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	Integration Joint Board
Held on	14 February 2018
Agenda Item	11
Title	Update on Unscheduled Care Plan

Summary

This report updates the Integration Joint Board on Scottish Government request regarding unscheduled care update and details HSCP contribution to the Greater Glasgow and Clyde cross system work on unscheduled care planning.

Presented by	Candy Millard, Head of Strategic Services

Action Required

The Integration Joint Board is asked to:

- approve the East Renfrewshire HSCP Plan for Unscheduled Care for implementation from April 2018 for sharing with Scottish Ministers;
- note the HSCP's contribution to cross Greater Glasgow and Clyde whole system planning for unscheduled care.

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

☒ Finance/Efficiency	☒ Policy	☐ Legal	☐ Equalities
☐ Risk	☐ Staffing	☐ Property	☐ IT

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

14 February 2018

Report by Chief Officer

UPDATE ON UNSCHEDULED CARE PLAN

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 for 2017/18 and beyond.

RECOMMENDATION

2. The Integration Joint Board is asked to:
   - approve the East Renfrewshire HSCP Plan for Unscheduled Care for implementation from April 2018 for sharing with Scottish Ministers;
   - note the HSCP's contribution to cross Greater Glasgow and Clyde whole system planning for unscheduled care.

BACKGROUND

3. The Integration Joint Board is responsible for strategic commissioning for unscheduled care services for our East Renfrewshire population. The Integration Joint Board approved a commissioning strategy for unscheduled care at its meeting of 29 March 2017. Since East Renfrewshire is part of the complex NHS Greater Glasgow and Clyde acute hospital system, this set out a series of actions for the HSCP and a series of expectations of Acute unscheduled care hospital services, that were agreed across all Greater Glasgow and Clyde HSCPs. The report set out some expectations about bed day reductions but did not set out targets for all emergency admissions and bed days.

4. A paper to the Integration Joint Board in September 2017 informed members of a review of Unscheduled Care governance arrangements. The new structures, effective as of August 2017, ensure integrated working at a strategic and operational level between the Acute Division of the Board and HSCPs. At Sector level, the Delivery groups strengthen integrated working on a geographic basis. Through these groups we have been implementing and updating our unscheduled care plans, with a view to learning across the system and rolling out successful tests of change.

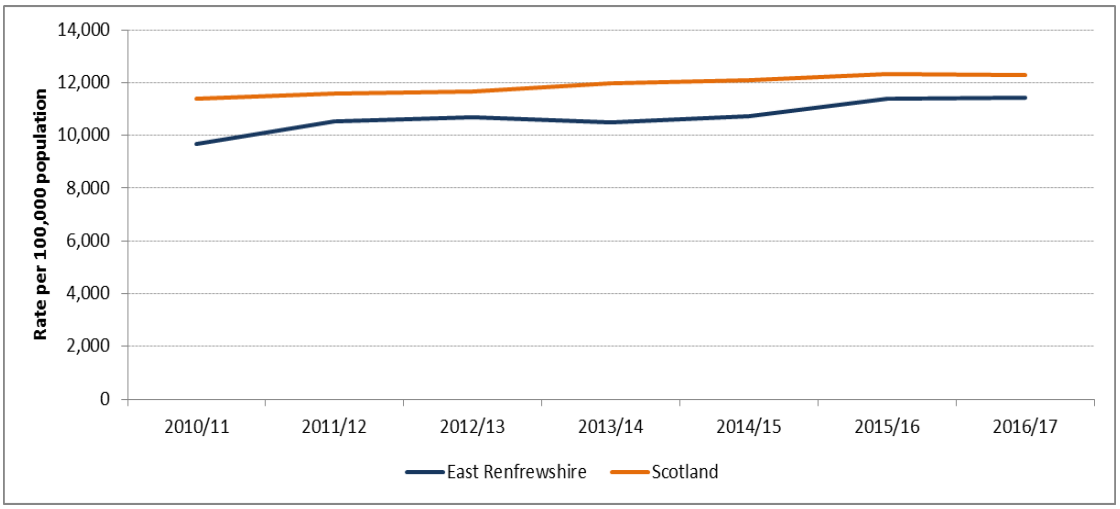
5. Appendix 1 contains a request from Scottish Government and Cosla that we continue to share our unscheduled care objectives and progress with the Ministerial Steering Group. To support this process they have issued draft guidance and a template for partnerships to follow, and have offered support through the Information Services Directorate with data and analysis. This report will set out our progress to date on the

