To: **Renfrewshire Integration Joint Board**

On: **26 January 2024**

Report by: **Head of Health and Social Care**

Heading: **Unscheduled Care Winter Update**

Direction Required to Health Board, Council or Both	**Direction to:**	
	1. No Direction Required	X
	2. NHS Greater Glasgow & Clyde	
	3. Renfrewshire Council	
	4. NHS Greater Glasgow & Clyde and Renfrewshire Council	

1. Summary

1.1. This report provides the mid-year update to the IJB on how Renfrewshire and other HSCPs within NHSGGC are working with Health Board colleagues to deliver whole-system change against our urgent and unscheduled priorities to minimise the impact of unscheduled care during Winter 2023/24.

2. Recommendation

It is recommended that the IJB:

- Note the content of this report.

3. Purpose and Background

3.1 The purpose of this report is to update the IJB on developments in the delivery of the HSCP's Unscheduled Care agenda ahead of Winter 2023/24.

3.2 At its meeting in March 2022 the IJB received an update report on the Unscheduled Care Design and Delivery Plan for the period 2022/23 to 2024/25. Subsequently the NHSGGC Board and HSCP Chief Officers have adapted to the requirement for Scottish Government assurance through refinement of the governance structure for Urgent and Unscheduled Care.

3.3 Unscheduled care work across NHSGGC is directed by the Unscheduled Care Design and Delivery Plan 2022/23 to 2024/25.

Ratified by all 6 IJBs, this detailed how HSCPs would seek to operate in conjunction with acute sector colleagues to meet the unprecedented levels of unscheduled care across NHSGGC and meet the continuing challenges of an aging population with increasing complex care needs. This plan will be refreshed and brought back to IJBs in 2024.

3.4 As noted in the most recent update to IJBs on unscheduled care in January 23, national improvement work and reporting on unscheduled care has been organised into High Impact Change Areas (HIC) whilst improvement work remains true to the action plan detailed in the Design and Delivery Plan. GGC HSCPs are participating actively in three HICs.

- HIC 3 – Virtual Capacity
- HIC 7 – Discharge without Delay
- HIC 8 – Community Focused Integrated Care

4. Trends in Unscheduled Care

4.1 Presentations

Figure 1 below shows the rate of presentation across all facilities in NHSGGC. Thus far seasonal patterns of attendance are being observed for 2023, however attendance numbers are down 7% on 2019 figures. This could be attributed to the significant efforts within community and Primary Care on early intervention, prevention and signposting of service users to planned care. Renfrewshire closely follows the wider NHSGGC trend. Despite the decrease in numbers, anecdotally from front-line staff there is an increase in the complexity of the patients who are attending, which may explain the increased average length of stay (Para 3.3). A breakdown of attendances per HSCP by 100,000 of population is included at Figure 2.

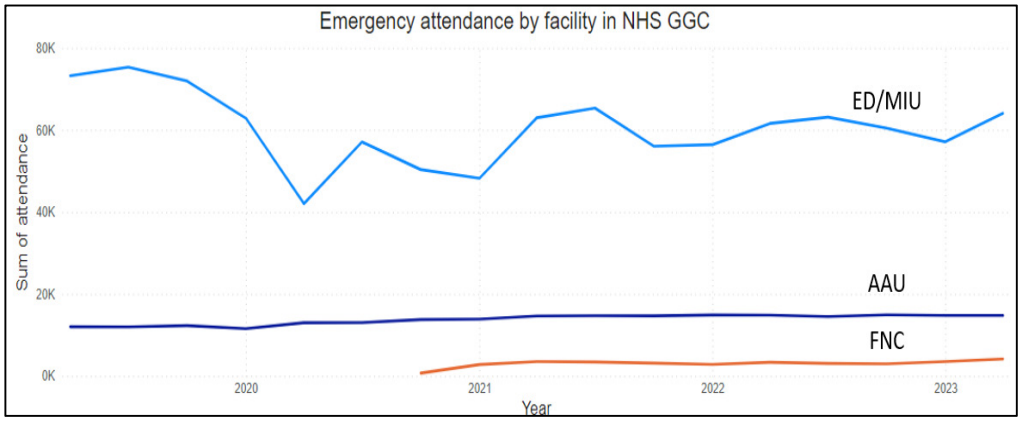

Figure 1. Quarterly counts of attendances to Emergency department (ED)/ Minor Injury Unit (MIU), Acute Assessment Units (AAU) and Flow Navigation Centre from 2019 to 2023. Source: NHSGGC Emergency Department dataset.

