This paper relates to Agenda Item 4

Title/Subject:	**Chief Officer Report**
Meeting:	**Integration Joint Board**
Date:	**5 August 2016**
Submitted By:	**Chief Officer**
Action:	**For Decision/Noting**

1. INTRODUCTION

1.1 The purpose of this report is to update members of the Integration Joint Board (IJB) on current developments within the Falkirk Health and Social Care Partnership and to outline proposals to improve the end to end care pathway for older people to avoid admission to hospital, reduce the length of stay in hospital, to enable timely discharge and to support people to remain in their own home as long as possible.

2. RECOMMENDATION

2.1 Members of the IJB are asked to:

- agree the proposal to develop a strategic whole system approach including a Frailty Pathway and a Discharge to Assess model.
- agree that the proposed change programme is developed as outlined in section 6
- request the Chief Officer to work with Senior Colleagues to complete the required detailed work and report back to the next meeting of the Board in October.

2.2 Note the progress of the Programme Board and the associated workstreams.

3. BACKGROUND

3.1 The Board agreed at the meeting in March that three key areas of work should be undertaken:

- Development of the Delivery Plan
- Review of Partnership funding and
- Development of the Financial Recovery Plan

3.2 Members of the IJB continue to be concerned about the number of patients delayed in their discharge in the post winter period and have requested officers to report back to this meeting.

4. PROGRESS UPDATE

4.1 Progress has been made in all the areas and detailed in separate reports on this agenda. In the interim work has progressed on the Delivery Plan and associated workshops have taken place including one on Delayed Discharge. As a result of the workshop it is clear that a 'whole system' approach is required to address each component of the current pathway and community based services and supports to improve outcomes. It is clear, on review of the evidence, that there is no single solution; rather an integrated approach is required to align our resources more effectively for improvement.

5. Recovery Plan

5.1 Since the Board meeting in June the Leadership group has been meeting regularly to monitor the Recovery Plan and is now beginning work to develop the budget strategy for 17/18.

5.2 A Leadership group of senior managers, including finance, operations and governance has met regularly to review and implement the Recovery Plan considered by the IJB at its meeting on 3 June. An update on the budget position is detailed in the report at agenda item 6.

5.3 At the IJB meeting in June Board members identified that there were additional funding pressures, namely Ward 5, that had not been taken into account in the reports on the IJB Budget and the Partnership Funding. The Board requested that consideration to funding this was brought forward in a proposal to the August Board meeting.

6. Delayed Discharge

6.1 Members of the IJB have received regular reports on Delayed Discharge, the current update is reported in a separate paper on this agenda. Concern was expressed at the IJB meeting in June that Ward 5 has continued to remain open since April to accommodate the ongoing pressures at a cost of £87k per month. This is addressed as part of the IJB Budget and Recovery Plan on this agenda. In addition there is concern about the potential impact on delays in discharge of the planned closure of the beds in Oakbank and Summerford.

'Wicked Issue' workshop

6.2 A workshop was held on 21 June, with support from the ihub from Health Improvement Scotland, to address the on-going local challenges associated with delays in discharge. Attendance included a cross section of health and social care, third and Independent sector colleagues. The outputs from the workshop indicate a shared vision and aspiration to take a 'whole system approach' to address each element of the patient pathway to improve outcomes including:

- Development of patient pathways using the Frailty model and Comprehensive Geriatric Assessment (link to current work by Geriatricians and Physicians)
- Home is Best: Introduction of Discharge to Assess Model this will ensure that people are assessed in their own homes immediately on discharge home and tailored packages of care and support are put in place and reviewed regularly. There is evidence from elsewhere in the UK that this should improve outcomes, reduce delays in discharge and length of stay.
- Review of data on patient flow and bed modelling .
- Commissioning to improve flexibility/ review and sustainability
- Standardising and improving assessment and review across the whole system
- Develop a comprehensive Re-ablement model and review intermediate care provision.
- Explore retaining Summerford to develop the Intermediate Care Model in advance of developing a new facility utilising the current l capital commitment.

6.3 Many of the building blocks for this 'whole system' are in place, ALFY, Closer to home, Discharge Hub, Frailty Clinic etc and are being reviewed as part of the partnership funding review and can be realigned to deliver this model.

6.4 There is evidence from NHS Ayrshire and Arran that developing a Frailty Pathway in the Emergency Department has been successful in improving outcomes, reducing admissions, re-attendances and readmissions to hospital. The key results are detailed in Appendix 1.