objectives and propose an update to our objectives and plans drawing on our cross system unscheduled care planning work and commitments.

REPORT

Unplanned Admissions

6. East Renfrewshire's rate of emergency admissions is lower than the Scottish rate. However there is some indication that, in contrast to Scotland, admissions from East Renfrewshire were rising more quickly. Last year we had a lower rise than in 2015/16 of 0.67%. Each month our unplanned admissions to acute hospitals are around 750 patients but in the winter months this can rise to over 800. The winter of 2016/17 was mild with low prevalence of flu and norovirus, which impacted favourably on our figures, although we had a spike in admissions in March.



7. Management information for the first six months of 2017/18 indicates a lower admission rate than the previous year but in recent months we have seen an increase in admissions, potentially linked to flu and other respiratory conditions. Therefore our objective for 2017/18 is to halt the rise in emergency admissions and return to 2015/16 levels (759 admissions per month).

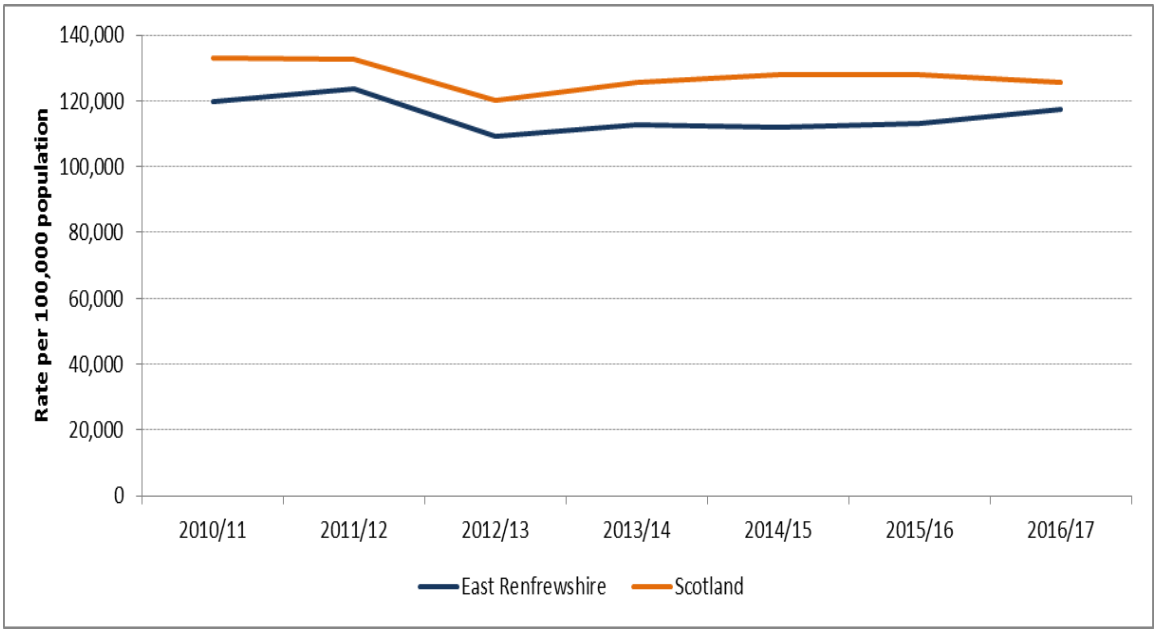
8. Admissions to hospital from East Renfrewshire care homes have seen a gradual increase. Although our admissions are lower than many other areas, our growing care home estate is a risk to us. We have commissioned work from colleagues in the independent sector to undertake a thorough piece of research with all stakeholders, including GPs and care homes, to help us understand what leads to an admission and what actions we might take together to support residents in their care home.

