BCF 2016/17

Scheme Review

East 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
Transforming Lives, Strengthening communities - Building capacity in the voluntary sector	205.39
Re-design of Dementia Services East Lancashire	1,563.69
Redesigned Intermediate Care supported by • Integrated Discharge Function • Intermediate care allocation team • Intensive Home Support • Navigation Hub/Directory of Services	13,647.33
Lancashire wide • Integrated Offer for Carers – Support and Respite • Reablement • Transforming Community Equipment Services • Integrated Neighbourhood / Care Teams Lancashire-wide	 **2, 536.17** **1,807.64** **3,987.78** **1,200**
Lancashire County Council • Telecare services Lancashire CC • Care Act	 **254** **1,014.34**
Total	26,216.34

Transforming Lives, Strengthening communities - Building capacity in the voluntary sector

Original rationale for scheme.

To work with partner public sector agencies and the voluntary sector to develop a coordinated approach to earlier intervention. This will prevent and/or delay demand on statutory health and care services and wider public services. In addition the scheme will:

- Improve access to support in people's neighbourhoods linking to the wider development of Integrated Neighbourhood teams.
- Promote a collaborative approach to provision of information, advice, guidance and support.
- Encourage a coordinated, lead professional approach (supported by voluntary sector partners) to develop provision that meets the requirements of those with more complex needs.
- Reduce duplication of activity across agencies.
- Improve quality of life and experience of services within East Lancashire.
- Maximise potential to bring inward investment into East Lancashire.

This scheme builds on a strong and long standing local partnerships with partner agencies and the Voluntary, Community and Faith (VCF) sector, focused on building community assets and resilience, providing tailored information, signposting and partnership approaches to statutory provision.

Primary prevention	Hospital	Community	Secondary prevention
X	X	X	X

Re-design of Dementia Services East Lancashire

Original rationale for scheme.

To redesign of memory assessment services (MAS) in order to:

- Develop an improved open access route to the local population on a neighbourhood basis, connected to Primary Care.
- Improve and sustain dementia diagnosis rates, by having stream-lined processes for screening and diagnosis that deliver prompt decision making, enabling early access to co-ordinated care.
- To deliver a comprehensive post-diagnostic support structure aligned to a re-designed Memory Service.
- Deliver information and support to enable decision making for people with dementia and their carers, leading to extended independence for people with dementia and their carers.
- Our approach is centred on the principle of building 'dementia friendly communities' to provide a supportive environment for dementia care in the community.

This scheme will deliver a primary care based model of Dementia diagnosis including pre and post diagnostic support that will continue to reduce the dementia diagnostic gap and improve access to support for people with suspected and diagnosed dementia and their carers in East Lancashire. This will be through a more efficient and open access into Memory Assessment Services.
Services (MAS)

Primary prevention	Hospital	Community	Secondary prevention
X		X	X

Redesigned Intermediate care

Original rationale for scheme.

- To re-balance community integrated intermediate care services and short term bed based services to provide each individual the opportunity to recover and achieve their optimal level of skills, confidence and independence.
- A community based Intermediate care allocation team (ICAT) service with a multidisciplinary team that focuses on managing patients through the pathways for Intermediate care.
- A community based Intensive Home Support (IHS) service with a medically-led multidisciplinary team that focuses on patients with the highest risk of a hospital admission or requiring intensive support following a hospital admission.
- The Care Navigation hub will provide a capacity management system for out of hospital care enabling full use of resource and ensuring flow across the community bed based system. A comprehensive Directory of Services (DOS) will be developed for health and care professionals to enable them to access the appropriate services. It will also have a capacity monitoring function to help referrers understand their options to make best use of resources within the local health and care economy.

Primary prevention	Hospital	Community	Secondary prevention
X		X	X

Activity during 2016/17

Scheme element	Planned activity	Actual Activity	Reason for any difference between planned and actual
Transforming Lives	No target set	167 people supported	No target set due to approach taken to mobilise service across each neighbourhood in EL
Voluntary Sector CVS	Small Grants £500k	£466k disseminated via grants 300 referrals to Community Navigators 596 Volunteers recruited and will provide 26,353 hours	Small underspend on small grants due to scheme only being operational from June 2016
Voluntary Sector Age UK	920 people supported	550 people supported	Service mobilised part way through year due to delay in staring scheme
IDS	2600 referrals	3325 referrals	Overall activity includes all complex cases, not all referrals feed through into service delivery
ICAT	5475 referrals	7281 referrals	Service has expanded hours in year and developed as support to IHSS and wider Intermediate care bed base
Intensive Home Support Service (IHSS)	1,185 people supported	2,868 people supported	Service has evolved to support step down from hospital as well as admission avoidance
Navigation Hub	1400 calls	223 calls	Utilisation of Navigation Hub in EL has been low due to crossover with ICAT. Is now being re-designed as the Clinical Assessment service as part of Urgent care re-design

