Midlothian Integration Joint Board
Audit and Risk Committee

Thursday 5th March 2020, 2.00pm

Performance Monitoring of the Midlothian Acute Services Plan

Item number:	**5.4**

Executive summary

This report is concerned with the new Midlothian Acute Services Plan laying out a series of actions over the next two years designed to reduce demands on acute hospitals. This is a key responsibility of the IJB. However, it is very challenging given the growing and ageing population and the increasing number of people living longer with long-term health conditions. In view of this, it is vital that a strong performance management system is in place to ensure the plan remains on track in terms of implementation and impact. This report outlines the approach now underway to manage performance thereby enabling the Partnership to continually adapt and reshape its services.

Board members are asked to:

1. *Approve the approach to performance management*
2. *Agree to receive six monthly performance reports to reinforce the need for progress to be maintained.*

Report

Performance Monitoring of the Midlothian Acute Services Plan

1 Purpose

1.1 The purpose of this report is to seek approval for the approach now in development, to the measurement of the impact of local community services in relation to the demands on acute hospitals.

2 Recommendations

2.1 As a result of this report Members are asked to:

2.1.1 Agree to the overall approach to ensuring effective measurement of the impact of community services upon the hospital system

2.1.2 Agree to receive progress reports, including performance information, on a six monthly basis

3 Background and main report

3.1 The need to adopt a whole system approach to the delivery of health and social care was reflected in the requirement to integrate services provided by the Councils and NHS Boards and crucially, in the required delegation of the budget for unscheduled care (unplanned attendances and admissions) in hospitals.

3.2 Nationally, while there has been good progress in integrating services, the Audit Scotland Report, *Review of Integration* (November 2018), reported much less progress in the delegation of hospital services.

3.3 In order to bring about improvement in this regard locally, a new forum, the Midlothian Acute Services Planning Group, now meets regularly, chaired by the Chief Officer and involving the Clinical Director for Primary Care in Midlothian, local Heads of Service and Strategic Planning staff from the Royal Infirmary.

3.4 This group meets monthly and has overseen the construction of a local plan designed to reduce pressures on acute hospitals in terms of attendances at A&E; unplanned admissions; and through earlier discharge. Alongside these service and system developments has been a commitment to strengthen working relationships between acute hospital and community-based staff.

3.5 The Midlothian Plan is now in place although the conclusions of the Integrated Impact Assessment, undertaken on 30th January 2020, have yet to be incorporated in the Plan. Alongside this plan, and in response to Scottish Govt. placing NHS Lothian at level 3 of the national performance framework, a short-term plan covering the six months between October 2019 and March 2020 was developed

and the local Planning Group monitors progress on a fortnightly basis. Active management during this period is particularly important given the increasing demand routinely experienced by hospitals over the winter.

3.6 In order to ensure delivery of the Plan a formal performance monitoring system is being introduced which will actively oversee actions and the impact of service developments and system improvements. Key aspects of the Plan will also be reflected in the Directions issued to NHS Lothian and Midlothian Council for 2020-2021.

3.7 The national MSG indicators are currently the main mechanism for checking the progress of Health and Social Care Partnerships. Locally, these are reported to the IJB regularly and to the Joint Management Team every month. However, these indicators fail to reflect adequately the changing demands on the whole system including significant population growth; increasing numbers of people with long-term health conditions and frailty; and a rapidly ageing population, with a consequent increase in conditions such as dementia and cancer. Progress is being made in developing a performance framework for community services that are intended to have a direct effect on the demands on acute hospitals. The main local services whose performance has a direct impact on the capacity of acute hospitals are listed at appendix 1 for information.

