To:	**Renfrewshire Integration Joint Board**
On:	**20 March 2020**

Report by: **Chief Officer**

Subject: **Performance Management Report: Unscheduled Care**

1. Summary

1.1 The purpose of this report is to update on Renfrewshire Health and Social Care Partnership's (HSCP) performance against the six Scottish Government Ministerial Strategy Group (MSG) 2019/20 targets for unscheduled care.

2. Recommendations

It is recommended the IJB note:

- the NHSGGC Strategic Commissioning Plan for Unscheduled Care Services will be presented at the June 2019 Integration Joint Board meeting'; and
- Renfrewshire HSCP's performance against the Ministerial Strategy Group (MSG) for 2019/20 and the ongoing work to reduce our reliance on unscheduled care.

3. Background

3.1 Unscheduled care is the unplanned treatment and care of a patient, usually as a result of an emergency or urgent event. Most of the focus on unscheduled care is on accident and emergency attendances and emergency admissions to hospital.

3.2 Unscheduled care is an important area of focus for Renfrewshire HSCP, working in partnership with NHSGGC Acute and local Primary Care Services. The IJB had a 'set aside' budget of £31,242k in 2019/20 for commissioning unscheduled care however, to date there has been no scope to use the budget differently.

3.3 The health and social care system in Greater Glasgow and Clyde is facing unprecedented levels of demand. The demand for acute hospital services has increased by 4.2% since 2017/18 and there is also evidence that people are using A&E services more now than previously.

3.4 With an ageing population, and changes in how and when people choose to access services, transformation is required in order to meet patients' needs in different ways and for the public understand better how to use services.

3.5 NHS Greater Glasgow and Clyde Health and Social Care Partnerships, in partnership with secondary care colleagues and other third and independent partners are currently producing a draft Strategic Commissioning Plan for adult (18+) Unscheduled Care Services across the Board area. The plan 'The Challenge is Change' is part of the Moving Forward Together programme and will support people better in the community; develop alternatives to hospital care; and create new ones to safely reduce the over reliance on unscheduled care services. The final Plan will be presented for approval to the IJB in June 2020.

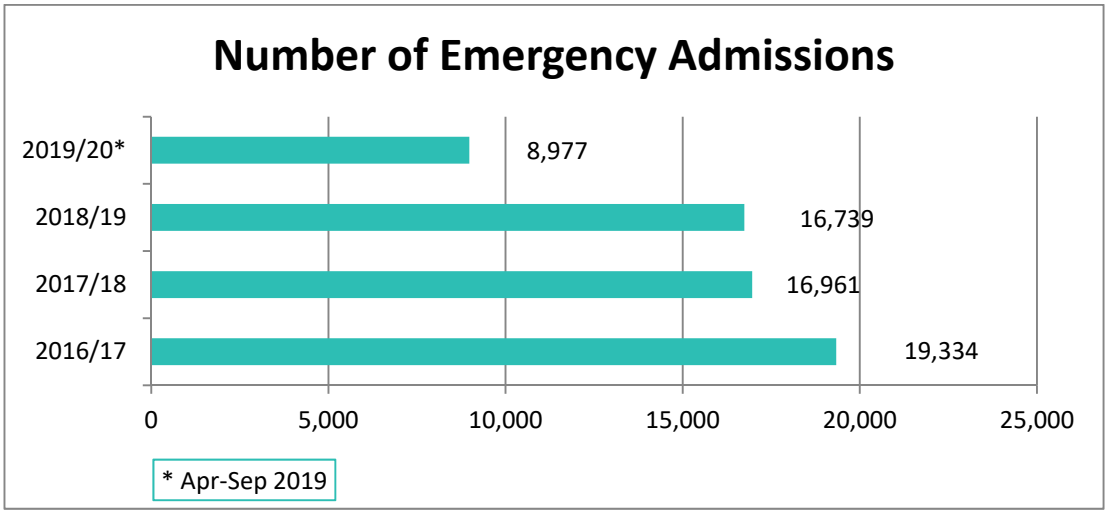
4 Scottish Government Ministerial Strategy Group (MSG) Targets

4.1 We have focused our attention in the last year on tracking progress and working to achieve the six MSG targets as part of our overall performance management process. The targets focus on:

- Emergency admissions (18+).
- Unscheduled Hospital Bed Days for Acute Specialties (18+).
- A&E attendances (18+).
- Delayed discharge bed days (18+).
- Percentage of last 6 months of life spent in the community (all ages).
- Proportion of 65+ population living at home (supported and unsupported).

