



HEALTH AND WELL BEING BOARD: 22 JANUARY 2015

**REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES
AND DIRECTOR OF HEALTH AND CARE INTEGRATION**

**IMPROVING THE URGENT CARE SYSTEM IN LEICESTER, LEICESTERSHIRE
AND RUTLAND: FOCUS ON HOSPITAL DISCHARGE**

Purpose of Report

1. To provide an analysis of hospital discharge performance and assurance of actions being taken to improve performance, in the context of the changes underway across Leicester, Leicestershire and Rutland to improve the urgent care system.

Background, policy framework and previous decisions

2. Nationally the NHS is expected to transform the delivery of urgent care in line with the Urgent and Emergency Care Review led by Sir Bruce Keogh and Professor Keith Willets.
<http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf>
3. This is in recognition that we continue to place an over reliance on urgent and acute care within England's health and care system. With our demographic profile of an ageing population with increasing numbers of long term conditions, including those associated with frailty and dementia, our care system is becoming unsustainable in its current form. England's health and care system now needs to adapt rapidly and offer more preventative services alongside integrated, effective, resilient and sustainable community based alternatives to urgent and acute care.
4. The national Urgent and Emergency Care review was carried out in two phases during 2013 and 2014 and the findings and implications of the review have since been translated into the NHS Mandate
<https://www.gov.uk/government/publications/nhs-mandate-2015-to-2016> which sets out what the NHS is expected to deliver on an annual basis.
5. The requirement to redesign urgent care was further reinforced in NHS England's Five Year Forward View publication in 2014, which calls for the introduction of new models of care across a range of services, including urgent care. <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

SECTION A: An overview of discharge requirements and the impact of delayed discharges.

6. Delays in discharging people from hospital are governed by the Delayed Discharges Act (2003) which sets out the process by which discharges occur and how these are measured and reported.
7. Delayed discharges refer to those people who are medically fit to leave hospital but are awaiting arrangements to be made to enable them to be discharged. They may be going home (with or without support), to a care home, or to another hospital setting.
8. The definition(s) of a delayed transfer of care and how this is measured is described in more detail in Appendix 1.
9. Not all people who are deemed medically fit for discharge are a delayed transfer of care per the nationally defined definition(s). However the aspiration of all agencies in Leicester, Leicestershire and Rutland is that all patients who are medically fit to move out of hospital setting will do so as soon as possible, irrespective of the national definition of a “delayed transfer.”
10. This is because from a patient outcome perspective, no one should stay in hospital longer than medically necessary. Being delayed in hospital can lead to a loss of mobility, mental and physical function, place people at risk of acquiring secondary infections and ultimately impact on a person’s independence and ability to return home.
11. Such delays also significantly affect the urgent care system as a whole e.g. they affect patient in flow and out flow from hospital beds, and affect service delivery and performance across the entire system of acute care, community care, primary care and social care.
12. Most people leaving hospital do not need any additional support or are supported by their family/carer. Some patients will continue to require health care support to go home either because they need further treatment or rehabilitation at home or they are eligible for health funded Continuing Health Care. Some patients need social care support to go home in the form of equipment or home care to help with personal care tasks.
13. There are a range of reasons why someone’s transfer of out hospital may be delayed; some of these problems are internal to hospital processes such as awaiting a doctor to agree the discharge or waiting for medication or transport to be arranged, other reasons are delays to transferring into NHS community beds/services, into a residential care home, into a home care package, or for equipment/adaptations in the home.

14. Fundamental to effective care transfer is designing a streamlined discharge service which places patients at the centre of the approach, assesses their individual needs and priorities, and coordinates the most appropriate and effective treatment, advice, and reablement in support of their discharge needs. Where applicable this should include assessing and addressing a carer's needs for support.
15. Effective discharge requires close liaison and communication with NHS community based services, GP practices, housing services, domiciliary care providers, nursing and care homes, community based voluntary sector support, as well as with carers and families themselves.
16. Patients and carers should feel empowered to manage their care, rehabilitation, and transfer and receive health and social care that is delivered in a seamless and integrated manner.
17. The provisions on the discharge of hospital patients with care and support needs are contained in schedule 3 of the Care Act 2014 and the Care and Support Regulations 2014.
18. These provisions aim to ensure that the NHS and local authorities work together effectively and efficiently to plan the safe and timely discharge of NHS hospital patients into local authority care and support services where applicable.
19. Communication between the NHS and local authorities about the discharge of inpatients is achieved through operational joint working within hospitals and social community based teams. Documentation includes the use of "section 2" and "section 5" notifications (named after the sections of the Delayed Discharges Act of 2003).
20. A section 2 requires the NHS to notify the local authority of any patient's likely need for community care services – it is a trigger for assessment and care planning, and the Act sets out the requirement for the local authority Social services to assess within 3 days.
21. A section 5 notifies the local authority of the proposed date of the patient's discharge. On receipt of a section 5 notification the local authority has 24 hours to put in place community care services (notifications received after 2pm on a Friday and Saturday, or 5pm other days are counted as received on the following day).
22. Successful discharge relies on an agreed set of information being provided about each person being discharged so that core information needed between agencies is clearly recorded and shared to enable a safe transfer of care. This is sometimes referred to as the "safe transfer minimum data set." This is essential information to achieve a clear and smooth discharge and to

document the formal transfer of professional accountability for the care and treatment of the individual being discharged from one organisation to another.

