AGENDA ITEM NO 10

REPORT NO IJB 64/24

ANGUS INTEGRATION JOINT BOARD

30 OCTOBER 2024

URGENT AND UNSCHEDULED CARE PEFORMANCE UPDATE REPORT

REPORT BY JILLIAN GALLOWAY, CHIEF OFFICER

1 ABSTRACT

To update the Integration Joint Board (IJB) on performance in relation to Urgent and Unscheduled Care in Angus, highlighting areas of risk and to detail an update on the progress of winter plans and actions being progressed to reduce delays and unmet need within Angus Health and Social Care Partnership (AHSCP) services.

2 ALIGNMENT TO THE STRATEGIC PLAN

This work aligns to the following priorities of the Angus IJB Strategic Commissioning Plan 2023-2026:

- Priority 1 - Prevention and Proactive Care
- Priority 2 – Care Closer to Home
- Priority 3 – Mental Health & Wellbeing and substance use recovery

3 RECOMMENDATIONS

It is recommended that the Angus Integration Joint Board: -

(i) Discuss, acknowledge and support the ongoing programme of work in relation to Urgent and Unscheduled Care; and

(ii) Acknowledge the recent performance information and the progress of the specific actions being taken in Angus.

4 BACKGROUND

Urgent Care refers to the need for medical treatment for a condition or injury which is not considered to be imminently life threatening but could worsen if left untreated and Unscheduled Care describes the need for unplanned medical care often because of an accident.

Traditionally, the Emergency Department (ED) has been seen as the primary location to receive urgent and unscheduled care. However, for many, ED will not be the right place for their healthcare need. NHS Scotland provides for the urgent and unscheduled care needs of the population through a variety of services including GP practices, minor injury clinics and pharmacy treatment.

i NHS Tayside Urgent and Unscheduled Care Board

The purpose of the Urgent and Unscheduled Care Programme Board is to provide a forum for oversight of all major plans, confirming and communicating the programme vision, approving the programme priorities and monitoring the achievement of plans of the Tayside Urgent and Unscheduled Care Programme.

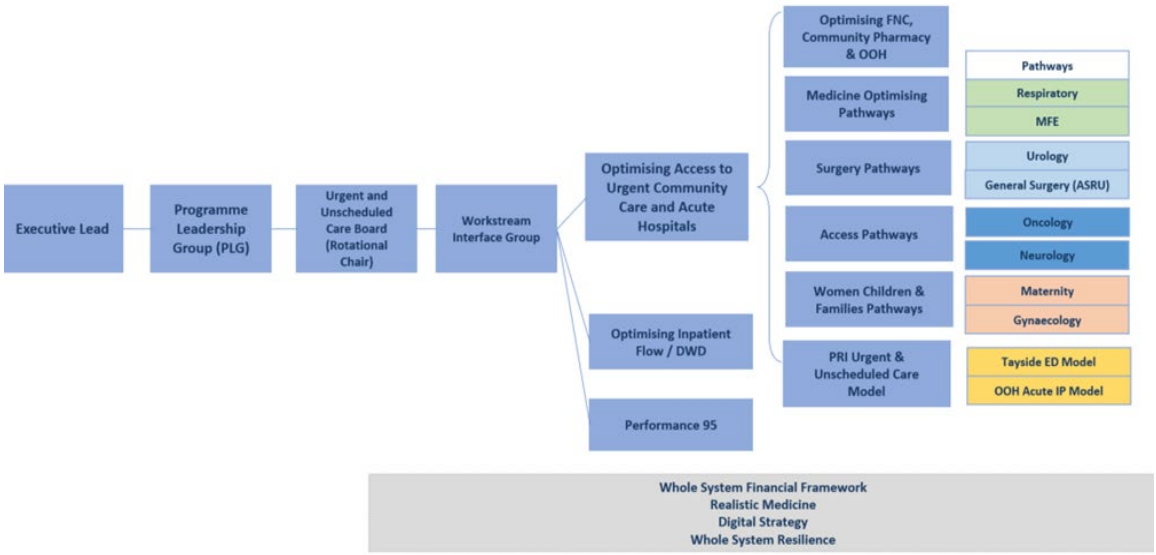
This will include:

- contribution to relevant strategic plans and associated work-streams and projects.
- monitoring and review of relevant actions.
- providing assurance regarding progress.

The Board will work collaboratively with multidisciplinary representatives from across NHS Tayside to develop strategic plans and associated work streams to review current pathways, alongside improving quality, efficiency and reducing unwarranted variation of our service delivery models.

The Programme Board has a co-chair arrangement, to ensure that each constituent part of the Programme is represented as well as ensuring clear and transparent governance arrangements.

An overview of the Programme Structure is depicted below:



The Programme has three key workstreams, each with a specific Quality Improvement aim, geared towards improving our service delivery and provision of safe, equitable care to the citizens of Tayside.

Performance 95
Performance 95 is driven to make sure that NHS Tayside meets and exceeds the National 4-hour target; ensuring 95% of patients are seen and assessed within 4 hours of their arrival. This workstream is focused on driving Quality Improvement across our EDs and Acute Medical Units (AMUs). Our focus within AMU is to ensure that 70% of patients are admitted, assessed, treated and discharged within 72 hours of their arrival.

Optimising In-patient Flow / Discharge Without Delay
The primary focus of this workstream, is to ensure that each acute in-patient area is achieving or exceeding the upper quartile average length of stay. Furthermore, embedding the principles and associated processes for Planned Day of Discharge, ensures those areas are focused on Discharge Without Delay, bringing a multi-disciplinary team approach to managing the patient pathways.