9. Reductions in unplanned admissions require clear condition specific pathways; we are undertaking a programme of work with colleagues across Greater Glasgow and Clyde to look at pathways for a range of conditions across primary and secondary care. This will build on the unplanned care work underway in acute hospital receiving, diverting patients at point of admission. We anticipate that this will enable us to deliver a 4% reduction on our emergency admissions: 2018/19 target of 8736 (728 per month).

10. In 2018/19, we will:
    - Continue to work in collaboration with medical staff in the Older Adult Assessment Unit at QEUH to avoid admission to downstream beds.
    - Review and redesign support to maintain people in care home environment
    - Undertake and implement integrated out of hours service review with Health and Social Care Partnership across Greater Glasgow and Clyde linking to local 24/7 responsive services

Occupied Bed Days

11. Our rate of occupied bed days increased in 2016/17 by 6.9%. Management information is showing that this increase is not continuing but we do not anticipate a significant reduction for 2017/18. Our objective is to reduce the 2016/17 figure by 2% reducing our bed days from 64041 to 62761.



12. As reported last year, over 10% of bed days are occupied by potentially preventable admissions. The top 3 reasons for admission identified in a recent analysis were COPD, Influenza and Cellulitis. We anticipate that the condition specific pathways work with colleagues across Greater Glasgow and Clyde will enable us to deliver a further 4% reduction in acute emergency bed days in 2018/19: target 60201.

13. In 2018/19, we will:
    - Maintain proactive HSCP hospital in reach activity
    - Participate in cross Greater Glasgow and Clyde programme of work to develop pathways for COPD, cellulitis, chest pain, self-harm, falls and abdominal pain
    - Work with colleagues in Glasgow and acute to develop an integrated acute/community COPD service

Accident and Emergency

14. East Renfrewshire A&E attendance is lowest across Greater Glasgow & Clyde. Between 2015/16 and 2016/17 there was an overall increase of 2.1% in accident and emergency attendances from East Renfrewshire. Current projections for 2017/18 show a 3-4% increase, however we need to explore whether this includes the use of the minor injuries units where we are redirecting patients to reduce demand on acute hospital sites.

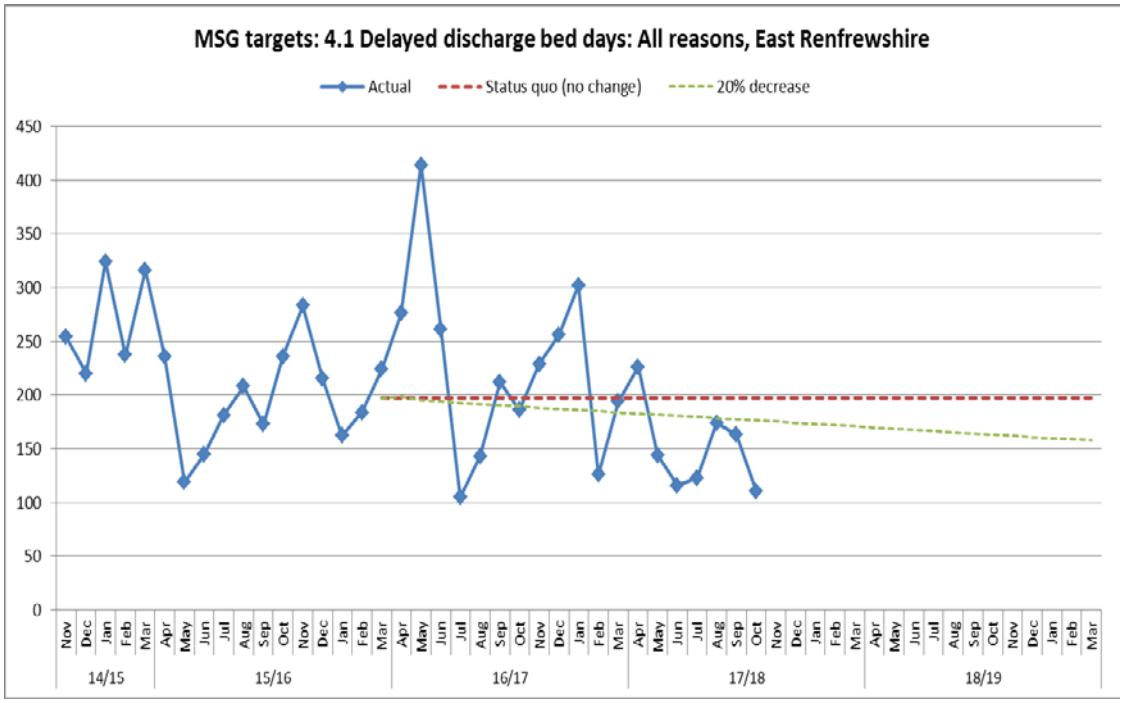
15. In 2018/19 we aim to continue to increase attendance at minor injuries units and halt the increase in accident and emergency attendances.

