REPORT

SUBJECT:	Understanding Progress Under Integration – Improvement Objectives 2019/20
TO:	Integration Joint Board
Lead Officer for Report:	Chief Accountable Officer
Author of Report:	Performance Manager
DATE:	8 March 2019

1. PURPOSE OF REPORT

1.1 This paper is coming to the Board:

For approval	☒	For endorsement	☐	To note	☐

1.2 The purpose of the report is to seek the Board's approval for the attached improvement objectives set out against the six priorities of the Understanding Progress Under Integration workstream led by the Ministerial Strategic Group for Health and Community Care.

2. ROUTE TO THE BOARD

2.1 This paper has been:

Prepared By: Performance Manager	Reviewed By:	Endorsed By:

3. RECOMMENDATIONS

3.1 The Board is asked to note and approve the contents of the report and its appendices for sharing with Scottish Government.

4. BACKGROUND/SUMMARY OF KEY ISSUES

4.1 In early 2017, the Scottish Government established a framework to provide quarterly progress updates to the Ministerial Strategic Group for Health & Community Care covering six agreed priorities that support the ambitions set out in the Scottish Government's Health and Social Care Delivery Plan. These priorities are:

a. Number of emergency admissions into acute specialties
b. Number of unscheduled hospital bed days
c. Number of A&E attendances and the number of patients seen within 4 hours
d. Number of delayed discharge bed days
e. Percentage of last six months of life spent in the community

f. Percentage of population residing in non-hospital setting for all adults and people aged 65+

4.2 The Scottish Government and COSLA wrote to Integration Authorities in December 2018 asking each Integration Authority to share details of how they expect activity to change under each indicator for the period 2019/20. The guidance notes and format for sharing objectives has been reviewed and updated and is more prescriptive than in previous years.

4.3 Following consultation with partners across the health and social care system, a set of draft improvement objectives have been devised and are attached as appendix 1 to this report. The Local Intelligence Support Team (LIST) from Information Services Division (ISD), have provided the partnership with projections for each of the indicators based on previous trend information and assuming everything remains the same. These projections and our improvement trajectories are reflected in a series of run charts included as appendix 2.

4.4 The prescriptive nature of the reporting template requires us to follow a certain structure and format, which is helpful in that it improves consistency of information and standardises reporting. However, it does not allow integration authorities much flexibility in the presentation of the information.

4.5 For ease of reference, the broad improvements set out in the appendix are.

i) To maintain a 0% change4.2 in emergency admissions, based on 2017/18 baseline
ii) To reduce Unscheduled Bed Days across all specialties by 10%, based on 2016/17 baseline
iii) To reduce rate of growth in A&E Attendances to 2%, based on 2017/18 baseline
iv) To reduce delayed discharge bed days by 5%, based on 2017/18 baseline
v) To increase the percentage of the last 6 months of life spent in community settings by 3.4 percentage points, based on 2015/16 baseline
vi) To maintain a 0% change in the percentage of people aged 65+ supported and unsupported at home, based on 2015/16 baseline.

5. IMPLICATIONS

5.1 NATIONAL OUTCOMES
The Understanding Progress Under Integration is seen as a means of better understanding how well Integration Authorities are delivering against the national health and wellbeing outcomes.

5.2 ASSOCIATED MEASURE(S)
None

5.3 FINANCIAL
None

5.4 PEOPLE
None

5.5 INEQUALITIES
EQIA Completed:

Yes	☐	No	☐	N/A	☒

6. BACKGROUND PAPERS
None

7. APPENDICES

Appendix One - Understanding Progress Under Integration: 19/20 Improvement Objectives
Appendix 2 – Improvement Run Charts for 19/20 Objectives

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CHIEF ACCOUNTABLE OFFICER

Members seeking further information about any aspect of this report, please contact Graeme Cowan on telephone number 07946702861.