Scheme Redesign of Dementia services East Lancs

Activity during 2016/17

Scheme element	Planned activity	Actual Activity	Reason for any difference between planned and actual
Increase no of referrals	2874 (66.7%) Had to reach a diagnosis target of 66.7	2886 (73.7%)	Significant increase
Improve waiting times	0-6 weeks	0-6 weeks 107 7-9 weeks 1 10-12 weeks 2	Significant improvement 37.75% seen within 6 weeks

Transforming Lives, Strengthening communities - Building capacity in the voluntary sector

Barriers / Challenges to successful delivery	Managed by….
Data sharing and single case record	Lead by Police – includes all stakeholders
Risks	Managed by…
Organisational commitment to co location	Lead by Police – includes all stakeholders

Scheme: redesign of Dementia services East Lancs

Barriers / Challenges to successful delivery	Managed by….
Pennine Lancs solution to fund Pre – post diagnostic service provided by VCFS funded non-rep April – Sept 2017.	Pennine CCG's
Risks – Service ceases September 2017	Pennine CCG's
Commissioners working to identify costs savings to identify repetitive funding for Pre-Post diagnostic service continuation with VCFS	Pennine CCG's

Redesigned Intermediate Care supported by an Integrated Discharge Function, Intermediate Care Allocation Team and Navigation Hub/Directory of Services

Barriers / Challenges to successful delivery	Managed by….
Inability to move to a fully integrated discharge function due to organisational constraints. IT interoperability to support electronic sharing of Trusted Assessment documentation. National re-design of Urgent care system shifted focus for Navigation hub	Joint operational meetings, daily integrated planning meetings Development of TA document, paper copy used Incorporated within re-design
Risks	Managed by…
Ability to move the model quickly enough, organisational sovereignty issues	System leadership

Intensive Home Support

Barriers / Challenges to successful delivery	Managed by….
IHSS • Stimulating GP referrals to prevent admissions • Ensuring a split between admission avoidance and early support discharge (ESD)	 CCG / ELHT CCG / ELHT
Risks	Managed by…
IHSS • Developing a PL solution to support admission avoidance and ESD	CCG / ELHT / LCFT

Transforming Lives, Strengthening communities - Building capacity in the voluntary sector

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

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

Re-design of Dementia Services East Lancashire

	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.	
5	Seven-day service.	
6	Trusted assessors.	x
7	Focus on choice.	x
8	Enhancing health in care homes.	x
Alignment with Plans		
Urgent and Emergency Care		
A&E Delivery Board		
Operational plan (s)		x
Other…		

Redesigned Intermediate Care supported by an Integrated Discharge Function, ICAT, Intensive Home Support and Navigation Hub/Directory of Services

	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…		

BCF 2016/17

Estimated impact	A reduction of?	Details
NELs	7%	Reduction in NEL activity overall
DTOC	0%	DToC has increased to 5.02% in year (16/17), reflecting the challenges faced across the acute care sector. (nationally DToC has been challenged in 16/17). Aim is to reduce to the national level below 3.5% of occupied bed days.
Residential/Nursing home Admissions	768.1	Calculated from permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population.
Effectiveness of reablement services	81.2%	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Other Number of A&E attendances VB11Z (Emergency Medicine coding no investigation/significant treatment)	 4% 23%	 Reduction in A&E attendances overall Reduction in number of people going to A&E and requiring no investigations or significant treatment.

Further work is required to understand the precise impact of BCF projects on the headline figures above.

