AGENDA ITEM No.10

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board
Agenda Item	10
Title	HSCP Unscheduled Care Programme Update

Summary

As requested at the June meeting of the Integration Joint Board this paper provides an update on the HSCP Unscheduled Care Programme.

The report details progress on our Scottish Government expectations regarding unscheduled care and cross system work on our unscheduled care programme to deliver against our objectives for 2019/20

Presented by	Kim Campbell, Localities Improvement Manager

Action Required

The Integration Joint Board is asked to:-

- note the HSCP performance against MSG targets
- note the HSCP's contribution to cross Greater Glasgow and Clyde whole system planning for unscheduled care
- recognise the challenges given our growing elderly population and our limited primary and community care resources

Implications checklist – check box if applicable and include detail in report

☒ Finance	☐ Policy	☐ Legal	☐ Equalities
☐ Risk	☐ Staffing	☐ Directions	☐ Infrastructure

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

14 August 2019

Report by Chief Officer

HSCP UNSCHEDULED CARE PROGRAMME UPDATE

PURPOSE OF REPORT

1. This report updates the Integration Joint Board on progress on our Scottish Government expectations regarding unscheduled care and cross system work on our unscheduled care plan to deliver against our objectives for 2019/20.

RECOMMENDATION

2. The Integration Joint Board is asked to:
   - note the HSCP performance against MSG targets
   - note the HSCP's contribution to cross Greater Glasgow and Clyde whole system planning for unscheduled care
   - recognise the challenges given our growing elderly population and our limited primary and community care resources

BACKGROUND

3. Reducing unscheduled care activity is a key priority of the health and social care integration agenda. Increasing numbers of older people in our population, and longer life expectancy for those with life limiting illness and disability, is to be celebrated. There is, however, a resultant increase in demand both in terms of numbers and complexity across the health and social care economy. In order to militate against the impact of this, concerted effort across the whole system is needed to ensure person centred safe, efficient and effective care.

4. The Integration Joint Board approved the HSCP annual targets in relation to the Ministerial Steering Group (MSG) objectives for 19/20 at its meeting of 20 March 2019. NHS Greater Glasgow & Clyde (NHSGGC) and all six HSCPs with GG&C collaborated to prepare the trajectories for the MSG indicators for 2019/20.

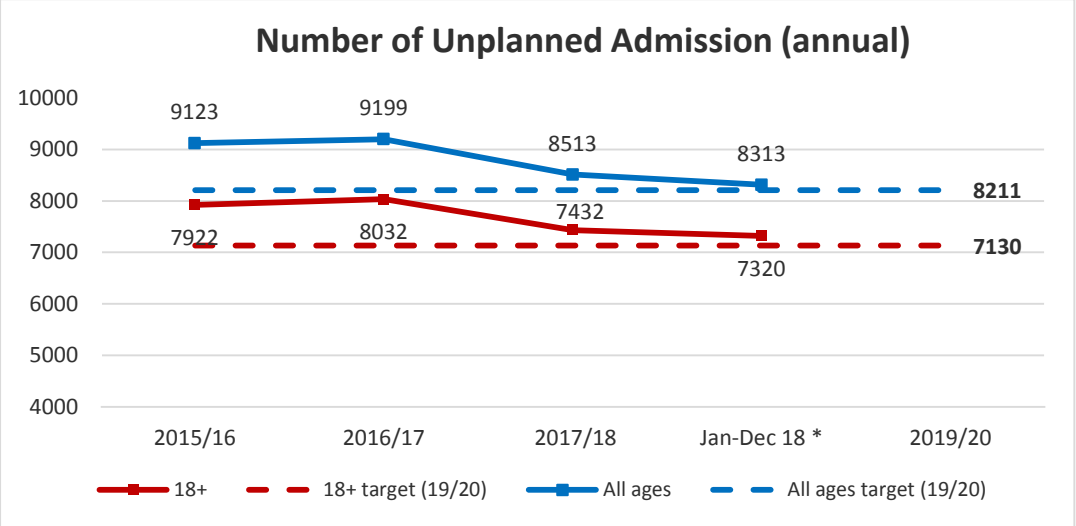
5. Partnerships do not have an unscheduled care programme for under 18s at this time, and the activity is not part of Set Aside arrangements. Currently the board wide unscheduled care programme and the unscheduled care work stream of Moving Forward Together is focused on adults.

