Appendix 1

Perth and Kinross Health and Social Care Partnership

Older People and Unscheduled Care Board

High-level performance report for Audit and Performance Committee

Tuesday 120219 09:15 Version 12

Version 11

Key messages

- After significant service change and investment, performance on delayed discharge is improving, especially in PRI. Delayed discharge was the number one performance issue for the Partnership at its inception. Over the last 3 years the Partnership has been working closely with the Scottish Government to learn from other areas and improve our performance around delays. Significant time and resource investment has been made to improve our performance and the data clearly indicates our improvement.
- Emergency admissions for older people remain relatively stable and there has been an appreciable reduction in associated bed days during 2018. There is also evidence of higher levels of readmissions during this period which we will investigate further.
- Perth and Kinross is performing well at supporting people at end of life in the community, with a percentage above the Scottish average. This performance has been on the increase since 2016
- Care at home hours continue to increase as might be expected however the numbers of clients supported is not increasing with the same speed. An improvement project is underway to ensure the Partnership commissions an efficient, effective and quality Care at Home service so we can continue to meet demand within current resources.

1 Introduction

The OPUSC Board have agreed a set of performance measures that will be used to measure success in delivering strategic priorities. Whilst this is under continual review, this report summarises performance against the OPUSC measures agreed across older people and unscheduled care. The report consists of three sections; the first relating to unscheduled care, the second to older people with an emphasis on those residing in the community and finally areas of future development.

2 Perth and Kinross Profile

2.1 Demographics

P&K has a proportionately large elderly population and this is growing over time. In 2017 there was an estimated 34,515 people aged 65 and over in Perth & Kinross (approximately 22.8% of the population). It has been projected that, by 2041, the population of those aged 85 and over will increase by 130% from the 2016 population (Source: NRS, 2017). This is shown in Figure a below:

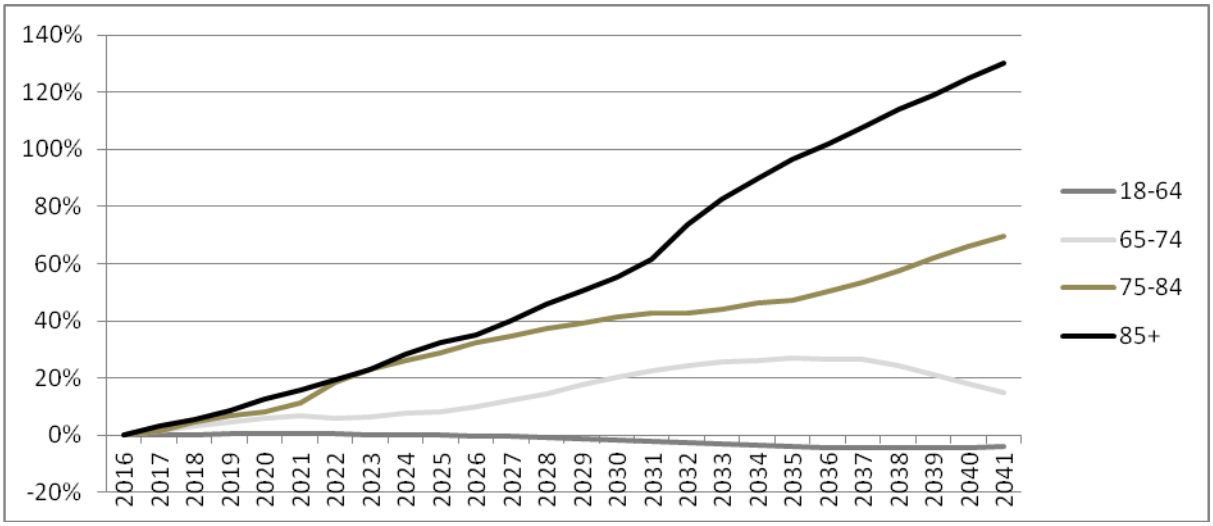

Figure a Projected P&K Population - % increase from 2016

Life expectancy and healthy life expectancy are increasing for both men and women, but so is the length of time spent in ill-health. The number of chronic conditions increases with age and the prevalence of dementia is strongly correlated with age. In Scotland, Dementia has a prevalence rate of 14.5% and 16.4% for males and females respectively for those aged between 80 and 84. Perth & Kinross has an estimated 3,333 residents with Dementia (Source: Alzheimer's Scotland, 2017).

Figure b illustrates the demographic change that Perth & Kinross has experienced from 1982 to 2017. It shows that demographic pressures are coming from a baby boom period which is now entering into our 65+ age group and will require increased demand for services.

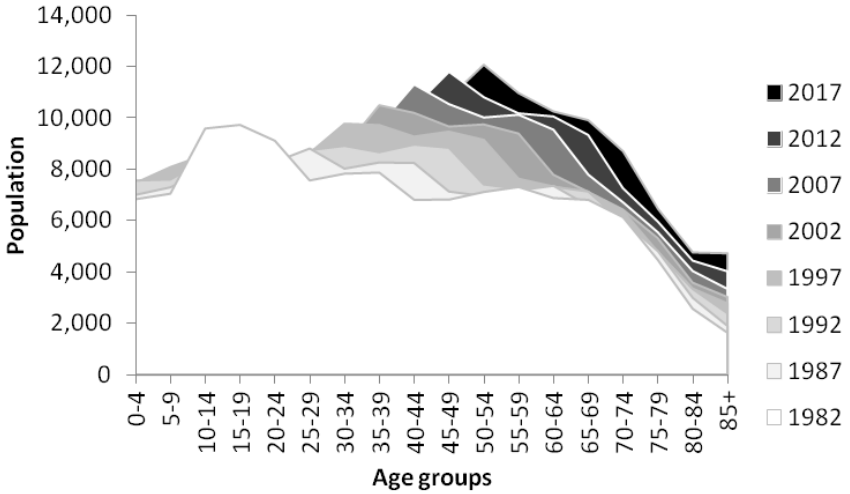

Figure b Historical and projected working age and 65+ populations for P&K

Over the past decades, the population of Perth and Kinross has steadily risen by a little under one percent per year. However, the older components of the population have been growing more quickly than the working age component.

