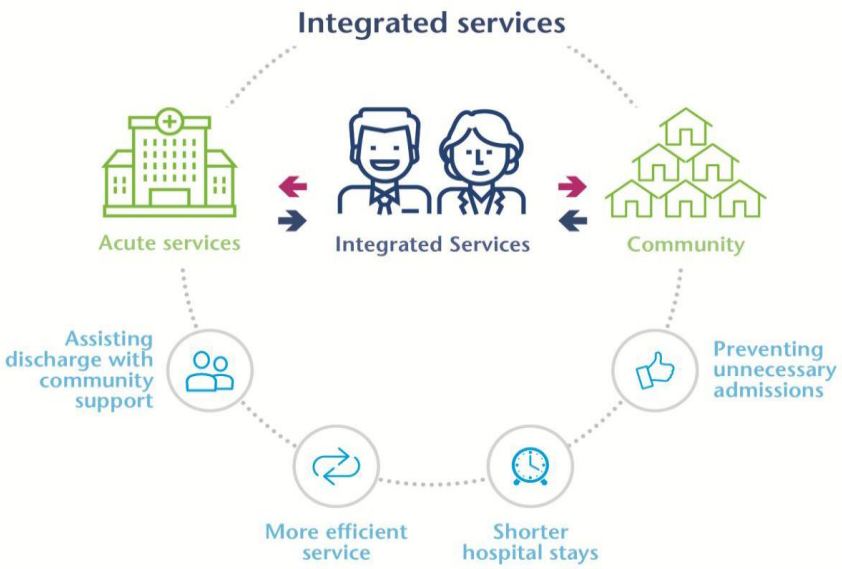
West Dunbartonshire
Health & Social Care Partnership

Unscheduled Care Commissioning Intentions



2017 - 2020

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Background

West Dunbartonshire Health & Social Care Partnership Board is responsible for the strategic planning and reporting of a range of health and social care services delegated to it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council (described in full within its approved Integration Scheme).

The Partnership Board's:

- Mission is to improve the health and wellbeing of West Dunbartonshire.
- Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.
- Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.

The Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of its Integration Scheme (as per the Public Bodies [Joint Working] Act 2014). The Council and the Health Board discharge the operational delivery of the services delegated to the Partnership Board - except those related to the Health Board's Acute Division services most commonly associated with the emergency care pathway - through the partnership arrangement referred to as West Dunbartonshire Health & Social Care Partnership (WD HSCP). The Partnership Board is responsible for the operational oversight of the HSCP.

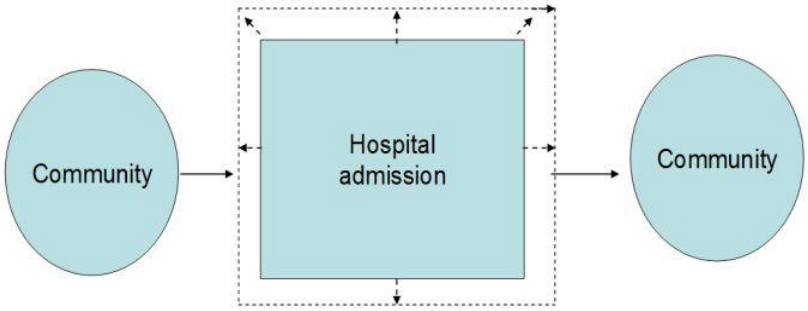
As required by legislation, the Partnership Board is responsible for strategic planning for unscheduled care with respect to the population of West Dunbartonshire. In doing this, it is obliged to work closely with the Health Board as well the other Integration Joint Boards within the Greater Glasgow & Clyde area. Unscheduled care is the unplanned treatment or care of an individual usually as a result of an emergency or urgent event. This usually takes the form of presentation at Accident and Emergency services which can result in an admission to hospital.

Improving unscheduled care is a shared priority for the Partnership Board, its neighbouring Integration Joint Boards, NHS Greater Glasgow & Clyde and the Scottish Government. This reflects the challenges presented by a "wicked" combination of continuing shifts in patterns of disease to long term conditions; growing numbers of older people with multiple conditions and complex needs; and a pressurised financial environment. Critical to this is the on-going work and developments to shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment. At the same time, waste and variation in clinical practice need to be addressed, alongside promoting the reliable implementation of effective interventions.

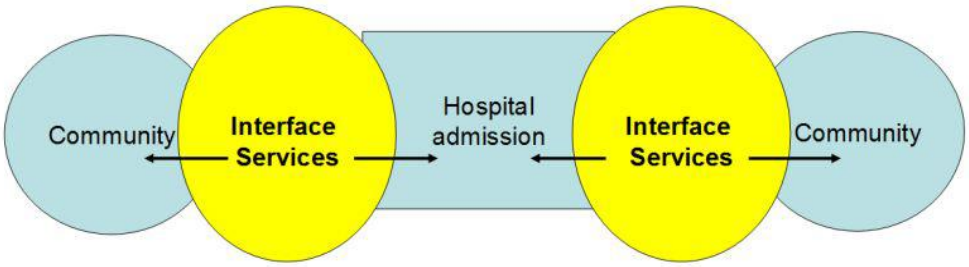
The *NHSGGC Clinical Services Strategy* (2015) aims to ensure that:

- Care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway.
- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements.
- Sustainable and affordable clinical services can be delivered across NHSGGC.
- The pressures on hospital, primary care and community services are addressed.

It describes a system under increasing pressure in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and joint planning (as illustrated below).



It envisages moving to a system of care that focuses on providing care where it is most appropriate for the patient (as illustrated here).



This is based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits. Working differently at the interface (represented by the yellow circles above) 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.

Similarly, the *National Clinical Services Strategy* (2016) provides a Scotland-wide framework for action, with an emphasis on:

- Taking a person centred approach
- Ensuring services are safe, sustainable, efficient and adaptable over time
- Ensuring care is provided closer to home wherever possible
- Ensuring services are integrated between primary and secondary care
- Providing affordable solutions to utilise available funding as effectively as possible.

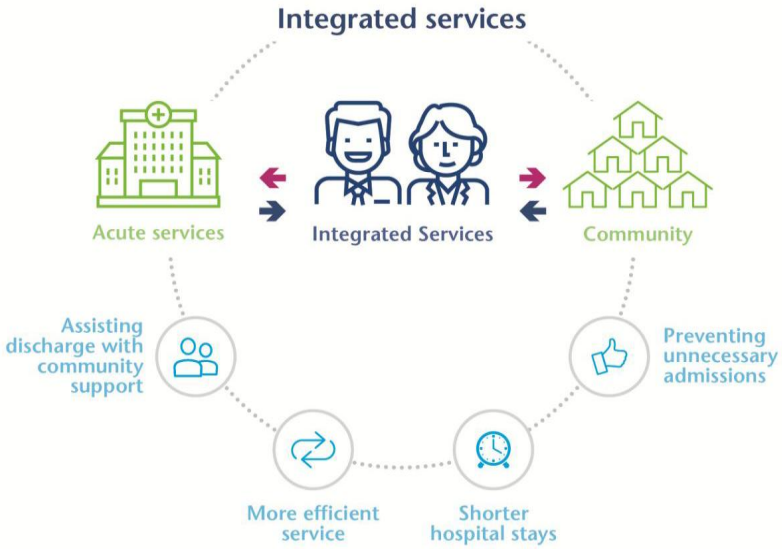
The *National Health & Social Care Delivery Plan* (2016) emphasises that the integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. It argues that the people most affected by these developments, and for whom the greatest improvements can be achieved, are older people, people who have multiple, often complex care needs, and people at the end of their lives. Too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs.

In addition, *Realising Realistic Medicine: The Chief Medical Officer for Scotland Annual Report 2015/16* asserts that the people receiving health and care should be at the centre of clinical decision-making; and highlights the imperatives for:

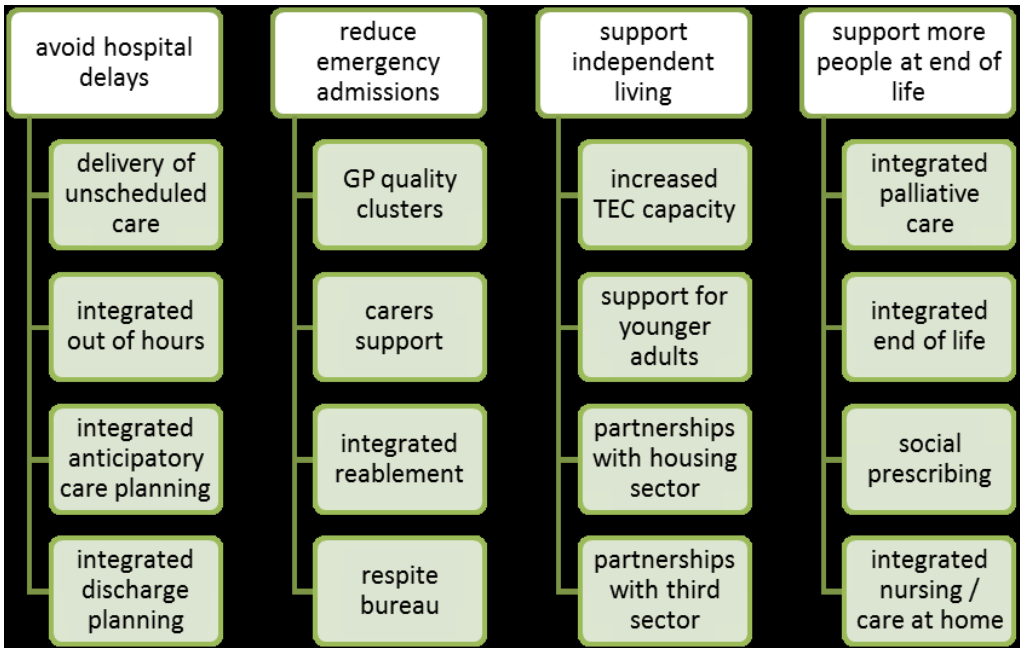
- Reducing harm and waste.
- Tackling unwarranted variation in care.
- Managing clinical risk.
- Innovating to improve.

Following the publication of the National Clinical Strategy and the Health & Social Care Delivery Plan, NHSGGC's Acute Services Committee agreed an approach to planning the changes required to transform Acute Services in line with the direction set by these initiatives - *Transforming Delivery of Acute Services Programme* (2017). This included:

- An appreciation that while there continue to be increasing amounts of money spent on the NHS, that the growing demands from patients and the changing health needs of the population will only be met by shifting resources from acute hospitals to the community.
- A commitment that more support will be developed in the community to enable people to stay locally and out of acute hospitals unless necessary.
- An expectation that new approaches to the effective delivery of care and support for people with multiple health conditions will result from better integration and investment. An acknowledgement that while any redesign of acute hospital services is likely to impact on all NHSGGC acute hospital sites, the Health Board remains committed to the delivery of acute services from all of the main acute hospitals, i.e Queen Elizabeth University Hospital, Glasgow Royal Infirmary, Gartnavel General, New Victoria Hospital, New Stobhill Hospital, Royal Alexandra Hospital, Inverclyde Royal Hospital and the Vale of Leven Hospital.



All of the above chimes with the Partnership Board's Strategic Plan 2016-19 and its strategic commissioning priorities for adults and older people – summarised as follows:



In the region of £70 million of the HSCP's budget – across both health and social care spend and activity – is allocated towards delivering community services that address these strategic commissioning priorities. For context, this is over half of the HSCP's direct budget and that does not include the support derived by the HSCP's Family Health Services or Prescribing budgets (in terms of funding for Primary Care); nor its share of acute "set aside" resources, which is currently estimated at £17 million.