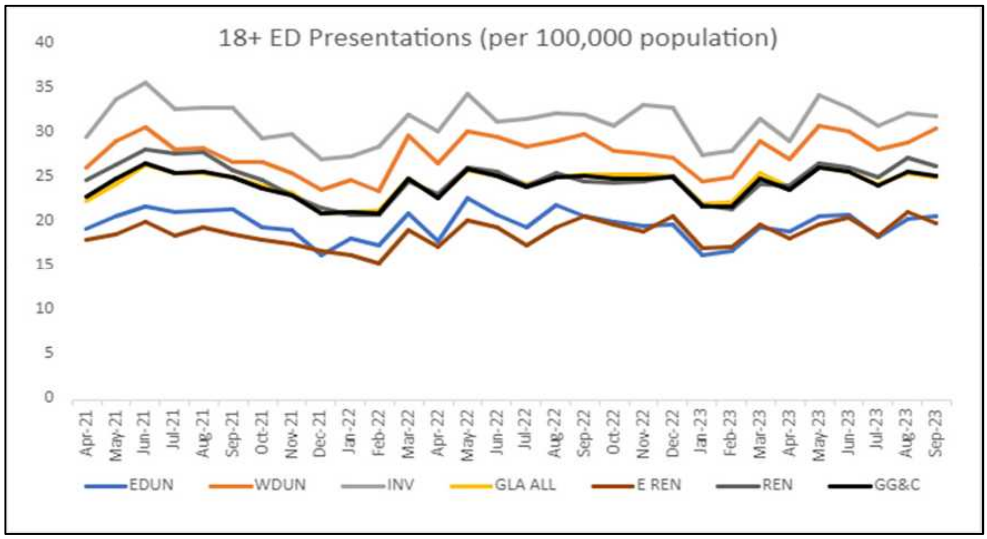

Figure 2. ED/MIU attendances per 100,000 population. Source: NHSGGC Microstrategy

4.2 **Admissions.** Emergency admission rates appear to have stabilised post-pandemic with NHSGGC admission rates closely following Scottish rates overall. Admission rate per 100,000 population by HSCP is shown at Figure 3.

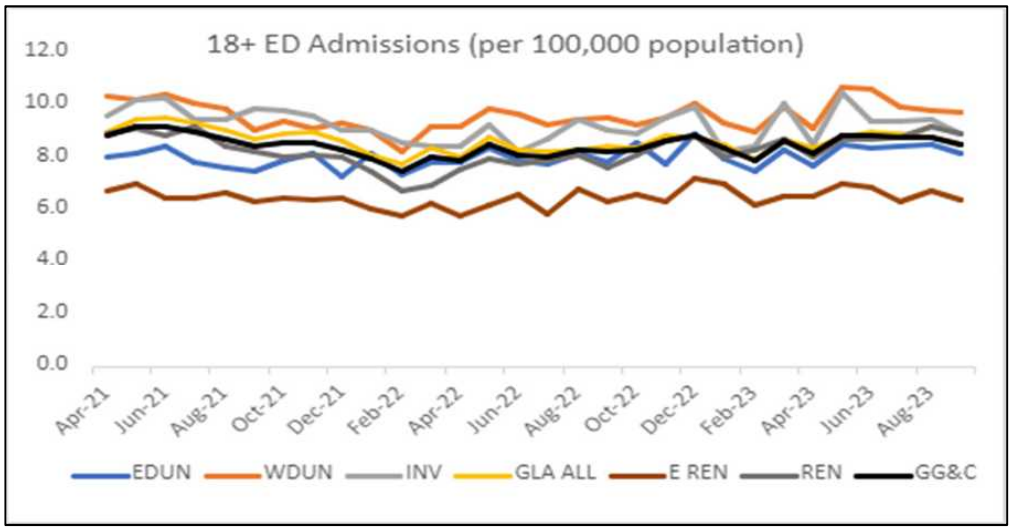

Figure 3. ED/MIU admissions per 100,000 population. Source: NHSGGC Microstrategy

4.3 **Average Length of Stay**. Overall, mean length of stay in NHSGGC has increased from 8.3 days in 2019 to 10.2 days in 2023 (January to June only). This has remained above the Scottish average throughout the time-period (9.0).