3 Unscheduled Care

Unscheduled care is a term used to describe any unplanned health or social care.

3.1 Delayed discharges

Over the past four years, there is an improving picture in relation to delayed discharge for Perth and Kinross. Year on year, the median number of people delayed daily has been reducing, and we have recently witnessed a low level that is unprecedented since 2014. For patients, this represents a reduction of the impact of unnecessary time spent in hospital. We know that unnecessary bed days are associated with reduced function. This improvement therefore represents improving quality of care.

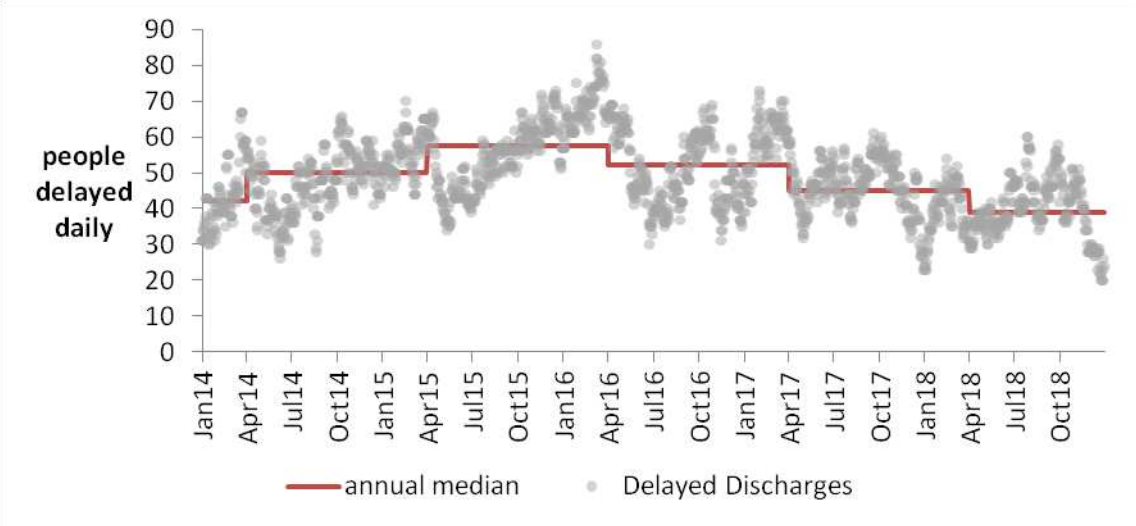

Figure 1 People experiencing delay (daily measurement) (Source: EDISON via QlikView)

As well as representing improvement at the patient level, this has resulted in a reduction of inpatient bed days lost to delay (Figure 2). This is an important aspect of our efforts to improve inpatient capacity and flow.

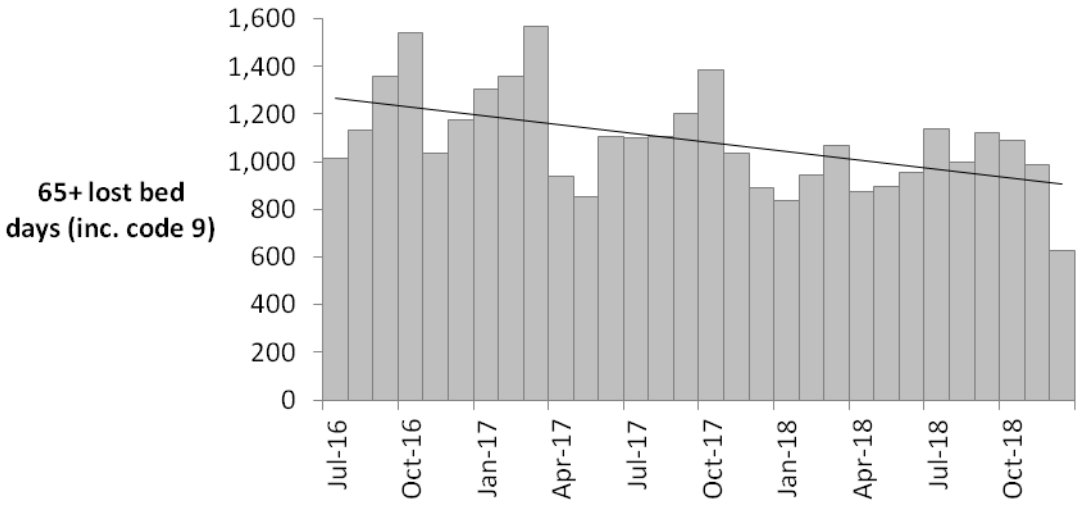

Figure 2 Bed days lost to delay monthly (Source: EDISON via QlikView)

There is evidence of improvement in all types of site. However the District General Hospital of Perth Royal Infirmary, which has seen a strong focus on reducing delays, has demonstrated the most rapid decline in bed days lost to delays.

