EAST AYRSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

INTEGRATION JOINT BOARD: 25 JANUARY 2017

REPROVISIONING OF INPATIENT CARE AT KIRKLANDSIDE HOSPITAL STAKEHOLDER ENGAGEMENT PROCESS UPDATE

Report by Annemargaret Black, Head of Community Health and Care

Support Officer - Irene Campbell, Programme Improvement Manager

PURPOSE

1. The purpose of this report is to provide an update to the IJB on engagement plans that intend to support service change and re-provide inpatient care previously delivered from Rowallan Ward on the Kirklandside Hospital site. A previous verbal report was provided to East Ayrshire Integration Joint Board on 24 November 2016 and NHS Ayrshire & Arran Board meeting held on 12 December 2016.

2. This report sets out the proposed engagement process and associated activities in line with Scottish Government's CEL4 Guidance on Informing, Engaging and Consulting People in Developing Health and Community Care Services.

BACKGROUND

3. The 2016 Community Hospital Review in East Ayrshire recognises the value of services provided from Kirklandside Hospital to patients, their families and staff. Kirklandside was built in 1909 and following contraction of services over the past decade hosts the Rowallan Ward building which until recently had a total of 25 beds, one male and one female ward. Both wards were Nightingale Wards, a style that is in the form of now very unusual in 21st century healthcare systems.

4. The Review presented both quantitative and qualitative data ensuring that the staff views were presented in the report. The review highlights that the Nightingale Ward described above is not conducive to modern healthcare delivery and does not meet quality, dignity and privacy requirements that people deserve. East Ayrshire Model of Care group commissioned a mock Healthcare Environment Inspectorate (HEI) to provide further qualitative understanding of the ward and a number of staff were involved in the HEI process which took place on 6 April 2016.

5. During the mock HEI a number of environmental issues were raised. It was then decided based on these findings that a risk assessment of the environment within Rowallan Ward would take place. In the period between the mock HEI and risk assessment a number of improvement measures were put in place and the number of beds were reduced to 17 to accommodate better spacing between beds to better meet infection control standards.

6. The risk assessment was carried out and a number of hazards were identified and included areas such as equipment contaminated with microorganism, cross infection due to restricted separation of bed space, patient moving and handling hazards and slips/trips/falls in restricted places, musculoskeletal hazards to staff due restricted space and a number of other issues.

7. As a result of the mock HEI and subsequent risk assessment a decision was made to temporarily decant patients from Rowallan to Ward 2, Woodland View, Ayrshire Central Hospital site and East Ayrshire Community Hospital (EACH), Cumnock. Meetings took place with patients and families to discuss plans and provide choice of decant location either to Woodland View or EACH. The move of patients with staff was completed by 20 August 2016. Staff were given the choice to move to either decant location.

8. The temporary decant will continue whilst the options appraisal and engagement process takes place. Initial engagement has taken place with employees and a meeting took place on 18 November 2016 with 25 staff to advise them of the above decision and the forthcoming engagement process. Staff engagement has taken place and continues. East Ayrshire Staff Partnership have also been involved to support the workforce.

THE STRATEGIC CONTEXT

9. In 2011, the Scottish Government set out its strategic vision (2020 Vision) for achieving sustainable quality in the delivery of healthcare services across Scotland. This vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

   - we have integrated health and social care;
   - there is a focus on prevention, anticipation and supported self-management;
   - when hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm;
   - whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions; and
   - there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

10. Integration and the creation of Health and Social Care Partnerships provides an opportunity to comprehensively review current services and models of care to best meet needs and expectations. In response to the local and national pressures for change, NHS Ayrshire & Arran, along with the three Ayrshire Health and Social Care Partnerships have embarked on an ambitious three-year programme of service change – New Models of Care for Older People and People with Complex Needs – which aims to:

    Avoid hospital admission by developing

    - Practice attached teams (including social work, DNs, CPNs, pharmacy and community connectors)

- Practice aligned / complex care teams (including care at home, ICES, AHPs, ANPs, EMH / ME consultants)

We are moving towards 7-day community-based working; re-allocating resources from acute to community; and developing a new skills mix, particularly around end of life care.

Reduce time spent in hospital through

- The complex care team liaison with the Combined Assessment Unit (CAU) and involvement in discharge planning
- Rehabilitation delivered at home as the norm.

11. The review of community hospitals in East Ayrshire was carried out to give the HSCP an understanding of the provision and to support the local New Models of Care work that feeds into the pan-Ayrshire work.

12. Consideration now has to be given to ensuring the provision of services that addresses the concerns raised in the review, and meet acceptable standards of quality care. The Care Inspectorate, for example, requires care services in Scotland to reflect dignity, privacy, choice, safety, realising potential, and equality and diversity. The widely accepted six dimensions of quality (developed by the Institute of Medicine) should underpin future provision thus ensuring care that is safe, effective, patient-centred, timely, efficient and equitable.

INFORMING AND ENGAGING PROCESS

13. The Scottish Government and Scottish Health Council (SHC) are aware of the intention to proceed to engagement to achieve service change. A meeting took place with the local SHC on 17 November 2016 to advise them of this intention and to seek advice. The SHC have participated in the East Ayrshire Model of Care group overseeing the review of local community hospitals.

14. A further meeting took place with SHC on 23 December 2016 where more detailed advice on service change and engagement was provided. A reference group has been convened to take forward an options appraisal process. It is important to ensure that a range of key stakeholders are involved and the group comprises stakeholders from the following areas: EAHSCP Head of Service, EAHSCP Senior Manager, Service Manager, Associate Nurse Director, Consultant Geriatrician, Rowallan Ward staff member, East Ayrshire Advocacy, public/patient representative, carer representative, Third Sector representative, staff side and SHC.

15. At this stage of the process wider engagement is not required however EAHSCP will progress wider engagement with stakeholder groups as described in the engagement plans at appendix 1.

16. The group will meet on a weekly basis and the first meeting will take place on 13 January. The group will be chaired by the Head of Community Health and Care Services. At the first meeting of the group a background paper setting out the rationale for change, key drivers and strategic influences will be presented.

17. The following will also be presented for approval:

- Draft terms of reference
- A draft engagement and communications plan
- Advice and guidance from SHS on service change and engagement process expectations

18. The remit of the group is to develop and agree a set of options for service re-provision and to assist with the wider stakeholder engagement and communication. The option appraisal process is as follows:

- Options developed with key stakeholders (group members)
- Development process will be in place to ensure that there is consensus on options
- The group will agree criteria and weightings, option appraisal and scoring process
- Agree preferred options for feedback to those involved
- EQIA process
- Forward all relevant papers, decision making documents and options to Scottish Health Council (SHC) to seek their view on the status of the service change.

19. It is anticipated that the work of the group will be completed by mid-February 2017 at the very latest and all information submitted to SHC by that date. A response from SHC is likely to be made within 10 days of receipt of the report.

20. Progress reports will continue to be provided to both IJB and NHS Ayrshire & Arran Board as required throughout this process.

FINANCIAL IMPLICATIONS

21. There are no direct financial implications arising from this report.

HUMAN RESOURCE IMPLICATIONS

22. There are no direct human resource implications arising from this report.

LEGAL IMPLICATIONS

23. The processes in this report will support the IJB conform to CEL4 Guidance on Informing, Engaging and Consulting People in Developing Health and Community Care Services.

COMMUNITY PLANNING

24. There are no community planning implications arising from this report.

EQUALITY IMPLICATIONS

25. An equality and diversity impact assessment will be undertaken as part of the informing and engaging process. The EQIA will assess the engagement process.

RISK IMPLICATIONS

26. SHC may decide that this is considered major service change which could delay any decision making on preferred options.

RECOMMENDATIONS

27. It is recommended that the IJB:

(i) Notes the process and timeline set out in this paper to support an engagement and options appraisal process.
(ii) Endorses the approach engagement and agrees to receive further reports on progress.

Implementation Officer

Annemargaret Black
Head of Community Health and Care Services, East Ayrshire HSCP
13 January 2017

Appendix 1

Reprovision of services provided at Rowallan Ward, Kirklandside Hospital.

Draft Involvement/Engagement Communications Plan

January 2017

1. What service change is being proposed?

The East Ayrshire Integration Joint Board have approved a process of public engagement on the following proposed service change:

- Re-provision of care of elderly inpatient beds from Kirklandside Hospital, Rowallan Ward, Kilmarnock.

2. What does this mean for older patients in the Kilmarnock area?

Older patients from Kilmarnock requiring longer term care were admitted to Rowallan Ward, Kirklandside from Crosshouse Hospital and Ayr Hospital. However, since August patients from Rowallan Ward, Kirklandside were moved on a temporary basis to either to Woodland View, Irvine and East Ayrshire Community Hospital, Cumnock. This move continues while alternative options are developed.

The development of options for this re-provision will help to ensure that patients from Kilmarnock requiring longer term care will continue to have access to services that offer high quality care in a modern health setting.

3. Informing, engaging and consulting with those affected

Patients and public

We will deliver an inform and engagement programme with people from Kilmarnock. This will run for approximately 6 weeks from January until mid February 2017. This programme will be shaped by a stakeholder reference group to include representatives from patient groups, Older Peoples Advocacy Services and the local Third Sector.

The stakeholder reference group will oversee the development of a range of communications resources and will help shape and develop involvement, engagement and communications planning. They will advise on the best means of engaging with those affected and local communities.

At the end of this period of engagement a decision will be made on whether to move to a period of full public consultation.

This is the first draft of the communications and engagement plan.

Staff

Arrangements are in place to engage with staff and this process will ensure that staff have the opportunity to take part and comment at all stages. Staff will be involved in the following ways:

- Staff meetings
- 1:1 interviews
- Discussion groups

4. Proposed Communications Activity

Proposed communications include:

- Dedicated information on the NHS Ayrshire & Arran website and the East Ayrshire Health and Social Care Partnership website. This will include clear information describing the proposed re-provision, the numbers affected, what the changes mean for those affected, timescales of the engagement process, how people can become involved and make comments. The website will also include information on the role of the stakeholder reference group.
- An information sheet to be distributed widely to community groups including carers associations, third sector organisations, GP surgeries in Kilmarnock and Community Pharmacies in Kilmarnock.
- Use of corporate NHS Ayrshire & Arran and EAHSCP social media accounts (Twitter and Facebook) to launch the engagement and direct affected communities to our website for more information. The twitter account has a sizeable following with more than 700 followers.
- Dedicated briefings to elected members and local MSP

5. Proposed engagement activity

Activity to include:

- Public engagement will be undertaken by the East Ayrshire Health and Social Care Partnership and shaped following discussions with the stakeholder reference group and will include:

- Information and engagement materials shared with local stakeholders
- Meetings with local community groups and organisations in Kilmarnock
- Information sessions
- Social media communications/interactive

6. Equalities Considerations

We intend our involvement and engagement activities to be fully accessible to all communities. Throughout the plan we will use easy to read information, presented in easy to read formats. If required, we will provide information in alternative languages or formats.

Our use of the internet to host key papers and information will help make them accessible to the wider population or those who have difficulty travelling. We will ensure that all meeting venues for the stakeholder reference group or for public activity are fully accessible. We will reimburse out of pocket expenses and/or make suitable arrangements to support people to attend the Stakeholder Reference Group.

