NHS Board meeting
30 October 2019

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SUBJECT: A Whole System Approach Unscheduled Care

1. PURPOSE

This paper is coming to NHSL Board:

For approval	☐	For endorsement	☐	To note	☒

1. ROUTE TO THE BOARD

This paper has been:

Prepared	☒	Reviewed	☐	Endorsed	☐

1. SUMMARY OF KEY ISSUES

Attendances at A&E have increased across Lanarkshire (up 4% against 2018/19). Data has been made available from West of Scotland Regional Planning partners and Lanarkshire Information Services which have shown some opportunities for improvements, taken as a whole system approach between acute and community (Health and Social Care Partnerships).

To explore these opportunities for improvement there have been number of meetings and two workshops with representatives from acute and community sectors. These have generated the following 'high level' areas for improvement. Further workshops are planned in the North.

The overarching philosophy of this work is to support a 'home first' approach.

These actions for improvement are related to the following themes.

1. **Front Door Actions (A&E)**
   Actions – Redirection, Signposting, Enablement
2. **Back Door Actions (Delayed Discharge)**
   Actions- Rapid Response Enablement, Care at Home, Social Work, Discharge to Assess
3. **Enhanced Community Teams/ Locality Led Response**
   Actions – Health Care Support Workers, Marie Curie Service Support
4. **Urgent Care Out of Hours**
   Actions – Workforce Plan in place to create an alternative workforce to GPs
5. **Intermediate Care**
   Actions – Maximise opportunities for Intermediate Care in Local Authority Beds and Community Hospitals
6. **Enablers – IT/ HR (Workforce)/ Finance/ Transport**
   Actions- There is a number of enablers which are needed to support unscheduled care pathways.

A whole system vision in relation to A&E attendances/ unscheduled care is required order to ensure long term sustainability.

4. STRATEGIC CONTEXT

This paper links to the following:

Corporate Objectives	☒	AOP	☒	Government Policy	X
Government Directive	☒	Statutory Requirement	☐	AHF/Local Policy	☐
Urgent Operational Issue	☐	Other	☐		

5. CONTRIBUTION TO QUALITY

This paper aligns to the following elements of safety and quality improvement:

Three Quality Ambitions:

Safe	☒	Effective	☒	Person Centred	☒

Six Quality Outcomes:

Everyone has the best start in life and is able to live longer healthier lives; (Effective)	☐
People are able to live well at home or in the community; (Person Centred)	☒
Everyone has a positive experience of healthcare; (Person Centred)	☒
Staff feel supported and engaged; (Effective)	☒
Healthcare is safe for every person, every time; (Safe)	☒
Best use is made of available resources. (Effective)	☒

6. MEASURES FOR IMPROVEMENT

A measurement plan is under development to support the whole system unscheduled care action plan to demonstrate improvements.

7. FINANCIAL IMPLICATIONS

Detailed costings are being verified as part of the considerations of Winter Planning funding.

8. RISK ASSESSMENT/MANAGEMENT IMPLICATIONS

Risks are captured in Partnerships Risks Registers

9. FIT WITH BEST VALUE CRITERIA

This paper aligns to the following best value criteria:

Vision and leadership	☒		Effective partnerships	☐	Governance and accountability	☒	
Use of resources	☒		Performance management	☒	Equality		☐
Sustainability	☒						

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT / FAIRER SCOTLAND DUTY

Yes.
No ☒

11. CONSULTATION AND ENGAGEMENT

A range of partners have been involved in the development of the MSG indicators.

12. ACTIONS FOR BOARD

The Board is asked to:

Approval	☐		Endorsement	☐	Identify further actions	☐
Note	☒		Accept the risk identified	☐	Ask for a further report	☐

1. Note the actions taken to date and the direction of travel; and

2. Note that these actions will continue to be refined and will be presented to the Development Day on 27 November 2019.

13. FURTHER INFORMATION

For further information about any aspect of this paper, please contact

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Appendix 1

Whole System Approach to Unscheduled Care

All health and social care services in Lanarkshire are working together to ensure people are only admitted to hospital for unscheduled care where there is no suitable alternative. If they are admitted their care will be transferred to home or a homely setting that maximises their independence as soon as any new risks identified can be safely managed. Where attendance at hospital can be avoided this will be supported where possible.

In implementing this strategy the overall aim would be to improve performance against the emergency access target by 5% to 93% as well as impacting on unscheduled care bed days overall and delayed discharge bed days in particular.

