**ITEM No …8……….**

**REPORT TO:** **PERFORMANCE & AUDIT COMMITTEE – 29 MAY 2018**

**REPORT ON:** **UNSCHEDULED CARE**

**REPORT BY:** **CHIEF FINANCE OFFICER**

**REPORT NO:** **PAC31-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to provide assurance to the PAC that a comprehensive analysis of unscheduled care performance has been provided to relevant professionals and groups in order to support improvements.

## 2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Notes the content of this report and the analysis of unscheduled care (section 5 of this report and appendix 1).

2.2 Requests the Unscheduled Care Board to consider the findings of the analysis with a view to informing operational decision making and improvement actions.

2.3 Instructs the Chief Finance Officer to present a follow up paper to the PAC, containing an action plan which describes how the data will be used by practitioners and the Unscheduled Care Board to make continuous improvements, timescales for improvement actions and the anticipated impact of these actions.

## 3.0 FINANCIAL IMPLICATIONS

None.

## 4.0 BACKGROUND INFORMATION

4.1 Unscheduled hospital care is one of the biggest demands on the Partnership resources. Many hospital admissions are avoidable and often people either remain in hospital after they are assessed as fit to return home or they are readmitted to hospital shortly after they were discharged. In 2016-17, 28% of Dundee's health and care budget was spent on hospital stays which was the third highest in Scotland.

4.2 Rates of unscheduled admissions, bed days and readmissions within 28 days varies considerably across local community planning partnerships (LCPPs), with a general correlation between high usage of unscheduled care and deprivation. At Quarter 3, 2017/18 Dundee had the:

- 10$^{th}$ highest rate of emergency admissions for the 18+ population, however had the 2$^{nd}$ lowest in its family group;
- 7$^{th}$ highest rate of emergency bed days for the 18+ population, and was 5$^{th}$ highest in its family group;
- highest rate of emergency readmissions within 28 days and was also highest in its family group.

4.3 These indicators are monitored in the Quarterly Performance Report and are included in the Q4 report (PAC30-2018 on this agenda) and the Annual Performance Report (Report number DIJB29-2017) presented to the Integration Joint Board Meeting held on 29 August 2017.

4.4 The PAC held on 12 September 2017 requested that an in-depth analysis of unscheduled care data relating to hospital readmissions be completed to assist senior managers and the Unscheduled Care Board to fully understand the reasons for high unscheduled care usage and use the data to inform improvements in services and outcomes for people. The Unscheduled Care Board consists of senior operational managers who work collaboratively to make decisions and guide improvements in unscheduled care. The Unscheduled Care Board has experienced difficulties in resourcing this and the analysis in appendix 1 has been produced as an interim report until necessary resources are identified.

4.5 The data used for this report is taken from the SMR01 national dataset and trend data shows annual rolling totals for each financial quarter since 2014/15 Quarter 4 (April 14 to March 15) up to 2017/18 Quarter 3 (January 17 to December 17). This allows the reader to observe trends in the data and to identify which quarters the data climbs or falls. For national comparisons against all 31 partnerships, the indicators only show financial year 2016/17 as this is the latest period that is published at Information Services Division (ISD) for unscheduled care activity (2017/18 activity will be published in September 2018). This report has also included the under 18 age groups as the admission and readmission rates for this age group has increased sharply in the last two years and these patients may contribute to an increasing admission rate for all adults in the near future.

## 5.0 WHAT THE DATA IS TELLING US

5.1 As at 2016/17, the 28 day readmission rate for people for all ages across Scotland was highest in Dundee. In Respiratory Medicine, this equated to 1 in 4 Dundee residents being readmitted which was the highest in Scotland.

5.2 As at 2016/17, 28 day readmissions as a rate of the population for all ages were similar to the Scottish readmission rate.

5.3 In 2017, Gastroenterology and General Surgery (excluding Vascular) and Respiratory Medicine appeared to have had an excessive number of 28 day readmissions for people of all ages living in Dundee when compared to the same specialties in all of Scotland. Geriatric Medicine performed similar to Scotland, whilst Accident and Emergency and General Medicine performed better than Scotland.

5.4 In 2016/17 the emergency admission rate was similar to the Scottish rate for the 18+ and 75+ age groups. In General Medicine and Geriatric Medicine admission rates were lower than the Scottish rate but admission rates were higher than the Scottish rate in Accident and Emergency and Respiratory Medicine.

5.5 In 2016/17 potentially preventable admissions (PPAs), as a rate of the population, was above the Scottish rate and the admission reason with the highest number of PPAs was Chronic Obstructive Pulmonary Disease (COPD), with over 600 admissions that could have been prevented. Influenza and pneumonia was the third main reason for PPAs with over 300 admissions that could have been prevented. Approximately 200 PPAs were due to diabetes complications. Diabetes PPAs as a rate of the population in Dundee, and also as a rate of the diabetes prevalence population, is higher than Scotland.