16. In 2018/19, we will achieve this through:
    - Work with GP clusters on Primary Care Strategy
    - Continue to work with GPs to divert frequent attenders with issues of social isolation and anxiety to link worker support freeing up GP appointments
    - Increase publicity about self-help and alternative supports including redirection to pharmacy and minor injuries units

Delayed Discharges

17. East Renfrewshire HSCP has significantly invested in reviewing 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. Our expectation for 2017/18 was that we would maintain our performance level, whilst our stretch aim was to cap our delayed discharges at 5, equivalent to 150 bed days lost per month.

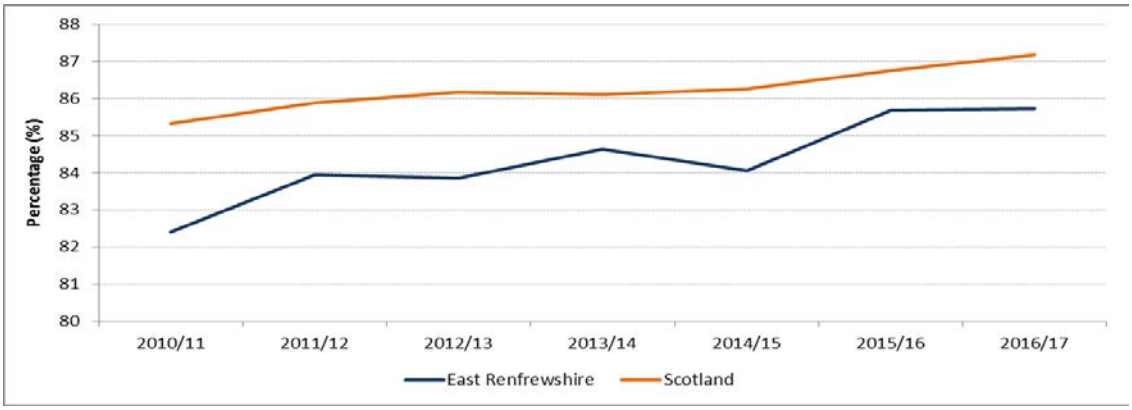
18. During 2017/18, we only exceeded our 5 delayed discharge performance figure in April. Since then despite having two highly complex adult cases we are on track to for a 20% decrease in delayed discharges.



19. Our target for 2018/19 should be to continue with the 20% reduction target, with our next aim a maximum of 4 delayed discharge or 120 bed days each month.
    - Continue use of dashboard information to anticipate older people approaching ready for discharge and actively plan with them and their families
    - Continue to promote Power of Attorney, through mental health and wider HSCP services offering support though Carers Centre

End of Life

20. 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. Across East Renfrewshire the percentage of residents who spent the last six months of life at home or in a community setting in 2016/17 was 85.8 compared with 85.7% in 2015/16 an increase of 0.1%. We anticipate that this will increase at a similar level in 2017/18.