The ScotPHO Health & Wellbeing Profile for West Dunbartonshire confirms the relatively higher levels of poor health within the area compared to Scotland as a whole, reflecting the relatively pervasive and high level of deprivation across the area. In 2015 the area has the second highest premature mortality rate per 100,000 population at 570 (Scotland 441).

West Dunbartonshire – under the auspices of the Community Health & Care Partnership – introduced integrated operational teams and arrangements for local adult services in 2014. These included:

- Single point of access staffed by senior practitioners and professionals.
- Community Older People's service, including sensory impairment.
- Community Adult Care service, including physical disability.
- Community Hospital Discharge service, including hospital ward-based early assessors and community-based nurse-led beds.
- Integrated Out-of-Hours services, including district nursing, care at home, palliative care and medicines compliance.

For 2015/16, the HSCP was the best performing in Scotland for:

- Percentage of adults supported at home who agreed that their health and social care services were well co-ordinated - 85% (Scotland 75%).
- Percentage of adults receiving any care or support who rated it as excellent or good – 88% (Scotland 81%).
- Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections – 93% (Scotland 83%).

The HSCP was also:

- The second best performing for percentage off adults supported at home who agreed that they are supported to live as independently as possible – 89% (Scotland 84%).
- The 5th lowest rate of readmissions to hospital within 28 days per 1,000 population at 78 (Scotland 95).

The HSCP has worked with primary care colleagues and other stakeholders (including Council housing and NHS acute services) to establish planning arrangements for its two locality areas: Alexandria & Dumbarton; and Clydebank. These are coterminous with the three recently confirmed GP clusters within West Dunbartonshire (as per the 2016/17 General Medical Services agreement between the Scottish GP Committee and the Scottish Government). Work programmes are being developed and led by the local practitioners involved – the ones of most relevance here being on Chronic Obstructive Pulmonary Disease (COPD) and frailty (i.e. the decreased ability to withstand illness without loss of function).

The Partnership Board has also recognised the importance of adopting a balanced approach to manage the additional unscheduled care pressures and business continuity challenges that are faced in winter (as noted within its local Strategic Risk Register). Across the six partnerships within the Health Board's area, the Chief Officers have all

agreed that each HSCP produces a winter plan. These reflect the 12 critical areas within the national *Preparing for Winter Guidance*, including the national *6 Essential Actions to Improving Unscheduled Care*:

- Clinically-focused and hospital management.
- Realignment of hospital capacity and patient flow.
- Patient rather than Bed Management - Operational Performance.
- Medical and surgical processes arranged to take patients from A&E through the acute system.
- Seven-day services targeted to increase weekend and earlier-in-the-day discharges.
- Ensuring patients are cared for in their own homes or a homely setting.

The HSCP has made use of funding provided by the Integrated Care Fund, Technology Enabled Care (TEC) Programme and support from Information Services Division (ISD) to interrogate the effectiveness of these interventions, both short and long term. The analysis of this work has demonstrated emerging evidence of early supported discharges directly from the wards and a decrease in the number of unplanned admissions as a result of investment in - for example - integrated out of hours care at home and district nursing services, out of hours availability of nurse led beds within the community and effective locality planning with GPs. These have driven and contributed to improved performance in a number of key metrics as illustrated in Figures 1, 2 and 3 below.

Figure 1: West Dunbartonshire Admissions from Accident & Emergency 2014 – 2016 (Source: ISD)

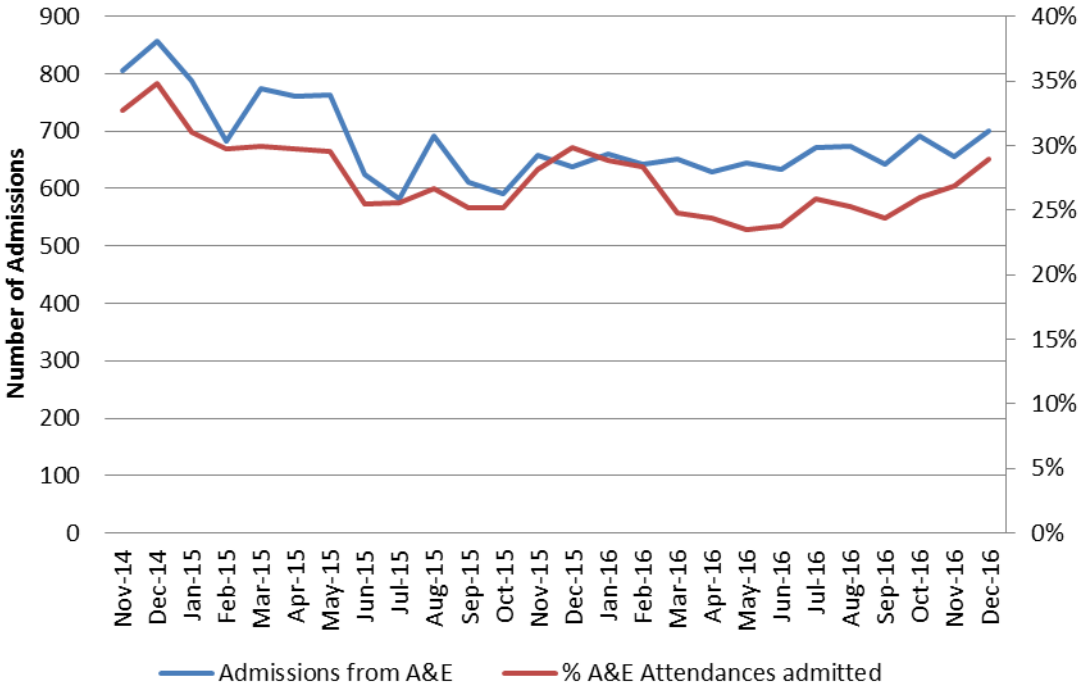


Figure 2: West Dunbartonshire Unscheduled Bed Days 2014 – 2016 (Source: ISD)

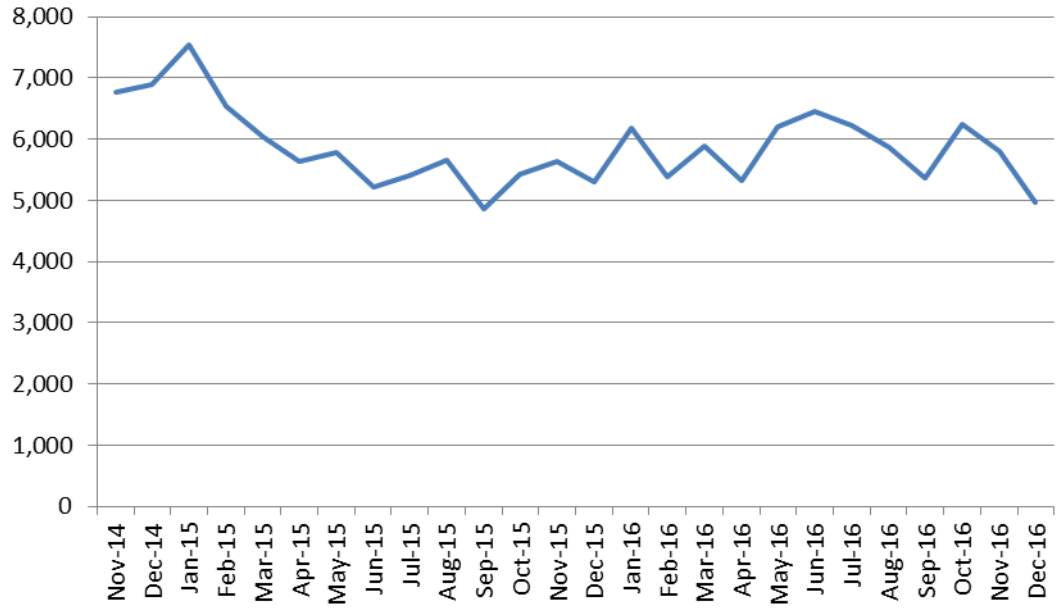
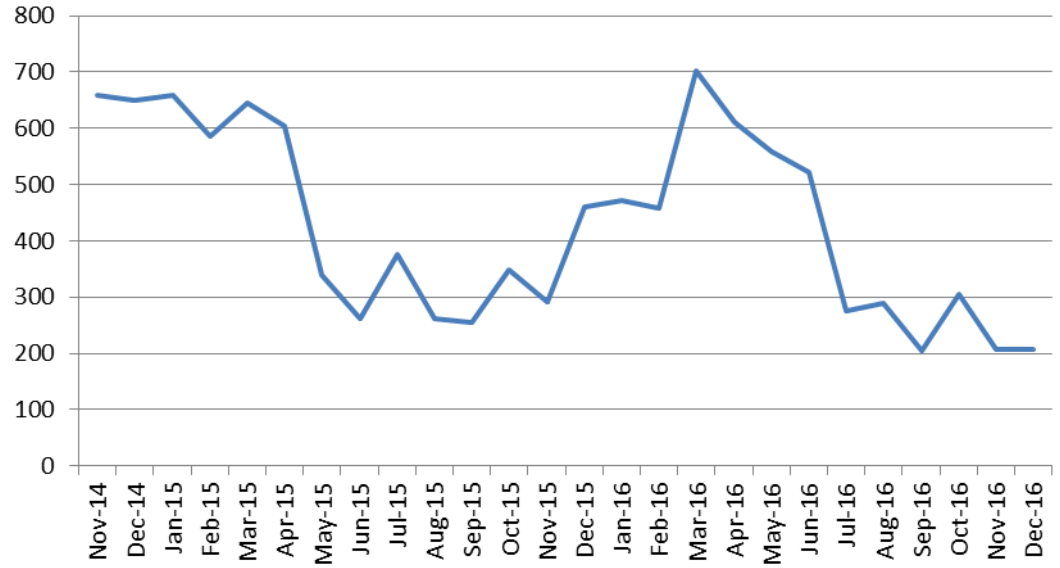
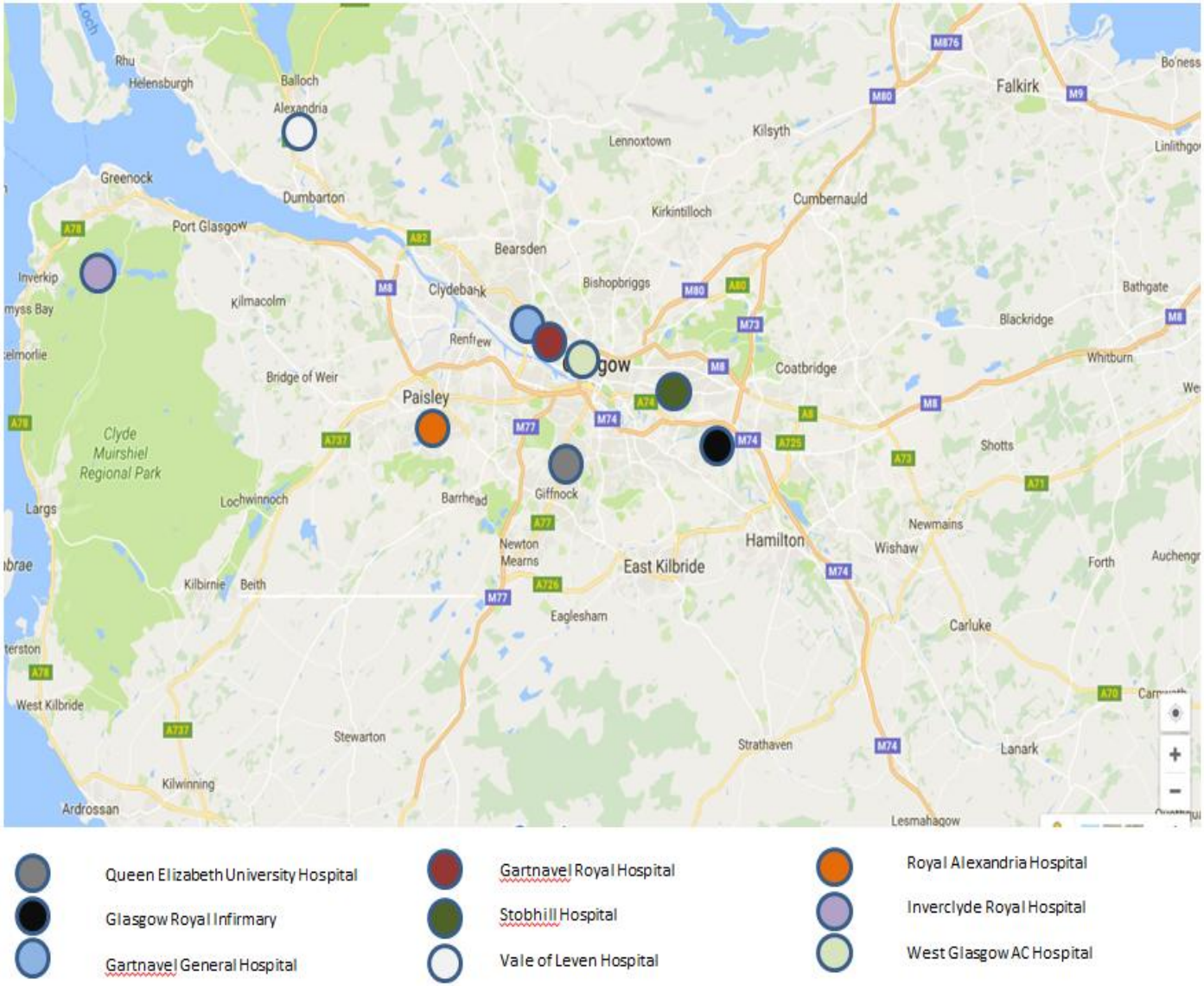