5.6 The average length of stay across all age groups decreased between 2015/16 Quarter 4 and 2017/18 Quarter 3. Average length of stay in Respiratory Medicine has always been about a day less than the Scottish average and has decreased from 7.5 days in 2014/15 Quarter 4 to 6.7 days in 2017/18 Quarter 3. The very low average length of stay in this specialty could be contributing to the high readmission rate.

5.7 As at 2016/17, the emergency bed day rate (per 100,000 population) in the Dundee 18+ age group was above the Scottish rate; there has been a decrease of 13% in the 75+ age group, the rate for the 18-74 age group has remained steady and the rate for the under 18 age group has been continually increasing in Dundee since 2015/16.

5.8 Monthly occupied bed days for Dundee emergency inpatients aged 18+ treated at Ninewells Hospital have remained lower than pre-March 2016 levels. For Dundee non-elective inpatients aged 18+ treated at Royal Victoria Hospital, there was a statistically significant decrease in monthly occupied bed days between May 17 and December 17.

5.9 Dundee emergency bed days in 2017/18 were below the trajectory set in February 2017 (-2.7%). A new trajectory was set in February 2018 (-3.4%) to reflect the improved position; Dundee emergency bed days have so far been below this new trajectory.

5.10 The number of accident and emergency (A&E) episodes where the patient was admitted from a care home has increased by 54 episodes from 265 episodes in 2015/16 to 319 episodes in 2016/17. The number of A&E episodes that resulted in an admission has also increased by 54 from 112 in 2015/16 to 166 in 2016/17. The reason for the majority of A&E episodes for care home residents were trauma / injury. In both 2015/16 and 2016/17, trauma / injury accounted for 64% of all A&E episodes for care home residents.

## 6.0 OPERATIONAL PRIORITY AREAS

### 6.1 Models of Support, Pathways of Care

6.1.1 A range of stakeholders across NHS Tayside and the three Partnerships are involved in a Delphi process which will give a better understanding of pathways. This involves a survey which is completed by health and social care professionals to gather information regarding critical processes in a pathway. This will be used to improve outcomes for people and system efficiencies.

6.1.2 Frail people who are acutely unwell may need at times to be in hospital. They are supported there by a highly effective Acute Frailty team. This includes in reach into a number of other in patient areas. Where people do need to go to hospital this is only for the length of time they need to be in hospital and they will be able to step down as quickly as possible using a range of supports and resources such as an Assessment at Home service and an Intermediate Care unit. This ensures that assessment is undertaken at home or in a homelike setting rather than an acute hospital. This is supported by a multidisciplinary Discharge Hub

6.1.3 A domiciliary care provider has been commissioned to carry out a test of change which enables social care assessment to be completed in the person's own home with intensive round the clock social care support tailored to meet the person's changing needs on a daily basis. This has supported us to address National Indicators 19 and 22, by ensuring people are discharged more efficiently from a hospital setting, and has improved patient outcomes with a 26% reduction in care home placement. This test has contributed to the reduction in bed days lost for standard delays over 17/18.

6.1.4 We recognise that one group with particularly complex needs are those who live in care homes and we are in the process of developing an integrated Care Home team. This builds on the work that has taken place over the past few years to support care homes.

6.1.5 A primary care improvement plan to implement the new GP contract is in development. There are six priority areas – urgent care, mental health, musculoskeletal, community treatment centres, immunisation, pharmacy.

6.1.6 Further development of discharge planning arrangements for adults with mental ill-health, physical disability, acquired brain injury, learning disabilities and autism is also being progressed. Following a review of the hosted acute liaison service for people with learning disabilities, a further nursing post is in the process of being recruited to. This will ensure smoother transitions to and from acute care, strengthen interfaces between community / acute services and provide support and awareness raising activity within the acute sector.

6.1.7 There is an understanding of the '6 essential actions for unscheduled care' and the Unscheduled Care Board is focussing on developing 7 day services to reduce variation in weekend and out of hours working and also in providing care closer to home.

6.1.8 There is now a Mental Health Officer post established within the Integrated Discharge Hub which supports improved decision making around the use of Adults with Incapacity and Section 13Z(A) of the Social Work (Scotland) Act. This has significantly reduced the episodes of Code 9 delays, as well as the bed days lost for each individual patient.

**6.2 Person Centred Care and Support**

6.2.1 Data has identified that respiratory, gastro and general surgery are priority areas for the Unscheduled Care Board. To date initiatives have worked well for older people but need to be rolled out to younger age groups.