6.5 A Frailty Pathway and a Discharge to Assess model have also been developed in West Lothian as outlined in Appendix 2. This has had considerable impact on delays in discharge, admissions and length of stay.

6.6 It is important that patients are discharged in an appropriate and timely manner once their acute and immediate needs have been met. The risks of prolonged length of stay in hospital are infection, worsened state of confusion/disorientation, physical deterioration and reduced independence. Benefits reported from Discharge to Assess models include:

- Improved health and wellbeing outcomes for patients
- A patient's needs have been frequently found as less resource intensive than predicted in a hospital environment, saving demand on social services resources
- Patients and relatives report increased satisfaction.
- Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient
- Reduced length of stay
- Reduced risks associated with vulnerable patients remaining in hospital
- Increased discharge rates
- Hospital beds are freed
- Increased patient flow through the hospital

6.7 It is proposed that we establish a Change programme to underpin the Delivery plan to support the transformation required to improve outcomes. This work will become the first strand of that programme.

An analysis of patient flow, potential costs and bed modelling will be completed to test the potential effectiveness of this model. This will be reported back to the board with a detailed action plan to the next meeting in October.
The benefits of the frailty pathway could be extended to prevent admission by use of the assessment model in primary care to enable responsive early interventions: care at home, rehabilitation / re-ablement and referral.

The current Partnership funding is supporting several elements of an end to end pathway including:

- ALFY
- Closer to Home,
- Discharge hub,
- Frailty Clinic
- Telecare
- Summerford re-ablement support

6.8 These elements could be better aligned to form a comprehensive and cohesive structure based on assessment, early intervention, re-ablement prevention of admissions, shorten hospital stay, prompt discharge to assess, tailored packages of care, supported by Frailty Pathway, comprehensive geriatric assessment and intermediate care.

6.9 The development of this overarching programme will address the issues re ward 5, delays in discharge and the closure of residential beds in Oakbank and Summerford and the committed capital investment for an intermediate care facility as part of a 3-5 year plan.

6.10 It is proposed that every effort is made to close ward 5 in the short term, And that in order to avoid alleviate pressure, Summerford remains open and is developed as an intermediate care facility with ‘step up’ and ‘step down’ beds. This will enable the full pathway to develop alongside a comprehensive re-ablement model in advance of a new facility being built. If this is agreed the current budget saving previously agreed by Falkirk Council would need to be offset. A fully costed model for Summerford will be developed, submitted to the next IJB meeting in October

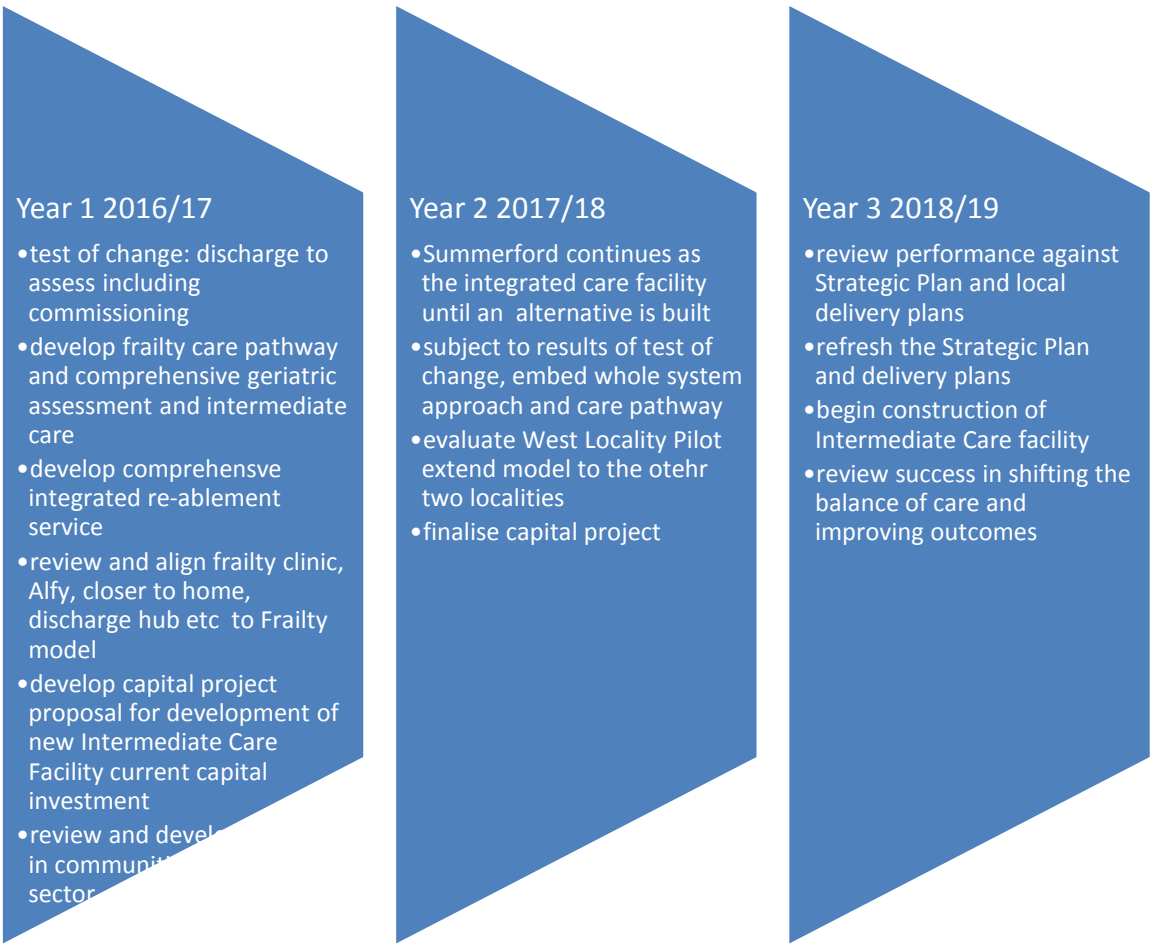
6.11 Partnership funded initiatives can be re-aligned to support tests of change, service redesign and to inform disinvestment. There is potential to use the West Locality Pilot to develop community supports and self-management as well the use of the Frailty model.