Optimising Access to Urgent Community Care & Acute Hospitals
This workstream is focused on supporting owners of specialist and generalist pathways, to reduce acute admissions and activity by 5%. This will be achieved through whole system collaboration, identifying opportunities for proactive diagnostics allowing for earlier intervention and a reduced need to seek acute care.
Ensuring patients receive the right care, as close to home as possible, is pivotal in supporting the delivery of our aim.

The work of the Programme Board supports the Optimising Urgent and Unscheduled Care Workstream as part of the NHS Tayside ADP and the leverage points from Centre for Sustainable Change and Delivery.

ii Angus Urgent and Unscheduled Care Steering Group

The Angus Urgent and Unscheduled Care Steering Group are responsible for managing the delivery of improvements to local urgent and unscheduled care in line with the Urgent and Unscheduled Care National Collaborative and aims of the GMS 2018 contract. The Urgent and Unscheduled Care National Collaborative (UUCC) is a Scottish Government programme with eight workstreams which aims to 'deliver the right care, in the right place, for every person, every time'.

The Angus Urgent & Unscheduled Care Steering Group oversee a programme of work to improve each stage in a person's urgent care journey and deliver physical and/or mental urgent health and care needs as close to home as appropriate, in a timely way, making the best use of resources to deliver the best possible outcomes 24 hours a day, 7 days a week.

The Terms of Reference for the Urgent and Unscheduled Care Steering Group need to be refreshed and workstreams realigned to those of the Urgent and Unscheduled Care Programme Board for NHS Tayside. The Angus Urgent and Unscheduled Care Steering Group has a workplan which is aligned to the NHS Tayside Urgent and Unscheduled Care Programme Board and national priorities as well as local priorities in Angus, mainly supporting with Priority 2 Care Closer to Home.

iii Winter Planning

In September 2024, ahead of the Scottish Government's Winter Plan, health boards and Health and Social Care Partnerships were asked to work in collaboration as a whole system to complete a Winter Preparedness Checklist to provide an overview of Tayside's state of readiness for winter. Winter resilience priorities promote the strengthening of whole system planning to ensure there is resilience across key areas for supporting seasonal increases in demand.

In addition to the Winter Checklist, Health Boards and Health and Social Care Partnerships have also been asked to submit a quarterly Whole System Discharge Planning Self-Assessment Tool. The Self-Assessment is designed to provide assurances to Scottish ministers that the Delayed Discharge and Hospital Occupancy Action Plan is being enacted as part of preparations for winter.

A separate winter plan report (Item 11) is being submitted to AIJB in October 2024.

5 CURRENT POSITION

Unscheduled Care Performance

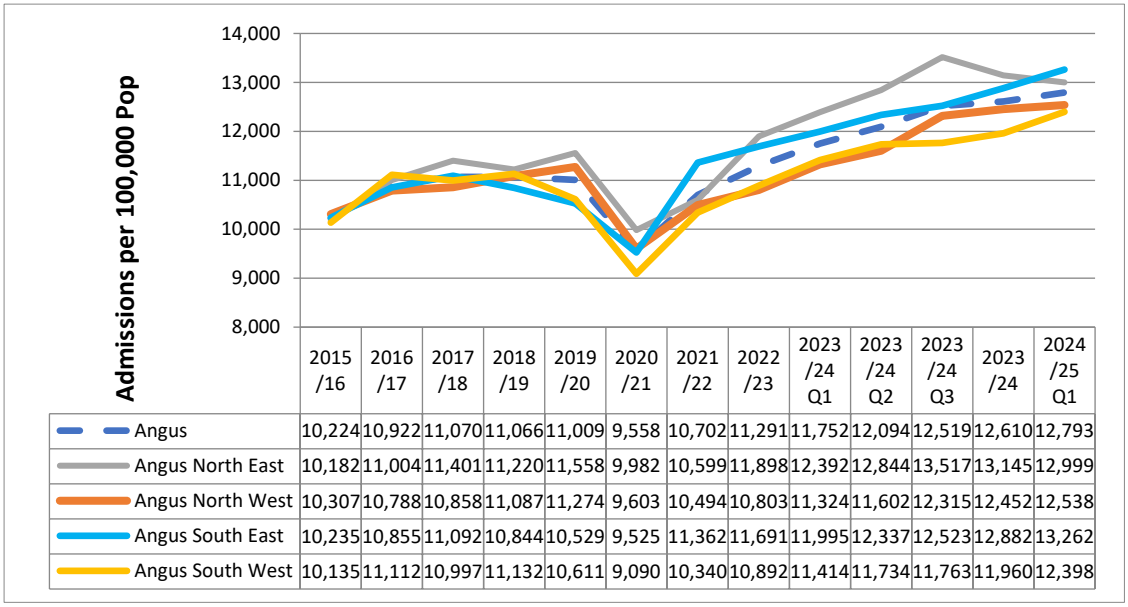
Unscheduled Care performance refers to the effectiveness and efficiency of health and social care services provided to patients who seek medical attention without a prior appointment or scheduled visit. This encompasses a range of services, including emergency departments, urgent care centres, and walk-in clinics.

The information below provides an overview of some of the Urgent and Unscheduled Care performance across Angus.

i Emergency Admissions

Chart 1 below shows the number of Angus emergency admissions (per 100,000 population) since 2015/2016. This includes emergency admissions at any hospital across Scotland for those with a home postcode in Angus across all age ranges.

