Report

Hub Test of Change

Edinburgh Integration Joint Board

11th March 2016

1. Executive Summary

1.1 The purpose of this report is to update the Board on the approach and actions around the implementation of the Hub model, to progress improvements on the whole system pathway and discharge from hospital

2. Recommendations

2.1 To note and support the whole system approach that the Edinburgh Partnership is taking to improve the whole system pathway and discharge from hospital.

3. Background

3.1 An early action that had been agreed on a whole system basis, through Lothian's Winter Plan 2015-16, was a test of change to develop a *Locality Hub* model for older people. The approach fits with the Lothian partners intention of 'doing something differently', and moving away from a bed based model of support for winter.

3.2 This also fits with the national *Living Well in Communities, September 2015,* priority areas on prevention, pathways and delayed discharges, which sees a key action to reduce the number of bed days occupied through delayed discharge, by testing and implementing innovative solutions to redesign whole system responses across all sectors.

3.3 Instead of the traditional long lead in time planning for change on a large scale across Edinburgh, improvement methodology has been utilised to test this change in the South East, (SE) locality, with a dynamic approach of direct application, iteratively developing, reviewing and improving the systems and processes to make the change happen successfully.

3.4 Now that progress on infrastructure set up and application is being achieved, spread will occur in a methodical way in the other three Edinburgh localities.

3.5 This action orientated work streams contribute to five of the priorities agreed in Edinburgh's Strategic Plan:

- Right care, right place, right time
- Prevention and early intervention
- Managing our resources effectively
- Person centred care
- Making best use of capacity across the whole system

4. Main report

4.1 The aim of the Hub model is to change the way of working in Edinburgh, to an assets based approach, optimising all the community resources from all providers, and improve integrated working across Acute, Primary care, Health & Social Care services, ensuring people are in the right place at the right time by:

- Preventing avoidable admission
- Increasing the number of supported discharges to this locality and get patients home
- Developing a co-ordinated, responsive model of care through the locality hub approach

This will allow people to:

- stay at home safely
- be discharged home safely, within 72 hours of discharge decision being made
- receive the right care and support in a responsive manner

4.2 The Edinburgh Partnership took ownership of this test of change in October 2015, including those people who are over 75 years of age, or who are in a care home and are over 65years of age, and have been actively working strategically and operationally through the key elements of the Project Plan to:

- Develop referral mechanisms and pathway: this is complete, and is starting to be tested using real cases

- Identify the Hub infrastructure requirements and costs: this is almost complete. Final structural changes to the Liberton facility are underway. Hub Huddles are now operational after having been tested to ensure timing and information availability is optimised, as well as being clear about where responsive support will occur. Cases are now being actively worked through in South East, with a portfolio of Case Studies being developed for future learning about different actions that may have been taken to support people in a more appropriate environment rather than being admitted to hospital, or actions to expedite discharge arrangements.

- Consider the hub workforce, recruitment and training requirements and costs: Clinical Support Workers have been recruited to enhance this function, with induction underway. Wider discussions are underway to consider the wider workforce changes, with there being a high degree of enthusiasm and willingness encountered thus far, to do things differently

- Identify how impact will be measured, and performance monitored, recorded and reported: a key set of measures have been identified, with our HIS Local Integration Support Team contributing to the development of the performance framework

- Develop a communications strategy, in order that staff and other stakeholders are informed of improvements: this is underway, and will be part of the overarching Strategic Plan communications to identify progress against the agreed priorities

- Identify mechanism for evaluation of the implementation process: HIS colleagues are involved with the Partnership on this

4.3 To progress the South East Test to the whole of Edinburgh, there was a workshop for key clinical staff, managers and other stakeholders on the 29th January to share the early learning, Project Charter and Outline Project Plan. This included sharing the experience of some of the key challenges encountered. Key actions from this session include:

- Each of the Interim Locality Managers in the other three areas are now underway in identifying their Hub base, and setting up their own operational groups
- The Operational and Steering Group membership reflecting the agreement to include older people with metnal mental health within the Hub, and other key stakeholders such as the ambulance service, and workforce development
- The importance of securing project management support, and a case to be made for this
- Agreement on the core measures, and securing the support to administer this
- Each Hub ensuring local engagement with the third and independent sectors
- Ensuring links with the professional advisory committee
- Development of a communication strategy, in line with the Strategic Plan priorities, for both staff and wider communities to help keep people informed of new ways of working
- Agreement to have another learning event in three months to take stock on progress

4.4 The level of willingness of staff in South East to work in a different way has been evident through the energy they have brought to this innovation, with feedback thus far including a feeling of empowerment to try things differently in this iterative improvement process.

5. Key risks

5.1Key risks are associated with patient experience, quality of care, and performance against standards and targets for delays in discharge. In time, the performance information will clearly identify progress made across Edinburgh.

5.2 There is a risk that the partners can't agree a process, principles or methodology for taking improvements forward. Based on the South East experience, this seems low.

5.3 There is a risk that there will be resistance to change operationally in the long term, as this model of working will mean staff will be supported to work in a different way.

6. Financial implications

6.1 There has been start up costs associated with the South East Test of around £210k, for the clinical support worker posts, and SMART Boards for all four localities. There are likely to be additional infrastructure and project management and support costs moving forward, which will be developed.

7. Involving people

7.1 Edinburgh Partnership has engaged with, involved, and consulted with the local population, staff and other stakeholders and had in place a formal consultation process as part of developing the Strategic Plan, with these work streams being key actions to deliver against the agreed priorities within the Strategic Plan.

8. Impact on plans of other parties

8.1 The key impact is on the whole system pathway for older people, which will impact partners within acute care. To this end, the IJB Chair has arranged a whole system *Discharge from Hospital* event for Edinburgh has been arranged for the 8th March 2016, for the senior management teams across the Royal Infirmary and Western General Hospitals, and the IJB Executive Team, to consider the key priorities and impacts for discharge from hospital and other preventative measures.

8.2 This initial event will be followed up by a second stakeholder event that will include colleagues form East and Midlothian as there may be implications for their overarching pathway too, however, they both have

locality hub models now established.

8.3 Additionally, there are links with the Anticipatory Care Plan and High Resource Individuals that is being undertaken across Edinburgh, and this has actively been included win the Hub development work, to ensure appropriate preventative responses too, for those small number of people who use 50% of the Health and Social Care resource a high level of service.

Background reading/references

Living Well in Communities 2015:
http://blogs.scotland.gov.uk/health-and-social-care-integration/2015/12/02/living-well-in-communities/

http://www.google.co.uk/url?url=http://www.ccpscotland.org/hseu/wp-content/uploads/sites/2/2015/10/LWiC-design-proposal.docx&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjw39Ly5fHKAhUJVhQKHWD4CGgQFgggMAQ&usg=AFQjCNG1dfB04c9fCl-iUENVhmS4Ag4bog

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Links to priorities in strategic plan

Priority 2 – Prevention and Early Intervention	People will be supported through appropriate response, to remain at home or in a homely setting
Priority 3 – Person Centred Care	Care and interventions will be wrapped around the individuals, with the most appropriate response form the statutory, third or independent sectors being arranged.
Priority 4- Right	

Care, Right Time, Right Place	People will be supported at home for as long as possible, and will only remain in hospital for as long as is required, with timely discharge being arranged.
Priority 5 – Making best use of the capacity across the system	It is clear form previous recommendations associated with Living Well in Communities and delayed discharge management, that there is room for improvement to make better use of workforce, capacity and financial resources in a more cohesive way
Priority 6 – Managing our resources effectively	As priority 5