iBCF 2017/18

Proposals of Morecambe Bay CCG

Summary

Scheme Title	Description and aims	£s in 2017/18
Altham Meadows Intermediate Care Centre (AMICC)	AMICC is focussed on offering an integrated nursing and rehabilitation service to the people of North Lancashire as an alternative to hospital care. AMICC will improve the care pathways of our most vulnerable patients by providing outcome-based, person-centred coordinated care. 21 Beds (13 intermediate care and 8 clinically enhanced) with Step Up and Step Down functionality. Key Objectives: Reduce unnecessary acute admissions and readmissions to hospital or long-term residential or nursing care by facilitating effective transfers of care into intermediate care. Reduce the length of stay in an acute bed. Work closely with Acute, Community and Primary Care Services to ensure timely and effective transfers of care, designed with the patient goals and needs at the centre of every decision. Provide support and encouragement to individuals to enable them to live as healthily and independently as possible, in a suitable and safe environment, that meets all their identified needs, improving their quality of life and allowing them to make personal choices where possible, in relation to their care. Work collaboratively as an Integrated Health and Social Care Team including Voluntary agencies in order to facilitate maintenance of a healthy lifestyle and emotional well-being. Support patients in learning to self-care which may include use of telehealth solutions.	£750,000
Crisis Hours and Enhanced Therapies	 Expedite discharge work with patients to identify goals that can help maintain, regain, or improve independence by using different techniques, changing the environment, and using new equipment with an aim to improve functionality and reduce re/admission to an acute setting. Adhere to principle of 'Home First' 	£210,000
Total	Total is dependant upon allocation of overall pot of iBCF Funding.	£960,000

Overall Vision

- Improve rate of DTOCs
- Integration and Collaboration between Health and Social Care
- Increased step up and step down functionality
- Reduce LoS
- Improved acute flow
- Work to Principles of Home First
- Enhance Patient Quality and Experience

Issue to be addressed

- Improve rate of DTOCs critical part of the DTOC pathway to ensure a reduced admission rate to long term care
- Increased step up and step down functionality
- Reduce LoS
- Improved acute flow

Existing activity

- No existing activity in this unit as it is currently not operational.
- The intermediate service offer for the North Lancs area is at Dophinlee Care Home; this facility is not registered to deliver nursing care.
- The National Audit for Intermediate Care outlines key elements of a functional Intermediate Care system and the ability to deliver nursing care over a 24 hour period is a key recommendation which is currently not available in the North Lancashire Footprint.

Proposed new or additional activity

- 21 Beds in total
- 13 Standard beds and 8 Enhanced
- Assumed 85% Occupancy Levels
- Co-Located enterprise between Health and Social Care
- On-site OT and SW support

Delivery timeline

- 'Handover' June 2017
- Awaiting CQC Inspection June 2017
- Commence Operational Delivery July 2017

Costs

This is a collaboration across multiple organisations - LCFT (lease and Building), LCC (OT and links to reablement) and BTH (Therapies). Where possible, this scheme utilises existing resource to keep costs at a manageable level.

Total Cost: £1.5m

Total Cost Required: £750,000

Spending plan...monthly spend in 2017/18

 Spending plan will be based on an even apportionment of funding split across remaining months of 17/18 FY.

Planned impact	A reduction of?	Details
NELs		
DTOC	Local 33%	Locally agreed figure to achieve national target
Residential Admissions		
Other – Financial Saving	£2,061,730	Forecast savings based on 85% occupancy over 12 month period

How will impact be measured and reported?

Robust reporting against key KPIs as outlined below and feeding into Urgent Care and ICC Governance Structures where all organisations across the Bay Area are represented and provide operational and strategic scrutiny of scheme delivery

- User and staff views
- Bed days
- DTOC
- Length of stay over 7 days
- Occupancy of unit over 85%
- Audit

Barriers / Challenges to successful delivery	Managed by
 Completion of refurbishment in timely manner Recruitment of suitable and sufficient workforce 	External Provider overseen by CCG and LCC Workforce plan with multiple providers
Risks	Managed by
 Recruitment in a timely manner Risk of failing initial CQC inspection 	Project Team led by LCC and CCG.

	Alignment with High Impact Change Model of Transfers of Care	Yes=
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.	Χ
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		