The distribution of lengths of stay is not uniform. As can been seen in Figure 4, over half (53.5%) of admissions from January to June 2023 lasted four days or less. There is however a notably large proportion (17.3%) of stays lasting fifteen days or more.

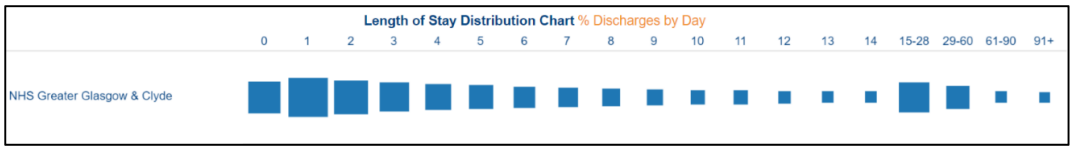

Figure 4. Breakdown of length of stay by day for inpatient stays. Source: PHS

4.4 **Predictive modelling**. HSCPs enlisted the support of Public Health Scotland to predict A&E attendances and emergency admissions through Winter 2023/24. Using logistic regression modelling predicted values have been determined with a range of 95% certainty. This information has informed HSCP and acute demand and capacity planning and workforce measures in advance of Winter.

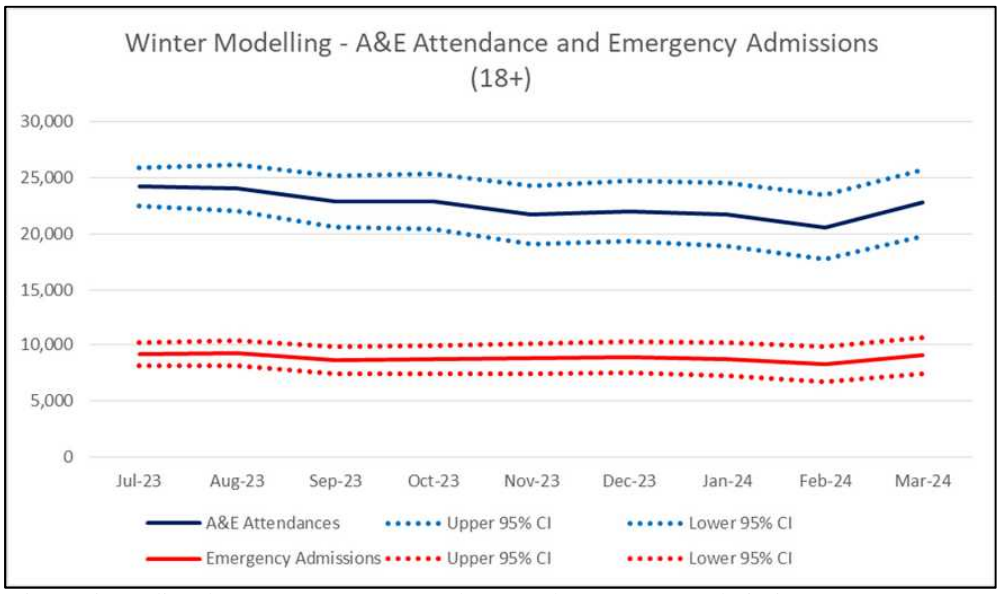

Figure 5. Predicted NHSGGC A&E attendance and Emergency Admissions with 95% confidence intervals. Source: PHS Scotland – MSG Data

5. Unscheduled Care Intervention Progress

5.1 The following key interventions led by HSCPs are now live across NHSGGC. A summary of interventions across acute and community services can be found at Appendix 1.

