

# Isle of Wight health and care sustainability plan

January 2019



# Executive summary

**This report is the Isle of Wight (IW) clinical and financial sustainability plan to 2021/22. It will be followed by an implementation plan by end of February 2019.**

The **IW health and care system serves a population of 140,000 people** with significant seasonal population increases. Despite the presence of an integrated Trust (acute, community, mental health, ambulance) with a co-terminal IW Council for the island geography, **historic challenges remain**. These include **recent leadership changes, IW Trust restructuring, marginal gains from prior care redesign** and **lack of clarity on the acute service model** for the island.

Despite historic progress in some areas such as hospital front door activity, there is a **strong case for change**. On demand this relates to **5% of the population with complex needs using more than one third of total health and care resources** (over £100m), without a fully comprehensive care model for their needs. On quality, **IW Trust has CQC ratings that require improvement**, particularly for community services and the **system lacks a comprehensive community mental health model of care**. A deep dive into the IW acute **length of stay challenge** via a bed audit and independent clinical review highlighted **43% of patients medically fit to leave have waited for over a week**.

Our **long term vision** that “**people will live healthy and independent lives**” will be realised in the long term. **Right now**, we will start this journey by **achieving clinical and financial sustainability** for our health and care system.

Our **sustainability plan** consists of **three domains – care models, productivity and networks**. Care models include **community supported care, mental health and supporting return to home**. Productivity focuses on **IW Trust productivity, CCG QIPP priorities and IW Council social care productivity**. The ambulance service and mental health care model will be networked with other providers to accelerate relevant service change.

**Next steps** will focus on **high impact** areas for care **quality/safety and financial sustainability**. These are **productivity initiatives** for IW Trust, IW CCG and IW Council plus **work to reduce length of stay** for medically fit patients via a multidisciplinary discharge team and enhanced flow and discharge processes.

# This sustainability plan had been designed to conclude previous work on strategy and to provide clarity on health and social care improvements in the next few years.

## Collective response

Since **October 2018** we have taken **collective action** across the health and care system to meet the **requirement for a clinical and financial sustainability plan**.

We have **formed an executive group** to accelerate system decision making consisting of executive leads, chairs, system finance lead and a councilor from IW Trust, IW CCG and IW Council.

To **develop working relationships** in this group we have used external support to guide our decision making and challenge process.

We recognised that the existing case for change was not comprehensive enough and was partially out of date. As a result we rapidly **determined the health and care case for change**.

The case for change work identified a large scale **length of stay challenge**. This led to us **commissioning a bed audit and independent clinical review** of all Trust beds to determine actions to remedy this challenge.

We have doubled the meeting frequency of our **system finance group** to develop this plan for improvement for the IOW.

## Priority action

This sustainability plan outlines **focus areas to complete by 2021/22**. We have **already started work** on areas that will have **greatest quality/safety and financial impact**.

We are **accelerating productivity/QIPP programmes** across the care system. This includes schemes for all three organisations:

- **IW Trust** – *outpatient reductions; theatres utilisation*
- **IW CCG** – *Increasing range of primary care services*
- **IW Council** – *ASC retendering services; modernization; reconfiguration*

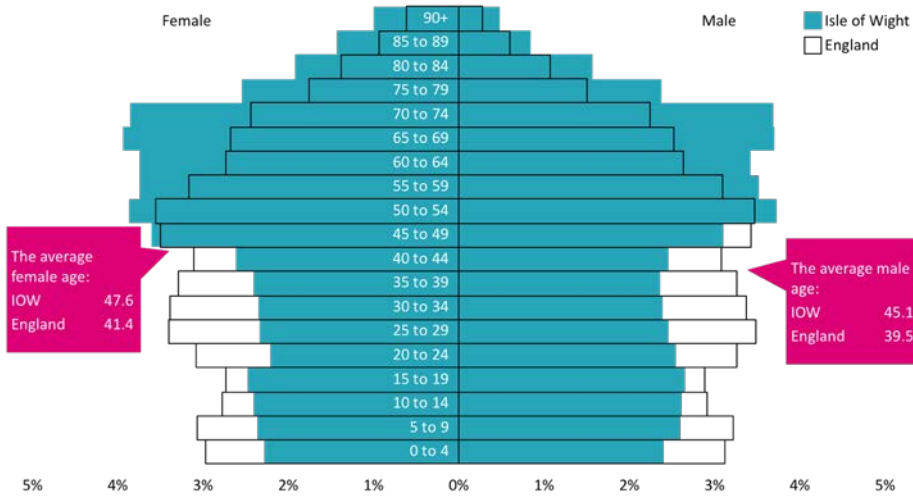
We are implementing a new **multidisciplinary discharge team** to reduce the time patients spend in hospital once they are medically fit to leave.