Figure 3: West Dunbartonshire Delayed Discharge Bed Days 2014 – 2016 (Source: ISD)



Each HSCP also participates in the planning work across the wider NHS system to enable the delivery of effective unscheduled care. The importance of the latter reflects the fact that residents of West Dunbartonshire are admitted to and receive acute care from nine acute sites across NHSGGC (as overleaf).



Queen Elizabeth University Hospital

Glasgow Royal Infirmary

Gartnavel General Hospital

Gartnavel Royal Hospital

Stobhill Hospital

Vale of Leven Hospital

Royal Alexandria Hospital

Inverclyde Royal Hospital

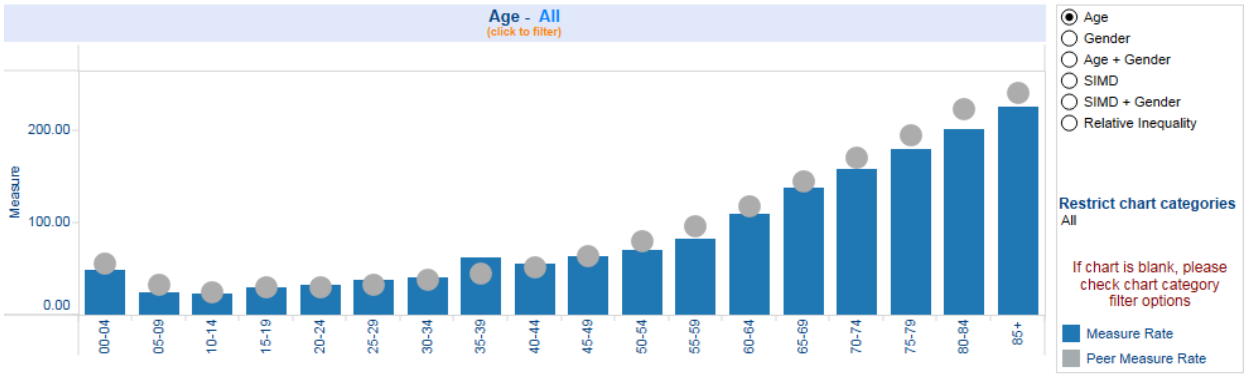
West Glasgow AC Hospital

Analysis of Current Performance

Unplanned Admissions

Figure 4 shows the admission rate per 1,000 population resident from West Dunbartonshire HSCP (blue bar and line).

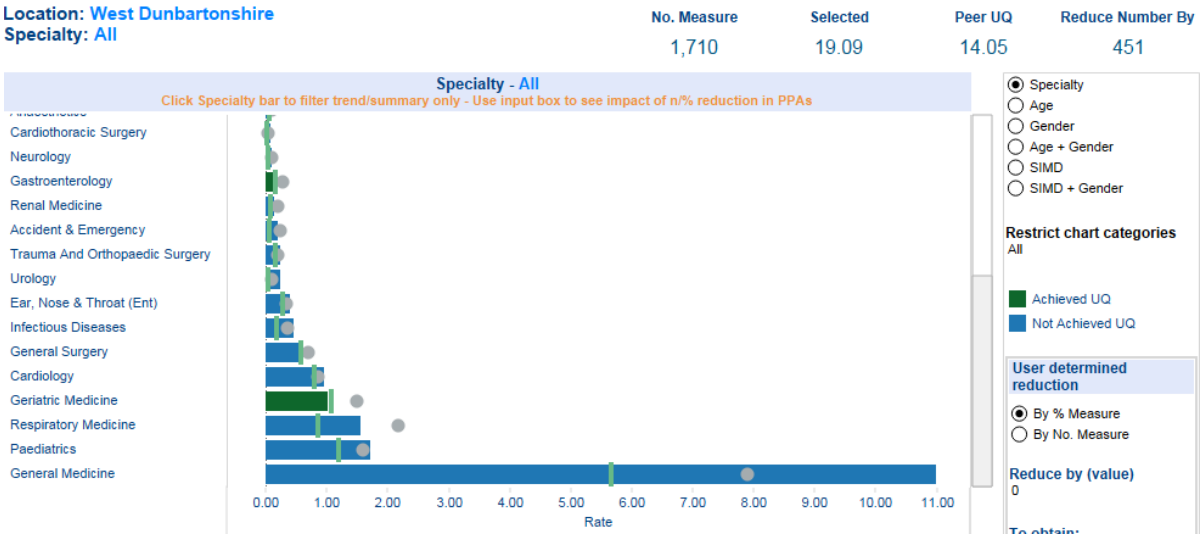
Figure 4: Admissions per 1000 Population Resident from July – September 2016 West Dunbartonshire HSCP (Source: NSS Discovery)



West Dunbartonshire's admission rate is higher compared to the admission rate per 1,000 population among our peers (gray dot and line) for those aged 20-44 years. There was a requirement to review where admissions were preventable to acute services against speciality; this supports decision making linked to community focused activities and acute specialties.

Figure 5 shows the rate of PPAs (number of potentially preventable admissions per 1,000 population) by specialty and the summary for all specialties.

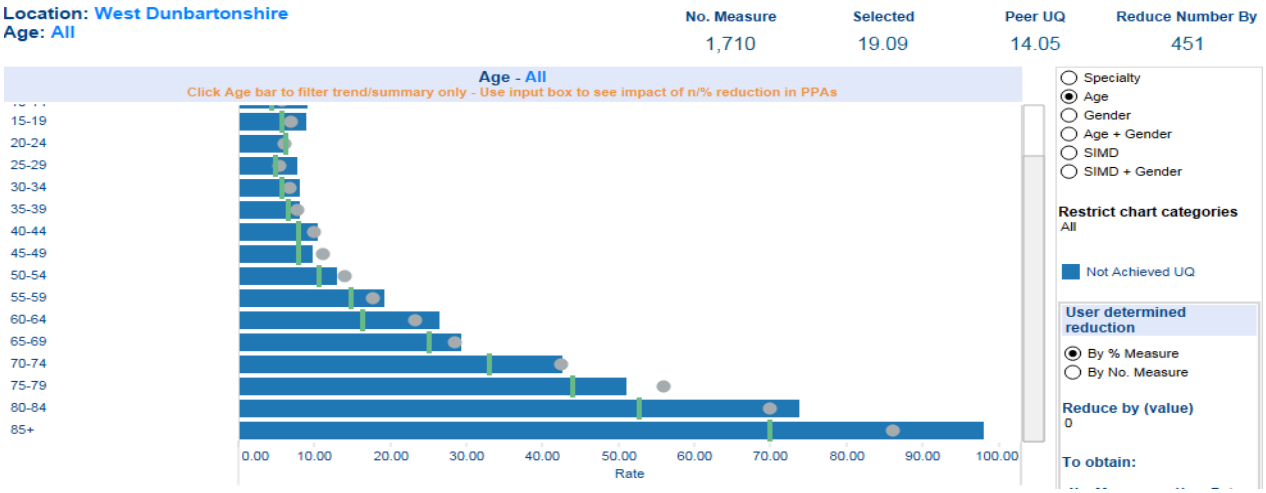
Figure 5: West Dunbartonshire HSCP Potentially Preventable Admissions - All Specialties 2015 (Source: NSS Discovery)



The blue bar and line are the rate for West Dunbartonshire HSCP; the grey dot and line are the rate for our peers and the green line represents the upper quartile (UQ) of the peer rate. We estimated that during 2015 there were 1,710 potentially preventable admissions across all specialties, giving a rate of 19.09 per 1,000 population. Had our rate been in line with our peer rate of 14.05 per 1,000, we would have had 451 fewer admissions. This calculation can be done for each specialty: so in general medicine we would have had 479 fewer admissions; and in respiratory medicine we would have had 63 fewer admissions in 2015.

Figure 6 details the age bands of the 1,710 PPAs - we have higher rates than the peer average for those aged 80 and over. Four hundred and ten of the PPAs were admissions where the main condition being managed was COPD and these equated to 2,687 bed days.

Figure 6: West Dunbartonshire HSCP Potentially Preventable Admissions – Age Bands 2015 (Source: NSS Discovery)



Currently there are more than 1400 anticipatory care plans (ACPs) in place across West Dunbartonshire to seek to understand and manage, in the community rather than acute, some of our most vulnerable citizens. Working with acute services, we would be seeking to establish a system whereby community staff, Scottish Ambulance Service and acute clinicians routinely use anticipatory care plans and the summary recorded on e-KIS (the electronic Key Information System) as part of the assessment process to avoid admission and to expedite discharge.

Moving forward, we will be ensuring that access to community services is enabled following an ACP and that services are comprehensive and include nursing, care at home, respite, pharmacy support and rehabilitation, palliative care and specialist disease specific nursing support. This will also include a focus on high risk individuals; and developing stronger links and pathways with acute colleagues to manage patients with long term conditions diagnosed in the community.

Occupied Bed Days for Unscheduled Care

As a rate per 1,000 population West Dunbartonshire has the 4th highest number of emergency admissions in the GGC area and the 4th highest bed days rate.

