AGENDA ITEM No.9

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 29 March 2017
Agenda Item	9
Title	Strategic Commissioning Plan for Unscheduled Care

Summary

This report updates the Integration Joint Board on Scottish Government expectations regarding unscheduled care and details HSCP and cross system work to develop a commissioning strategy for unscheduled care for 2017/18 and beyond.

Presented by	Candy Millard, Head of Strategic Services

Action Required

The Integration Joint Board is asked to:

- Approve the East Renfrewshire Strategic Commissioning Plan for Unscheduled Care for implementation from April 2017;
- Endorse the HSCP's commitment to cross Greater Glasgow and Clyde whole system planning to further develop and implement shifts in the balance of care.

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

☒ Financial	☒ Policy	☐ Legal	☐ Equalities
☐ Efficient Government	☐ Staffing	☐ Property	☐ IT

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

29 March 2017

Report by Chief Officer

STRATEGIC COMMISSIONING PLAN FOR UNSCHEDULED CARE

PURPOSE OF REPORT

1. This report updates the Integration Joint Board on Scottish Government expectations regarding unscheduled care and cross system work to develop a commissioning strategy for unscheduled care for 2017/18 and beyond.

RECOMMENDATION

2. The Integration Joint Board is asked to:
   - Approve the East Renfrewshire Strategic Commissioning Plan for Unscheduled Care for implementation from April 2017;
   - Endorse the HSCP's commitment to cross Greater Glasgow and Clyde whole system planning to further develop and implement shifts in the balance of care.

BACKGROUND

3. The Integration Joint Board is responsible for strategic commissioning for unscheduled care services for our East Renfrewshire population. As an area with a ten year history of integrated health and social care and a strong commitment to reshaping care for older people; East Renfrewshire has already redesigned local services with a focus on prevention, anticipatory care, rehabilitation and recovery, whilst delivering considerable management and efficiency savings. Throughout this period we have demonstrated a strong performance on delayed discharge and lost bed days.

4. One of the key factors in our strategic needs assessment is that East Renfrewshire has an ageing population with increasing life expectancy. The most marked population increase will be in our 80-84 and over 85 age groups. This increase is most marked in our Eastwood localities. These oldest residents are most likely to experience increased ill-health and disability, coupled with issues around mental health and isolation. As a result of this they are the greatest users of health and social care services.

5. Planning for delayed discharge and unscheduled care was identified as a priority area by the Strategic Planning Group. When we were made aware of the new funding earlier in 2016, we took the opportunity to review how we were currently managing discharges from hospital. We decided to take a broader view of discharge, looking at it as a process, beginning when people were still at home, rather than a single discharge event. We have called this area of work Safe and Supported rather than delayed discharge to emphasise this wider approach.

6. We set up four 'Safe and Supported' work groups to develop proposals for tests of change using improvement methodology.
   a) Prevention and Anticipatory Care
   b) Point of Possible Admission
   c) During Admission
   d) Discharge from Hospital

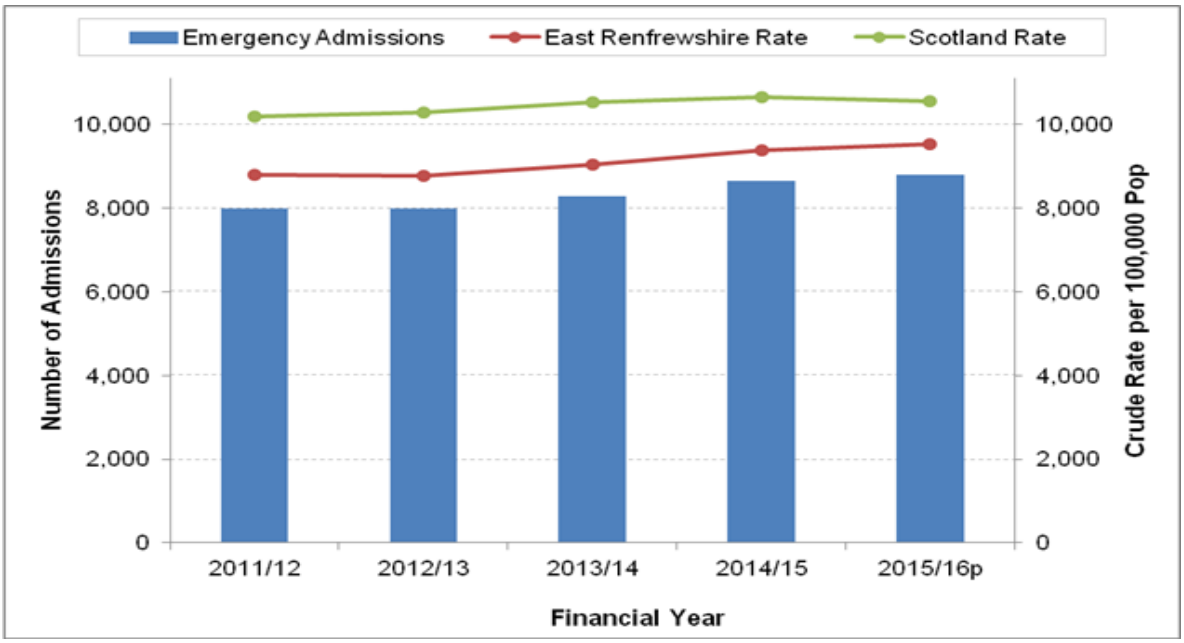
7. These task and finish groups which included third sector, independent sector, carers, health and social care staff and managers, GPs and acute clinicians identified a range of additional improvement opportunities for us to test. These tests are included in the commissioning strategy below.