A dedicated Programme Improvement Manager, Irene Campbell will facilitate the engagement process. If you or anyone you know would like to ask her questions or talk through the proposal please contact Irene on 01563 503330 or email Irene.campbell2@aapct.scot.nhs.uk

This plan does not negatively impact people based on age, sex, race or any other protected characteristics, with the exceptions of the considerations noted above.

7. Next steps

The draft Involvement and Communications Plan will be taken to the first meeting of the stakeholder reference group on 13 January for comment and further development.

December 2016 – February 2017

Activity	Type of consultation	Techniques/methods	Key steps	Timelines
Local elected members, MSP and MP				
Identify all members for participation in engagement.	Face to face as preferred by members	Range of ways: • Presentation • Interactive discussion session Obtain views on: • stated reasons, options and benefits of change	Communicate with identified members to invite participation and ascertain preferred format Conduct the meetings Analyse views emerging from the meetings	December 2016

		• change processes • Alternative options		
Staff consultation				
Identify all staff groups for participation in engagement. **Kirklandside staff** 18 x Band 2 1 x Band 3 15 x Band 5 2 x Band 7 AHP Ensure written information is available.	Focus Groups 1:1 meetings Suggested format: 3 groups (Band 2) 2 groups (Band 5) Mixed groups Option to include 1 x Band 3 in one of the 1:1 meetings to be scheduled as required	Range of ways: • Consultation document/statement • Presentation • Interactive discussion session • 1:1 meetings Obtain views on: • stated reasons, options and benefits of change • change processes • Alternative options	Communicate with staff to invite participation in discussion groups or 1:1 meetings if requested. Email and invite to be sent to all stakeholders Conduct the meetings Analyse views emerging from the meetings	End of November – 31 December Ongoing
Other staff Woodland View EACH AHPs Staff who link with the ward	Mixed group meeting	Range of ways: • Presentation • Interactive discussion session Obtain views on: • stated reasons, options and benefits of change • change processes • Alternative options	Communicate with identified staff to invite participation in discussion groups Conduct the meetings Analyse views emerging from the meetings	Ongoing

Patients and Families				
Identify families and carers for participation in engagement.	1:1 meetings Telephone calls	Range of ways: Service Manager to provide all contact details. Programme Improvement Manager to make contact. Obtain views on: • stated reasons, options and benefits of change • change processes • Alternative options	Arrange meetings. Analyse views emerging from the meetings	December 2016 – January 2017 Ongoing
Community / Public				
East Ayrshire PPF	Attend local PPF meeting	Presentation and interactive discussion at EAPPF meeting. Will also provide opportunity for written comments from group.	Arrange agenda slot for January or February meeting.	January/February 2017
Third sector EACVO to identify relevant groups for consultation process	Set up meetings with range of stakeholders identified by EACVO	Presentation and interactive discussion to identified groups and organisations by attending their meetings. Will also provide opportunity for written comments/submissions during the consultation period.	Request agenda slot for January/February meetings.	January/February 2017

Vibrant Communities To link with colleagues to identify relevant groups for consultation process.	Set up meetings with range of stakeholders identified by Vibrant communities	Presentation and interactive discussion to identified groups and organisations by attending their meetings. Will also provide opportunity for written comments/submissions during the consultation period	Request agenda slot for January/February meetings.	January/February 2017
Report/business case			Findings from all discussion groups/meetings and written submissions to be incorporated in the Business Case	Ongoing during the consultation. To be completed by mid March 2016

East Ayrshire COUNCIL

NHS Ayrshire & Arran

East Ayrshire Model of Care Programme Review

East Ayrshire Health and Social Care Partnership

Version No:	
	Final version
Prepared by	
	Irene Campbell Programme Improvement Manager Kevin Mills Information Officer Michael Byers Planning and Performance Officer
Effective from	August 2016
	Date August 2016
Review Date	
	Date TBA *Not appropriate if an annual report, to be used for policy documents*
Lead reviewer	
	Annemargaret Black Head of Health and Communities
Dissemination Arrangements	
	Via MOC Programme Group

Executive Summary

1. A combination of factors including extended periods of increasing: life expectancy, multimorbidity and health deprivation have escalated health and social care needs in East Ayrshire to an extent that current services are struggling to meet demands. This situation will intensify in future years, as the older aged population will grow and resources will inevitably diminish. This represents significant challenges in terms of providing sustainable services which meet the needs of our population.

2. Redesigning key services and exploring new models of care represent realistic avenues to overcome such provision challenges to an extent. This process is aided with the integration of Health and Social Care under one partnership, providing an opportunity to implement such improvements across numerous care systems.

3. A literature review was undertaken to explore and consider other and alternative models of care. A range of literature was reviewed to inform the following topics: Nurse-led care, Home-based Intermediate care, Integrated Health, Social care and Housing, Mapping care pathways, Placed-based systems of care, Developing services and Innovative solutions.

4. In addition, this report evaluated numerous aspects of current adult services delivered through community hospitals in East Ayrshire. A range of information sources were utilised to assess current situations and to identify aspects which work well and key areas which could be improved.

5. In terms of activity and expenditure, Kirklandside resources were predominantly consumed by non-emergency inpatient patients aged 65+, who presented as Geriatric Medicine cases. Capacity at Kirklandside is an issue, as bed occupancy has remained consistently high since September 2012 (>92% in most months) and various pressures were identified in staff interviews.

6. A site evaluation deemed Kirklandside Hospital to be unfit for purpose, with an estimated £1,597,486 backlog expenditure required to bring the hospital into an acceptable condition. Notable overspending has occurred and increased over the last four years at Kirklandside, with a 16.9% overspend occurring in 2015. This trend coupled with the highlighted maintenance work required, suggests that considerable spending will continue at Kirklandside Hospital in future years.

7. The current Kirklandside workforce is predominantly comprised of band 2 (50%) and band 5 (39%) staff. 83% of the current workforce is aged 46+ and 42% are aged 56+. Interviews highlighted that staff perceive good: team working, communication and relationships with patients to work well at Kirklandside. All staff agreed that patients have become increasingly complex in recent years and concerns regarding patient violence were raised. Staff criticised the physical state of the hospital building and commented that the Nightingale Ward can render disease control and privacy issues.

8. In regards to activity and expenditure at EACH, a significant extent of resources were consumed by non-elective inpatient patients aged 65+, who presented as either GP (Other than Obstetrics) or Geriatric Medicine cases. In terms of capacity, evidence suggests that EACH resources could be utilised to a greater extent. The currently closed Holmburn Ward contains 13 unused beds, providing potential capacity for further care specialties. An accident and emergency facility was suggested by EACH staff. The average bed occupancy rate between May 2011 and April 2016 was 75%.

10. A site evaluation of EACH concluded the state of: the hospital building, engineering services and statutory compliance to be acceptable, rendering the hospital to be deemed fit for purpose. The evaluation noted that the space available at EACH is currently underutilised and that an estimated £558,266 of backlog expenditure is required. A period of underspending occurred at EACH between 2012 and 2014, however 2015 was overspent by £99,554 (3.5%).

11. The current EACH workforce is predominantly comprised of: band 5 (42%), band 2 (35%) and band 3 (11%) staff. 68% of the workforce is aged 46+ and 20% are aged under 41. Interviews highlighted that staff perceive: organisation, team work, team meetings and training opportunities to work well at EACH. However, various concerns including: staffing issues, GP and ANP cover, increased pressures and inefficient appointment processes were raised by staff. The closure of the Holmburn Ward was unanimously regarded as a waste of resources by staff.

12. A number of recommendations are offered in this report. Key recommendations include the application of: whole systems working, place based systems of care, co-production principles, integrated services, tests of change and housing into all future models. Further community based alternatives should also be explored and the utilisation / re-opening of the Holmburn Ward at EACH should be considered.

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Model of Care Programme Review – East Ayrshire

1. Introduction

With an increasing ageing population and many people living longer with long term conditions, the health and social care needs of our population will rise in the coming years. As the needs of our population become more complex due to co and multi-morbidities current models of care will not meet the future needs of our local population. It is important that we fully explore how we can develop and redesign services to meet the needs of our population. It is vital that we provide local services that are designed to meet the needs of our local communities.

The main focus of this review will be on adult services delivered through community hospitals. There are many challenges to our system and this review will consider both current as well as future challenges when looking at models of care and where that care can best be delivered. For example, many of our current services delivered through community hospital are provided in a hospital that was built in 1909 and in this case we are essentially delivering 21st century healthcare in facilities designed for the health needs of early 20th century populations.

Integration and the creation of the Health and Social Care Partnerships provides us with an opportunity to comprehensively review these services and models of care whilst considering how we best integrate and transform services to meet our future requirements with improved outcomes for patients, carers, families, staff and communities.

If we are to meet the vision that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting, we must redesign a system of support to make this vision a reality.

Using whole systems integration can ensure that we make our systems more streamlined, efficient and effective ensuring our services are person centred and fully meet the needs of our services users.

This review will consider past and current service provision provided in our community hospitals before setting out options for consideration for future service delivery to ensure that we deliver safe, efficient, timely, effective, patient centred services to meet the national outcomes.

2. Aims and Objectives

To review all current services delivered through community hospitals in East Ayrshire and to provide and develop a range of options and recommendations for new models of care that meets the needs of patients who currently require long term care and future patients' requirements.

To develop a work programme that presents options and emerging recommendations for consideration for future delivery of care. This will provide options for new models of care with a focus on maximising independence, improvement to quality of life and more specialist care in a range of settings.

3. Desired Outcomes

To achieve the Scottish Government's 2020 Vision where by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that our local healthcare system will:

- Deliver integrated health and social care
- Focus on prevention, anticipation and supported self-management
- If hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

4. Methodology

By incorporating Best Value Review principles a robust process was followed:

- Project planning – robust plan developed to ensure that all requirements are identified and fully support the direction of the East Ayrshire Model of Care Programme Board

- Data collection – ensured that all required data is available for full analysis and must include the following – a focus on activity, capacity, demand, existing use, admission, discharge, length of stay demographics, services pressures, infrastructure, staffing and workforce planning, vacancies, absence cover, finance and all other relevant information. Undertake a literature review to consider other/alternative models of care

- Service evaluation – appropriateness of service, clinical needs of patients, treatment, identify any gaps

- Specifying future requirements – fully in line with strategic vision to include locations, communities, services that fit with models of good practice, who is best placed to deliver service (independent / voluntary sector)

- Evaluating options for service delivery - identify and engage with stakeholders, consider option appraisal and identify work streams to take this forward. Develop a series of recommendations for consideration and an associated action plan, stakeholder engagement plan and communications plan.

The review incorporated both quantitative and qualitative data for analysis. Data was analysed from a range of both local and national databases. A literature review was also undertaken to consider the literature relating to models of care, intermediate care and aspirations for a whole systems approach.

5. National and Local Policy

National and local policy drivers are in place to support this process, namely: 20:20 vision, The Quality Strategy and The Strategic Plan. The Scottish Government's 20:20 Vision sets out that:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- If hospital treatment is required and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centred of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

This is further supported by the three quality ambitions set out in the Quality Strategy, that we deliver services that are safe, effective and person centred as well as a focus on efficiency, timeliness and equity. Also, Healthcare Improvement Scotland's Care of Older People in Hospital Standards sets out 16 standards in relation to the hospital care of older people in Scotland to ensure that 'standards are equally applicable to all patients using NHS services in Scotland'. The values set out in our Partnership Strategic Plan must also be met as we ensure that we provide services that are seamless, empowering, supportive and inclusive.