Table 1: Emergency Admissions and Bed Days April 2015 – September 2016 (Source: ISD)

	2015/16				April - Dec 2016			
Partnership of residence	**Emergency Admissions**	**Rate per 1,000 population**	**Bed Days**	**Rate per 1,000 population**	**Emergency Admissions**	**Rate per 1,000 population**	**Bed Days**	**Rate per 1,000 population**
East Dunbartonshire	11,734	110	82,836	774	8844	83	58,519	547
East Renfrewshire	9,077	98	59,830	644	6928	75	45,644	491
Glasgow City	77,331	128	504,983	833	59043	**97**	381,475	629
Inverclyde	10,566	**133**	72,888	**917**	7527	95	53,174	**669**
Renfrewshire	22,670	130	128,980	739	16979	**97**	94,319	540
West Dunbartonshire	10,602	118	66,395	741	8101	90	52,436	585

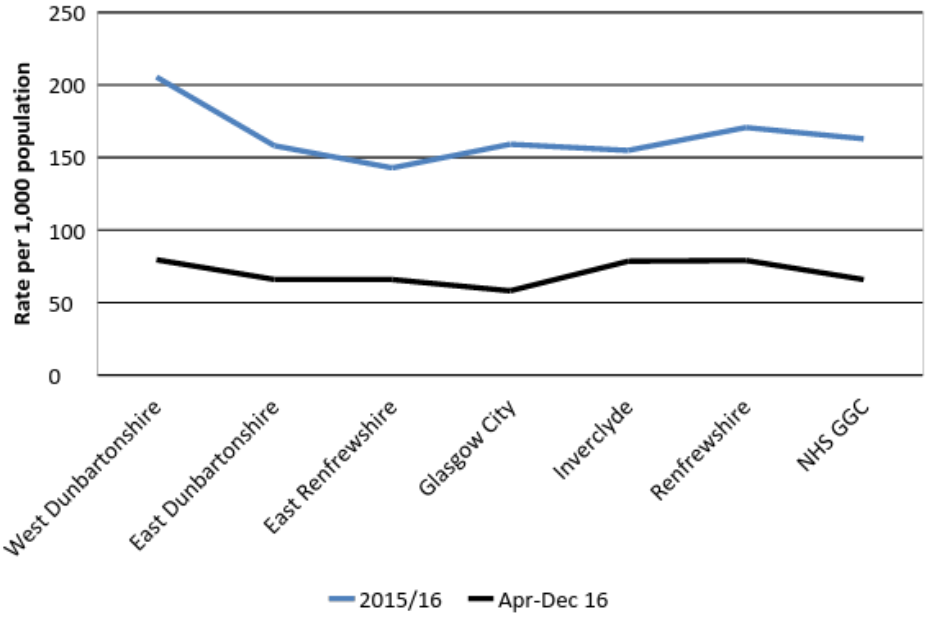
The proportion of bed days consumed by elective rather than non-elective admissions for West Dunbartonshire residents was the highest in the GGC area in 2015/16 and reduces to the second highest during April – September 2016. This equates to 18,404 bed days in 2015/16 and 7,119 in April – September 2016.

Table 2: Proportion of Non-Elective and Elective Admissions and Bed Days April 2015 – September 2016 (Source: NSS Discovery)

	2015/16				April - Sep 2016			
	Non-Elective		**Elective**		**Non-Elective**		**Elective**	
	Admissions	Bed Days	Admissions	Bed Days	Admissions	Bed Days	Admissions	Bed Days
West Dunbartonshire	39.6%	78.9%	60.4%	**21.1%**	40.6%	83.4%	59.4%	16.6%
East Dunbartonshire	38.7%	83.3%	61.3%	16.7%	40.0%	85.8%	60.0%	14.2%
East Renfrewshire	39.6%	82.2%	60.4%	17.8%	39.9%	84.2%	60.1%	15.8%
Glasgow City	47.1%	84.3%	52.9%	15.7%	48.1%	88.4%	51.9%	11.6%
Inverclyde	45.5%	86.0%	54.5%	14.0%	44.1%	85.6%	55.9%	14.4%
Renfrewshire	44.3%	81.4%	55.7%	18.6%	43.4%	82.8%	56.6%	**17.2%**
NHS GGC	44.6%	83.4%	55.4%	16.6%	45.1%	86.5%	54.9%	13.5%

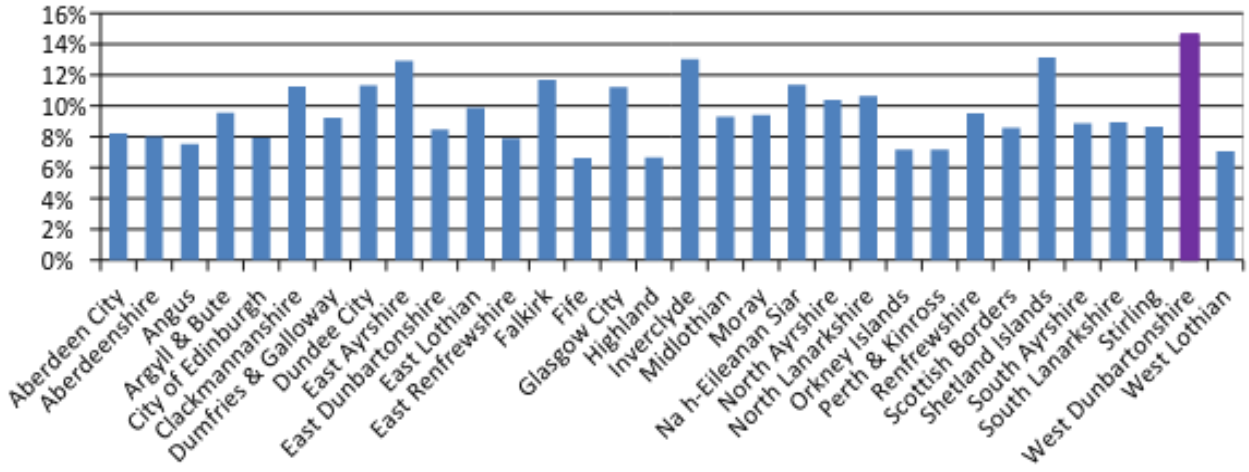
Similarly the rate of elective bed days per 1,000 population was the highest in GGC area from April 2015 to September 2016.

Figure 7: Elective Bed Days per 1,000 population 2015/16 (Source: NSS Discovery)



In 2015/16 West Dunbartonshire had the highest proportion in Scotland of people aged 75 and over living at home with support.

Figure 8: Balance of care: Percentage of population supported at home 75+ 2015/16 (Source: ISD)



Moving forward, there is need for GP Clusters and Localities to increase GP awareness of options in the community for care at home – particularly out of hours (where this is an integrated service with district nursing). Acute services will also need to demonstrate progress in working towards compliance with externally benchmarked upper quartile length of stay across all sites and specialties. This supports optimisation of discharge processes across all sites and specialties to create an earlier in the day discharge profile and increase weekend discharges, whilst the HSCP will expand hospital discharge services to enable the discharge of more complex cases.

Accident & Emergency

Table 3 details levels of attendance at Accident & Emergency (A&E) by West Dunbartonshire residents. In comparison with other partnerships within GGC we had the 3rd highest rate per 1,000 population in 2015/16 and at December 2016 had the 2nd highest rate.

Table 3: A&E Attendance Rates NHSGGC April 2015 to September 2016 (Source: ISD)

	2015/16		April - Dec 2016	
	Attendances	Rate per 1,000 population	Attendances	Rate per 1,000 population
East Dunbartonshire	27070	253.1	20717	193.7
East Renfrewshire	25303	272.3	19432	209.1
Glasgow City	201295	332.0	153141	252.6
Inverclyde	29387	**369.6**	22362	**281.3**
Renfrewshire	56112	321.4	43598	249.8
West Dunbartonshire	28906	322.6	23395	261.1

Figure 9 below shows improving trends for both the proportion of admissions following presentation at A&E and performance against the 4 hour target.

Figure 9: Admissions from A&E and 4 hour target West Dunbartonshire November 2014 to December 2016 (Source: ISD)

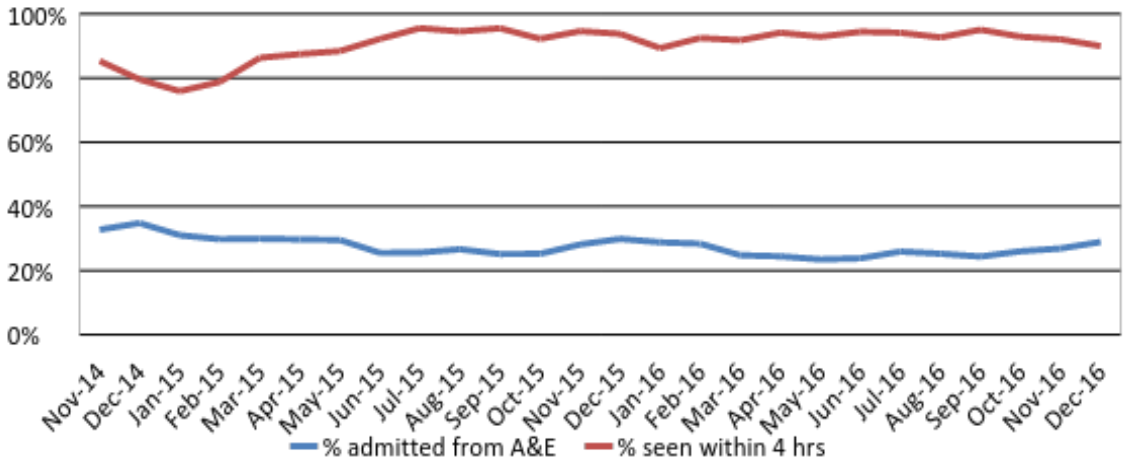
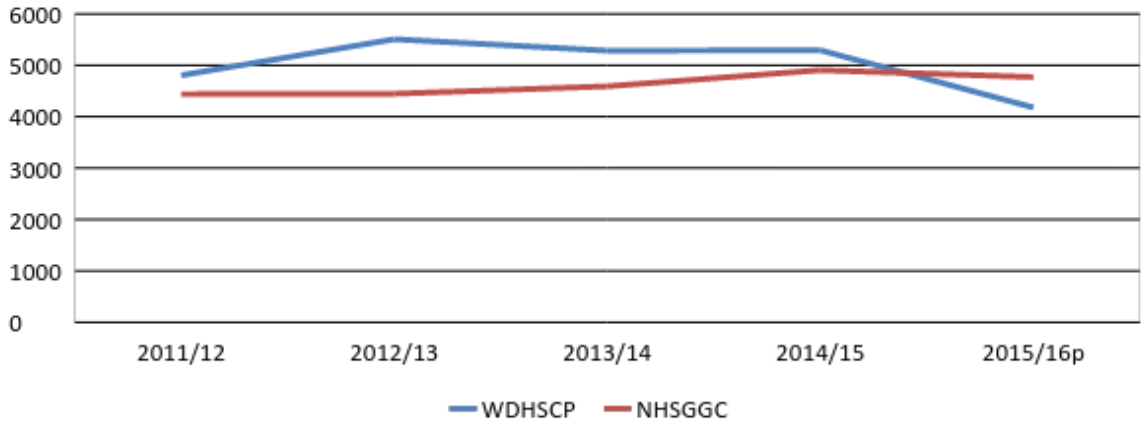