3.8 The key development is that a number of these services are now required to estimate, as far as possible, the impact of their interventions in relation to reduced hospital demand in terms of bed days saved and costs avoided. Inevitably, these calculations involve a judgement about what is likely to have happened if the service in the community had not been provided and, as such, cannot be considered wholly accurate. However, the current arrangements whereby the impact of these interventions are not considered alongside performance against the MSG indicators, does not provide a full picture of the demands on the whole system. One graphic example of this is the continuing high numbers of people delayed in hospital awaiting a care at home package. Considered in isolation this could suggest a failure to make progress but when considered in a broader context it is clear the demands on the service have grown considerably; there are now one thousand more hours of care at home provided every week than a year ago.

3.9 The two services that are actively adopting this approach to performance management are the Community Respiratory Team and the Discharge to Assess Team; Tables 1 and 3 provide some information about their performance during 2019-20 (see Appendix 2).

3.10 Other services are developing alternative indicators. One example is the Hospital at Home Team. The current performance is shown in Table 2 Appendix 2 providing data on similar indicators to inpatient care-numbers of patients and occupancy level. While occupancy levels are relatively low, this is in part a consequence of the service's ability to discharge the patient as soon as they are medically fit because they are already living at home. Work is now being undertaken to measure the complexity of the patients admitted to hospital at home in terms of frailty and long-term health conditions and how their length of stay compares to similar patients admitted to an acute hospital.

3.11 Another example is the new approach to supporting frail patients. The Midlothian HSCP and GP Cluster are using analytics and quality improvement to improve the

frailty system of care. One of the measures in the efrailty evaluation framework is the impact on unscheduled care in hospital. The graph in Table 4 Appendix 2 is included as an illustration of how the HSCP is using data to track progress. MidMed is one of the initiatives in the eFrailty programme. A paired T-test (a statistical hypothesis test) has been used to assess the impact of MidMed of risk of unplanned hospital admission and indicates that between June and December 2019 MidMed has had a positive impact on risk of admission compared with other frail practice populations in Midlothian. Further, more robust, data will emerge during 2020 to understand the impact of the efrailty programme.

3.12 The Care at Home Support Team has a remit to support good quality care in local care homes. One dimension of this work is to avoid where possible, unplanned admissions to hospital. Table 5 Appendix 2 illustrates a continuing decline since June 2015 of attendances and admissions to acute hospitals from local care homes.

3.13 The objective of this work is to ensure that decisions regarding service design and investment are based on a comprehensive understanding of the demands and interventions across the whole system, not only what is happening within the Acute Hospital setting.

3.14 More broadly, the Partnership has now committed to adopt a more rounded approach to performance management incorporating a methodology referred to as "contribution analysis". This recognises that, while quantifiable data is very important, the complexity of the health and care system is such that change in performance is seldom attributable to one service or intervention alone. The challenge is to introduce ways of evidencing that a service has made a meaningful and worthwhile contribution to improving performance. This will include quantifiable data but also other measures such as patient stories and the views of staff.

4 Policy Implications

4.1 A key objective of the Integration policy is to increase the capacity of community services and avoid further expansion of acute hospitals services if possible. The purpose of the Midlothian Acute Services Plan is to help this become a reality given the continual rising pressures on acute hospitals.

5 Directions

5.1 While this report does not require a new Direction to be issued, the requirement to deliver the new Midlothian Acute Services Plan with a robust performance management system in place will be included in the 2020-21 Directions.

6 Equalities Implications

6.1 An integrated impact assessment is underway and will be completed by the end of January 2020

7 Resource Implications

7.1 There are no direct financial implications arising from this report. The set-aside budget for Midlothian is in the region of £18m although the methodology for agreeing this level of resources is under review. However, the IJB does have a responsibility to ensure the demands made upon the hospital system are commensurate with the budget available.

8 Risk

8.1 The risks of failing to support the hospital system effectively include people being delayed unnecessarily in hospital and scheduled operations being cancelled because the unplanned activity has put too much pressure on the system.

9 Involving people

9.1 The key staff are those involved in delivering these services, ensuring that they are able to record the impact of their interventions in avoiding demand on the hospital system. This is being progressed through the relevant team managers.

