

**Board Meeting**

**19<sup>th</sup> August 2014**

**Director Emergency Care and Medical Services,**

**Acute Services Division**

**Unscheduled Care**

**Recommendation**

The Board is asked to:-

- a) Note that the Local Unscheduled Care Plan has been approved by the Government with an associated allocation of £1,766,457
- b) Note that the Government has funded an additional £1,100,000 to facilitate the discharge of Glasgow City Council residents from hospital
- c) Note the ongoing service redesign work ongoing in NHS services and with partners
- d) Approve the allocation of £1,000,000 additional investment required in 2014/15
- e) Note that elements of this will require to be considered as part of the Board's financial plan for 2015/16 and beyond.

**1. Background**

- 1.1 In 2013 the Government announced a three year National Unscheduled Care Programme designed to ensure that patients were admitted or discharged from Emergency Departments (ED) as soon as possible with a view to ensuring that 95 % of patients were treated in accordance with the standard by September 2014 and 98 % by April 2015.
- 1.2 The Board prepared a Local Unscheduled Care Action Plan (LUCAP) and this was approved by a national evaluation panel on 31<sup>st</sup> July 2014.

**2. Current Performance**

- 2.1 Members will be aware that Board performance has been at 90% for recent months. The most recent performance is described in Paper 14/48. Most patients waiting in an ED are waiting for an inpatient bed to be made available to them
- 2.2 A review of activity has been undertaken and this illustrates that, whilst the number of patients attending Emergency Departments (EDs) and Minor Injury Units (MIUs) remained static in 2013/14, the number of people admitted following an ED attendance has risen by 2.4% compared to the previous year. By the end of June 2014 attendances were 2.6% higher than the first quarter last year.
- 2.3 At the Royal Alexandra Hospital (RAH), the Western Infirmary and Glasgow Royal Infirmary (GRI) patients referred by a GP for a medical admission are not seen in the EDs but in separate medical assessment units (MAU) and activity in these units in 2013/14 was

4% higher than the previous year. The first quarter of the current year shows a continued increase.

### 3. **Service Improvement**

#### 3.1 Work with partners

Work with partner agencies is key to ensuring that people receive the right care, in the right place, at the right time.

Inverclyde Community Health and Care Partnership are leading a project with Public Health and acute services looking at the use made of acute services, how these best meet the needs of the population and what service improvements can be made. This involves local practitioners and service users.

In Renfrewshire a programme is underway to further develop the service model envisaged in the case for change developed as part of the Clinical Services Review. This also is led by local practitioners and service users and includes colleagues from Renfrewshire Council.

Work in ongoing with the Scottish Ambulance Service (SAS) looking at providing alternative routes that the SAS can direct patients to without having to bring them to hospital. This includes considering how best to meet the needs of those who have fallen in their own homes and those with mental health needs.

#### 3.2 Work across NHS services

Colleagues work jointly across acute and community services to ensure that people can be cared for at home or in a homely setting for as long as possible and are discharged as soon as they are ready for this to take place.

Community services are establishing new support to care homes within their areas and considering how district nursing services support their patients. Particular focus is being given to ensuring that people with life limiting and long term illness have anticipatory care plans in place so that it is clear what action is needed in a crisis. All areas are also looking at how those at the end of their lives can be supported in their own homes, if that is their preference.

Mental health services are working with those in other emergency services such as Police Scotland, the SAS and Emergency Departments to ensure that full use is made of the comprehensive range of crisis services available.

#### 3.3 Work within Acute Services

The length of time someone stays in hospital will vary according to their clinical needs but we know that sometimes people could be discharged sooner with better communication between staff and with patients and their families. The majority of patients leave hospital in the afternoon despite many having been fit to go home from the morning. Acute wards are looking at their local processes to ensure that discharge decisions are implemented as soon as possible.

The Medical Admissions Units allow a proportion of patients to receive rapid tests and investigations and then be discharged very quickly. The range of conditions for which this is

appropriate is under review and alternatives to admission such as next day out patient appointments are being developed in both medical and surgical specialties.