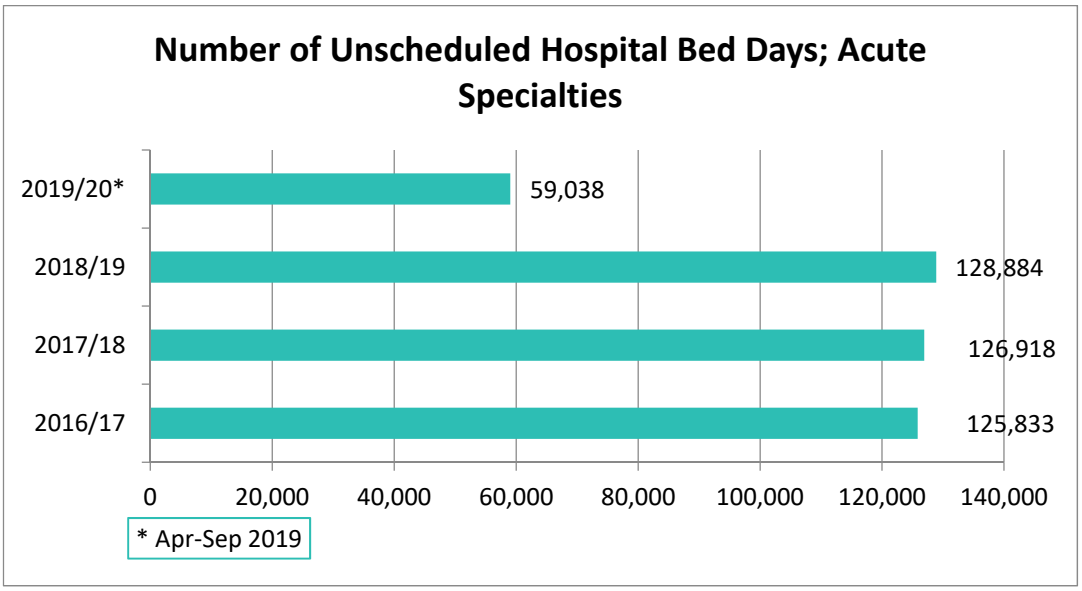
4.2 The data presented in this paper is the most up to date confirmed figures for Renfrewshire. For emergency admissions and unscheduled hospital bed days in acute specialties the data is available for the period April to September 2019. For A&E attendances and delayed discharge bed days (18+) the data is available for the period April to November 2019.

5 Emergency Admissions for Renfrewshire (18+)



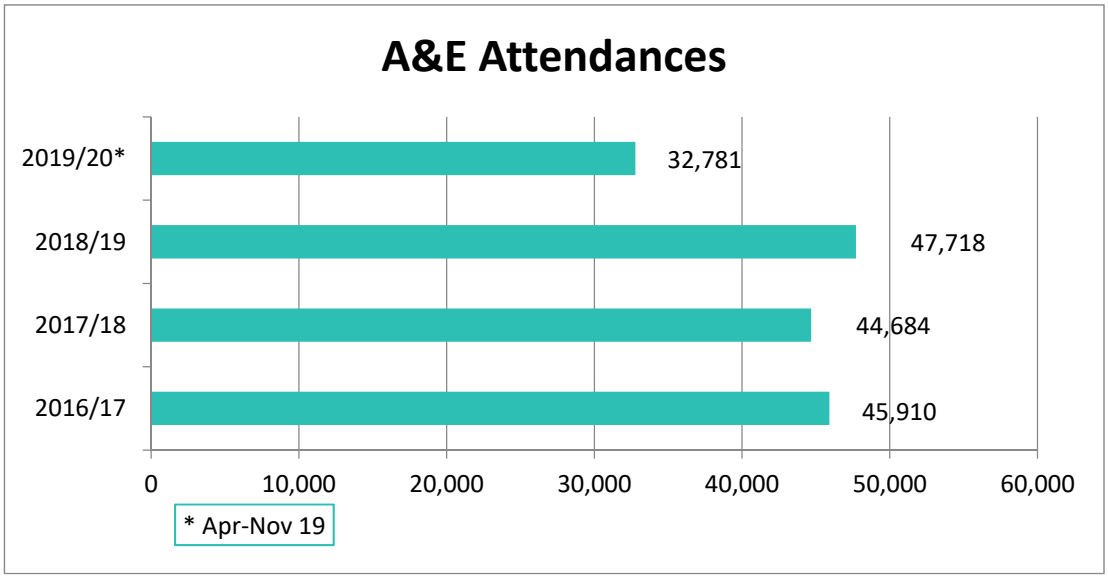
5.1 The HSCP target for 2019/20 for emergency admissions (18+) is 17,502. April to September 2019 shows 8,977 emergency admissions which is an 8.0% increase on the same period in 2018 (8,309). It is likely that emergency admissions will exceed the 2019/20 target at financial year end.

