AGENDA ITEM

13

Falkirk
Health and Social Care
Partnership

Title/Subject	**Whole System Working: Unscheduled Care and Delayed Discharge**
Meeting:	**Integration Joint Board**
Date:	**7 December 2018**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 The purpose of the report is to provide members with a strategic overview of the current position and future strategic direction to put in place the integrated system required to deliver improved outcomes for hospital patients and to reduce delays in their discharge.

2. RECOMMENDATION

The Board is asked to:

2.1. note the range of improvement work currently underway including unscheduled care

2.2. agree to invite the Scottish Government (Delayed Discharge Policy Lead) to present at the Board development session in the New Year.

3. BACKGROUND

3.1. Members of the IJB have received regular updates on delayed discharges. This has been through the Chief Officer and Performance reports, workshops and presentations on key work including the Discharge to Assess pilot and Frailty at the Front Door Collaborative.

3.2. Professional leads made a joint presentation on delayed discharge at the Board meeting on 5 October to complement the Board report. The presentation included a detailed analysis of the multiple factors which can delay the timely discharge of patients from hospital and outlined current performance and the ongoing work across the HSCP and acute and community hospital sites.

3.3. It was agreed that a board development session will take place to consider a refreshed action plan, combining actions on unscheduled care and delayed discharge. This session is being planned to take place in the New Year.

3.4. In the interim the Chair of the IJB requested a report to provide an overview of the current position and future strategic direction to reduce delays in discharge.

4. CURRENT POSITION

4.1. Preventing avoidable admission and supporting discharge

The Public Bodies (Joint Working) (Scotland) Act 2014 is intended to ensure that health and social care services are integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care.

4.1. In addition to core services, there are a range of initiatives funded across Forth Valley and Falkirk to tackle and improve various aspects of the pathways in and out of community and hospital care. The IJB currently invests 54% (£2,399,458) of Partnership Funds in to prevention of admissions to hospital and supporting discharge. These funds support a range of initiatives including: Closer to Home; the Frailty Clinic and the discharge hub. An update on the performance of these initiatives is included in the IJB Partnership Funding report as a separate agenda item.

4.2. There is therefore significant staff and financial resource invested in this work. However on review the impact on the numbers of people delayed in their discharge has been disappointing and performance is not showing sustained improvement.

4.3. There are a number of attributable factors. One that merits further consideration is the impact of fragmentation of leadership as core services and initiatives are currently led by different Directorates and managers. This does not foster the system required to ensure smooth pathways in and out of services and the community.

4.4. The IJB has two key levers that could significantly begin to address this. The first is linked to the development of an integrated management structure and establishment of integrated locality teams. The second lever is to reframe the investment of Partnership Funds to support the service transformation required to develop a cohesive whole system partnership approach.

4.5. Unscheduled care

A new Unscheduled Care team, led by a Programme Manager, was established within Forth Valley Royal Hospital (FVRH) earlier this year. The team focus is on unscheduled care and the delivery of the Scottish Government ‘Six Essential Actions’ programme.

4.5.1. The team report to the Medical Director, who also chairs the Forth Valley Unscheduled Care Programme Board (UCPB). The purpose of the Board is to work in partnership to:

- oversee system wide activities, initiatives, actions and performance around unscheduled care
- oversee activities across the Partnerships in relation to Unscheduled Care
- seek to streamline approaches and activity across the system where possible

- co-ordinate action to ensure delivery of targets
- ensure appropriate escalation to enable swift decision making if any significant redesign is required.

4.5.2. The UCPB reports to the Senior Leadership Team (SLT) within NHS Forth Valley. In addition it also reports to the respective Leadership Groups within the two HSCP's. Any major service change will require endorsement of the NHS Senior Leadership Team prior to escalation to the NHS Performance and Resources Committee, NHS Board and Integration Joint Boards for approval.

4.5.3. The key priority areas of the UCPB for focus include:

- 6 Essential Actions and Building Blocks
- Delayed Discharge
- IHO activity
- Activities to support Partnership unscheduled care objectives
    - ED 4 hr wait
    - Unplanned admissions (include attendance)
    - Unplanned bed days
    - Delayed Discharges
    - End of Life Care
    - *Shifting the balance of care spend* (outcome of work undertaken so linkages required)

  Relevant links to:
    - OoH review
    - Primary Care Transformation
    - Linkage/Understanding to Partnership Funded projects and their impact
    - Winter Planning

- Clinical Quality and Safety.

4.5.4. National Improvement Advisors from the Scottish Government are working with the UCPB and the team on improvement work to address the ongoing challenges in FVRH emergency department (ED) and to improve performance. A robust improvement plan over the next 12 months is in place, adopting a whole system approach to improved performance. Tests of change will be applied to certain functions within ED to improve the patient, staff experience and performance against the 4 Hour Emergency Access Standard.

4.5.5. The roll out of the 'Getting Forthright' initiative will see a whole system approach to ED and unscheduled care; working with our partners in identifying and addressing bottlenecks which impact on flow, and learning from tests of change, as well as promoting success. The team is engaging with staff across the acute and community hospital sites, social care and primary care colleagues to map acute and community discharge pathways to drive improvement. An improvement action plan is attached at appendix 1 for information and the outputs from this work will feed into the IJB Board Development session.

