Date	9 November 2021
Agenda Item	9

Report to: West Lothian Integration Joint Board

Report Title: Update on progress of the Home First programme and the position with temporary closure of St Michael's Hospital in response to staffing pressures

Report By: Head of Health

Summary of Report and Implications	
Purpose	This report: (tick any that apply).
	- seeks a decision ☑
	- is to provide assurance ☑
	- is for information ☐
	- is for discussion ☐
	The purpose of the report is to provide a situational update on the Home First Programme and the current position with the temporary closure of St Michael's Hospital from August 2021. Additionally, this report seeks to provide assurance to the Integration Joint Board (IJB) that the Home First programme is underpinned by a whole system governance structure and data analysis to ensure any recommendations are evidence- based and worked through with stakeholder involvement.
Recommendations	1. The IJB is asked to support the positive step in incorporating St John's Hospital phase 2 development and expanding scope of the Older Peoples Commissioning Board, to include adults over the age of 18 years who require access to urgent unscheduled care. *2.* To note the change of name of the Older Peoples and People Living with Dementia Commissioning Board to '*West Lothian Community and Acute Care Commissioning Board'.* 3. It is recommended that the IJB continues to support an extension of the temporary closure of St Michael's Hospital until 31 March 22 with monthly monitoring, to evaluate the evolving staffing levels and allow for modelling of short, medium and longer-term bed needs across the health and social care system.

	4. Finally, the IJB is asked to be cognisant of the need to prioritise IJB reserves to increase the capacity to deliver care at home services internally in response to current pressures on the system.
Directions to NHS Lothian and/or West Lothian Council	Not required.
Resource/ Finance/ Staffing	• There is impact on operational & financial pressure to the Health and Social Care Partnership • Transferring staffing resource to acute to ensure safe staffing levels. • Reduce agency costs for SMH and Baillie wards.
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014
Risk	Risks and limitations of access to care at home staff to support whole system flow
Equality, Health Inequalities, Environmental and Sustainability Issues	
Strategic Planning and Commissioning	
Locality Planning	
Engagement	Engagement with Strategic Planning and Commissioning Boards.

Terms of Report

1. Background

1.1 The IJB agreed in September 2021 to support an extension of the temporary closure of St Michael's Hospital to the end of November acknowledging that, in view of the continued staffing pressure within the whole system, a definitive decision on the future reopening of the hospital was unlikely before 2022.

1.2 The West Lothian Health and Social Care Partnership (WLHSCP) has continued to manage the demand for 3 community pathways; Hospital-based Complex Care, Palliative step-up and community rehabilitation within Baillie ward at Tippethill since August 2021. The demand for community beds has shown a reducing need with an audit of use of in June 2021 showing occupancy by 85 people, compared with the position in September where only 70 beds were being used a reduction of 18%.

1.3 Despite the reduction in use of community beds, there remains a relentless pressure on the whole system to manage urgent unscheduled care, reduce unnecessary hospital attendance

and support people to go or stay at home. WLHSCP has performed well and managed to sustain lower levels of delayed discharges for the last 18 months despite increasing hospital activity over the last 6 months. Delayed discharges have been rising over the past four months, however, but this is as a result of lack of care at home supply and available care home beds rather than being related to reduced community hospital provision at St Michael's. Work is continuing to support a culture of discharge decision making at the right point to prevent people being put onto a HBCCC or Care Home pathway too early in a person's acute phase of illness.

1.4 Work is ongoing to improve care at home supply within West Lothian and a separate paper has been submitted to the IJB outlining the current position. It should be noted that inability to provide adequate levels of care at home in order to meet assessed need both on discharge from hospital and in the community, poses a significant risk to flow through the health and social care system. The principles of the Home First programme are founded on an aim to support people in their own home as far as possible and inability to secure sufficient levels of care in the community compromises the partnership's ability to deliver the home first approach and programme. .

