# BCF 2016/17

Scheme Reviews

Central Lancashire

# Guidance

- The intention of the review is to tell the story of each scheme's development, delivery and impact.
- Where there is quantitative evidence this should be highlighted.
- Where there is no quantitative evidence this should be explained
- Where qualitative comment is given this represents the LA or CCG's view.
- Each scheme is to have its own review slides completed.
- Any narrative to be kept brief, bulleted if appropriate and original i.e. not copied from scheme description.
- The logic model should reflect the planned and actual . An example logic model is provided separately.

# Summary

| Scheme Title | £s in 2016/17 |
|---|---|
| BCF08 Lancashire health economy whole system urgent care transformation programme – Community Beds/Intermediate Care | £5,972,000 |
| BCF09 Lancashire health economy whole system urgent care transformation Programme – Effective Discharge | £446,000 |
| Total | £6,418,000 |

# BCF08 Lancashire health economy whole system urgent care transformation programme – Community Beds/Intermediate Care

| Original rationale for scheme. |
| --- |
| The aim of this scheme is to improve access to the right level of care in a timely manner for those patients who need intermediate care, thereby:<br>• Avoiding unnecessary admission to acute care<br>• Promoting faster recovery (or discharge if admitted)<br>• Reducing the need for residential or domiciliary care in the longer term. |

| Primary prevention | Hospital | Community | Secondary prevention |
| --- | --- | --- | --- |
| Support to stay safely and happily at home? | Avoidance and discharge? | Support to return home, reablement and recovery.? | Stabilisation, maintenance, rebuilding resilience.<br>Self care? |
| Yes | Yes | Yes | Yes |

# BCF09 – Lancashire health economy wholes system urgent care transformation programme – Effective Discharge

| Original rationale for scheme. |
| --- |
| Improve patient experience of discharge, reduce length of stay, delayed transfers of care and unplanned readmissions, increase patient flow and deliver efficiencies across the system. The service will deliver consistent robust processes with defined performance indicators and measures. The IDS service will also support appropriate use of SUSD and ensure patient flow is managed across the pathway. |

| Primary prevention | Hospital | Community | Secondary prevention |
| --- | --- | --- | --- |
| Support to stay safely and happily at home? | Avoidance and discharge? | Support to return home, reablement and recovery.? | Stabilisation, maintenance, rebuilding resilience. Self care? |
| No | Yes | Yes | Yes |

**BCF08 Lancashire health economy whole system urgent care transformation programme – Community Beds/Intermediate Care**

# Activity during 2016/17

| Scheme element | Planned activity | Actual Activity | Reason for any difference between planned and actual |
|---|---|---|---|
| Community Beds | 95% | 95% | Bed occupancy was as predicted |
| Rapid Response | 95% | 97% | Service demand was above plan, but managed within resource |
| Frailty Service | 64 | 64 | No planned activity for 16/17 however service offered ED deflection during Winter |

**BCF09 – Lancashire health economy wholes system urgent care transformation programme – Effective Discharge**

# Activity during 2016/17

| Scheme element | Planned activity DTOC level | Actual Activity DTOC level | Reason for any difference between planned and actual |
|---|---|---|---|
| Integrated discharge service | 3.5% | 10% | Not achieved DTOC level as expected due to delays in IDS service go live. In Central Lancashire there has been significant pressures in social care assessment, waits for long term care packages/placements |

# BCF08 Lancashire health economy whole system urgent care transformation programme – Community Beds/Intermediate Care

| Barriers / Challenges to successful delivery | Managed by…. |
|---|---|
| There have been local economy challenges in implementing the Step Up pathway due to concerns with safety and quality with providers which has impacted on us achieving the outcomes we would have liked, this was around home based provision rather than bed based. | SRG/A&E delivery board, Urgent Care Programme Delivery Group along with project meetings |
| The unstable independent care home sector resulted in a lack of market capacity for us to fully implement some of the discharge to assess pathways. | Care Home collaborative has worked to improve process and relationships |
| Risks | Managed by… |
| • Risk regarding recruitment of appropriate clinical staff to support implementation of frailty unit.<br>• Lack of consultant geriatrician support to sustain service<br>• Risk regarding implementation of package of care (inc social needs and housing adjustments). This potentially will require increased reliance on crisis care to meet 72 hour unit turnaround.<br>• Financial risk linked to achievement against projected activity assumptions<br>• Additional pressure placed on current community resource with increased turnaround times | Frailty implementation group |