8. East Renfrewshire is part of the complex NHS Greater Glasgow and Clyde acute hospital system. Our Health and Social Care Partnership has been working with the five other Health and Social Care Partnerships, NHSGGC Acute Services and NHS Health Board planning to ensure that we can develop an overarching Strategic Plan for Acute Services and work together to co-ordinate capacity and resource levels required for the Set Aside budget. A series of whole system planning meetings and workshops have been held over the last year to share data, benchmarking findings, commissioning intentions and improvement plans.

REPORT

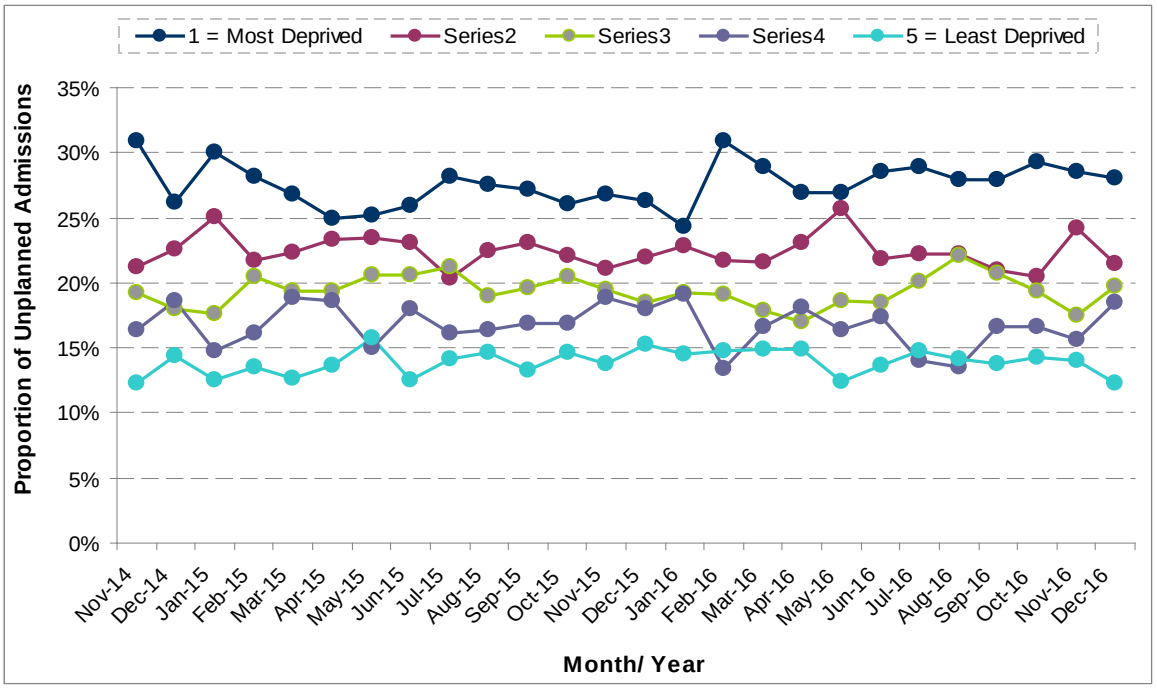
Unplanned Admissions

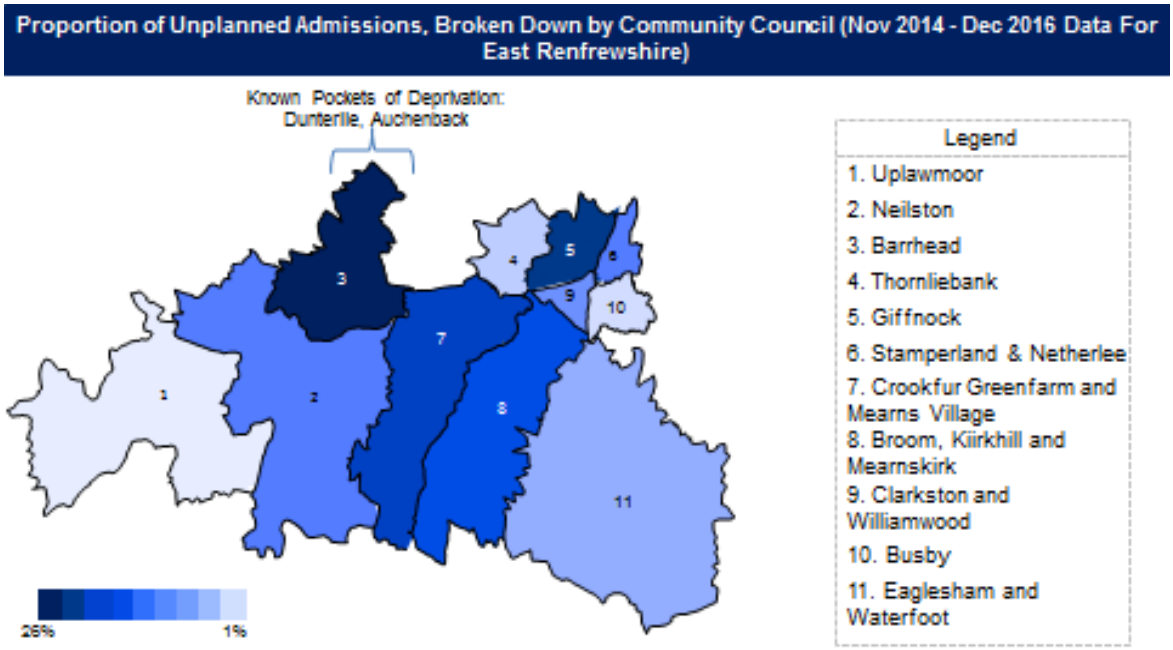
9. East Renfrewshire's rate of emergency admissions is lower than the Scottish rate. However there is some indication that in contrast to Scotland admissions from East Renfrewshire are rising. This is shown in the chart below:



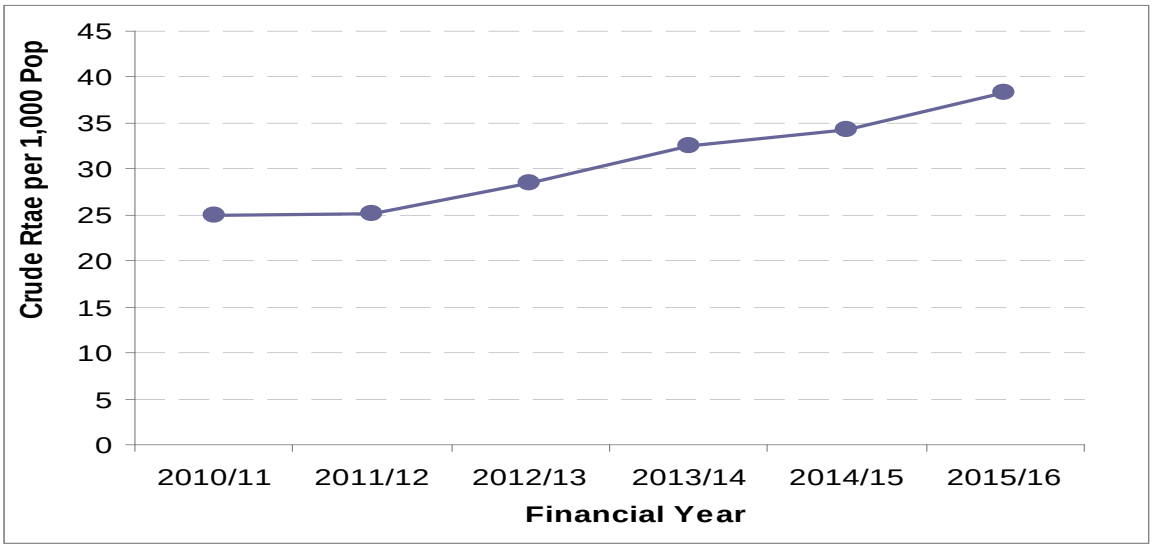
Source: ISD Scotland. These data were extracted from SMR01 in September 2015. p: provisional

10. Within East Renfrewshire a greater number of unplanned admissions are from related to deprivation, but there are variations by locality that require further exploration with our GP clusters.





11. Admissions to Hospital from East Renfrewshire Care Homes have seen a gradual increase since 2011/12 to 2015/16, as illustrated in the chart below. This is in the context of an increase in care home beds in East Renfrewshire and reduction in NHS continuing care beds. There is variation in admission rates between Care Homes which requires further exploration.

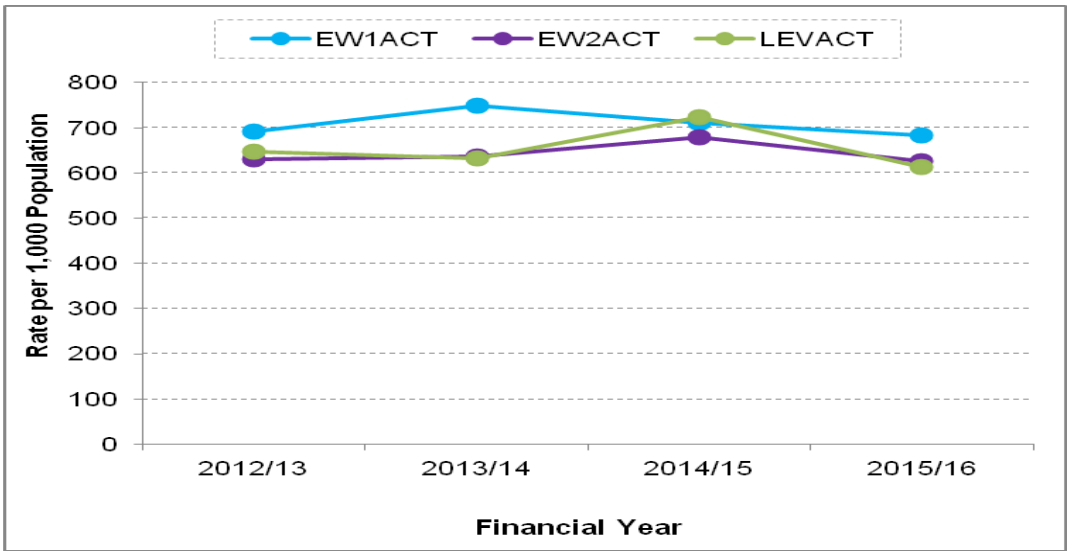


12. In 2017/18, we will work in partnership with GPs and acute colleagues to have a targeted approach to reducing the emergency admission rate. This will include developing and testing a range of step up models; immediate response for people at risk of acute admission and diversion work at point of admission.