6. This report provides an update on the latest data available (April – December 2018) to track our progress towards the MSG targets and gives an overview of recent activity within the partnership and across GG&C.

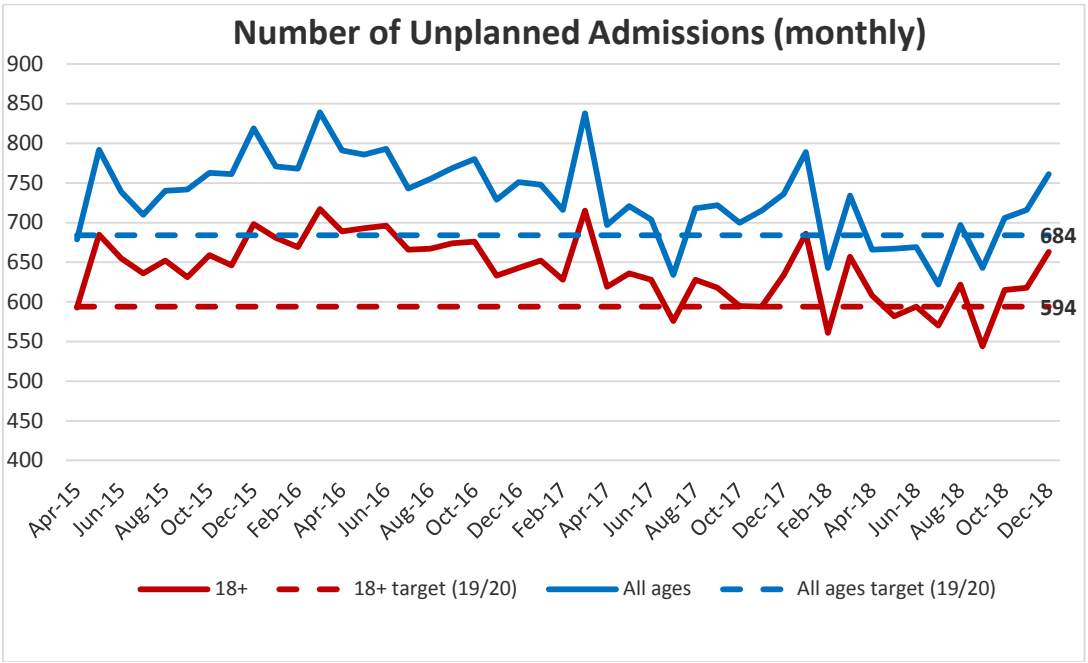
REPORT

Unplanned Admissions

7. East Renfrewshire's number of Unplanned Admissions has been improving year-on-year since 2016/17 and this trend is replicated across all age groups. Since the baseline year of 2015/16 there has been a 7.6% drop in admissions for adults (18+) and a 9.6% drop for all ages. The 2018/19 figure indicates that we are on course to meet our agreed 2019/20 target in the coming year.



*full year data not available for 2018/19. We present Jan-Dec 2018 to give 12 month data.



8. Admissions to hospital from East Renfrewshire care homes have continued to reduce since May 2018 (n26) to June 2019 with (n16) recorded. Although our admissions are lower than many other areas, our growing care home estate continues to be a risk to us. Care Homes have positively engaged with the Unscheduled Care Improvement Programme. An Improvement forum has been initiated with agreement to share performance data and activity.