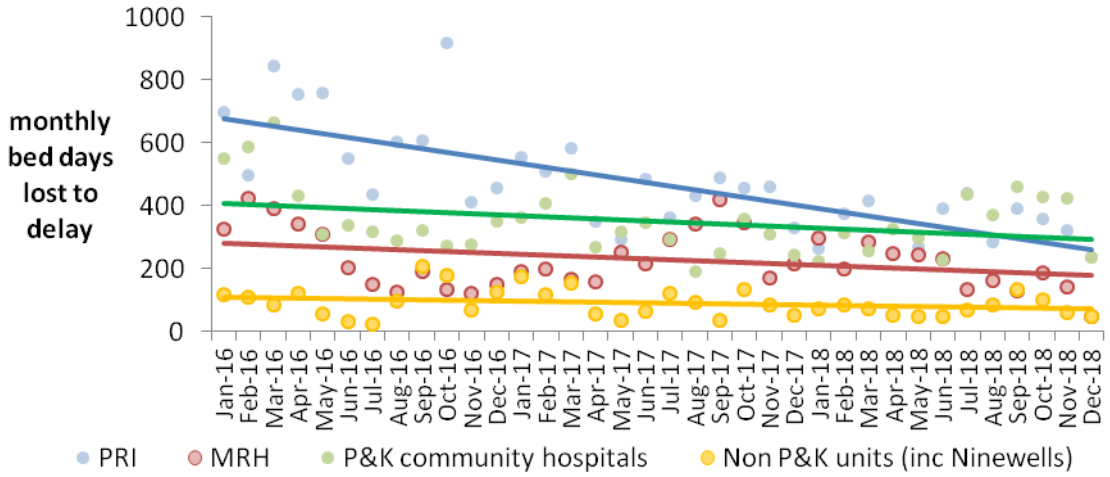

Figure 3 Bed days lost to delay monthly by facility type (Source: EDISON via QlikView)

3.2 Delayed Discharge Improvement Actions:

The general reduction in bed days lost due to delayed discharges seen in 2017 appears to remain. The festive period, unusually, saw this improvement continue. The most feasible explanation for maintaining lower numbers is the impact of the actions that have been undertaken in the last two years to improve performance.

A range of improvement actions have been taken forward to improve our performance in relation to delayed discharge. These actions have been introduced at various times and after each one is introduced it adds to the positive impact of the last. These improvements included:

- the introduction of an almost immediate Monday to Friday placement authorisation process (June 2016)
- the introduction of integrated action planning for individuals
- a faster track welfare guardianship process (August 2016)
- an increased capacity of the Hospital Discharge Team (December 2016)
- the introduction of a Discharge Hub (April 2017)
- the introduction of HART (January 2018)
- the introduction of Frailty Team (October 2018)

3.2.1 Ongoing Improvement

Improvements for this year increased focus on:

- continuing to develop a single discharge process across Tayside
- implementing Care at Home improvement Plan
- Further work on Frailty and Discharge to Assess.
- exploring causality relating to the observed variation in complex lost bed days
- a Focus on recruitment and retention of care staff across whole of health and social care and partners
- Working in partnership with the 3rd and independent sectors to achieve sustained reductions in this area. For example, we are testing a Royal Voluntary Service model to support discharge through Winter Planning Monies which will be evaluated within the 2019.

3.3 Unscheduled Hospital care

The following charts illustrate patterns of unscheduled hospital care use for Perth and Kinross older people since April 2016. These charts are based on the same data as used for the Ministerial Group Indicators.

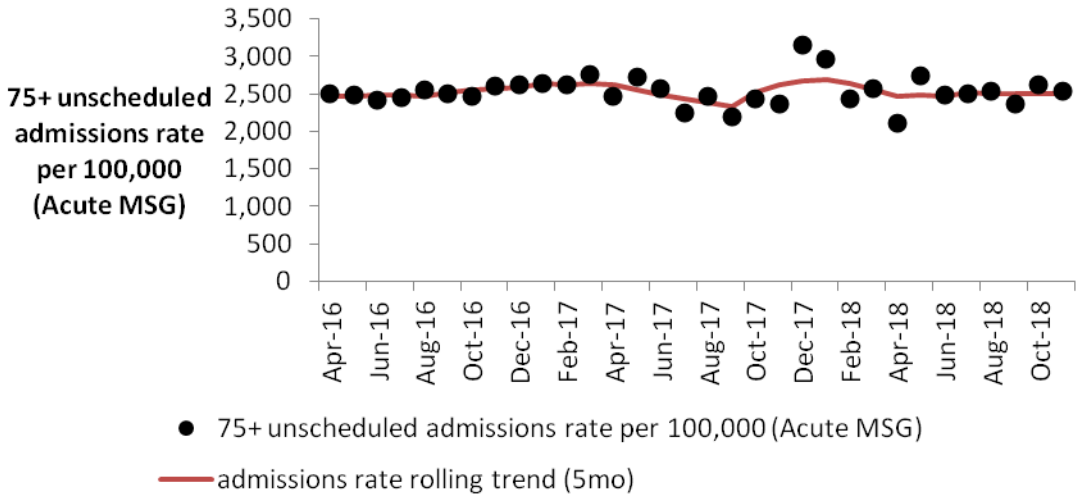

Figure 4 75+ unscheduled admissions per 100,000 population (Source: ISD)

Figure 4 illustrates the rate of unscheduled admissions per 100,000 for the 75+ population. In December 2017 there was a 33% increase in the unscheduled admission rate for the 75+ population compared to November 2017's rate. This increase in admissions may have been caused by the adverse weather experienced during this period resulting in exceptional demand on services due to respiratory conditions and flu like illnesses. Unscheduled admission rates were also relatively high in January 2018 which may be attributable to the considerable increase in falls rate as shown in Figure 12. Rates started to become stable again in May 2018.