Chart 1

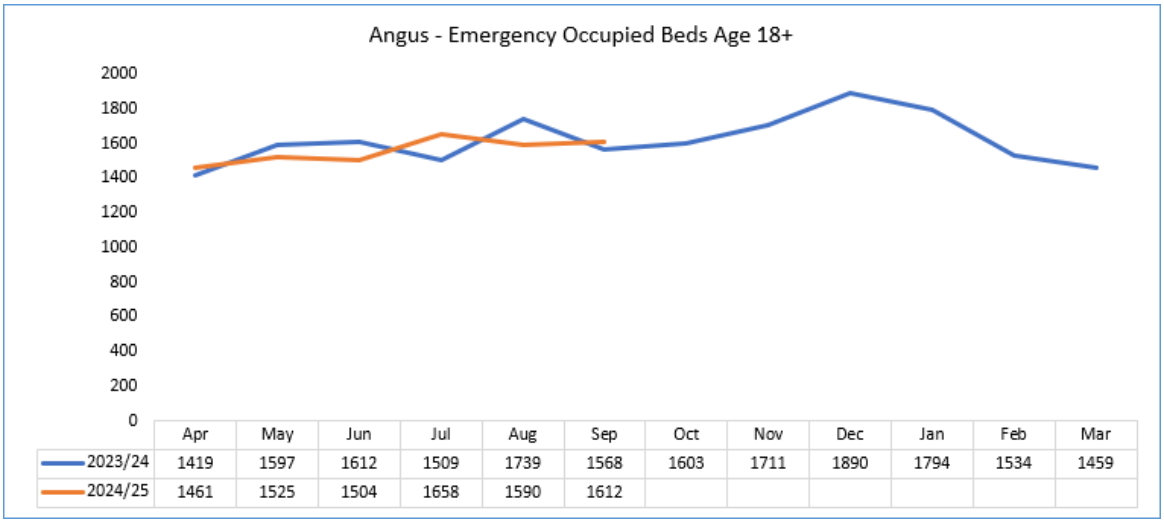


	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24	2024/25 Q1
Angus	10,224	10,922	11,070	11,066	11,009	9,558	10,702	11,291	11,752	12,094	12,519	12,610	12,793
Angus North East	10,182	11,004	11,401	11,220	11,558	9,982	10,599	11,898	12,392	12,844	13,517	13,145	12,999
Angus North West	10,307	10,788	10,858	11,087	11,274	9,603	10,494	10,803	11,324	11,602	12,315	12,452	12,538
Angus South East	10,235	10,855	11,092	10,844	10,529	9,525	11,362	11,691	11,995	12,337	12,523	12,882	13,262
Angus South West	10,135	11,112	10,997	11,132	10,611	9,090	10,340	10,892	11,414	11,734	11,763	11,960	12,398

Following the impact of the COVID-19 pandemic in 2020, emergency admissions have continued to rise beyond pre-pandemic levels. Admissions in the Southwest have risen again since Q3 of 2023 with admissions in the Northeast reducing. Southeast admissions continue to rise since 2021/2022. Admissions from the Northwest appearing to remain at the same level over the last two quarters.

Activity information classed as Large Hospital Set Aside is now routinely shared in IJB Finance reports. The latest activity information from NHS Tayside is shown below. Chart 2 shows that for 2024/25, to the end of September, LHSA activity was running at roughly the same levels as in 2023/24. Separate comparisons with financial year 2019/20 (Pre Covid-19) suggest there has been an increase in activity of c15% since 2019/20 with consequent resource implications.

Chart 2

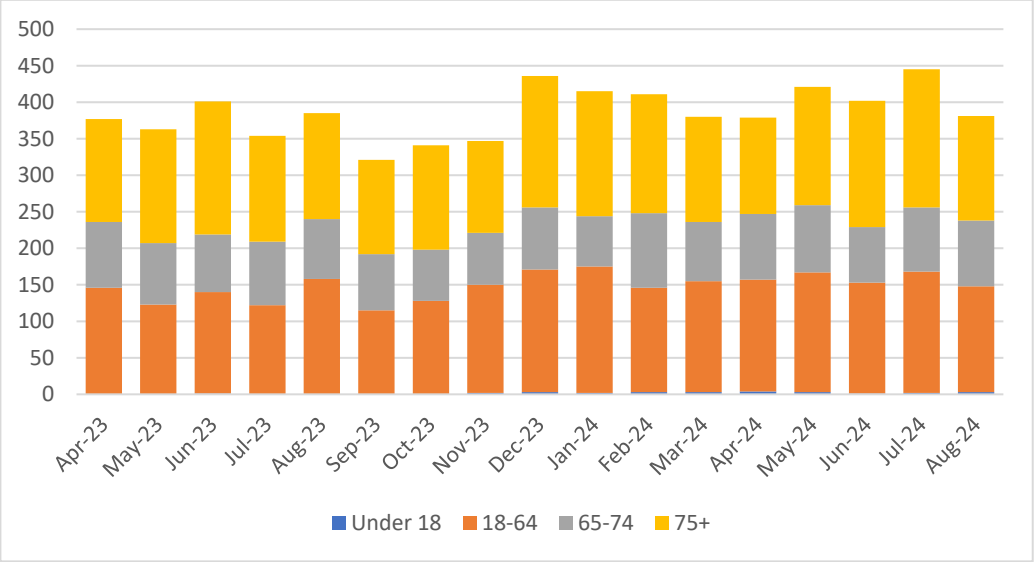


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/24	1419	1597	1612	1509	1739	1568	1603	1711	1890	1794	1534	1459
2024/25	1461	1525	1504	1658	1590	1612						

ii Acute Medical Unit (AMU) Attendances

Chart 3 below shows the number of attendances at AMU each month through 2023/2024 and 2024/2024. Although there has been slight variance across the year, there has been no major shift in AMU attendances.

