NHS Grampian

Clinical Strategy Review - Unscheduled Care

1. Actions Recommended

The Board is asked to:

- Consider the actions that are being progressed to deliver on the priorities set out within the Clinical Strategy in relation to unscheduled care.
- Acknowledge the whole system approach to unscheduled care and its role within the clinical strategy.
- Note the status of progress with the development of the 2019/20 Winter (Surge) Plan.

2. Strategic Context

The clinical strategy has four key components, namely unscheduled care, planned care, self-management and prevention. A key aim within the clinical strategy was to continue to move activity from unscheduled to planned, from planned to self-managed and to support prevention wherever possible. This paper provides some oversight of the work undertaken within unscheduled care.

NHS Grampian has demonstrated resilience in unscheduled care, including over the winter period when services can be under greater pressure, and performs positively against the national average. Much of the resilience is due to the efforts and hard work of committed and conscientious staff in our hospitals and communities as well as comprehensive cross-system planning and delivery. There has been considerable development of community based activity to minimise unplanned admissions to hospital and to facilitate supported discharge when admission does take place.

3. Matters relevant to the recommendation

a. System wide approach

The NHS Grampian Unscheduled Care (USC) Programme Board (Chief Officers from Acute and the three Health and Social Care Partnerships) ensures there is a co-ordinated approach to cross sector, high level leadership and governance. The work of the Unscheduled Care Programme Board is informed by the Grampian Clinical Strategy, and Integration Joint Board (IJB) Strategic Plans and through discussion with the System Leadership Team.

Working collaboratively across the whole system, multi-disciplinary staff work closely to focus on people's needs. We have seen the further evolution of the safety brief model which includes a daily conference across all sectors. We have developed integrated discharge pathways that cross sectors, close working relationships in partnership with other agencies to streamline processes and colleagues continue to develop new approaches to improve outcomes. We have been particularly successful at reducing the number of bed days spent in hospital by those awaiting discharge.

b. National Unscheduled Care Programme

We participate fully in the national Unscheduled Care Programme focusing on delivery of the six essential actions[1]. We operate a fully staffed small team to deliver the national Programme and are focused around the two acute sites, including dedicated site-based Improvement Managers embedded in the local teams for Aberdeen City, Aberdeenshire and Moray.

Each of the six headline actions provide opportunities to shape improvement activity, with sufficient flexibility to allow local interpretation and prioritisation. In this way teams at all levels can use the six essential actions framework to devise, test and build new ways of doing things that could provide a better unscheduled care experience for their patients and populations.

The impact of these improvements are measured nationally against the 4 hour access standard which aims to ensure that 95% of patients attending A&E anywhere in Scotland are seen, treated and discharged or admitted within four hours. Performance for the past five years can be seen for Aberdeen Royal Infirmary (ARI) and Dr Gray's Hospital (DGH) in Figures 1 and 2.

