iBCF 2017/18

Proposals of
West Lancashire

Summary

Scheme Title	Description and aims	£s in 2017/18
Community Hub	One place, flexible hub for intermediate Care, re-ablement and Rehab. Increase capacity for D2A	£175K
Seven-day Integrated Discharge pilot (intermediate care)	Integrated working between 2 current teams Move to 7 day working	£71,763
Home First Workforce Development	Generic Therapy and Nursing assistant – training posts	£81,463
Frail Elderly Discharge App	Workforce development Simplifying a complex system	TBC
Total		£328,225

Overall Vision

- Reducing DTOC
- Large increase between 2015/16 and 2016/17
  - 69.5% increase in DTOC
  - 13% increase in XBDS Cost
- Increase capacity in the community to enable more step down and step up
- Increase options for Home First model
- Increase integrated working

Scheme 1 Community Hub

Issue to be addressed; Discharge to Assess Capacity

- Already discharge to assess via CERT, but limited capacity
- 14 Re-ablement beds and 5 Intermediate Care Beds (max 10 during Winter)
- Spot purchases during times of pressure – unplanned/reactive
- Re-ablement beds high utilisation and often limited beds available
- Need more Step Up to prevent admissions

Existing activity

- District Council Property at Hall Green – different types of accommodation for flexible needs
- Private partner interested to develop site and rent back to NHS, initial meetings and scoping underway

Scheme 1 Community Hub

Proposed new or additional activity

- Development of a community hub for step up/down
- Re-ablement and intermediate care in one place not scattered across patch (reduced spot purchases)
- Increase capacity to enable Discharge to Assess
- Link to Well Skelmerdale development of economy
- Social Care Hub/team co-location
- Accomodation flexible - 24/7 care and self contained rooms, on site facilities for OT and reablement
- Re-location Hospital re-hab ward to more appropriate community setting
- Integrate with Older Adult Mental Health and Frailty pathways

Delivery timeline

- Development of site – 12 to 18 months
- Procure provider to manage service
- Frailty Pathway development with S&O Trust (existing workstream) – 10 to 12 months

Scheme 1 Community Hub

Costs

- Needs further scoping with private property developer
- Refurbishment and set up costs cica £150K
- Further Equipment costs £25K
- Total 2017/18 = £175K
- Benefits
  - On-going Bed cost met by existing budgets
  - Less travel time for staff will increase capacity
  - Increase capacity for Discharge to Assess and step down
  - Reduction in XBS and long term placements

Scheme 1 Community Hub

Planned impact	A reduction of?	Details
DTOC	2-5%	Needs to be confirmed when Bed numbers confirmed
Residential Admissions	LA figure	Difficult to disaggregate to CCG level
Other		

How will impact be measured and reported?
Re-ablement and Intermediate care bed availability – EMS **Reduction in Spot Purchases – CCG reporting** **Reduction in Assessments carried out in Hospital – CSU reporting**
Increase number of Step up admissions to unit – CERT data

Scheme 1 Community Hub

Barriers / Challenges to successful delivery	**Managed by….**
• Workforce – availability of suitable workforce • Contract variation with Acute provider - current provider of rehab ward	Various workforce strategies and links with Edge Hill/UCLAN Commissioning Intentions
Risks	Managed by…
• Timescales for developing site • Provider procurement timescales	

Scheme 1 Community Hub

	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.	
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…		

Scheme 2; Seven-day Integrated Discharge pilot

Issue to be addressed - DTOC

- CERT and Intermediate Care Social Care Team separate processes and working practices
- Cases allocated via central systems not local working
- Limited interaction between teams
- Delays transferring from intermediate and crisis care to long term packages affects whole system flow

Existing activity

- CERT and Intermediate care Social Care Team have regular meetings and MDTs
- One Health funded Social Worker joins CERT one day per week currently

Scheme 2; Seven-day Integrated Discharge pilot

Proposed new or additional activity (including quantity)