6.2.2 The COPD team continues to work closely with the population of Dundee and those that provide support to manage this condition across the spectrum of self management, primary and secondary care. A variety of initiatives support this including the COPD discharge service which provides support to patients following necessary hospital admission to prevent readmission. Also the use of health care support workers help individuals to self manage. This is all being further supported by the Managed Care Network which will include pathway development.

6.2.3 A sub-group of the Unscheduled Care Board has been convened to improve how anticipatory care information can be shared with the appropriate professionals and is available when required.

**6.3 Building Capacity**

6.3.1 Work has commenced to train a range of people (including homecare workers and district nurses) to identify when people are deteriorating (including delirium).

6.3.2 An asset based approach is being used in Dundee to support people to be healthier and independent for longer in their own community. This involves working in partnership to co-design services with the statutory, third and independent sectors and with individuals, families and communities. Key to the success of these models is the ability to work in localities, to identify people at an early stage of their journey where things do go wrong and provide comprehensive assessment, early intervention and anticipatory care. This is done through our Enhanced Community Support and Post Diagnostic Support teams. Where people do start to deteriorate, a range of services will be provided to allow them to maximise their recovery and independence in their own home. This includes a Dundee Enhanced Community Support Acute service.

**6.4 Early Intervention / Prevention**

6.4.1 A Power of Attorney Campaign has been implemented in partnership with Angus and Perth and Kinross Health and Social Care Partnerships, and this will take place annually. The campaign was supported by additional local awareness raising events in Dundee to help to promote Power of Attorney, reduce the need for guardianship and enable people to be discharged from hospital when they are well. Initial data gathering indicates an increase in Power of Attorneys and this will continue to be monitored over coming years.

6.4.2 A number of priority areas have been agreed to reduce hospital admissions due to a fall and these are detailed in report number PAC32-2018 on this agenda. These include a focus on a preventative approach which will support active ageing, health improvement and self management to reduce the risk of falls.

6.4.3 A partnership approach to supporting people experiencing distress is being taken to develop a range of supports. These include; a safe place (accommodation with the right support at right time), agreed pathway for timeous access to support, out of hours support and peer support.

6.4.4 The service has increased the availability of high intensity, psychological interventions within Community Mental Health Teams (CMHT) whilst also decreasing the need for high intensity psychological interventions by enabling more mental health staff to provide appropriate low intensity psychology interventions and support at earlier stages of the patient journey.

6.4.5 There has been a development around the creation and sharing of a palliative scorecard which allows an assessment of need to be identified and shared across both health and social care teams.

### 6.5 Localities and Engaging with Communities

6.5.1 Building on the potential strengths of developing communities within the locality concept, we are looking at developing Care and Treatment Centres that will be based for communities to access within their own areas for a range of treatments. This will build on our successful model developed by the district nursing service for the treatment of leg ulcers and expanding on the number and type of treatments that will be available.

6.5.2 The service plans to increase overall capacity within the Psychological Therapy service to:

- Increase the availability of a range of specialist psychological therapies
- Support the skill development of the wider workforce within Mental Health Services (cross sector) to ensure the best use of resources.

6.5.3 Plans are underway to enhance community mental health services. This will include quicker access to the right kind of support 24/7 through the development of stronger pathways between acute / community and primary services. The flexible use of available social care resources across a number of providers in the city has in recent years led to quicker response times, including where people are at risk of unnecessary hospital admission or where they require support on discharge.

## 7.0 RISK ASSESSMENT

| **Risk 1 Description** | The risk of not reducing the usage of unscheduled care could affect; outcomes for individuals and their carers, spend associated with admissions, bed days and readmissions if the Partnership's performance does not improve. |
|---|---|
| **Risk Category** | Financial, Governance, Political |
| **Inherent Risk Level** | Likelihood 3 x Impact 5 = Risk Scoring 15 |
| **Mitigating Actions** (including timescales and resources ) | - An in depth analysis of unscheduled care data is included in this paper.<br>- The Unscheduled Care Board is prioritising improvements in this area.<br>- Senior Operational Managers will continue to be consulted with in order that findings can be used to make improvements. |
| **Residual Risk** | Likelihood 3 x Impact 3 = Risk Scoring 9 |
| **Planned Risk Level** | Likelihood 3 x Impact 3 = Risk Scoring 9 |
| **Approval recommendation** | The risk level should be accepted with the expectation that the mitigating actions are taken forward. |

## 8.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

## 9.0 CONSULTATIONS

The Chief Officer, Head of Service - Health and Community Care and the Clerk were consulted in the preparation of this report.

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DATE: 8 May 2018

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