6.12 Colleagues from the ihub have offered to support this improvement work. Further meetings have been set up to progress this alongside the delivery plan.

6.13 Scottish Government recently announced investment to support Primary Care and Urgent Care Transformation. The plans are currently being developed and will take account of the current partnership fund investment and strategic outcomes.

6.14 It is proposed that that a senior Change programme board is formed to develop and oversee the project. A draft three year plan is outlined below at Table 1.

Table 1 Outline Plan



6.15 The Chief Officer will continue to work to establish a Joint Management Group to oversee the development of the Change Programme and Locality pilot

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7. Programme Board and Work stream Update

This section provides a progress report on the programme of work to implement health and social care integration and ensure the Partnership meets their statutory obligations. The IJB has received regular reports noting the programme of work overseen by the Programme Board and work streams to ensure the Board is satisfying itself that all relevant matters are being progressed in a timely manner.

7.1 The key achievements since the report in June 2016 and future actions for these work stream groups are attached at Appendix 3.

7.2 There remains commitment from all partners to ensure the Partnership meets it's statutory obligations under the Public Bodies (Joint Working) (Scotland) Act 2014 and the ongoing commitment is noted in the Support Service report as a separate agenda item.

7.3 There are a number of pieces of joint work that are still in progress, the Finance work stream requires to complete the financial element of the scheme of delegation. The full scheme of delegation is required to clarify issues of responsibility and accountability.

8. CONCLUSIONS

8.1 A strategic approach is required to address the range of issues that result in the current levels of delayed discharge and care home placements in Falkirk.

8.2 It is proposed that this is addressed through a 3 year plan as part of a wider Change programme underpinning the delivery of the Strategic Plan.

Resource Implications

A full model of finance and resources required will be developed and submitted to the next IJB meeting in October. It is anticipated that there is scope within the current Partnership funding to realign current work and to undertake tests of change.

A fully costed model for Summerford will be developed, submitted to the next IJB meeting in October including the need to offset the budget saving previously agreed by Falkirk Council.

Impact on IJB Outcomes, Priorities and Outcomes

The delivery plan and change programme and infrastructure are being designed to deliver the outcomes described in the Integration scheme and Strategic Plan.

Legal & Risk Implications

A statement that highlights any legal issues and risk that may arise, relating to the integration authority or the constituent partners.

Consultation
As the programme is developed staff, communities and stakeholders will be consulted in the development of the plans.

Equalities Assessment
There will be appropriate consideration of the equalities implications and equalities impact assessments will be completed as the programme develops.

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Approved for Submission by: Chief Officer

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List of Background Papers: