

15. UNPLANNED CARE PLANNING FRAMEWORK

15.1 Analysis of Local Position

- 15.1.1 Within Renfrewshire unplanned care spans the organisational boundaries of acute and primary care services and social work services to prevent avoidable hospital admission, support timely discharge and maximise independent living. The Rehabilitation and Enablement Managed Care Network (R&E MCN) was established in 2008 as a sub group of our Older People's Joint Planning, Performance and Implementation Group. The R&E MCN has a broad membership from Acute, Primary Care, Social Work, Voluntary Organisations, Hospice and members of our Public Partnership Forum. A detailed work plan is in place and is linked closely to our work on long term conditions and the emerging Primary Care Framework.
- 15.1.2 The future Community Rehabilitation and Enablement Service model has been developed in partnership locally and approved by the NHSGGC Coordination Group with a view to implementation from April/May 2010. This will introduce a community rehabilitation service across Renfrewshire, delivered by two geographical teams. Renfrewshire Community Health Partnership has in recent years worked with partners to develop a range of services that facilitate earlier and supported discharge, prevent avoidable admissions and reduce delays to discharge. This provides a strong foundation for ongoing development.
- 15.1.3 Phase one of a Single Point of Access (SPOA) to existing intermediate care services was implemented in July 2009, promoting a co-ordinated approach to supported discharge, supporting unnecessary admissions from home or Accident & Emergency. Evaluation of phase one will be used to inform further development of the SPOA as we establish the full community rehabilitation and enablement service.
- 15.1.4 The Unscheduled Care Collaborative (UCC) was a national project in place from 2005-2008. The aim of the programme was to improve patient and carer experience and satisfaction. This was achieved by improving access and reducing waits and delays across unscheduled care patient pathways. The project adopted a whole system approach in order to identify and change areas where blockages in the system impacted across both primary and secondary care. The collaborative in Renfrewshire achieved a 98% target, which was sustained by December 2007. To date there has been consistency with the 98% target on breaches.
- 15.1.5 The Scottish Patients at Risk of Readmission and Admission (SPARRA) data was incorporated into a Local Enhanced Service during 2009/10. This provides a risk stratification for people >65 years who have >50% risk of readmission to hospital. In Renfrewshire sixteen out of thirty practices signed up to the programme which is currently being evaluated. The LES evaluation report is expected in April 2010.
- 15.1.6 The SPARRA data is also used by our two Intensive Care Managers (ICM) targeting those at 50% and above risk of readmission. Information is sent to GPs and District Nursing Teams and the ICM then liaises with them and targets those patients in the high risk category. They now work with all 30 GP practices across Renfrewshire.

A local Integrated Falls Service has been implemented in Renfrewshire as part of the NHSGGC Falls Service. A referral pathway within A&E to the falls service has allowed for those patients identified at highest risk of falling to be seen and assessed in their home. Through the R&E MCN an initiative has been supported by

the Scottish Ambulance Service to enable ambulance crews to refer directly to the falls service. This is for individuals they attend that have had a fall but do not require hospital care.

A Falls Coordinator has been appointed for the acute service to support and deliver the strategy and pathway.

- 15.1.7 A 'telehealth' pilot was undertaken in a Paisley GP practice between October 2008 and July 2009. This approach uses medical monitoring devices to capture patient health data in a 'remote environment' and transfer it to a clinician, using internet technology. The pilot was initiated in response to the need to address the growing pressure on acute services from increasing emergency hospital admissions and prolonged hospital stays of people with Long Term Conditions (LTCs) particularly Chronic Obstructive Pulmonary Disease (COPD). The pilot has demonstrated limited success with COPD patients, particularly the avoidance of emergency hospital admission. We have been unable to secure additional funding to continue this model and are in the process of exiting the patients in the pilot. As part of our work on long term conditions, we consider alternative options to improve management of COPD patients in line with best available evidence.

15.2 Numeric Analysis

- 15.2.1 Our SPOA has provided data for the period July 2009 to February 2010. A total of 1,040 referrals have been made to SPOA in the 8 month period reported. 9% of these referrals have required hospital admission. 1% of the patients referred refused any input from services. An in depth evaluation for the first 2 month period is in final draft and will make recommendations for phase two of SPOA from April 2010. Future development of the service is included in the Rehabilitation and Enablement redesign.
- 15.2.2 The target for NHSGGC is that 98% of people attending Accident and Emergency Departments will wait less than 4 hours. At the Royal Alexandra Hospital in Paisley, this 98% target was achieved at March 2009. The rate reduced to 97% at June and September 2009 and to 96% in December 2009. Renfrewshire's rate is similar to the NHSGGC average for 2009.

