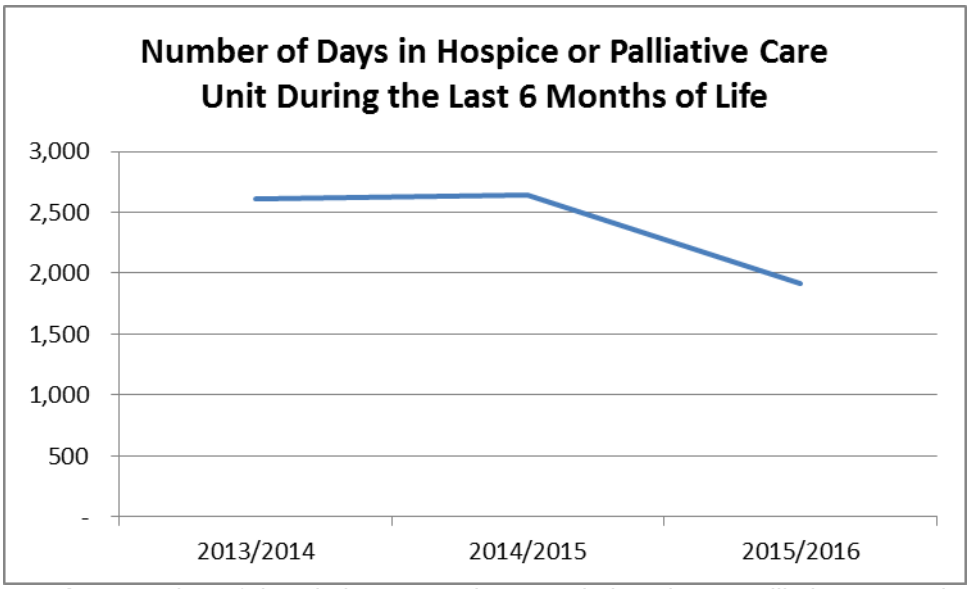
7.6 Our future planning depends on having a reliable sense of the number of bed days required in each setting for end of life care, and then a clear picture of what we want to change, and by how much. Graph 7 indicates that on average, each year between 2013 and 2016, community services provided 140,000 days of care and support to people who have reached the last 6 months of their lives. End of life care accounted for, on average, 23,000 hospital bed days per year (graph 8), and around 2,400 hospice or palliative care unit bed days per year (graph 9).



Graph 7: Number of days in last 6 months spent in community



Graph 8: Number of days in last 6 months spent in hospital



Graph 9: Number of days in last 6 months spent in hospice or palliative care unit

7.7 Clearly our future planning needs to encompass all care and support needs, including but not exclusively end of life care. For most people, support needs become greater as they get older, and our planning for older people's services is underpinned by the drive to keep people in their own homes or a homely setting whenever possible. The

National Clinical Strategy and the NHS Greater Glasgow and Clyde Clinical Services Strategy both highlight the advantages of care being delivered outwith a hospital environment if at all possible. Most of the support options currently established were developed in a previous context, driven by numeric systems targets and metrics rather than patient outcomes. The establishment of HSCPs represents an opportunity to reshape our thinking, and presents the challenge to statutory services to work together to re-imagine care and support so that it genuinely improves the quality of life as well as outcomes for those who need our services, while demonstrating better value for money.

7.8 These principles will underpin our planning with acute services, and our performance will be measured on the shift we make out of hospital and into more appropriate models, gauged on the metrics described within the graphs in this report.

7.9 Officers, professional care staff and clinicians from the HSCP and the acute sector will work together over the next few months to develop useful answers to the requirements described at 5.4, and in the context of the suite of acute commissioning intentions at 6.1.

8.0 PROPOSAL

8.1 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, and the IJB is asked to approve this approach.

9.0 IMPLICATIONS

9.1 **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					

Legal

9.2 There are no legal implications in respect of this report.

Human Resources

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

Equalities

9.4 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

9.4.1 **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**.**

9.4.1.1 **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.

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

Not applicable.

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

Not applicable.

9.4.1.4 **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.

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

Not applicable.

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

Not applicable.

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

Not applicable.

9.5 **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.

9.6 **NATIONAL WELLBEING OUTCOMES**

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

9.6.1 **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.

9.6.2 **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.

9.6.3 **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.

9.6.4 **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.

9.6.5 **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.

9.6.6 **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.

9.6.7 **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.

9.6.8 **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.

10.0 CONSULTATION

10.1 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.

11.0 LIST OF BACKGROUND PAPERS

11.1 As detailed at 4.3 – available on request.