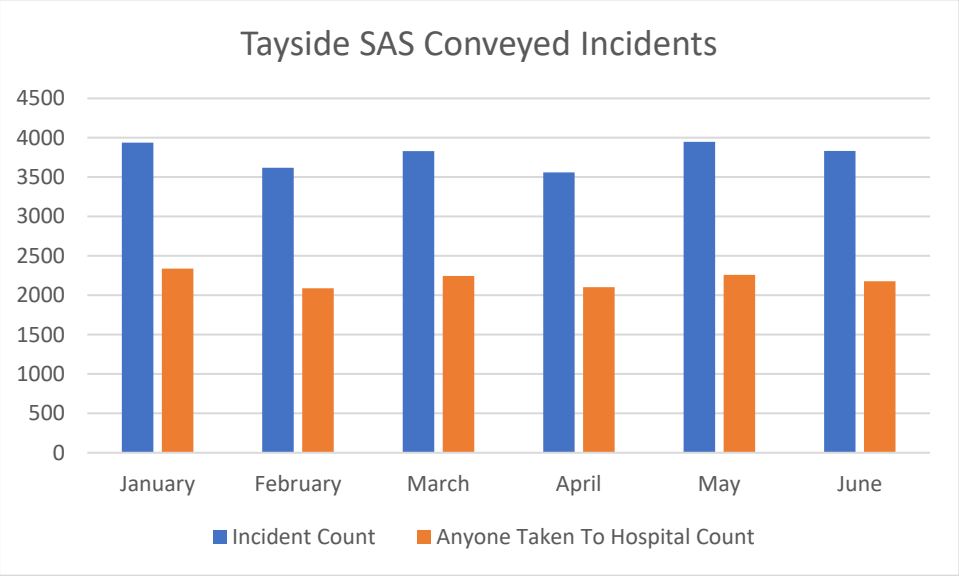
Chart 3



iii Scottish Ambulance Service (SAS)

Chart 4 below shows the number of incidents attended by the Scottish Ambulance Service across Tayside from January 2024. It also shows how many of those incidents resulted in a conveyance to hospital. Although SAS record the destination hospital, they do not record which receiving unit the patient is conveyed to. From the data below, the number of incidents and associated conveyances have remained static.

Chart 4



iv Average Length of Stay (LoS) (Angus patients only)

There are two Community Hospitals in Angus, Arbroath Infirmary and Whitehills Hospital with a total of 48 Medicine for the Elderly beds. The service works with people to ensure people are not in hospital for longer than they need to be by delivering rehabilitation to ensure they can return home. 28 days in the local target length of stay with community hospitals, this target allows us to focus on care and treatment with everyone working on discharge from hospital. Angus is currently achieving this target with the average LoS in Arbroath Royal Infirmary at 17.1 days and Whitehills Community Care Centre at 22 days.

People who live in Angus requiring specialist rehabilitation following a stroke can be admitted to Royal Victoria Hospital, Dundee, Wards 4 and Ward 5. The target LoS in hospital for people who have had a stroke is 42 days. Recently the Angus Discharge Team have been working closely with these wards to reduce the average LoS, August 2024 position for Ward 4 was recorded as 29 days and 23.8 days for Ward 5.

v Discharge without Delay (DwD)

A national pathfinder programme, Discharge without Delay (DwD) has been rolled out across Scotland. This is supported by the Scottish Government DwD Steering Group and improvement teams. One of the aims of the programme is to delivery Discharge without Delay within both community and acute settings, working in close partnership with hospital and community teams to agree the most effective and efficient process to ensure positive outcomes for patients.

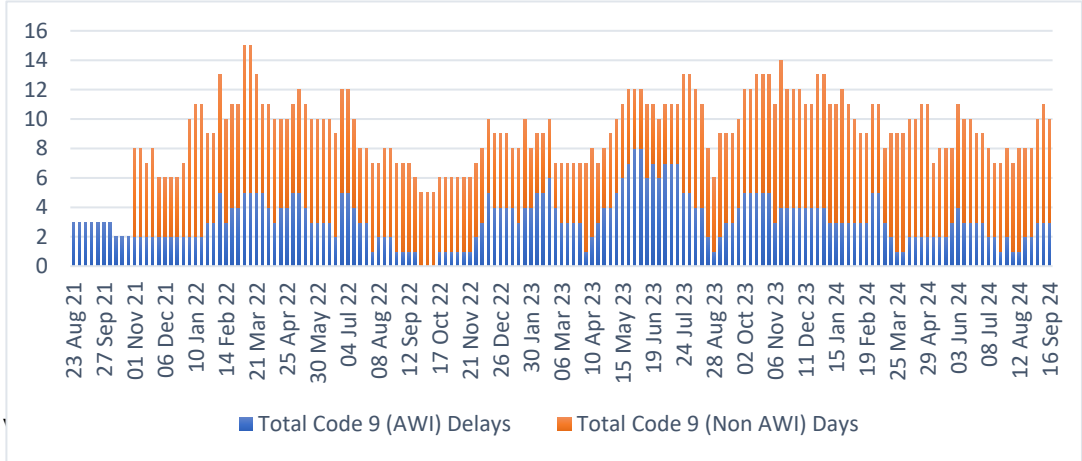
In Angus there is a continued focus on people in hospital who may need social care intervention to enable them to leave hospital safely. AHSCP work closely with teams and wards across NHS Tayside to optimise flow. Angus Discharge Team attend weekly multi-disciplinary meetings across Ninewells, Royal Victoria Hospital, Perth Royal Infirmary, Arbroath Royal Infirmary and Whitehills Community Care Centre, working together on discharge plans for people who need assessment. The past year has seen closer working relationships across disciplines with teams using the ethos of DwD to ensure a smooth transition from hospital to home. Social Care partners are now fully embedded into the discharge process within wards with the MDTs now fully operational as joint teams. Hospital delays in Angus remain one of the lowest in Scotland.

The Adults with Incapacity (Scotland) Act 2000 allows for a nominated person to make some or all decisions on the adult's behalf and ensure that their best interests, views and the least restrictive options are considered. For many adults this results in the application of a Guardianship Order to safeguard their welfare and manage their financial or property affairs.