9. Work continues with colleagues across Greater Glasgow & Clyde to develop pathways for a range of conditions across primary and secondary care to reduce unplanned admissions. The top 5 most common primary diagnosis upon admission for East Renfrewshire are shown in the table below. These are potentially preventable conditions:

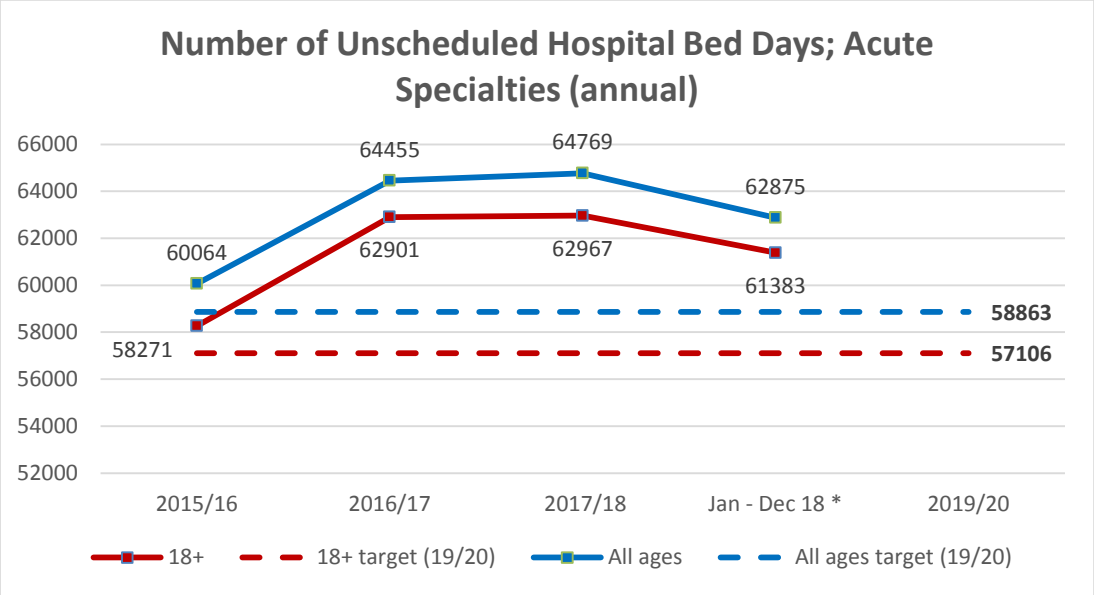
Primary Diagnosis	No	%
URINARY TRACT INFECTION SITE NOT SPECIFIED	233	2.9
UNSPECIFIED ACUTE LOWER RESPIRATORY INFECTION	228	2.8
SEPSIS UNSPECIFIED	170	2.1
CHEST PAIN UNSPECIFIED	167	2.0
PNEUMONIA UNSPECIFIED	133	1.6

Top 5 Most Common Primary Diagnoses upon Emergency Admission to Hospital and Associated Bed Days (2018/19 Data for East Renfrewshire Residents)

10. Since March 2019, we have:
    - Implemented 'intermediate bed' capacity within Bonnyton House to provide support for individual at risk of an admission in the community setting using local resource including Advanced Nurse Practitioner, Physiotherapist, Occupational Therapy and Hospice support. This test of change is being monitored.
    - Implemented the Rockwood Dalhousie Frailty Assessment tool across our RES teams. Since November 2018 more than 500 assessments have been completed, which assign a Frailty score to each individual assessed. This assessment is completed at time of assessment and following intervention to measure improvement and will allow us to target interventions at those who will benefit the most.
    - Sharing of the Frailty score for individuals with the acute sector and GPs is being developed

Occupied Bed Days due to Unscheduled Admissions

11. Unscheduled hospital bed days increased in the first year but have shown an improving trend to December 2018. Despite this we are still above the 2015/16 position by 5.3% for adults (18+) and 4.7% for all ages. We will continue to work towards our ambitious targets.