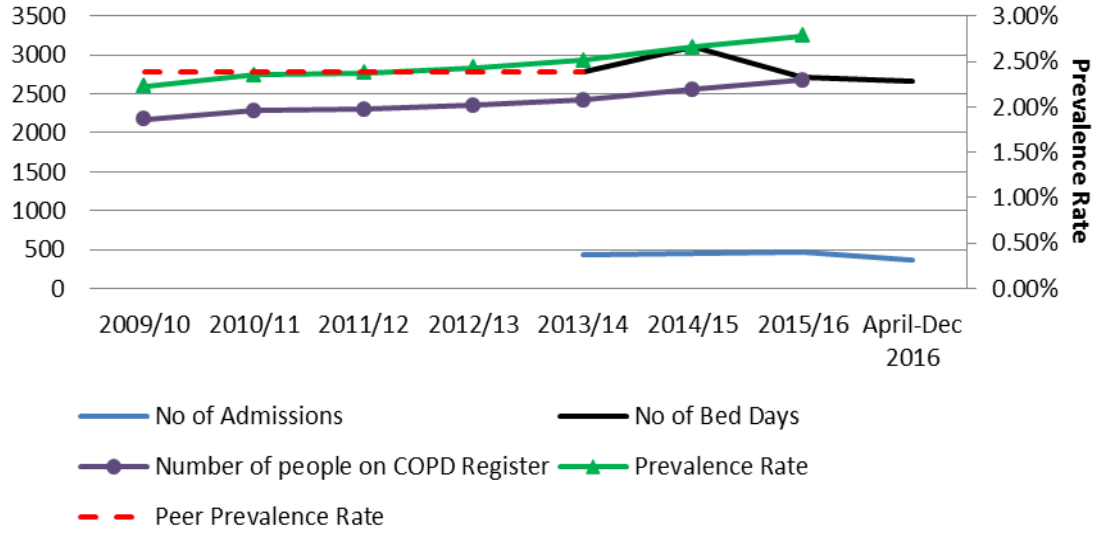
Figure 10 illustrates that there has been a steady decrease in crude rates of multiple emergency admissions among West Dunbartonshire patients aged 85 and over from 2012/13, while there has been an increase across NHS Greater Glasgow and Clyde during the same time period. This is despite the fact that the 85+ population in West Dunbartonshire has increased by 3.4% from 2012 to 2015 (National Records of Scotland Mid-Year Population Estimates). The 85+ population in NHS Greater Glasgow and Clyde has increased by 5.2% over the same period.

Figure 10: Multiple Emergency Admissions (3+) patients aged 85+ yrs: Crude rates per 100,000 (Source: ISD Scotland)



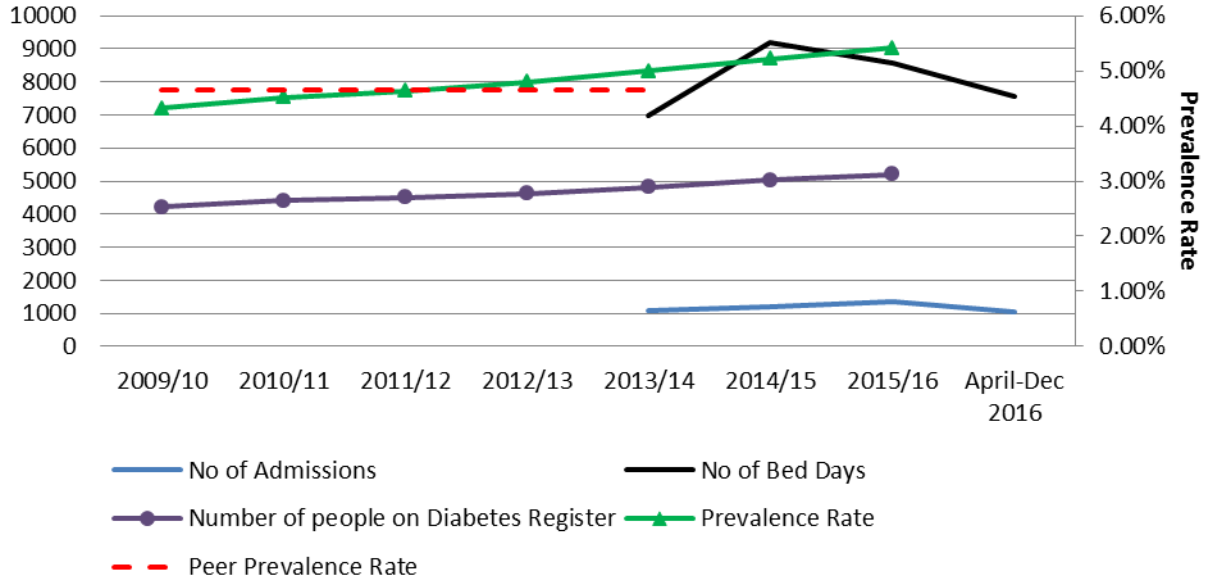
The HSCP COPD programme – which has a focus on do-not-attendees - aligns closely to the more mainstream support provided to patients in the community. A dedicated COPD nursing service is available and managed within district nursing. They provide direct patient support alongside training, advice and support to generic services within care homes and care at home services. Given that West Dunbartonshire has an increasing number of people with COPD - linked to lifestyle and previous employment - continued investment in community approaches is necessary if we are to manage performance around hospital admissions.

Figure 11: COPD Admissions and Bed Days against Prevalence (Source: NSS Discovery and QOF)



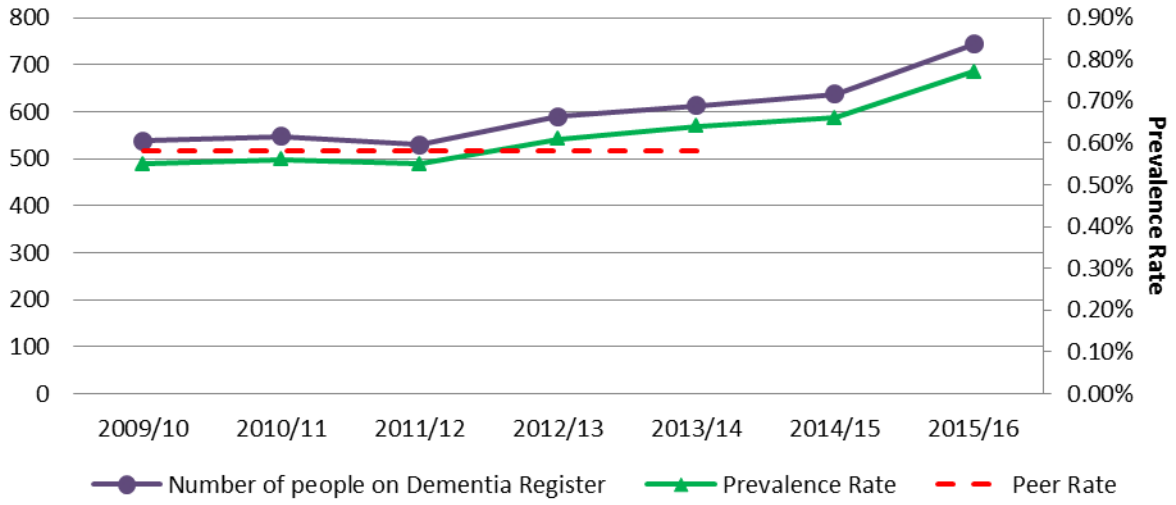
There has been a 23% increase in both the number of people on the COPD register and those on the Diabetes register between 2009/10 and 2015/16. Although we do not yet have full year 2016/17 data, the number of admissions and bed days has stayed fairly static since 2013/14 with a possible decrease particularly in diabetes admissions. This intimates the effectiveness of community interventions with regard to long term conditions, continuing to ensure innovative models of integrated care for people living with multi morbidity and complex care needs.

Figure 12: Diabetes Admissions and Bed Days against Prevalence (Source: NSS Discovery and QOF)



Working as part of the Frailty work stream in our Localities, we will be seeking to ensure that appropriate information to primary care and acute clinicians on assessed need at the point of decision is available (including the options for home based care). In partnership with acute and primary care, we will be seeking to create and implement redirection pathways back to minor injury units, primary care and other community services including community pharmacy. We will work to enable discharge of complex cases, through early identification and tailoring of services for people living with dementia, those requiring aids and adaptations and adults with incapacity (AWI).

Figure 13: Dementia Prevalence Rates (Source: QOF)

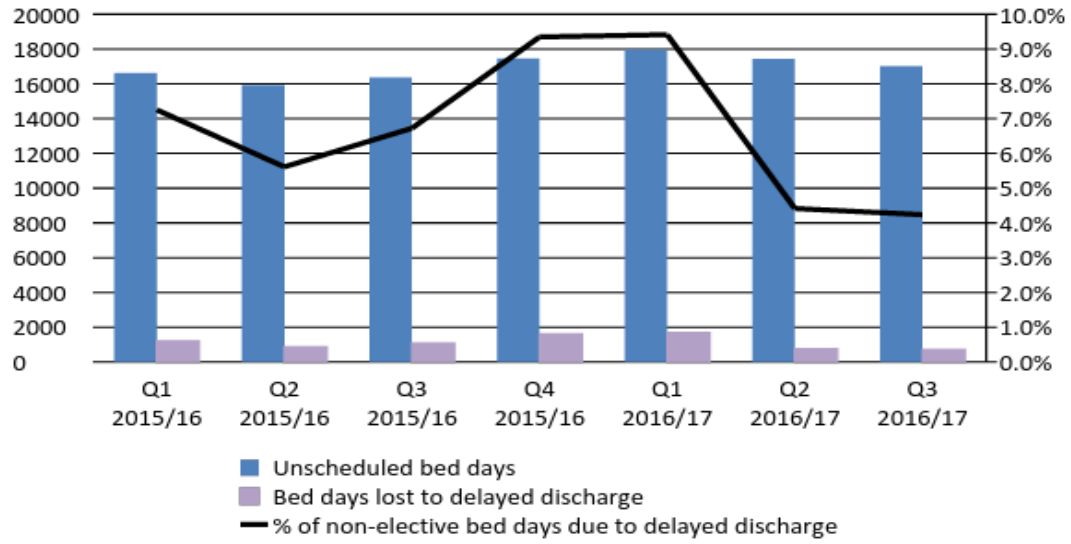


Utilising our Local Engagement Networks (which are the HSCP's mechanisms for consultation and engagement) we will continue to work with communities on appropriate use of A&E departments alongside acute colleagues.

Delayed Discharges

Figure 14 below details the proportion of bed days lost to delayed discharge. The significant reduction in Qtr2 2016/17 is largely due to the national change in the definition and calculation of delayed discharges

Figure 14: Bed days lost to delayed discharge as a proportion of all non-elective bed days West Dunbartonshire HSCP April 2015 – December 2016 (Source: ISD)



Based on a matrix of community health and social care interventions in West Dunbartonshire there is a demonstrable decrease in bed days lost and in the numbers of delayed discharges as outlined in Figure 15 below.