4.7. **External review and support**

In 2017/18 following a request from the Chair of the NHS Forth Valley Health Board, Brian Slater, Delayed Discharge Policy Lead, Scottish Government reviewed each element of Falkirk delayed discharge pathways. The review was conducted in a series of visits and interviews with a range of senior medical, clinical, nursing and social work and operational staff. A report was produced, designed to be a basis for discussion by officers, to help frame further work to reduce delays in discharge and makes a number of conclusions.

4.7.1. The report findings were presented in a workshop attended by a cross section of clinicians, General Managers, GPs and HSCP staff in June 2018. This is also informing the review of the Delayed Discharge Action Plan by the Delayed Discharge Steering Group. The report was also circulated to members of the IJB following a decision of the IJB meeting on 5 October.

4.7.2. The report concludes that staff show good commitment to tackle delayed discharge and identifies strategies required for sustained improvement. An assessment of progress aligned to these conclusions is summarised below:

	need to create a focus to keep people in their own homes and resource community services to deliver this
	identify those at risk and develop a more participatory and preventative approach to reduce the risk of crisis admission to hospital and early placement in care homes. This requires investment in intermediate care, reablement, use of technology enabled care
	fully implement a Discharge to Assess/ Home First approach
	need strong and joint leadership with clear ownership of the problem and authority for improvement vested in the Chief Officer
	require wholesale change in the current cultures and behaviours at all levels in the partnership, staff need to be empowered to make the difference
	can secure an early win to build on the integrated localities and establish truly integrated teams. These should be multi disciplinary; community based providing in-reach to local health and care facilities
	review intermediate care
	review the use of community hospital
	require a radical transformational agenda and need to move at pace

4.8. **Discharge to Assess/Home First Approach**
The presentation and report at the IJB meeting on 5 October illustrated the variability in performance against the causes of delayed discharge. While performance has improved in relation to packages of care, it has not been sustained over a prolonged period. At the same time care home delays are more volatile.

4.8.1. As a partnership, we need to address each element of culture, behaviour and practice that is creating this variability in the application of the current care pathways and agreed policy and procedures. For example, the Board has previously agreed to adopt a Home First policy that would move away from decisions about long term care being made in the midst of a crisis, to a timely discharge with reablement and assessment of people's longer term care and support needs. However we are aware of variability in adherence to Home First as a core principle, which will be addressed in the actions detailed in section 5 below.

4.8.2. Home First should also be the default response in both acute and community setting. This should consider how integrated locality teams, working with GP's, can support someone to stay at home with extended reablement support and enhanced care and treatment to avoid unnecessary hospital admissions and support appropriate and timely discharge.

4.8.3. As part of the pathway the use of step up/ step down beds /intermediate care and community hospital beds is a key element. On paper, the Partnership appears to have resources targeted at key areas in the pathway, however these services could be better joined up to realise the impact they should have.

4.8.4. As noted in the Chief Officer report, a report on Delayed Discharge and Out Of Area Placements for people with a Learning Disability has recently been published. The report makes a number of recommendations for Integration Authorities, which will be considered with the publication of a new integration framework for Keys to Life expected to be published early next year.

5. FURTHER REQUIRED ACTIONS

5.1 Taking into account the Scottish Government report and conclusions, local initiatives and developments in unscheduled care and discharge planning, the following actions are recommended:

- increase the pace of integration to develop the integrated locality teams to transform models of care and support and link better to GP's and primary care
- build on the unscheduled care and six essential actions work
- address culture, behaviour and practice challenges across the whole system

- identify and target those at risk of unnecessary hospital admission and ensure that individuals can remain in and return to their homes and communities
- affirm our commitment to a 'Home First' approach and culture across the whole system
- clarify governance to ensure that the IJB discharges its responsibility for unscheduled care through the HSCP and ensure that there is cohesion across the whole system
- reframe what Partnership Funding investment and service transformation is required to develop a cohesive whole system partnership approach.

5.2 A Board development session is being planned for January. It is proposed that we invite Brian Slater, Scottish Government, to present his findings, along with the work of the Ministerial Strategic Group for Health and Community Care, and examples good practice from other HSCP's. This will sit alongside presentations on current local developments in unscheduled care and the discharge planning improvement plan.

6. CONCLUSIONS

The report provides and overview of the ongoing work and the need to adopt a comprehensive and integrated whole system approach to improve pathways and develop a Home First ethos.

The challenge locally is to bring all of the work together with clear overall leadership and responsibility, rationalising the number of working groups to systematically address each element of the system to deliver the required improvement.

Resource Implications
There are no costed management resource implications arising from this report.

Impact on IJB Outcomes and Priorities
The development of the whole system and the Home first approach is essential to deliver the strategic plan outcomes and shift the balance of care.

Legal & Risk Implications
This report proposes actions required to deliver the requirements set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

Consultation
The report has been developed as a summary of ongoing work on whole system approaches and takes account of previous presentations and reports.

Equalities Assessment
There is no requirement to complete an equalities assessment.

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Approved for submission by: Patricia Cassidy, Chief Officer

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