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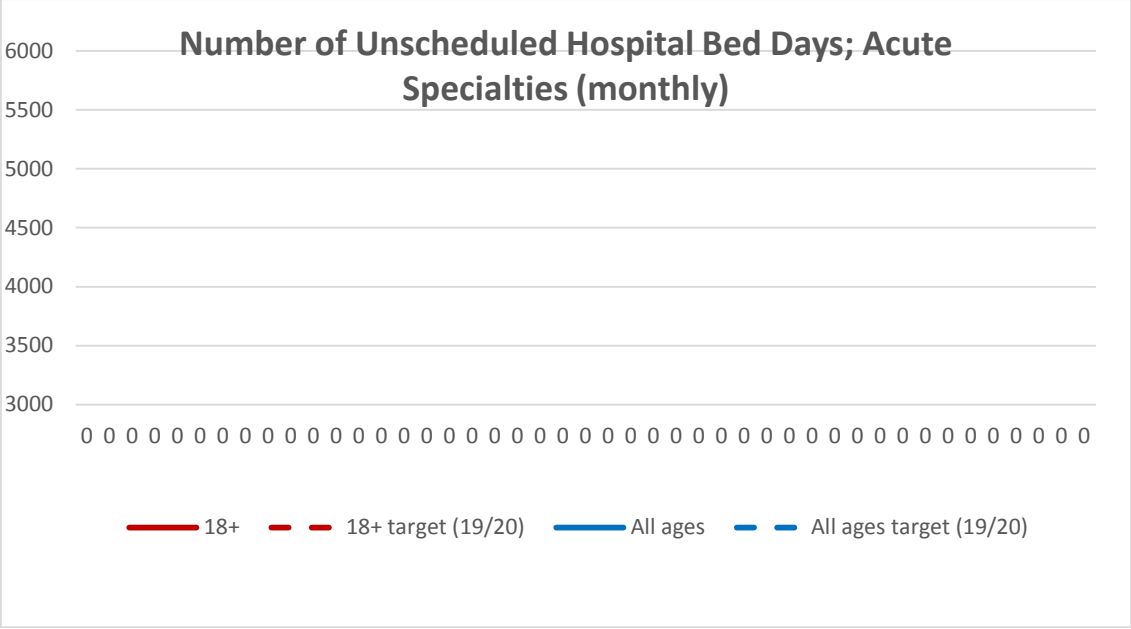
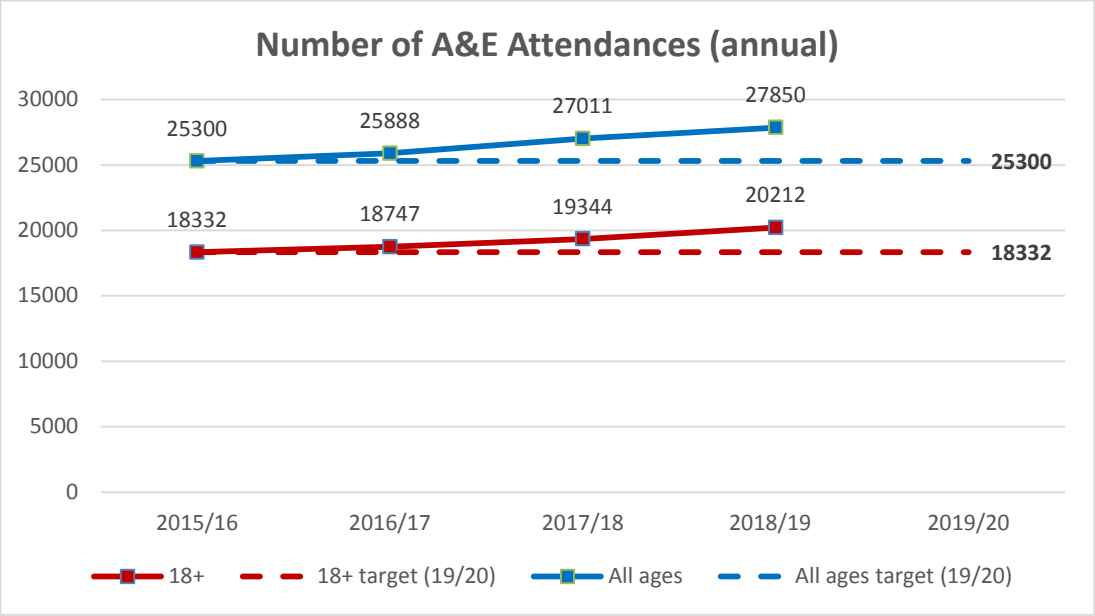
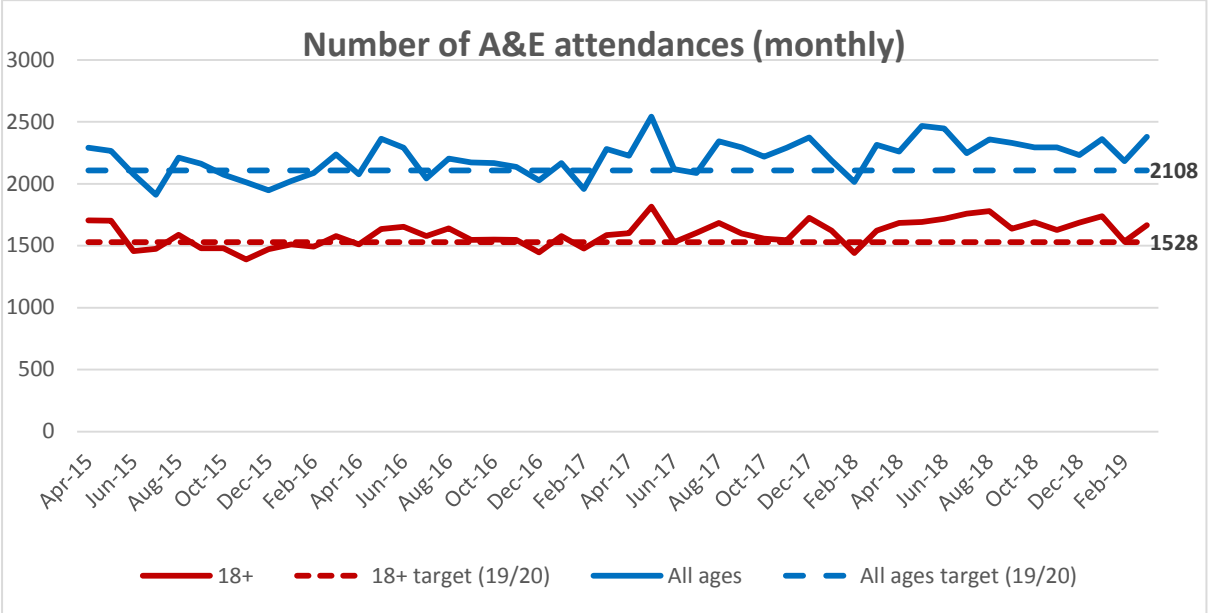


