south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership **Held on**	**Integration Joint Board** **14th December 2022**
Agenda Item:	**7**
Title:	**Acute Interface Improvement Plan**

Summary:

The purpose of this report is to update IJB members about the 2 week Whole System intervention that took place in the two acute hospital sites in November 2022 and the related ongoing and emerging work

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Recommendations:

It is recommended that the Integration Joint Board note the contents of the report and requests further updates on the action areas set out in the report

Route to meeting:

Update report for IJB.

Directions:		**Implications:**	
1. No Directions Required	☐	Financial	☐
2. Directions to NHS Ayrshire & Arran	☐	HR	☐
3. Directions to South Ayrshire Council	☐	Legal	☐
4. Directions to both SAC & NHS	☐	Equalities	☐
		Sustainability	☐
		Policy	☐
		ICT	☐

ACUTE INTERFACE IMPROVEMENT PLAN

1. PURPOSE OF REPORT

1.1 The purpose of this report is to update IJB members about the 2 week Whole System Intervention (WSI) that took place in the two acute hospital sites in November 2022 and the related ongoing and emerging work.

2. RECOMMENDATION

It is recommended that the Integration Joint Board note the contents of the report and requests further updates on the action areas set out in the report

3. BACKGROUND INFORMATION

3.1 In October 2022 the 3 HSCP Directors together with the NHS A&A Director of Acute Services requested that a focused 'whole system intervention' be put in place across the 2 Acute Hospital sites for 2 full weeks (including weekends).

3.2 The purpose of this intervention was set out as:

In recent months, there have been several Discharge without Delay (DwD) events across UHC and UHA. These have focused on working together to identify barriers to discharge and flow within our health and social care system. The teams have been able to pinpoint areas of improvement and are now working to implement these. Following on from this, we are currently planning for a whole system intervention, which is scheduled to take place over two weeks starting 7 November 2022.

This 14-day whole system event is sponsored by the three Directors of our Health and Social Care Partnerships (HSCP). It will focus on community services increasing their reach into acute services at University Hospitals Ayr and Crosshouse. You can expect to see us work as one team for Ayrshire and Arran residents, with more HSCP management and partners in the third and independent sector more involved in multi-disciplinary discharge planning and preventing admissions.

The 14-day event will be based on collaboration and mutual learning with the aim of putting in place sustainable improvements for the benefit of our citizens. We will provide updates at the end of weeks one and two of the event.

3.3 The expectation was that key Acute and HSCP staff would prioritise this short programme. (In South Ayrshire, this created a tension between managing the demands of the Adult Inspection and the Whole System work but significant numbers of HSCP staff managed to support the 2 week process).

4. REPORT

The 2 week intervention started on 7th November and continued through to Sunday 20th November.

4.1 Leadership and staffing support

Rosemary Robertson (Associate Nurse Director for South Ayrshire HSCP and Leona Walker (Manager of Unscheduled Care) were the two site leads in UHA.

Staff supporting the process included senior HSCP and Acute Hospital managers and clinicians, representation from services such as Discharge Without Delay, Hospital at Home, Advanced Care of the Elderly, Intermediate Care, District Nursing, AHPs (including Consultant Physiotherapist), Social Work, Reablement and Care at Home, Care Home Clinical Support Team, Mental Health and East Ayrshire Carers Centre. On some days we had Dr Philip Hulme – CD for the HSCP- present to provide Primary Care input.

4.2 Programme

Essentially the following were the key daily components of the work, at least in the case of UHA where most of South Ayrshire HSCP's time was committee:

- Daily planning meeting of senior staff and clinicians at 9am in UHA
- Dividing staff into smaller review units who carried out mid-morning 'rounds' within ED, CAU and most of the salient Wards
- In addition, on some days staff from HSCP and others sat in on the incoming phone calls to the CAU from GPs to consider the appropriateness of the request for CAU attendance (this included HSCP CD on one occasion)
- 'Ward' visits included white board meetings and the reviews of all patients with the expectation of better flow through the hospital and discharge
- Review meetings with feedback from the individual 'teams' identifying some key areas of progress (such as accelerating discharge or changing the pathway for the patient) together with learning points
- Further Ward based work and on-going routine activity
- Daily feedback meetings with the 'commissioners' (the Directors) to consider progress and learning.
- An Action Plan was then created at a site level and an overarching one created at an Ayrshire level.

4.3 Reflections on the 2 week exercise:

- On the UHA site, there was high levels of commitment from all parties and a respectful collegiate spirit with staff willing to learn from others and to support each other practically.