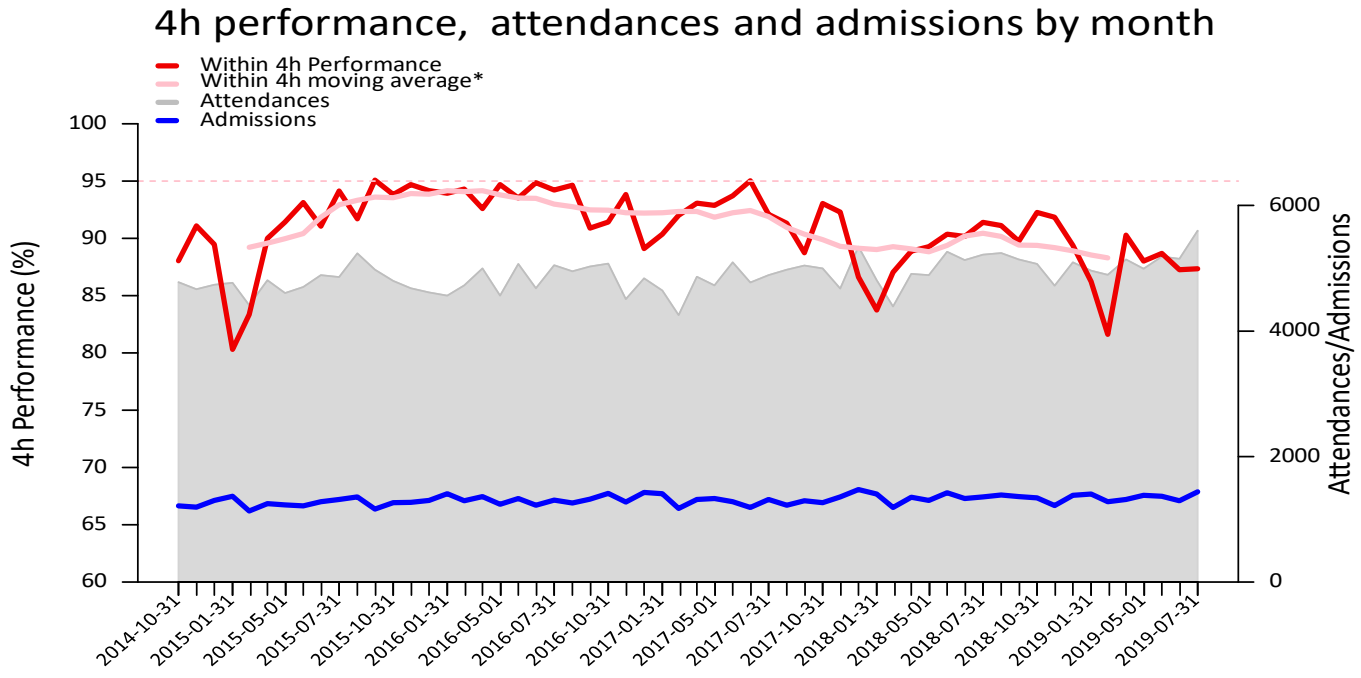
Health and Social Care Partnerships (HSCPs), as part of the national requirements, have developed plans for the following indicators, which are monitored by their respective IJBs:

- Unplanned admissions
- Unplanned bed days
- A&E attendances
- Delayed discharge bed days
- Last six months of life at home
- Balance of care

These plans set out how the partnerships, with their wider communities and the Board will deliver optimum performance within resources available.

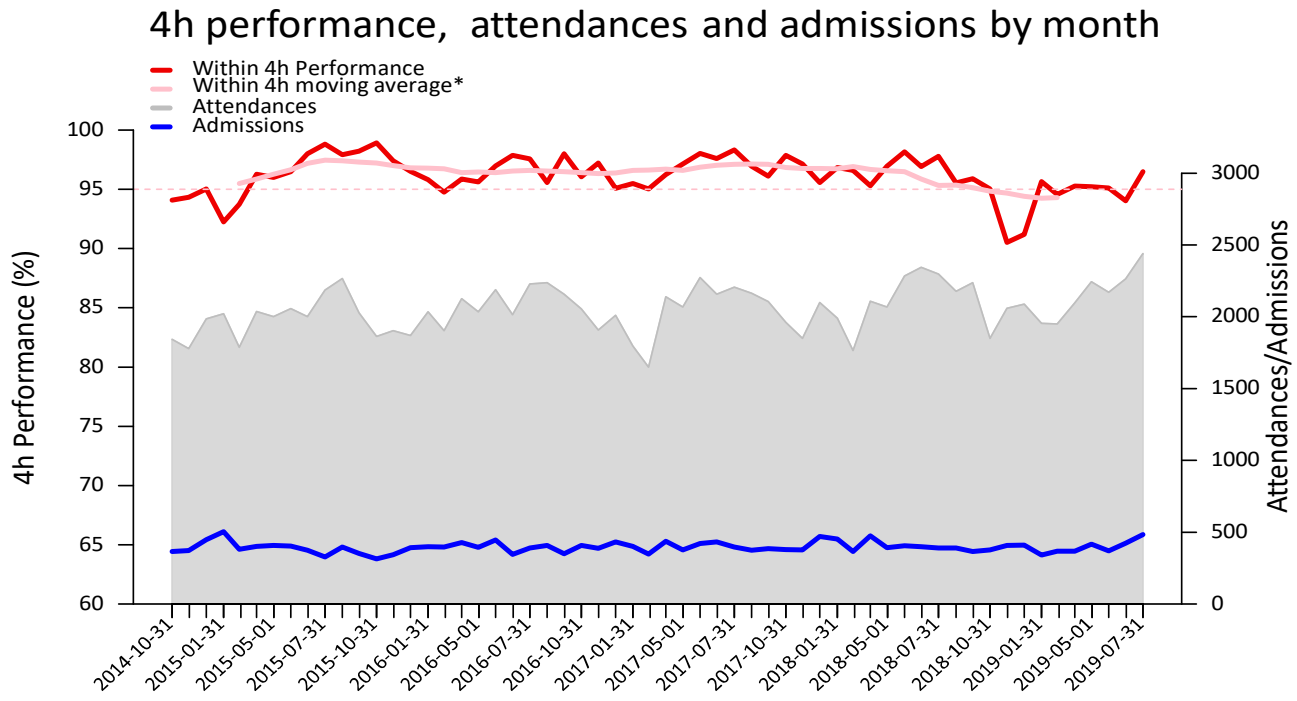
[1] Six Essential Actions 1. Clinically focused and empowered hospital management team; 2. Hospital Capacity Patient Flow (emergency and elective) re-aligned; 3. Patient rather than bed management; 4. Medical and Surgical processes aligned; 5. Seven day services appropriately targeted; 6. Patients are cared for in their own homes or a homely setting