# BCF09 – Lancashire health economy wholes system urgent care transformation programme – Effective Discharge

| Barriers / Challenges to successful delivery | Managed by…. |
|---|---|
| There has been an increased usage of this service to support admission avoidance. This does not cover 0-4 for childhood respiratory. We are looking to see what pathways we can do for this age group. | SRG/A&E delivery board, Urgent Care Programme Delivery Group along with project meetings |
| Risks | Managed by… |
| • Failure of health and social care economy to agree the redesign of a fully integrated discharge team leading to continuation of a disjointed and inequitable service.<br>• Potential for financial impact not to be realised resulting in lack of cost effective services being delivered.<br>• Potential lack of support from HR and union representatives throughout the staff consultation for the radical redesign of an integrated discharge team, resulting in non delivery.<br>• Failure of scheme to provide expected benefits. | LTH Implementation Managers |

# BCF08 Lancashire health economy whole system urgent care transformation programme – Community Beds/Intermediate Care

| | Alignment with High Impact Change Model of Transfers of Care | Yes= X |
|---|---|---|
| 1 | Early discharge planning. | x |
| 2 | Systems to monitor patient flow. | x |
| 3 | Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. | x |
| 4 | Home first/discharge to assess. | x |
| 5 | Seven-day service. | x |
| 6 | Trusted assessors. | x |
| 7 | Focus on choice. | x |
| 8 | Enhancing health in care homes. | |

| Alignment with Plans | |
|---|---|
| Urgent and Emergency Care | x |
| A&E Delivery Board | x |
| Operational plan (s) | x |
| Other… | |

# BCF09 – Lancashire health economy wholes system urgent care transformation programme – Effective Discharge

| | Alignment with High Impact Change Model of Transfers of Care | Yes= X |
|---|---|---|
| 1 | Early discharge planning. | x |
| 2 | Systems to monitor patient flow. | x |
| 3 | Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. | x |
| 4 | Home first/discharge to assess. | x |
| 5 | Seven-day service. | x |
| 6 | Trusted assessors. | x |
| 7 | Focus on choice. | x |
| 8 | Enhancing health in care homes. | |

| Alignment with Plans | |
|---|---|
| Urgent and Emergency Care | x |
| A&E Delivery Board | x |
| Operational plan (s) | x |
| Other… | |

| Estimated impact | A reduction of? | Details |
|---|---|---|
| NELs | 2.5% increase overall | NEL's saw a reduction in admissions via GP for patients 75+ |
| DTOC | 1.7% increase | |
| Residential Admissions | 1.3% overall reduction | Preston and South Ribble saw a reduction but Chorley had a slight increase. |
| Effectiveness of reablement services | | Passport to independence only commenced in July 2017 in Central Lancashire |
| Other | | |

# BCF08 Lancashire health economy whole system urgent care transformation programme – Community Beds/Intermediate Care

| INPUTS | ACTIVITES | OUTPUTS | OUTCOMES |
|---|---|---|---|
| Review of Bed Based Intermediate care beds | Review existing service specifications | Re-wrote service specifications to extend inclusion criteria | More patients able to access intermediate care |
| Community Frailty Model | Map current patient journeys | Revised targets for length of stay in intermediate care services | Services meet needs of patients with complex discharge needs and post-acute recovery |
| COPD | Baseline analysis of acute frailty admissions | Trusted assessor and discharge to access pathways developed | Increase in same day discharge |
| | Implementation of a Frailty Service | Actively manage people through the intermediate care pathway ensuring that they receive the optimum duration of service. | Reduction in LOS awaiting assessment |
| | Care planning and coordination | Manage demand and oversee capacity to allow an overall view of patient flow, demand and capacity and inform future commissioning decisions. | Improved utilisation of intermediate care beds |
| | | Community based step up frailty pathway | 100% of patients to discharged from a frailty bed within 72 hours of arrival |
| | | Comprehensive geriatric assessments completed in a community setting | Reduction in hospital admissions for people aged 75+ |
| | | | Individuals maintaining independence in their own homes |
| | | | Acute bed capacity is freed-up |
| | | | Improved patient flow through acute system |
| | | | Increase in frailty patients managed in their own home |
| | | | Improved health and well-being of people who live longer with a better quality of life |