SECTION B: Local Context for Redesigning Urgent Care in Leicester, Leicestershire and Rutland

Better Care Together

23. The redesign of an urgent care system within any health and care economy is a complex undertaking. It requires a number of critical elements such as:
- a. A fundamental review of the inflow and outflow of patients across multiple organisational boundaries and care pathways
 - b. A clear understanding of the reasons for the current position and the case for change, including achieving a clear and shared understanding of the relationship and dependencies across all dimensions of the health and care system.
 - c. An evidence base supporting the case for change and proposed solutions for improving inflow and outflow, including how the impact will be measured and the rate of improvement to be achieved.
 - d. Strong joint leadership to implementing new pathways and interventions across the system, which are likely to require significant cultural change within/across organisations and with the public
 - e. A shared vision and financial plan for achieving quick wins and medium term sustainable solutions
24. In Leicester, Leicestershire and Rutland's (LLR's) health and care system local partners across the whole health and care system are already tackling the redesign of Urgent Care as part of *Better Care Together* a five year programme to transform a range of health and care pathways across LLR. There is recognition that our work to redesign urgent care is not short term operational pressures related but also must focus on medium term solutions.
25. The case for change, supporting evidence base and future vision for LLR was developed during 2014, culminating in the publication of the Better Care Together (BCT) Five Year Plan in June 2014.
26. A Strategic Outline (investment) Case and detailed delivery plans for each of the BCT "workbooks" (e.g. Urgent Care, Older People, Planned Care etc.) have since been developed.

27. In 2014 the government introduced the Better Care Fund which has provided local authorities and their NHS partners with early opportunities to support the redesign of urgent care in their local areas.

Leicestershire's Better Care Fund

28. In order to meet national and local delivery requirements, Leicestershire's Better Care Fund Plan, which is discharged through a pooled budget, must demonstrate how the interventions within the plan will reduce emergency admissions, improve hospital discharge, improve reablement and prevention and support people to remain independent in the community for as long as possible.

29. A proportion of the Better Care Fund is subject to payment by results to drive early achievement in reducing emergency admissions during 2015.

30. Crucially, Better Care Fund Plans are joint plans across the health and care system. They have to be approved at Health and Wellbeing Board level and require the explicit endorsement of acute sector partners.

31. Leicestershire's Better Care Fund Plan was submitted and approved by NHS England in 2014. It is constructed under 4 themes:

- a. Unified Prevention
- b. Long Term Conditions
- c. Integrated Urgent Response (4 schemes targeted to reducing emergency admissions)
- d. Hospital Discharge and Reablement
- e. BCF Plan on a Page
http://www.leics.gov.uk/leics_county_bcf_submission_supplementary_appendix_b_bcf_plan_on_a_page.pdf and link to full document
<http://www.leics.gov.uk/healthwellbeingboard/bcfsubmission.htm>

Dr Ian Sturgess' Report and Recommendations

32. Given the scale and complexity of the challenges we face in LLR, the health and care economy commissioned independent clinical adviser Dr Ian Sturgess to review our current position with respect to Urgent Care and provide recommendations based on his global expertise in this field.

33. The review was conducted between mid-May 2014 and mid-November 2014 by Dr Ian Sturgess, a former senior consultant geriatrician with extensive experience in the improvement of urgent care systems across the UK and overseas.

34. During the six-month review period, Dr Sturgess spent time with clinicians and staff in primary care, acute and community hospitals, mental health services, NHS 111 and out of hours care, urgent care centres and social care teams to identify improvements across the health and social care system in Leicester, Leicestershire and Rutland.
35. Due to the nature and number of providers and services in primary and community services, Dr Sturgess was unable to visit everyone. However, his time spent in the wider system was spread between health and social care and focused on those services which have the most links with urgent and emergency care.
36. Dr Sturgess' full report and the system-wide action plan put in place to address the issues he raises were published via all three CCG Governing Body meetings in December 2014 and reported in the local media.
<http://www.westleicestershireccg.nhs.uk/sites/default/files/Paper%20G%20-%20LLR%20Urgent%20Care%20Review.pdf>
37. Dr Sturgess found that; *“The local system has the potential to be high-performing but is relatively fragmented with barriers to effective integrated working. Performance against the national 4-hour wait standard for the Emergency Department is a reflection of the performance of the whole health and care system”*.
38. The findings of the report focus on 4 themes:
- a. **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department.
 - b. **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs.
 - c. **Improving processes within Leicester’s Hospitals** – improving the Emergency Department and patient flow within the hospitals to improve patient experience and ensure there is capacity in all areas.
 - d. **Discharge processes across whole system** - ensuring there are a small number of simple discharge pathways with swift and efficient transfers of care
39. The recommendations have supported and strengthened LLR’s existing approach to redesigning the urgent care system and have been mapped into existing short and medium terms plans.