All of these values must underpin service transformation and the direction of health and social care in East Ayrshire.

6. Current Situation

Current service provision is made through a range of community based services throughout East Ayrshire. Services are delivered via the North locality and South locality service structures. The range of services provided is set out in the tables below. As well as community based services there are two community hospitals at Kirklandside, Kilmarnock and East Ayrshire Community Hospital, Cumnock.

Table 1

Services and Operational Responsibilities

North Locality	**South Locality**
Social work locality services	Social work locality services
Hospital social work team	District nursing
District nursing	ICES including community alarm responders
Community hospital in-patients and day hospital Kirklandside Out-patient clinics	Community hospital in-patients and day hospital – East Ayrshire Community Hospital Out-patients Department
Older peoples mental health	Older peoples mental health
Care homes	Care homes
Care at home	Care at home
Day care	Day care
Acute liaison	Acute liaison
Resource allocation group (RAG)	Review team
Contracts and commissioning care at home	Community alarm/risk management
Sensory impairment	Contracts and commissioning care homes
Moving and handling	Adult concern initial response team (ACIRT)
Range of AHP Services delivered throughout locality	Range of AHP Services delivered throughout locality
Range of pharmacy services	Range of pharmacy services
Equipment Store	

It is within this context that this review has taken place.

6.1 East Ayrshire Demography

The current East Ayrshire population (approximately 122,000) is comprised of: 17.3% children aged 0-15, 62.9% individuals aged 16-64 and 19.7% older aged individuals aged 65+. This demographic composition is fairly consistent with the national age structure.

However, continued periods of increasing life expectancy, decreasing birth rates and outward working age migration are anticipated to render significant age structure shifts in East Ayrshire over the next two decades. 0-15 and 16-64 age group populations are projected to decline by 5.4% and 13.5% respectively by 2036. This demographic shift will also oversee a significant increase (44.6%) in the 65+ age group, whom are projected to comprise 28.7% of the East Ayrshire population by 2036.

Increasing longevity is a positive indication of health improvement, however this projected situation will create a number of challenges in terms of healthcare dependency and service provision. Old age wellbeing and healthcare dependency are currently key concerns in East Ayrshire. 58% of the aged 65+ population are physically limited by long term health conditions, with many of which suffering from more than one condition (multi-morbidity). In addition, East Ayrshire rates of: emergency, multiple emergency, respiratory-related and falls-related admissions are significantly higher than national averages.

Such levels of health deprivation have rendered older aged individuals to be primary consumers of health and social care services in East Ayrshire, with 42% (£119 million) of Health and Social Care financial resources being spent on older people. This is reflected in community hospital activity, as patients aged 65 and over comprised 99.3% of episodes at Kirklandside Hospital and 85.6% of episodes at EACH.

The highlighted circumstances in East Ayrshire are set to intensify over the next twenty years, as the older aged population will grow considerably and resources for services will inevitably diminish. This situation represents significant challenges in terms of the sustainable provision of services which meet the needs of local populations.

7. Summary of Literature Review

A literature review was undertaken to consider other and alternative models of care for potential implementation in East Ayrshire. A range of literature was reviewed to inform the following topics: Nurse-led care, Home-based Intermediate care, Integrated Health, Social care and Housing, Mapping care pathways, Placed-based systems of care, Developing services and Innovative solutions.

Nurse-led Care

A number of studies observed Nurse-led units to provide a similar standard of care to that of inpatient care despite using fewer resources on a daily basis. The majority of relevant studies observed no increased risk of adverse health outcomes and recorded predominantly positive patient and staff feedback regarding the care provided. This model was found to better prepare patients for discharge and to reduce the risk of readmission and discharge to institutional care, alleviating an extent of pressure across health and social care systems. However, Nurse-led units were found to increase the total duration of care, generally resulting in a higher resource consumption than inpatient care which was not offset by potential long term savings.

Home-based Intermediate Care

A range of literature cited Home-based Intermediate care to provide positive outcomes in terms of: preventing avoidable hospital admission, facilitating discharge and improving the physical capacity and psychological wellbeing of service users. The initial costs of implementing Home-based Intermediate care were found to be either similar or lower than that of acute inpatient care, however this model was associated with prolonged durations of care, resulting in an overall higher resource consumption. Home-based Intermediate care patients were highly satisfied with this model, however levels of staff satisfaction were mixed across studies.

Integrated Health, Social care & Housing: The Keiro Model

Literature regarding collaborative working between health, social care, housing and the independent sector was reviewed. The Keiro Model was observed to achieve potential cost savings of £428,301 in community care per patient over a ten year period. This model is also cited to provide positive patient outcomes and care experiences, however more data is required to support this assertion. It was noted that high occupancy rates were critical for the success of this model.

Mapping Care Pathways

Simulation tools can be employed to simulate real-world systems as they evolve over time, with the ability to test a range of scenarios over days, months or years to predict future situations. It was noted that a sufficient amount and quality of data is required to successfully undertake this method and meet objectives, which can be time consuming.

King's Fund Place-based Systems of Care

A study by the King's Fund (Ham, Alderwick. 2015) highlights the importance of developing new models of care to counteract changes in demography and healthcare demand. The paper asserts that collaborative working through place-based systems of care represents the best opportunity for NHS organisations to overcome key challenges. The study emphasises the importance of i) allowing sufficient time for new models to develop and ii) making the best use of resources through collaboration. The report provides a guide of 10 principles for developing systems of care.

Developing Services: Experiences from Europe

Literature was reviewed (Leichsenring, 2004) to compare and evaluate different models of care from various European countries. This process revealed common themes in terms of service co-ordination and integration issues such as cultural and professional differences and hierarchal division. A number of promising pathways were outlined in this paper and key priorities for effective service provision were identified. These included: joint working, involving people in service design, central points for advice, social connectivity and the role of families and wider networks.

Innovative Solutions

Literature by The Innovation Unit (Wilson, Langford. 2016) was reviewed to consider alternative and innovative models of care. 'Patient Hotels' is a promising concept which is best described as a 'normal hotel', except guests are patients and staff are trained nurses. This model provides: a relaxed, social, person centred and less clinical environment which empowers patients to self-manage. Patient Hotels have been observed to provide positive outcomes for patients and the average cost of a hotel bed (in Lund, Sweden) was nearly one-third of a hospital bed (£90 vs. £260), representing a significant saving. Another promising concept is the 'Ginger.io' app, which has pioneered behavioural tracking of conditions. This form of technology-based care can effectively: monitor conditions (feeding back to clinicians), encourage active service user participation and assist in the self-management of long term conditions.

8. Data Collection and Analysis

Data has been requested via the Pan Ayrshire Models of Care Steering Group and the datasets and all associated activity is being led by the North Ayrshire Health and Social Care Partnership on a pan Ayrshire basis. This local review fully complements this process. At the time of writing this report full datasets are not as yet available.

The datasets requested included the following:

- Length of stay by condition
- Patients under age 65 by condition
- Patients over age 65 by condition
- Readmissions
- Transfers
- Discharge

A significant amount of work has been undertaken in East Ayrshire to identify locality needs. The collated data considers locality comparisons in relation to:

- Life expectancy
- Elective admissions
- Emergency admissions
- Lifestyle and risk taking behaviours
- Older age health
- Economic deprivation
- Locality prevalence rates for the following conditions: asthma, cancer, CHD, COPD, CKD, depression, diabetes, hypertension, obesity, smoking related, stroke and TIA

Local Data

In addition to the above requests, a range of local data has been obtained via NHS and local recording systems. Data has been analysed in relation to workforce profiles, length of stay, bed occupancy, NHS Ayrshire & Arran Datix reporting and community profiles. Analysis of these data is set out in this report for both Kirklandside Community Hospital and East Ayrshire Community Hospital.

Key themes emerged in relation to both community hospitals and these are set out in this paper.

9. Kirklandside Hospital

9.1 Kirklandside Hospital Site Evaluation

Kirklandside Hospital is comprised of 10 blocks (6 clinical, 4 non-clinical) with 25 beds. The hospital itself occupies 2.80Ha of the 6.67Ha site, which is owned. The total net book value of the property is £1,715,449, with the land comprising a value of £320,000.

In terms of the current situation at Kirklandside Hospital, extensive maintenance work is required to ensure the site is in an acceptable condition. The hospital building was deemed to be in a relatively good condition, however the site was noted to be "tired, dark and in need of refurbishment". The following structural work is required: Roof = £167,182, Internal fabric / Decoration = £152,702 and External fabric = £127,657.

The current condition of engineering facilities at Kirklandside are unacceptable and in need of replacement / refurbishment. The main areas of work required are: Boilers = £480,000, Electrical systems = £213,812 and Steam systems = £150,000.

Statutory compliance at Kirklandside Hospital is currently satisfactory, however various areas of work have been identified: Water safety = £44,890, Equality Act compliance upgrades = £45,305 and Asbestos management = £40,000.

Space at Kirklandside was deemed to be fully utilised, however two ward buildings are currently unused and isolated areas of underutilisation and overcrowding are prevalent. Kirklandside Hospital has been deemed unfit for purpose and in need of 'major' repair / refurbishment. The table below sets out a summary of the total backlog costs requred to bring Kirklandside Hospital into an acceptable condition.

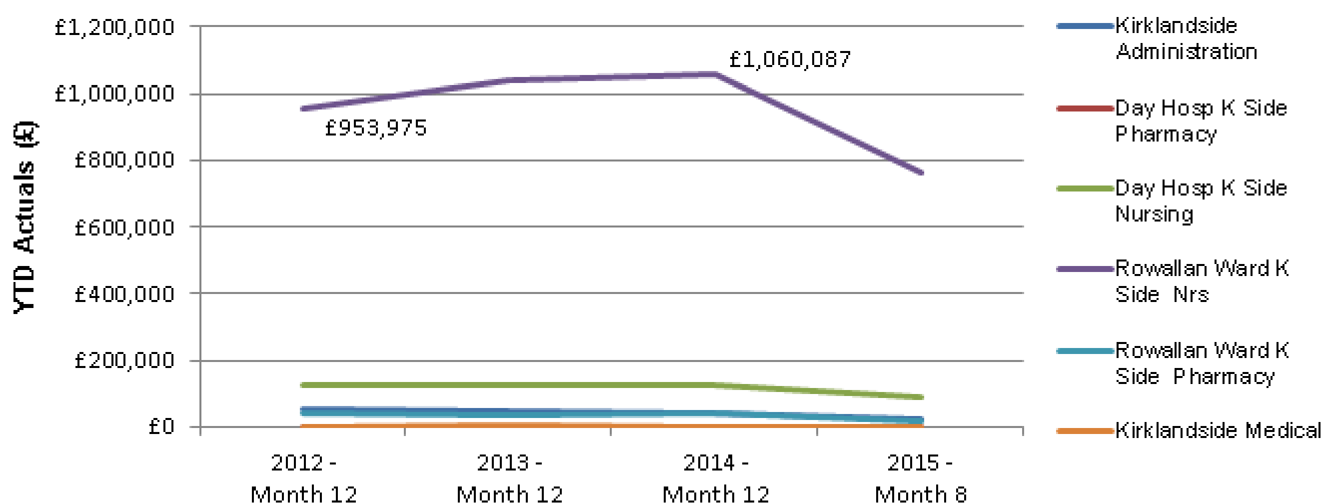
Kirklandside Backlog Cost Summary	
Building	£502,592
Engineering	£888,702
Statutory	£206,191
Total	**£1,597,486**

9.2 Kirklandside Hospital Finances

	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
2012	£1,109,344	£1,109,344	£1,167,335	- £57,991 / 5.2%
2013	£1,154,534	£1,154,534	£1,257,542	- £103,008 / 8.9%
2014	£1,129,228	£1,129,228	£1,270,540	- £141,312 / 12.5%
2015	£1,153,515	£1,153,515	£1,348,894	- £195,379 / 16.9%

- The annual budget fluctuated between 2012 and 2015, with a 4% increase over the four year period.
- Notable overspending occurred and increased in every proceeding financial year at Kirklandside, ranging from 5.2% (2012) to 16.9% (2015) overspends.
- This trend suggests that a considerable overspend will occur in 2016.