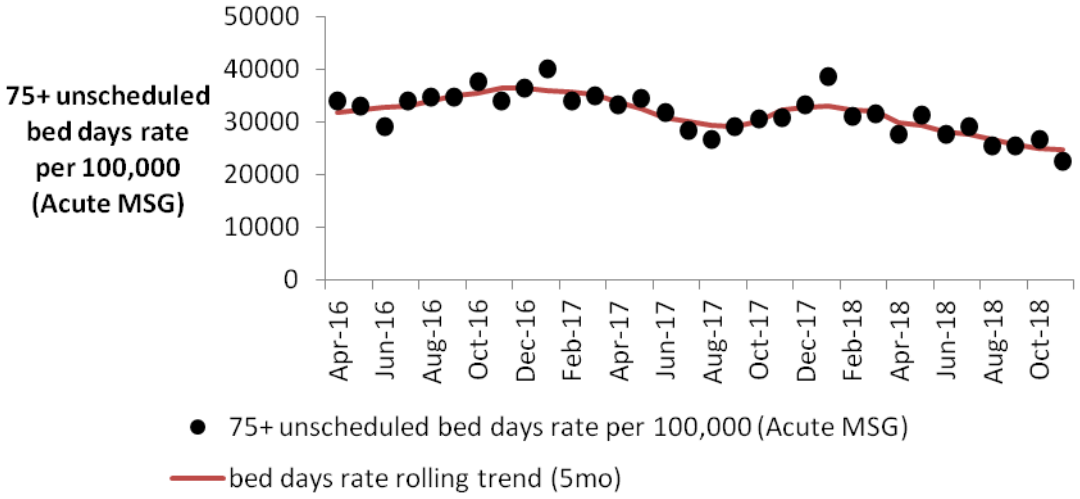

Figure 5 Bed day rates for75+ unscheduled admissions per 100,000 population (Source: ISD)

Figure 5 shows the 75+ Unscheduled bed days rate per 100,000. The bed rate has been steadily decreasing since December 2016. However, similar to Figure 4 Unscheduled admission rates, there was an increase in unscheduled bed days commencing November 2017 with a particular spike in January 2018. Unscheduled bed day rates continued to decrease from January 2018.

3.3.1 Readmissions

A readmission occurs when a patient is admitted as an inpatient to any specialty in any hospital within a specified time period following discharge from a continuous inpatient stay. Readmission rates reflect several aspects of integrated health and care services - including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners.

Figure 6 shows the percentage of admissions within 28 days following discharge for 75+ Perth and Kinross residents.

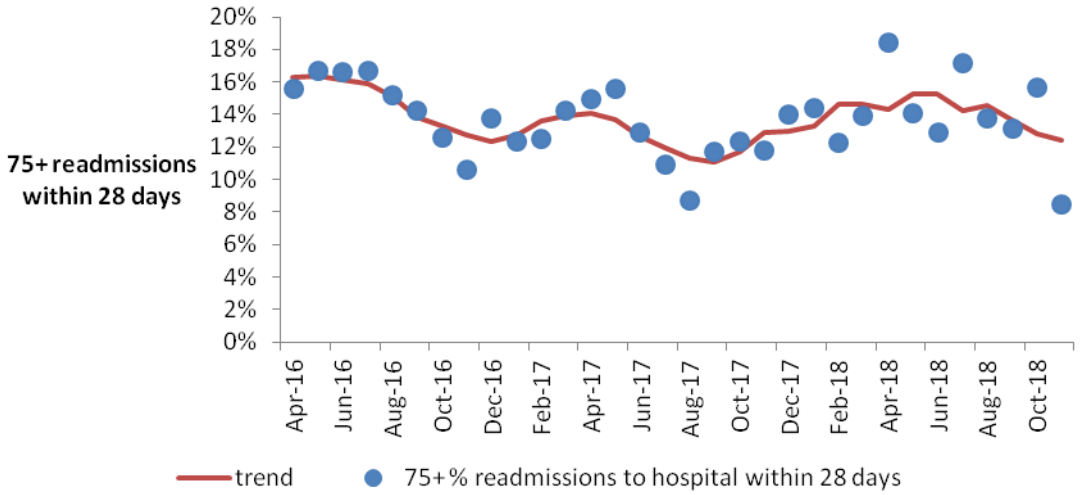

Figure 6 Percentage of admissions within 28 days following discharge for 75+ Perth and Kinross residents. The red line is a rolling average based on two months before and after each data point. (Source: ISD)

From the same period, the unscheduled admission rate has remained relatively stable, but readmissions (which remained fairly consistent since 2017) saw an increase during 2018 up until the end of the year. Interestingly, readmission rates at the tail end of the year were relatively low, reducing from 15.7% in November to 8.5% in December. The pattern of readmissions and its relationship to wider patterns of unscheduled care (e.g. admissions and bed days) prompts further investigation.

We are currently exploring readmissions data to better understand relationships and variation with previous years in relation to, for example, diagnoses on subsequent and readmission, and the delays between these events. Until we understand the data set in relation to each sub locality and identify the readmission cohorts and key variables relating to these groups, we will be unable to give a robust understanding of current data.

Local tracking requires to be set up with responsibility shifting to each sub locality integrated team to understand the data set for each area.

3.3.2 Ongoing Improvements

Improvements for this year include:

- Improving early intervention and prevention approaches by building on the enhanced community support model within integrated care teams.
- Delivering an enhanced respiratory community support approach to provide specialist support to patients with COPD and asthma within their own homes
- Enhance technology enabled care and home health monitoring to help sustain community living.
- Work in collaboration with NHS Tayside to support the redesign of patient's pathways for scheduled and unscheduled care
- Support the implementation plans for the Primary Care Improvement Strategy in relation to the development of Advanced Nurse Practitioner role, Community Care and Treatment Services and Urgent Care Services.

4 Older People

This section covers adults aged 65 plus supported in the community.