6. Unscheduled Hospital Bed Days; Acute Specialties (18+)



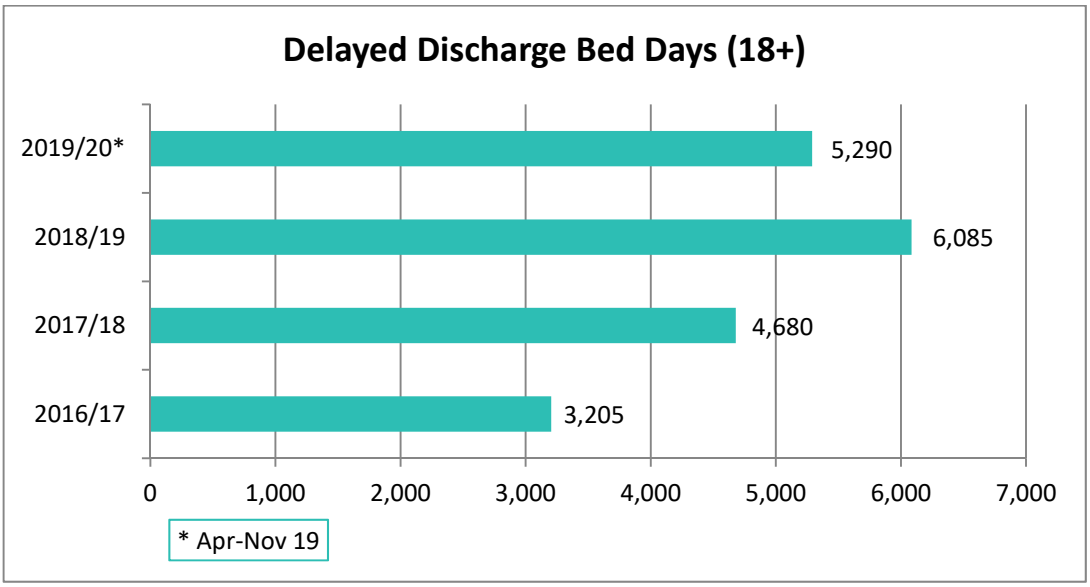
6.1 The HSCP target for 2019/20 for unscheduled hospital bed days in acute specialities is 123,976. April to September 2019 shows 59,038 unscheduled bed days which is a decrease of 10% on the same period in 2018 (65,827). It is likely this target can be achieved by financial year end. Given demand is increasing and the number of bed days is decreasing, it is reasonable to assume this data suggests a shorter length of stay for patients.

7. A&E Attendances (18+)



7.1 Our target for 2019/20 for A&E Attendances (18+) is challenging at 45,123. April to November 2019 shows 32,781 attendances which is a 2.3% increase on the same period in 2018 (32,046). It is likely that A&E Attendances will exceed the 2019/20 target at financial year end.

8. Delayed Discharge Bed Days (18+)



8.1 The 2019/20 target for delayed discharge bed days (18+) is 4,501 and performance from April to November 2019 has already exceeded the annual target at 5,290. The 2019/20 number of bed days lost due to delays in discharge is projected to exceed the 2018/19 figure of 6,085.

8.2 It is important to see this performance against the increasing number of referrals from the acute service to support people in their discharge, and the high level of demand for services from both the community and hospital settings for all care groups. Hospital discharge referrals received through ASeRT (the social care referral intake team who take referrals for all adult services) have increased from 1,105 in 2018/19 to 2,208 for the period April 2019 to 13 February 2020, some of which could be attributed to the shorter length of stay for patients described at 6.1.

8.3 While it is positive that people are managing to stay at home longer and are more independent now than in previous years, the support required from services to achieve this puts additional pressure on resources. In addition, more people prefer palliative and end of life care in their own home where possible. The Free Personal Care for under 65s also impacts on Care at Home financial resources.

8.4 Reducing delayed discharges is a key priority for the HSCP to get people out of hospital and back into a homely setting in the community as soon as they are medically fit. The HSCP is proactively addressing the pressures being faced in our Care at Home Services to manage the referrals coming from the acute service to support people in their discharge:

- The Care at Home Team continually review all activity on packages of care to ensure resources are maximised and the service operates effectively and efficiently. This includes deployment of staff to different geographical areas to meet demand.