Within Primary Care and Community Setting	Acute Setting
▪ HSCP Hospital Connector work in collaboration with medical staff in the Older Adult Assessment Unit at QEUH to avoid admission to downstream beds ▪ Sharing of Practice Activity Reports and other data with GPs to review use of acute service via GP cluster monthly meetings. ▪ 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 ▪ Monitor care@home and responder service responsiveness and step up capacity as required ▪ Fit for the Future end to end service review and pathway redesign with support of TRIST (Tailored Response Improvement Support Team)	▪ Establish mechanisms whereby GPs can access advice from senior acute medical staff pre-admission relating to the need for admission and/or options other than admission. ▪ HSCPs and acute services will identify a joint scoring matrix for identifying patients at risk of unnecessary admission. ▪ Establish a consistent system whereby HSCPs are alerted by acute services, at the point of admission, of all patients identified as at risk of unnecessary admission. ▪ Establish GP access to a range of options for patients at the point of pre-admission, for example urgent next day outpatient appointment by speciality and direct access to diagnostics. ▪ Review and optimise admissions pathways across acute sites with a view to reduce inappropriate variation.

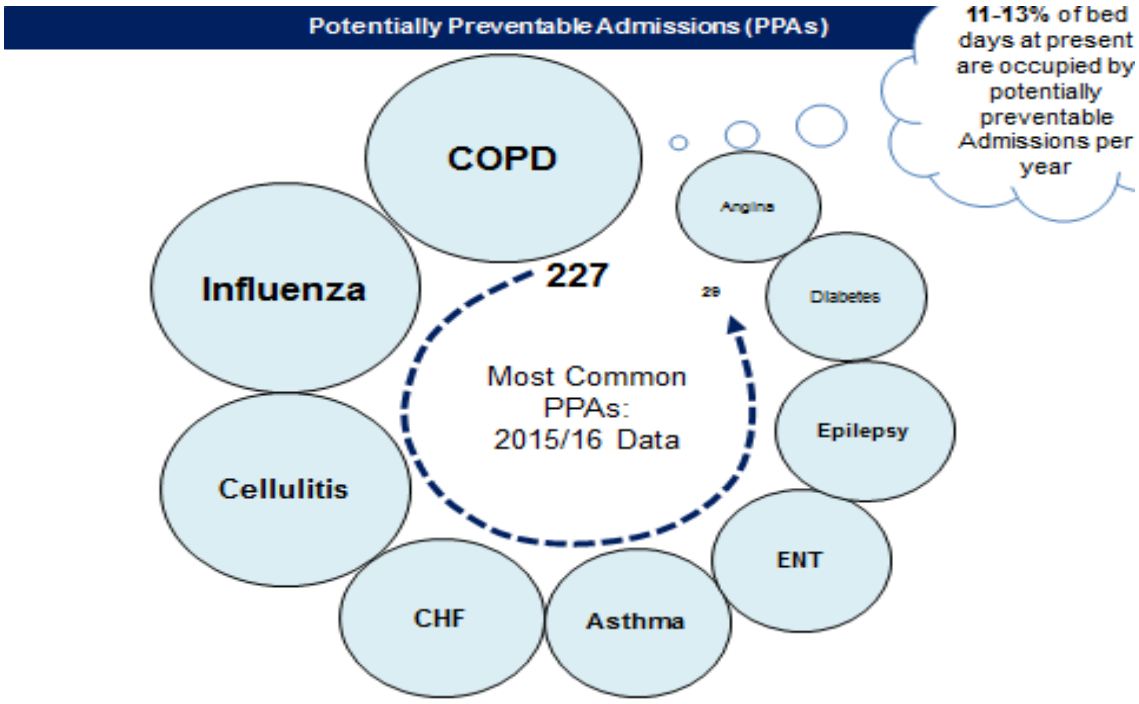
Occupied Bed Days

13. There is variation in the occupied bed days across our localities. Whilst our Levern Valley locality has the highest number of emergency admissions, the number of bed days occupied is less than the other localities. This would appear to be due to a younger population however further analysis is required. The chart below illustrates the variation in occupied bed day rate across the 3 localities.



ISD

14. Over 10% of bed days are occupied by potentially preventable Admissions per year. The top 3 reasons for admission identified in a recent analysis are COPD, Influenza and Cellulitis. This offers opportunities to support these individuals at home using anticipatory care planning.



15. In 2017/18, we will work with acute services to focus on reducing the number of occupied bed days. As an HSCP we will intensify our in reach activity and focus on shared care pathways for people with potentially preventable conditions. Our expectation is that acute services will develop and implements plans for achieving reduced lengths of stay.