10 Background Papers

10.1 Midlothian Acute Hospital Services Plan 2019-22

10.2 Joint Management Team Performance Report January 2020

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DATE	21 January 2020

Appendices:

1. **Main Service Developments designed to reduce demand on Acute Hospitals**

2. **Performance data relating to three services:**

   Table 1: Community Respiratory Team
   Table 2: Hospital at Home
   Table 3: Discharge to Assess
   Table 4: Emergency Admissions of Frail People
   Table 5: Care Home Admissions to Hospital

Appendix 1

Community Services whose performance impacts on demand on Acute Hospitals

SERVICE	
Hospital at Home	15 places
Intermediate Care-Residential	35 assessment rehabilitation and interim beds
Midlothian Community Hospital	40 intensive rehabilitation and complex care 40 mental health and dementia (reducing to 20)
Interim Care Home Places	7 purchased from private sector
Care at Home	Overall Capacity 8,000 hours per week
Care Home Support Team	Support high quality care and minimise admissions to hospital (See Appendix 3 for trend)
Primary Care GPs	10/12 Open Lists January 2019
District Nursing	41 District Nursing Staff. Of particular note is the work undertaken to support palliative care patients remain in their own home rather than in hospital
Primary Care (Wider Team) Additional capacity	Physiotherapy in all practices Wellbeing in all practices Pharmacy 5 FTE working across Practices Psychiatric Nursing in 8 Practices
Frailty Service	3 GPs plus 14 GP session across 14 Practices. Red Cross FTE Support Worker. District Nurse and OT in Winter Frailty Team (1.8 FTE)
Anticipatory Care Plans	GPs, Frailty Teams, Community Respiratory Teams, District Nurses (palliative care) and the Care at Home Support Team all working to improve the proportion and quality of ACPs
Intermediate Care Community Services	Discharge to Assess Team
	Community Respiratory Team
	Falls Practitioner
	Rapid Response Service
Working with 'Frequent Attenders' at A&E	Community Health Inequalities Team
	Local Multi-Disciplinary Team Meetings 6 weekly
Managing Flow in and Out Hospital	Daily Delayed Discharge Meetings

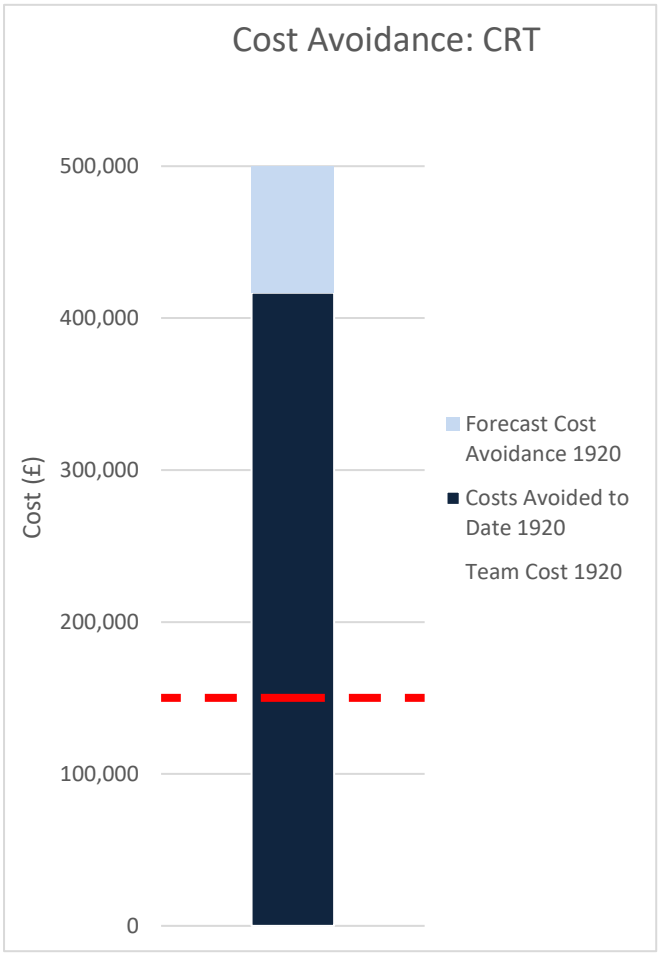
	Flow Hub (based in Bonnyrigg HC)