Appendix 1 – Understanding Progress Under Integration: 19/20 Improvement Objectives

Health and Social Care Partnership: North Lanarkshire

Age Group for indicators 1 to 3: All ages

	1. Emergency admissions				2. Unplanned bed days					3. A&E attendances			
Objective	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20*	Acute	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20*
	2017/18	46,241	0% change	46,241		2016/17	243,614	10% decrease	219,253	2017/18	122,137	2% increase	124,580
					Geriatric Long Stay	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*				
						2016/17	71,907	10% decrease	64,716				
					Mental Health	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*				
						2016/17	28,959	10% decrease	26,063				
How will it be achieved	A range of overarching actions have been developed and agreed by the Lanarkshire Unscheduled Care Improvement Board and Whole System Delayed Discharge Group against three priorities 0- Frailty, Front Door decision making & Frequent Attenders: Frailty • Creation of a pan-Lanarkshire Frailty pathway that spans both acute and community • Roll out of electronic Frailty Index in community and frailty screening in Emergency Departments • Development of an early warning system from existing data sources • Creation of Frailty Units on the 3 acute sites through reconfiguration of existing beds • Development of a workforce plan and training needs analysis to ensure we have the correct multi-disciplinary skills across the system • Roll out of integrated Locality teams, including rapid response, with close links to Frailty Units • Creation of an Organisational Development programme to support the development of closer links between acute and community teams Frequent Attenders • Creation of a consistent and reliable method of identifying frequent attenders and those in high risk groups for attendance • Development of workforce model that would provide a number of case managers/key workers to support the development of individualised plans for frequent attenders. This also needs to recognise the strong role of existing staff such as Paramedics and Link Workers • Development of multi-disciplinary case management approaches spanning acute and community services • Connection with Locality link workers and voluntary sector to ensure a wide range of Locality supports and services are available for identified individuals • Develop the Crisis Response within community teams, including particularly Mental Health and Addictions services, closely linked with colleagues in Police Scotland and the Scottish Ambulance Service Front Door • Create a plan for the consistent roll out of the Rapid Emergency Assessment Care Team (REACT) model across all three sites, including capital works and new staffing models • Undertake a detailed analysis of emergency department attendances across the three sites • Expand and develop a pan-Lanarkshire Directory of Services for REACT • Undertake a review of 'hot clinic' provision across three sites as part of the above exercise • Complete the 'Reducing Reliance on ED' short life working group and create a consistent action plan for delivery across the system • Explore developments around the acute/community interface • Create a plan around enhancing community pathways around a number of key areas including IV antibiotics, Deep Vein Thrombosis (DVT), Respiratory and Heart Failure												
Notes					2016/17 baseline used due to completeness issues with more recent data.								

Appendix 1 – Understanding Progress Under Integration: 19/20 Improvement Objectives

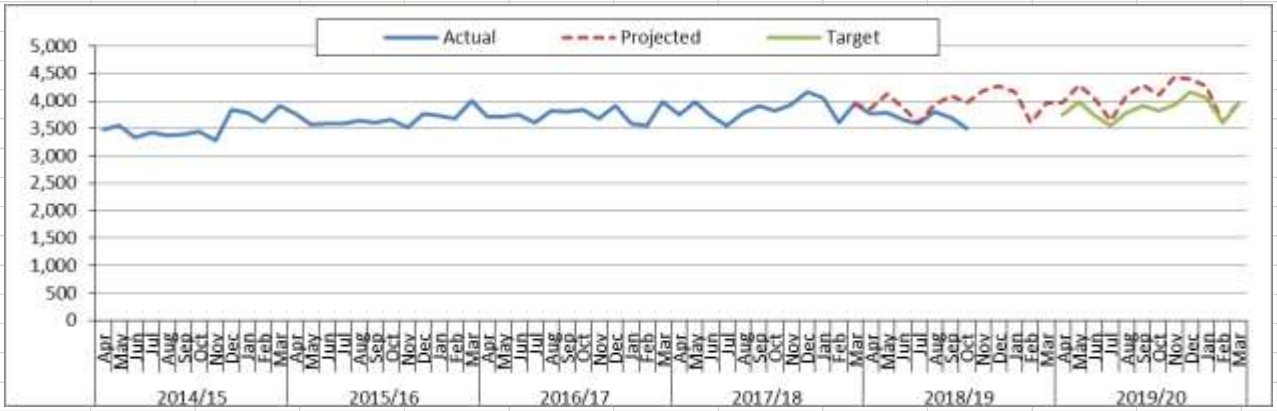
Health and Social Care Pa North Lanarkshire

