4. ACUTE PLANNING FRAMEWORK

4.1 Analysis of Local Position

4.1.1 Renfrewshire CHP engages with acute services at a number of levels. Planning structures include the GP Forum, the PEG (and ePEG) and MCNs (Managed Clinical Networks) and other whole system planning groups.

The Chair of the Medical Staff Association at RAH attends meetings of our GP Forum which are held quarterly to lead discussion on primary/secondary care interface issues. Recent discussions have included clinicians from general surgery, ENT, general medicine and urology on service development/redesign at the RAH. Acute Clinicians and Managers attend meetings of ePEG which focus on development of long term conditions strategy in respect of diabetes, respiratory medicine and coronary heart disease (a number of the outputs required can only be delivered by secondary care, hence the need to include such in these discussions).

The local Renfrewshire Diabetes Group is well established which links with the work of the Diabetes MCN. It is also planned to establish a local Respiratory Forum, similarly linked to the Respiratory MCN, to take forward the LTC work on COPD and asthma.

4.1.2 The CHP Clinical Director links with RAH in respect of winter bed pressures and liaises with local GPs to advise on this and on alternatives to hospital admission/more planned urgent admission as appropriate.

4.1.3 Main interface areas include:

- Ensuring appropriate arrangements for delivering a balance of care for local people.
- Discharge management and information (including primary care and pharmacy).
- Renfrewshire GP practices actively participating in the current Board-wide audit of discharge documentation from secondary care.
- Medicines management and hospital prescribing.
- Discussions with secondary care clinicians at GP Forum on the Electronic Care Summary and its use within the hospital setting, particularly in respect of repeat medication and recent acute medicines that have been prescribed.
- Access to investigations including DEXA.
- Improving use of Electronic referral.
- Demand management.
- Improving how the CHP works in partnership with Acute services.

4.2 Numeric Analysis

4.2.1 The key activity relating to Acute Services is as follows:

- 300 serious assaults have been recorded
- Approximately 740 domestic abuse incidents occur
- 220 assault episodes (for residents) requiring overnight hospital treatment are recorded
- 370 children are admitted to hospital for dental conditions
- Over 1,600 heart disease patients are admitted to hospital

- Over 12,000 patients are admitted as a medical emergency. This is an age-sex standardised rate of 6,609.7 per 100,000 population in Renfrewshire. The lowest rate is in Houston at 3,876.5 and the highest in Ferguslie at 11,912.1 per 100,000 population
- For multiple admissions, the rate in Renfrewshire is 1,287.2 per 100,000 population; 5% above the Scottish average. The lowest rate is in Ralston at 783.4 and the highest in Ferguslie at 2,619.8 per 100,000 population
- With unintentional injury patients, the rate in Renfrewshire is 1,095.6 per 100,000 population; 8% above the Scottish average. The lowest rate is in Houston at 499.8 and the highest in Ferguslie at 2,290.5 per 100,000 population
- The crude rate per 1,000 population of new attenders at A&E from GP Practices in Renfrewshire for the period November 2008 to October 2009 was 304.8. This ranged from a low of 203.6 to a high of 476.8 (standardised rate per 1,000 Practice population) across the GP Practices.
- Smoking cessation rates for the acute sector in Renfrewshire have decreased over a 3 year period from 65% in 07/08 to 44% in 08/09 and 35% for the period April to December 2009. Numbers are small though (less than 75 per year setting quit date) and therefore rates can fluctuate considerably from year to year.

4.3 Health Gap and Key Issues

4.3.1 The key issues locally remain minimising admission and readmission to hospital for older people. The development of an improved model for Rehabilitation and Enablement services is key over the next 3 years. This will result in a more comprehensive suite of services, including home care, which will prevent hospital admission and facilitate discharge. As part of the implementation of community rehab, we will carry out an EQIA to ensure we develop the service with equalities in mind from the beginning.

Other key areas for the CHP will be the development of service pathways with Acute services that improve the service inputs and outcomes for patients. Specifically, our work on LTCs will be a priority here - diabetes, COPD and asthma.

4.3.2 We will focus on appropriate use of Accident and Emergency services, particularly addressing frequent service users.