SECTION C: Overview of Performance Management of Urgent Care

40. Within the NHS, Clinical Commissioning Groups are responsible for commissioning urgent/acute care including accident and emergency and ambulance services, and are accountable to NHS England for the delivery of the associated performance and quality targets.
41. Depending on the level of escalation in each area of the country, daily/weekly/monthly reporting into government departments and individual organisations is taking place.
42. Along with performance reporting into CCG Boards and NHS Trust Boards, across England multiagency “System Resilience Groups” oversee the performance of the local health and care system including urgent care performance.
43. A number of areas within England have been designated as *challenged health economies* due to ongoing poor urgent care performance and these areas have been subject to additional performance management by NHS England over the last 12 months.
44. This includes the LLR health and care economy where, in addition to the System Resilience Group, a weekly meeting takes place, called the Urgent Care Board, which is targeted to improving the operational day to day position of the urgent care system.
45. The Health and Wellbeing Board receives quarterly reports on performance across the health and care system through the performance dashboard and has received specific reports on the issues affecting the urgent care system during the last 12 months, including reports from Local Health Watch.
46. Performance of the Urgent Care System is measured through a number of national measures including for example the performance against the accident and emergency 4 hour wait, the rate of emergency admissions, ambulance performance and delayed transfers of care.
47. In terms of performance against the national waiting time standard for accident and emergency, which is an indicator of overall urgent care system performance, the national target states that 95% of patients should be seen within 4 hours.
48. The latest (national – England) performance data for the period October to December 2014 shows the target was not achieved in the last quarter, with performance at 92.6%, and a deteriorating position is being reported into January 2015.

49. Over recent weeks the pressure on emergency care across the country has been escalating. Approximately 6-12 acute trusts in England declared major incidents in order to cope with demand seen over the Christmas period 2014, and this situation has persisted well into January 2015.
50. This has placed increased political and media scrutiny on the NHS urgent care system, and upon the barriers and contributory factors to urgent care capacity and performance generally e.g:
- a. The availability, capacity and uptake of alternatives to accident and emergency attendances e.g. use of NHS 111, urgent care walk in centres, GP services, pharmacy advice.
 - b. The responsiveness of adult social care services and NHS community services in assessing, sourcing and arranging care for patients outside of hospital once someone is medically fit for discharge.
 - c. The ability of the ambulance service to respond to peaks in demand, including the impact on handover times incurred at busy accident and emergency units, and the impact on response times generally for both 999 and non-life threatening ambulance calls.
51. In terms local performance in LLR, University Hospitals of Leicester's (UHL's) accident and emergency department performance was 88.7% against the 95% target for accident and emergency as at December 2014 (year to date figure) and a deteriorating position was reported into early January 2015.
52. UHL has declared major internal incidents on several occasions in recent months to address pressures of demand, but these did not result in closing to admissions, and at the time of writing this report UHL do not currently have a major incident in progress.
53. The position with respect to trends in emergency admissions is as follows:
The total number of emergency admissions across LLR in 2012/13 were 91,898 and in 2013/14 were 89,268
54. The total number emergency admissions across LLR in 2014/15 *April to November 2014 is estimated at 64,779* (e.g. part year). This is subject to further validation.
55. UHL emergency admissions (all adults) running at approx. 221 per day in December 2014 (source UHL Board report).
56. Although the admissions figures for 2014/15 are yet to be finalised and validated it is expected that admissions locally will have risen *by at least 6%* in 2014/15, with some areas of the country forecasting an 11% increase in this financial year.

57. The context of our performance on delayed transfers of care must therefore be understood within a rising trend in admissions being experienced nationally and locally.

SECTION D How are delayed discharges measured and how are we performing?

58. There are three metrics that are used to measure delayed transfers of care and this can lead to different figures being presented by different agencies.

59. Appendix 1 describes the definition for each metric and our current performance.

60. If using all patient delays (ASCOF measure Part 1) at the end of November 2014 the average number of patients delayed per 100,000 population was 17.44, which represents an increase of 6.69 (or 62.2%) above the level reported for November 2013.