We are creating standard **discharge protocols and processes** (from front door to return to home) to reduce the time that patients spend in hospital.

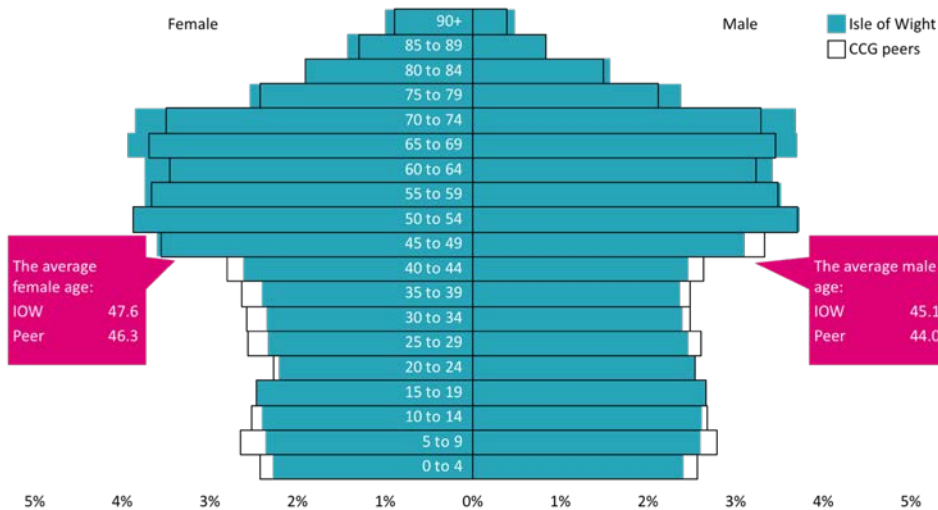
# Drivers for change

# The Isle of Wight population is older and more deprived with more people living alone than nationally

Population of the Isle of Wight and England  
%



Population of the Isle of Wight and peer CCGs  
%



The Isle of Wight population is **older than the England average by six years.**

While there is variation in deprivation across the island, overall **deprivation ranks in the lower quartile compared with peer group areas** and ranks **83 out of 326 local authorities nationally.**

**Living environment deprivation also ranks in the lower quartile** compared with peer group areas.

**Education is ranked lowest in the index of multiple deprivation against peer group areas** and ranks **44 out of 326 local authorities nationally.**

**Health deprivation overall is almost 50% lower than the national mean.**

More people **live alone on the Isle of Wight (15%)** than **nationally (12%).**

The island has **greater incidence of dementia, stroke and LD than nationally.**

*For analysis in this report we have compared IW care demand and capacity with peers that exhibit similar population and disease profiles.*

SOURCE: ONS mid-year estimates 2017; RightCare peers and Kernow CCG; IMD 2015; IW JSNA 2015

## Demand for care services on the island is predominantly driven by 5% of service users requiring 36% of resource, with acute length of stay being a challenge

Today, we provide health and care services to our **population of 140,000 people**. The most complex cohorts represent **5% of the population (7,000 individuals)** whom use **36% of the total resources (£106m out of £294m)**.

**A&E activity** in 2017/18 was only 1.7% higher than the peer top quartile and is **better than the national top quartile**  
**Non elective spells in 2017/18** were **lower than** both the **national and peer** top quartile.

Demand for **999 services have fallen** compared with a national increase and are increasingly more **likely to result in a “see and treat” outcome** instead of “see and convey” compared with the national trend.

Although **111 calls** have grown compared with the national average, there has been a **1.5% increase in people triaged to “no other service”** whereas nationally this outcome has fallen.