Figure 1 Aberdeen Royal Infirmary



Source: ISD for data relating to the period between the months October-2014 and July-2019
*Moving average based on 10 months

Figure 2 Dr Gray's Hospital



Source: ISD for data relating to the period between the months October-2014 and July-2019
*Moving average based on 10 months

c. Cross system working for delivery

Joined up system planning for unscheduled care improvement is delivered by the Grampian Unscheduled Care Delivery Group. Its membership is drawn from all sectors and wider partners (e.g. Scottish Ambulance Service) and it has oversight of system performance and improvement planning. Directed by the Unscheduled Care Programme Board, the USC Delivery Group ensures whole system delivery of the strategic objectives. In addition the delivery group ratifies spending plans for National Unscheduled Care funding, approves annual work plans and monitors system performance data.

Under this integrated approach, we have already seen developments that aid unscheduled care arrangements such as the provision of a dedicated Allied Health Professions (AHP) service embedded within the Emergency Departments at ARI and DGH providing comprehensive assessment and identification of frail elderly patients. Detailed Physio and Occupational Therapy assessments can support the avoidance of admission and the timely re-enablement of patients within community setting.

Using a quality improvement approach the testing and implementation of Discharge/Flow Co-ordinators across a number of speciality wards within ARI and & DGH has seen an improvement in patients' discharge planning, bringing their time of discharge earlier in the day and reducing unnecessary delays for patients whilst improving patient flow through the acute hospital setting.

In conjunction, the availability of 7 day a week service to screen and assess patients with complex discharge needs by the integrated discharge hub team has facilitated an increase in the number of complex discharges that occur at weekends and reduced unnecessary delays in returning patients to their homes or homely setting.

Collaborative working across the whole system is supporting ongoing tests of change to design and develop discharge pathways for patients requiring a minimal increase to their social care support. This approach is based upon the augmented care being provided by local response teams such as Aberdeenshire Response Care at Home Team (ARCH) and Moray Pitgaveny Response Team, whilst the assessment of need is carried out and additional social care scheduled.

The success of cross system working is based in the effective "Building and Bridging" of networks across all sectors within the whole system. This was the theme of the 2019 Annual Unscheduled Care Conference held on 27 August at the Doubletree by Hilton Hotel, Aberdeen. It provided an opportunity to share learning through short presentations from staff and colleagues leading on a number of unscheduled care improvement initiatives across Grampian as well as facilitating the opportunity for delegates (77 staff from Acute, HSCPs and Third Sector) to create and expand networks through a number of interactive workshop sessions.

d. Challenges within the system

The previous section has highlighted some of the very positive cross-system work and it is important that the challenges being faced within all parts of our system are still recognised. In our population we are seeing the demographic changes that were forecast; people living longer is a success story for health care, however our staff report that in general they are seeing older, sicker and frailer patients. Patients with complex co-morbidities are a factor too and managing the increasing levels of acuity of these patients is a challenge.

Whilst emergency admissions are reasonably stable over the five-year timeframe (Figures 1 & 2) the pressure that is felt within the acute hospital system is widely and frequently reported by staff. One of the key challenges for the Unscheduled Care Programme Board and the unscheduled delivery team is to understand this and, with the support of the SLT, to determine how to support a sustainable delivery model. The Unscheduled Care Programme Board is also seeking to develop more sophisticated performance measures which allow us to understand improvements in both the community and the hospital whilst being able to further understand the increasing pressure which is felt by all teams.

Whist we aspire to be resource efficient, our staffing levels and high level of vacancies can mean that it can be difficult to be as flexible in our planning for surges in demand as we would aim to be. This is evident in our rota planning for festive periods when it is challenging to scale up staffing levels at peak times across both health and social care.

Maintaining patient safety is paramount and at times striving to ensure this in conjunction with the staffing challenges experienced can lead to a negative impact upon unscheduled care targets as well as increasing the stress experienced by staff.

e. Winter (surge) planning

The Grampian Winter (Surge) Plan consolidates the individual plans of the Health and Social Care Partnerships in Aberdeen City, Aberdeenshire and Moray, and the NHS Grampian Acute Sector. The Plan also includes the arrangements implemented by key partners including NHS24, the Scottish Ambulance Service and local authorities within Grampian.

In Grampian there is an established process for winter planning which is undertaken as a year-round planning cycle and incorporates an integrated approach with the application of business continuity principles. Partners, including NHS24, Scottish Ambulance Service, the three Health and Social Care Partnerships and Local Authorities, are key to the process and participate in joint planning workshops and debrief exercises.

It is recognised that winter planning is complex and can be challenging. This is addressed by early planning at local and team level, and by building this into sector, divisional and board level plans. This proactive approach provides the opportunity to explore and test responses to winter pressures.

Testing of local plans and local teams' understanding of winter responses ensures confidence in the process and provides the opportunity to practise response arrangements as well as the chance to identify any gaps in planning ahead of winter. Tabletop exercises are taking place in each of the Health and Social Care Partnerships and the Acute Sector. In addition a cross sector event will bring staff together from across the Health and Social Care system, the acute sector and colleagues from the Scottish Ambulance Service to test the joint approach that is in place across all organisation and how the plans dovetail together, how risk is assessed across the board and how Command and Control functions across the joint approach.

In accordance with Chief Executive, NHS Scotland letter (4th September 2019) there is a requirement for Boards in Winter 2019/20 to deliver on:

- Reducing attendances wherever possible by managing care closer to home.
- Managing/Avoiding admissions wherever possible
- Reducing length of stay
- Focus on flow through Acute Care
- Appropriate levels of workforce.

The detail of the initiatives being taken to deliver these requirements will be set out in the Grampian Winter (Surge) Plan 2019/20 which will be presented for Board approval in November. The Grampian Winter (Surge) Plan will be submitted to the Government once agreed by the Board.

In terms of actions that are being taken to increase capacity during peak periods we would highlight the following

- All frontline staffing rotas will be complete by the end of October 2019 for those areas that are required to respond immediately to increases in demand align staffing rotas accordingly, for example the Emergency Department and Acute Medical Initial Assessment Unit.

- Plans to provide surge capacity and resource over the winter period for the predicted increase in medical admissions are being finalised. The plan will ensure priority access for cancer and urgent patients whilst endeavouring to maintain the balance between elective and unplanned surgery; all of this is cognisant of the requirement to also deliver elective waiting time trajectories.

- The high level performance management of the Grampian Winter (Surge) Plan for 2019/20 will be through the System Leadership Team which is chaired by the Chief Executive and includes the Chief Officers of the Acute Sector and the three Health and Social Care Partnerships.

- The Grampian Influenza (Flu) Immunisation programme is run in conjunction with the National Programme and commenced on the 1 October 2019. The programme will continue to focus on target groups (full detail can be seen in the Grampian Winter (Surge) Plan 2019/20). A publicity campaign to encourage NHS Grampian staff as well as social care staff, including those working in care homes, providing care at home and in the voluntary sector, was conducted during September. A local initiative to increase access to flu immunisation for staff will see "Peer to Peer" vaccination tested in some wards at ARI before being rolled out to other areas.

f. National and local resources

The Unscheduled Care Delivery Group has approved the expenditure of national unscheduled care funding resource for 2019/20 on the following three initiatives which support the key objectives of the programme to reduce emergency department attendances, manage/avoid admissions and reduce length of stay

Know Who To Turn To Winter Campaign

- Communication of key information on services available to support the public in accessing the most appropriate service for their particular health need will be delivered by the use of: TV & Radio Advertising, Social Media (Facebook & Twitter) & Media Releases. In addition, Health Point Teams (NHS Grampian's Health Information centres) will be fully briefed to provide information on all our key messages and details on National advice lines such as NHS Inform.

Get Up Get Dressed Get Moving (End PJ Paralysis)

- The premise of #endPJparalysis is remarkably simple, enabling hospitalised patients to get up, dressed and moving in order to prevent deconditioning. This is important because 65% of patients admitted to hospital are 65 or older and a person over 80 who spends 10 days in a hospital bed will lose 10% of muscle mass. This can be the difference between going home and going to a home. In Grampian several initiatives and patient information are being developed to encourage and support staff and patients to follow this simple approach to ensure patients can return to their home or homely settings as soon as they are clinically well enough to do so.

Fit To Sit

- In conjunction with End PJ Paralysis the national Fit2Sit campaign encourages frontline health professionals and paramedics to put an end to patients lying down on trolleys and stretchers if they are well enough to sit or stand. In the Emergency Departments and Acute Medical Initial Assessment Units in Grampian, comfortable appropriately designed chairs are available to enable patients who are well enough to sit. This encourages patients to walk if they can, to prevent deconditioning, increase mobility and retain a patient's independence. In addition, it reduces crowding and delays in busy Emergency Departments.

In addition to the funding allocation made by the Scottish Government for unscheduled care and winter resilience, there has been significant local investment made in Grampian by the NHS and the Health and Social Care Partnerships to improve responsiveness and resilience ahead of Winter 2019/20.

During winter up to 20% of acute assessment beds can be taken by patients with exacerbations of Chronic Obstructive Pulmonary Disease (COPD), with similar increased activity in Emergency Departments and due to the nature of COPD, unlike some other diseases, there is reduced recovery after each exacerbation.

In 2018/19 an integrated partnership approach was taken to reduce the impact of winter on people with COPD, by raising awareness of the preventative actions which can be taken by this patient cohort.

This approach included the circulation of a COPD Information Bundle to all registered COPD patients through GP practices advising the benefits of attending Pulmonary Rehabilitation Classes, having a Flu vaccination, using inhalers correctly; seeking medical advice promptly if feeling unwell and managing their condition in cold weather. Community Pharmacies provided additional support to this initiative by using the Making Every Opportunity Count approach (MEOC) and discussing the COPD Information Bundle with COPD patients when they visited Community Pharmacies.

Data and indications show that this integrated approach with further refinement should be included in winter planning to support promotion of a self-management approach that can lead to a reduction in acute hospital admissions for COPD patients during the winter period (see Appendix 1)

Preparations to enhance and repeat this initiative for Winter 2019/20 have begun.

4. Responsible System Leadership Team Member and contact for further information

If you require any further information in advance of the Board meeting please contact:

Responsible System Leadership Team member:	**Report author & contact for further information:**
Adam Coldwells Chief Officer Aberdeenshire HSCP adam.coldwells@nhs.net	Kate Livock Programme Manager for Six Essential Actions for Improving Unscheduled Care katelivock@nhs.net

September 2019

Appendix 1 – Outcomes from the 2018/19 winter bundle for COPD

Winter Information Bundle Review 2018 – 2019

Aim

The aim of this initiative was to reduce the impact of winter on people with Chronic Obstructive Pulmonary Disease (COPD). Primarily to be measured in Secondary Care, by raising awareness of the preventativeactions which can be taken by this patient cohort.