- With the significant levels of staff commitment there were indeed good examples of patients being supported to reduce hospital stays, change their clinical process, speed up discharge and identifying opportunities for mitigating the need for attendance/admission
- Providing this intensity of staff support beyond a short (2 week period) would not be possible – people were leaving behind day jobs and community based support to create the hospital based outcomes – this could be a questionable use of finite resources although there was clear impact in having additional (community) staff involved in the hospital setting
- The Whole System Intervention (WSI) supported 60 Discharges with intervention from the MDT in Ayr Hospital. These interventions changed patients' journeys, re-assessed and re-calibrated packages of care and arrived at a better and shared understanding of risk – the starting assumption was 'home first'.
- A key positive aspect of the exercise was the clarity of understanding it provided for participants on the exact way discrete services operated, how they might be used better and the articulation between services improved.
- The Hospital at Home Service has only recently become a fully staffed service so it was a positive opportunity for this service to identify how it might work with others and for other teams to understand how best to link with this new service
- Some of the staff had only recently started and the exercise formed part of the induction process.
- Having key clinical leaders and support staff from acute and community together increased knowledge of how services operate in these two loci and the ways in which risk is mitigated in each setting.
- Learning re services was not just between acute and community. Sometimes community services did not work as an effective and coherent whole.
- Having modest third sector support in situ (ie Carers support staff) was highly valued and made a huge difference to supporting the carers of patients.

4.4 Emerging issues an areas identified for improvement

There were a range of issues that were identified as being areas where improvement could be made:

- Preventing admissions
- Greater MDT presence at front door
- Ways to reduce transfer from CAU to ward
- Ways to reduce length of stay
- Ways to speed discharge

4.5 System-wide issues

There were system issues identified such as:

- General incompatibility of ICT systems between Acute, Primary Care, HSCP NHS and HSCP Council systems
- Timeous access to patient information particularly for out of hours services (for example, better use of eKIS)
- Equipment access issues or simple steps to make equipment supply quicker
- Differences in how patients are assessed for support at home with different risk levels applied differently according to profession
- The challenge in GP Practices in getting quicker access to diagnostics such as from blood tests
- The capacity limitations of some key disciplines that form part of MDT working - such as AHPs (Physiotherapy as an example)
- This linked to the issue of deploying staff from another part of system intensively for 2 weeks but with significant impact on the usual focus of work

4.6 Cross-cutting improvement areas

There were cross cutting areas identified that need clear whole system consideration such as:

- Supporting Care Homes to reduce unnecessary admission and support timeous discharge
- Reviewing pathways associated with falls in the home where hospital attendance/admission could be reduced (for example, revisiting protocol with SAS re falls)
- Understanding the system response to delirium and ensuring patient pathways are clear, coherent and widely understood and utilised.
- Understanding other key clinical pathway areas such as for respiratory conditions such as COPD
- Considering those admitted with significant mental health issues and/or alcohol based problems often with other related clinical issues. Also managing better those ‘social’ referrals where there were significant socially rooted issues driving clinical need.
- Utilising technology better in relation to prevention of admission and supporting discharge
- Moving towards whole system 7 days working and greater out of hours working in general
- The perennial challenge of recruitment and retention across the system from Consultant Care of the Elderly physicians, advanced level nurses, key AHPs and Social Care staff.

4.7 Education/Learning

Another highly significant area to build on was cross cutting MDT education and learning opportunities. Whilst this might include formal learning sessions, seminars, 'show and tells' it might also include shadowing of staff between teams. During the 2 week process, by chance, there were also opportunities to share information on the work within the context of WSI and also a Medics learning session.

4.8 Key areas to shape planning around short/medium and long term

Essentially there were many ways highlighted where improvements could be made to:

- Reduce unnecessary hospital presentations and admissions
- Anticipate and manage patients with high risks of admission pre-emptively
- Work as a coherent whole rather than as discrete services, teams and disciplines
- Address practical and bounded issues such as equipment supply and access to diagnostics
- Better understand the use of appropriate technology
- Better understand how families/carers can be supported within communities beyond the hospital episode
- Better understand how community based third sector services can support patient pre and post admission
- The learning from the WSI and Medics education session highlighted that there was a lack of clarity on how access to support and what services where available. There was also an emphasis on better education to illustrate how AWI, Guardianship, Power of Attorney, Care at Home assessment impacted on delays from hospital.
- There is also a need to re-visit pre-existing strategies and plans, for example, in relation to falls prevention pathways and work on key Long-term Conditions such as respiratory/heart failure/diabetes with some joint approach with colleagues from Managed Clinical Networks
- In relation to the process in community and in hospital settings to 'prescribe' care, there is the need for further process mapping to identify the best precipitant opportunities for asset based conversations and assessments to take place

