ANNEX 1 – Detailed Scheme Descriptions

Discharge & Reablement

Scheme ref no.
HDR
Scheme name
Hospital Discharge and Reablement
What is the strategic objective of this scheme?

Case for Change

Better Care/Better Value national benchmarks show that University Hospitals of Leicester (UHL) is currently ranked 73 in terms of performance on length of stay and there is a £3.8m opportunity to the health economy if this moved into the top quartile of performance nationally.

Length of stay (LOS) has continued to rise in LLR with an increase of 19% in the last financial year for patients staying 11 days or more, with the majority of these patients aged over 65.

A LOS of 11 days or more is detrimental to frail older people in terms of:

- Increasing their levels of dependency while in hospital
- Reducing their potential to return to their usual place of residence
- Reducing their potential to maintain their previous baseline of functioning[1].

During 2014/15 University Hospitals of Leicester commissioned Dr Ian Sturgess to review the overall performance of the urgent care system including the barriers to discharge both within and outside of the acute trust. He has presented evidence from other health and care economies nationally and internationally which have reduced LOS for frail and older patients and reduced the consequential longer term demand on health and care system as a result[2].

The LLR system is seeking to mirror the results achieved in other health and care economies though the reconfiguration of services and activity shifts associated with the LLR five year plan.

Dr Sturgess' findings and recommendations have been incorporated into the LLR five year plan workstreams for Urgent Care and Frail Older People, as well as into UHL's internal transformation programme where changes to clinical culture and practice are taking place to focus clinical care on preventing admissions and reducing LOS.

The Leicestershire Integration Executive has also received the findings from Dr Sturgess' as part of the impact assessment undertaken across the BCF interventions for 2014/15 and 2015/16, where we have been considering the interventions that will have the greatest impact on reducing delayed discharges and avoiding emergency admissions

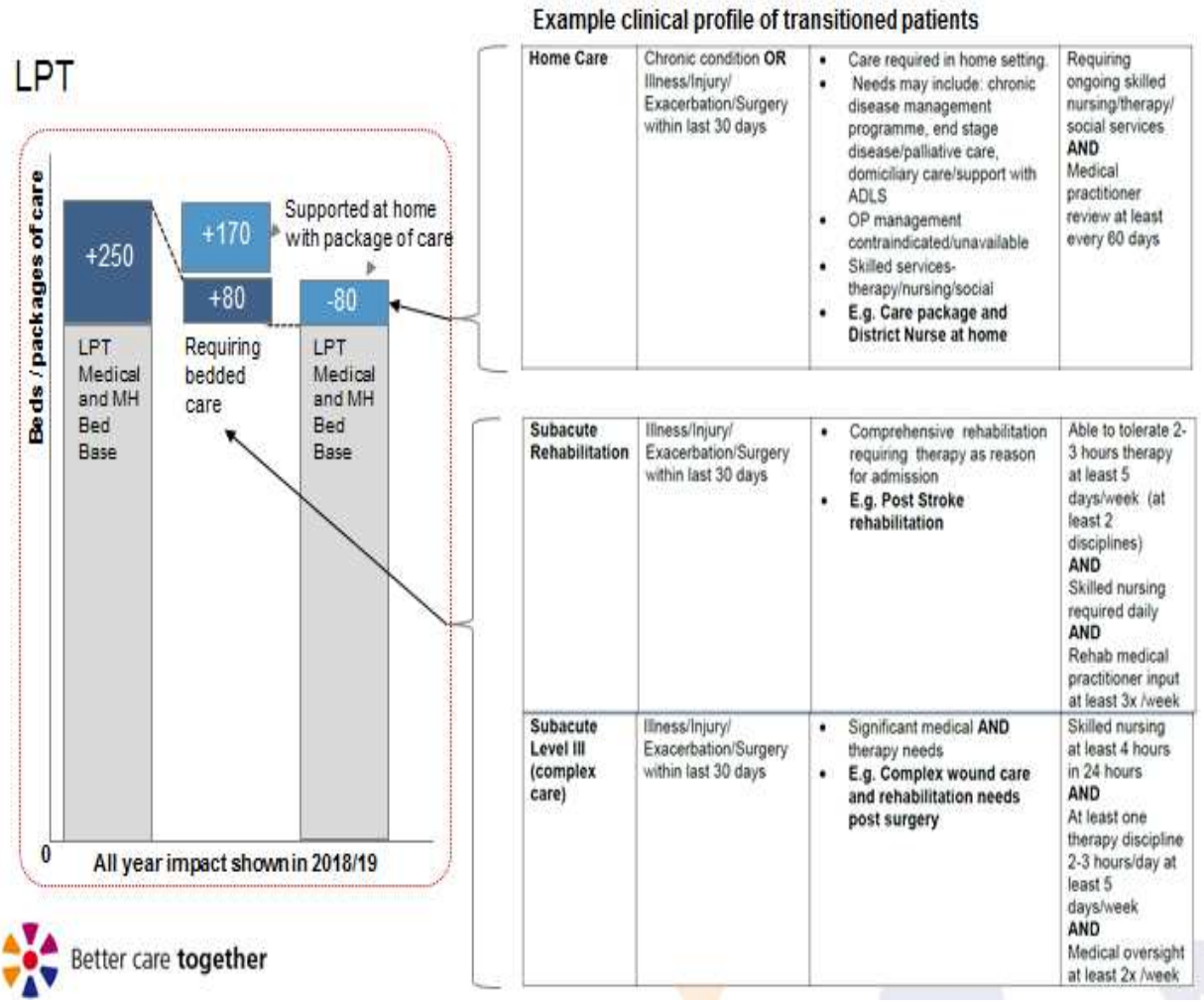
The local health and care economy's performance on delayed bed days and delayed transfers of care has also been a significant barrier to reducing LOS and performance in Q1 2014/15 has deteriorated. Reducing delayed bed days is one of the national metrics for the BCF and our BCF local plan is therefore responding to this challenge.

