iBCF 2017/18

Proposals for
Central Lancashire

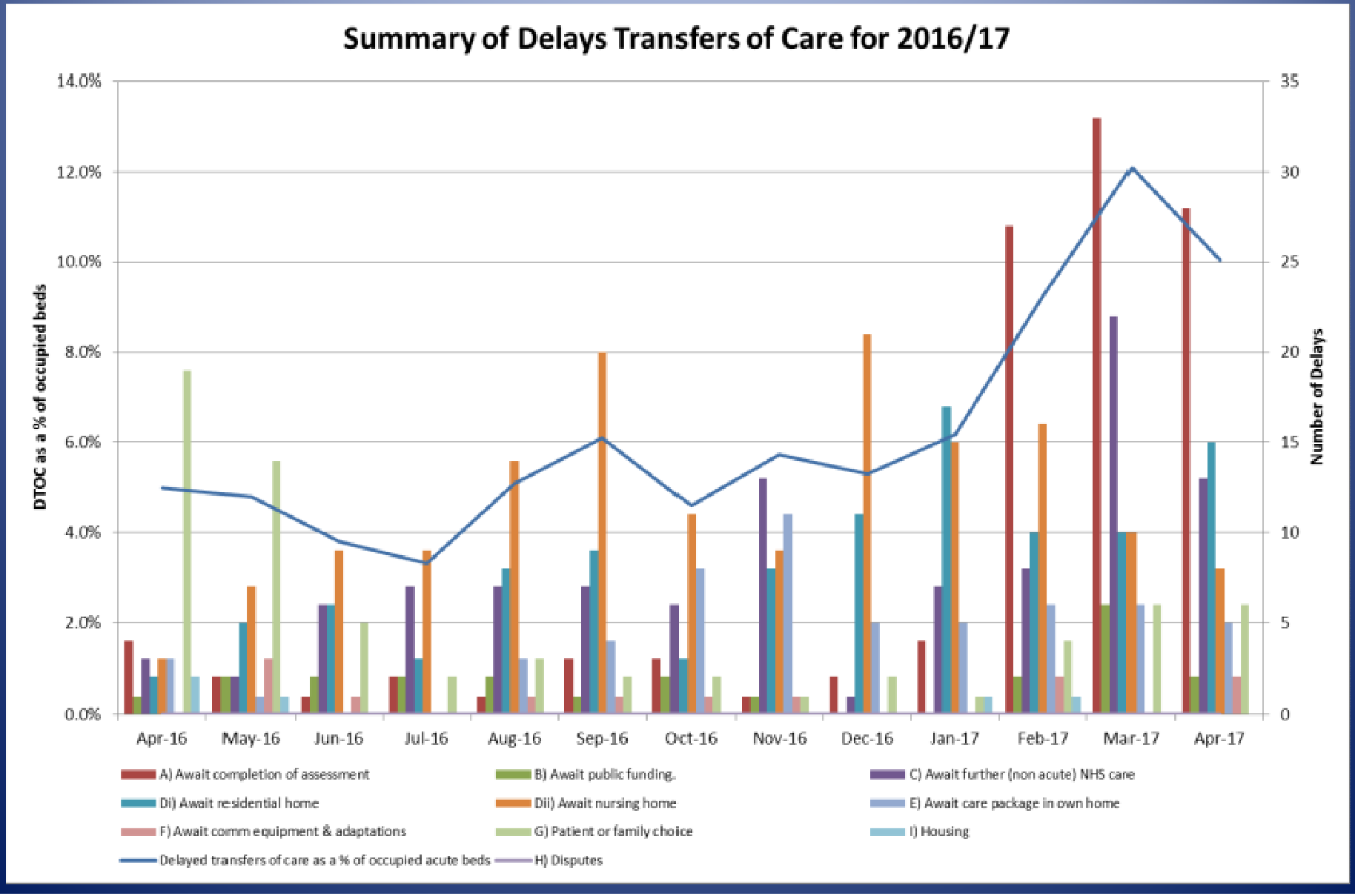
Summary

Scheme Title	Description and aims	£s in 2017/18
Social Work Assessment Capacity – 7 Days	Increase social work capacity in the Integrated Discharge Service at both hospital sites and in the community across 7 days	£159K
Central Allocation Team for Care and Health	Single point of access for intermediate care, managing capacity and demand in services, with additional crisis support capacity	£532.5K
Care Home Support Model	The proactive, preventative service will wrap around residents in a care home setting, working to prevent inappropriate visits to A&E, avoidable admissions, reduce delayed transfers of care and length of stay.	£517K