Objectives

- A whole system approach will be agreed between hospitals, community and General Practice teams that changes current parameters of care to emphasise that the default place of care for people is in their own home and the community and that hospital is used only when necessary and for the shortest period that is needed to facilitate a safe transfer back to the community.
- That this strategy is developed and implemented through a programme of engagement across that whole system.
- The concept of "clinically **ready for discharge**" should be replaced with a revised concept of "clinically **safe for transfer** to community"
- Patients and their families will be informed that "home first" is the expected outcome for all people admitted to hospital and that if increased care needs are identified the norm will be for this to be further assessed in the home setting before longer term decisions about care are made.
- Estimated dates of discharge will be established as soon as practical within an admission and teams will start to plan discharge in advance of a clinical decision that it is safe to transfer an individual.
- Services will develop community or locality led discharge for patients known to community services. In practice this means:
    - Community services need to be informed about people presenting to hospital at the point of a decision to admit and not at point of readiness for transfer back to community.
    - Community services will take lead in agreeing parameters for facilitating discharge for patients that are known to them, in partnership with clinical team in hospital and discharge co-ordinators.
- An IT solution that allows for patient tracking between community and hospital to support above will be identified to support this change of approach. In addition an IT system that identifies individuals likely to require complex assessment at point of admission should be deployed.
- Where individuals present for first time in crisis leading to admission and ongoing care needs are identified then Discharge to Assess will be the default process for determining those needs. It will be made clear to hospital staff, patients and their families that the hospital team will only make recommendations for initial support on transfer home and that

determination of ongoing need will only take place after a period of reablement in the home setting.

- A framework of services to support safe transfer to community care is set out within this strategy and where gaps in that framework are identified business cases will be developed to rectify.
- Patients and their families will be informed that emergency minor ailment assessment can be supported in community services such as pharmacies, treatment rooms and other agencies and that an emergency department is not always the right place for minor ailment treatment. Community services need to be informed on minor ailment demand to help inform the needs of people who presently choose emergency department services
- Analysis of referrals from NHS 24 and of flow around health Board boundaries will be carried out and reviewed to better understand the impact of these factors on changes in rates of presentation across the system.
- In parallel with the unscheduled care strategy, work continues in development of Long Term Condition pathways and the Frailty Strategy implementation that will ensure a shift in the balance of care to planned and anticipatory care for these groups reducing the need for unscheduled care.

Definition of terms

Clinically safe for transfer - medical condition has stabilised to a point where management in a non-hospital setting is possible provided pre-admission levels of support/care are in place. If any new risks or needs have been identified through the admission there are plans in place to manage those on a short term basis with a view to further assessment at home.

Estimated Date of Discharge – the likely date at which a person will be clinically safe if treatment they require follows a normal course. This is not a fixed date and will vary but allows community staff to begin to plan for discharge arrangements.

Locality led discharge – where health and social care staff are already working with patients and their families in the locality they will take the lead role in determining need for support and care on discharge and in negotiating the point of “safe for transfer” with the hospital clinical team.

Discharge to Assess – The default position will be that where a person requires a revised assessment of their needs this will be carried out at home, usually after a period of re-ablement. Hospital teams will only review short term requirements for support/equipment to allow transfer home and assessment of ongoing need will be completed at home wherever possible

Home First – An approach that sets out to ensure that wherever possible the default destination for discharge from hospital will be the person’s home in preference to another hospital or nursing home bed.

Re-Direct Plus – An approach that will enhance emergency department attendances in their re-direction to appropriate community services.