Kirklandside Cost Centres



- Rowallan Ward K Side Nrs spending increased by 11.1% (£106,112) between 2012 and 2014, representing the highest cost centre at Kirklandside in this period.
- Kirklandside Administration spending reduced by 15.5% (£7,818) between 2012 and 2014.
- Kirklandside Medical, Rowallan Ward K Side Pharmacy and Day Hospital K Side Nursing spending fluctuated between 2012 and 2014.

9.3 Review of Kirklandside Hospital

9.3.1 Kirklandside: Quantitative Data

A total of 272 episodes and 9,485 beddays took place at Kirklandside Hospital between 2013/2014. All episodes were comprised of inpatient Geriatric Medicine cases. The vast majority of episodes were comprised of patients aged 65 and over (99.3%), whom consumed 99.5% of beddays and accounted for 99.5% of total expenditure at Kirklandside.

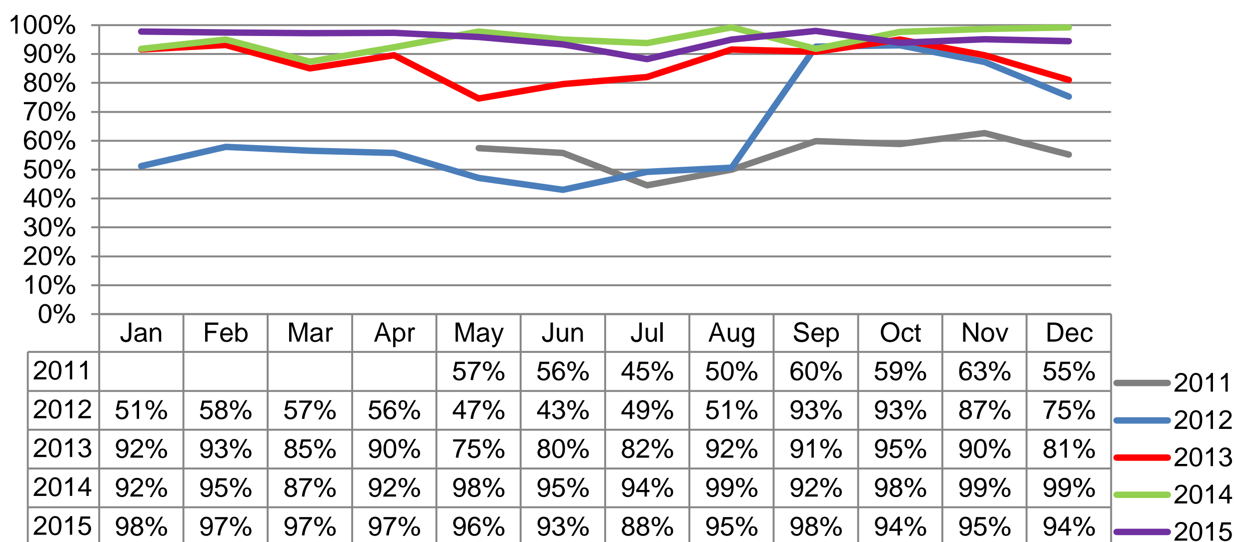
The average expenditure per episode at Kirklandside was £10,102 and the average cost per bedday was £290, with a total net cost of £2,747,690 between 2013/14.

Kirklandside: Most prolific conditions by activity (2015)					
Admissions		Avg length of stay (days)		Episodes	
Dementia	39	Asthma	98	Dementia	39
Arrhythmia	28	All Arthritis	57	Arrhythmia	28
CHD	26	Parkinsons	55	CHD	26
Diabetes	25	Stroke	52	Diabetes	25
Renal Failure	22	Dementia	42	Renal Failure	22
Cancer	18	Diabetes	40	Cancer	18
COPD	18	Alzheimers	39	COPD	18

Conditions which accounted for the highest numbers of admissions / episodes at Kirklandside in 2015 were: Dementia, Arrhythmia, CHD and Diabetes.

The conditions which were responsible for the longest stay durations at Kirklandside throughout 2015 were: Asthma (98), All Arthritis (57), Parkinsons (55) and Stroke (52).

Kirklandside Bed Occupancy: 2011-2015



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2011					57%	56%	45%	50%	60%	59%	63%	55%
2012	51%	58%	57%	56%	47%	43%	49%	51%	93%	93%	87%	75%
2013	92%	93%	85%	90%	75%	80%	82%	92%	91%	95%	90%	81%
2014	92%	95%	87%	92%	98%	95%	94%	99%	92%	98%	99%	99%
2015	98%	97%	97%	97%	96%	93%	88%	95%	98%	94%	95%	94%

Bed occupancy increased significantly between 2011 and 2015, particularly during 2014 and 2015. From September 2012, bed occupancy has remained consistently high >92% for most months between September 2012 and December 2015. Bed availability was also near full capacity >93% in every month throughout 2015 with the exception of July (88%).

Kirklandside Beddays by Age: 2013/14

	% of Total Beddays	No of Beddays	Beddays per 10,000 pop
< 65 patients	0.5%	44	4.4
65+ patients	99.5	9,441	4,128
65-74 patients	16%	1,520	1,171
75-84 patients	49%	4,648	6,292
85+ patients	34.5%	3,273	13,459
Total		9,485	775

Patients aged 75-84 consumed 49% of the total beddays (4,648), accounting for 6,292 beddays per 10,000 population. Patients aged 85+ consumed over one-third of beddays (3,273) and the highest number of beddays per 10,000 population (13,459).

Kirklandside Admissions (2015)

Financial Year	Non-Emergency Admissions	Emergency admissions
2012	215	-
2013	238	-
2014	241	-
2015	236	-

* Emergency admission figures (small numbers) were suppressed by NSS to protect patient identity.

The vast majority of admissions throughout 2015 were non-emergency, with less than five emergency admissions occurring in this period. The number of admissions steadily increased from 215 in 2012 to 236 in 2015, marking a 9.8% increase over four years.

Kirklandside resources were predominantly consumed by non-emergency inpatient patients aged 65+, who presented as Geriatric Medicine cases throughout 2013/14.

9.3.2 Kirklandside Datix Reports

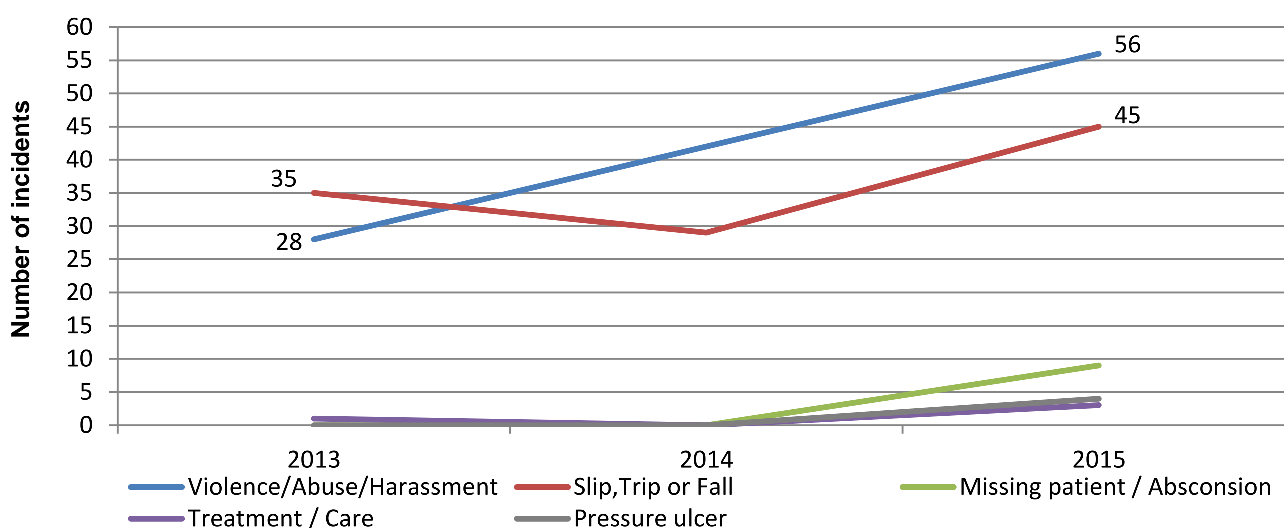
Datix is a patient safety and risk management software for healthcare incident and adverse event reporting.

Kirklandside Datix Report: 2013-2015

Category	2013	2014	2015	Total
Caldicott, Confidentiality and Data Protection	2	0	1	3
Contact with / Exposure to Hazard	6	5	4	15
Equipment (including Electro Medical)	2	4	1	7
Fire, Fire Alarms and Fire Risks (inc Smoking)	13	16	6	35
Health & Safety Miscellaneous	1	1	0	2
Infrastructure and Service Related	0	0	1	1
Loss or Theft of Property (not medicine)	0	0	2	2
Medicine Related	4	5	2	11
Missing patient / Absconsion	0	0	9	9
Mortality	1	0	0	1
Moving & Handling	6	4	2	12
Needlestick/Clinical Sharp/Blood	2	2	0	4
Pressure Ulcer	0	0	4	4
Security Related Incidents	13	4	0	17
Slip, Trip or Fall	35	29	45	109
Treatment / Care	1	0	3	4
Treatment/Procedure/Ongoing Monitoring and Care	4	2	0	6
Vehicle Related	4	3	0	7
Violence/Abuse/Harassment	28	42	56	126
Other - Only use this if no other category is appropriate	3	2	0	5
Total	125	119	136	380

* This report includes all patient, staff and visitor related incidents. A single individual may be represented in multiple recordings.