Social work support to GP Practice collaboratives	Social work support embedded with Mental Health and Physical Health service to support patients with social care needs presenting at GP Practices	£43K
Total		£1,251,500

Overall Vision

- To reduce Delayed Transfers of Care (DToC) currently 9.9% at 18/6/17
- Top 3 pressures in DToC attributed to:
  - Assessments
  - Waits for Residential/Nursing Home placements
  - Waits for Intermediate Care
- Identified schemes aim to:
  - Reduce waits for assessment
  - Embed Home First principles including care homes
  - Better utilise intermediate care resources
  - Avoid non-elective admissions

Overall Vision



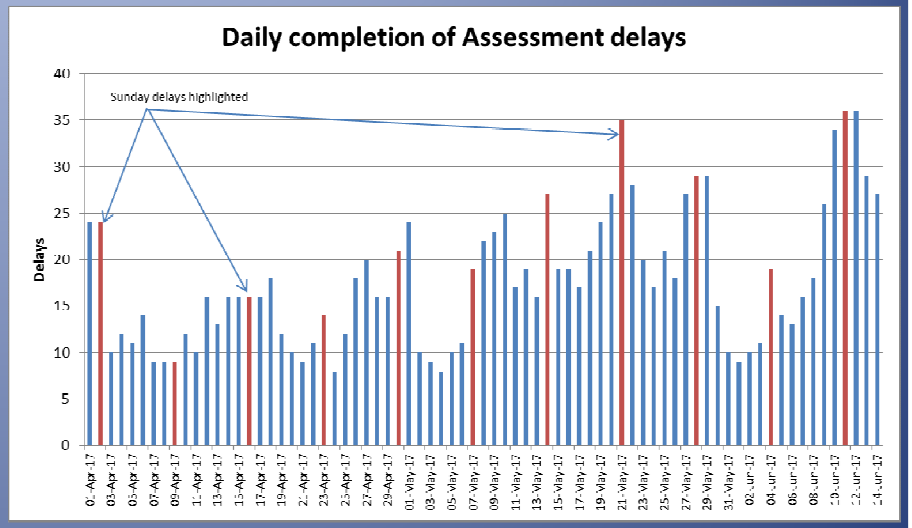
Social Work Assessment Capacity – 7 Days