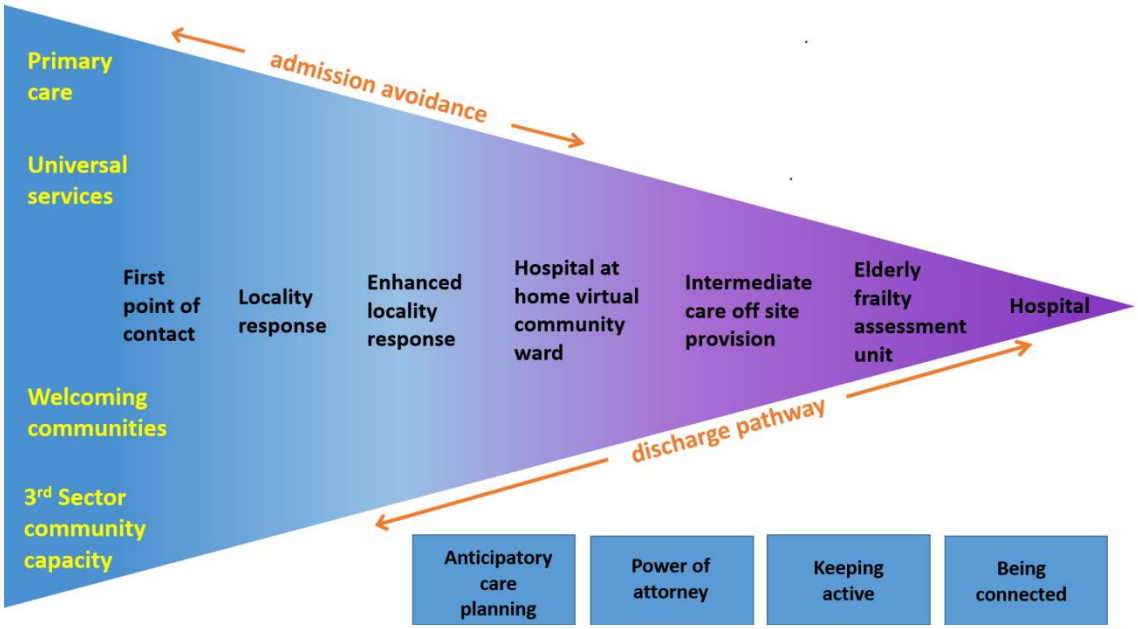
Measures of success/outcomes

When successfully implemented the unscheduled care strategy will deliver against the following indicators:

- Reduction in unscheduled care bed days across the whole system
- Reduced referrals through discharge hubs resulting in reduction in delayed discharges
- Reduction in number of people discharged from hospital to care home or other setting other than home.
- Shortened lengths of stay in acute and intermediate (off site) beds across the system
- Rise in proportion of time spent at home (balance of care and end of life care indicators)
- Reduction in the number of patients who wait longer than four hours for assessment in an emergency department
- Increased emergency access performance that meets with the national target

Further measures of improved outcome and balancing measures will be developed.

Framework of services for unscheduled care



Services in the community have a dual role in early intervention to prevent deterioration and admission and also to facilitate early discharge. Acute healthcare services can support in providing details of frequently attended people whose assessment and or interventions would be best supported in the community setting.

Locality response captures all services routinely available within locality with scope for rapid involvement. These include ICST (SL), Integrated rehab teams (NL), district nursing, home support etc. Capacity to escalate levels of support within these teams either to prevent admission or facilitate discharge needs to be assessed and potentially increased.

Enhanced locality response envisages a more comprehensive "wrap round" level of care for people with a higher level of dependence being supported at home by current community nursing and AHP teams. At present 60% of care home admissions transfer directly from acute settings. With a "Home First" approach we would aim to reduce this and the delays due to complex assessment by providing Discharge to Assess with the option of more intense home and /or healthcare support, prof to prof over the 24 hour period for a strictly time limited assessment period. On the discharge pathway this would equate to the "Hospital to Home" model currently in place in some other Boards. This is an identified gap within the current Lanarkshire framework.

Hospital at Home will be primarily targeted towards admission avoidance in the over 65s, allowing an acute care model with consultant physician (H@H) providing the medical leadership of clinical team delivering care in the home environment. In some the support of H@H may be used to facilitate discharge where there is ongoing need for acute care input but other factors mean transfer home can be managed safely.

Intermediate care/off site provision – there is a recognition that for some people a further stay in a residential setting will be helpful in preparing them for safe transfer to the community. Our off site beds and intermediate care provision should be geared to delivering time limited targeted programmes that help as many people as possible to reach a point where the next stage of assessment of their needs can be carried out at home.

Frailty assessment unit will provide acute hospital assessment with a view to facilitating very early discharge in partnership with the community and with the other services highlighted above. Again, this requires early and full discussion with teams already involved in caring for these people in the community setting.

Other acute hospital wards/beds will provide appropriate care to point at which it is clinically safe to transfer care to one of the services above.

Re-direction plus will direct patients to the right place for their 'minor Illness' assessment and or treatment. Enhancing this service with shadowing skills set of community and acute nurses will support delivery of care in community settings with the potential to increase public knowledge on the choices available. Supplementary to this public awareness and education would be revised to support people in choosing the right place.

An action plan has been developed against these principles. This will be submitted to the NHS L Corporate Management Team, and North and South Senior Management Teams for ratification week beginning 28/10/19.