Appendix 2

Integrated Health and Social Care Scrutiny Proposal: Integrated Recovery Programme

Summary

1. Integrated health and social care is part of the current scrutiny work programme, and in December 2015 the OSPB approved a proposal for scrutiny which focused on the Integrated Recovery Programme.

2. However, ongoing changes in the arrangements and standards of integration of health (adult care integrated recovery) are such that a scrutiny exercise is not the most effective way to consider the issue at present and would not be the best use of limited scrutiny resources.

3. It is recommended that the scrutiny exercise is revised to allow a greater focus to be placed on emerging issues in particular:

    - Any substantial changes proposed as a result of the review of integrated recovery beds being considered by the Health and Wellbeing Board, which emanated from the study of the Worcestershire Systems Resilience Group (2014), and must be considered under the Health Overview and Scrutiny Committee (HOSC) remit.

    - The relevant recommendations of Lord Carter's Report[1] on hospital productivity, which should be considered by HOSC as and when appropriate.

Background

4. The Integrated Recovery programme is a joint programme of work involving the county's Clinical Commissioning Groups and Worcestershire County Council and consists of a series of commissioning projects that aim to work towards greater integration of health and social care for older people – particularly who need support to regain their independence following a crisis at home or admission to hospital.

5. The programme is developing rapidly across Worcestershire, with increasing emphasis on commissioning and delivering health and social care recovery services in a more joined up way. To date, work has focussed on services which support people in their own homes and bed based care, currently provided within Resource Centres, Community Hospitals and Care Homes. In November 2015 the Health and Wellbeing Board (H&WBB) agreed a timetable for reviewing and re-commissioning non-acute recovery beds by October 2016, in order to secure improved service user outcomes and improved efficiency. More recently, as part of the Programme, a procurement exercise has recently concluded which secures a new provider for the Timberdine Community Unit (a service previously provided by WCC, prior to the council confirming its intention to move to a commissioning only authority)

[1] Operational productivity and performance in English NHS acute hospitals: unwarranted variations', is Lord Carter's independent report, commissioned by the Department of Health to review efficiency in hospitals and how large savings can be made by the NHS.

6. Nationally, a report by Labour peer Lord Carter, commissioned by the Department of Health, on operational productivity and performance in English NHS acute hospitals (February 2016) has touched on many of the key issues, including factors which effect the timely discharge or transfer of people following an acute hospital admission. The report is available on the Department of Health's website here

7. The Council is committed to greater integration of health and social care, to develop better co-ordinated, streamlined and effective services around the needs of patients, their families and carers. Integration of health and social care is a huge and complex area across multiple organisations and services, and based on the principle of co-production, includes work on new models of care, patient flow, joined up assessment and case management, inter-operability of IT systems and an emphasis on self-care with coordinated, multidisciplinary, proactive support and intervention.

Health and Wellbeing Board - Commissioning of Recovery Beds

8. At its meeting on 3 November 2015, the Board considered (agenda item 6). Integrated Recovery Services in South Worcestershire; Commissioning of recovery beds

9. It was reported that a review of current and required recovery bed capacity was undertaken during 2014 on behalf of the Worcestershire Systems Resilience Group (SRG) and the findings were presented to SRG in June 2015.

10. Details of the conclusions about the future requirements for recovery beds are set out in summary:
    - There are too many beds currently – this is estimated to be an excess is 85 beds by 2017/18.
    - The analysis shows that current beds are not always located in areas of highest demand, but reflect historical decisions around location of community hospitals and other inpatient facilities.
    - Currently, the length of stay in some facilities is longer than it needs to be for some people.
        - If length of stay is reduced for Step up beds and Pathway 2 ***nursing*** beds, the modelling suggests there will be sufficient capacity between the new single integrated community-based inpatient nursing and rehabilitation unit and the community hospitals.
    - The analysis shows a requirement for a small number (approximately 6) of Pathway 2 ***residential*** beds, as well as a continued need for Plaster of Paris beds.
    - The modelling demonstrated a continued requirement for Pathway 3 discharge to assess beds.

11. Considering options for how the beds might be commissioned in the future, the Board endorsed a timeline which included:

    - Decision on preferred configuration: January 2016
    - Notification to current providers: January 2016
    - If required, tender issued: February 2016
    - If required, contract(s) awarded: August 2016

- Revised services to start: October 2016.

Note to members, for information - Lord Carter's Report

12. Lord Carter published a Government Report in February 2016 in which it was highlighted that delays in discharging patients out of hospital after treatment could be costing the NHS in England £900m a year.

13. It was reported that nationally nearly 1 in 10 beds was taken by someone medically fit to be released. However, delayed discharges are likely to prove an intractable problem, as it is largely not down to the actions of hospitals. Vulnerable and frail patients cannot be released if there is not the support in the community from home care workers or district nursing staff or a place in a care home**.**

The Carter recommendations also included reference to the following:

(i) The Department of Health, NHS England and NHS Improvement should work with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers;

(ii) NHS England and NHS Improvement should work with trust boards to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community;

(iii) All acute trusts should make preparations to implement the recommendations of this report by the dates indicated, so that productivity and efficiency improvement plans for each year until 2020/21 can be expeditiously achieved; and

(iv) NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice;

(v) NHS Improvement should develop a national people strategy and implementation plan by October 2016 that sets a timetable for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from "ward to board", so that transformational change can be planned more effectively, managed and sustained in all trusts;

(vi) NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care;

(vii) All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives;

(viii) Trusts should, through a Hospital Pharmacy Transformation Programme, develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists

and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities;

(ix) Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017

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