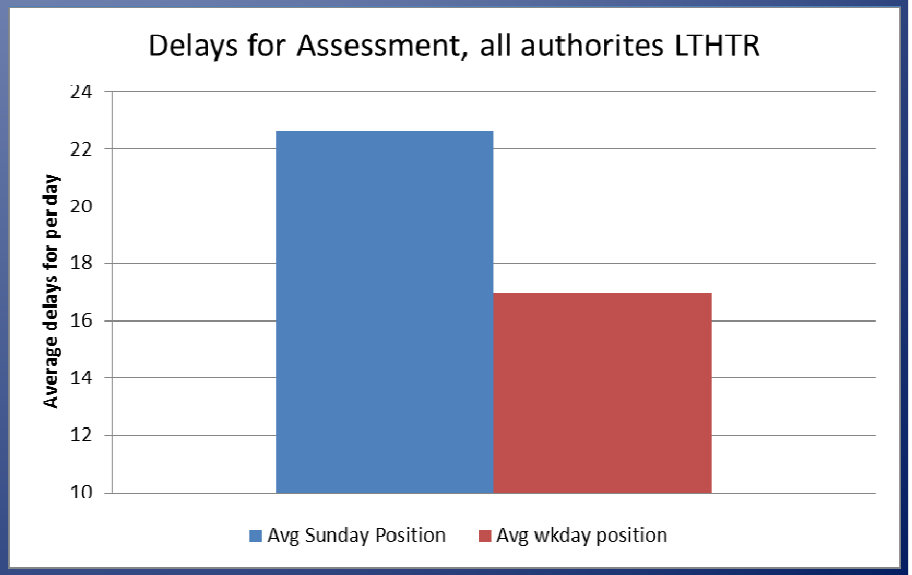
Issue to be addressed

- Flow stops at the weekend for SW assessments in all areas
- Monday morning commences with a back log of unallocated cases for SW in acute setting
- Local Authority not meeting notification to timeframe for assessment
- 7 Day services principle not met
- Families not always able to attend assessments during the week.

Existing activity

- No current SW weekend assessments
- LTH IDS operate a 7 day service offer without social workers
- Resilience money supported some weekend working but relied on volunteers and not consistent
- Number of delays for SW assessments are 33% higher on Sunday recording than the rest of the week (Apr 1st 2017 to June 15th 2017)





Social Work Assessment Capacity – 7 Days

Proposed new or additional activity (including quantity)

Core hospital staffing from 1/7/17

Mon to Friday	2 x grade 9, Social Workers
already agreed and in place	8 x grade 8 (1.5 WTE = health funded)
	6 x grade 6 Social Care Support Officer

This was increased following LCC demand and capacity modelling

Additional from iBCF

Option 1 - Increase core staffing but model over split week e.g. 1 team works Mon – Friday and other works Fri – Mon

Option 2 – Weekend only staff via agency for both acute and intermediate care

Social Work Assessment Capacity – 7 Days

Delivery timeline

- 3 months to recruit and train staff on LCC processes and systems. (sooner if agency)

Benefits

- Reduce baseline bed day delays attributed to SW assessments
  - Actual YTD 1 April to 14 June 2017 1,336
  - Option 1 model bed day delays reduction to 685
  - Option 2 weekend only staff bed days reduction to 1,169

Social Work Assessment Capacity – 7 Days

Costs

Option 1

- Additional resource to core team but split working week into 2 teams

  -Have one team work Mon- Fri and another Fri – Mon this would give increased resource on busiest days Mon and Friday but adequate resource over 7 days flexibly across intermediate care and hospital

- 3 x grade 8 SW and 3 x grade 6 SCSO
- Total cost £207k full year 2017/18 £159k (9months)

Option 2

- Agency staff to cover weekends

	Hospital Resource	Intermediate Care Resource
•	3 x grade 8 SW (2 days per week)	2 x grade 8 SW (2 days per week)
•	2 x grade 6 SCSO (2 days per week)	1 x grade 6 SCSO (2 days per week)

Total cost £124k full year 2017/18 £95k (9months)

Social Work Assessment Capacity – 7 Days

Planned impact	A reduction of?	Details
NELs		
DTOC	49% Option 1 12.5% Option 2	Option 1: The change of rota to Monday to Friday, Friday to Monday, shows an increase in capacity on core hours of 103%, if this matches the reduction in delays for assessment we predict an effect based on number of daily delays year to date (1 Apr 2017 to 14 Jun 2017) from 1,336 to 685 days. Option 2: The increased capacity in social worker provision over the weekend is expected to lead to a reduction in delays for assessment by 12.5% over the period. We predict that for the actual number of daily delays year to date (1 Apr 2017 to 14 Jun 2017) this would have meant a reduction from 1,336 to 1,169 days.
Residential Admissions		
Other		

Social Work Assessment Capacity – 7 Days

How will impact be measured and reported?
The impact will be measured days waiting for Social Worker assessments for LTH as reported on daily DTOC report

Social Work Assessment Capacity – 7 Days

Barriers / Challenges to successful delivery	**Managed by….**
Workforce recruitment and retention Integrated working between LTH/LCC to maximise impact of the Integrated Discharge Service Access to all services across 7 days	LCC/CCG LTH/LCC All partners
Risks	Managed by…
Workforce recruitment and retention	LCC/CCG

Social Work Assessment Capacity – 7 Days

	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.	
7	Focus on choice.	
8	Enhancing health in care homes.	