Appendix 2

Table 1 Community Respiratory Team Performance

Area	Type	Cost Avoided to Date (£)	Forecast Cost Avoidance (£)
RIE	Prevention of Admissions	322,560	387,072
RIE	Facilitated Discharge	94,080	112,896
Totals		**416,640**	**499,968**

	Activity Data			
Month	**Prevention of Admissions**	**Bed Days Saved**	**Facilitated Discharges**	**Bed Days Saved**
April	14	84	7	28
May	12	72	5	20
June	22	132	10	40
July	22	132	9	36
August	24	144	3	12
September	22	132	1	4
October	15	90	10	40
November	8	48	9	36
December	30	180	16	64
January	23	138	14	56
February				
March				
Totals	**192**	**1152**	**84**	**336**



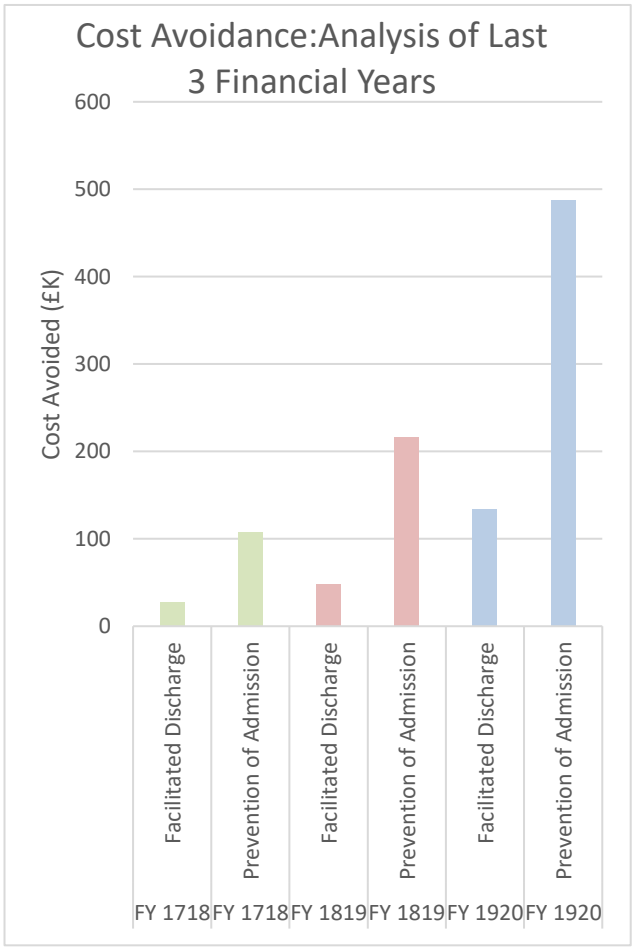


Table 2 Hospital at Home

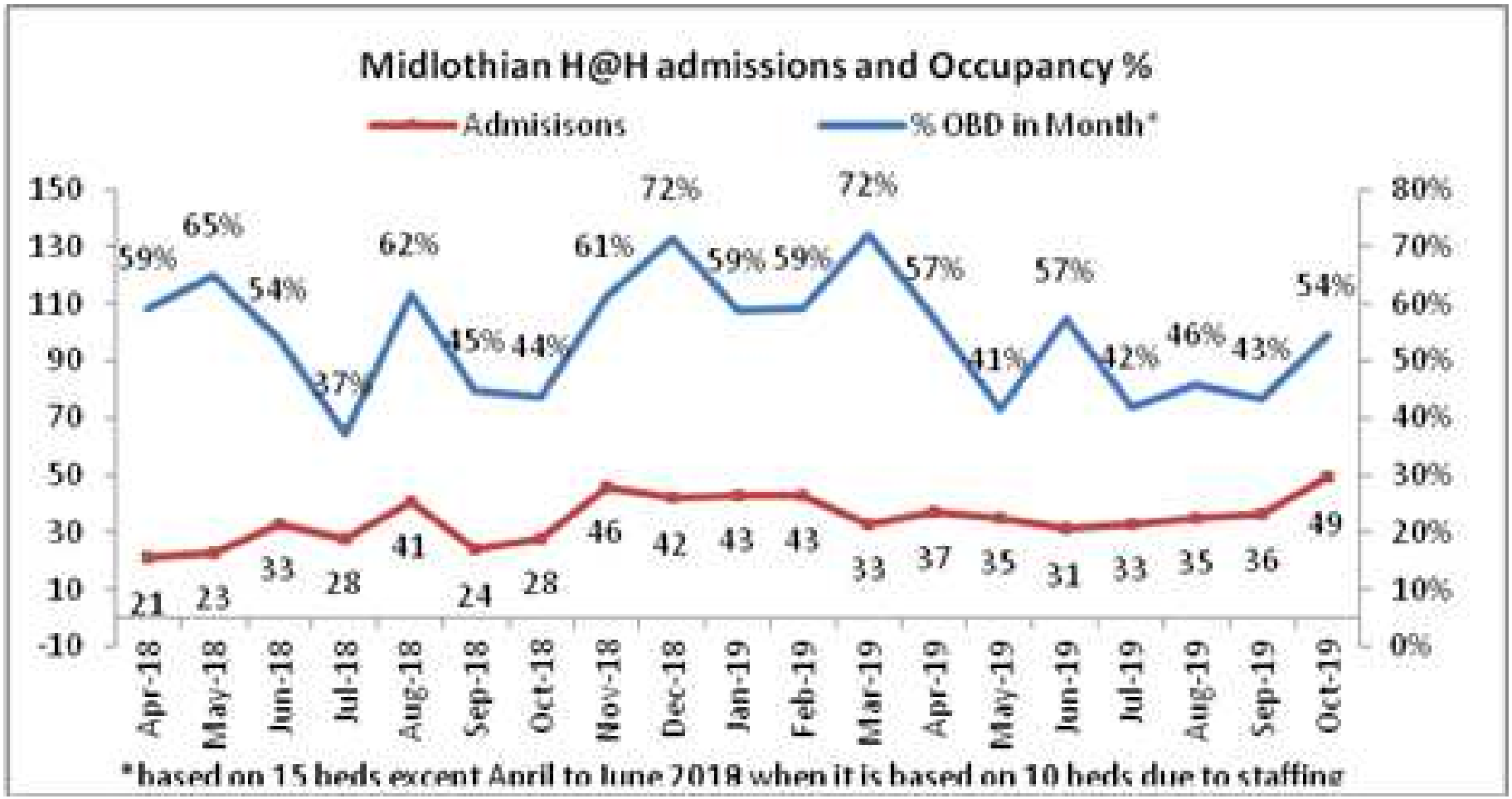
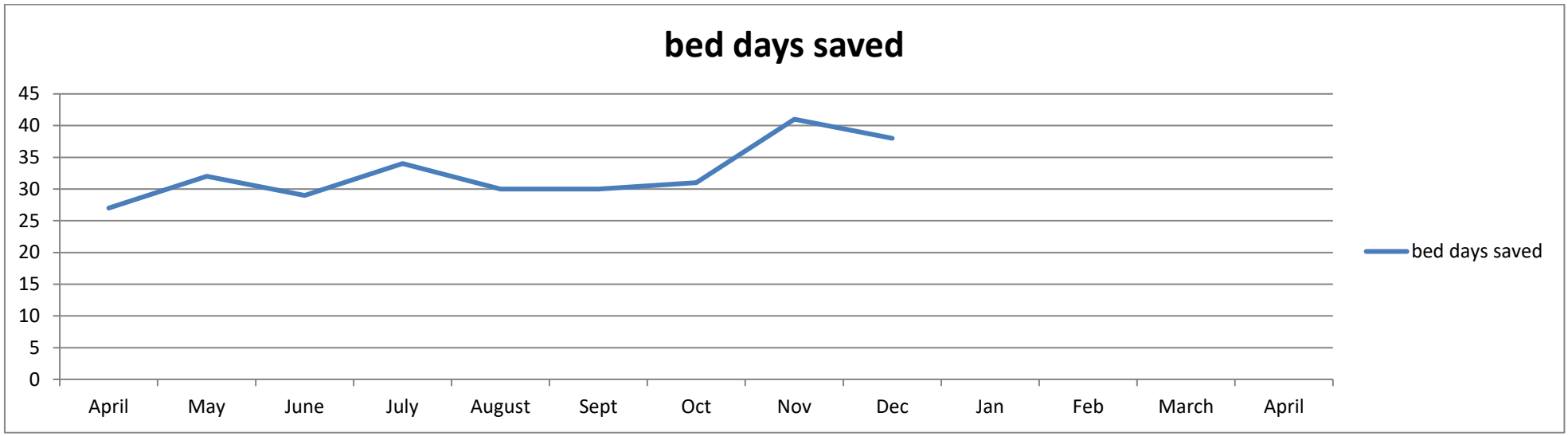