Chart 5 below shows the number of patients waiting on Adults with Incapacity (AWI) legislative process to be concluded. The number in blue shows the number of patients undergoing this process while in hospital with the orange showing where there has been a conclusion to the AWI process however there is no accommodation suitable to meet their needs.

At service level there appears to have been an increase over the past 12 months in patients being admitted with a Power of Attorney in place. This could be evidenced in chart 5 as the need for the Adults with Incapacity process while in hospital appears to be decreasing.

Chart 5



i

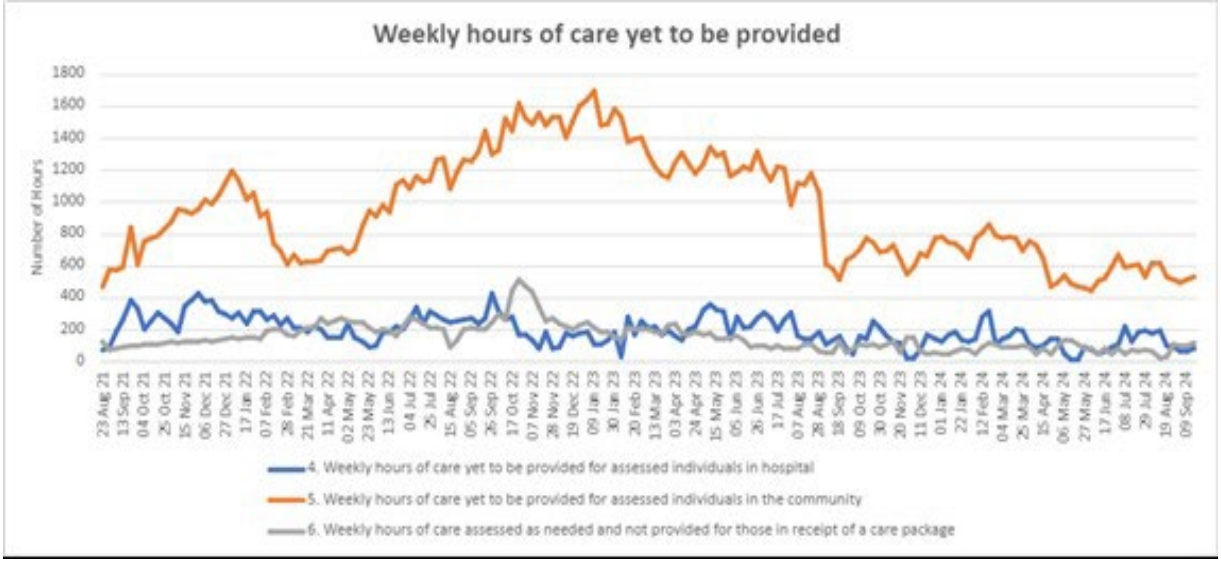
Accessing Care and Support

AHSCP provide weekly data returns to the Scottish Government to illustrate unmet need across the services. This focusses particularly on waits for Care at Home services, Statutory Social Care Assessments and Social Care Reviews.

The data reported covers the number of hours and people, who have an assessed need that is not being met by a commissioned care at home service. The level of assessed need ranges from low and moderate to substantial and critical, and this data is used locally to ensure resources are prioritised to those with higher level needs. Some people with a lower-level needs are being supported by unpaid carers, however at present, this is classed by Scottish Government as an unmet need. AHSCP are one of several Partnerships who are currently engaging in a National Unmet Social Care Need Workshop with Scottish Government, where a clearer definition of unmet need will be agreed, alongside a greater understanding of the resourcing requirements to meet unmet needs nationally and locally. Eligibility criteria is in place to ensure that focus remains on prioritising packages of care for individuals in hospital to support with the wider pressures, however the risk is reduced availability for critical services required for people living at home. Although services are usually put in place for planned discharge dates. Chart 6 below demonstrates the number of weekly hours yet to be provided.

As at the 14th October 2024 the number of hours delivered weekly to people in Angus was 12,673 hours with 1,347 people receiving a care provision. Our ERT service delivered an additional 504 hours of enablement to 76 people. Included within these hours are 133 hours of mainstream personal care delivered by ERT where care has not been sourced for an ongoing package of care from a mainstream service provider. This is due to a lack of available care at home provision across Angus. Across Angus the number of people assessed as requiring a care package which has not been sourced is currently 73. This equates to 558 hours of care yet to be sourced and recorded as an unmet need. The number of people on the same day in hospital assessed and waiting for a package of care (PoC) to be sourced was 10 at a total of 112 hours.

Chart 6



vii Enablement Response Team (ERT) and Community Alarm

There are four Enablement and Response Teams (ERT) throughout Angus. The teams provide enablement support from 7am until 10pm, seven days per week, and community alarm response 24 hours per day/365 days per year.

ERT provides an assessment of personal care, meal preparation, prompts and reminders to eat and drink, medication prompts and reminders, moving and handling including transfers and repositioning of people with sores and skin breaks.

Referrals to ERT can be made directly to the service by several different professionals in the community setting including social workers, home care assessors, care co-ordinators, GPs, District Nurses, Occupational Therapists and Physiotherapists. Referrals to support discharge from hospital are made by the Dundee Discharge Hub for Ninewells Hospital and the Angus Discharge Team for community hospitals.

In addition to an increase in people choosing to remain at home for end-of-life care, there is a higher number of younger people with complex mental health, history of drug and or alcohol use, people with a physical disability following a traumatic event being referred to the ERT service with support often also provided by District Nursing and Community Alarm. Charts 7 – 10 demonstrate the ERT activity over a three-year period.

Chart 7

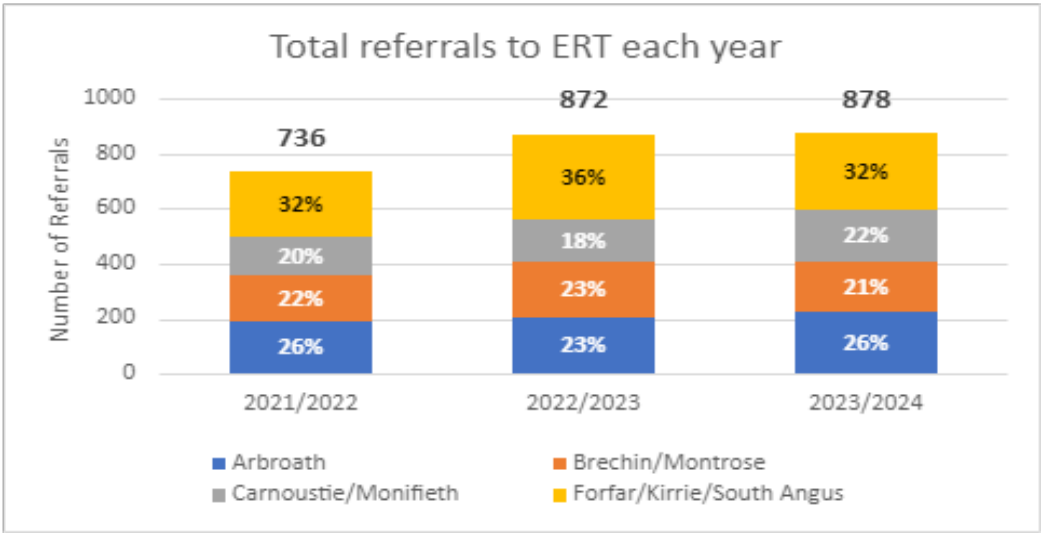


Chart 8

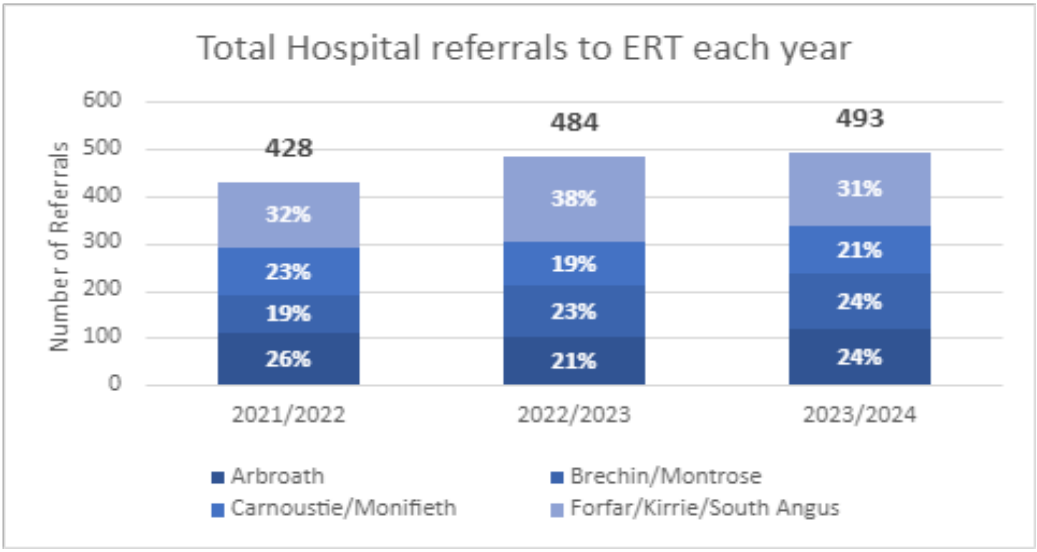


Chart 9

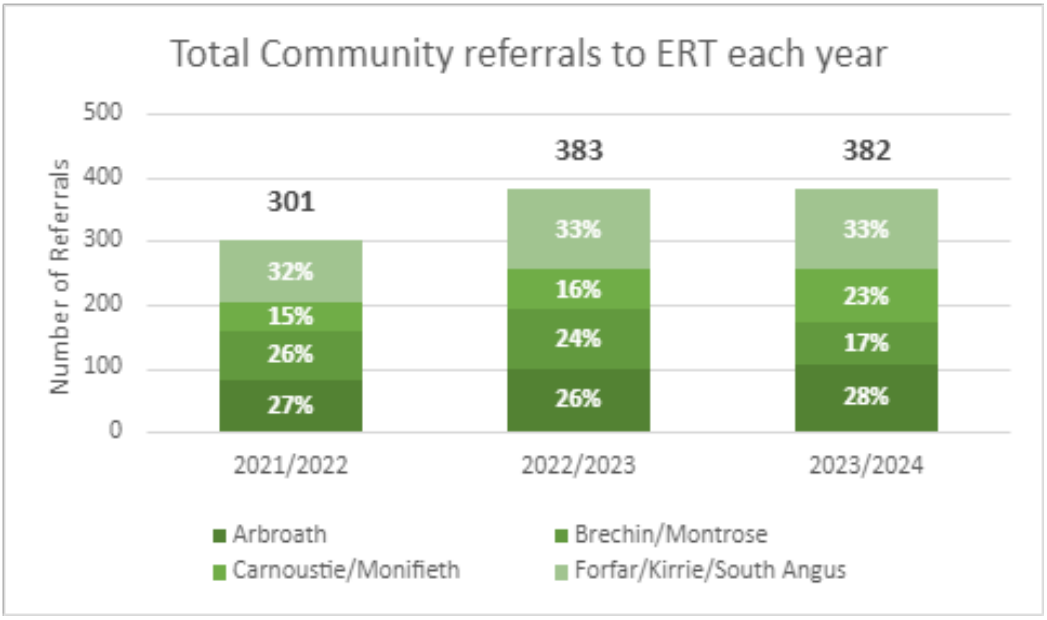
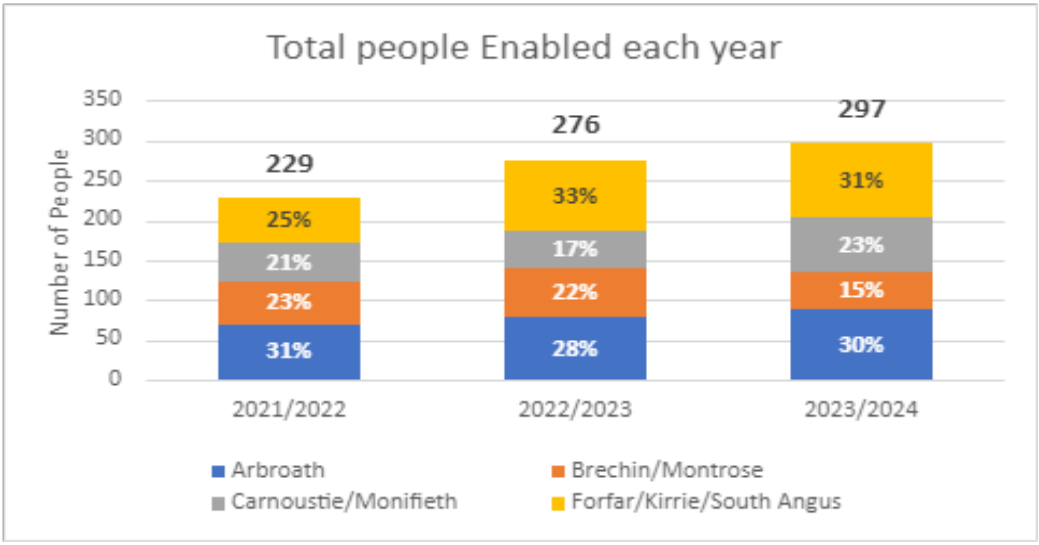