4.9 The table below summarises the range of themes and issues

Summary of South Ayrshire Actions

Note - Key to Locus

- Community prevention of admission (CPE)
- Front Door (FD)
- Hospital based support (HBS)
- Back door (BD
- Preventing re-admission (PRA)

Locus of issue	Area of concern	Issue emerging	Timescale
CPE	**Access to community IV Anti-biotics**	Many individuals in hospital who could have had IV medication delivered at home or in a homely setting	Short Medium
CPE	**GP Access to Near patient testing**	Allowing GPs timeous access to blood testing and results	Short Medium
FD	**Alternative arrangements for GP related referrals**	Through the hub there were many referrals from GPs that could have had an alternative route – OOH, DNs, SPQ. There is scope to improve referrals to OOH Service, SPQ and DNs if resourced for 7 day working	Short Medium
CPE	**Supporting community Urinary/Catheter arrangements**	Referrals and presentation for blocked catheters, urinary retention and UTI's	Short
CPE **FD**	**Complex patient admissions**	Many patients arrive with complex needs who could and should be dealt with in community settings	Medium Long
CPE **FD**	**Mental Health and addictions**	High representation of associated issues related to alcohol i.e. Falls, cirrhosis and complex medication conditions	Medium Long
CPE **FD**	**Respiratory/COPD/Chest**	Elderly patient admissions with pneumonic aspirations, COPD where community support could prevent admission	Medium
CPE **FD**	**Falls**	Presentations seen due to falls with acute delirium, dementia, UTI and musculoskeletal issues	Medium Long
CPE	**Social Referrals**	Many presentations of individuals unkempt living in squalor situations, non-	Medium Long

		functioning household, isolation	
CPE	**Community Delirium pathway and management**	Presentations due to acute infections Managing delirium in community pre-admission	Short Medium
CPE	**Care Homes**	Unnecessary care home related admissions Difficulty in accessing a prescription for care homes residents.	Short Medium
FD	**Access to Front Door MDT resource including AHPs**	Frailty assessments and decision making to turn people around at the front door	Short Medium Long
FD **BD**	**Hospital based support for mobility and activity**	Using Health Care Assistants or equivalent to ensure people do not use functional ability within hospital stay	Short Medium
FD	**Better use of ACE Practitioners**	Clarity re role and how that fits into broader front-door arrangements	Short
FD **BD**	**Signposting**	There is a lack of clarity of how and who to access for support within the community	Short Medium
CPE **FD** **BD**	**AWI/Guardianship**	There was an emphasis on the need to know how AWI, Guardianship, Power of Attorney, care at home assessments impacted on delays from hospital	Short Medium
CPE **BD**	**Equipment**	Urgent review of Community Equipment Store	Short
CPE **FR** **HBS** **BD**	**Carers Support**	Additional South Ayrshire support in situ	Short Medium
CPE **BD**	**Clarifying Biggart and Girvan CH functions**	Particular focus on Biggart function as part of the wider complement of in patient services	Short Medium

CPE **BD**	**Ensuring best use of new South Lodge Step Up facility**	Once new facility operational, ensure best and most effective use of beds	Short Medium
All	**Information, training and awareness raising re different MDT (and other) roles and linked team functions**	Through written information, shadowing and formal education and learning sessions	Short Medium
HBS **BD**	**Chest, Heart and Stroke Hospital to Home service**	Underused across both hospital sites	Short
CPE	**Co-location of key Teams**	Longer term aspiration once facilities are available	Long
All	**Systems/Processes**	Challenge identified of not having electronic systems that allow staff access to expedite information and outcomes	Medium Long
All	**7 Day and extended hours working**	Potential for extended whole system working	Medium Long

Planning locus:

Planning is taking place on both Ayrshire-wide and local bases through:

- South Ayrshire local Discharge Without Delay Delivery Group (to meet weekly initially) and report into DMT and Driving Change
- Ayrshire-wide – through Discharge without Delay group

5. STRATEGIC CONTEXT

5.1 *Objective 3: We work together to give you the right care in the right place*

Objective 7: We make a positive impact beyond the services we deliver

6. IMPLICATIONS

6.1 Financial Implications

6.1.1 N/A

6.2 Human Resource Implications
6.2.1 N/A

6.3 Legal Implications
6.3.1 N/A

6.4 Equalities implications
6.4.1 No issues

6.5 Sustainability implications
6.5.1 No issues.

6.6 Clinical/professional assessment
6.6.1 A range of clinicians are involved in this work from Medical Consultants and GPs, senior Nurses and AHPs

7. CONSULTATION AND PARTNERSHIP WORKING

7.1 The work is the fruit of strong partnership working between HSCP, VASA, SAC and other third sector organisations.

8. RISK ASSESSMENT

8.1. Low risk

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