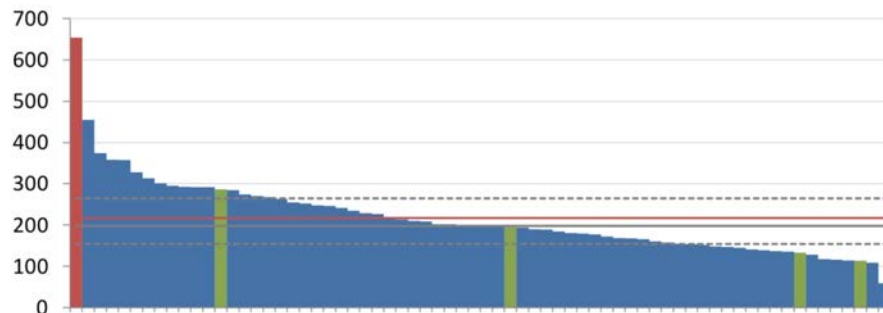
Since April 2015, **A&E attendances and non-elective spells have fallen** (2.1% and 0.6% average per quarter, respectively) compared with peer and national increases

Demand for **older adults admitted to social care** is **similar to the national mean** but presents a **25% opportunity** to move to **peer top quartile**.

# IW Trust has the highest mental health adult rate of admissions and the lowest mental health adult length of stay in the country

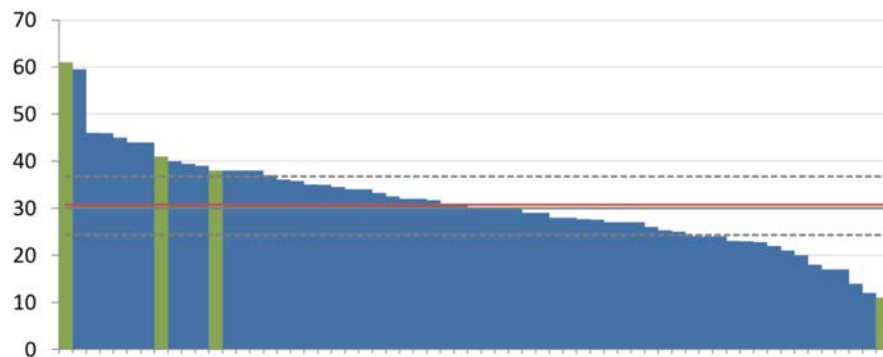
## Adult acute admissions

Admissions per 100,000 weighted population



## Adult acute length of stay

Days



Adult acute **admissions for mental health** were the **highest** of any mental health Trust in England in 2016/17 despite two peers in the national upper quartile

Conversely, the adult **length of stay is the lowest of any in the country**. This suggests that there is a “revolving door” care model for mental health whereby service users are admitted due to lack of effective community provision.

This was **corroborated by an independent clinical review** that confirmed repeat attendance for mental health inpatients known to the IW Trust.

**Older adult** mental health **admissions are also in the lower quartile** compared with nationally, again partly due to the lack of a community model of mental health care.

Adult **costs per occupied bed day are almost £600**, compared with the **national mean of just over £400**.

SOURCE: NHS mental health benchmarking 2016/17, CF analysis

# The independent clinical review highlighted three sets of challenges to address

## Management and metrics



### **Lack of available and consistent data** on pathway delays

The focus of the system is **not getting the hospital down to a safe level of occupancy** – even on OPEL 4 the responses across the system do not seem to make a material impact.

## Systems and processes



A **complex multitude of models of care** both in the hospital and in the community

**Poor links between hospital and community** and poor links with **nursing home community beds and GPs**

**Lack of specialist pathways** in community rehab (e.g. non weight bearing; “maintenance” rehab approach), MH (e.g. emotionally unstable personality disorder) and housing (e.g. bariatric)

Lack of community provision for **services that could easily be delivered outside of hospital** – e.g. IV antibiotics

**Perceived lack of social care availability** – patients reportedly waiting for packages or residential / nursing homes

**Case note management is inconsistent** and assessments are not started until patient is medically fit for discharge–  
**lack of discharge planning**

**MFFD ward is under-resourced** in terms of therapies support and expediting discharge

**Patchy community MH services** due to issues with staffing and increasing use of agency staff as well as a perceived difficulty in keeping up to date with services that are available

## Leadership, capabilities and behaviour



**Need for system and clinical leadership** to focus on collective and internal approaches to tackling excess length of stay

A **risk averse culture** with a lack of sense of urgency that appears to be historic

**Poor communication** between all parties

Mindset is not that bedded capacity is a scarcity and therefore **beds are being used when more appropriate alternatives exist**



The background consists of three overlapping geometric shapes: a large dark blue trapezoid on the left, a light blue triangle in the top right, and a green triangle in the bottom right. The text 'Future vision' is centered within the dark blue area.