Figure 15: Number of acute bed days lost to delayed discharges 65+ April 2014 – December 2016 including Adults with Incapacity (AWI) (Source: NHS GG&C)

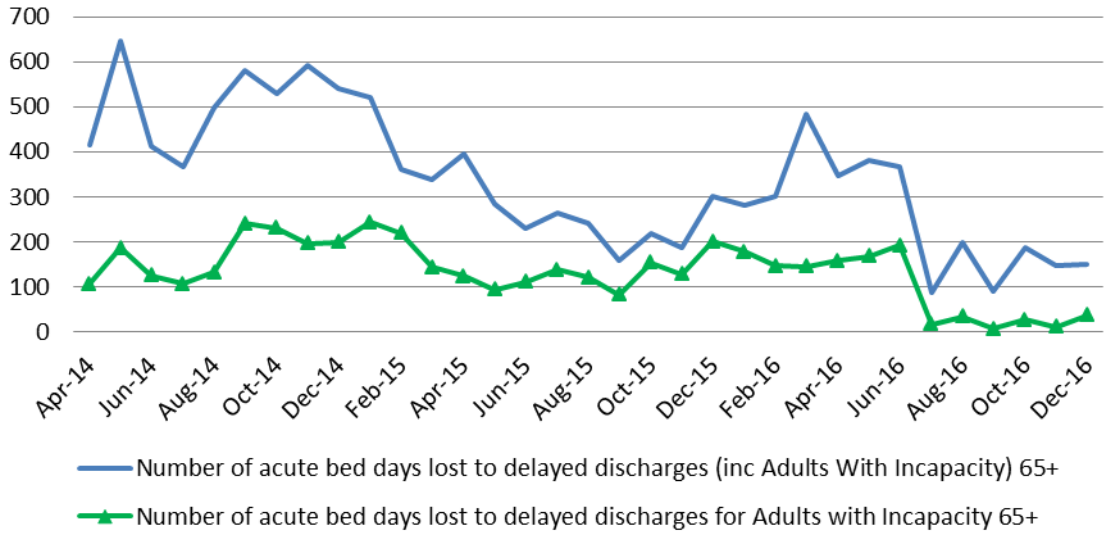
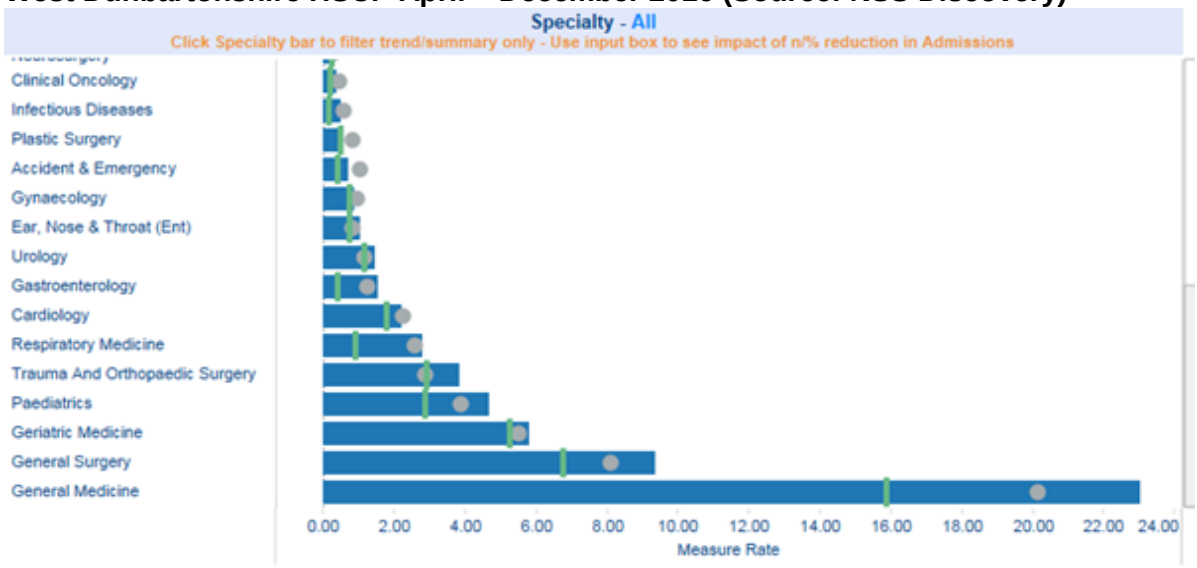


Figure 16 below gives a breakdown of the destination following admission as a rate per 1,000 population for the non-elective admissions in April – December 2016.

Figure 16: Non-elective admissions rate per 1,000 population – destination by specialty West Dunbartonshire HSCP April – December 2016 (Source: NSS Discovery)



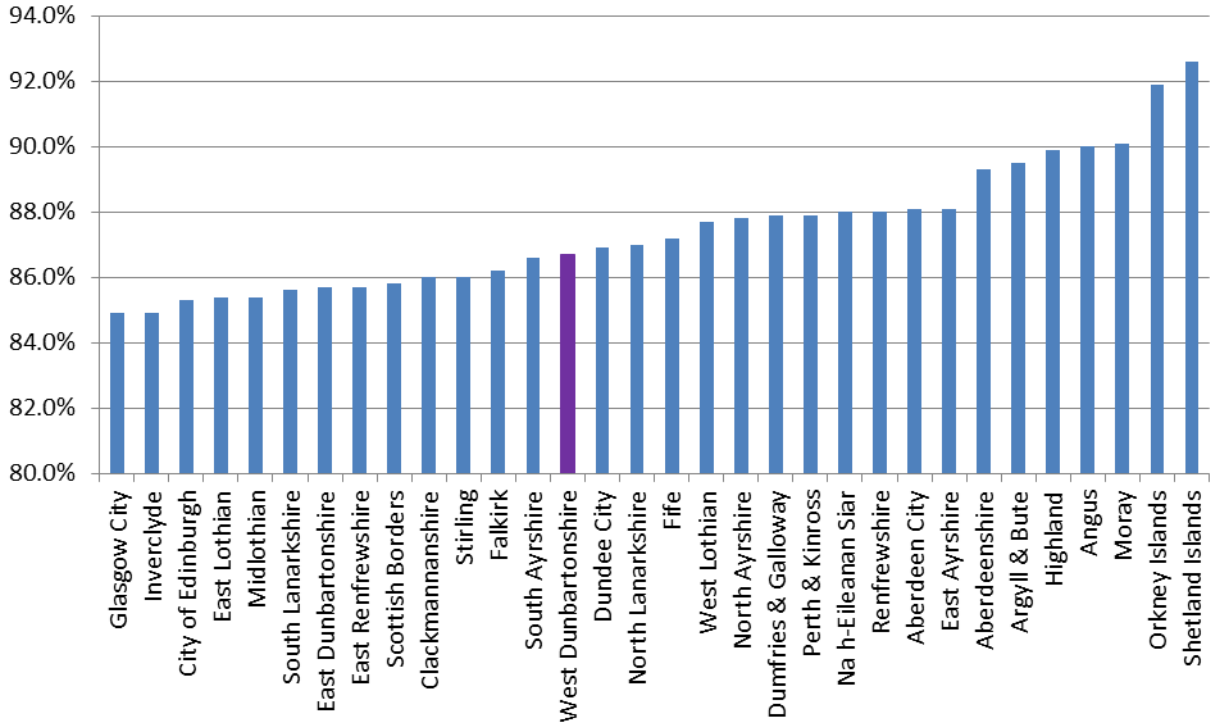
With the delivery of an Early Assessors programme where practitioners are now attached to discharging wards across GGC, we are able to begin the management of individuals' discharge at the point of admission; and as such aim to avoid unnecessary re-admission. There are no delays for care at home services for those coming out of hospital and a reorganisation of community services has supported more flexibility for timings of hospital discharges to home; as stated earlier the already integrated community services ensure a streamlined pathway for acute services supporting fewer delays for the patient. Our prescribing team, through a dedicated Care at Home Pharmacy service will continue to support improved compliance with medicines for older people, supporting discharge and reducing risk of re-admission.

There is continued work with NHS primary care contractors to expand and develop their role within communities. This is alongside sustained capacity building with the third sector to provide community based supports; as well as specific and targeted support to carers; and a continuous improvement programme with the independent sector to guarantee robust quality assurance and care governance across the whole sector. An already agreed West Dunbartonshire Housing Contribution Statement provides the framework for appropriate and sustainable housing options for those at risk of unnecessary hospital admission, at the point of discharge or at risk of re-admission.

<u>End of Life Care</u>

Figure 17 shows data from ISD Scotland on Quality Outcome Measure 10 – the percentage of the last six months of life spent at home or in a community setting by health board. This measure is used to chart progress made by boards towards implementation of the national "Living and Dying Well action plan".

Figure 17: Quality outcome measure 10: Percentage of last six months of life spent at home or in a community setting by HSCP 2015/16 (Source: ISD)



This particular measure was chosen as a proxy for the preferred place of death as no data are recorded for the latter. It should be noted that this is a broad measure that includes people who died from causes that may not have required palliative care services (e.g. heart attacks). However, patients who died from external causes (e.g. unintentional injuries) were excluded.

The figure shows that there is variation by HSCP in this measure. West Dunbartonshire has the 19th lowest percentage of time spent at home or in a community setting in the last six months of life across Scotland but the second highest percentage when compared to HSCPs within the GGC area. This measure is crude and does not include any correction for demographic differences.

This information can be used to make an estimate of the potential reduction in bed days (Table 4 overleaf) and beds that could occur if West Dunbartonshire HSCP were to reduce inpatient hospital stays towards the end of life, for example, by increasing community palliative care services.

Table 4: Estimate of potential reduction in bed days: West Dunbartonshire HSCP compared with Renfrewshire (Best performing in GGC)

Number of deaths in West Dunbartonshire 2015 (Source: NRS) (Less external causes of death in line with ISD calculations)	1,056
Total bed days in hospital in the 6 months prior to death for those people who died within 2015/16	25,631
Total possible bed days (if all people who died spent all of final 6 months of life in hospital)	192,720
Average % of time spent in hospital in last 6 months of life in West Dunbartonshire 2015/16	13.3%
Average % of time spent in hospital in last 6 months of life in Renfrewshire 2015/16	12%
If % in West Dunbartonshire was the same as in Renfrewshire	
Potential reduction in bed days in hospital in the 6 months prior to death	2,505
Potential reduction in beds (adjusted for an 85% occupancy rate)	8

The calculation outlined above was carried out by multiplying the percentage of time spent in hospital seen in Renfrewshire HSCP with the total possible bed days seen in West Dunbartonshire HSCP to calculate the number of bed days that would have theoretically been used in West Dunbartonshire. This was then subtracted from the number of bed days that were actually used in West Dunbartonshire. We estimate that 2,505 bed days and 8 beds could be reduced over a year period.

As previously stated, integrated community services are supported by specialists, and end of life care is no exception. District nursing services and care at home services provide integrated services both in hours and out of hours; providing ongoing care as well as emergency care and respite care within the community, in partnership with GPs, to avoid unnecessary admissions to acute. Additionally palliative care specialists provide training, support and advice to care homes to support people with dying well at home or in a homely setting.

Table 5 shows estimated numbers of in-patient beds accounted for by admissions from Care Homes. In the year 2015, there were 3,421 emergency admissions to hospital of patients resident in care homes across NHSGGC. These patients accounted for 31,951 occupied in-patient bed-days. Assuming an average occupancy level of 85%, for West Dunbartonshire HSCP this would correspond to approximately 7.5 in-patient beds. In addition to support from palliative care specialists, our Prescribing Support Team will continue to provide medicines training, support and advice to care home and care at home services to reduce avoidable admissions to acute services.