61. If using just the combined adult social care and NHS patient delays (ASCOF measure Part 2) at the end of November 2014 the average number of patients delayed per 100,000 population was 4.22, which represents an increase of 2.19 (or 107.9%) above the level reported for November 2013.

62. If using the Better Care Fund Metric, which is an average of all delayed bed days per month per 100,000 adult population, as at the end of November 2014 the average number of delayed days per month was 403.17, an uplift of 46.62 (or 13.1%) above the 2014/15 Q3 target of 356.55

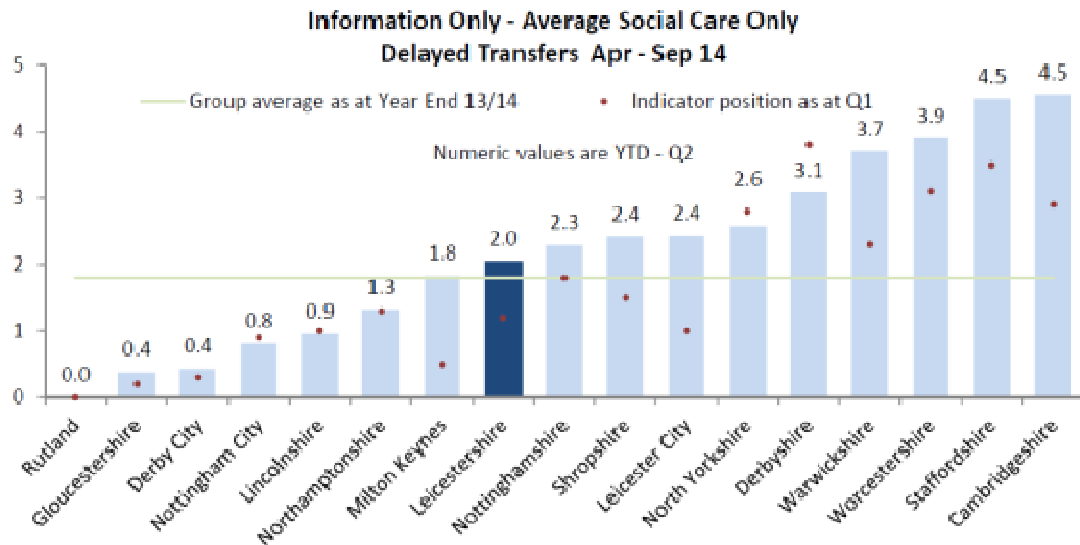
63. In addition to the above metrics the NHS measures delays by the total number of patients delayed divided by the total number of occupied beds.

64. As of 27 November 2014, against the national target of 3.5%, current performance for Leicestershire patients delayed at UHL is at 5.65%, for LPT (community hospitals) is at 17.69% and for all providers is at 7.33%

65. Appendix 1 illustrates that, irrespective of the delayed discharge definition/measure used, we are currently under performing in terms of hospital discharge as a health and care system.

66. In terms of delays that are attributable to social care alone, this currently represents 12% of all delayed discharges in Leicestershire.

67. The graph below shows the relative position of Leicestershire's adult social care delays compared to its peer group of councils.



68. Leicestershire's performance has deteriorated since September and is now at 3.1, but we do not yet have comparator figures available from the peer group.

69. **As we have already agreed that one of our health and system wide priorities within Better Care Together is that no one who is medically fit for discharge should stay in a hospital bed longer than necessary, local partners have been developing a joint analysis of the position and have put in place a joint response, through the work of the Urgent Care Board.**

SECTION E: Reasons for our deteriorating performance

70. Recent analysis suggests a number of factors have placed pressure on our ability to discharge people swiftly from hospital once medically fit within our urgent care system.

71. Due to this there is not one single factor, or one single solution to this position so our joint response has to address a number of concurrent issues within the local health and care system.

72. The current position has been affected by a combination of factors including:

- a. Changes to patient flow such as:-
 - i. the upward trend in emergency admissions
 - ii. increases in elective care throughput to meet the national 18 week target
- b. More proactive work to discharge people more rapidly from hospital (reduction in length of stay)

- c. Operational barriers across the health and care system
 - d. Operational/process barriers within individual organisations
 - e. Impact of patient choice on discharge planning
 - f. Lack of an integrate capacity planning approach across the health and care system, in particular to predict surges in demand
 - g. Unintended consequences of actions taken in response to operational pressures during the last 12 months.
73. Analysis shows an increase in admissions of at least 6% already this financial year across LLR which will have placed additional demands right across the health and care system including into discharge planning and into social care services.
74. Analysis shows an increase in elective activity (planned operations), in particular from July 2014 onwards, to improve local performance on the achievement of the 18 week pathway for planned care. This is a positive action by commissioners and providers in the NHS to invest in reducing the waiting for patients in key specialities.
75. Analysis shows a reduction in the average length of stay for patients in UHL. This is a positive action by NHS commissioners and providers in terms of progressing more timely discharge and minimising the negative impact of longer stays in hospital on both patients themselves and the health and care system as a whole.
76. In response to operational pressures there has been an approach taken to fast track certain cases through the health and care system. At times this can lead to ineffective/inefficient decisions affecting care packages, and/or over commissioning of care, which can in turn lead to readmissions or further rapid work needed in the community to adjust assumptions.
77. Further analysis is needed on readmission trends and causes to assess the impact of this during 2014/15 so that lessons learned can be extracted into future operational policy.
78. NHS related delays have been increasing – which can be seen in the analysis of delayed bed days in LPT’s community hospitals (see appendix 2).
79. Continuing Health Care pressures continue to grow both financially and operationally which is also a contributing factor to the capacity constraints within the overall health and care system.
80. Targeting freeing up capacity in community hospitals will have a positive effect on system flow throughout our health and care system. CCGs are

already undertaking additional analysis into the reasons for delays in this cohort of patients and more information may be available about the findings of this work by the time of the HWB Board meeting in January.

81. Pressure on discharge from both acute and community hospital settings has also been caused by limitations to local care home capacity and home care services capacity. The impact can be seen when:
 - a. The care needed is not available or not available at the exact specification requested (times of day, preference/skills of carer etc.)
 - b. The nursing/care home *place of choice* may not be available at the time of discharge
 - c. The home situation requires further work before a person can go home so a longer stay in a community hospital bed/temporary stay in a care home may be needed.
82. A cohort of people have been discharged from UHL over the last 6-8 months into temporary care home placements, while their needs are further assessed.
83. This action was taken by NHS commissioners as an operational response to free up capacity in the acute sector, but has led to some unintended consequences.
84. The capacity of the local care home market has been affected by these interim “discharge to assess” cases, further exacerbated by a proportion of these cases then being unable to move on to other settings of care.
85. There are also some acknowledged internal barriers within UHL affecting discharge such as delays caused by awaiting clinical decisions, waiting for medication or transport to be arranged, the need to streamline discharge processes generally in conjunction with other agencies, and the need for additional advice and support needed from community staff such as primary care coordinators in order to build awareness/confidence in discharge planning when accessing community alternatives.
86. There are also a number of workforce factors affecting staffing into urgent care nationally and locally.
87. UHL now have an active action plan in place to address the internal process barriers which are affecting the urgent care system as a whole and this set of actions forms part of the overall LLR integrated urgent care action plan.
88. There are acknowledged pressures and capacity problems in the county’s home care market which have led to a rise in the number of people waiting for care packages.

89. This has been coupled with ongoing operational problems being experienced within/related to the home care market including:
- a. 'Recruitment and retention problems by some care providers
 - b. Inability to find carers in some rural areas
 - c. Unprofitable cases for providers where the cost of care and travel do not provide an economic incentive
 - d. 'Silted up' of the care pathway by cases being 'stuck' in reablement and unable to move on
 - e. Commissioning of large packages of care for Continuing Health Care patients, with delays in reviewing these and realising the potential to step down and free up care capacity.
90. Since November 2014, the LA has put in place a new system to review care packages two week post discharge. There is emerging evidence from this process of some 'over prescribing' of care by hospital and local authority staff at the point of discharge.
91. This has resulted in more capacity being used than was potentially actually needed in a proportion of recent cases. The review process is releasing a significant number of hours of care per week back into the system which is gradually having a positive impact on capacity.

SECTION F: Summary Of Findings

92. It can be seen from the above analysis that we have experienced a number of patient flow changes in the health and care system over the last 12 months.
93. Some of these are very positive changes taken by commissioners and providers in the NHS to improve patient care, the impact of which could have been better predicted in terms of their timing and impact on the throughput of activity into discharge flows, including into care home pressures and home care packages.
94. It can also be seen from the above analysis that we have experienced a number of operational issues and barriers (further endorsed by Ian Sturges' report) that have prevented:
- a. The health and care system from responding effectively in a coordinated way to changes in patients flows
 - b. Existing routine systems and pathways to operate optimally, including during periods of increased activity.

95. This indicates the need for more effective joint working operationally and a more sophisticated approach to modelling activity flows and undertaking capacity planning across the system, so that a more coordinated and effective response can be in place, in particular to respond to surges in activity.

SECTION G: Actions in Progress to Reduce Delayed Discharges

96. The redesign of Urgent Care in LLR is being delivered through two elements of work focused on both the short term and medium term position
- a. Short term (tactical) actions
 - i. The LLR Integrated Urgent Care Action Plan (November 2014 – April 2015)
 - ii. Governance: LLR Urgent Care Board
 - b. Medium term solutions
 - i. The “Better Care Together” LLR Five Year Plan (Urgent Care Workstream)
 - ii. Governance: LLR Better Care Together Delivery Board
97. The Urgent Care Board has developed an integrated action plan to address the overall issues affecting the urgent care system in LLR. The action plan is constructed around three areas:
- a. Reducing **DEMAND** (inflow) through “out of hospital care” to ease pressure on the emergency department.
 - b. Increasing **FLOW** through UHL and community hospitals to optimise capacity
 - c. Improving **DISCHARGE** (outflow) to minimise length of stay and maximise recovery

98. One of the key actions being taken is to simplify and streamline the discharge pathways for LLR into the pathways into the pathways indicated on this diagram:

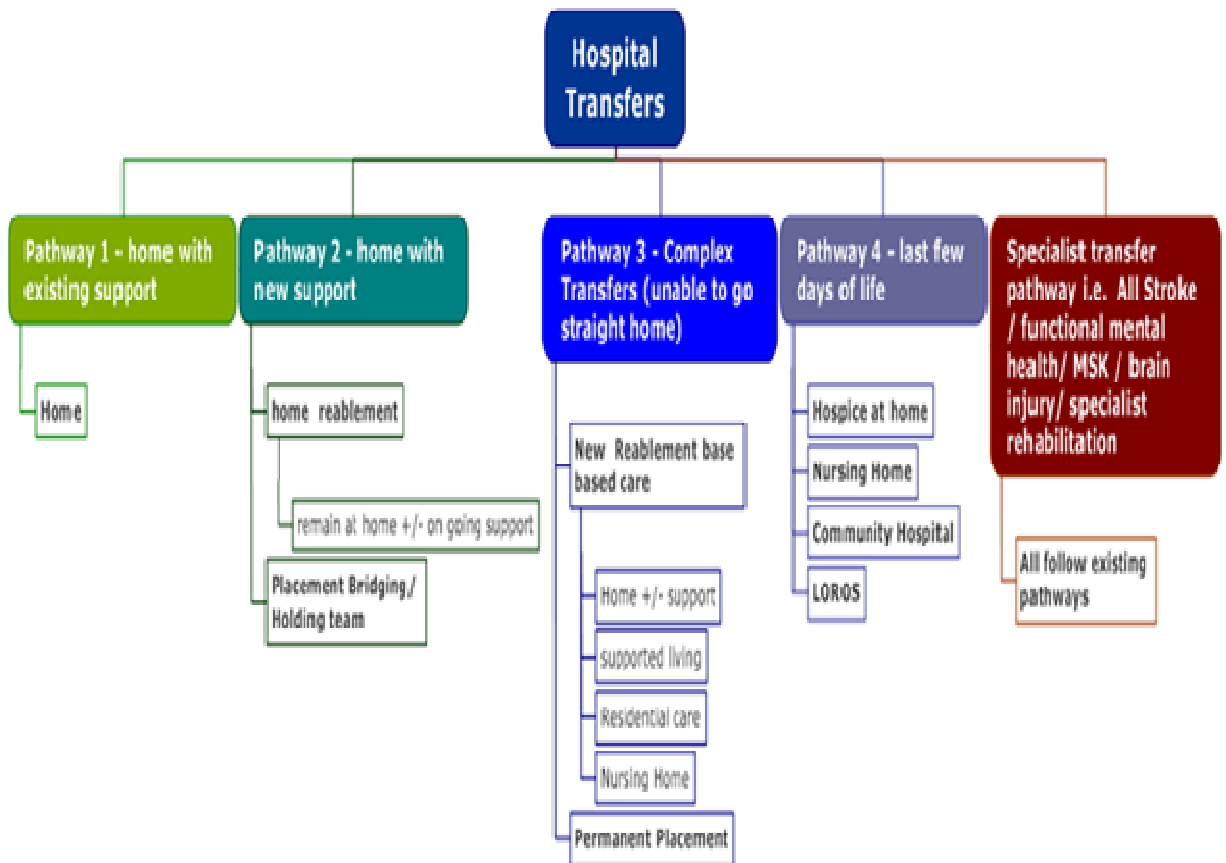


Table 1 below summarises the actions being taken within the LLR Integrated Urgent Care Action Plan to improve discharge (outflow)

Implementation of new discharge pathways	<ul style="list-style-type: none"> • Pilot scheme for pathway 2 (home with support) underway within the county – first 20 patients currently being evaluated. • Pilot schemes being put into place across LLR for pathway 3 (Bedded enablement placement) in progress
Assessment and Information sharing	<ul style="list-style-type: none"> • Minimum data set for discharge has been agreed by all partners – this will give a coherent assessment and improve communication between all partners, including care homes • Electronic solution identified and is in the process of being implemented

Effective use of resources	<ul style="list-style-type: none"> • Processes internal to UHL are being reviewed to avoid delays e.g. pharmacy responsiveness, increasing consultant cover at weekends. • Improved protocols in all community hospitals so that the right level of need is assessed, informal care is maximised, and avoid over prescribing of formal care. • Joint workshops with UHL and social care staff to promote greater understanding and improve sizing of care packages - to include promotion of alternatives such as the VCS hospital to home service/ informal support/ meals only provision/ shopping calls. • Targeted Early Reviews within 2 weeks of hospital discharge to independent sector provision • Greater scrutiny and initial challenge of proposed packages • Daily Liaison between social care and UHL base wards to reduce length of stay/minimise lost bed days • Maximise uptake of intensive crisis response service including in accident and emergency services • CHC group reviewing process and delivery of CHC services to optimise care offers. An action plan supports the work of this group. • Joint work to ensure the right balance of health and social care input into cases. • Improved decision making in the adult social care customer services centre • 7 day working developments across the system • Adult social care staff placed in the emergency room to divert cases • Adult social care staff attending more ward rounds and case conferences
Effective commissioning	<ul style="list-style-type: none"> • Joint approach to commissioning services across health and social care specifically in

	<p>the areas of domiciliary care and care homes.</p> <ul style="list-style-type: none"> • Develop appropriate tools to support the brokerage function; Provider networking and local package management; Managing the provider framework - domiciliary care services • All commissioning workers are to ensure that the Brokers receive accurate, up to date information to enable packages of care to be placed with independent sector providers and closed/reduced where appropriate • Greater flexibility/less prescription of home care call times • Provider reviews that can reduce care safely • Supporting increased efficiency in provider runs • Improved brokerage
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The Integrated Urgent Care Action Plan has a performance dashboard which is updated weekly tracking achievement of improvements against a range of metrics including the impact on aspects associated with improving hospital discharge.

99. Medium term solutions to improve the urgent care system are being led by the Better Care Together Urgent Care Workstream. These include:

- a. UHL emergency floor redesign as part of capital solution
- b. Single point of access developments
- c. Maximising non-admitted ambulatory care pathways
- d. Further improvements to continuing health care and discharge pathways
- e. Further improvements to Mental health crisis response for adults and children

SECTION H: Resource Implications

100. A Strategic Outline (investment) Case to support the five year plan in process of submission to NHS England.
101. The Leicestershire BCF pooled budget will continue to support medium term solutions as well as short term actions, subject to evaluating impact of interventions. The BCF is currently investing in the following in support of the urgent care system:

- a. An assessment service for frail older people at Loughborough Hospital to avoid admissions to hospital
 - b. An integrated crisis response service which offers a 4 hour response time and then provides 72 hours of support in a care crisis to avoid hospital admissions
 - c. A new falls pathway with the ambulance service so that those who do not need to be conveyed to hospital can be supported at home.
 - d. 7 day working in primary care across county CCGs (pilots in specific localities in the county) so that those with complex care needs can access ongoing GP support over the weekends.
 - e. Additional discharge support within UHL and LPT such extending the work of primary care coordinators who support hospital discharge, providing more bridging of care placements at home while ongoing care packages are arranged, providing housing expertise.
 - f. Reviewing all care packages after 2 weeks to ensure care is stepped down where applicable
102. Items a) to d) will be subject to formal independent evaluation to ascertain their impact on admissions avoidance as part of the BCF programme, with future funding decisions based on the results of this work.
103. In terms of expenditure from the BCF targeted specifically to improving hospital discharge there is £1.2m allocated in 2014/15, increasing to £3.8m in 2015/6.
104. In addition to this, £6m has been set aside for reablement, an element of which will be targeted to support to patients being discharged from hospital.
105. The vast majority of the BCF investment is linked to staff employed in assessment and review of patients / service users. Other areas of expenditure include funding the Assertive Inreach service in UHL and NHS provided Step down services.
106. Investment in the medium term will be focussed on the following areas:
- a. £250k for the expansion of the primary care coordinators service (assertive inreach provided by LPT) –located at UHL
 - b. £230k to invest in a rostering system that will improve efficiency at the Single Point of Access (SPA) service provided by LPT and possible integration with social care

- c. £90k has been identified to implement the Minimum Data Set (MDS), a tool to support the safe transfer of patients across the health and social care system.