21. 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 hospice. 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.

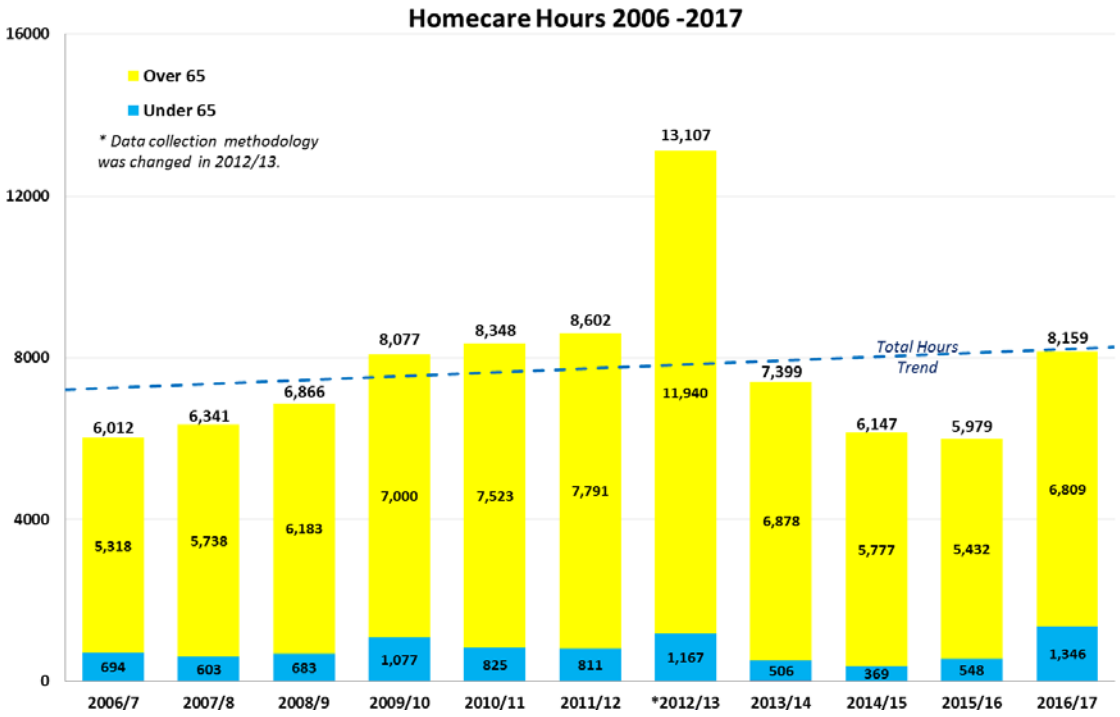
22. In 2018/19, we anticipate an increase in the percentage of residents who spend the last six months of life at home or in a community setting to 86%.

23. We will achieve this through:
    - Developing an additional 6 palliative care/end of life beds at Bonnyton House
    - Working in collaboration with local hospices to strengthen our supports to people in the community

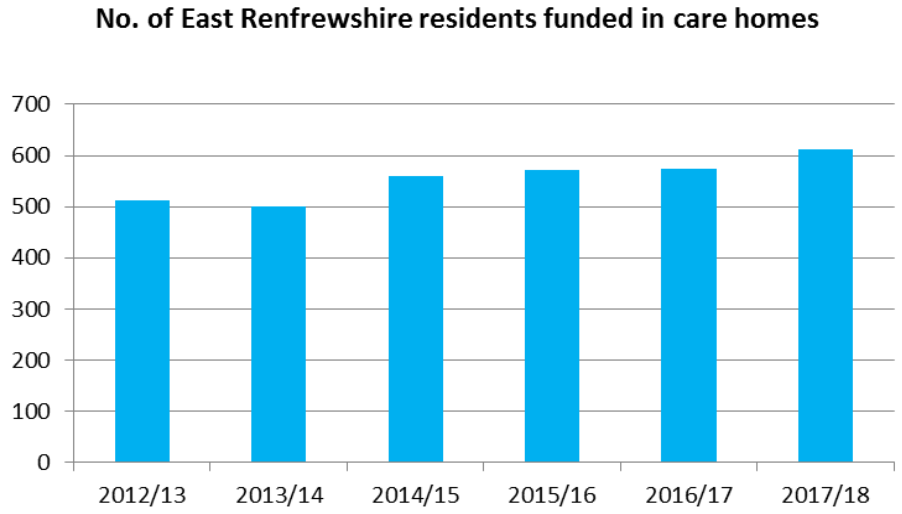
Balance of care across institutional and community services

24. The table overleaf 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 re-ablement and hospital discharge teams), which we have rectified for 2016/17.The chart below the table shows the actual trend in home care hours. We expect this to be reflected in the official statistics later this year.

	Setting	2013/2014	2014/2015	2015/2016
East Renfrewshire	Home (unsupported)	98.0%	98.0%	98.1%
East Renfrewshire	Home (supported)	1.1%	1.0%	0.9%
East Renfrewshire	Care home	0.6%	0.7%	0.7%
East Renfrewshire	Hospice/Palliative Care	0.0%	0.0%	0.0%
East Renfrewshire	Community hospital	0.0%	0.0%	0.0%
East Renfrewshire	Large hospital	0.3%	0.3%	0.3%



25. However we are seeing an increase in care home admissions as illustrated in the chart below that requires further exploration.



26. In 2018/19, we will:
    - Review care home admissions to understand increases
    - Progress redesign of care at home and telecare responsive services to increase capacity and flexibility

FINANCE AND EFFICIENCY

27. 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.

28. 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

CONSULTATION AND PARTENRSHIP WORKING

29. Our unscheduled care work is built on work developed in consultation with partners and staff through the Safe and Supported programme.

30. Partnership working and cross Greater Glasgow and Clyde Governance arrangements were described in the paper to the Integration Joint Board in September 2017 as described in paragraph 4 of this report.

IMPLICATIONS OF THE PROPOSALS

Policy

31. This Strategic Commissioning Plan responds to the policy expectations of the Scottish Government Health and Social Care Delivery Plan.

CONCLUSIONS

32. This report updates the Integration Joint Board on the Scottish Government Ministerial Steering Group and Cosla request regarding unscheduled care update. Whilst it is fully acknowledged that acute services are under pressure, it must be recognised that so are primary care and community services. 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

33. The Integration Joint Board is asked to:

- approve the East Renfrewshire HSCP Plan for Unscheduled Care for implementation from April 2018 for sharing with Scottish Ministers,
- note the HSCP's contribution to cross Greater Glasgow and Clyde whole system planning for unscheduled care.

REPORT AUTHOR AND PERSON TO CONTACT

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January 2018

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Scottish Government
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COSLA

To: Chief Officers Integration Authorities

22 November 2017

Dear Colleagues

UNDERSTANDING PROGRESS UNDER INTEGRATION

We are writing to provide you with an update on our work to develop a plan for sharing progress updates on integration with the Ministerial Strategic Group for Health and Community Care (MSG).

We wanted firstly to thank you for sharing your local objectives on the initial six indicators in February. As you know, we used this information to provide MSG with a summary overview of Integration Authority ambitions around these indicators, progress to date and some of the challenges facing Integration Authorities in delivering on their objectives. MSG appreciated the time you took in developing and sharing your local objectives to support them in their role in providing political leadership for, and oversight of, integration.

Since then we have been considering how best to provide regular progress updates to MSG. With the agreement of the Chief Officer network, we established a small working group comprising lead officers for strategic commissioning and performance in Integration Authorities, Chief Finance Officers, data analysts and SG officials. The group has met three times to discuss possible approaches and suggested a potential framework for providing future updates to the MSG. This framework is outlined below.

During our discussions, we've reflected in some detail on a number of issues, for instance, how best to balance the presentation of a manageable number of common data points for all areas with more bespoke narrative insights that can help to draw out the richness of local variation; how to explore specific themes such as end of life care; how to explore the quality of service user experience; how best to recognise normal fluctuations in performance, particularly between frequent reporting dates. We've also shared experiences on setting local objectives.

Based on the these discussions, the working group has suggested the following outline framework for sharing regular progress updates with MSG based on four key elements:

a) Quarterly data on the six indicators but in time building on these indicators for example to reflect the contribution of primary and social care.
b) Comparison between progress in Integration Authorities and projections set out in local plans, and also with the likely result had no changes been made
c) Overarching narrative summary, drawing out emerging themes from across Integration Authorities
d) Local illustrations, inviting individual Integration Authorities to contextualise their progress with a presentation to the group and opportunity for discussion. Over time we aim to involve a wide range of Integration Authorities depending on the purpose / theme of the MSG meeting.

Taking account of the proposed framework, we have agreed with the working group and Chief Officers that we will co-produce a paper providing an update on progress for the next MSG meeting on 13 December, drawing on the recent annual performance reports, and will invite one or two partnerships to present at the meeting.

Beyond this meeting, we have agreed with the working group and Chief Officers that it would be helpful to provide MSG with an updated overview of local objectives and ambitions relating to the six indicators. We are aware that some Integration Authorities will have reviewed and updated their objectives since sharing them in February. You are therefore each invited to share your updated objectives for 2018/19 by 31 January 2018, following which we will provide an overview, with input and support from the working group and partnerships, for MSG for their meeting on 21 March 2018. We recognise that, as before, you will want to engage a range of partners in this process.

To support the process, we have developed draft guidance and a suggested format for sharing objectives with advice from the working group, ISD and others. This should help to simplify the task locally and will provide consistency across information shared. As before we would anticipate that there would be local support for developing objectives from the LIST team and other local analysts drawing on collective advice on best practice around developing objectives.

We will work with the working group and Chief Officers to expand the range of indicators used going forward. In view of the move to a single national social care dataset, we have agreed with the working group that we should feed in views around about the social care data collected to ensure that it provides intelligence which supports the planning and delivery of integrated services.

We would be grateful if you would provide your updated 2018/19 local objectives for MSG by 31 January 2018 to be sent to NSS.Source@nhs.net. We recognise that you will want to agree these objectives with your IJB, so if that is not possible within the timescale, we would be happy to accept interim objectives. We would welcome any feedback on this approach and the guidance – please contact my colleague Fee Hodgkiss fiona.hodgkiss@gov.scot or 0131 244 5429.

Yours faithfully

Alison Taylor Paula McLeay

Alison Taylor
Deputy Director
Integration Division

Paula McLeay
Chief Officer Health and Social Care
COSLA

East Renfrewshire HSCP	Unplanned admissions	Unplanned bed days	A&E attendances	Delayed discharge bed days	Last 6 months of life	Balance of Care
Baseline	15/16 Fin Year (Total Number of Unplanned Admissions) **N =9,107** 16/17 Fin Year (Total Number of Unplanned Admissions) **N = 9,168** Percentage Increase **0.67%**	15/16 Fin Year (Total Number of Unplanned Bed Days - Acute) **N = 59,930** 16/17 Fin Year (Total Number of Unplanned Bed Days - Acute) **N=64,041** Percentage Change – Acute **Increase of 6.9%** Quarter Ending Mar 16 (Total Number of Unplanned Bed Days – Mental Health) **N = 3,300** Quarter Ending Mar 17 (Total Number of Unplanned Bed Days – Mental Health) **N=3,123** Percentage Change	15/16 Total Number of Attendances at A&E **N = 25,300** 16/17 Total Number of Attendances at A&E **N = 25,812** Percentage Increase **Increase of 2.1%**	15/16 Total Number of Delayed Discharge Bed Days (All Reasons) **N = 2,366** 16/17 Total Number of Delayed Discharge Bed Days (All Reasons) **N=2,704** Percentage Increase **Increase of 14.3%**	15/16 Percentage of Last 6 Months of Life by Setting **Community 85.7%** **Hospice/ Palliative Care unit 0.5%** **Community Hospital 0%** **Large Hospital 13.8%** 16/17 Percentage of Last 6 Months of Life by Setting **Community 85.8%** **Hospice/ Palliative Care unit 0.4%** **Community Hospital 0%** **Large Hospital 13.8%** Percentage Changes **Community 0.1% Increase** **Hospice/ Palliative Care unit 0.1% Decrease** **Community Hospital 0%**	Almost no change at all in balance of care between 14/15 and 15/16 for all ages. 98.1% unsupported at home (up 0.1%). Slight change for those aged 75+ as lower percentage of population home supported, 9.4% down to 7.9%. Resultant increase in unsupported at home from 82% to 83.6%.