Table 5: Estimated numbers of in-patient beds accounted for by admissions from Care Homes

Partnership	Calculated Beds
East Dunbartonshire	9.0
North East Glasgow	21.9
North West Glasgow	22.7
South Glasgow	18.3
West Dunbartonshire	7.5
East Renfrewshire	6.3
Renfrewshire	11.1
Inverclyde	6.1
Total	**103**

Acute services will be seeking to establish a consistent system in place whereby HSCPs are given early notice by Acute Services of patients who require end of life care; thus supporting improved earlier identification of patients who require end of life care within the community. This should allow community services to deliver effective palliative care in the community and ensure appropriate communication with acute and GPs. This will include access to community based rehabilitation and step up/step down services and access support from acute service geriatricians.

Commissioning Unscheduled Care

The King's Fund – in their report *Transforming our Health Care System* – recognised that although the impact could be highly positive, redesigning the urgent and emergency care system is likely to be highly challenging. That report then suggested that specific actions for commissioners could include:

- Providing effective signposting to help patients choose the right service.
- Ensuring that hospital and community services can adjust service levels in response to changes in demand, so that need and provision are kept in balance.
- Ensuring that A&E departments adopt best practice for handling 'majors' including early senior review.
- Ensuring that hospitals and local authority social service and housing departments work effectively together to reduce delayed discharges and shorten lengths of stay.
- Mapping and analysing patient flows around the system to identify bottlenecks and the scope for changing pathways to reduce the use of hospitals and to ensure that there is sufficient capacity across the health and social care system.

This document then seeks to build on the body of work undertaken to-date by the HSCP and NHSGGC's Acute Division, and set out the Partnership Board's commissioning objectives to improve unscheduled care for residents of West Dunbartonshire**. At its heart is a commitment to invest, redesign and deliver an effective infrastructure of community services**. In doing this, this document sets out initial commissioning directions for NHSGGC and its Acute Division; and a proposed improvement agenda for primary care, both of which emphasise the expectations to realise realistic medicine. Crucially, it is predicated on the understanding that the detailed development and then implementation of said objectives will require collaboration, engagement and professional leadership – both within West Dunbartonshire and across NHSGGC.

NHSGGC has created the Unscheduled Care Collaborative to respond to the agreed need for a 'whole system' approach, which is led by its Acute Division; and includes engagement with colleagues in Primary Care and the Scottish Ambulance Service. This programme of clinically led improvement work is being progressed but has already identified a number of interim recommendations for immediate consideration and for action during 2017, the adoption of which would be supported by this document, i.e.:

- Medical capacity should be realigned to reflect patient demand in both the receiving areas and across the hospital system.
- Options to improve Assessment Unit same day discharge efficiency should be progressed to reduce performance variation and avoid unnecessary short stay admissions.
- Improvement projects undertaken within various Sectors as 'tests of change' should be rolled out as part of a Board wide work programme over the next 12 months.

Once the work programme is completed, the expectation is that the Acute Division will engage with the GGC partnerships to consider the final findings and recommendations.

In accordance with Scottish Government's emerging indications with regards to measuring the impact of health and social care integration, this document is then setting out the commissioning objectives for the Partnership Board in respect of acute - and particularly unscheduled - care with regards to the following inter-connected themes:

- Communication.
- Unplanned admissions.
- Occupied bed days for unscheduled care
- A&E performance.
- Delayed discharges.
- End of life care.
- Balance of spend across institutional and community services.

(1) COMMUNICATION - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Services Led
• Provide easy access to enhanced community services to avoid admission and encourage early discharge. • Maintain delayed discharges at a low level and ensure Adults With Incapacity (AWI) pathway enables timely and appropriate discharge from acute. • Provide robust and enhanced community services to enable higher acuity patients and those in need of Palliative Care to be managed at home or in a community setting. • Ensure e-KIS is used to provide information on available services and access.	• Create opportunities for clinical conversations pre-admission and at the point of discharge. • Ensure Anticipatory Care Plans (ACPs) are comprehensive and information is provided for Scottish Ambulance Service (SAS) and acute physicians as well as enhanced community services using e-KIS.	• 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. • HSCPs and acute services will identify a scoring matrix for identifying patients at risk of unnecessary admission. • 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.

(2) UNPLANNED ADMISSIONS - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Establish integrated and community-based Immediate Care Teams to work with GPs, managing patients for whom an admission would otherwise be needed. • To establish joint acute/community/SAS systems to monitor and audit the use of e-KIS • Ensure that access to community services is enabled following ACP and that services are comprehensive and include nursing, care at home, respite, pharmacy support and rehab, palliative care, specialist nursing support. • Offer individuals who do not attend COPD appointments to manage their condition remotely using TEC equipment.	• Establish integrated and community-based Immediate Care Teams (nursing and home care) to work with GPs. • Ensure that individuals with a frailty index have an ACP in place and recorded on e-KIS. • Continue to develop self-management programmes for patients with long term conditions such as COPD. • Primary Care works collaboratively to identify and manage frail older patients. • Work with GP Clusters to assess and address variation between GP practices.	• 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.

3rd Sector Interface led

- Delivery of Dementia Friendly West Dunbartonshire

(3) OCCUPIED BED DAYS - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Target support to nursing homes with a focus on reducing demand on primary care, reduce admissions to acute care, deaths in hospital, and ensure demand for out of hours services is appropriate. • Expand hospital discharge services to enable the discharge of more complex cases.	• Increase GP awareness of options in the community for care at home. • Review practice arrangements for urgent and house calls which may lead to inappropriate peaks in SAS call outs and hospital attendance or admission	• 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.

(4) ACCIDENT AND EMERGENCY - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Ensure appropriate information on assessed need at the point of decision is available including the options for home based care. • Continue to work with communities on appropriate use of A&E. • Work with ISD to identify those who regularly attend A&E and their profile, especially those with a care package >£50k.	• Agree a process for seeing redirected patients with GP Clusters and/or LMC [via NHSGGC Primary Care Support] • Establish a process whereby GPs are able to access agreed imaging investigations to support diagnosis and decision-making.	• Create and implement redirection pathways back to minor injury units and primary care. • 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.

(5) DELAYED DISCHARGES - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Further strengthen communication between acute and primary care/community teams to support acute consultants and families with discharge planning. • Effective medicines management at point of admission and discharge. • Offer individuals coming out of hospital the opportunity to benefit from a clearer assessment of their needs by using TEC equipment.	• Further strengthen communication between acute and primary care/community teams to support acute consultants and families with discharge planning. • Effective medicines management at point of admission and discharge	• Establish a system whereby community staff, SAS and acute clinicians routinely use anticipatory care plans and the summary recorded on e-KIS 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.

3rd Sector Interface led	Housing Led
Delivery of Link Up staffed by older people volunteers.	• People with particular needs have access to suitable housing with support to optimise independence and wellbeing.

(6) END OF LIFE CARE - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Deliver effective palliative care in the community and ensure appropriate communication with Acute and General Practice. • Provide appropriate home based care to patients and families. • Improving care in nursing homes and reducing referrals for assessment and enabling early discharge.	• Improve earlier identification of patients who require end-of-life care whilst in community	• Establish a consistent system in place whereby HSCPs are given early notice by acute services of patients who require end of life care.

3rd Sector Interface led

- Delivery of Palliative Care Befriending Service
- Delivery of Palliative Care Friendly West Dunbartonshire approach

(7) BALANCE OF SPEND ACROSS INSTITUTIONAL AND COMMUNITY SETTINGS

Table 6 provides the estimated expenditure in A&E Departments across all NHSGGC acute sites on attendees from West Dunbartonshire

Table 6: A&E Attendances by WD residents at NHSGGC A&E Departments and Minor Injury Units (Patients Aged 18 and over) 2014/15 (Source: ISD)

VOL	IRH	RAH	GRI	STOB	VIC	SGH	RHSC	WIG	TOTAL	Direct Cost
8511	59	4348	505	70	167	817	2	9010	23489	**£2,251,406**

Table 7 provides estimated costs for West Dunbartonshire HSCP consumed bed days per specialty in 2015/16. Since this data has been derived from the 2015/16 linked analysis file, the costs are provisional, as they have been mapped from the 2014/15 Costs Book. The actual costs may be different when the 2015/16 Costs Book has been published, and mapped to the 2015/16 activity.

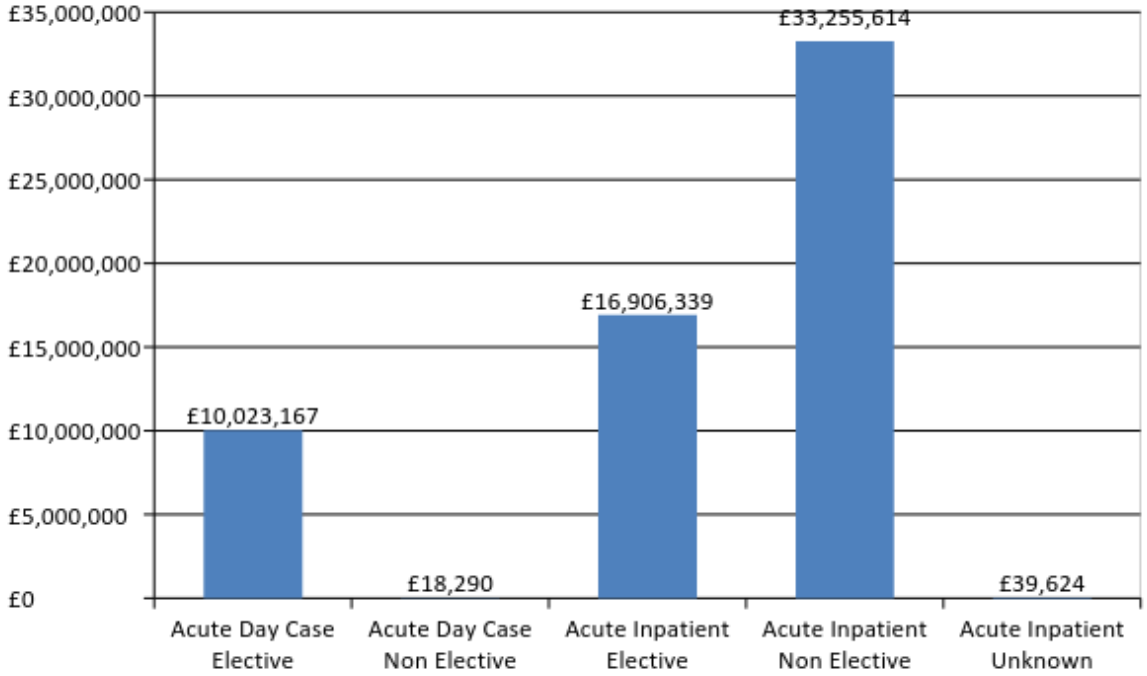
Table 7: Cost per bed day by specialty – West Dunbartonshire HSCP 2015/16 (Source: ISD IRF)

Speciality	Cost per bed day
Learning Disability	£3,143.61
Diabetes	£1,911.91
Ear, Nose & Throat	£1,507.68
Plastic Surgery	£1,358.70
Neurology	£1,160.63
Orthopaedics	£888.89
Urology	£705.79
General Surgery	£659.77
General Surgery (ex. Vascular)	£638.02
Gastroenterology	£624.14
Endocrinology	£505.50
General Medicine	£422.09
Dermatology	£419.62
Nephrology	£405.50
Rehabilitation Medicine	£330.80
Geriatric Medicine	£288.55
Psychiatry of Old Age	£254.49
General Psychiatry	£247.91

West Dunbartonshire's current performance suggests that whilst progress is being made there continue to be challenges for partnerships and acute services alike to continue to decrease presentations at A&E departments and unnecessary admissions to hospital. The approach moving forward will be to continue to develop local and GGC wide initiatives based on performance and evidence from across the system including the "small tests of change" being undertaken by the Unscheduled Care Collaborative.