4.1 Proactive Care and Support at Home

4.1.1 Care at Home

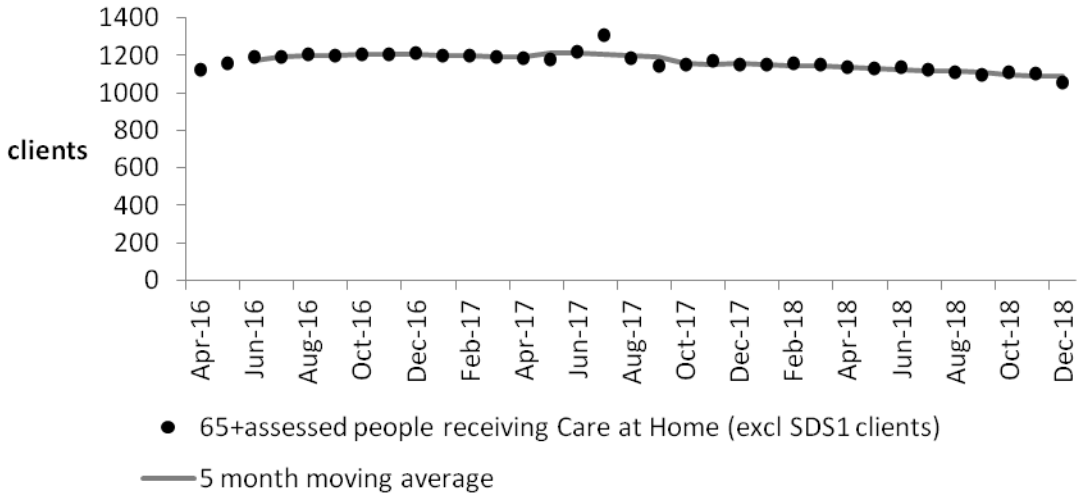

Figure 7 65+ Care at Home clients (excluding SDS option 1) (Source, local data)

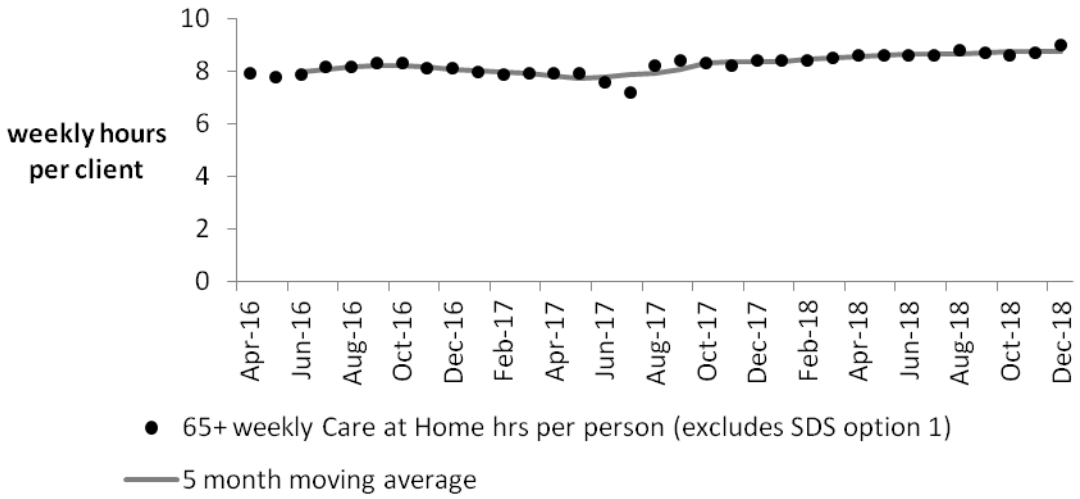

Figure 8 65+ weekly Care at Home hours per person, excluding SDS option 1 (Source: local data)

Figure 8 shows a stable, if slightly reducing, number of adults supported by care at home while figure 9 shows an increasing number of hours per person since April 2016. This is in line with the expectation that the complexity of needs of people supported at home would be increasing in line with demographic trends. The Partnership has reviewed the sustainability of the current Care at Home service model in light of these increasing hours a Care at Home improvement plan has been developed to look at efficiencies within the service.

4.1.2 Reablement

There has been a decrease in reablement by 3% from 2016/17. This drop has been attributed to supporting a very elderly population with increased frailty. Instead of being referred to reablement, these people are by-passing the reablement process and are being referred direct to Care at Home as reablement is assessed as unlikely. This is more clearly seen in figure 4 where we are apparently seeing a continual slow reduction in the numbers of people who achieve independent living after reablement. Further analysis of this situation is required to fully validate that this is what we are observing.

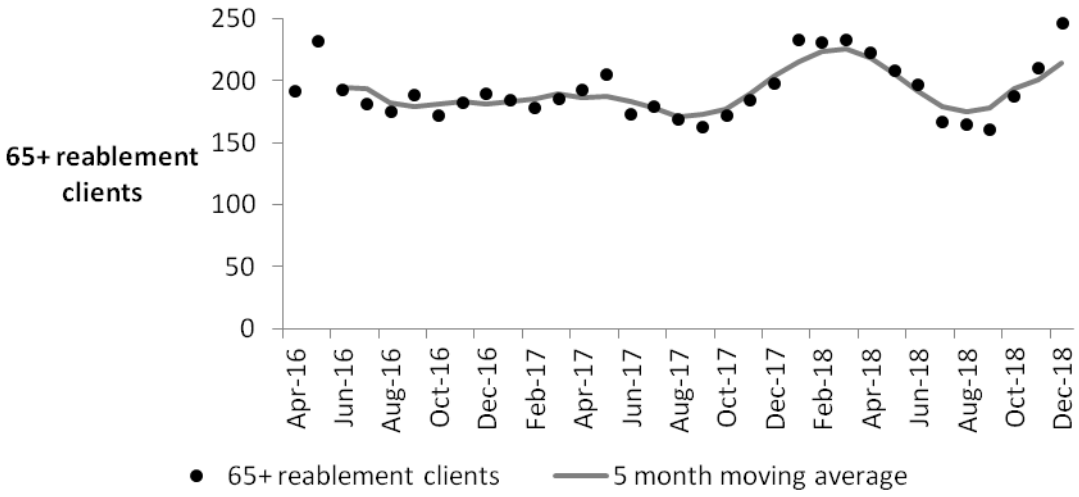

Figure 9 65+ reablement clients (Source: local data)