12. Improvement activity:
    - Developed our use of the 'in patient' dashboard to identify East Renfrewshire residents in hospital beds across Glasgow & Clyde strengthening our in reach activity across all acute sites
    - Participated in the GG&C FIP Unscheduled Care Group where sharing of best practices was supported to benchmark against and develop pathways for COPD, cellulitis, chest pain, self-harm, falls and abdominal pain
    - Small test of change of Home and Mobile Health Monitoring Florence (FLO) to support self-management of COPD

Accident and Emergency

13. This is a very challenging area with A&E attendances across GG&C rising. East Renfrewshire A&E attendance continues to be the lowest across Greater Glasgow & Clyde. Our target is to return to baseline performance at 2015/16. For adults, A&E attendances have increased by 10.3% since 2015/16 and by 10.1% across all ages.

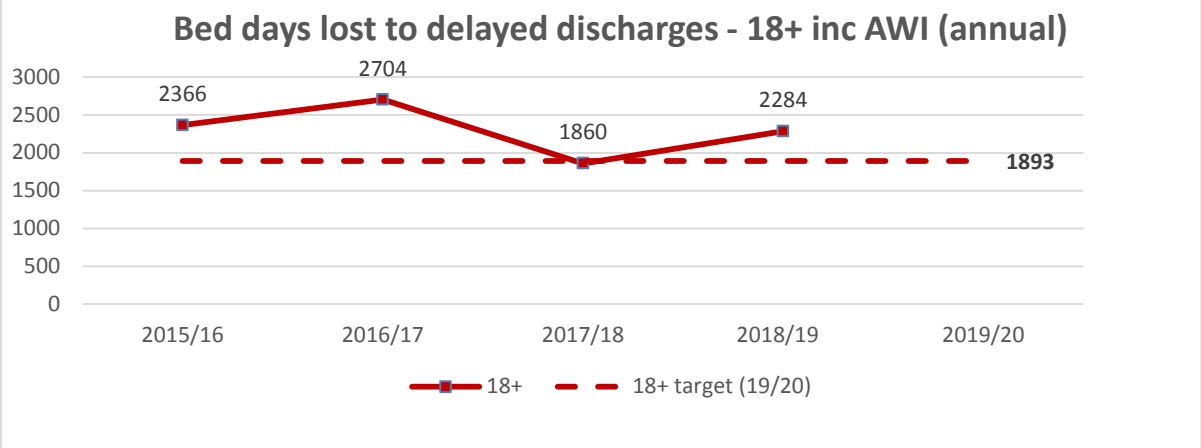


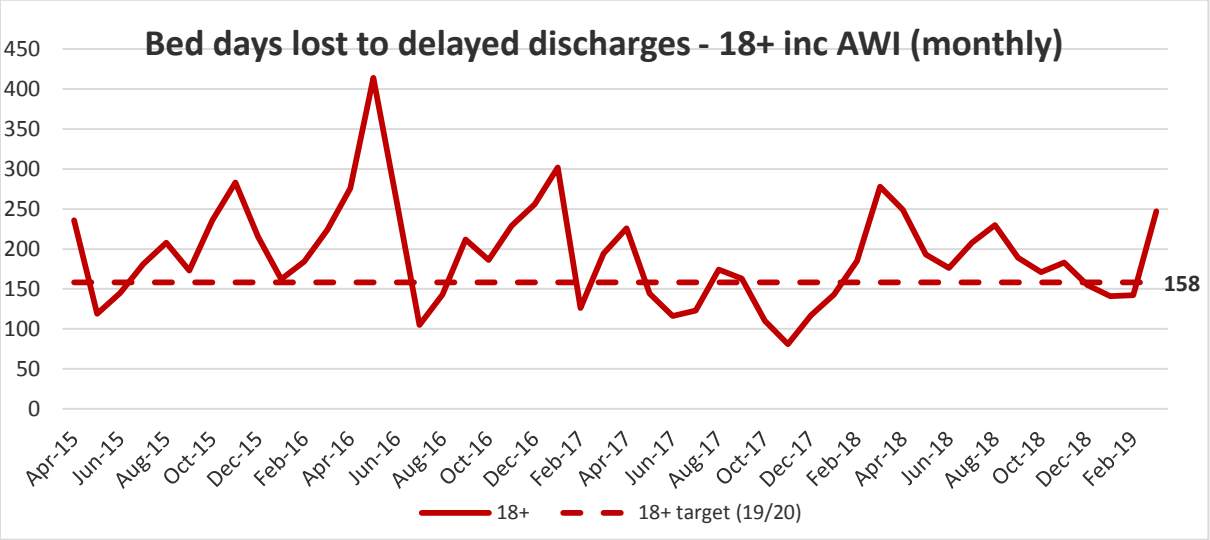


14. Across NHSGGC, there are a range of work streams underway which will impact on reducing attendances at A&E over 2019/20. These include
    - work on a redirection policy, directing people from A&E to more appropriate services;
    - the roll out of Primary Care Improvement Plans, which will see the introduction of a range of new professional roles in primary care; and
    - focused work to support individuals who frequently attend A&E to be supported more effectively in the community.

