Joined Up Care Derbyshire

INTEGRATED CARE PARTNERSHIP
17 April 2024

ITEM 10

Report sponsor:	Tracy Allen, Chief Executive Derbyshire Community Health Services – NHS Executive Lead for Place
Report author:	Kate Brown Director of Place & Partnerships, Derby and Derbyshire Integrated Care Board

Integrated Care Strategy: Age Well/ Die Well Update

Purpose

1.1 To provide the Integrated Care Partnership (ICP) with an update on some of the work underway to develop and deliver the age well/ die well key area of focus within the Integrated Care Strategy.

Recommendation

2.1 To acknowledge the work and progress to date; updating on the detailed information presented at the February Integrated Care Partnership meeting.

Reason

3.1 To ensure delivery of the Integrated Care Strategy.

Supporting information

4.1 Progress continues across the range of activities supporting the ambition to enable older people to live healthy independent lives at their normal place of residence for as long as possible. Integrated and strength-based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible and maximize a return to independence following escalations.

4.2 A refresh of the discharge programme of work to support and improve experience and efficiency has been agreed with all partners. The key areas of work were agreed:

- Improve the **involvement of Derby and Derbyshire citizens** in shaping discharge outcomes and pathway developments.
- Continue to **improve business intelligence data** in terms of quality, analytics and reporting.
- **Supported home care discharges** (pathway 1) conduct a gap analysis of current delivery against the national intermediate care framework.
- **Community bedded care** (pathway 2) review all P2 bedded care and propose a new operating model.
- **Long term care following discharge** (pathway 3) clarify ambition of using a 'discharge to assess' model before entering long term care.
- **Delivery of Care transfer hub –** ensure trusted assessor and strength-based approach.
- Joint planning and pooling of the relevant **system funds** to enable improvement and transformation.
- Roll out of system to improve **discharge data recording** (OPTICA).
- Continue to develop the **VCSE** support for discharge.
- **Mental Health:** improve integrated working for discharge support.

4.3 There have been some changes to how discharge work is governed to better separate (and protect) the planning and activity to drive improvement from work focussed operationally on immediate pressures and escalations when help is needed with solutions to complex delays and issues.

4.4 It has been necessary to commission additional activity to support people with care reablement at home. A careful balance is being managed to phase down the external activity in line with increased capacity and resilience of health and care teams following transformation work. This is a challenging system issue needing collaboration between partners and a confidence in agreed actions

4.5 Activity is underway to review current processes, issues, challenges and find innovative ways to improve our offer and use of community beds (statutory and independent) a number of actions have been agreed;

- Mapping our current understanding of the pathway leading to long term care (pathway 3),
- Gaining a better understanding of the processes around assessment of mental capacity relating to decisions for discharge,
- Defining how and when assessments take place in our pathways,
- Review of the Home of Choice Policy with an aim to achieving a system agreement and sign-up to one approach.

4.6 There is also work underway to map total spend on discharge across the system. A large component of the funding is within the Better Care Fund (BCF) of which the new Adult Social care Discharge fund (ASCDF) is one element. More work is required to fully understand what activity this spend generates and the related outcomes of the whole system. There is agreement to use the 2024/25 ASCDF to support delivery of the priorities.

4.7 We are pleased to note the creation of a 12-month post recruited by Healthwatch, dedicated to enhancing the citizen voice in the discharge process. This will be through comprehensive engagement with citizens and other system groups to capture experience and feedback regarding discharge. The post aims to work closely with the Discharge Improvement Team and other system engagement teams to bring the patient/citizen voice into the discharge improvement process and develop a sustainable way of seeking, evaluating, and applying this into the future.

4.8 There continue to be additional and improved care across community settings to try and reduce the need for hospital care. We are now delivering level 1 falls recovery service across Derby & Derbyshire with most areas operating that 8am -8pm seven days per week and there is level 2 provision where local navigation hubs are live (Chesterfield and Derby City). This has been set up with Local Place Alliances securing provision within agreed parameters. Currently flow of cases to the services is low and work is underway with the 111 and 999 providers to increase utilisation.

4.9 Places are also currently establishing multi organisational group focussed on falls prevention, mapping and sharing details of services related to falls prevention and have agreed to provide regular updates, escalate issues, identify and implement opportunities through a collaborative system learning group. This group has also showcased work occurring with Derbyshire Fire and Rescue, and Age UK's new Live Stronger for Longer falls prevention programme for Derbyshire.

4.10 It was reported to the ICP in February that Derby City Council and Derbyshire Community Health Services (DCHS) were working through consultation and governance regarding a formal partnership agreement to deliver rehabilitation and reablement. This has received positive support through all relevant routes and is now being finalised. Whilst not proceeding formally there is a strengthening of integrated working between DCHS and Derbyshire County Council Adult Social Care and the approach to community bedded care referred to above regarding discharge includes NHS and LA provision.

4.11 It is proposed that the next time the age well and die well element of the strategy is featured at the ICP there is a focus on end of life. The Integrated Place Executive received information at its last meeting which highlighted a number of areas of progress. A few a listed below.

- There is a planned reconfiguration of the palliative care teams at University Hospitals Derby & Burton which will create greater system resilience and reduce duplication.

- An end of life care Joint Strategic Needs assessment has been undertaken and discussions are now underway to develop a quarterly dashboard which will enable targeted education and training with Primary Care Networks, practices and care homes via end of life facilitators and education events

- There is a workstream focussed on ensuring communities drive change. Patient experience and views from carers will inform the programme of work. To try and address some of the culturally sensitive issues around end of life care links are being developed with the Derbyshire BME forum.

- Operational focus is on the processes to enable rapid access to assessment for need based social care and increasing the use of taking control through opportunities such as personal health budgets.

- A workshop was held in February which gave an opportunity for many organisations to find out about the different services that children and young people who are bereaved can access and to identify gaps or barriers and to consider opportunities to work differently.

4.12 In the February update we referenced the potential to use external support to accelerate the whole system community transformational change needed. The proposal for this is still under consideration within the challenging financial position that all partners find themselves. Work continues across the opportunities but without additional capacity and capability.

Public/stakeholder engagement

5.1 Incorporated within the specific programmes of work.

Other options

6.1 None considered

Financial and value for money issues

7.1 Maximising health and care value and outcomes through increased integrated planning and delivery is a significant driver in all programmes supporting the age well and die well ambitions.

Legal implications

8.1 None identified

Climate implications

9.1 None identified

Socio-Economic implications

10.1 The individuals targeted through this key area of focus are people who may have had an ill heath episode, or at risk as they are living with a long term disability or health conditions. Improving these services will mean that more people will be able to benefit and see an improvement to their overall heath and well being which is likely to positively impact on health inequalities, as many people experiencing health inequalities are disabled, older people and those affected by frailty.

Other significant implications

11.1 None identified

This report has been approved by the following people:

Role	Name	Date of sign-off
Legal		
Finance		
Service Director(s)		
Report sponsor	Tracy Allen, Chief Executive Derbyshire Community NHS Services	09/04/24
Other(s)		

Background papers:	N/A
List of appendices:	