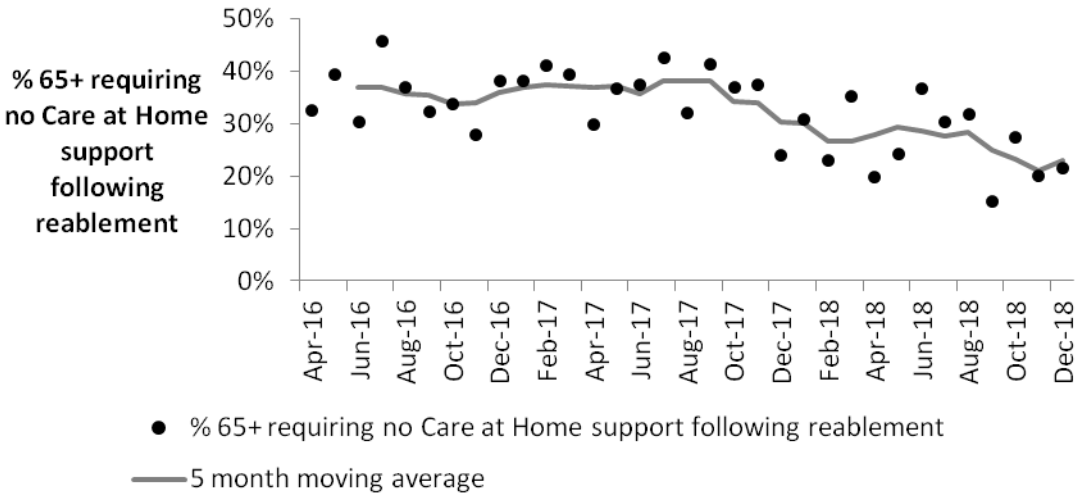

Figure 10 Proportion of 65+ reablement clients who do not require a package of care following reablement (Source: local data)

This performance outcome needs further refinement, as the Reablement service is expected to not only remove the need for care where possible and appropriate, but also to reduce the levels of care for those already in receipt to best meet their needs. In Section 4, a further refinement of this performance indicator is suggested.

4.1.3 Technology Enabled Care

Perth and Kinross are active in a range of Technology Enabled Care (TEC) strategic initiatives, for example:

- Perth and Kinross is one of three areas participating in the Scottish Government's 'analogue to digital' pilot. This will assist the implementation of a fully digitised telecare service in Perth and Kinross;
- The Perth and Kinross telecare service recently attained TSA accreditation. We will continue to ensure provision of a high quality service and maintain accreditation;

- A new SMART flat is being developed in the centre of Perth where staff can receive training and an understanding of the benefits of the different types of Telecare equipment, and where people can visit to try out the range of telecare supports that are available in Perth and Kinross;
- The telecare team will offer training and information sessions to professionals and the public to continue to increase the number of people supported with Telecare;
- The telecare will support transformation projects and the implementation of the TEC strategy.

We will be developing a performance view in relation to TEC capable of demonstrating the impact of the above strategies, including a drill down in relation to specific equipment types.

4.1.4 Falls prevention

Falls represent the most frequent and serious type of accident in the over 65 age group causing significant physical and psychological distress for older people and their carers, not to mention substantial cost implications for Health and Social Services. Evidence states that by introducing well-organised services, based on recommended practice and evidence-based guidelines falls and fractures can be reduced in older people.

Within Perth and Kinross, for the last few years the rate of falls month-on-month illustrates complex variability (Figure 11). Overall there is a very slight increasing trend. While on average, there are 180 65+ falls admissions per 100,000, this has usually varied from 30-40 above and below this. Moreover we observed a considerable spike in this measure for January 2018, where the rate almost reached 300 (293). We are investigating this unusually high incidence of falls for January 2018 to help us understand reasons for variation.

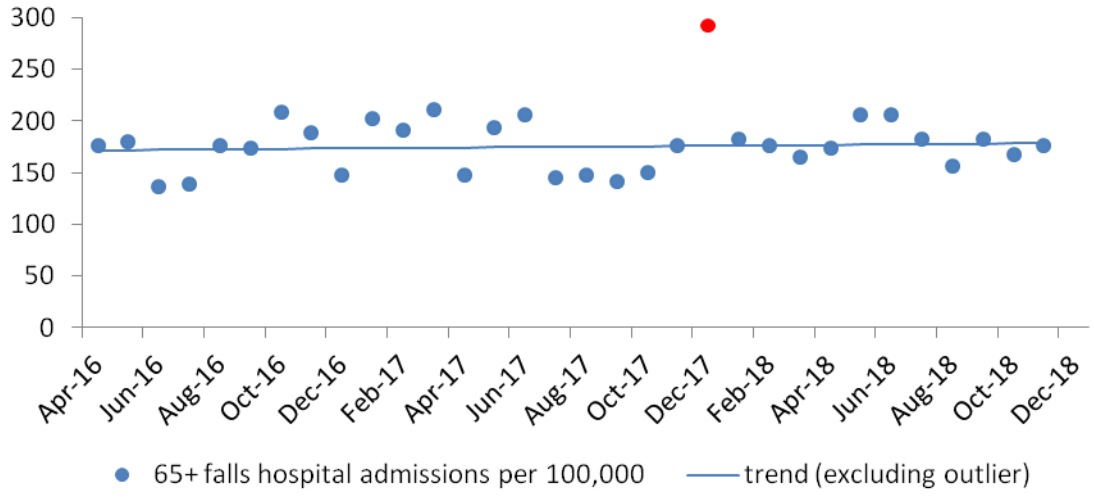

Figure 11 Perth and Kinross 65+ falls hospital admissions per 100,000 (Source: ISD). Note: trend line based on data that excludes the January 2018 outlying data point.

As well as normal random variation, month-on-month variability may be explained by other factors such as: risk management at the individual level; variations in how falls are managed in the community; street/pavement conditions; weather forecast accuracy; and corresponding service responses to inclement weather.