Kirklandside Incident Trends: 2013-2015



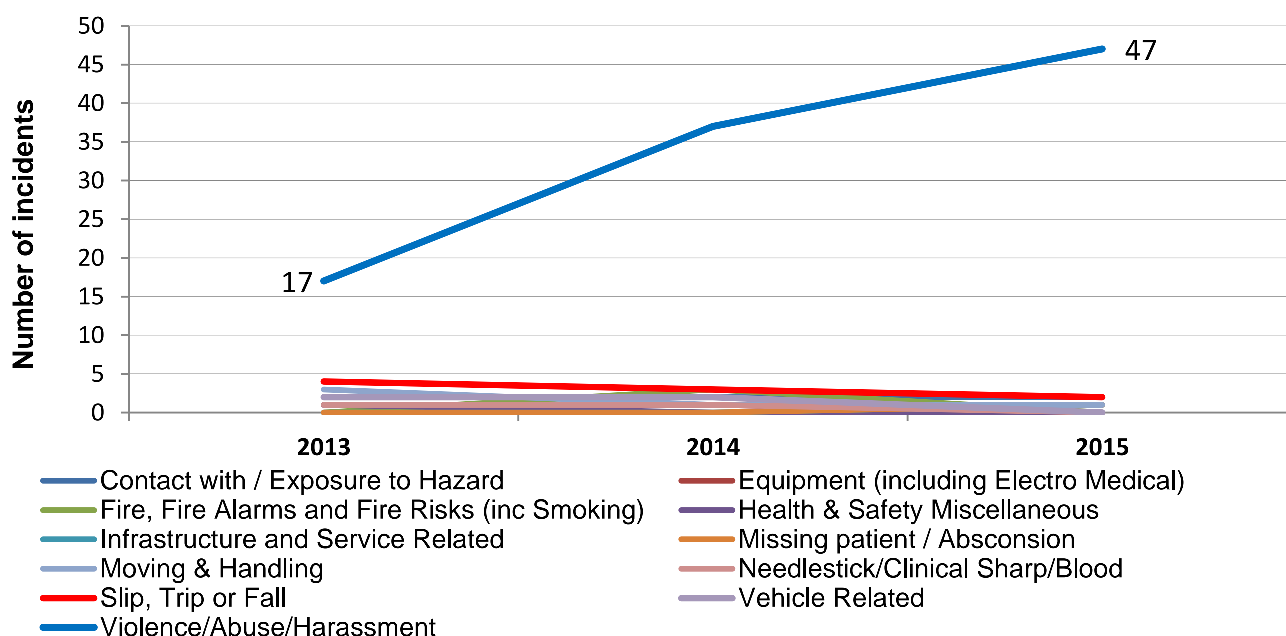
- Violence / Abuse / Harassment incidents increased by 50% between 2013 and 2015.
- Slip, Trip or Fall incidences increased by 29% between 2013 and 2015.
- No Missing patient / absconsion incidents were recorded between 2013 and 2014, however 9 incidents were recorded in 2015.
- Treatment / Care and Pressure ulcer incidences increased in 2015.
- No mortality, Treatment / procedure / Ongoing Monitoring and Care or security related incidents were recorded in 2015.
- Violence / Abuse / Harassment and Slip, Trip or Fall incidents represent key issues.

Kirklandside Staff Only Datix Report: 2013-2015

Category	2013	2014	2015	Total
Contact with / Exposure to Hazard	2	2	2	6
Equipment (including Electro Medical)	1	1	0	2
Fire, Fire Alarms and Fire Risks (including Smoking)	0	3	0	3
Health & Safety Miscellaneous	1	0	0	1
Infrastructure and Service Related	0	0	1	1
Missing patient / Absconsion	0	0	1	1
Moving & Handling	3	1	1	5
Needle stick/Clinical Sharp/Blood	1	1	0	2
Slip, Trip or Fall	4	3	2	9
Vehicle Related	2	2	0	4
Violence/Abuse/Harassment	17	37	47	101
Total	31	50	54	135

* This report is comprised of staff only incidents.

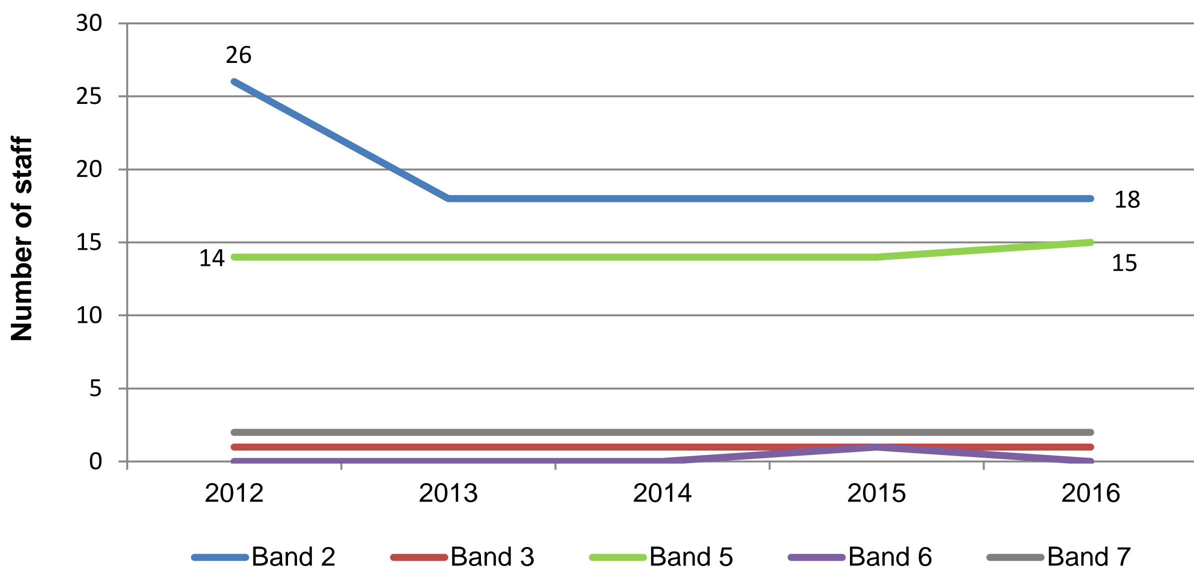
Kirklandside Staff Incident Trends: 2013-2015



- The number of recordings in every incident category either decreased or remained fairly static between 2013 - 2015, with the exception of violence / abuse / harassment.
- Violence / abuse / harassment incident recordings increased significantly (176%) and was the most prevalent incident recorded between 2013 and 2015 (101 incidents).
- The increased incidence of violence / abuse / harassment at Kirklandside over the last three years is a cause for concern.

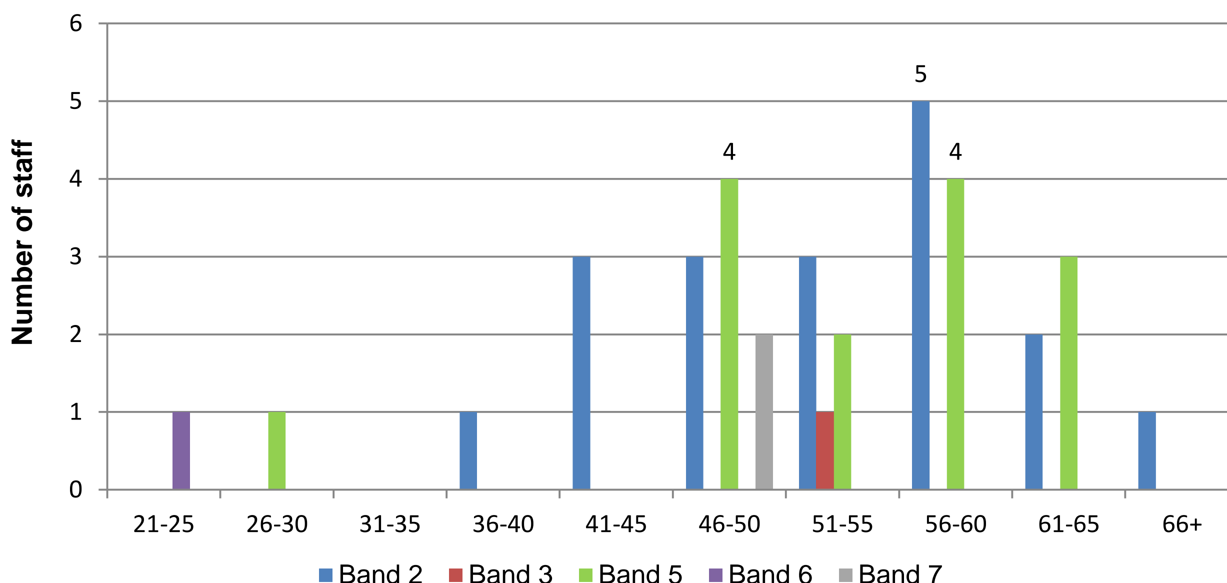
9.3.3 Kirklandside Workforce

Kirklandside Staff Headcount by Banding: 03/2012 – 01/2016



- The number of band 2 staff decreased by 31% between 2012 and 2013 and remained static at 18 staff until 2016.
- Band: 3, 5, 6 and 7 staff numbers remained fairly static between 2012 and 2016.

Kirklandside Workforce: Banding by Age (02/2016)



- 83% of the workforce is aged 46+.
- 42% of the workforce is aged 56+.
- 3 members of staff (8%) are aged under 41.
- 50% of the workforce is comprised of band 2 staff, 61% of which are aged 51+.
- 39% of the workforce is comprised of band 5 staff, 50% of which are aged 56+.

9.3.4 Kirklandside: Qualitative Data

It was vital to hear the views of a range of staff working at Kirklandside as well as external staff who provided services at Kirklandside. Semi-structured one to one interviews took place, in which participants were asked questions around the following themes:

- What works well
- What doesn't work well
- What would you do to improve how we work?

Interviews took place with 9 staff from Rowallan Ward and the Service Manager. A good mix of staff participated, including a Charge Nurse, Nursing Assistants, Staff Nurses and the ANP who visits once a month. All staff were aware that although comments were not attributed to individuals in the team, there was a possibility that their quotes used in the

report may be recognised as belonging to them. All staff acknowledged this and agreed to participate.

In relation to what works well, the overwhelming view from all staff who worked in the ward was that there was very good team working and that it was a happy environment to work in. All commented that communication within the team was good and worked well. All staff felt that relationships were good with staff but also with friends and relatives of patients. All staff agreed that the Nightingale Ward made it easier to look after patients and that long term patients had good rapport with staff. The Service Manager affirmed such views, commenting:

“staff provide a high standard of care…know the patients well…have a good rapport with patients and their relatives”

In relation to what doesn’t work well, a number of areas were identified and key themes emerged. All staff commented that the type of patients in the ward had become increasingly complex over the years. This had an impact on the volume and type of work undertaken for everyone in the team. Staff acknowledged that although the Nightingale Ward layout was easier for looking after patients it also had a negative impact in a number of areas including infection control as beds are too close together. This also impacted on privacy and dignity for patients as well as the issues caused by the mix of patient type.

“...not a good mix of patients for example, end of life patients and patients with challenging behaviour are on the same ward ...confused patients trying to climb into bed with end of life patients...”

Other areas raised were the increased number of patients posing challenges to staff and this impacted on an increase in the number of violent incidents. There was a suggestion that there should be an increase in palliative beds to reduce these types of incidents. Staffing was also highlighted to be a considerable issue at Kirklandside:

“staffing issues can cause real problems…no junior doctors are on site and we cannot pull staff from elsewhere”

The environment was another area that was consistently raised by all staff with views ranging from the lack of bus service to the isolation of the hospital especially for the night shift staff. The state of building was a consistent theme with all staff saying that it was in constant state of disrepair.

“the building has lots of problems, the place is falling apart, storage space is limited, paint is coming off the walls...”

In relation to improving the service, staff had many ideas ranging from a total redesign and rebuild at the site, separate car parks for staff and separate toilets for staff. Staff commented that there was no dedicated staff area such as a staff room. Out of all staff interviewed however, all wanted to keep the ward where it was but to revamp it.

Suggestions ranged from:

“full redesign and rebuild...keep ward where it is but revamp”

“Knock down 3 and 4 and build a new unit including a day hospital’

“Introduce more services / co-location on site for multi-disciplinary and joint working…this would allow for better planning and care for complex patients”

In relation to services delivered to patients, comments were made about additional male staff being on duty to work with male patients as it was felt that male colleagues had the ability to cope more effectively with *“the more challenging patients”.*

Other issues raised included the lack of a hairdresser on site. The hairdresser had been off sick for some time resulting in a loss of this service to patients.

A consistent theme throughout all interviews was that patient needs were more complex than in previous years. This resulted in many staff being disappointed that they now had *“limited opportunity to interact with patients as they are all very busy*”. All staff commented that increased staffing would make a considerable difference to this or a change in the type of service offered to patients.

Views were sought from an external perspective and an interview took place with a consultant geriatrician from an NHS board in another area who has been working in Ayrshire in another capacity and had links with Kirklandside.

The consultant recognised that staff were committed, caring and compassionate and doing the best job in challenging circumstances within a challenging environment not suited to respect patients’ individual dignity especially end of life patients. The Nightingale

ward system is not a good environment for care in the 21st century and comment was made that it may be one of the last Nightingale wards in Scotland. Vulnerable adults should have a right to privacy, especially at the end of their lives and this ward system is not a good environment of care. There was no privacy for patients or their friends and families. Therefore, some standards set out in Healthcare Improvement Scotland's Care of Older People in Hospital Standards could never be met in this environment.

Observations and comments:

"stress and distress impacts on the whole ward"

10. East Ayrshire Community Hospital (EACH)

10.1 EACH: Site Evaluation

East Ayrshire Community Hospital comprises 49 beds (25 frail elderly and 24 GP staffed): Burnock Ward - 24 beds, Roseburn Ward - 12 beds and Holmburn Ward (currently disused) - 13 beds. The community hospital is complemented with: a frail elderly day hospital, an outpatient suite, a social work team and rehabilitation services, which are located on the site.

The hospital building itself occupies 3.29Ha of the 7.33Ha site. The net book value of the property is £13,036,085, with the land comprising a value of £10,000. The hospital tenure is PFI, which requires a decision to be made on the continued use of the property after 2021/22.

In terms of the current situation at EACH, the building was considered to be “Clean, bright, welcoming and in good overall condition”, however an amount of maintenance work is required to bring the site into an acceptable condition. Several areas of building work have been identified, including: Sanitaryware and Internal fittings upgrades = £25,000, Roads and Car parks = £10,000 and Internal fabric and Decoration = £15,000.

The current condition of engineering services was also considered to be in a good functioning condition, with main expenditure required on the following areas: Electrical system upgrades = £12,000, Boilers and Heating systems = £12,000 and Site Lighting upgrades = £10,000.

The statutory compliance at EACH is currently satisfactory, however the following maintenance work is required: Water services = £100,000, Medical Gases = £100,000 and Equality Act compliance upgrades = £32,226.

The site was deemed to be fit for purpose, however it was noted that the space available at EACH is currently underutilised and an extent of maintenance work is required. The table below sets out a summary of the total backlog costs requred to bring EACH into an acceptable condition.

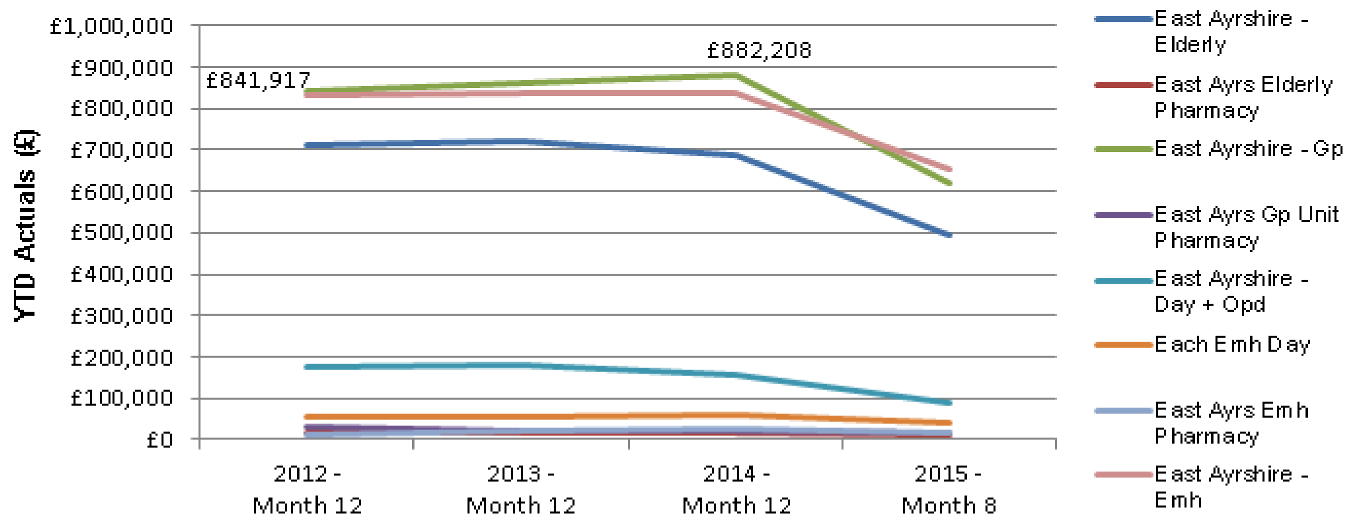
EACH Backlog Cost Summary	
Building	£100,000
Engineering	£89,000
Statutory	£369,266
Total	**£558,266**

10.2 EACH: Finances

	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
2012	£2,715,049	£2,715,049	£2,676,169	£38,880 / 1.4%
2013	£2,738,899	£2,738,899	£2,720,182	£18,717 / 0.7%
2014	£2,775,380	£2,775,380	£2,690,574	£84,806 / 3.1%
2015	£2,832,367	£2,832,367	£2,931,921	- £99,554 / 3.5%

- The annual budget increased every year between 2012 and 2015, with a 4.3% increase over the four year period.
- Spending fluctuated between 2012 and 2014, however spending increased by 9% (£241,347) in 2015.
- Underspending occurred between 2012 and 2014, however 2015 was overspent by £99,554 (3.5%).

EACH Cost Centres



- GP and Elderly Mental Health spending gradually increased between 2012 and 2014, representing the highest cost centres at EACH in this period.
- EMH Day and EMH Pharmacy spending gradually increased between 2012 and 2014.
- 'Elderly' spending decreased by 4.6% (£33,295) between 2013 and 2014.
- GP Unit Pharmacy spending decreased by 29.8% (£9,042) and 'Day and Opd' spending decreased by 13.4% (£24,335) between 2013 and 2014.

10.3 Review of East Ayrshire Community Hospital (EACH)

10.3.1 EACH: Quantitative Data

A total of 1,266 episodes and 25,242 beddays took place at EACH between 2013/2014. The majority of episodes were comprised of GP (Other than Obstetrics) cases (78.2%), followed by Geriatric Medicine cases (19.1%). Episodes were predominantly inpatient cases (90.8%) and non-elective cases (88.3%). The majority of episodes were comprised of patients aged 65+ (85.6%), whom consumed 95.5% of beddays and accounted for 96.3% of total expenditure.

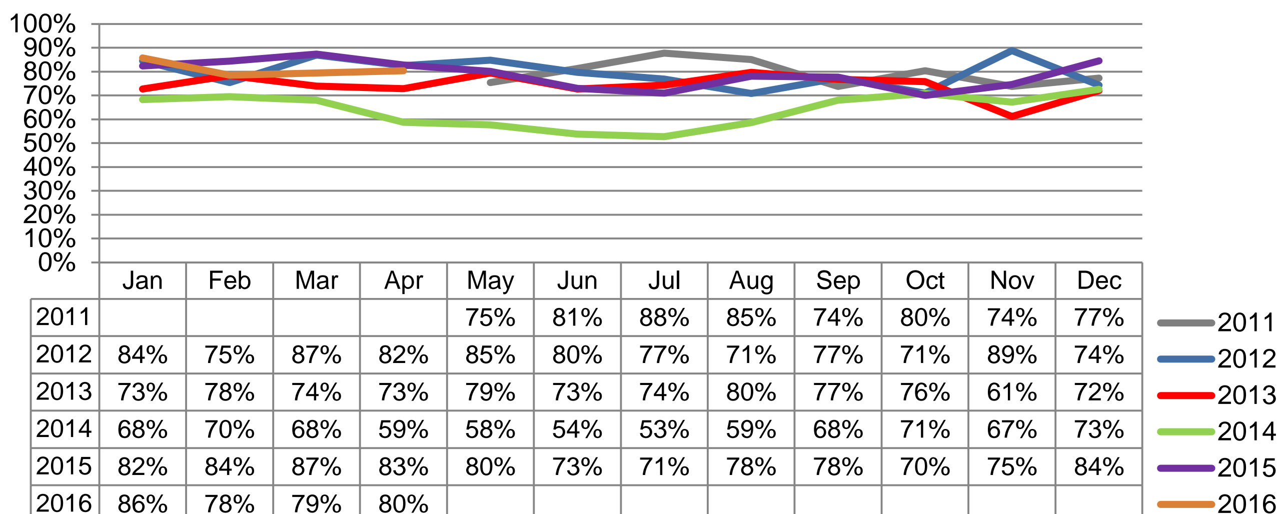
The average expenditure per episode at EACH was £11,066 and the average cost per bedday was £555, with a total net cost of £14,009,434 between 2013/14.

EACH: Most prolific conditions by activity (2015)							
Elective Admissions		**Emergency Admissions**		**Avg length of stay (days)**		**Episodes**	
Renal Failure	44	Renal Failure	121	Parkinsons	38	Renal Failure	165
Diabetes	41	CHD	108	Dementia	27	CHD	144
CHD	36	COPD	91	Stroke	21	Diabetes	127
Asthma	32	Diabetes	86	Alzheimers	20	COPD	104
CLD	30	Cancer	69	All Arthritis	20	Cancer	91
Cancer	22	Stroke	65	Arrhythmia	18	Stroke	86
Stroke	21	Arrhythmia	59	Diabetes	17	Arrhythmia	80
Arrhythmia	21	Dementia	37	Heart Failure	17	Dementia	57

Conditions which accounted for the highest number of elective admissions in 2015 were: Renal Failure, Diabetes, CHD and Asthma. Similarly, Renal Failure, CHD, COPD and Diabetes accounted for the highest number of emergency admissions at EACH in 2015. The conditions which accounted for the longest stay durations throughout 2015 were: Parkinsons (38), Dementia (27), Stroke (21), Alzheimers (20) and All Arthritis (20).

Bed occupancy at East Ayrshire Community Hospital fluctuated considerably between May 2011 and April 2016, with occupancy ranging from 53% in July 2014 to 89% in November 2012. The yearly average rate steadily declined between 2012 and 2014 by 19% however, occupancy increased between 2014 and 2015 by 19%. Occupancy was relatively low throughout 2014 ranging from 53% in July to 73% in December. However, occupancy increased during 2015, ranging from 87% in March to 70% in October. The first 4 months of 2016 has ranged from 86% January to 78% February. The average bed occupancy rate between May 2011 and April 2016 was 75%.

EACH Bed Occupancy: 2011-2016



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2011					75%	81%	88%	85%	74%	80%	74%	77%
2012	84%	75%	87%	82%	85%	80%	77%	71%	77%	71%	89%	74%
2013	73%	78%	74%	73%	79%	73%	74%	80%	77%	76%	61%	72%
2014	68%	70%	68%	59%	58%	54%	53%	59%	68%	71%	67%	73%
2015	82%	84%	87%	83%	80%	73%	71%	78%	78%	70%	75%	84%
2016	86%	78%	79%	80%								

EACH Beddays by Age: 2013/14

	% of Total Beddays	No of Beddays	Beddays per 10,000 pop
< 65 patients	4.5%	1,129	113
65+ patients	95.5%	24,113	10,576
65-74 patients	19.4%	4,900	3,774
75-84 patients	47.6%	12,010	16,258
85+ patients	28.5%	7,203	29,630
Total		25,242	2,062

Patients aged 75-84 consumed almost half of the total beddays (12,010), accounting for 16,258 beddays per 10,000 population. Patients aged 85+ consumed 28.5% of beddays (7,203) and the highest number of beddays per 10,000 population (29,630).

EACH Admissions: 2011 - 2015

Financial Year	Non-Emergency Admissions	Emergency admissions
2011	245	711
2012	189	916
2013	266	896
2014	302	845
2015	304	755

A total of 1,059 admissions took place at EACH throughout 2015, of which 28.7% were non-emergency and 71.3% were emergency admissions. Elective admissions steadily increased by 24.1% between 2011 - 2015 and the number of emergency admissions increased 6.2% in the same period.

A significant extent of EACH resources were consumed by non-elective inpatient patients aged 65+, who presented as either GP or Geriatric Medicine cases throughout 2013/14.

10.3.2 EACH: Datix Reports

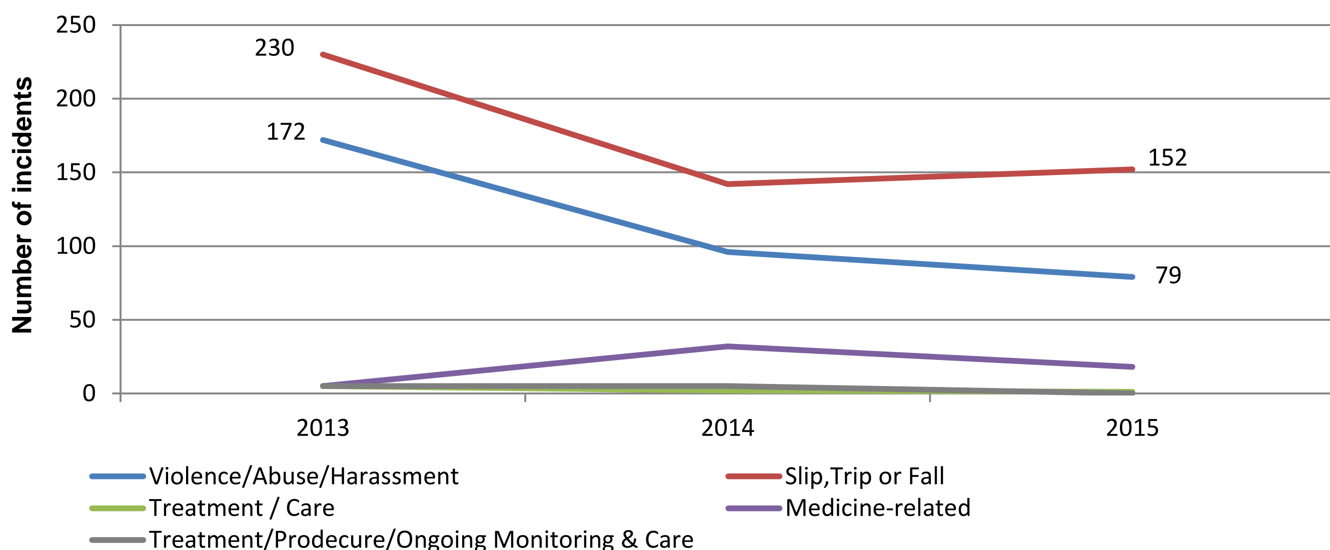
Datix is a patient safety and risk management software for healthcare incident and adverse event reporting.

EACH Datix Report: 2013-2015

Category	2013	2014	2015	Total
Appointment, Admission, Transfer, Discharge	3	12	1	16
Blood Transfusion	1	0	0	1
Caldicott, Confidentiality and Data Protection	1	0	0	1
Contact with / Exposure to Hazard	5	10	6	21
Diagnosis, Failed or delayed	1	1	0	2
Equipment (including Electro Medical)	8	10	4	22
Fire, Fire Alarms and Fire Risks (inc Smoking)	6	7	7	20
GP Practice Reporting ONLY	9	4	0	13
Health & Safety Miscellaneous	0	1	0	1
Implementation of care or ongoing monitoring/review	9	2	0	11
Infrastructure and Service Related	34	8	5	47
Investigation Requests / Reports / Specimens	0	1	2	3
IT Systems, IT Security or Telecoms	1	2	1	4
Loss or Theft of Property (not medicine)	0	1	0	1
Medicine Related	5	32	18	55
Missing patient / Absconsion	0	0	2	2
Mortality	1	0	0	1
Moving & Handling	6	2	3	11
Needlestick/Clinical Sharp/Blood	0	1	0	1
Nutrition	0	0	1	1
Patient Info Related (electronic/case record, charts, documents)	6	5	1	12
Pressure Ulcer	0	0	4	4
Security Related Incidents	18	16	4	38
Self-Harm / Suicide	2	1	1	4
Service Related Incidents	2	2	0	4
Slip, Trip or Fall	230	142	152	524
Treatment / Care	5	2	1	8
Treatment/Procedure/Ongoing Monitoring and Care	5	5	0	10
Vehicle Related	2	2	0	4
Violence/Abuse/Harassment	172	96	79	347
Other - Only use this if no other category is appropriate	7	3	0	10
Total	539	368	292	1199

* This report includes all patient, staff and visitor related incidents. A single individual may be represented in multiple recordings.

EACH Incident Trends: 2013-2015



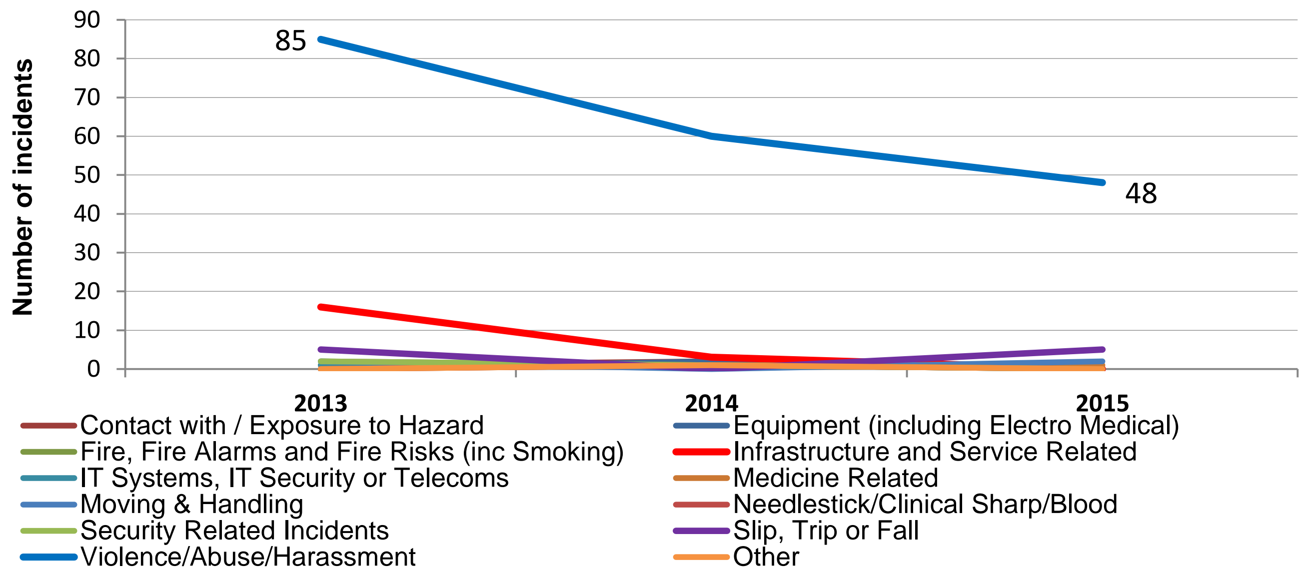
- Violence / Abuse / Harassment incidents decreased by 54% between 2013 and 2015.
- Slip, Trip or Fall incidents decreased by 34% between 2013 and 2015.
- The number of: Mortality, Treatment / care, Self-harm / Suicide, Treatment / Procedure / Ongoing Monitoring and care and Security-related incidents decreased between 2013 and 2015.
- Missing Patient / Absconsion, Medicine-related, Nutrition and Pressure ulcer incidents increased between 2013 and 2015.
- Despite decreasing considerably, Violence / Abuse / Harassment and Slip, Trip or Fall incidents remain the most prevalent issues at EACH.

EACH Staff Only Datix Report: 2013-2015

Category	2013	2014	2015	Total
Contact with / Exposure to Hazard	1	2	0	3
Equipment (including Electro Medical)	0	2	0	2
Fire, Fire Alarms and Fire Risks (inc Smoking)	2	1	0	3
Infrastructure and Service Related	16	3	0	19
IT Systems, IT Security or Telecoms	1	1	0	2
Medicine Related	0	1	1	2
Moving & Handling	2	0	2	4
Needle stick/Clinical Sharp/Blood	0	1	0	1
Security Related Incidents	2	1	0	3
Slip, Trip or Fall	5	0	5	10
Violence/Abuse/Harassment	85	60	48	193
Other	0	1	0	1
Total	114	73	56	243

* This report is comprised of staff only incidents.

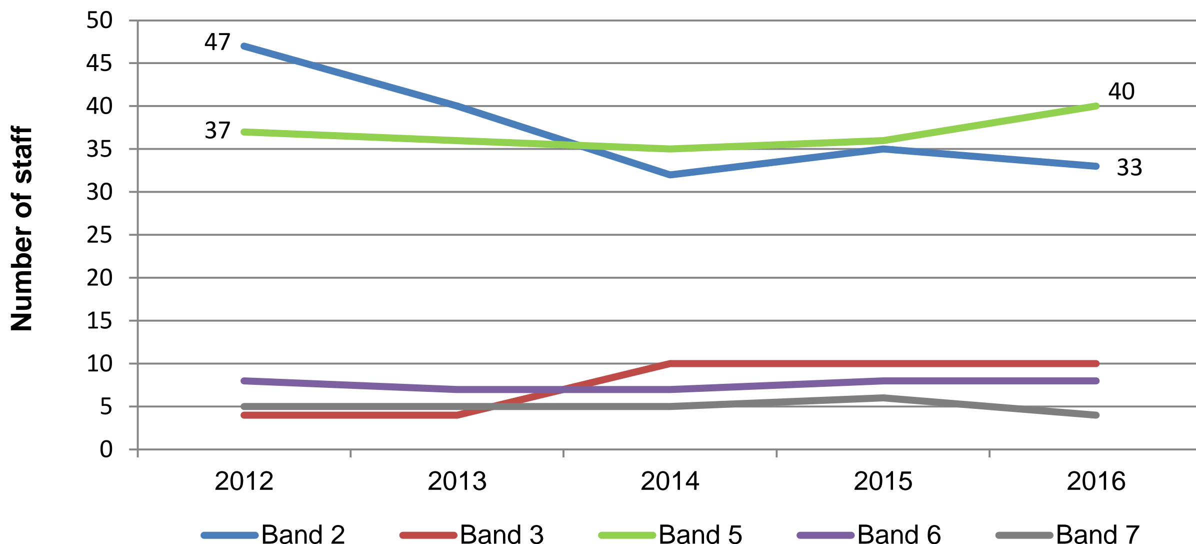
EACH Staff Incident Trends: 2013-2015



- The number of recordings in every incident category either decreased or remained fairly static between 2013 and 2015.
- The number of violence / abuse / harassment incidents decreased significantly (44%) between 2013 and 2015.
- The number of infrastructure and service-related incidents decreased from 16 in 2013 to 0 in 2015.
- Despite declining, violence / abuse / harassment was the most prevalent incident recorded at EACH, with a total of 193 recordings between 2013 and 2015