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

Central Allocation Team for Care and Health

Issue to be addressed

- Delays in people being discharged following assessment due to no capacity in intermediate care
- Short Term Care placements (STC) as no option to provide intermediate care to see if individual could manage after period of rehabilitation
- Passport to independence reablement due to commence impact has yet to be felt
- Over 45% of people in the wrong bed based intermediate care setting as admission is driven by capacity
- 95% of bed based intermediate care is step down with very little step up activity or admission avoidance
- Delays in people leaving intermediate care due to waits for long term domiciliary care packages

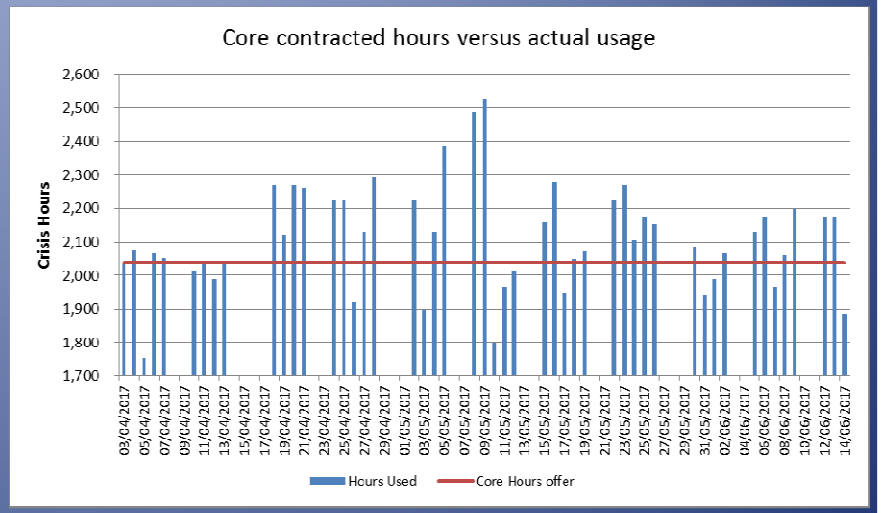
Existing activity

- Current referrals routes are inconsistent across referring groups
- No overview of capacity in current services or management of intermediate care pathway

Central Allocation Team for Care and Health – Crisis

Issue to be addressed

- Delays in people being discharged following assessment due to no homecare capacity
- Many Short Term Care placements (STC) as no option to put intensive homecare to see if individual could manage after period of settling.
- Passport to independence reablement due to commence but concern that this still wont be sufficient capacity if promoting home 1st
- 300hrs per week additional funding due to end 25 July, yet daily in central no capacity. The data shows that YTD 17/18 33 out of the 49 days recorded were over the core hours contracted



Existing activity

- Currently contracted as crisis/dom rehab 2039hrs per week
- From 9 August shift of contracted hours will reduce crisis to 938 with increase in reablement.
- All current capacity used including temp additional hours. (2339hrs)
- DTOCS for patients waiting home care services

Central Allocation Team for Care and Health

Proposed new or additional activity

- Integrate additional social work resource into the existing MAP service across 7 days
- Allocation of intermediate care is done centrally by one team with a directory of services to support capacity and demand management
- Team will support the Integrated Discharge Service with Discharge to Assess
- Link to community based Frailty Assessment Service
- Co-located multi-disciplinary team with access to additional Crisis Support hours
- Supported by additional posts:
  - Team Manager (OT)
  - 2 x Social worker
  - 2 x SCSO posts