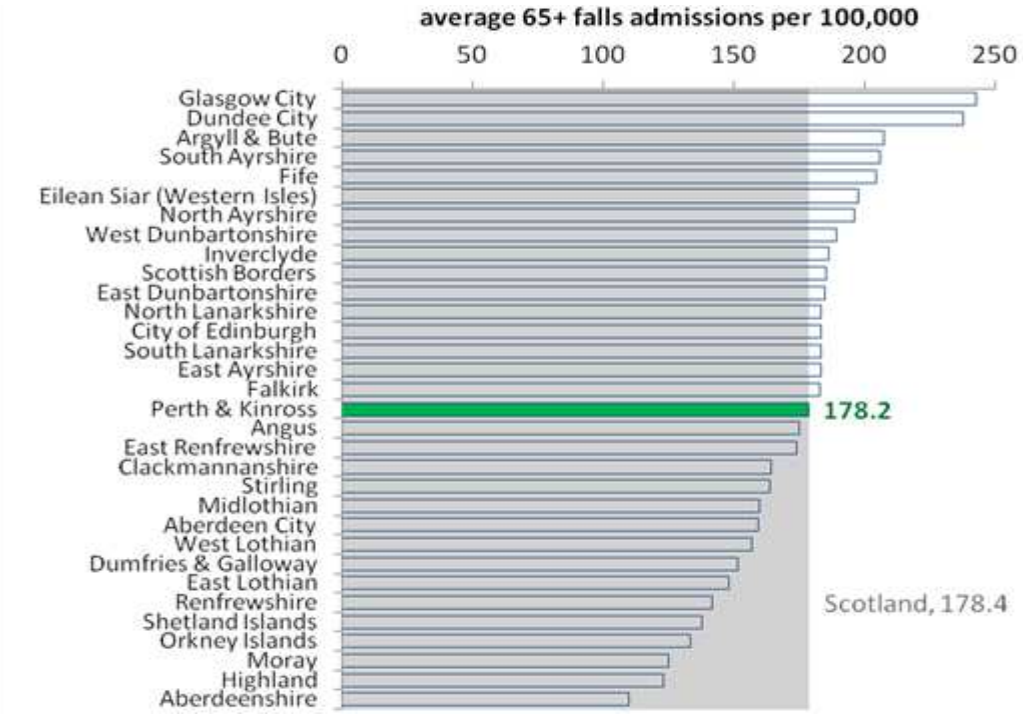

Figure 12 Average 65+ monthly falls admissions per 100,000 (2017/18, Source: ISD Table 16 - Emergency admissions to hospital as a result of a fall)

In relation to other partnerships, the rate of 65+ falls admissions for Perth and Kinross reflects that of Scotland as a whole (Figure 12). There may be underlying reasons for the variation in performance between partnerships (for example there may be an urban/rural component). However, cognisant of such complexities, we seek to drive this performance indicator towards that demonstrated by "similar" partnerships that demonstrate lower rates.

Our continuing focus on falls prevention includes the following key actions:

- Continue to embed the Scottish Government Framework for Action 'Falls Prevention and Management in the Community';
- Develop an improved performance view capable of highlighting the impacts of the above initiatives;
- Investigate the spike in falls admissions seen during January 2018 in relation to other areas in Scotland and contextual factors.
- Continue to benchmark Perth and Kinross against other partnerships.

4.1.5 Supporting people at the end of life

The proportion of the last six months of life spent in the community relate directly to individuals' preferred place of care at the end of their life. As there is no national and systematic data recorded on a person's preferred place of care at end of life, it is not possible to represent people's preferences. Instead a surrogate measure is used, i.e. "Percentage of last six months spent at home

or in a community setting". Although this is not a direct measure of compliance with an individual's preferred place of death, it can serve to provide a broad indication of progress.

Figure 13 illustrates the percentage of time people aged 75+ spend in the community within the last six months of their life. While there is a degree of variation month on month, the chart illustrates a slight increase over the last three years. In addition, for all age groups, Perth and Kinross performs relatively well in comparison with other partnerships and with Scotland as a whole (Figure 14).

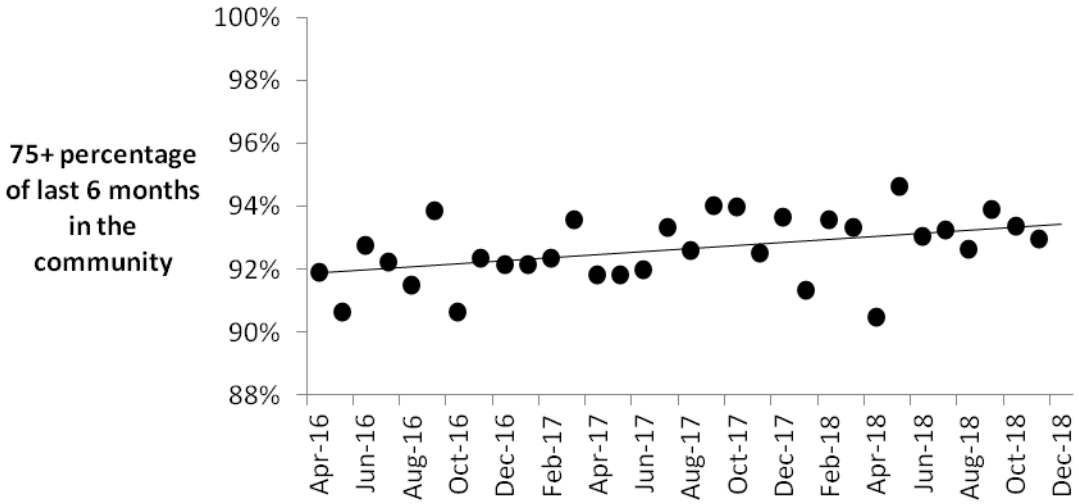

Figure 13 Percentage of time people aged 75+ spend in the community within the last six months of their life (Source: ISD)

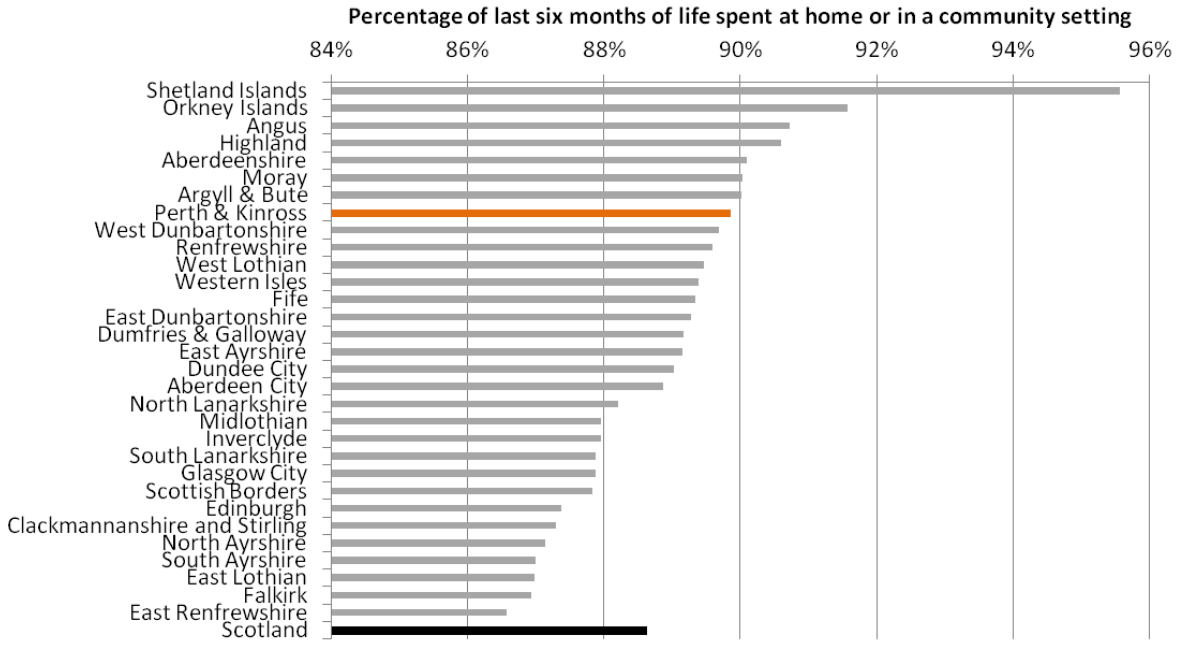

Figure 14 Percentage of last six months of life spent at home or in a community setting for Scottish partnerships: 2017/18 (provisional) (source: ISD QOM tables)

Community teams support people to stay at home for as long as possible. Community nursing teams supported by local homecare teams and HART ensure early discharge and support to ensure patients are managed at home for end of life care where it is the person and families choice to do so. This is further supported by a Marie Curie Nurses/Carers as part of the NHST Commissioned service through Marie Curie

In addition, Enhanced Community support is available in some parts of Perth and Kinross, which allows an early intervention and wraparound service to people who are deteriorating and at risk of hospital admission. This forms part of an Integrated Care Team approach and will support the key worker test of change in sub localities.

4.2 Residential and Nursing care

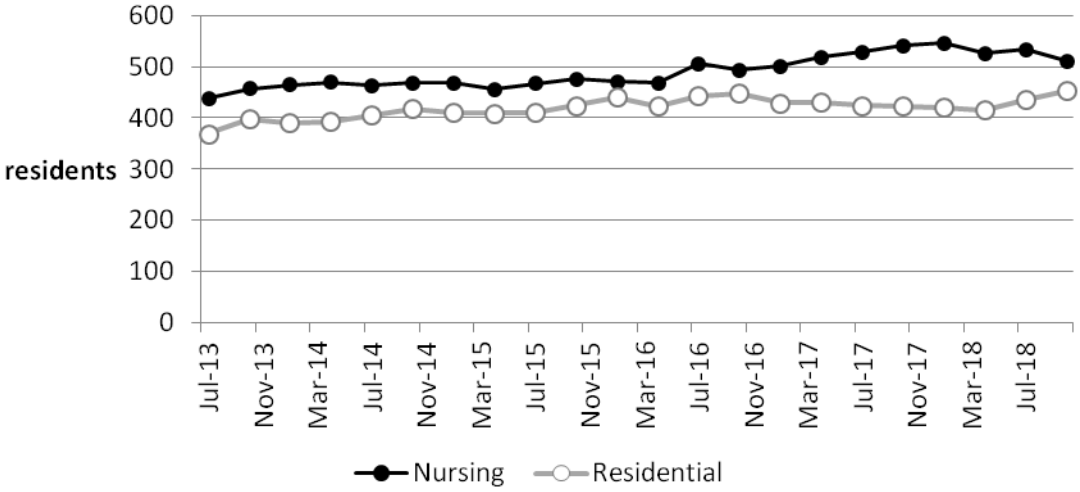

Figure 15 Number of residents in residential and nursing care homes (Source: local data)

Since April 2018 there has been a slight increase in the demand for residential care. Conversely, we may be seeing a reduction in nursing home residents. These trends are at variance with more recent year's data which has shown from 2017 a decrease in residential placements. This was in line with our strategic priorities of increasing support to client's in the community to enable them to remain living within their own homes and thus avoid a care home placement. Further study is required to analyse if this increase from mid-2018 is a short term statistically anomaly or in line with longer term trends.

5 Future Performance Reporting Areas

In order to understand whether we are achieving the aspirations of the strategic objectives outlined by the Older People and Unscheduled Care strategy we are working towards becoming more sophisticated in the data we are gathering. We aim to be able to gather the following data so we can gauge our performance in these key areas.

- *Reduction in Care Hours Following Reablement*
- *The Number of Community Anticipatory Care Plans Completed For People Following Diagnosis of Dementia*
- *Number of people in Supported Living Services*
- *Number of Occupational Therapy Assessments*
- *Supporting Individuals with Frailty (eFrailty Tool)*
- *Numbers of People with Continence Issues provided with Support in the Community*
- *Performance Information on Intermediate Care (incl. Rehabilitation and Community Hospital Support)*
- *Number of People Supported by Telecare in the Community*