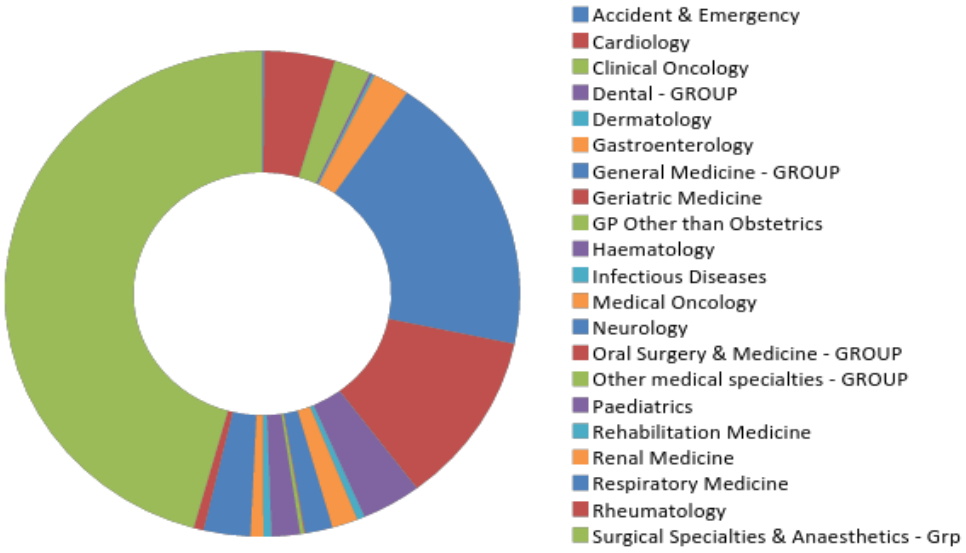
In order to provide more timely activity and costs information to support capacity planning, information available has been expanded to also include activity and estimated costs for 2015/16. It should be noted these costs are purely an estimate and it is therefore important the methodology and caveats below are considered when using this information.

Figure 18: 2015/16 West Dunbartonshire HSCP Acute Activity - Estimated 'Live' Costs (Net) (Source: ISD/IRF)



Derived costs have been estimated for 2015/16 by applying inflated (by 1%) 2014/15 site and line number specific unit costs (e.g. nursing cost per day; overheads proportion) to the more recent activity.

Figure 19: 2015/16 West Dunbartonshire HSCP Acute Activity - Estimated 'Live' Costs by Specialty (Net) (Source: IRF/ISD)



Using available estimated information, and within the current commissioning parameters, following indicative attributable costs have been estimated based on current service modelling; current levels of activities and current levels of spend attributed to West Dunbartonshire; and existing data (reflected earlier within this paper). However, it should be noted that these figures continue to be estimates based on the

current cost book; and, importantly, do not account for variations in demographic profile. As such, they are included here for illustrative purposes.

Table 8: Bed Days Lost to Delayed Discharge (Source: ISD)

Bed Days Lost to Delayed Discharge 2015/16 - Standard Delays	Bed Days Lost	18+ pop	Bed Days Lost Rate per 1,000 pop(18+)	Reduction in Bed Days Lost	Cost per Bed Day	Annual Cost	Beds released	Equivalent cost
West Dunbartonshire	2236	71878	31.1					
East Renfrewshire	1682	72062	23.3					
If West Dunbartonshire reduced to East Renfrewshire's rate	1675	71878	23.3	561	£422.09	£236,792	1	£130,848
Best performing in Scotland: Renfrewshire	2216	140747	15.7					
If West Dunbartonshire reduced to Renfrewshire's rate	1128	71878	15.7	1108	£422.09	£467,676	3	£392,544
Bed Days Lost to Delayed Discharge 2015/16 - Code 9s	Bed Days Lost	18+ pop	Bed Days Lost Rate per 1,000 pop(18+)	Reduction in Bed Days Lost	Cost per Bed Day	Annual Cost	Beds released	Equivalent Cost
West Dunbartonshire	2596	71878	36.1					
Renfrewshire	3883	140747	27.6					
If West Dunbartonshire reduced to Renfrewshire's rate	1984	71878	27.6	612	£422.09	£258,319	1	£130,848
East Dunbartonshire	868	85740	10.1					
If West Dunbartonshire reduced to East Dunbartonshire's rate	726	71878	10.1	1870	£422.09	£789,308	6	£785,087
East Renfrewshire	684	72062	9.5					
If West Dunbartonshire reduced to East Renfrewshire's rate	683	71878	9.5	1913	£422.09	£807,458	6	£785,087
Best performing in Scotland: Inverclyde	506	64741	7.8					
If West Dunbartonshire reduced to Inverclyde's rate	561	71878	7.8	2035	£422.09	£858,953	6	£785,087

- Cost per Bed Day - IRF 2015/16 General Medicine bed West Dunbartonshire HSCP based on 2014/15 Cost Book
- Annual Cost - Based on Actual Bed Day reduction
- Beds released - Based on 85% occupancy (310 bed days annually)
- Equivalent Cost - Based on 85% occupancy

Again it must be noted that these are estimated costs and may vary from actual costs - as more detailed budgetary information becomes available these figures can be reviewed and refreshed. However the variance is likely to be greatest where:

- There is a material difference between Costs Book unit costs in the later years and those for 2014/15.
- Misalignments exist between Scottish Morbidity Records (SMR) activity data and the Costs Book activity (e.g. for mental health specialties for some sites).

Delays are classed as Code 9s in those circumstances:

- Where the patient lacks capacity, is going through a Guardianship process, and for whom the use of S13za of the Social Work (Scotland) Act 1968 is not possible.
- Where the patient is delayed awaiting availability of a place in a specialist facility, where no facilities exist and an interim move would not be appropriate (i.e. no other suitable facility available).
- For those patients for whom an interim move is not possible or reasonable.

Table 9 details emergency admissions and the conditions being managed within an acute setting for West Dunbartonshire residents during 2015/16 with estimated costs based on the 2014/15 cost book. These admissions equate to almost £8.5 million and 19,629 bed days.

Table 9: Emergency Admissions West Dunbartonshire residents 2015/16 (Source: ISD)

Main diagnosis being managed	Occupied Bed Days	Cost per Bed Day	Total Cost
Pneumonia	3,076	£437.43	£1,345,545.52
Cerebrovascular diseases	3,096	£370.86	£1,148,191.55
Other diseases of the urinary system	2,798	£379.40	£1,061,558.66
Chronic obstructive pulmonary disease	2,684	£382.70	£1,027,166.91
Other acute lower respiratory infections	2,016	£448.40	£903,968.45
Other diseases of the nervous system	1,521	£573.00	£871,527.79
Acute myocardial infarction	1,290	£592.68	£764,551.52
Other diseases of the respiratory system	1,704	£421.82	£718,786.34
Heart failure	1,444	£426.96	£616,526.67

There is a small amount of variation in costs per bed day across sites detailed overleaf for the three disease groups of particular interest to this process.

Table 10: Emergency Admissions West Dunbartonshire residents by site 2015/16 (Source: ISD)

Main diagnosis being managed	Vale of Leven	Royal Alexandra	Glasgow Royal	Queen Elizabeth University	West Glasgow
Diseases of the respiratory system	£428.46	£470.37	£357.65	£444.25	£299.35
Diseases of the circulatory system	£396.87	£426.37	£454.66	£463.91	£327.18
Diseases of the nervous system	£428.46	£456.06	£410.69	£636.83	£353.51

We are exploring a percentage target of reduction in the overall set aside budget in 2017/18, thereby delivering significant savings and potential redirection to the HSCP. It is likely that this will require a reduction in acute inpatient beds across a number of hospital sites – as articulated within the NHSGGC Transforming Delivery of Acute Services Programme and as the programme's impacts are realised. The bed calculations in the section above are HSCP planning assumptions that require testing and modelling as part of the wider NHSGGC whole system approach.

Key Commissioning Objectives

HSCP Led

- Agree a way of working between acute sites and all six HSCP community services, using a proportion of set aside budget to support development of interface services out-with acute sites.
- To appropriately invest, develop and redesign community based services.

Primary Care Led

- Provide support to community based services to optimise the management of patients in the community.

Acute Led

- 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.
- Acute services to review and ensure effective medicines management at point of admission and discharge.
- Demonstrate progress in working towards delivering the externally benchmarked upper quartile length of stay across all sites and specialties.

3rd Sector Interface led

- Seek to maximise monies to community third sector organisations by levering in external funding sources.

Delivering Performance under Integration

There is a need for each of the partnerships within Greater Glasgow and Clyde to develop joint commissioning intentions across the system; this approach will require effective joint planning with the Acute Services Division. Proposals will need to be agreed before subsequent presentation and agreement by each HSCP Integrated Joint Board. As has been stated previously in this paper, there is a commitment and an appetite for more joined up initiatives. Emerging areas for a collective across all the partnerships and acute services are:

- Management of frailty and associated conditions including falls management.
- Management of COPD and response to exacerbations.
- Management of nursing homes beds.
- Delivery of step up/step down supports and intermediate care.
- Delivery of integrated ACP processes.

The development of this approach will require collaboration between the Acute Division and each of the local partnerships; whilst acknowledging the range of delivery models within each partnership area and the organisation of local services and agreed Locality priorities. Moreover, shared and agreed outcomes will need to reflect the financial planning in each partnership as well as across the system; including shifts in resources between shared parts of the system and identifiable needs and demands with specific partnership areas.

There is a requirement for a clear and transparent reporting system linked to performance; to ensure that impacts and results can be appropriately reported, measured and delivered to meet the priorities of the Scottish Government as described earlier. Work is on-going across NHSGGC to confirm differential targets for different partnerships with respect to the following indicators:

- Reduction in the number of unplanned admissions (percentage).
- Reduction in the number of occupied bed days for unscheduled care (percentage).
- Reduction in the rates of attendance at A&E (percentage).
- Reduction in the number of delayed discharges delayed more than 3 days to 0 for non-complex[1] codes.
- Reduction in the number of delayed discharges (all codes).
- Increase the proportion of people dying at home or in a homely setting (percentage).

Once that work has been completed, the proposed targets in relation to this commissioning document will be presented to the Partnership Board for approval. Thereafter, the Partnership Board will be kept appraised of progress and developments; and those targets will be explicit within the routine public performance reporting presented to and scrutinised by the Partnership Board.

[1] Standard delays (excluding Code 9s).

Appendix 1 – Summary of Commissioning Directions for NHSGGC Acute Services

- Implement initial recommendations of Unscheduled Care Collaborative clinically led improvement work; and engage with Partnership Board on final findings and recommendations.
- 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.
- 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.
- 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.
- Create and implement redirection pathway back to minor injury units and primary care.
- 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.
- Establish a system whereby community staff, Scottish Ambulance Service and acute clinicians routinely use anticipatory care plans and the summary recorded on e-KIS 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.
- Establish a consistent system in place whereby HSCPs are given early notice by acute services of patients who require end of life care.
- 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.