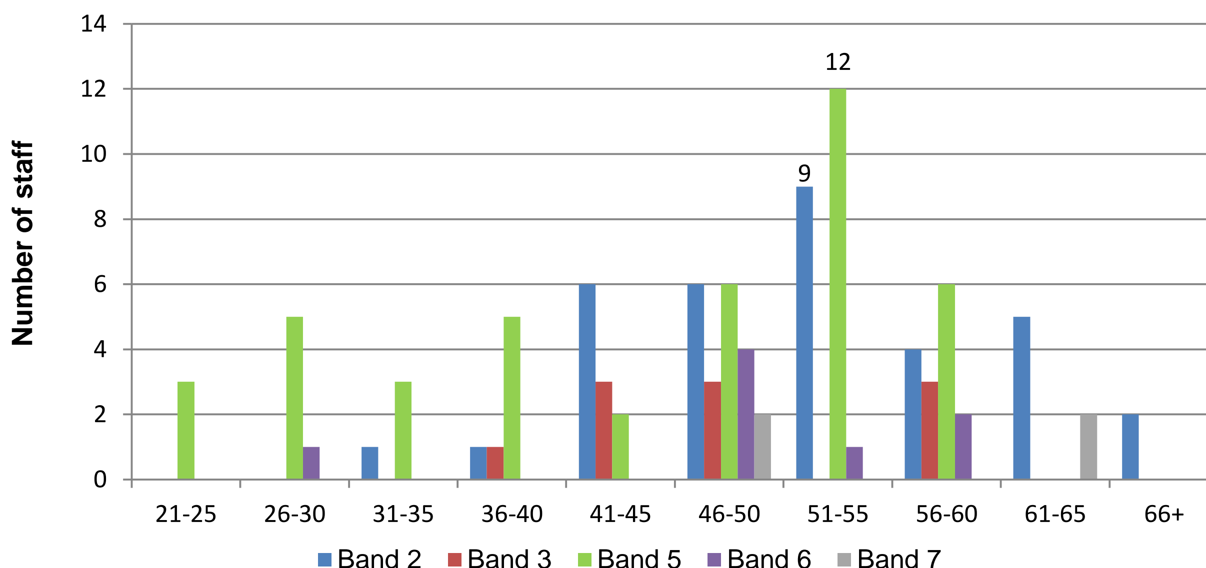
10.3.3 EACH: Workforce

EACH Staff Headcount by Banding: 03/2012 – 01/2016



- The number of band 2 staff decreased by 30% between 2012 and 2016.
- The number of band 5 staff increased by 8% between 2012 and 2016.
- The number of band 3 staff increased from 4 to 10 staff members between 2013 and 2014 and remained static at 10 staff until 2016.
- Band 6 and 7 staff numbers remained fairly static between 2012 and 2016.

EACH Workforce: Banding by Age (02/2016)



- 68% of the workforce is aged 46+.
- 43% of the workforce is comprised of band 5 staff, 57% of which are aged under 51.
- 35% of the workforce is comprised of band 2 staff, 59% of which are aged 51+.
- 20% of the workforce is comprised of staff aged under 41.

10.3.4 EACH: Qualitative Data

It was vital to hear the views of a range of staff working at EACH and semi-structured one to one interviews took place with 13 members of staff from the Roseburn and Burnock Wards. All participants were asked questions around the following themes:

- What works well
- What doesn't work well
- What would you do to improve how we work?

Roseburn Ward

Interviews took place with 7 staff working in the following roles: Auxiliary nurse, Staff Nurse and Deputy Charge Nurse. All staff were aware that although comments were not attributed to individuals in the team, there was a possibility that their quotes used in the report may be recognised as belonging to them. All staff acknowledged this and were happy to take part.

In relation to what works well, all staff agreed that they work well as a team and support each other. Communication in the team was considered by all to work well and staff feel valued and listened to. Regular team meetings take place and staff commented that excellent training opportunities are available. The majority of staff agreed that the ward is well organised and that communication with other departments and services is good. Staff regarded facilities at EACH to be excellent. A range of services are provided at EACH and care plans are always adapted to meet the needs of the patient. All staff agreed that services provided in the Roseburn Ward effectively bridge the gap between hospital and home.

"we are like a wee family...a tight knit unit"

In relation to what doesn't work well, a number of areas were identified and key themes emerged. Staff shortages can be problematic and at times the appointment process as EACH is slow and inefficient. Pressures have increased notably in recent years and staff safety has been compromised on a number of occasions (patient related). Communication could work more effectively between health and social work. Staff unanimously commented that the empty Holmburn Ward is a waste of resources and that overall the hospital could be better utilised. Comments were made about the lack of Minor Injuries unit and the potential for additional specialties on site. Other areas highlighted were insufficient GP and ANP cover and staff commented that there is lack of patient privacy in the ward.

"staffing can be a nightmare"

"Holmburn ward has become a dumping ground…it is a waste"

Staff gave a range of responses in relation to how to improve services. Re-opening the Holmburn Ward and fully utilising all resources available at EACH were unanimous responses. In addition, increased staffing numbers and GP and ANP cover were highlighted to make a difference. The introduction of an Accident and Emergency department and / or Minor Injuries Unit would be welcome. Empowering nursing staff to introduce more nurse-led care was also suggested and the introduction of male staff e.g. night porter and nursing staff would make current staff feel safer during night shifts. A mix of patients would be welcome including younger patients.

Burnock Ward

Interviews took place with 6 staff working in the following roles: Nursing assistant, Staff Nurse and Deputy Charge Nurse. All staff were aware that although comments were not attributed to individuals in the team, there was a possibility that their quotes used in the report may be recognised as belonging to them. All staff acknowledged this and agreed to take part.
In relation to what works well, staff are supportive of each other and work well together. Working with experienced nursing staff provides reassurance and confidence regarding decision making. There was an opportunity to get to know patients and as EACH does not use many bank staff the patients know the staff and good relationships are formed. EACH is a friendly and relaxed workplace and is very much a local facility as local people do not have to go to Crosshouse or Ayr. Care from ward to home is good and staff felt that this works well for continuity of care.

"Staff have a greater ability to develop positive relationships with patients and provide more effective care"
"EACH is friendly and relaxed place to work"

In relation to what does not work well, a number of areas were identified and key themes emerged. The shortage of staff was a consistent key theme raised by all staff interviewed and comments were made about how this can affect staff morale. Getting bank staff in the summer months is a struggle and this didn't help. Comment was also made about the extra pressures placed on staff due to these shortages and that this can cause tension. Some staff considered it a very hierarchical place to work. Type of patient mix was also raised and comment was made that this can be unsettling for other patients. Another improvement area highlighted was being asked to complete paperwork that was very

often duplicating other paperwork already on file. Staff felt that the empty ward at EACH should be utilised. There has been a lack of consistency in the Service Manager role with staff citing 4 managers in the last 3 ½ years.

“Desperately need more staff”
“much needed posts are not being filled”

Staff gave a range of responses in relation to improving services including re-opening Holmburn Ward as well as fully utilising all resources available at EACH. Staffing levels was very much the biggest issue and all staff raised this. Improved staffing numbers would make a difference as well as more GP and ANP cover. The introduction of male staff e.g. night porter and nursing staff would make staff feel safer especially during night shifts. Increased nursing assistant capacity during night shift would also be of great benefit to the team. The introduction of a Minor Injuries Unit would be welcome. Basing the manager on site as well as consistency in management is needed for future service improvement.

11. Key Themes / Findings

Emerging themes / areas for consideration

There are a range of themes and emerging themes set out below:

- Ageing population living longer with multiple conditions
- Ageing population is rising and will continue to rise
- Continuing health and economic inequalities based on demographic analysis
- Patients in community hospitals more complex than before
- Problematic providing equity of care in old and out of date premises
- High bed occupancy rates at Kirklandside > 92%
- Increased reporting of violent events (Kirklandside)
- Nightingale Ward system is outdated
- More complex patients
- Aging workforce
- Ensure all services are accessible by public transport
- Whole systems working and place based systems of care principles are key
- Include all stakeholders when developing and designing future services

12. Conclusions

This review has considered demographics, financial information, site evaluations, workforce profiles and the composition of our patient population at Kirklandside Hospital and East Ayrshire Community Hospital over the past 3 years. In addition, a literature review was undertaken to provide a range of alternative ways of working including community, social and technological areas for consideration to develop and design our services to meet the needs of our ageing population and those with complex needs. The literature also set out approaches such as place based systems of care and simulation modelling for developing new services.

Kirklandside Hospital continues to have high occupancy rates and increased Datix reporting in regards to violent and abusive incidents. Significant investment is required to modernise and move away from the outdated Nightingale ward system currently in place.

In contrast, the average bed occupancy at East Ayrshire Community Hospital was 75% and there has been a reduction in the number of violent and abusive incidents and this trend is continuing.

Overspending occurred and increased in every proceeding year at Kirklandside Hospital between 2012 and 2015 (by as much as 16.5%). In addition, an estimated £1,597,486 of backlog maintenance costs are required to bring Kirklandside Hospital into an acceptable condition. These findings suggest that considerable financial investment would be required to upgrade and prolong the service life of Kirklandside hospital.

A period of underspending occurred at EACH between 2012 and 2014, however 2015 was overspent by 3.5% and a backlog cost of £558,266 is required. As the tenure is PFI, a decision on the continued use of the property after 2021/22 is required.

Staff interviews captured a range of personal opinions regarding the delivery of services and a number of key themes were identified and incorporated in this review.

Workforce planning is crucial to the development of future models of care. This review has shown that Kirklandside Hospital currently has an aging workforce with a significant extent of the workforce aged 56 and over. In contrast, East Ayrshire Community Hospital has a younger workforce and these factors must be fully taken into consideration when planning future services. There is a range of planning tools and processes that can be used to take this forward.

Continued assessment of demographics can inform the composition of patient population, reasons for admission and community/social alternatives when considering new models of care. To meet the Scottish Government's 20:20 vision, new ways of working must be introduced using a whole systems approach and fully integrated working is crucial to delivering equitable, quality efficient and effective services for all in East Ayrshire.

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13. Recommendations

- Apply whole systems working and place based systems of care approaches to develop future services
- Apply the principles of co-production
- Fully integrate services
- Incorporate housing into all future models
- Tests of change – identify and take forward new models
- Further exploration of community based alternatives to hospital care – more community links with ICES
- Follow HIS standards to ensure frail elderly population access equitable services across the partnership
- Wide ranging programme of stakeholder engagement to take forward the development and design of future services
- Consider utilisation of Holmburn Ward at EACH

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* Please refer to extended literature review for the complete list of references.

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Lead Reviewers Designation (   )

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