Age Group for indicators 1 to 3:

	4. Delayed discharge bed days (18+)					5. Percentage of last 6 months of life spent in community (all ages)				6. Proportion of 65+ population living at home (supported and unsupported)			
Objective	All reasons	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*	*Baseline year*	*Baseline percentage*	*Percentage point change*	*Expected 2019/20 %*	*Baseline year*	*Baseline percentage*	*Percentage point change*	*Expected 2019/20 %*
		2017/18	36,834	5% decrease	34,992	2015/16	86.6%	3.4 increase	90.0%	2015/16	96.1%	0% change	96.1%
	H&SC/patient and family related reasons	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*								
		2017/18	30,862	5% decrease	29,319								
	Code 9	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*								
		2017/18	5,972	5% decrease	5,673								
How will it be achieved	The actions already listed will have an impact on delayed discharge bed days, in addition to the following workstreams being delivered via the partnership's Strategic Commissioning Plan: • The rehabilitation demonstration project which commenced in Motherwell in September 2017, integrating physiotherapy and occupational therapy staff from acute services, Community Assessment and Rehabilitation Service and Locality teams (health and social work) has delvieered positive results in relation to waiting times and outcomes. This model was rolled out to the remaining five localities in October 2018. • The new model of Home Support has also been rolling out across each Locality, with additional reablement teams soon to commence in all six Localities. A key element of this model is the creation of rapid response, supporting the development of the discharge to assess approach and also unscheduled responses within the Localities to reduce admissions. • A whole-system working group is in place to commence the roll out of discharge to assess in North Lanarkshire.					• Develop and implement integrated multidisciplinary locality teams • Implement new model of Home Support • Grow capacity in the Third sector to ensure community supports • Implement new model of palliative care services and specialist hospice provision • Further development and use of Anticipatory Care Plans to support people to die in their place of choice. Support for people whose wish is to die at home.				• Develop and implement integrated multidisciplinary locality teams • Implement new model of Home Support • Roll out new model of rehab • Implement model of discharge to assess • Review and enhance current Hospital at Home model • Grow capacity in the Third sector to ensure community supports • Develop and implement proposals to reduce the reliance on residential and acute care, whilst strengthening community based supports			
Notes	2017/18 baseline used as first full year of data using current data definitions.												

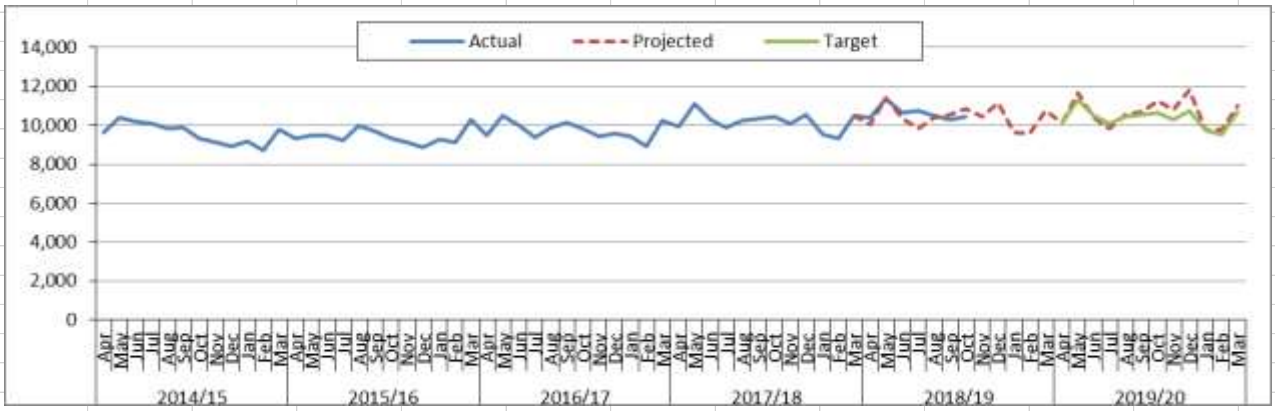
Appendix 2 – Improvement Run Charts for 19/20 Objectives

1. Emergency Admissions



2. Unscheduled Bed Days - All Specialties

3. A&E Attendances



4. Delayed Discharges - All reasons