Central Allocation Team for Care and Health

Delivery timeline

- Workshop planned to map existing referral pathways 29th June to inform phased introduction
- Establish directory of services and team processes and recruit to team for go-live in September
- Crisis Hours - lead in time for provider is minimum 6 weeks and this may need to be on a phased basis, plan is to have all hours in place by 1 September 2017 to manage additional seasonal demand

Central Allocation Team for Care and Health

Costs

- Employment of additional staff from September across 7 days
  - 1 x Band 8a Team Manager posts (2.27 WTE)
  - 2 x Grade 8 Social Workers (4.54 WTE)
  - 2 x Grade 6 Social Care Support Officers (4.54 WTE)
  - Full Year cost £452k, 7 months costs £263k
  - One off set up costs equip etc. £7500

Crisis

- Continuation of 300 hours per week for 39 weeks from 25/7/17 = £157k, Full Year £209k
- Additional contingency of up to 200 hours from 25/7/17 = £105k, full year £140k

- 2017/18 = £263k workforce and £262k crisis £7.5K and one off set up = £532.5k
- Full Year cost £ 452k workforce plus £ 349k Crisis = £801k

Benefits

- A reduction in avoidable hospital admissions
- An increase in step-up access from community settings
- A reduction in inappropriate referrals and duplicate assessments with better consistency
- A reduction in care home admissions and high cost support packages
- Better outcomes for patients/customers and a seamless transition through intermediate care

Crisis support will become residual as benefits from CATCH and passport to independence are realised

Central Allocation Team for Care and Health

Planned impact	A reduction of?	Details
NELs	TBC	Better use of intermediate care will prevent admissions where individuals have exacerbations of illness and need temporary support either prior to attending an acute hospital or where ED has deemed no medical reason for admission.
DTOC	1.5%	Access to capacity in intermediate care services will allow same day discharge. Additional benefits as patients are stepped up.
Residential Admissions	TBC	Will reduce STC placements where there is a lack of home based care or uncertainty of night time needs
Other		

Central Allocation Team for Care and Health

How will impact be measured and reported?
Baselines will be established against key benefits and trajectories set to monitor improvement The continued funding of extra hours for Crisis care will ensure that there is enough capacity for Chorley, Preston and South Ribble. Usage of additional crisis hours would be monitored and manged as part of CATCH process.

Central Allocation Team for Care and Health

Barriers / Challenges to successful delivery	Managed by….
Workforce recruitment	CCG/LCC
Integrated working between all partners to maximise impact of the Central Allocation Team for Care and Health	CCG/LCC/LTH/LCFT
Access to all services across 7 days	CCG/LCC
Risks	**Managed by…**
Ambitious timescales	CCG/LCC
Workforce recruitment	CCG/LCC

Central Allocation Team for Care and Health

	Alignment with High Impact Change Model of Transfers of Care	Yes= X
1	Early discharge planning.	
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.	
8	Enhancing health in care homes.	
Alignment with Plans		
Urgent and Emergency Care		X
A&E Delivery Board		X
Operational plan (s)		X
Other…		

Care Home Support Model

Issue to be addressed

- Inappropriate visits to A&E and avoidable admissions from Care Home residents.
- Above average number of delayed transfers of care following admission.
- The number of Social Care assessments required to be carried out.
- Length of stay in acute care and length of stay for patients in short term placements in homes.
- Ineffective communication links between Health, Social Care and Care Home staff.

Existing activity

- Health - Core GMS to Care Home residents.
- Social Care - Social Care assessments carried out for patients ready to leave hospital setting.
  - Annual reviews of residents within a Care Home setting.
- Full draft specification for the service

Care Home Support Model

Proposed new or additional activity (including quantity)

- Develop a comprehensive enhanced primary care service to the care home residents. That will include:
- timely and regular assessments/reviews for all residents, to include mental health, dementia and frailty assessments.
- Establishing a health and social care MDT to provide a minimum number of weekly sessions in each home with proactive GP involvement.
- Building more effective communication links between Health, Social Care and Care Home staff to ensure patients are not delayed unnecessarily when transferring out of an acute setting.