1.5 The WHSCP continues to work with NHS Lothian to identify the capacity required to alleviate flow pressure in the acute hospital. –In addition, an exercise is underway to recruit 30 additional Health Care Support Workers to supplement care at home provision and alleviate some of the existing pressures.

2 Home First Programme Progress

Workstreams and Projects

2.1 The IJB will recall from previous reports that the Home First Programme work has commenced at pace, with some workstreams further advanced than others. This is largely due to the limiting project capacity and operational pressures due to the pandemic. The three workstreams are as follows

- Workstream 1 – Community prevention, early intervention and pre-hospital attendance (to include access to Community Single point of Contact and Flow Centre pathways
- Workstream 2 – Primary/Community proactive and longer term intervention, Intermediate Care pathways and intervention, delivery models in acute front doors, admission pathways and hospital discharge
- Workstream 3 – Bed Based review and bed utilisation in medicine and rehabilitation across acute and community sites
- Dementia Project Group and Palliative Care Group to underpin these workstreams

2.2 Workstream 1 is currently working with partners to develop a model for joining resources to deliver information, advice and support in community settings across West Lothian. The project is working in partnership with the councils Advice Shop and aims to deliver a model of early intervention and prevention using existing community assets.

2.3 Workstream 2 is launching the Community Single Point of Contact project on 3 November 2021, through an engagement workshop involving both internal and external stakeholders, service users, carers and families. This will bring a significant development to the community

to enable professionals to access rapid urgent care within the community to support people to remain independent.

2.4 Workstream 3 - The bed-based whole system review has undertaken significant work to understand the current and changing demand in community beds including focused work on length of stay, frequency of patient reviews and new ways of working. The work has seen a reduction in the number of community beds occupied, and reduced length of stay between two snapshot audits undertaken in June and Sep 2021.

2.5 Over the last 6 months there has been a significant reduction in the number of people being identified as requiring a continuous care hospital pathway (Health Board Complex Clinical Care known as HBCCC), with all options to place a person closer to home, in the least restrictive environment, being the default position. This has resulted in falling occupied bed days and shorter lengths of stay within community hospitals.

2.6 Further work is underway to review pathways and relationships between mental health assessments for older people, HBCCC and care home beds to understand how many beds will be required in the short, medium and longer-term having considered if more people on these pathways could be better managed in their own home or an alternative homely setting.

2.7 The Dementia remains a priority within the Home First programme and a multi-agency group is progressing pathway mapping and understanding of the current and projected demand for community support. The project group is reaching out to the local dementia voice group to ensure that there is representation and active engagement with all aspects of the project work.

3. Home First Programme Expanding Scope

3.1 The Home First transformation programme was established to deliver the strategic intentions and actions within the Older People and People Living with Dementia Commissioning Plan. It is acknowledged that one of the strategic priorities, to introduce a single point of contact (SPoC) through which access can be obtained to urgent care and support, also spans services for adults 18 yrs and over. For that reason, the original programme is now extended to include unscheduled care for adults. The changing scope also impacts St John's hospital unscheduled care phase 2 transformational work which leads on from phase 1 and redesign of the emergency department.

3.2 Since July 2021, the WHSCP and the St John's Hospital management teams have met regularly to explore the interdependencies between the existing Home First and the St John's Hospital Phase 2 programmes. The phase 2 transformational work focuses on the utilisation of beds within the hospital and pathways and diversion opportunities to community services.

3.3 The view was that there would be significant benefits to merging the programmes of work to avoid fragmentation and duplication and ensure a whole system approach to transformation. It was agreed at the Older People's and People living with Dementia Commissioning Board in September 2021 that the scope of the board would be extended to reflect the need to consider adults over 18years as well as the need to incorporate the hospital phase 2 programme. It was agreed that the Older People and people living with dementia Commissioning Board would change its name to '*West Lothian Community and Acute Care Commissioning Board'* from October 2021 to reflect the changes. Governance structures have also been amended are included in appendix 1.