In Renfrewshire the average rate of A&E attendance per month in 2009 was 2,953 per 100,000 population. The lowest rate in 2009 was 2,717 in January and the highest was 3,210 in June. Renfrewshire achieved the NHSGGC target throughout 2009 and remained below the average NHSGGC rate throughout the year.

- 15.2.3 For 2008/09, emergency 2+ hospital admissions for those aged 65+ were 5,806 per 100,000 population in Renfrewshire. This is below the GGC average of 6,298. While the rate for Renfrewshire has reduced from 5,969 in 2006/07 it has increased by 35% from a rate of 4,280 in 2001/02.

15.3 Health Gap and Key Issues

- 15.3.1 To reduce the numbers inappropriately attending A&E, awareness needs to be raised with the public to consider alternatives to A&E and encourage more appropriate options such as practice nurses, GPs and pharmacists available in primary care.
- 15.3.2 A deprivation profile for the CHP patient population >65 has been developed and was used as a tool to inform the redesign of the district nursing model. It will also be

used for the Palliative Care scoping exercise to identify areas with the highest levels of deprivation and older aged population. This deprivation profile is useful to ensure services are targeted at those in most need and ultimately reduce emergency admissions of those aged 65+.

15.4 Outcomes Table

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
<p>1. Unplanned Care has a clear place at the centre of NHSGGC planning, decision making, resource allocation, communication and public engagement.</p>	<p>The Renfrewshire Rehabilitation and Enablement Managed Care Network (MCN) will ensure unplanned care services are clearly defined and established in the planning process.</p> <p>Ensure engagement and joint working between primary and secondary care, independent contractors(including SW services, SAS, NHS24, and Voluntary orgs which will allow for:</p> <p>A shared decision process for the MCN and the JPPIG (Joint Planning, Performance and Implementation Group) on service delivery and use of resources</p> <p>Proposals around innovation and new ideas to be taken to the MCN and then for final approval at the JPPIG</p> <p>Work with the PPF to strengthen engagement with patients and encourage engagement and involvement of patients, carers and communities in ongoing service delivery/development</p> <p>The RES service will develop a satisfaction questionnaire that will be given to all people discharged at end of the service</p>	<p>Monitored and reviewed through the work plan</p> <p>Discuss membership of MCN and invite representative from NHS24</p> <p>Monitor and review</p> <p>HEAT Target: T7 Improvement in the quality of healthcare experience</p>

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
	<p>Develop focus groups to engage and seek views of the service users and public as to the service delivery</p> <p>Develop system through advocacy service to offer support to those people who may not be able to complete questionnaire</p> <p>Develop and implement a structure to follow up on any immediate concerns/actions that result from the survey results</p> <p>The UCC group will provide information to the PPF to share with the public. Information will be made public through the current mediums of PPF magazine/council magazine.</p> <p>Bulletin to all staff and partners quarterly with information on referrals/no. supported discharge/admissions avoided</p> <p>Start implementation of phase 2 Single Point of Access in July/August 2010</p>	<p>KPI: 100% of all patients will receive a questionnaire; with an aim of:</p> <ul style="list-style-type: none"> - 30% return in year 1 - 45% return in year 2 - 60% return in year 3 <p>Engage with patient involvement facilitator. Engage through the PPF/ROAR/Seniors Forums/DRC (2 focus groups)</p> <p>Develop system to report to MCN & JPPIG</p> <p>Update in PPF magazine 2x yearly Council magazine 1x yearly</p> <p>Communication survey on effectiveness and content of the bulletin</p> <p>Aim to increase referrals by 20% by Jan 2011</p>

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	<p>Details of service available in all ambulance vehicles to enable direct access as required to SPOA</p> <p>Direct access for all people to RES service</p>	<p>HEAT Target: T10 To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11.</p> <p>Monitor referrals from SAS to SPOA</p> <p>Monitor number of people self referring to service</p>
<p>2. All parts of the organisation work well together to provide the full range of planned and unplanned services.</p>	<p>Carers framework is implemented Carers self assessment will be made available to identify carers needs</p> <p>Training needs analysis already completed will now inform the requirements for training to ensure an professionally trained workforce</p>	<p>Establish baseline figures</p> <p>TNA shared with Learning and Education; populate training programme for staff in service</p> <ul style="list-style-type: none"> - 70% staff will be trained in care management - 100% of new employees to the RES service will undergo care management training within the induction programme
<p>3. Patients can access unplanned care services at the place and time they need it</p>	<p>Identify gaps in relationship between GP OOH services, pharmacy and out of hours arrangements in other services in line with the national target to reduce A&E attendances</p> <p>Continue to developed service provision within OOH facilitating the development of</p>	<p>HEAT Targets: A8 Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11.</p> <p>T10 To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11.</p>