Objectives

- 5% reduction in hospital admissions (Baseline 2017/2018 Total 29)
- 5% reduction in bed days (Baseline 2017/2018 Total 207) (4154 days)
- Increase number of Pulmonary Rehabilitation (PR) class participants by 10%
- Achieve immunisation target rate for cohort (Baseline 2017/2018 Total 46.9%)

Approach

As part of an overall Winter planning activity, Chief Officers took an integrated Partnership approach, supported by NHS Grampian's Modernisation Directorate, to focus on the COPD cohort of Respiratory patients.

During winter up to 20% of acute assessment beds can be taken by patients with exacerbations of COPD, with similar increased activity in Emergency Departments and due to the nature of COPD, unlike some other diseases, there is reduced recovery after each exacerbation.

With ease of access to clinical opinion via our established Respiratory MCN, and by using baseline data to measure and track COPD admissions rates, we aimed to provide an optimised bundle of information for patients, and therefore reduce unscheduled Respiratory admissions to hospital over the winter period of 2018/2019.

Methods/Inputs

Letter sent to all (approx. 74) GP practices across Aberdeen City, Aberdeenshire and Moray requesting they circulate a COPD information bundle for patients which included:

- Data extraction instructions to identify the appropriate patients (Appendix 1a)
- Information on the benefit of attending Pulmonary Rehabilitation (PR) classes which included a direct telephone number for patient self-referral (Appendix 1b)
- An easy to read self-help poster about Respiratory conditions (Appendix 1c)

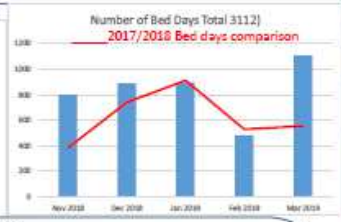
Letter sent to all Community Pharmacists across Aberdeen City, Aberdeenshire and Moray promoting a 'Make Every Opportunity Count' (MEOC) approach to support this patient cohort, thereby, helping to reduce exacerbations that result in attendance at A&E or admission to hospital.

Participating GP Practices

Aberdeen City	Aberdeenshire	Moray
Buckburn	Aboyne	None*
Carden	An Caorann	
Cults	Ballater	
Danestone	Banchory	
Hamilton	Cruden	
Elmbank	Deveron	
Garthdee	Fyvie	
Kincorth	Insch	
Links	Inverurie	
Oldmachar	Skene	
	Torphins	
	Turriff	

*See comment in costs box

Baseline Graphs



Interventions

Community Pharmacies delivered vital support by providing information to reinforce patient self-management, increase number of Flu immunisations, provide weather awareness information, review inhaler use, educate on correct inhaler technique and to ensure that their Pharmacy was signed up to the Unscheduled Care PGD to issue rescue antibiotics.

Pulmonary Rehabilitation (PR) GPs were provided with information on PR classes for promoting to patients as part of the self-care information bundle (Appendix 3). A self-referral telephone line was introduced over the winter period to allow patients to access PR without the need for a GP or nurse referral.

Pulmonary Rehabilitation Self-Referral Line Data - December 2018-March 2019

	September	October	November	December	January	February	March
PR Class Capacity (no.)	70	51	116	100	147	142	146
Full completion (no.)	19	28	16	8	19	18	32
Number on WL (no.)	346	314	204	154	327	276	270
Average wait on WL (days)	55	20	21.74	36.2	13.72	11.42	9.64

Self-Referral: 92 patients self-referred into the PR service by contacting a supplied phone number, **who would otherwise not have been able to request support**. Capacity increased in classes by an average of 54 places (68%) per month compared to the same period last year, and increased by 108% over the period. The number of people on the PR waiting list has fallen by (76) 22% from 346 in September 2018 to 270 at the end of March 2019, despite an increase in referral rates (likely due to the availability of self-referral).

New assessments: Due to the introduction of the self referral line, the number of new patient assessments increased by an average of 13 (28%). This number has been steadily increasing towards the end of the reporting period (February/March 2019 to an average of 69 self-referrals per month, compared to 45 in September/October 2018). A new administration process has since been introduced following the positive effect of this intervention.