Table 3 Discharge to Assess Team Performance



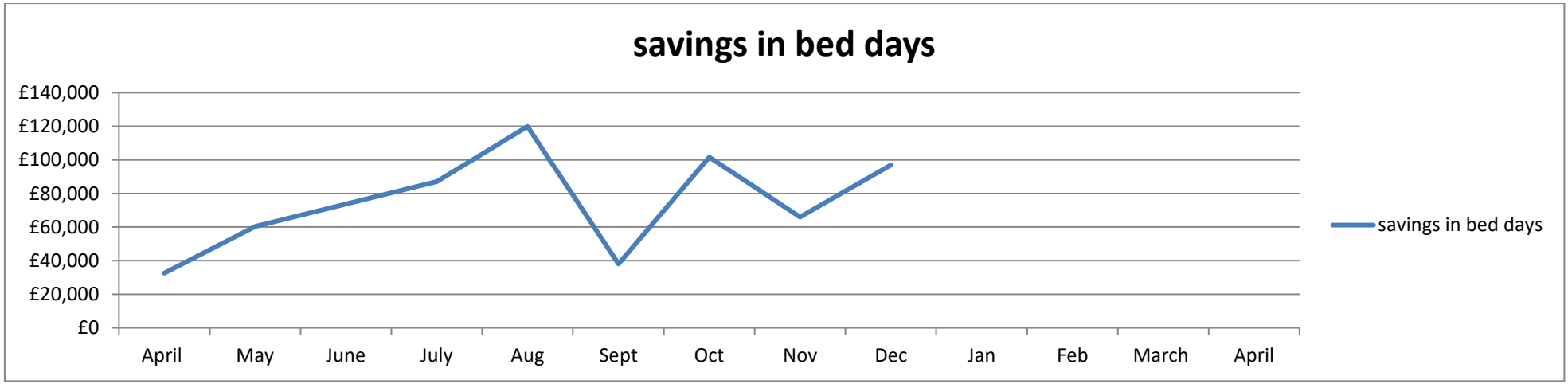


Table 4 Emergency Admissions of Frail People