**Future vision**

# Our long term vision will be achieved through continual improvement and innovation

Our vision is that **“people will live healthy and independent lives”**

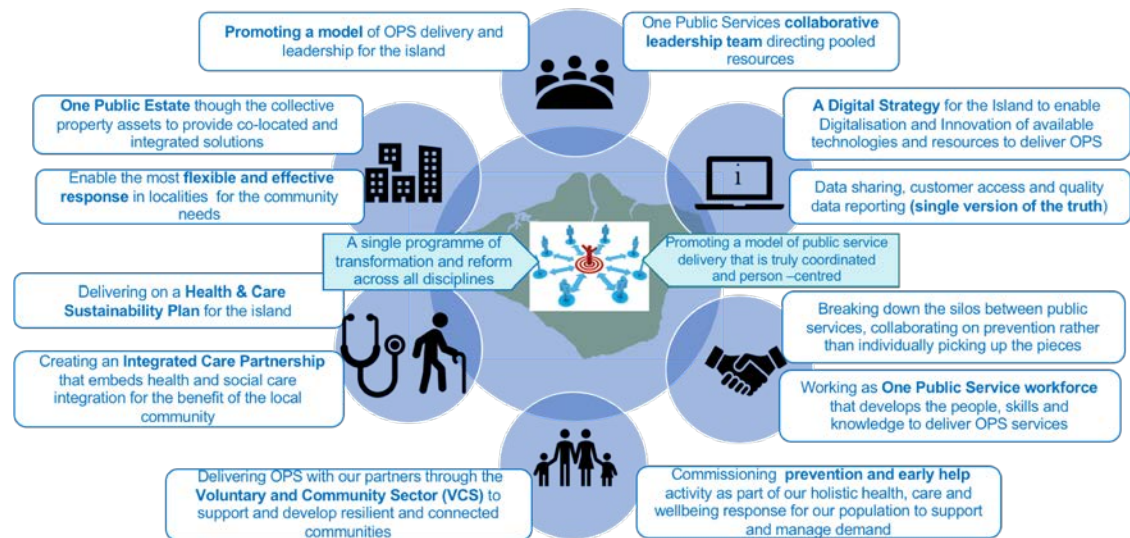
To achieve it we will make **continuous improvements** for the island population

Our work to develop **“One Public Service”** for the island (shown left) is one way we are coming together across IW Council, Trust and CCG to meet this vision

We **won’t avoid difficult decisions** and will stop work that doesn’t meet our vision

We will **innovate and learn as we improve services** and spread lessons across our whole care system