A new national project considering all patient flows through a hospital is due to start at GRI in September, this will look at how emergency and elective flows work in the hospital and the use of all types of facilities such as the ED, wards and Operating Theatres.

#### 4 **Investment**

Whilst service redesign and joint work continues and is making progress the results can take some time to be delivered sustained improvement.

There is therefore a need to take a number of immediate actions in order to ensure that patients can be admitted from our EDs.

Inpatient beds are a rapid solution to the issue and can be closed equally rapidly when the impact of other initiatives is felt. It is proposed to open additional beds on three hospital sites.

Review by a senior decision maker is required to ensure that patients have been promptly assessed, treatment initiated and a care plan agreed. It is proposed to appoint a Medical Nurse Practitioner to work at Inverclyde Royal; all other sites have this resource.

It is proposed to increase Emergency Nurse Practitioner hours in the ED at the RAH and it is proposed to appoint 4 additional Consultant Physicians.

A surgical assessment area will be established at the RAH to allow patients to move more quickly from the ED to specialist care.

A number of other initiatives will also be taken forward by local services.

This will require additional investment of £1,100,000 by the NHS Board in addition to the LUCAP allocation. The impact of the actions will be evaluated and should they deliver the planned levels of improvement they would be recommended for consideration for ongoing investment in 2015/16,

Anne Harkness  
Director of Emergency Care and Medical Services

## Appendix

### SHIFTING THE BALANCE OF CARE FOR OLDER PEOPLE: AN INTEGRATED 4 YEAR PLAN

#### Executive Summary

##### Introduction

The following note summarises the core elements of a report prepared by Glasgow City Social Work Services, Glasgow CHP and the Acute Services Division. It sets out the wider context within which a shifting of care for older people can be achieved over the course of the next four years and at the same time outlines the actions that are proposed to improve hospital discharge arrangements in 2014/15. Specifically it outlines:

- i) the strategic context;
- ii) the key change elements of the health and social care financial framework relating to older people;
- iii) the envisaged pre-requisites to manage system pressures through to 2017/18;
- iv) the pressures (cost and volume) on the acute system between now and full implementation date of 1<sup>st</sup> April 2015 and details the in-year actions and resources required to improve discharge performance; and
- v) the anticipated risks and mitigating management actions.

The summary covers the key issues of the report including the plan to reconfigure the balance of community based health and social care for older people and the core elements of the proposed change programme including the potential impact on hospital delays this financial year. It also identifies how the development programme will be funded on a recurring basis from 2015/16 and identifies the need for transitional resource this year to address the reduced levels of care home funding and ease anticipated pressures whilst the planned programme of change is implemented.

##### Shift in the Balance of Care

The report outlines the projected shift in the balance of care in financial terms and projected numbers of people supported, over what will be a very challenging next 4 years. It confirms the projected percentage shift in available resources away from hospital and long-term care to intermediate care, home care/ reablement, day care, telecare and community-based health care.

The fundamental risk remains the mismatch between available resources and demand, particularly where the system experiences unexplained surges in demand. Such risks can only be mitigated by the provision of lower cost community based alternative provision being the norm and able to be accommodated within existing budgets. The plan creates the potential for such an environment and culture to be put in place.

##### In-year actions required to improve discharge performance.

There is a continuing gap between the available care home budget and demand for placements. On average over the past 15 months, 73 patients have been discharged from hospital directly to residential/nursing care. There are currently 50 placements per month available for such purposes to the end of the financial year. The impact of this gap is that by the end of this financial year there could be approximately 160 further patients delayed in hospital awaiting funding.