- Referrals to the Care at Home Service are screened using reablement criteria to ensure the right care is in place once the assessment is complete. Cases are reviewed frequently and closed when services are no longer required.

- To encourage recruitment and staff retention, we now recruit on a rolling basis and to contracts that are more attractive to the workforce, reducing from 35 hours per week to 25 hours per week. Further work on the delivery model is underway.

- There are weekly meetings with the Care at Home Service Delivery Team Manager; Acute; and the Royal Alexandra Hospital Social Work Team to discuss discharge planning and review active cases/delayed discharges and agree appropriate actions. Beds within residential care homes are used to support discharge.

8.5 Appendix 1 shows Renfrewshire's delayed discharge performance alongside all HSCPs in Scotland. While our rate has increased from 19.8 per 1,000 population in 2017 to 46.2 in 2019, Renfrewshire had the fourth lowest rate across Scotland in 2019. The following table shows Renfrewshire's rate for the period 2017 to 2019 and the range of rates for each calendar year.

Rate of delayed discharge bed days per 1,000 population

	2017	2018	2019
Renfrewshire HSCP	19.8 Range across all HSCPs in Scotland 14.1 – 199.1 Renfrewshire 3rd lowest rate of all 31 HSCPs.	18.0 Range across all HSCPs in Scotland 14.7 – 185.0 Renfrewshire 3rd lowest rate of all 31 HSCPs.	46.2 Range across all HSCPs in Scotland 16.1 – 277.3 Renfrewshire 4th lowest rate of all 31 HSCPs.

9 Percentage of last six months of life spent in the community (all ages)

	2016/17	2017/18	2018/19
Renfrewshire	86.9%	88.4%	87.4%
Scotland	87.0%	88.0%	88.0%

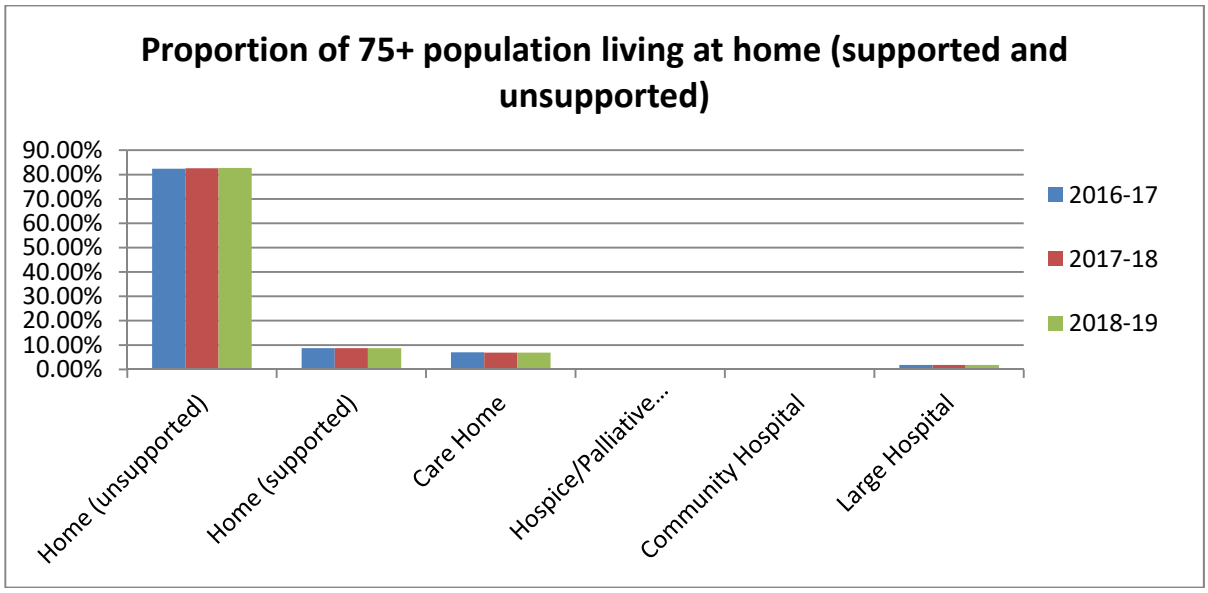
9.1 Over the last three years, the percentage of people spending the last six months of life in a community setting has remained fairly consistent, averaging at 87.6%. Our target for 2019/20 is to maintain the 2018/19 rate of 87.4%.