Within Primary Care and Community Setting	Acute Setting
▪ Maintain proactive HSCP hospital in reach activity. robust intermediate care criteria ▪ Review of High Resource Individuals at population and individual level to understand and improve complex patient journeys ▪ Develop integrated local COPD supports maximising use of telehealth and telecare to support people at home ▪ Focus Advanced Nurse Practitioner time on complex discharges at risk of readmissions and potentially preventable admission conditions	▪ Acute Services to demonstrate progress in working towards delivering the externally benchmarked upper quartile length of stay across all sites and specialties. ▪ Optimise discharge processes across all sites and specialties to create an earlier in the day discharge profile and increase weekend discharges.

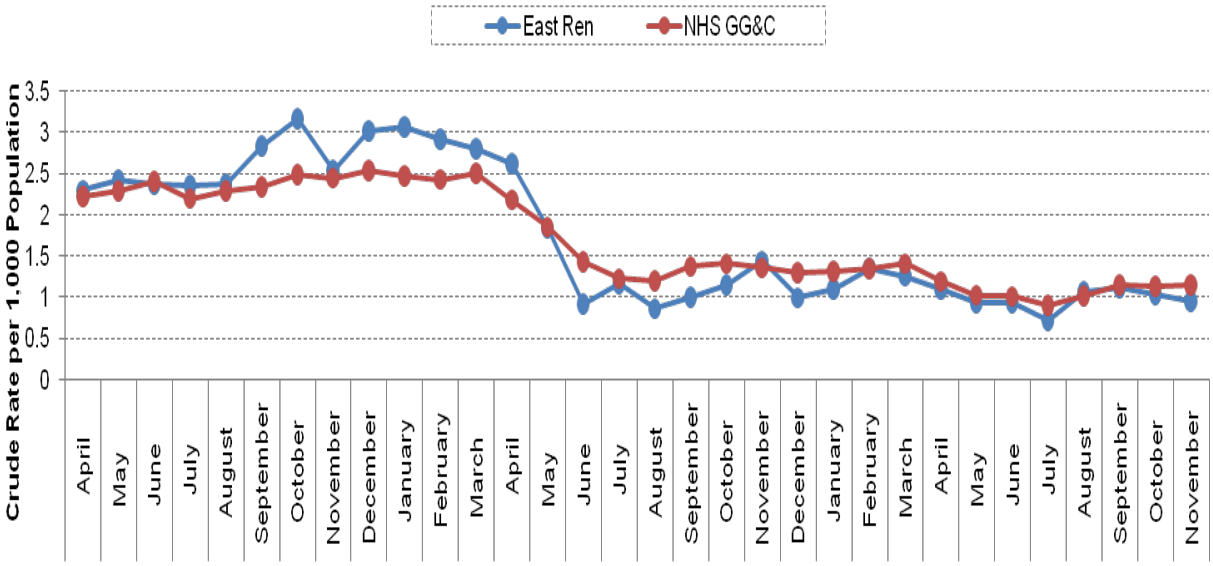
Accident and Emergency

16. East Renfrewshire A&E attendance is lowest across Greater Glasgow & Clyde, as shown in the table below:

	Jan 15 – Dec 15	Jan 16 – Dec 16
East Dunbartonshire HSCP	1424	1447
East Renfrewshire HSCP	1518	1435
Inverclyde HSCP	2976	3096
Renfrewshire HSCP	2639	2730
West Dunbartonshire HSCP	1574	1562
Glasgow City HSCP	2377	2303
All Greater Glasgow and Clyde	2650	2533

Source: ISD Scotland

17. East Renfrewshire patients attending A&E after a GP assessment has been just below the Greater Glasgow & Clyde rate since June 2015.



18. A total of 18,023 A&E attendances occurred in hours, 25.4% of those presenting were admitted, 10,148 A&E attendances which occurred Out-Of-Hours 30.8% were admitted. Arrival by ambulance was the second most popular mode of transport.