Delayed Discharges

15. During January to December 18/19 our delayed discharges average for all reasons was 8 days, if we average the days for those delayed due to health and social care reasons this reduces to 3. The average during the period January to April 2019 was 7, and for health and social care reasons was 3.5 days. The final 2018/19 figure was 3.5% lower than the 2015/16 baseline figure.



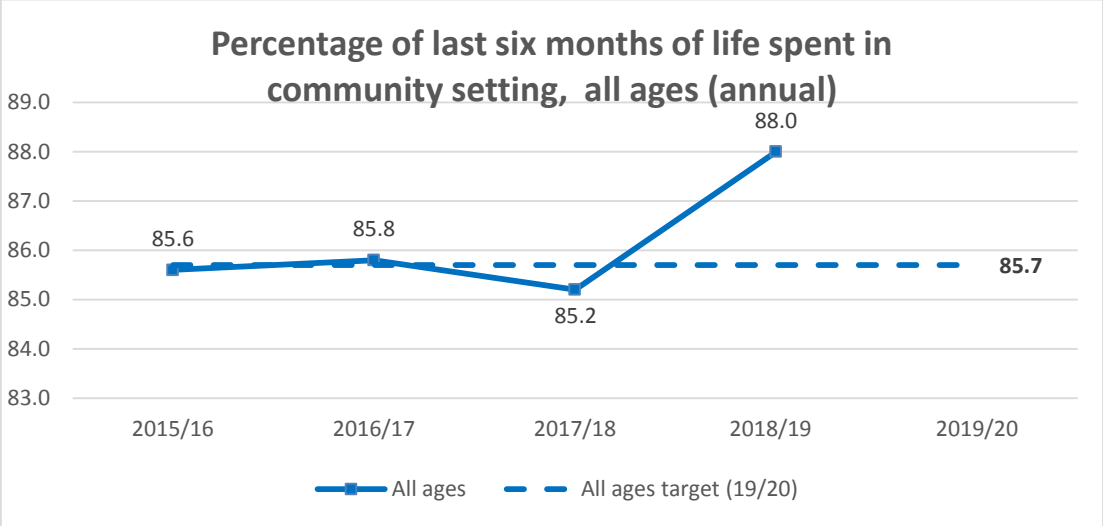


16. East Renfrewshire HSCP has significantly invested in reviewing skill mix, processes and systems to reduce delayed discharges and the number of lost bed days. This is reflected in our performance as one of the best areas in Scotland. In the first 3 months of 2019/20 our average weekly delayed discharge figure in NHSGGC was 3, which is on target.

17. Activity:
    - Continued use of dashboard information to anticipate older people approaching ready for discharge and actively plan with them and their families
    - Hospital to Home team implemented as part of new structure led by OT with social work and social work assistant staff to ensure strong in reach within all acute sites
    - Continue to promote Power of Attorney, through mental health and wider HSCP services offering support though Carers Centre
    - Use of 'Choices' meeting with support of Lead Clinicians to overcome delays as a result of family choices

End of Life

18. Our aim is to support people in the community and to die at home or in a community setting rather than in an acute hospital ward or emergency department. We have seen a sharp rise from 85.2% in 2017/18 to 88% in 2018/19.



19. Over the last four years there has been a reduction in the number of people ending their lives in hospice/palliative care units. We have committed to further partnership work on palliative care with our local hospices. The Integration Joint Board has approved a proposal that older people who need end of life care, who can't be supported to die at home, could also be supported by the development of six end of life care beds at Bonnyton House.