3.4 A proposed programme plan was ratified at the October 2021 Commissioning Board and is attached at appendix 2.

4. Review of Next Steps

4.1 There have been some challenges in securing project management support for the programme but two senior project managers have now been appointed and will join the team by the end of November.

4.2 However, health and social care within West Lothian continues to operate within challenging circumstances with high local Covid infection rates putting pressure on both acute beds and the wider system. All partners are challenged with staff absences and vacancies together with the limitation of care at home and care home supply. The staffing levels across the system remain critical, particularly in the acute hospital, due to high levels of staff absence and this is likely to continue for the foreseeable future.

4.3 In view of increasing infection rates and the need for acute beds to be available to treat patients who are Covid positive on separate acute pathways combined with a critical lack of qualified staff to manage the care, it is proposed that a decision on re-opening St Michael's should be deferred to the end of March 2022, unless the staffing position improves significantly or there is a need for the beds to be returned to use before then. This will allow for flexibility to manage bed demand, but will also provide time to model the bed requirements for the short, medium and longer-term, both in the acute and community settings.

4.4 Baseline analysis of use of acute beds is commencing in November 2022 with modelling being undertaken thereafter to inform development of a robust business case for going forward.

4.5 Critical to the future bed modelling is understanding whether people could be better managed in the community at home or a community bed, rather than in an acute bed. Pivotal to this work is the development of a same-day emergency care function at the hospital that will provide access to specialist medical input and diagnostics to increase the number of people who can be diverted and managed on community pathways, rather than being admitted to hospital.

4.6 The implementation of the Community Single Point of Contact as a priority this winter will have a significant impact on the community's ability to align pathways focussed on optimising a person's support and treatment in the community. This work will also see joint pathway development, decision making and support for managing urgent care needs across the whole health and social care system.

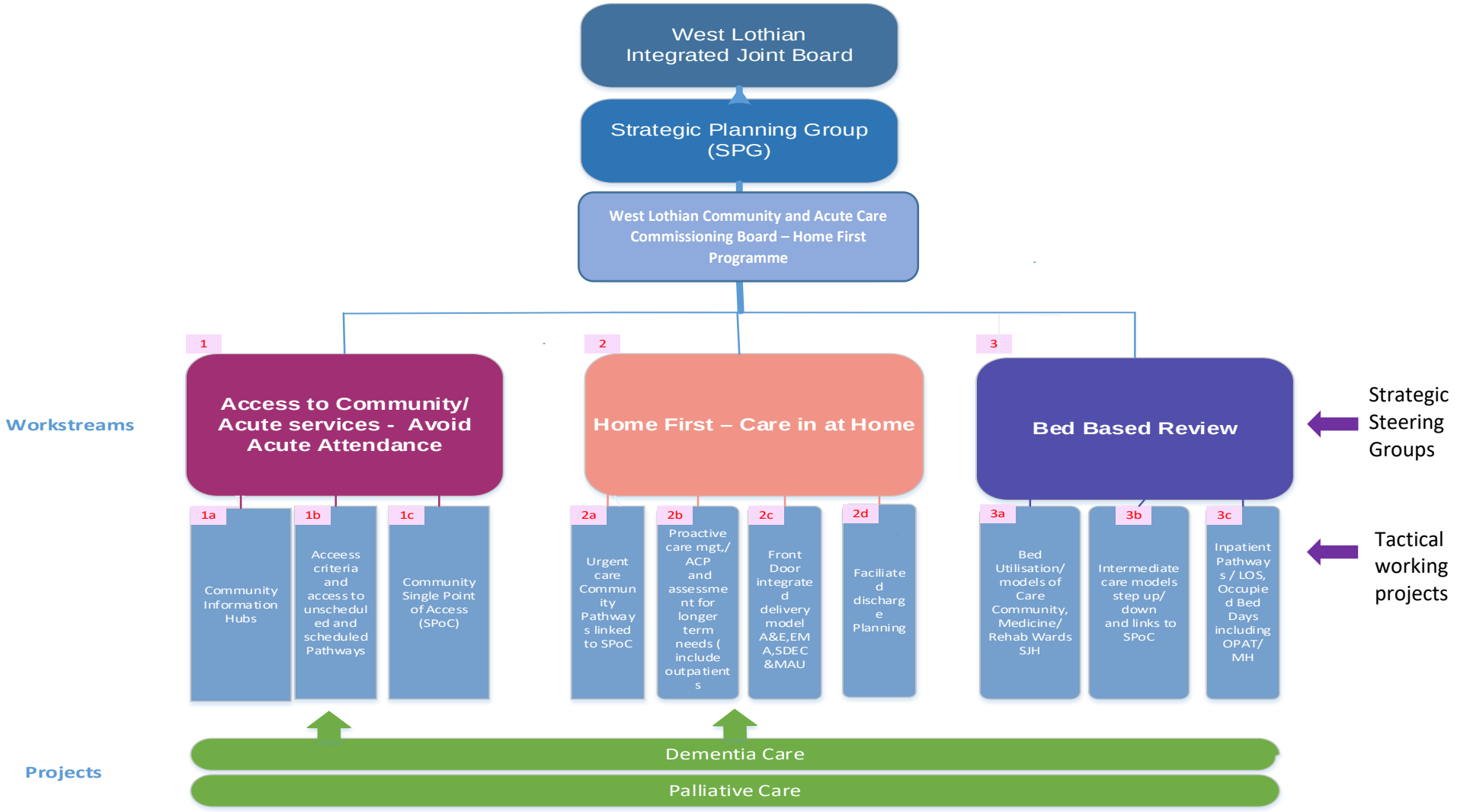
4.7 The Home First programme will place significantly more focus on engagement with stakeholders as the new project management staff come in post