Chart 10

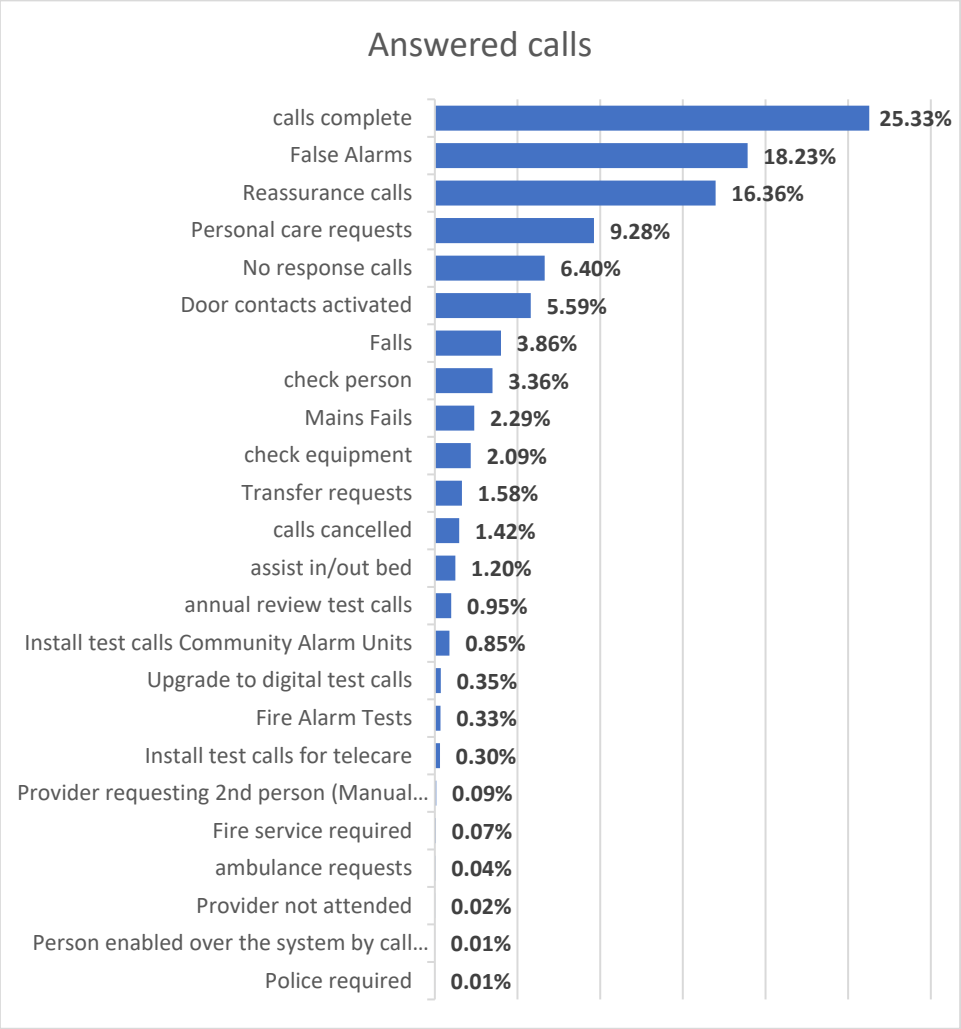


There are currently 3173 community alarm units installed in people's homes in Angus with an additional 399 pieces of telecare equipment installed. Work is ongoing towards switching the balance towards more people using telecare equipment alongside their own digital devices i.e. Amazon Echo, smart watches etc.

The types of calls that response attend vary and include personal care and continence care, transfers, falls and door contacts activated, the highest number of responder visits are to support personal care, no response calls, door contacts activated and falls.