5.2 **Hospital at Home**. The Hospital at Home (H@H) service continues to provide acute level care to individuals in their own home who would otherwise be admitted to hospital. This is currently provided in the South and Northwest localities of GCHSCP. Approval from the Greater Glasgow and Clyde Health Board Corporate Management Team has been given for scaling up the service system-wide, using a Nursing Midwifery & Allied Health Professional (NMAHP) model with support from a wider multi-disciplinary team, hosted by GCHSCP. During 2023 the service has expanded from 10 to 20 beds with ambition for further scale up, with 40 beds as an initial aim point, subject to future IJB approval. Negotiations are underway with Scottish Government and the

NHS Board & Partnership Chief Officers to identify revenue funding options for the scale up of the service.

5.3 **Home First Response Service**. This service has been established for a year within the Queen Elizabeth University Hospital and Royal Alexandra Hospital. Delivering an augmented multi-disciplinary team approach composed of community staff (Frailty Practitioners, Allied Health Professionals, Pharmacy and Frailty Support Workers) embedded and working alongside the acute team to identify, assess and turn around patients at the earliest opportunity, up to 72 hours post-admission. The service is routinely turning around over 50% of individuals diagnosed with frailty at the ED front door, with a threefold increase in community rehab referrals that is expected to continue into Winter. This work aligns with preventative measures such as the development of HSCP Frailty Pathways to support prevention/early intervention activity and anticipatory care planning to maintain individuals at home for longer, reducing risk of admission to hospital.

5.4 **Falls Pathways**. Work is ongoing to reduce the number of conveyances to ED following a fall.

- **Community Integrated Falls Pathway** in collaboration with the Scottish Ambulance Service (SAS) has a focus on referral to community teams for multifactorial assessment for those patients who are not conveyed, with a same day or next day follow up from HSCP team. Referrals from SAS are increasing incrementally with a recent review demonstrating the HSCP prevention and early intervention activity following referral to minimise the risk of further falls.
- **Care Home Falls Pathway**. Linking SAS crews with senior clinical decision makers through calls into the Flow Navigation Centre to minimise conveyances with a resulting reduction on pressures in ED. Results so far have shown that 62% of calls to FNC resulted in a non-conveyance.
- **Care Home Falls Test-of-Change**. Following a successful test-of-change in Glasgow City, training has been rolled out to Glasgow's 61 Care Homes, connecting Care Home staff with clinical decision makers. Using 'Near Me' video technology, a livestream consultation takes place between the FNC and the care home resident resulting in the formation of an action and treatment plan, which helps avoid an unscheduled and potentially lengthy attendance to the Emergency Department. For residents that still may require attendance to hospital as an emergency, the FNC will facilitate referral and ambulance transfer. An audit of Care Home Wi-Fi connectivity across NHSGGC has been implemented with a view to expanding this intervention into all HSCPs.

5.5 **Call before Convey for Care Homes**. On average 420 care home residents attend ED each month across NHSGGC. Whilst the Care Home Falls Pathway gives homes access to Flow Navigation Centre clinicians it only covers falls and no other reasons for attendance, which are predominantly respiratory and urinary issues. Building on the experiences of Ayrshire & Arran and East Dunbartonshire and the recommendations within the My Health, My Care, My Home framework published in 2022 a test-of-change for Winter 2023/24 is proposed subject to IJB approval. Funded through delegated NHSGGC funding to support care homes through Winter, the test will give care homes access to a senior clinical decision maker who can provide remote clinical assessment. This will provide timely contact with the potential to avoid delays experienced at NHS24 and the FNC thus reducing the likelihood of a call to 999. Access to senior clinical decision makers varies across HSCP, this has resulted in variation in the models being proposed. Renfrewshire has built upon existing arrangements which means a Senior Decision Maker is available from with the Care Home Nursing Service and District Nursing Service across seven days.

5.6 **Anticipatory Care Plans (ACP**). GGC's ACP programme was aligned with Unscheduled Care Programme in 2022 and the diligent work of implementation sub-groups across all HSCPs and in Care Homes, Hospice and Secondary Care continue to demonstrate success through the exponential rise in ACPs available on Clinical Portal, with over 5000 as of Oct 23 (Figure 6). In addition to raw numbers, work is on-going to improve the quality of ACPs available to support decision making. Lessons learned from the first cycle of improvement activity has been shared with all HSCPs and cycle two is underway. Additionally, Scottish Government have announced a national re-brand of ACP activity as Future Care Planning. This new terminology will be adopted across NHSGGC with the ACP materials and website being amended to reflect this change.