		– MH **Decrease of 5.4%** Quarter Ending Mar 16 (Total Number of Unplanned Bed Days – GLS) **N 2,807** Quarter Ending Mar 17 (Total Number of Unplanned Bed Days – GLS) **N=1,535** Percentage Change – GLS **Decrease of 45.3%**			**Constant** **Large Hospital 0%** **Constant**	
Objective	Halt rise in emergency admissions for 2017/18 and return to 2015/16 baseline of 9107 (759 per month). Reduce admissions by 4% in 2018/19 target of 8736 (728 per month).	Reduce the 2016/17 acute unplanned bed day figure by 2% in 2017/18 reducing our bed days from 64041 to 62761. In 2018/19 we will reduce this by a further 4%to 60201. This will bring us closer to our 2015/16 baseline.	Shift balance to increased minor injuries unit attendance and reduced And E attendances.	Our stretch aim was for 2017/18 was to cap our delayed discharges at 5, equivalent to 150 bed days lost per month. We are on track for a 20% reduction in delayed discharges. Our target for 2018/19 is to continue with the 20% reduction	Increase to 85.9% in 2017/18 and to 86% in 2018/19.	Rebalance the supported/unsupported at home to baseline level.

				target, with our next aim a maximum of 4 delayed discharge or 120 bed days each month.		
How will it be achieved	Continue to work in collaboration with medical staff in the Older Adult Assessment Unit at QEUH to avoid admission to downstream beds. Review and redesign support to maintain people in care home environment Undertake and implement integrated out of hours service review with Health and Social Care Partnership across Greater Glasgow and Clyde linking to local 24/7 responsive services	Maintain proactive HSCP hospital in reach activity. Participate in cross Greater Glasgow and Clyde programme of work to develop pathways for COPD, cellulitis, chest pain, self-harm, falls and abdominal pain Work with colleagues in Glasgow and acute to develop an integrated acute /community COPD service.	Work with GP clusters on Primary Care Strategy Continue to work with GPs to divert frequent attenders with issues of social isolation and anxiety to link worker support freeing up GP appointments Increase publicity about self-help and alternative supports including redirection to pharmacy and minor injuries units	Continue use of dashboard information to anticipate older people approaching ready for discharge and actively plan with them and their families Continue to promote Power of Attorney, through mental health and wider HSCP services offering support though Carers Centre	Develop an additional 6 palliative care/end of life beds at Bonnyton House. Work in collaboration with local hospices to strengthen our supports to people in the community.	Review care home admissions to understand increases. Progress redesign of care at home and telecare responsive services to increase capacity and flexibility.

Progress (updated by ISD)						
Notes			Between 2015/16 and 2016/17 there was an overall increase of 2.1% in accident and emergency attendances from East Renfrewshire. Current projections for 2017/18 show a 3-4% increase, however we need to explore whether this includes the use of the minor injuries units where we are redirecting patients to reduce demand on acute hospital sites.			There was some underreporting of care at home in the 2015/16 social care return. We have rectified this in the 2016/17 return which should rebalance the supported/ unsupported at home statistic.