BCF 2016/17

How was impact measured?
Overall impact on non-elective admissions, DToC and annual residential care admissions

Transforming Lives, Strengthening communities - Building capacity in the voluntary sector

Inputs	Activities	Outputs	Outcomes	Impact
Transforming Lives – multi agency interactions with small cohort of people	Single team – - Co location - MDT - Self management - Data sharing - Alignment to Integrated Neighbourhood Teams and early years service	Reduced duplication Lead professional Multi-agency response All age model	Short term Increased neighbourhood working Long term Reduced agency interactions	Reduced unnecessary A&E attendances / GP appointments Reduced NEL Admissions Reduced replication of activity across agency Improve quality of life
Building capacity in the Voluntary Sector	Increase universal offer Promote information, advice and guidance service	Reduced duplication	Improved universal offer to support statutory services in neighbourhood and acute	Improve quality of life Increased asset based development Support statutory services to free up capacity

Redesigned Intermediate Care supported by an Integrated Discharge Function, ICAT, Intensive Home Support and Navigation Hub/Directory of Services

Inputs	Activities	Outputs	Outcomes	Impact
Development of IDS	MADE meetings, Complex case tracking, DToC	Oversight of all complex discharges	Clear position on flow DToC	Maintained level of DToC below Lancashire average
Trusted Assessment Document (TAD)	Development of documentation	Use of TAD	Single assessment document	Better quality for patients
Development of ICAT	Oversee Intermediate care pathway	Oversight of all IC cases	Improved flow in IC services	Support flow, reduce DToC
Mobilisation of IHSS services	Recruit specialist team of Multi Disciplinary staff	Multi-agency response	Admission avoidance Improved multi agency working	Reduced unnecessary A&E attendances Reduced NEL Admissions Support DTOC
Development of Navigation Hub	7 day access for clinicians to hub, management of DoS	Sign-posting to services	Supported Primary care capacity	Support Primary Care Improve system navigation

Scheme logic model: Redesign of Dementia services East Lancs

Inputs	Activities	Outputs	Outcomes	Impact
Stakeholder engagement. Historical data. National drivers.	Redesign of service co-produced with provider including VCFS	Streamlined pathway. Better patient experience.	Improved quality of service for EL patients	Increased activity. Better support for people pre and post diagnosis.
As above ELCCG Quality Premium 16/17	Dementia LIS. Raising awareness with GP practices for early diagnosis and provide enhanced annual review for all people on the dementia register as from April 2017.	Improved practice focus	Increase the number of people accessing the service	Achievement of Dementia Quality premium (2016/17)
As above	Redesign of the service co-produced with providers including VCFS	Streamlined pathway.	Improving the waiting times. Improve patient experience	Increase in people waiting 0-6 weeks. Prevents deterioration of condition

Transforming Lives, Strengthening communities - Building capacity in the voluntary sector

Learning	How shared and who with ?
Significant learning across neighbourhoods in Pennine Lancashire	Shared through Lancs wide Early Action Group
Building capacity in the voluntary sector	Part of national programme with Age UK Work with whole sector to promote collaborative working.

Learning from delivery of the scheme: Redesign of Dementia Service East Lancs

Learning	How shared and who with ?
Significant learning across health and social care economy in Pennine Lancs	Shared through various CCG and provider forums
GP Learning Event to support LIS (October 17)	GPs across East Lancs
Significant role provide by VCFS in the Dementia pathway	Across the health and social care economy in East Lancs

Learning from delivery of the scheme: Redesign of Intermediate care

Learning	How shared and who with ?
Significant learning on models across the Intermediate and Urgent care pathway	AEDB, System leaders and iBCF development
National models for Urgent care have informed revision of Care Navigation approach	AEDB, PL transformation, UEC re-design
Informed regional approaches across Lancashire	Roll out of TAD, Home First and IDS have all been informed by pilot work in PL – UECN, BCF steering group

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
Transforming Lives, Strengthening communities - Building capacity in the voluntary sector	9	10	7	0	7	10	10	53/70
Re-design of Dementia Services East Lancashire	9	10	9	8	8	9	10	63/70
Redesigned Intermediate Care supported by an Integrated Discharge Function, Intensive Home Support and Navigation Hub/Directory of Services	8	10	9	7	9	9	8	60/70

Summary

Scheme Title	Retain ? X	Expand? X	Cease? X	£s in 2016/17	£s in 2017/18
Transforming Lives, Strengthening communities - Building capacity in the voluntary sector	x			205.39	205.60
Re-design of Dementia Services East Lancashire	x	x		1,563.69	1,345.87
Redesigned Intermediate Care supported by an Integrated Discharge Function, Intensive Home Support and Navigation Hub/Directory of Services	x	x		13, 647.33	13,904.26
Total				15, 416.41	15,455.73