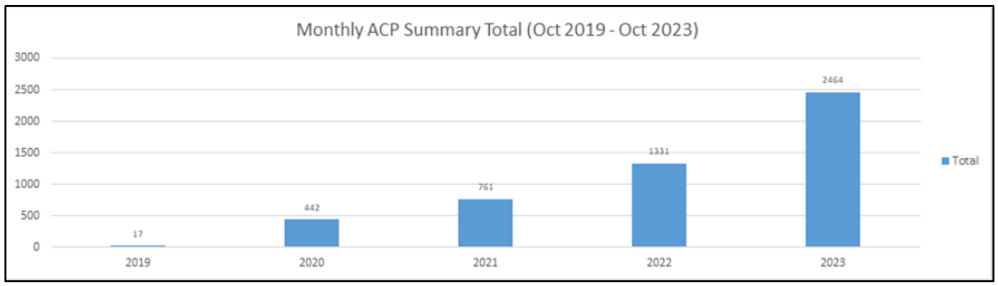

Figure 6. Monthly ACPs completed across NHSGGC. Source: Clinical Portal

Appendix 1 to
Unscheduled Care Winter 2023/24 Update

Pre-hospital UUC changes	Intended high-level outcomes
Flow Navigation Centre	Divert activity away from ED via virtual front door service
Mental Health Assessment Unit	Improved access to acute mental health support and reduction in mental health attendances to ED
GP Out of Hours workforce stabilisation	Ensure staffing levels sustainable and appropriate to population need
Call before Convey	Reduce unnecessary ambulance conveyances to hospital
Consultant Connect	Improve access to timely specialist advice and decrease hospital referrals from primary care
Interface Care	Outpatient Antibiotic Therapy: Reduce need for hospital admission due to antibiotic therapy Heart Failure Integrated Care: Reduce admissions due to heart failure Respiratory Integrated Care: Reduce admissions due to respiratory conditions (primarily COPD)
Hospital at Home	Reduce admissions to hospital where care could be provided instead in patients' own homes
In-hospital UUC changes	
Signposting and Redirection	Ensure patients are directed to most appropriate care and reduce unnecessary hospital waits / resource use
Rapid Acute Assessment	Reduce length of stay by facilitating rapid access to senior clinical decision-makers and medical investigations Improve patient flow (Continuous Flow Model)
Discharge without Delay	Reduction in delayed discharges by implementation of Discharge without Delay bundle
Home First Response Service	Reduction in admissions and stays less than 48 hours for frail patients who present at ED or AU

Implications of the Report

1. **Financial –** The legislation requires the IJB and Health Board to put in place arrangements to support set aside arrangements for unscheduled care, and is subject to external assessment. The Unscheduled Care Commissioning Plan delivers a joint strategic commissioning approach to unscheduled care which will deliver on the intentions of the legislation. The IJB's budget for 2023/24 includes a "set aside" amount for the commissioning of acute hospital services within scope (e.g. accident & emergency services). This is currently estimated to be £67,258,000 for Renfrewshire HSCP.
2. **HR & Organisational Development** – none
3. **Strategic Plan and Community Planning** – none
4. **Wider Strategic Alignment** – The approach outlined will have implications for the planning and delivery of acute hospital services for all 6 GG&C HSCPs.
5. **Legal –** The integration scheme for the IJB includes specific responsibilities for the strategic planning of certain acute hospital services.
6. **Property/Assets –** none
7. **Information Technology –** none
8. **Equality & Human Rights –** none
9. **Fairer Duty Scotland –** none
10. **Health & Safety –** none
11. **Procurement** – none
12. **Risk –** none
13. **Privacy Impact** – none.

List of Background Papers – Unscheduled Care Commissioning Plan (Design & Delivery Plan 2022/23-2024/25), March 2022

Author: Antoni Anderson, Lead Officer for Unscheduled Care Improvement.

Any enquiries regarding this paper should be directed to Carron O'Byrne, Head of Health and Social Care Services (Carron.Obyrne@renfrewshire.gov.uk)