Registered in Newbattle Practice

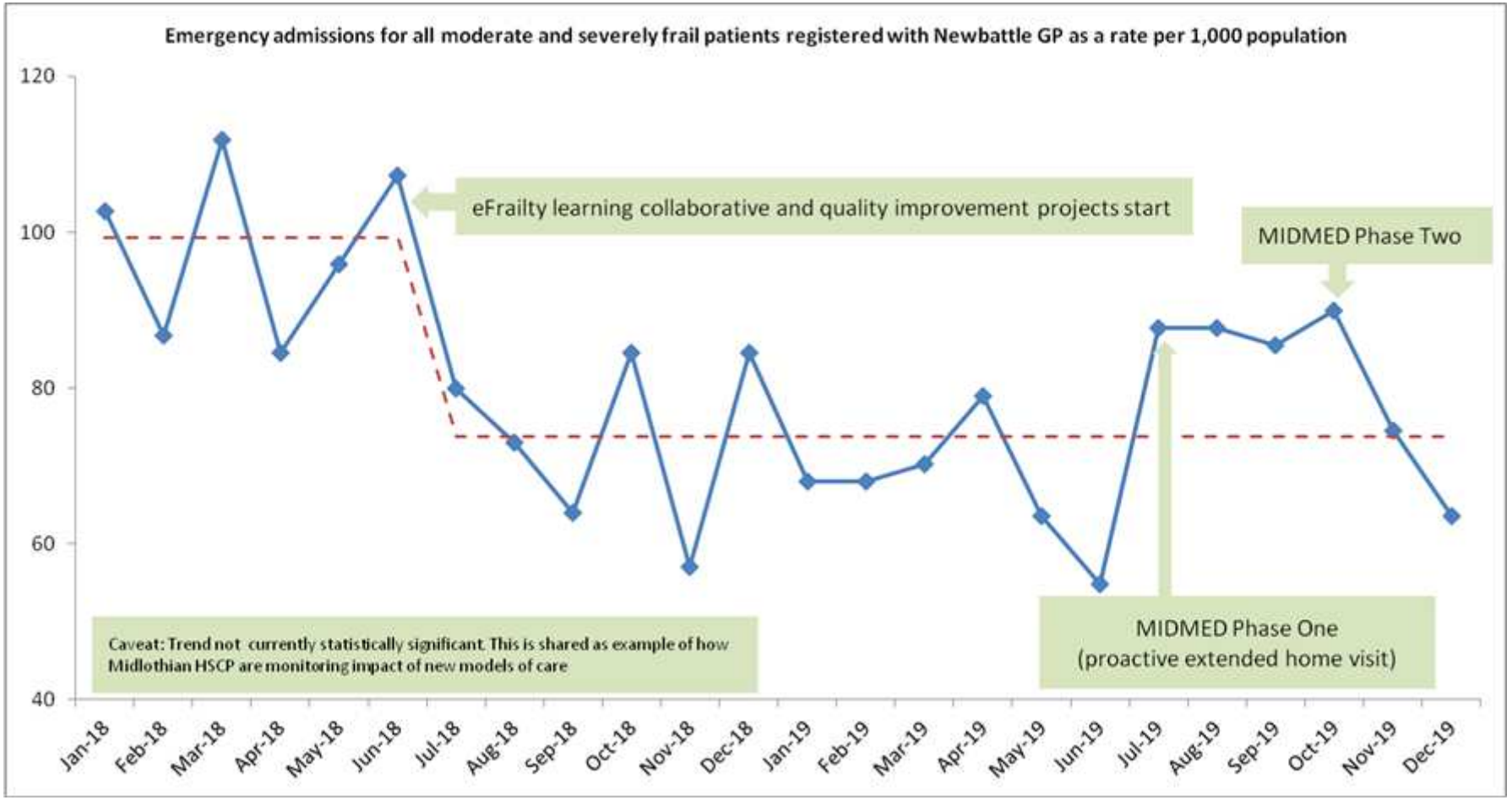


Table 5 Attendances and Admissions to Hospital from Care Homes