# BCF09 – Lancashire health economy wholes system urgent care transformation programme – Effective Discharge

| INPUTS | ACTIVITES | OUTPUTS | OUTCOMES |
|---|---|---|---|
| Implementation of the Integrated Discharge Service | Review existing discharge pathways | Effective and evidence-based clinical pathways | Increase weekend discharge rate |
| | Multi disciplinary working | Agreed cross organisational discharge pathways | Increase proportion of patients discharged home |
| | Reconfigure workforce to provide 7 day cover | IDS Service operates 7 day | Increase patient confidence to manage their own health |
| | Develop discharge to assess options | CHC discharge to assess pathway implemented | Reduction in emergency readmissions |
| | Embed trusted assessor pathways | | Acute bed capacity is freed-up |
| | | | Improved patient flow |
| | | | Improved health and well-being of people who live longer with a better quality of life |
| | | | Reduction in LOS |

## Learning from delivery of the scheme

| Learning | How shared and who with ? |
|---|---|
| It is difficult to evidence any one scheme has achieved impact as many schemes are interdependent, therefore in Central Lancashire 17/18 BCF plans are aligned to CCG delivery plans to better reflect BCF targets. | Urgent Care Programme Delivery Group – all stakeholders and partners |
| Service mobilisation alone does not always result in desired impact as pathway redesign and new ways of working takes time to embed | Urgent Care Programme Delivery Group – all stakeholders and partners |
| | |

## Qualitative assessment summary
## 1 –10 where 1 is “not at all” and 10 is “to a great extent”.

| | Is working as planned and delivering on outcomes | Represents value for money in the long term | Builds long term capacity for integration locally; enables new models of health and social care | Evidently supports people effectively, improving patients /service user satisfaction | Has buy in from all stakeholders and workforce: Frontline staff and political, clinical, managerial leaders | Reflects a truly whole system approach | Supports shift towards prevention/early help and community support/ self -help | Total / 70 |
|---|---|---|---|---|---|---|---|---|
| Community Beds | 8 | 9 | 7 | 8 | 9 | 7 | 8 | 56 |
| Rapid Response | 8 | 8 | 7 | 8 | 9 | 7 | 9 | 56 |
| Integrated discharge service | 5 | 8 | 7 | 7 | 5 | 6 | 3 | 41 |
| Frailty Service | 7 | 7 | 8 | 8 | 9 | 7 | 8 | 54 |
| COPD | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 56 |

## Summary

| Scheme Title | Retain ? X | Expand? X | Cease? X | £s in 2016/17 | £s in 2017/18 |
|---|---|---|---|---|---|
| Community Beds | x | x | | 1,028,091 – CSR<br>1,141,741 – GrP | 2,531,399 – CSR<br>3,168,069 - GrP |
| Rapid Response | x | | | 231,118 – CSR<br>312,491 – GrP | 378,731 – CSR<br>110,650 – GrP |
| Integrated discharge service | x | | | 181,818 – CSR<br>131,501 – GrP | 0 |
| Frailty Service | | x | | 534,473 – CSR<br>603,301 – GrP | 398,188 – CSR<br>1,639,390 – GrP |
| Lancashire health economy whole system urgent care transformation - Step up/Step down beds | x | | | 805,000 – CSR<br>1,009,000 - GrP | 0 |
| COPD | x | | | 207,530 – CSR<br>238,870 - GrP | 0 |
| **Total** | | | | **6,424,934** | **7,847,696** |