AGENDA ITEM No.11

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 20 March 2019
Agenda Item	11
Title	Ministerial Strategic Group for Health & Social Care Integration (MSG) – Draft Trajectories 2019/20

Summary

The purpose of this report is to present members of the Integrated Joint Board with the proposed 2019/20 Ministerial Strategic Group targets for East Renfrewshire Health and Social Care Partnership, and outline how the activity linked to achieving these targets links with the wider NHS Greater Glasgow & Clyde Unscheduled Care Programme.

Presented by	Candy Millard Head of Adult Health and Social Care Localities

Action Required

Integration Joint Board members are asked to:

- approve the 2019/20 Ministerial Strategic Group (MSG) targets
- note the HSCP involvement in the wider Board unscheduled care programme development and delivery

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

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

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

20 March 2019

Report by Chief Officer

MINISTERIAL STRATEGIC GROUP (MSG) DRAFT TRAJECTORIES 2019/20

PURPOSE OF REPORT

1. The purpose of this report is to present Integrated Joint Board members with the proposed 2019/20 Ministerial Strategic Group targets for East Renfrewshire HSCP, and outline how the activity linked to achieving these targets links with the wider NHS Greater Glasgow & Clyde Unscheduled Care Programme.

RECOMMENDATION

2. Integration Joint Board members are asked to:
   - approve the 2019/20 Ministerial Strategic Group (MSG) targets
   - note the HSCP involvement in the wider Board unscheduled care programme development and delivery

BACKGROUND

3. Each HSCP is required to set annual targets in relation to the Ministerial Strategic Group (MSG) objectives around unscheduled care. The targets proposed for 2019/20 for East Renfrewshire HSCP, and our performance against those for 2018/19 are appended to this report.

Greater Glasgow and Clyde Context

4. Partnerships in Greater Glasgow & Clyde provide health and social care services to the Board's population of 1.3 million and have a collective budget of £1.2bn. To fulfil their strategic planning responsibility for unscheduled care, HSCPs work closely with the NHS Board for Greater Glasgow & Clyde and Acute Services to deliver improvements in care for patients. The main providers of acute services in Glasgow and Clyde are the Queen Elizabeth University Hospital, Glasgow Royal Infirmary, Inverclyde Royal Hospital, Royal Alexandra Hospital in Paisley, the Vale of Leven Hospital, and ambulatory care centres at Stobhill and Victoria.

5. The HSCP programmes for unscheduled care are focused on three key themes:
   a. early intervention and prevention of admission to hospital to better support people in the community;
   b. improving hospital discharge and better supporting people to transfer from acute care to community supports; and,
   c. improving the primary / secondary care interface jointly with acute to better manage patients in the most appropriate setting.

REPORT

6. Unscheduled Care is a cornerstone 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 mitigate against the impact of this, concerted effort across the whole system is needed to ensure person-centred safe, efficient and effective care.

7. HSCPs have collaborated to prepare the trajectories for the MSG indicators for 2019/20 and have taken a consistent approach in this exercise. It is important to note that Partnerships have agreed:

   - Baseline year – partnerships have agreed to continue to use 2015/16 as the baseline year as this is consistent with the approach partnerships have taken nationally and is the year before integration;
   - Not to include trajectories for under 18s as the Board wide unscheduled care programme and the unscheduled care work stream of Moving Forward Together is focused on adults. Partnerships do not have an unscheduled care programme for under 18s at this time, and the activity is not part of Set Aside arrangements.
   - That trajectories reflect existing programmes of work, some of which will come into full effect in 2019/20, rather than new programmes of work so a realistic approach has been applied in setting trajectories. Further inroads into reducing activity is only possible through a more ambitious programme of work that would require a resource shift to facilitate.

8. Since the baseline year of 2015/16, A&E attendances across all 6 HSCPs have increased. Across NHS Greater Glasgow & Clyde there are a range of workstreams 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.

9. Assuming the projected impact of this range of workstreams, the HSCPS are anticipating that activity levels can be returned to the 2015/16 level or marginally below, by March 2020. In some areas, this will require an improvement of up to 25%.

10. MSG performance indicators include:
    - Number of emergency admissions
    - Number of unscheduled hospital bed days; acute
    - Number of unscheduled hospital bed days; geriatric long stay
    - Number of unscheduled bed days, mental health
    - Number of A&E attendances
    - Delayed discharge bed days
    - Percentage of last 6 months of life spent in the community
    - Percentage of 65+ living at home (supported or unsupported)

11. The proposed East Renfrewshire HSCP targets for 2019/20 are outlined in the table below, along with baseline 2015/16 and performance to date. Appendix 1 outlines the activity planned to support performance.