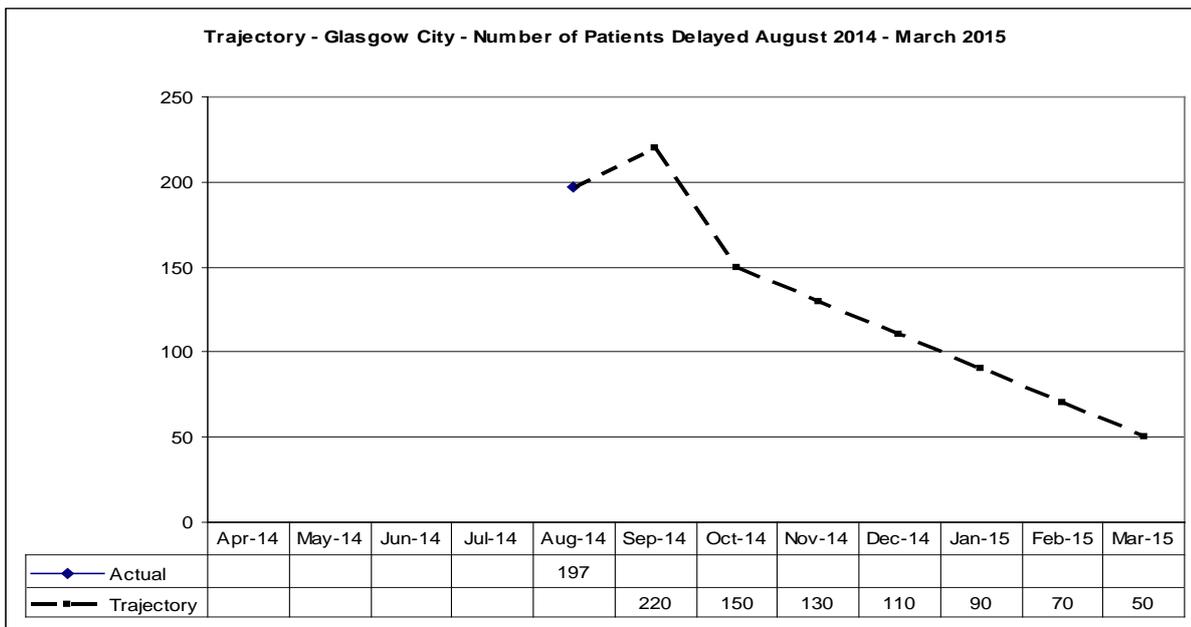
The report sets out the capacity gains and financial costs associated with meeting this pressure. The improvement plan, detailed in the report, is set within the context of a whole system shift in the balance of care for older people being developed in the Joint Strategic Commissioning Plan and is predicated on the assumption that all older people deemed medically fit for discharge (FFD) are discharged within 48 hours

to home or an intermediate care facility plus a comprehensive and integrated programme of service reform.

At the centre of the redesign/improvement plan are proposals to significantly increase the levels of intermediate care capacity in the city from the present 37 to 115 places. The hypothesis underpinning the redesign is that by facilitating discharge from the acute care system at or close to the FFD date, followed by comprehensive assessment, access is available to intensive rehabilitation and other appropriate care. It is assumed that more older people will be able to return to their own homes rather than be placed in nursing care. By October 2014, pending funding availability, negotiated tenders could be delivered in order to upscale the level of intermediate placements to facilitate discharges from hospital within 48 hours of FFD.

### Delayed Discharge Trajectories

The report indicates that if no corrective action is taken, by March 2015 approximately 160 further patients will be delayed in hospital awaiting funding resulting in a total of 350 delays. However, successful implementation of the improvement plans set out in the paper should deliver significant improvements in terms of a sharp reduction in the number of patients awaiting discharge as illustrated by the following trajectory



### Financial Framework

It is proposed that the full year cost of the improvement plan detailed in the report, totalling £3.764m, will be a first call on the Integration Fund received by Glasgow in 2015/16 and thereafter funded from within the re-directions predicted within residential/nursing purchasing reductions.

However, in the current year there remains a significant financial shortfall to meet the gap between the available care home budget and demand for placements, and at the same time initiate the improvement plan, in particular the expansion of intermediate care, detailed in the report. The additional funding required in 2014/15 can be summarised as follows:

Detail	2014/15 (£m)
Additional care home placement funding	1.6
Planned expansion of intermediate care	1.9

Contingency	0.18
Total	3.68

August 2014