20. We anticipate an increase in the percentage of residents who spend the last six months of life at home or in a community setting to 86% in 18/19 and have exceeded this.

21. We have re-invigorated our Palliative Care Forum and strengthened our collaborative working relationship with both Prince & Princess of Wales and Accord Hospices. A local Time to Think event was hosted at the PPW Hospice with a wide range of stakeholders to explore how we could support people in the community better during the last 5 months of life and to identify improvement ideas

22. Activity:
    - Test of change using beds within Bonnyton House to support palliative care/end of life support
    - Locality MDT huddles being implemented with support from clinician and ANP from PPW Hospice

Balance of care across institutional and community services

23. The table below shows the percentage of the population unsupported, and those cared for at home, in a hospice or in a hospital setting. In 2015/16 we saw a drop in people supported at home. This was due to some underreporting in our social care return (missing data for reablement and hospital discharge teams), which we rectified for 2016/17. The most recent data available is for 2017/18 and shows very little change.

Setting	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018[p]
Home (unsupported)	98.0%	98.0%	98.1%	97.8%	97.9%
Home (supported)	1.1%	1.0%	0.9%	1.2%	1.2%
Care home	0.6%	0.7%	0.7%	0.7%	0.7%
Hospice/Palliative Care Unit	0.0%	0.0%	0.0%	0.0%	0.0%
Community hospital	0.0%	0.0%	0.0%	0.0%	0.0%
Large hospital	0.3%	0.3%	0.3%	0.3%	0.3%

Living and Dying Well with Frailty Collaborative

24. The HSCP has submitted an application for consideration to participate in the Living and Dying Well with Frailty Collaborative, with 6 GP practices opting in to the improvement programme. Participation in this programme with a wide range of stakeholders will assist us to develop new models to support our Frail population with a view to improving earlier identification of those at risk allowing prevention activity to be targeted. Improving the health and wellbeing of our elderly population will contribute to the achievement of the targets set within the MSG unscheduled care and NHSGG&C unscheduled care programme.

CONSULTATION AND PARTENRSHIP WORKING

25. Our unscheduled care programme includes activity agreed as part of the Partnership working across Greater Glasgow and Clyde

IMPLICATIONS OF THE PROPOSALS

Finance

26. The Integration Joint Board's budget includes a "set aside" budget for the commissioning of specific acute hospital services as detailed in the Integration Scheme. The set aside budget is calculated in line with a formula set down by Scottish Government. Currently across NHSGGC this is a 'notional' budget.

27. Over recent years East Renfrewshire Council has invested in older people's services in recognition of our rising demographic. There has not been a similar investment from NHSGGC in community nursing and rehabilitation services

CONCLUSIONS

28. This report updates the Integration Joint Board on the Scottish Government Ministerial Steering Group regarding unscheduled care performance. Whilst it is fully acknowledged that acute services are under pressure, it must be recognised that so are primary care and community services. The growing elderly population across East Renfrewshire brings complexity; new models of care need to be developed to provide community supports throughout the frailty journey. Successful delivery of a shift in the balance of care requires the whole health and social care system to plan and work together. The report details HSCP contribution to the Greater Glasgow and Clyde cross system work on unscheduled care planning.

RECOMMENDATIONS

29. The Integration Joint Board is asked to:
    - note the HSCP performance from baseline year 15/16 against agreed targets recognising the challenges given our growing elderly population and our limited primary and community care resources
    - note the HSCP's contribution to cross Greater Glasgow and Clyde whole system planning for unscheduled care.

REPORT AUTHOR AND PERSON TO CONTACT

Chief Officer, IJB: Julie Murray

Kim Campbell, Localities Improvement Manager
Kim.campbell@ggc.scot.nhs.uk

Candy Millard, Head of Adult Health and Social Care Localities
candy.millard@eastrenfrewshire.gov.uk
0141 451 0749

July 2019

BACKGROUND PAPERS

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