107. In terms of core funding from adult social care, the Adults and Communities department have a dedicated social work team based in UHL including 2 staff based in the emergency department and staff dedicated to ward 2, along with posts specifically working with patients with complex needs, undertaking Decision Support Tool assessments to speed up the identification of Continuing Health Care eligibility. Link workers are also allocated from each community services locality to each of the community hospitals

108. Social care workers have implemented a more targeted approach to hospital discharge including proactive reviews two weeks post discharge. Although still early days, outcomes so far have been positive with a 54% reduction in the cost of packages of care following review

109. To support activity and system flow during the winter period an additional £12.9M has been allocated to LLR through national Winter pressures funding. The funding is allocated to the elective pathway to support the 18 week position and for the non-elective pathway to support the winter demand / surge pressures

110. There are 50 schemes identified within the funding plan of which 42 are aligned to non-elective care. The key areas the schemes are targeted at include:

- a) Minimising delayed discharges
- b) Implementing 7 day working
- c) Reducing A&E attendance and admissions
- d) Provision of additional capacity within primary care
- e) Implementations / improvement fo rapid assessment and treatment
- f) Improve established pathways
- g) Increased service capacity

Each of the schemes is being monitored and activity against plan reported monthly to NHS England

SECTION I: Improving the home care market in the medium term

111. The County CCGs and the LA have joined together to re-commission home care services in the medium term so that services are more responsive to the local health and care system. This is called the Help to Live at Home project.
112. A new joint commissioning specification and market approach is being developed focused on improving capacity within the market and achieving the maximum possible outcomes for people in terms of reablement and maintaining independence at home.
113. Financial modelling is being undertaken as the delivery model is developed. Gross expenditure on home care by the County Council totals c£25m per annum and the draft Medium Term Financial Strategy 2015/16 (MTFS) includes a savings requirement of £250k in 2015/16, increasing to £1m in 2016/17.
114. It is anticipated that joint commissioning of home care with Clinical Commissioning Groups would deliver wider savings. Data around CCG expenditure and savings assumptions have yet to be built into the financial model.

SECTION J: Risks

115. The Urgent Care Board has identified 5 key system level patient risks arising from current performance of our urgent care system as follows:-
- a. Lack of East Midlands Ambulance Service (EMAS) capacity resulting from volume/handover issues leading to patients waiting 'unsighted' in the community for a first response following initial telephone triage
 - b. Overcrowding in UHL's Emergency Department/Clinical Decisions Units leading to risk of high need patients being incorrectly prioritised and/or not being assessed and treated in line with their relative priority
 - c. Handover delays for EMAS crews at Leicester Royal Infirmary leading to risk of patients condition deteriorating while waiting
 - d. Short notice cancellation of elective procedures as a result of bed availability resulting in patients (including cancer patients) deteriorating while waiting for treatment
 - e. Overstretched nursing and medical ward staffing cover in UHL acute and LPT community hospital beds leading to harm from delays in care, treatment compliance and patient deconditioning
116. We have also referred earlier in this report (para 123) to the impact of delayed discharges on the outcomes of patients in terms of their reablement.

117. The LA have identified the following potential financial risks in relation to the position for adult social care:

- a. Further changes to care pathways being progressed within Better Care Together and the associated improvements in reduced LOS and reductions in delayed discharges will see increased activity (and cost) in social care. Impact and funding will be need to be modelled and identified for the 'left shift' as part of the work on the Strategic Outline Case, and within each workstream of BCT.
- b. The future model for the delivery of home care could see an increase in costs adding increased pressure to identify savings in other areas.
- c. Directions and conditions from NHS England on how the Better Care Fund should operate will influence investment decisions locally.
- d. Additional financial pressures arising from the Care Act could impact on the Council's current focus on supporting hospital discharge.

118. In addition to the above risks, the health and care economy faces considerable reputational risks particularly during this period of heightened political and media scrutiny, so it is imperative these risks are managed by strong joint leadership over the urgent care system and its action plan, both in the short and medium term.

SECTION K: Recommendations

119. It is recommended that:

- a. The Health and Wellbeing Board assess and discuss current performance in relation to delayed discharges as outlined in this paper
- b. The Health and Wellbeing Board consider this report in conjunction with the related report from Local Healthwatch on patient experience of discharge.
- c. That the Board seek further assurance as needed from partner agencies about the actions in progress to improve hospital discharge and the impact these will have.
- d. The Integration Executive and the Urgent Care Board are asked to consider in particular how the LLR health and care system can achieve a truly integrated approach to hospital discharge in the medium term.
- e. The Board should direct any additional analysis or actions through the Urgent Care Board which meets on a weekly basis.

- f. Where further detailed work is needed on County specific matters in support of the Urgent Care Board that the Integration Executive is asked to discuss and prioritise any such actions arising from this report at its meeting on 27th January, where this paper will also be received.
- g. That where applicable the Integration Executive recommends any adjustments needed within the Better Care Fund Plan in 2015/16 in support of the urgent care system.

Impact Assessments

120. Included within the remit of the Health and Wellbeing Board is responsibility for assessing the needs of local people including health inequalities, ensuring local commissioning plans are grounded in evidence contained within the joint strategic needs assessment (JSNA) and supporting delivery of a Health and Wellbeing Strategy to improve outcomes for the local population. Equality and Human Rights Impact Assessments will be required for individual proposals coming before the board in the course of its duties.

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