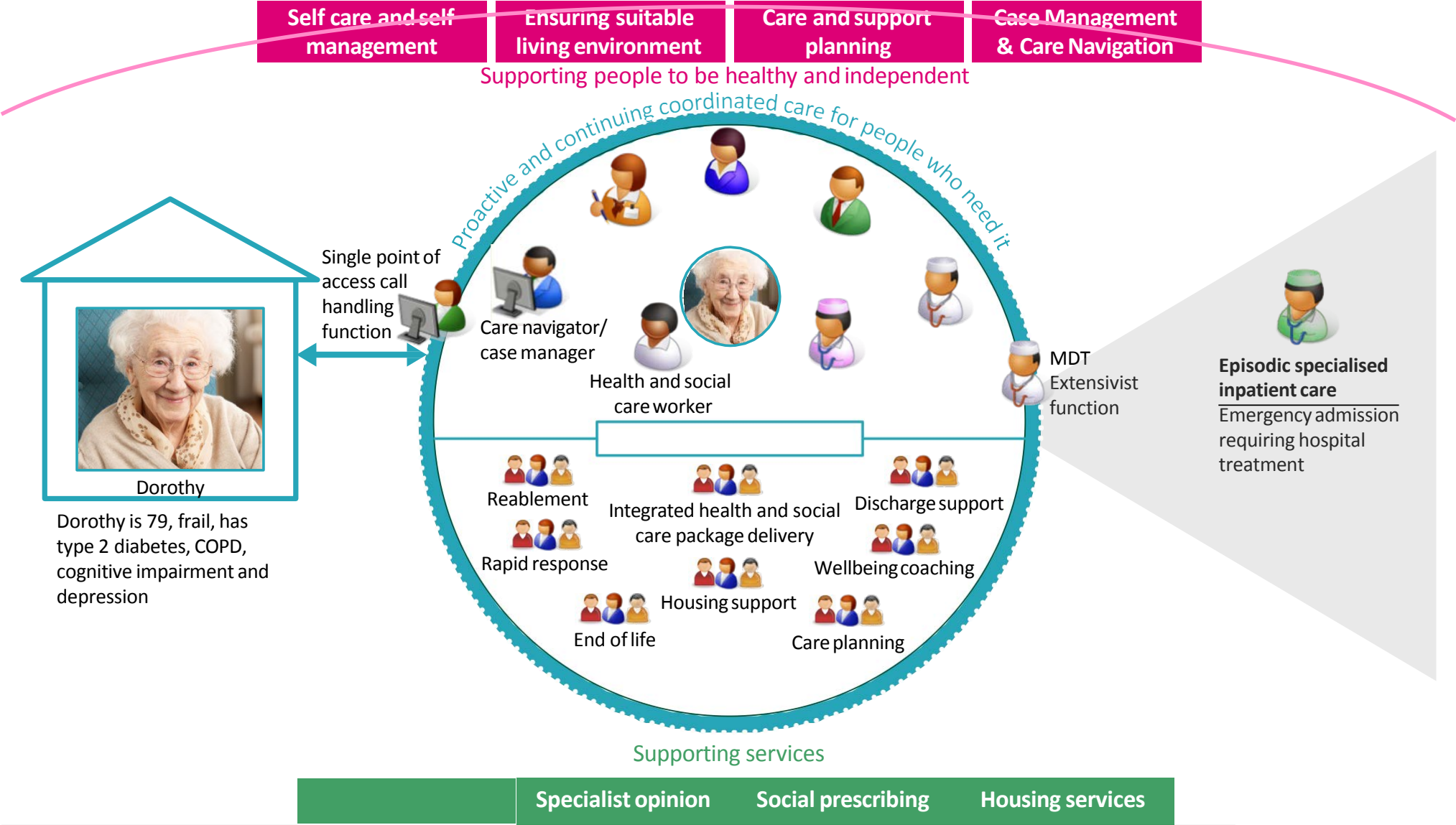
People will live healthy and independent lives



Source: IW system project board; IW One Public Service working group

# Care models

# The community care model will be built around an MDT with proactive and holistic care



# Eight interventions will improve care for older people with complex needs

## Supporting people to be healthy and independent

- 1 Empower self-care & self-management.** Support people and their carers to take control of the improvement, maintenance and recovery of their health and wellbeing. Promote individual management of care using education, carer support and peer involvement
- 2 Suitable living environment, meaningful activity and social integration.** Work to ensure people have a place to live and meaningful activities to do that will preserve long-term health & wellbeing. Includes housing support and improvements, “social prescribing”, social interaction with the community and employment support
- 3 Coordinated care & support planning with multi-disciplinary teams** People will be supported to create holistic care plans and crisis (anticipatory/ advance) plans in accordance with their wishes and the principles of realistic medicine.

## Coordinated care for people who need it

- 4 Integrated care in or close to the home.** Person centered, coordinated care and support, provided by a multi-disciplinary team (MDT), according to the person's individual care and support needs and plan. The MDT is likely to be co-located with a community setting at the level of a GP cluster
- 5 Single point of access** A single signposting point linked to any entry route for a person, GP, community services or acute staff to support people with their care
- 6 Rapid Response** The ability within an MDT to respond rapidly to a crisis or unexpected care need (physical, psychological or social) that left unattended would result in rapid deterioration or hospital admission
- 7 Transferring care, recovery and reablement** A pro-active, anticipatory service designed to target those people who are fit for discharge/transfer of care out of facilities, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating

## Supporting services

- 8 Access to expert opinion and timely access to diagnostics** The ability for primary care professionals to access a specialist opinion (relating to physical, psychological or social need) in the community setting and where appropriate, a specialist triage for diagnostics. Access to diagnostic services and the ability to ensure diagnostic results are full and timely will reduce the need for multiple outpatient appointments