UHL have also identified (per overall planning assumptions aligned to the LLR Better Care

[1] Refer to Ian Sturgess evidence base
[2] Refer to Ian Sturgess evidence base

Together Programme) that up to 450 beds could be reduced in the acute sector over a five year period if the health and care economy's performance on rates of admissions, discharge processes and LOS is improved. This will involve a number of changes spanning both elective and non-elective care across the eight workstreams of the LLR five year plan. A proportion of this change requires a shift of a targeted proportion of this activity into community based settings, including patients' own homes.

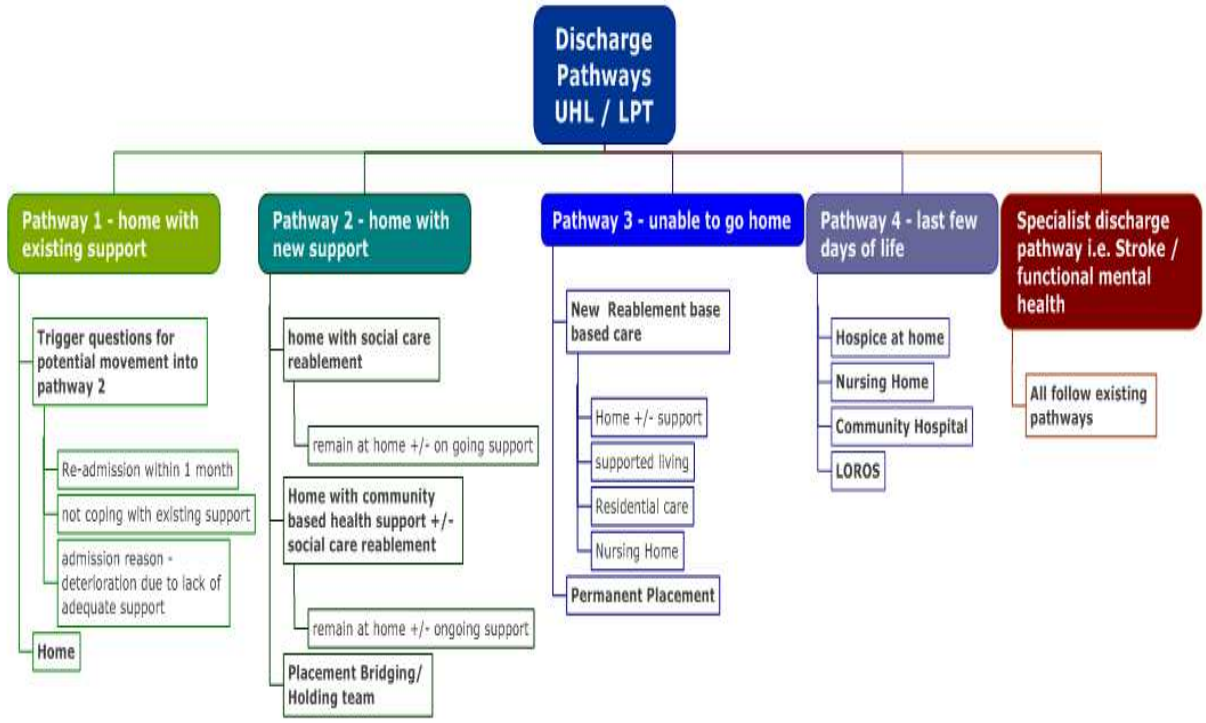
The diagram below, from the LLR five year plan shows where up to 250 beds worth of acute activity could be transitioned, primarily via Leicestershire Partnership Trust (the local NHS community and mental health provider) and social care providers, with a significant proportion replaced by alternative (non-bedded) pathways of care.



The Discharge Pathways diagram below shows the emerging proposals for simplifying discharge routes from the acute and community Trust to enable the shift, as part of the redesign of the local health and care.

This will reduce the acute care capacity and streamline the quality and experience of discharge for both patients/carers/families and the health and care professionals receiving patients back into the community.

The BCF interventions have been developed in support of the revised pathways.



Desired Outcomes

The LLR five year plan seeks to significantly improve LOS reduce delayed discharges across all settings of care, and simplify the discharge routes within the health and care economy.

It is anticipated that by October 2014 a trajectory for improving LOS performance will be agreed as part of the urgent care and frail older people workstreams of the LLR five year plan.

The discharge pathways from the acute trust will be simplified to five clear routes with system performance including (delayed discharges) measured against these routes, by setting of care

The number of delayed bed days will be significantly reduced

Patient and carer experience of integrated care at the point of discharge will improve

GP satisfaction with discharge arrangements will improve

More people will benefit from targeted reablement on discharge

BCF Plan Response Hospital Discharge and Reablement Case for Change
Leicestershire's BCF plan focuses on reducing LOS, improving Hospital Discharge and providing integrated targeted reablement to maintain people in the community for as long as possible. The will be achieved by:

- Integrated reablement teams in localities
- Expansion and further integration of single point of access to support integrated locality teams
- In reach services to reduce LOS and support hospital discharge for frail older people
- Improved housing support and expertise to discharge– both in the general acute sector and mental health acute sector
- Hospital to home support for vulnerable groups
- Implementation of the minimum safe data set for hospital discharge
- New jointly commissioned reablement and domiciliary care services, with improved focus on outcomes
- Improvements to the capacity and capability of the local domiciliary care market in Leicestershire (market development)

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Over the last 18 months there have been significant investments in a number of joint initiatives across the County such as strengthening hospital discharge through in reach. The BCF plan builds on this progress, focusing the system as a whole on avoiding admissions and reversing the upward trend in lengths of stay. A number of existing interventions will continue, along with additional investment being targets:

- BCF pooled budget
- System Resilience and Winter Planning resources
- Other external sources of transformation monies

The focus on the BCF plan will be on the following interventions in support of the LLR five year plan.

HDR1 – Integrated Reablement

HART Reablement

HART is the Council's Home Care Assessment and Reablement Team. Provides intensive support for up to 6 weeks to help service users maintain their independence in the community. Evidence shows that this type of service can reduce and/or delay the need for longer term, more costly services. The projected volume for this service is c425 over 17,000 hours.

Intermediate Care

LPT's intermediate care team co-works with the County Council's HART service to support hospital discharges, prevent avoidable readmissions and reduce the risk of falls. Projections to be confirmed by West Leicestershire CCG.

Integrated Residential Reablement

This is a step down service to support the discharge to assess the relevant pathway needed to support the patient back home. Patients are discharged from hospital to a short tem residential care placement for up to 6 weeks where their longer term support needs are assessed. Interventions from HART and other therapies support the service users to go back to their home. The service aims to avoid unnecessary admissions to long term residential care and reduces excess bed days in the acute service. Pathways 1, 2, and 3 will be included in the performance dashboard and will be reviewed on a monthly basis by the

Step Up/Step Down Programme Board.

A pilot project is starting in April 2015 with 5 beds initially, followed by an evaluation of effectiveness and then a plan to roll-out this model across the County.

An integrated health and social care service is currently being designed and a business case is currently being developed.

Hospital to Home
A reablement service provided by the RVS for patients who leave hospital with no family/local support. Volunteers work with patients for up to 6 weeks with a range of tasks to rebuild confidence and prevent social isolation, including preparing the patient's home for return from hospital, supporting them to access community activities and befriending.

Further Consolidation and Integration of Community Based Health and Care Services

The intent to integrate community based services further forms an essential part of the plan to avoid admission and support effective discharge and reablement.

The existing services that are in the process of being consolidated are:

- Intermediate care
- Single Point of Access
- Intensive community support (including night cover)
- Reablement (Health)
- Reablement (Social Care).

Service specifications will be redeveloped to focus broadly on two main streams of work

- Care that is **unable to be scheduled** defined as urgent/non routine (e.g. integrated crisis response services that may respond within two hours to one working day and may be accessed for up to three days)

- Care which is **able to scheduled** defined as routine/rapid. (e.g. a streamlined virtual ward/proactive care specification which will be common to all three CCGs in LLR, non-discharge related reablement).

As a result of these changes the rapid response services outlined in Theme 3 will be enabled and a number of other benefits will also be realised as follows:

- There will be improvements for patients, carers and families in their experience of care, including care planning and coordination.
- There will be process efficiencies in referral times and choices – by providing the acute Trust with a single discharge service.
- There will be process efficiencies in referral times and choices – by providing GP's, social care and community health services with a single service to avoid unnecessary acute admissions.
- We will be able to release savings as part of the overall LLR cost efficiencies.
- There will be savings in duplications between teams and inter-team referrals.
- There will be workforce improvements and broader skills training within the integrated team.
- There will be improvements to the coordination of care and the ability to provide more flexible care to suit the changing risks and needs of individuals.
- There will be improvements to records and data sharing for the integrated team.

HDR2 – Protected Reablement Services

Reablement

The overall aim of the programme is to maximise the recovery and independence of patients who would require supported discharge to leave a hospital setting through the following key activities:

1. Deploy a night sitting service to close the provision gap
2. Combine all intermediate care and reablement provision into a single service specification to meet the unplanned care need
3. Work with LPT to increase their capability to meet the acuity challenge the service faces.

Intensive Community Support

Intensive Community Support (ICS), provided by LPT, has contributed to a realignment of provision to ensure the services are "Fit for the Future" in meeting the increasing demand upon community services. This has created 48 virtual beds dedicated to providing interventions that keep people out of hospital. Linked to this, LPT provided Community Health Services have improved co-ordination with the goal of improving patient experience. System pathways, referral processes and system management have all been reviewed and improved so the patient experience is significantly more likely to be positive and the escalation of treatment to an acute setting is avoided.

HDR3 – Improving Mental Health Discharge

Approved Mental Health Professionals to carry out assessments and meet increasing demands. Predominantly based in hospital and crisis teams. Six FTE increase capacity within the social care team.

HDR4 – Implementing the Minimum Safe Data Set

During 2013/14 clinical, therapeutic and social care partners worked together to agree a minimum data set to enable the safe transfer of patients between care settings. Partners are now in the process of evaluating the best local technological solution for implementing the transfer of the data set and there are a number of options to consider with good clinical engagement across local providers.

Where similar data sets and technology have been introduced in other health economies a three day reduction in processing time for discharging older adults has been evidenced, and it has smoothed transitions generally across health and social care boundaries. As such this is an essential enabler to achieve our vision of health and care integration and support delivery of the LLR five year plan.

Some technological solutions can provide additional benefits such as a risk algorithm that allows clinicians to select another service option if there is insufficient capacity in the identified service, or if they feel that the particular circumstances of the patient warrant a different service offer. This will provide additional intelligence for commissioners when considering future service models.

The Integration Executive will be receiving the outcome of the option appraisal in the autumn of 2014/15 with a view to the preferred solution being implemented within this financial year. Resources are already identified in the BCF plan in this financial year. Pending the option appraisal the Integration Executive will also consider if additional resources will be needed either in year and/or into 2015/16, especially if a phased implementation is needed to enhance any aspects of functionality between systems.

HDR5 – Protected Hospital Discharge Services

Assertive In Reach

There is a highly skilled existing workforce of *primary care coordinators* who supply this service. Their work is particularly focused on accident and emergency and associated admissions units at UHL. However it has not been possible to achieve in reach into all base wards within University Hospitals of Leicester to date, due to a number of operational and cultural barriers.

As part of the impact assessment for the BCF partners reviewed the barriers to this service to identify

- how the impact of this service could be extended fully into UHL from an operational perspective
- quantifying the additional impact this could generate on improving discharge and reducing LOS.

Partners have therefore agreed the following:

- The service will be initially extended to support the transfer of patients from Ward 2 to demonstrate how the service can operate effectively on base wards.

- Extending resource into the base wards should not be to the detriment of the impact achieved for emergency admissions and the resource allocation will be adjusted using the BCF budget to enable this to happen.

- UHL will invest internally in cultural change to ensure the work of the primary care coordinators is viewed as an essential part of the ward team and a key enabler to discharge in every ward.

- A trajectory will be developed to show the impact of this service on reducing LOS and delayed bed days.

Step Down
"Integrate discharge and reablement support to maximise recovery and independence".

• Reduce non-elective emergency admissions by 1,040 in 2014/15 in each of the two CCGs of West and East Leicestershire
• Reduce length of stay through facilitating supported return to community and improved efficiency in discharge
• Reduce readmission rate through admission avoidance and ensuring comprehensive response at point of crisis
• Reduce escalation of Social Care need
• Reduce non-elective emergency admissions from Care Homes by 10% by end of March 2015
• Tackle variation in Care Home non-elective admissions

Maintaining the Social Care Assessment Pathway
Funding social workers in locality teams and hospitals to undertake community care assessments and reviews. This is to ensure that service users needs are correctly identified and outcomes met through support planning to ensure that they remain safe in their place of residence.

The service is delivered by Leicestershire County Council via 40fte social work staff. The target audience is people entitled to services under Leicestershire County Council's eligibility threshold (FACS substantial and critical).

This is a long established statutory duty under the Community Care Act 1990.

HDR6 – Multi-Disciplinary Review Team for Care Packages

The HART reablement team delivered by the County Council deals with c4,000 service users each year, of which 2,400 (60%) are hospital referrals. The HART service has a successful proven track record where 50% of the service users reabled do not require ongoing social care support.

Due to capacity issues in the independent sector home care market, there are instances where HART teams are unable to hand off cases to long term providers. As such this has an impact on HART's ability to accept new cases. In 2013/14 there were 845 cases linked to hospital discharge where the reablement pathway could not be followed due to this bottleneck. These cases were commissioned directly with the independent sector as prescribed by the hospital.

The packages of care commissioned by hospitals (where HART reablement is not available) to support a safe discharge are, in some cases, not matched to a service users actual needs and as such an element of 'over commissioning' is taking place. In addition to this, packages are not being reviewed in a timely fashion which then has the negative effect of service users becoming increasingly reliant on social care services. At this point it becomes more difficult to reduce the level of support required.

The service will be implemented under three separate strands.

1) Additional scrutiny of care packages at the point of discharge by Leicestershire County Council's Customer Service Centre to ensure that a patient is safely discharged with the appropriate level of support according to need.

2) Patients are reviewed between one and two weeks after returning home with a view to reducing packages of care where appropriate. This is the optimum time to review, when a service user's health is stabilising and informal support networks, for example family/friends, has been arranged.

3) Where service users have previously been discharged from hospital and their support package has not been reviewed, priority will be given to these cases. This will be funded from within existing LCC resources.

Outcomes of this scheme will include:

1. Improved utilisation of the independent sector home care market, increasing capacity. Financial modelling indicates that 130,000 hours of home care could be freed up.
2. The HART Team will be able to hand over post reablement cases improving the flow of service users going through reablement.
3. Reduction in the await care list as smaller packages of care being commissioned on discharge from hospital that would be easier to arrange.
4. Patients / service users will maintain their independence in the community with reduced levels of support needed from social care.

Subject to successful recruitment, it is anticipated that the new review process will have started by December 2014 and will help to alleviate the problems associated with winter pressures. It is estimated that the projected volume for this service will undertake c00 reviews of patients discharged from hospital.

The service will continue until March 2016 when the Help to Live At Home project will be implemented at which point this service will become 'Business as Usual'.

In order to measure the effectiveness of the scheme, data will be collected including:

- Number of service users reviewed
- Length of time between hospital discharge and review
- Package of care commissioned at discharge
- Package of care post review

Key performance indicators for the scheme will include:

- Reduction in hours of home care commissioned
- Increased activity within HART (reduction in referrals turned away)
- Reduced await care list

HDR7 – Developing the Single Point of Access

To ensure community based pathways can be navigated and utilised effectively, the further development of a community based Single Point of Access (SPA) is critical. The SPA provides a central resource for hospital discharge, rapid response urgent care in the community and coordinating integrated reablement services in the community.

A staged approach is being taken to developing the SPA so that it can adapt both in terms of capability and capacity to become an integrated hub for Leicestershire's health and care system in the future.

The initial stages shown below are already underway, but a business case will be scoped and developed to cover stages three and four leading into 2015/16.

- Stage 1: Initial investment/developments are focused on improving the capacity of the SPA to respond to the new integrated urgent response services. These include investing in improved navigation and associated standard operating procedures. These developments are targeted to come on line for the Winter of 2014 with an investment of £180k from winter planning monies.

- Stage 2: Improved capacity to response to EMAS pathways - Investment of £90k already identified

- Stage 3: (subject to business case in 2015/16) Extend the scope of the SPA to be able to allocate resource and operate capacity management with live scheduling of activities – this will require a number of IT and operational enhancements, and will be implemented with a view to alignment with Leicestershire County Council's adult social care customer services centre, in stage four

- Stage 4: (subject to business case in 2015/16) Option appraisal for integration with Leicestershire County Council customer services centre

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

HRD1 – Integrated Reablement
HART – The services are provided directly by Leicestershire County Council.

ICS – The services are commissioned by East Leicestershire and Rutland, and West Leicestershire CCG's
The service is delivered by Leicestershire Partnership Trust.

Residential Reablement – This service is currently commissioned by Leicestershire County Council and delivered via Care Homes.

Hospital to Home – This service is commissioned by Leicestershire County Council and delivered by Royal Voluntary Service.

HDR2 – Protected Reablement Services
Awaiting confirmation from West Leicestershire CCG

HDR3 – Improving Mental Health Discharge
This service is provided directly by Leicestershire County Council.

HDR4 – Safe Minimum Transfer Data Set Enabler
The business case for this is currently under development.

HDR5 – Protected Hospital Discharge Services

Assertive In Reach – This service is commissioned by East Leicestershire and Rutland and West Leicestershire CCG's.
This service is delivered by Leicestershire Partnership Trust

Step Down
Awaiting confirmation from West Leicestershire CCG

Social Care Pathway
These services are provided directly by Leicestershire County Council.

HDR6 – Multi-Disciplinary Review Team for Care Packages
The staff provided this service will be employed directly by Leicestershire County Council

HDR7 – Single Point of Access
The business case for this is currently under development.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local Evidence	National Evidence
LLR 5 year Strategy June 2014 Based on	Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.**

• LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data **Leicestershire JSNA** chapter on older persons, 2012: http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna_2012_full_length LLR Admission Avoidance Detailed Report - Emergency Department.	http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on intermediate care, re-ablement and rehabilitation, managing emergency activity, discharge planning and post-discharge support, mental and physical health needs and delivering integrated care. Making our health and care systems fit for an aging population. **The Kings Fund 2014**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population Includes a sections discharge planning, post discharge support and reablement. Intermediate care for frail older people: **NHS Benchmarking (2013)** http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php A Department of Health funded review showed that home care reablement is almost certainly cost-effective because of improved outcomes for users. http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf **Social Care Institute for Excellence 2011:** Reablement: a cost-effective route to better outcomes http://www.scie.org.uk/publications/briefings/briefing36/ And maximising the benefits of reablement: **Social Care Institute for Excellence 2013:** http://www.scie.org.uk/publications/guides/guide49/ Berkshire example of Early discharge and intensive community rehabilitation for stroke patients Naylor C et al. (2012) Long term conditions and mental health – the cost of co-morbidities. King's Fund and Centre for Mental Health. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf] [Accessed on 22/08/2014]. Can increase impact of rehabilitation by combining it with a psychological intervention (Page 14). The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?'

	The King's Fund: Naylor et al. 2013. Transforming our health care system. Ten priorities for commissioners. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf
Integrated Residential Reablement	Based on other studies: West Sussex CC. £361k investment = £600k saving. http://www2.westsussex.gov.uk/ds/mis/290212as16.pdf

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Reductions in LOS
- Reductions in delayed bed days
- Increased number of people at home 91 days after discharge into reablement services
- User Experience - measures from CQC inpatient survey and ASC survey relating to hospital discharge and independence
- Link also to system resilience plan (winter planning) metrics
- (insert reference to any clinical audit/statistical process control/evaluation etc.)

What are the key success factors for implementation of this scheme?

- Clinical expertise to develop the model of care
- Robust business cases
- Effective impact assessment
- Clear KPI's and evaluation approach
- Realistic trajectory for implementation
- Recruitment timelines
- Risk mitigation plans
- Clear project management and SRO roles
- Performance management of delivery via the Integration Executive
- Relationship management and joint leadership across agencies
- Maintaining alignment with the 5 year plan
- Relationship management between County, City and Rutland BCF.