	2015/16 Baseline (Av per month)	**2016/17 Number** (Av per month)	**17/18 Number** (Av per month)	**Indicative performance 2018/19** avg. Per month of data to date	**% reduction**	**Proposed Target 19/20** (avg)
Emergency Admissions	7,915 (660)	*8021* (669)	*7431* (619)	For 8 months to Nov 18 Av. 590	-10%	7,124 (594)
Unscheduled hospital bed days Acute	58,220 (4,852)	62,752 (5,646)	62,743 (5,229)	For 7 months to Oct 18 Av. 4,699	-2%	57,056 (4,755)
Unscheduled bed days Ger Long Stay	13,943 (1,162)	11,926 (994)	8,004 (667)	Mid-Yr fig 3,217 (Av. 1,609 per Quarter for Q1 and Q2)	-20%	11.154 (929)
Unscheduled hospital bed days MH	11,952 (996)	12,045 (1,004)	13,937 (1,161)	Mid-Yr fig 7,233 (Av. 3,617 per Quarter for Q1 and Q2)	0%	11,952 (996)
A&E Attendances	18,335 (1,528)	18,747 (1,562)	19,344 (1,612)	For 9 months to Dec 18 Av. 1,697	0%	18,335 (1,528)
Bed days lost to delayed discharge	2,366 (197)	2,704 (225)	1,860 (155)	For 8 months to Nov 18 Av. 200	-20%	1,893 (157)
Percentage of last 6 months of life spent in community (all ages)	85.6%	85.8	85.2	88% (Based on latest ISD data – Dec 18. No running figure published for MSG)	-0.1%	85.7%
Proportion of 65+ population living at home (supported and unsupported)	95.6%	95.7	95.9	No 18/19 data available yet	-0.1%	95.7%

12. Progress reporting and monitoring of performance against these trajectories will be included in local performance management arrangements and reported routinely at Greater Glasgow & Clyde level via the unscheduled care collaborative process.

CONSULTATION AND PARTNERSHIP WORKING

13. This work has been carried out in partnership between the 6 HSCPs within the Greater Glasgow & Clyde area and Acute Services.

IMPLICATIONS OF THE PROPOSALS

Finance

14. Long term considerations in relation to Set Aside

15. No other implications have been identified.

CONCLUSIONS

16. This report gives an overview of the work the HSCP is undertaking with partner HSCPs and acute services to reduce unscheduled care. The proposed East Renfrewshire HSCP targets for 2019/20, have been set from an analysis of performance since the 2015/16 baseline year and our expectations on the gains to be made from improvement activity along with developments underway.

RECOMMENDATIONS

17. Integration Joint Board members are asked to:
    - approve the 2019/20 Ministerial Strategic Group (MSG) targets
    - note the HSCP involvement in the wider Board unscheduled care programme development and delivery

REPORT AUTHOR AND PERSON TO CONTACT

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8 March 2019

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BACKGROUND PAPERS

IJB PAPER: 14.02.2018: Update on Unscheduled Care Plan
http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=21803&p=0

APPENDIX 1

MSG Unscheduled Care Action Plan

	2015/16 Baseline	ERHSCP Proposed Target 19/20	How will this be achieved
Emergency Admissions	7,915	-10% (7,124)	▪ Short Stay Intensive Rehabilitation ToC - AHP support within local authority care home aiming to prevent admission by proactive turnaround at the front door at ED/ARU and where possible preventing conveyance to A&E using local pathways. ▪ Implementation of Frailty score and Frailty & Falls Pathway development to support prevention and early intervention. ▪ Referral information for Hot Clinics and other community support services ▪ Advising Acute Consultants of services available in the community as alternatives to admission ▪ Anticipatory Care Planning approach standardised with a focus on transferring information to eKIS to support decision making at time of crisis
Unscheduled hospital bed days Acute	58,220	-2% (57,056)	
Unscheduled hospital bed days Geriatric Long Stay	13,943	-20% (11.154)	
Unscheduled hospital bed days Mental Health	11,952	0% (11,952)	
A&E Attendances	18,335	0% (18,335)	▪ Analyse data to identify repeat ED attendances at locality, cluster and GP practice level ▪ Engagement with local GP Practices to identify new pathways to support redirection ▪ Build on local Know Who to Turn To Campaign. ▪ Anticipatory Care Planning ▪ Boardwide redirection policy
Bed days lost to delayed discharge	2,366	-20% (1,893)	▪ Hospital to Home team implemented ▪ Delayed Discharge dashboard being proactively used along with improvement tools to support early in reach and effective discharge planning with individuals and their families. ▪ Choices meetings being fully utilised to support shared decision making ▪ Cross partnership working to look at AWI pathways ▪ Local AWI beds
Percentage of last 6 months of life spent in community (all ages)	85.6%	0.1 (85.7%)	▪ Palliative Care Group implemented and Action Plan developed ▪ Collaboratively working with PPW and Accord Hospices and wider stakeholders to develop a shared action plan to support palliative and end of life care in the community ▪ Cross partnership working to look at out of hours pathways.
Proportion of 65+ population living at home (supported and unsupported)	95.6	0.1 (95.7%)	▪ Progress redesign of care at home and telecare responsive services to increase capacity and flexibility