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	joint working and co-location with Renfrewshire 24 staff and OOH nursing staff. Working group in progress to develop joint competencies for staff across health and social work.	Identify gaps
4. Unplanned care services seek and are responsive to patient views	Complete evaluation of service users and carers' views on SPOA to address models of patient engagement and build on existing PPF structures	Reduced number of complaints Formal feedback mechanism in place e.g. through PFPI Progress joint patient satisfaction questionnaire survey with Local Authority
5. Unplanned care provide a range of services to meet patient needs in different settings and with appropriate entry arrangements	Development of an electronic directory of services that includes respite, care provider and voluntary sector services to reduce the reliance on secondary care	Monitor and review use of electronic directory of service by: - Monitoring number of HITS on the directory - Developing a survey to access feedback on the content/appropriateness/ease of use and benefits/update of information available to the public and staff Increase by 20% the number of people using the directory
6. Ensure that patients have information and access to alternative services to ensure that unplanned care services are used appropriately	SPOA will support the delivery of alternative to hospital admission 24/7 period. Information will be provided through the council magazine and GP surgeries from July/August 2010	Monitor SPOA in referrals to service; monitor access to directory of service; monitor onward referrals to other services
7. Unplanned services are designed to meet the needs of different equality groups and people in deprived communities.	Continue to implement child and adult protection training for all staff groups and ensure compliance with child and adult protection guidelines	4 EQIAs to be carried out and implemented within the first year of the new community Rehabilitation and Enablement Service. EQIAs planned for:

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
	<p>EQIAs carried out and implemented to address equalities issues</p> <p>Action Plan to be developed to take forward the recommendations of the Inequalities Sensitive Practice Project</p> <p>Develop plan for collection of data by equality group across the next 3 years</p> <p>Ensure all patient information conforms to the Accessible Information Policy</p> <p>Increase numbers of CHP staff undertaking the 1 day equality and diversity training</p>	<ul style="list-style-type: none"> - SPOA - Exit strategy for the service user - Service user information - Service specification <p>Action Plan in place and being implemented Move to SW SWIFT system to enable collection of appropriate data; agree data to be collected; present the data</p> <p>Service information will go through the process using EQIA</p> <ul style="list-style-type: none"> - Develop a service specification - Develop a service leaflet <p>100% staff will access e-learning module as part of the KSF process</p>
<p>8. Reduce the reliance on unplanned care services through provision of responsive primary, community and secondary care services.</p>	<p>Develop patient pathways across health and social care continuum that improves interface exchanges between primary care, secondary care, local authorities and the voluntary sector to achieve the HEAT targets</p> <p>Monitor the 48 hour access to GP service</p>	<p>HEAT Target: T8 Increase the level of older people with complex care needs receiving care at home</p> <p>HEAT Target: A8 Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11.</p>

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
	<p>Develop shared services for rapid response over the 24 hour period through the RES model</p> <p>Implement the developed model of support to A&E to enable older people, who require transport and follow up care at home, to be discharged from A&E</p>	<p>Monitor referrals to Renfrewshire Care24</p> <p>Collate baseline data to date. Increase referrals from A&E by 10% by March 2011</p>

15.5 Workforce & Finance

15.5.1 Workforce

The future community and rehabilitation and enablement will, in the first phase, be developed from a redesign of existing services and teams into an integrated single service. In year one the main challenge will be ensuring effective implementation the NHSGGC HR process, and subsequent redesign whilst maintaining existing service provision. This will require to be supported by a targeted learning and education focussed on optimising improved outcomes for service users and carers and continuing our cultural change programme. In parallel we will continue to discuss feasibility of future integration of social work physical disability services within our service model and to review existing CHP adult service provision.

15.5.2 Finance

Resources for the Rehabilitation and Enablement team are established and monitored through the Older People's JPPIG. This includes funding for the MATCH team, which will be transferring to the CHP in 2010/11. Whilst all the posts within the team have identified budget, the Older People's Financial Framework as a whole has financial pressures in 2010/11, and financial balance will be a significant challenge.

A separate financial framework exists for Carers expenditure, monitored through the Carers JPPIG.