4.4 Outcomes Table

Acute Planning

Outcome	Actions/ Activity required 2010/11	Change/Progress/Performance indicator
A2. Services provided meet the national access targets.	- Increase use of electronic referrals. - Ensure any suspected cancer referrals are appropriately marked. - Implement any referral guidance developed by speciality pathway groups in primary care.	- HEAT targets/ trajectories - A10. - 12 week waiting guarantee for 1st outpatient appointment/ 9 weeks from being placed on waiting list to admission for IP/DC procedure. - Cancer Targets/monitoring of. - 95% of all patient diagnosed with cancer begin treatment within 31 days of decision to treat, 95%of those referred urgently with a suspicion of cancer begin treatment within 62 days of receipt of referral. - HEAT A9. - Guidance followed.
B2. Efficient and economic services.	- Develop a comprehensive approach to demand management with CH(C)Ps. - Use GP Forum to open discussions with Secondary Care clinicians to improve patient pathways.	- Topics raised and discussed at GP Forum.
B4. There is whole system consideration of resources and how they shift as the balance of care changes.	Monitoring of service provision to ensure these are in balance and activities take place 'thro' managed processes and are agreed/funded. Develop interface between primary and secondary care through the RAH/CHP initiative described in the Primary Care Framework.	Working with GP Forum to monitor shifts. Proposal for wider consideration by March 2011.

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Outcome	Actions/ Activity required 2010/11	Change/Progress/Performance indicator
B6. Improved management of GP to hospital referrals through better use of technology resulting in a quicker and safer referral process for patients	All Renfrewshire practices now referring via SCI Gateway. It is not possible to send electronic referral to all hospital based services.	Monitor on-going performance via Acute Information. Increasing rates of electronic referral year on year. Increased number of services available through electronic referral.
D1. Reduce admissions to Acute Hospitals and reduced bed days.	Develop an effective rehabilitation and enablement service model.	Monitor level of admission and readmission levels and use of SPARRA data.
D2. Patients treated in the right place by the right person.	- Reduce A&E activity -through the redirection of A&E attendances at other services. - Care pathways between primary and secondary care are planned and designed in partnership with agreed feedback arrangements about utilisation and appropriateness. - Refer to primary care framework. - Refer to Older Peoples Framework/ rehabilitation and enablement work. - Refer to children and families planning Framework.	- Reduction in A&E attendances. - HEAT T10.
E2. Where patients require referral or intervention from secondary care there are clear routes and agreed criteria with primary care.	Continue to focus on them through GP Forum.	Monitoring of this through the local GP Forum.

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Outcome	Actions/ Activity required 2010/11	Change/Progress/Performance indicator
E4. There are agreed, effective and timely information flows between primary and secondary care in the most appropriate format.	Continue to focus on these through GP Forum. Develop a clear understanding of issues and impact re medicines management and hospital prescribing.	Monitoring of this through the local GP Forum. Discuss at Medicines Management Group.
E5. The mutual interdependence between primary and secondary care is recognised and planned for.	Continue to focus on these through GP Forum.	Monitoring of this through the local GP Forum.
E6. The shared responsibilities of primary care and secondary care are identified.	Continue to focus on these through GP Forum.	Monitoring of this through the local GP Forum
H3. All Children and young people should enjoy the highest attainable standards of physical and mental health.	- Breast feeding rate in GGC at 33.3% at 6-8 weeks - with improved breast feeding rate at discharge from hospital. - A plan in place to maximise breast feeding from poorer areas. - UNICEF Baby Friendly Accreditation. - Achieve agreed completion rates for child healthy weight intervention programme. - Refer to Children and Families Planning Framework. - Refer to Maternity Services Framework.	- Breast feeding rate in GGC at 33.3% at 6-8 weeks. - Maternity Unit targets for discharge. - UNICEF Baby Friendly Accreditation. - Monitoring of ACES service in response to HEAT 3.

4.5 Finance and Workforce

4.5.1 We continue to fund and resource our GP Forum to be an effective vehicle for monitoring and developing our interface with Acute Services.

4.5.2 Our development and investment in rehabilitation and enablement services (see Older People and Long Term Conditions Planning Frameworks) is where we drive work to reduce admission and readmission. Workforce issues are covered in that section.