Delivery timeline

- Mobilisation of service: 3 month lead in (1 October 2017)

Care Home Support Model

Costs

- Delivery of Service (per annum)
- Full MDT team including GP provision to cover 3791 beds across both CCG's
- 2 x Grade 8 Social Workers (top of grade) including travel

2017/18 6 months cost = £517k, Full year cost £1034k

Benefits

- Reduction in acute A&E and unplanned admissions.
- Reduce the number of delayed transfers of care following admission.
- Reduction in Social Care assessments to be carried out.
- Reduce length of stay in acute care and length of stay for patients in short term placements in homes.
- Build more effective communication links between Health, Social Care and Care Home staff.
- Reduction in demand for higher rate residential placements

Incorporate Care Home Effective Support Service (CHESS) currently commissioned by CCG

Any financial reduction in contracts to CCGs from this service will be aligned to fund this service in future and reduce iBCF funding contribution going forward

Care Home Support Model

Planned impact	A reduction of?	Details
NELs	15%	
DTOC	6%	Nursing Home Reduction of – 318 days Residential Home Reduction of - 230 days (trusted assessor)

How will impact be measured and reported?
DTOC – DTOC Daily report Monthly reporting to Performance Team
A&E Attends & NELS – Acute SUS data Monthly reporting from BI Team

Care Home Support Model

Barriers / Challenges to successful delivery	Managed by….
Mobilisation of providers and development of collaborative working in Primary Care Workforce – availability of suitable workforce	CCG/LCC CCG/LCC
Risks	Managed by…
Ambitious timescales	CCG

Care Home Support Model

	Alignment with High Impact Change Model of Transfers of Care	Yes= X
1	Early discharge planning.	X
2	Systems to monitor patient flow.	
3	Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector.	
4	Home first/discharge to assess.	
5	Seven-day service.	X
6	Trusted assessors.	X
7	Focus on choice.	X
8	Enhancing health in care homes.	X
Alignment with Plans		
Urgent and Emergency Care		X
A&E Delivery Board		X
Operational plan (s)		
Other…		

Social work support to GP Practice collaboratives

Issue to be addressed

- Improving all aspects of assessment – providing a holistic approach to the offer at primary care level
- Ensure Parity of esteem

Existing activity

- Planned project
  - for physical health monitoring for people with a serious mental illness
  - Integrated Health & Well Being service
  - Utilise the skills and knowledge of the existing Clinical Treatment Teams

Social work support to GP Practice collaboratives

Proposed new or additional activity (including quantity)

- Provide social worker link between existing services, offering specialist advice and assessment for vulnerable patients who need both clinical and social care in order to avoid escalation of treatment via OOH, ED and non elective activity.
- The role will enable GP's to access timely assessment and for patients to be assessed, supported and signposted to the appropriate agency e.g. social prescribing, housing, mental health services, third sector
- Each CCG locality to work on a collaborative footprint and to provide services on this basis with a social worker attached.

Delivery timeline

- Implementation September/October 2017

Social work support to GP Practice collaboratives

Requirement would be:

- 2 x grade 8 Social Workers including travel , 2017/18 6 months costs = £43k, full year costs £86k

Social work support to GP Practice collaboratives

Planned impact	A reduction of?	Details
NELs	10%	Of cohort of SMI patients
DTOC		
Residential Admissions		
Other		

How will impact be measured and reported?
The information to monitor will be identified from SUS data

Social work support to GP Practice collaboratives

Barriers / Challenges to successful delivery	**Managed by….**
• Managing expectation within primary care – requires clear referral criteria and assessment protocol • Recruitment • Establishing clear pathway links between agencies/providers • Ensure added value to existing programmes such as Early Action	CCG PC team LCC/CCG/LCFT All
Risks	Managed by…
Recruitment General Practice buy-In – requires phased approach	CCG/locality leads

Social work support to GP Practice collaboratives

	Alignment with High Impact Change Model of Transfers of Care	Yes= X
1	Early discharge planning.	
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.	
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…		