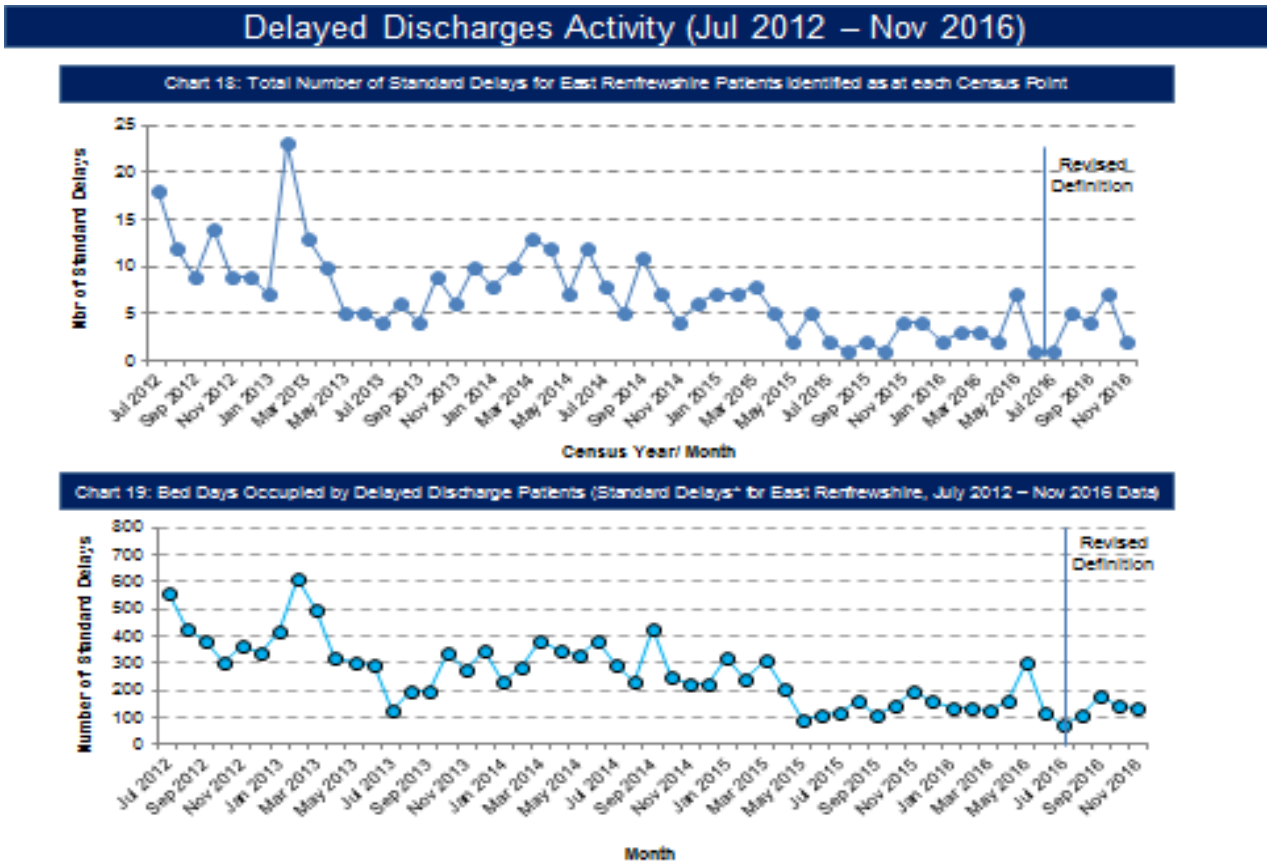
19. In 2017/18, we will work with acute services, Independent Contractors and voluntary sector partners to focus on reducing attendance at A&E services actively promoting alternative pathways and services. We expect acute services to redirect people attending accident and emergency departments inappropriately.

Within Primary Care and Community Setting	Acute Setting
▪ Work with GP clusters on access, triage models and alternative pathways/signposting ▪ 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 in community ▪ Developing Telecare Responder Service and upskill staff to respond to wider emergencies including non-injured fallers.	▪ Create and implement redirection pathway back to minor injury units and primary care. (Note: recognise that HSCPs need to agree with GP Quality Clusters and/or LMC [via Primary Care Support] a process for seeing redirected patients). ▪ Review the balance of staffing in A&E departments to ensure that frail older patients have speedy access to appropriate clinical support and imaging and investigations. ▪ Establish a process whereby GPs are able to access agreed imaging investigations to support diagnosis and decision-making.

Delayed Discharges

20. East Renfrewshire HSCP and the former CHCP 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. Whilst our stretch aim is to reduce the time people spend in hospital for this indicator we aim to maintain our current performance level.

21. In 2017/18, we will continue to prioritise and sustain effective and safe discharge to maintain and reduce the number of bed days lost due to delayed discharge. We will continue to invest in our integrated teams, inreach and connector activity.