# People will be supported to return to home with ten interventions

<p><b>1 Effective front door</b></p>	<p>An effective front door at acute hospitals can impact delays at the back door by reducing unnecessary admissions of patients who could be better cared for in the community</p>	<p><b>6 Seven-day service</b></p>	<p>Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people's needs.</p>
<p><b>2 Early discharge planning</b></p>	<p>In emergency care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours. In elective care, planning should begin before admission.</p>	<p><b>7 Trusted assessors</b></p>	<p>Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.</p>
<p><b>3 Systems to monitor patient flow</b></p>	<p>Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.</p>	<p><b>8 Focus on choice</b></p>	<p>Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.</p>
<p><b>4 Multi-disciplinary/ agency discharge teams</b></p>	<p>Coordinated discharge planning – based on joint assessment processes and protocols and on shared and agreed responsibilities – promotes effective discharge and positive outcomes for patients.</p>	<p><b>9 Enhancing health in care homes</b></p>	<p>Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.</p>
<p><b>5 Home first/ Discharge to assess</b></p>	<p>Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.</p>	<p><b>10 Care home availability</b></p>	<p>Providing care home places in the community, with the specific capabilities to manage the needs of complex patients will improve delayed discharge.</p>

LGA 'High impact change model', CF analysis

# We have developed a mental health blueprint that serves as a starting point for community mental health service development

Essential components	Required understanding	Progress	Gaps
<p>① Detailed understanding of the mental health population by cohort segmentation</p>	<ul style="list-style-type: none"> <li>• Common mental health disorders</li> <li>• Psychosis/severe mental illness</li> <li>• Dementia</li> </ul>	<p>TBC</p>	<ul style="list-style-type: none"> <li>• Segmentation analysis</li> <li>• Cohort spend</li> <li>• Cohort outcomes</li> </ul>
<p>② Service offer</p>	<ul style="list-style-type: none"> <li>• Urgent/crisis support</li> <li>• Liaison team</li> <li>• Integrated dementia team(s)</li> <li>• Single point of access</li> <li>• Wellbeing services</li> <li>• Recovery</li> <li>• Specialised placements</li> </ul>	<p>High level description in IW draft mental health blueprint</p>	<ul style="list-style-type: none"> <li>• Clinical impact on specific cohorts</li> <li>• Financial impact on specific cohorts</li> <li>• Investment required</li> </ul>
<p>③ Delivery approach</p>	<ul style="list-style-type: none"> <li>• Network</li> <li>• Community provision</li> <li>• Third sector</li> <li>• Inpatient care</li> </ul>	<p>TBC</p>	<ul style="list-style-type: none"> <li>• Network development with off-island provider(s)</li> <li>• Approach to working with third sector</li> </ul>

SOURCE: IW community mental health and wellbeing service business case draft January 2019

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**Next steps**



## Next steps

We are **delivering against this sustainability plan now** to address our significant sustainability challenges. We recognise that doing nothing will only exacerbate our current challenges (e.g. not acting now on the length of stay challenge will tip historic overall Trust performance at the front door in the wrong direction and increase quality/safety concerns).

We will move into **more detailed planning of additional activities from February**.

### Priority actions - Now

#### Accelerating productivity/QIPP programmes e.g.

- IW Council – *ASC retendering services; modernization; reconfiguration*
- IW Trust – *LoS; outpatient reductions*
- IW CCG – *Primary care services*

Implementing new **multidisciplinary discharge team** for patients medically fit but still in hospital

Creating standard **discharge protocols and processes** (from front door to return to home)

Implementing networked acute service specialties with off island providers (e.g. **urology network** between IW Trust and Portsmouth FT)

### Planning areas – February

Develop **implementation plan** for areas ready to deliver vs greater planning (Inc. need for formal consultation)

Understand local **capacity and capability to manage and deliver** change

Determine **local governance and leadership** model

Determine **savings phasing** and investment required (including **reinvestment**)

Determine **transitional funding** requirements

Develop **engagement plan**

### Longer term activities – March onwards

Accelerate wider **system engagement** (including GPs, staff and independent sector)

Focus on areas requiring further detailed planning support **with longer term gains** (e.g. prevention services)

Move into **new governance and leadership** model