9.2 In line with our Palliative and End of Life Care Plan 2019 – 2021, we endeavour to meet people's preferences and that may reduce the numbers of people who die in acute hospital settings and/or reduce the number of days people spend in hospital in the last 6 months of life.

9.3 We also monitor the number of deaths in acute hospitals as a percentage of all deaths in Renfrewshire for those persons aged 65 years and over and those aged 75 years and over. There has been good progress made with both these indicators with a substantial reduction from 51.9% in 2011 to 41.2% in 2019 for those aged 65+ and 51.2% in 2011 to 39.5% in 2019 for those aged 75+.

10. Proportion of 65+ population living at home (supported and unsupported)

10.1 In 2018/19 (for those aged 75+), 82.7% lived at home unsupported (possibly with unpaid carers); 8.7% were supported to stay in their own homes (i.e. received care at home services); 6.9% resided in a care home; and 1.8% were in hospital.



10.2 This picture has remained static over the three year period from 2016 to 2019 which is positive in light of the increase in our ageing population and dementia rates. The population in older age groups is due to rise in Renfrewshire, with an expected increase of 76% for those aged 75+ by 2041, when 14% of our population will be over 75 compared to 8% in 2016. We also expect to see a 47% increase in dementia prevalence by 2035. Dementia prevalence in 2017 was 2,994 people and the projected prevalence is 4,400 by 2035.

10.3 To reduce our reliance on unscheduled care we have prioritised the following activities:

- An awareness campaign to better inform the public on which health and care services to use that most appropriately meet their needs.

- As covered in section 8, work is ongoing to reduce delayed discharges in Renfrewshire. We begin care planning as soon as possible after a patient is admitted to hospital and involve the appropriate members of the multi professional team at the earliest opportunity.

- A Discharge Coordinator post was created in November 2019; this dedicated role works with families, Acute and HSCP Services to manage the discharge process. Acute and the HSCP meet 3 times a day to discuss discharge planning and review active cases/delayed discharges and agree appropriate actions. The assessment of needs with Mental Health Officers are carried out timeously, with a focus on early referral from the wards.

- There continues to be a range of care home beds available in the community at both residential care and nursing home levels. As noted in the data in this report, the majority of older people continue to live at home. Awaiting Care at Home services accounts for the majority of the non-complex delays in discharge, with service availability in the West Renfrewshire area a particular challenge. Much of this is due to the capacity of the Framework Providers and the Care at Home service directly provided by the HSCP. The focused work taking place to address this is outlined in section 8.

- Through the Frailty Collaborative - set up in May 2019 to support improvement in early identification and support for people aged 65 years and over to live and die well with frailty in the community - the aim is to use a common frailty tool across the NHS Board area to identify people at risk of hospital admission and support them and their families to manage their conditions.

- Improving Renfrewshire's residents' health and wellbeing and reducing the risk of falls and fragility fractures, we will continue to implement local priorities and Board-wide objectives to evidence progress towards the outcomes identified in the National Falls and Fracture Prevention Strategy for Scotland 2019 – 2024.

- Continuing to work with the third and independent sector, GPs and others to further reduce admissions from care homes. We are currently working with homes that have higher admission rates to understand what is driving this. In addition, encouraging the use of Anticipatory Care Plans and providing support to homes through our Care Home Liaison Nurses and newly appointed Advanced Nurse Practitioners.

- Continuing to work with other HSCPs and the NHS GGC Board and Acute Services to ensure appropriate use of the GP Out Of Hours (OOH) services to ensure services are stable and focused on quality and safety. There were a range of actions agreed by the NHS Board in February 2020 and we will work with others to ensure all steps are taken.

- Promoting and supporting the ‘red bag’ initiative in Renfrewshire care homes. The red bag contains important information about a care home resident's health in one place so they can receive quick and effective treatment by ambulance and hospital staff, with the aim of reducing residents’ length of stay in hospital.

- Appointing two new alcohol out-reach nurse posts which will target those individuals who do not currently engage with community services to help improve their life outcomes while reducing attendances at the Emergency Department. This will further enhance the work of the two Navigator posts that started at the Royal Alexandra Hospital in November 2019.

Implications of the Report

1. **Financial –** None
2. **HR & Organisational Development –** None
3. **Community Planning –** None
4. **Legal –** Meets the obligations under clause 4/4 of the Integration Scheme.
5. **Property/Assets –** None
6. **Information Technology –** None
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report.
8. **Health & Safety –** None
9. **Procurement –** None
10. **Risk –** None
11. **Privacy Impact –** None

List of Background Papers – None.

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