Waiting Times: Waiting times have reduced from an average of 36.2 weeks in December 2019 to 9.7 weeks in March 2019, although there remains considerable local variation. This has likely been due to the combination of increased capacity, and robust, consistent waiting list management achieved by the centralised administration model.

Flu Immunisations

Decreased uptake 2017/18 in red (See Observation box for explanation)

% uptake of flu vaccination by risk group (Target 75%)		
Clinical Risk Group < 65yrs	NHS Grampian	Scotland
Chronic respiratory disease	45.0% (1.9%)	44.6% (2.3%)

Source: Health Protection Scotland

Costs

Based on postage of £1.00 per letter and 1hr per 100 letters, claims were received from 22 GP practices across NHS Grampian.
Note: a number of GP practices disseminated the information bundle but have yet to reclaim costs.

GP Practice	Postage reclaim £1.00 per letter	3136.00
Pulmonary Rehabilitation	Physiotherapy Staff	13787.00
Pulmonary Rehabilitation	Administration Staff	2187.00
Pulmonary Rehabilitation	Venue Hire	1205.00
Pulmonary Rehabilitation	Equipment Hire	2000.00
	Total Spend	22315.00

TIMESCALE: PLANNING: SEPTEMBER 2018 TEST PERIOD: OCTOBER – MARCH 2018 AUDIT: JULY 2019

Target Impact

- 5% less hospital admissions (Total 29)
- 5% less bed days (Total 207)
- Increase no. of PR class participants (10%)

Recorded Impact 2018/2019

- 6.8% fewer hospital admissions (Total 40)
- 25% fewer bed days (Total 3112)
- Increase no. PR class participants (68%)
- 45% of cohort immunised for Flu

Additional Impact Measures 2018/2019

- Number of admissions 545 (585 2017/2018)
- Number of patients 442 (484 2017/2018)
- Average length of stay 5.7 days (7.1 days 2017/18)
- Phone calls to PR self-referral line 92

Observations

Feedback: Approx. 13 GP practices provided a range of feedback such as; data extraction instructions were not clear to follow and that the cost reclaiming process was too lengthy for small patient numbers. Others expressed extremely positive feedback such as; this "fresh, concise and no frills" approach is an ideal model for providing important information to patients.

Data: Flu immunisation data for 2018/19 cannot be easily compared to the previous winter period due to multiple issues with delivery of vaccines that had a detrimental effect on the uptake of flu vaccines, not only in Grampian but also nationally.

All results and outcomes related to admission rates, bed days, length of stay should be read with the caveat that it is not possible to determine the degree to which these positive reductions were attributable to this exercise, as there are complex factors which affect activity levels.

The overall approach taken in this exercise was simple, no-frills, using language aimed at the layperson and suing a short list of metrics. Nonetheless, it is also based on a robust, established clinical model for managing COPD with focus on proven interventions. A key factor in overcoming previous longstanding barriers to people accessing PR appears to be the centralised admin that was provided in the short term by this exercise.

Recommendations

- Data and indications seem to show that this integrated approach may be worth considering for future winter planning activities; for promotion of a self mgmt approach; for mainstreaming, and/or for repeating the 'no-frills but focused' approach to other areas, e.g. ACPs.
- To provide further refinement of the method enabling GPs to extract data to identify appropriate patient cohort.
- Consider permanent establishment of a centralised admin structure that ensure patients can self refer and PR resources across Grampian can be efficiently harnessed and allocated, based on the impact of this key feature of the exercise.

Appendix 1 – Information for GPs
a) Clinical Lead Letter for GPs and Data Extraction Guide
b) Pulmonary Rehabilitation Information Letter
c) Respiratory Conditions Information Poster

Appendix 2 – Information for Community Pharmacists
a) Clinical Leads letter for Community Pharmacists
b) Pulmonary Rehabilitation Information Letter
c) Respiratory Conditions Information Poster

Appendix 2 – Pulmonary Rehabilitation
a) Pulmonary Rehabilitation Summary April 2019