- Pilot integration of Social Care into Neighbourhood Community teams
- More sustainable funding – current team on short term funding
- Integrate with 'Building for the Future' vision of community services including SPA and Care Co-ordination
- Neighbourhood MDTs and Clinical Councils planned, need Social Care involvement
- Collective management of people in own home, keeping people independent
- Evaluation of new ways of working to show impact

Delivery timeline

- September onwards to ensure in time for winter
- Quick win – should be able to implement quickly

Scheme 2; Seven-day Integrated Discharge pilot

Costs

- Extend Employment of intermediate Care Social Care Team
  - 3xBand 6 staff from September
    - 2017/18 £66,763 for 7 months
- Evaluation of integrated working/new processes
  - Monitoring and evaluation approx. £5K
- Total for 2017/18 = £71,763
- Ongoing cost of workforce per annum £114,450
- Benefits
  - Evaluation to ensure cost effectiveness of new process
  - Reduction in DTOC
  - Integrated working

Scheme 2 Seven-day Integrated Discharge pilot

Planned impact	A reduction of?	Details
DTOC	6%	Reducing Intermediate Care Average LOS by 3 days would be equivalent of 5 extra beds.

How will impact be measured and reported?
More patients step down to re-ablement package – Trust data
Reduction of DTOC bed days due to awaiting re-ablement – Trust data

Scheme 2 Seven-day Integrated Discharge pilot

Barriers / Challenges to successful delivery	Managed by….
Fixed term posts – maximum 2 year Clarity of management and oversight	
Risks	Managed by…
Long term funding depended on outcomes	

Scheme 2 Seven-day Integrated Discharge pilot

	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.	x
4	Home first/discharge to assess.	
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)		
Other…		

Scheme 3; Home First Workforce Development

Issue to be addressed – DTOC/Home First

- Long waits for Community re-ablement and Falls services
- Health Therapy separate from Social Care Re-ablement
- Likely same patients on both waiting lists
- Development of Generic HCA Therapy and Nursing Assistant
- Joint Health and Social Care – training and rotation
- Support OTs /Nurses to deliver therapy plans and free up more skilled resources
- Provides Career progression and job opportunities for local enconomy
- Possible 2 year training posts linked to apprentice scheme
- Prevent re-admissions, support more patients to be supported at home
- Grow skills for future workforce & increase resilience

Existing activity

- New , therefore no current activity

Scheme 3; Home First Workforce Development

Proposed new or additional activity (including quantity)

- Training posts – 2 years Fixed
- 5/6 training posts – possibly as an apprentice scheme?
- Honorary contracts to allow rotation

Delivery timeline

- Training programme and rotation planning Summer 17
- New posts to commence September 2017

Scheme 3; Home First Workforce Development

Costs

- 5 potential Band 4 posts
  - 7 months from September £81,463
- On going cost 2018/19 per annum £139,650

Benefits

- Expected Increased re-ablement capacity and workforce
- Reduced long term packages/inappropriate packages
- Savings could be re-invested to deliver further training posts

Scheme 3; Home First Workforce Development

Planned impact	A reduction of?	Details
DTOC	2-5%	Increase re-ablement packages will increase flow Increase potential for Home First model
Residential Admissions	LA figure	Difficult to disaggregate to CCG level but would expect impact

How will impact be measured and reported?
Increased OT capacity – waiting list reductions
Increased number of people receiving re-ablement at home

Scheme 3; Home First Workforce Development

Barriers / Challenges to successful delivery	Managed by….
Management structure needs to be agreed Training programme needs to be planned	MOU CCG and LCC Links to UCLAN and Edge Hill
Risks	Managed by…
Interest in training posts may not be as much as expected	Link to Well Skelmersdale and Grow your own workstreams

Scheme 3; Home First Workforce Development

	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.	x
4	Home first/discharge to assess.	x
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		x
Operational plan (s)		
Other…		

Other Possible Schemes

- Workforce Development – Frail Elderly
  - Geriatrician led Training for GPs
  - Joint Care planning for complex patients
- Discharge App Development
  - One Acute Trust 2 systems – Southport and Formby CCG and Sefton LA vs West Lancashire CCG and LCC
  - Mobile App development
  - Simplify system for West Lancashire discharges