4.8 In conclusion, the IJB is asked to note progress and agree the priorities within the plan for the remainder of this financial year.

References	N/A
Appendices	Appendix One – Home First – West Lothian Community and Acute Care Commissioning Board governance structure Appendix Two – High Level programme plan for the Home First Programme

Contact	Jeanette Whiting Strategic Programme Manager Jeanette.Whitng@nhslothian.scot.nhs.uk 9 November 2021

Appendix 1 –Ratified Home First Governance Structure (incorporating St Johns Hospital Phase 2 programme) - October 2021



Appendix 2 - Home First Priorities for FY 2021/22 – Qtr. 3&4

			FY2021/22		FY 2022/23			
		Lead	Qtr 3	Qtr 4	Qtr 1	Qtr2	Qtr 3	Qtr 4
Workstream 1	**1A** Information Hubs	YL	Engagement, Test Model		Phased Implementation			
	1B Unscheduled and scheduled pathways to flow centre and SPoC		Unscheduled GP Access pathway to Flow Centre/Community SPoC					
	1C SPoC	FW?	SPoC Model/Recruitment	Implementation				
Workstream 2	**2A** Pathways responding SPoC	AM	Urgent Care Pathways					
	2B Community Proactive Care,MDT and		Proactive Care - Respiratory Pathways	Develop MDT	Community model(including e-frailty			
	2C Front Door attendancer avoidance models		Develop SDEC Model					
	2D Hospital Discharge		PDD Project					
Workstream 3	**3A** SJH Bed Utilisation and LOS		Baseline bed based by speciality - Unscheduled and scheduled care, including MH	Modelling	Prepare Business Case	Consultation		
	3B Intermediate Care (Community beds & Care Homes)	FW/RA	Mental Health Older People bed usage review - needs for beds for assessment, HBCCC and care homes.			Consultation		
	3C Internal Acute Pathways to reduce acute occupied bed days and LOS and PDD							
Dementia		SS	Complete the dementia Pathway mapping and current activity baseline					
Palliative					Scoping Project			