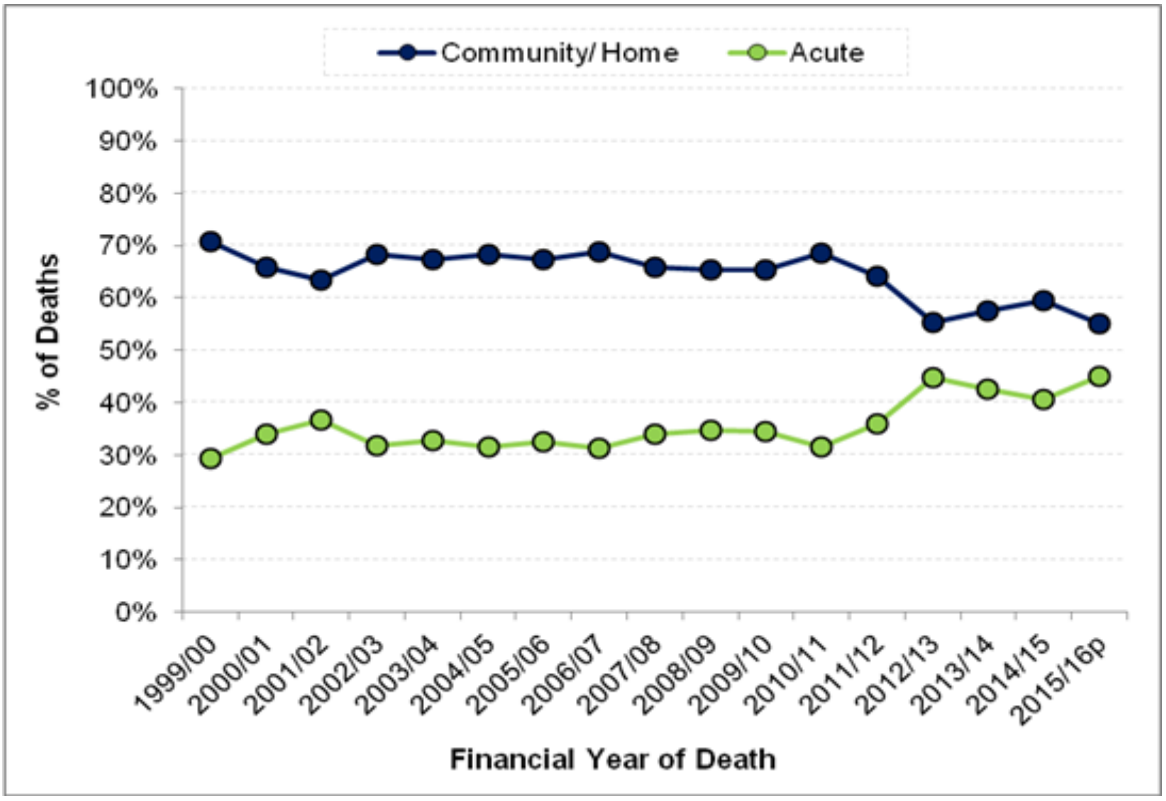


Within Primary Care and Community Setting	Acute Setting
▪ Ensure community staff routinely use anticipatory care plans with summary recorded on ekiss. ▪ Review Safe and Supported tests of change and pathways including inreach, connector and medicines management ▪ Proactively promote Power of Attorney, through mental health and wider HSCP services offering support though Carers Centre	▪ Establish a system whereby community staff, SSA and acute clinicians routinely use anticipatory care plans and the summary recorded on ekiss as part of assessment process to avoid admission and to expedite discharge. ▪ Strengthen discharge planning between acute discharge planning and community hospital teams including rehabilitation communication.

End of Life

22. Across East Renfrewshire the percentage of residents who spent the last six months of life at home or in a community setting in 2014/15 was 84.2%, compared with 84.7% across Greater Glasgow & Clyde. However over recent years the percentage of deaths occurring in acute hospital has increased. On average East Renfrewshire patients spend 6-10 days in hospital prior to death. (ISD Publication Percentage of End of Life Spent at Home or in a Community Setting, August 2016)

Percentage of Deaths not Resulting from an External Cause*, Broken Down by Location and Financial Year of Death (East Renfrewshire data)

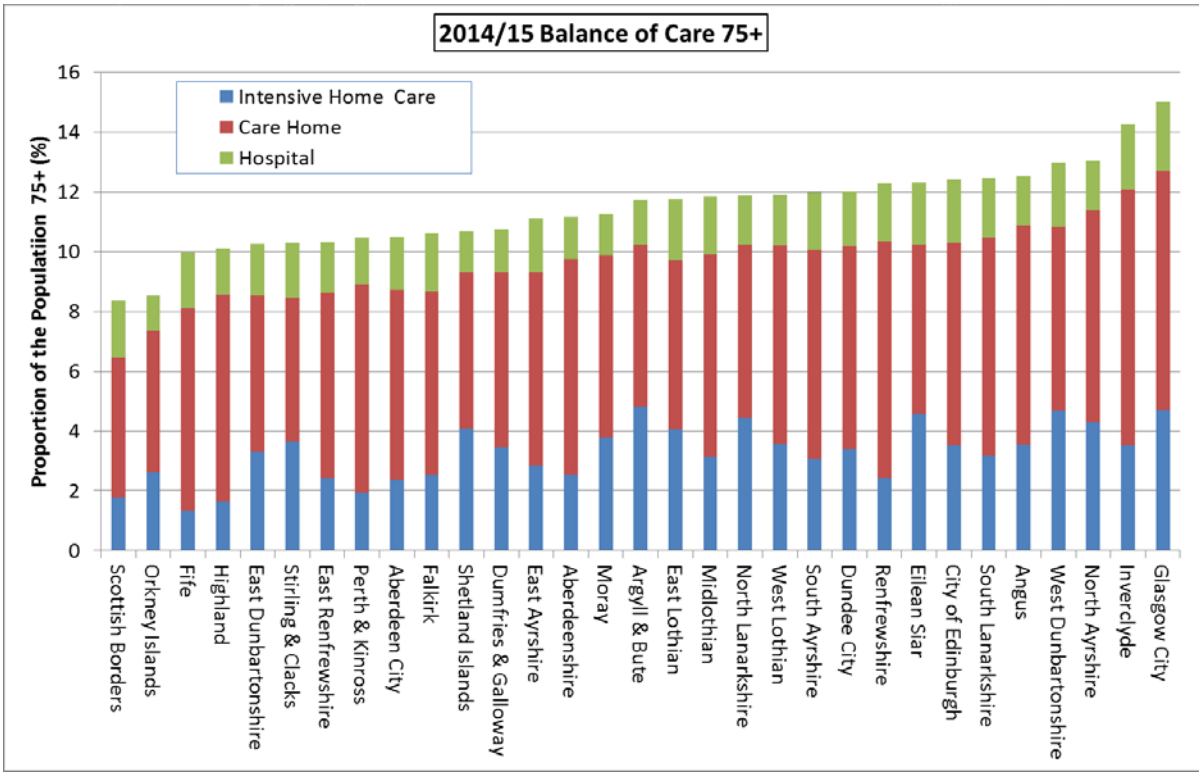


23. In 2017/18, we will work in partnership with GPs, local hospices and our Care Homes to support people to die at home or in a homely community setting.

Within Primary Care and Community Setting	Acute Setting
▪ Work with care homes to support end of life care ▪ Introduce satellite hospice palliative care clinic in Health and Care Centre	▪ Establish a consistent system in place whereby HSCPs are given early notice by Acute Services of patients who require end of life care.

Balance of spend across institutional and community services

24. The balance of care performance draws on social care data that does not account for number of older peoples' homecare packages which are provided through Self Directed Support (approximately 80 of people recorded as SDS Option 2 are over 65). 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.



25. In 2017/18, we have already committed to work in partnership with acute and Other Health and Social through reduced demand generated by the redefinition of eligibility for NHS continuing complex care. Further benchmarking and modelling work will be carried out across the NHS GGC system.

Within Primary Care and Community Setting	Acute Setting
▪ Carry out benchmarking work with other HSCP areas and review alternative models which contribute to a shift in the balance of care.	▪ Acute services to review and ensure effective medicines management at point of admission and discharge. ▪ Agree a way of working between acute sites and all six HSCP community services through which a proportion of set aside budgets is used to support development of interface services out-with acute sites.

26. Through the actions described in the sections above, we expect to see the following changes and improvements in services:

- A reduction in the level of admission to hospital from care homes by 20% (2 beds)
  - Average number of unplanned admissions from a care home in East Ren recorded in the last 5 years = 288
  - Average length of stay for an East Ren PPA = 10.1 days (between 2011/12 -2015/16)
  - 20% reduction in our unplanned admissions from care homes from 288 to 230
  - If average length of stay for an East Ren PPA is 10.1 days, then this reduction will have saved (58*10.1) = 586 bed days, i.e. 2 beds.

- Capping the level of delayed discharges at 5 (since 2012/13 a saving of 10 beds)

Financial Year	Bed Days Occupied by Delays (excluding code 9's)	Nbr of Beds Occupied
2012/13	5643	15
2013/14	3282	9
2014/15	3578	10
2015/16	1682	5

- Reduction in potential preventable admissions by 25 % (6 beds)
  - Average number of PPA's recorded in the last 5 years for East Ren = 1289
  - Average length of stay for an East Ren PPA = 7.3 days (between 2011/12 -2015/16)
  - 25% reduction from 1289 to 967 (a reduction of 322 PPA's)
  - If average length of stay for an East Ren PPA is 7.3 days, then this reduction will have saved (322*7.3) = 2,351 bed days, i.e. 6 beds

- A reduction in the number of people who die in hospital at 40%.

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, but our commissioning strategy will require this to become an actual budget.

28. We are discussing a percentage target of reduction in the overall set aside budget in 2017/18, thereby delivering significant savings and potential redirection to the HSCP. It is likely that this will require a reduction in acute inpatient beds across a number of hospital sites, as the programme's impacts are realised. The bed calculations in the section above are HSCP planning assumptions that require testing and modelling as part of the wider NHSGGC whole system approach.

CONSULTATION

29. These commissioning intentions build on work developed in consultation with partners and staff through the Safe and Supported programme. Strategic planning group session have been held on
    - Clinical Services Strategy
    - Care Home Market and Institutional Care
    - Acute Planning and Commissioning

PARTNERSHIP WORKING

30. In line with the Integration Scheme there has been joint partnership working between Chief Officers and between HSCP and Acute planning and clinical colleagues.
    - Whole System Planning Group
    - Chief Officers Meeting
    - Clinical Senate
    - Queen Elizabeth University Hospital Interface Meeting

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. East Renfrewshire has made significant progress in reducing bed days lost to delayed discharge and with Acute colleagues has contributed to reducing lengths of stays. Having analysed the data with ISD support we consider that there are further opportunities to reduce unscheduled care bed days. As an HSCP this will require us to build on our Safe and Supported improvement programme, working together to develop and implement further tests of change to deliver the commissioning plan. It will also require the acute services to implement the commissioning directions, which are consistent across the partnerships in Greater Glasgow and Clyde area.

33. 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.

RECOMMENDATIONS

34. The Integration Joint Board is asked to:
    - Approve the East Renfrewshire Strategic Commissioning Plan for Unscheduled Care for implementation from April 2017;
    - Endorse the HSCP's commitment to cross Greater Glasgow and Clyde whole system planning to further develop and implement shifts in the balance of care.

REPORT AUTHOR AND PERSON TO CONTACT

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28 February 2017

KEY WORDS

A report detailing the IJBs commissioning intentions for unscheduled care.

acute care, unplanned admissions, unscheduled care, hospital discharge, accident and emergency; commissioning, strategic plan