Chart 11 demonstrates the types of answered calls to community alarm,

Chart 11



viii Care Homes

There are 28 care homes, 25 external and 3 internal across Angus, 11 provide nursing care and 17 provide residential care only with a total of 1022 beds across all four localities. There are national concerns around the fragility of the older peoples care home market and Angus is no exception to this. There is a noticeable reduction in the number of care home beds available each year and a reduction in the number of beds available to service users funded via the national care home contact, with care homes reporting that it is preferable, and more sustainable, to offer facilities to people who would like to fund their own care. Many care homes advise that they allocate beds available to people who wish to self-fund their own care over funded National Care Home Contract (NCHC) service users. This presents a high level of risk in terms of bed availability for local authority service users.

Currently 226 beds in Angus are available to people who wish to fund their own care. AHSCP has continued to support Angus residents changing needs and to support a reduction in delayed discharges for Angus residents by introducing four interim care beds in Seaton Grove. This allows residents to move to a care home setting, closer to home whilst they await a care package at home and to support their recovery to live independently prior to going home. AHSCP also continue to spot purchase interim beds in locality areas to support timely discharge from hospital when a package of care to support care at home is not available and where it is appropriate to do so.

6 CONCLUSION

The evolving landscape of urgent and unscheduled care in Angus reflects a concerted effort to provide timely, appropriate healthcare solutions for the community. With an emphasis on reducing reliance on the Emergency Department, the collaborative initiatives championed by the Urgent and Unscheduled Care Programme Board and the Angus Steering Group exemplify a strategic approach to health and social care delivery. These efforts prioritise person-centred care, ensuring that individuals receive the right treatment in the right setting, enhancing outcomes and efficiency.

Through structured workstreams focused on quality improvement, performance metrics, and community integration, Angus HSCP is committed to addressing the diverse needs of its population. As demonstrated by ongoing initiatives such as the Discharge without Delay programme and enhanced community support services, the emphasis on timely access to care continues to be paramount.

Despite challenges, including rising emergency admissions and the complexities of care delivery, proactive measures are being implemented to optimise resources and improve patient flow. The focus on community-based care solutions, alongside strategic winter planning, underscores the importance of resilience in healthcare provision.

Moving forward, continued collaboration across multidisciplinary teams will be essential in navigating the complexities of urgent care, ensuring that every citizen of Angus has access to safe, effective, and equitable health and social care services. The commitment to innovation and responsiveness will be vital in meeting the dynamic needs of the community, fostering a healthier population and a more sustainable health and social care system.

7 FINANCIAL IMPLICATIONS

While this report does not have any direct additional financial implications for AIJB, AIJB does commit a significant part of its overall financial and workforce resources to services reflected in this report.

8 RISK MANAGEMENT

This paper is linked to Strategic Risk 28, which relates to the potential failure to achieve the ambitions outlined in the Angus Integration Joint Board's Strategic Commissioning Plan 2023-2026.

Risk Description	As a result of significant financial and workforce pressures there is a risk that Angus Integration Joint Board (IJB) will fail to meet the ambitions outlined within the Strategic Commissioning Plan 2023 - 2026 and deliver on the priorities outlined in the SCP. This would result in a failure to improve the health and wellbeing outcomes of the population of Angus.
Risk Category	Quality of care
Inherent Risk Level	Level Likelihood **5** x Impact **5** = Risk Scoring **25** (**Extreme** risk level).
Mitigating Actions	• Ongoing dialogue with NHS Tayside, Angus Council, Scottish Government and via national forums. Identify and progress actions within the Strategic Delivery Plan to ensure services improve the experience for service users, improve the experience for staff, lead to better health outcomes and lower the cost of care. • Strategic Planning Group - overseeing the delivery of the Strategic Commissioning Plan. • Strategic Delivery Group and Strategic Performance Group - overseeing the delivery of all priorities ensuring they are on target and make a positive impact on national indicators and local performance indicators.
Residual Risk Level	Likelihood **5** x Impact **4** = Risk Scoring **20** (**Major** risk level)
Planned	Likelihood **3** x Impact **4** = Risk Scoring **12** (**Major** risk level)

Risk Level	
Approval recommendation	Even with the progression of all agreed actions, this risk remains high. Scheduled reporting and monitoring will continue alongside the further development of risk mitigation actions.

9 PUBLIC HEALTH IMPLICATIONS

The burden of disease is set to increase as people live longer with more long-term problems. This is already resulting in pressures on health and care services and is likely to get worse meaning people may struggle to access the care they need. Such delays have the potential to cause distress and worsen medical problems. Unscheduled care services are at the forefront of this challenge. AHSCP continues to focus on ensuring people can access the care they need from the most appropriate person at the right place and right time. It is vital that improvements continue to be made to meet the growing needs of patients.

10 CLIMATE SUSTAINABILITY IMPLICATIONS

There are no direct climate sustainability implications that arise directly from this report.

11 EQUALITY IMPACT ASSESSMENT, CHILDREN'S RIGHTS AND FAIRER SCOTLAND DUTY

A screening assessment has been undertaken and a full combined Equality Impact Assessment, is not required for the following reason(s): this is a performance update report only.

12 COMMUNICATION AND ENGAGEMENT

It is important that people know where to go to get the right care for their needs. This helps to make sure GP, and A&E services are available for people who really need them. To ensure people receive a consistent message regarding accessing urgent and unscheduled care, AHSCP regularly share the NHS Tayside 'Getting the right care in the right place' messages.

13 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans, and this is provided for in Section 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Angus Council and NHS Tayside.

Direction Required to Angus Council, NHS Tayside or Both:	
No Direction Required	X
Angus Council	
NHS Tayside	
Angus Council and NHS Tayside	

REPORT AUTHOR: Rachel Bennison, Programme Manager, Angus HSCP
Cindy Graham, Service Leader, Community Hospitals and Hospital Discharge, Angus HSCP
Lisa Prudom, Service Manager, Primary Care, Angus HSCP

EMAIL DETAILS: tay.angushscp@nhs.scot