Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

Open Report on behalf of Glen Garrod, Executive Director Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**22 May 2019**
Subject:	**Winter Funding Update Report**

Summary:

The purpose of this report is to provide a summary to Members on Winter Funding for Adult Social Care Services to alleviate winter pressures on the NHS.

Actions Required:

Committee to note and consider the report.

1. Background

In October 2018 the Secretary of State for Health and Social Care announced £240m of additional funding for Councils to spend on Adult Social Care services to help Councils alleviate winter pressures on the NHS, getting patients home quicker and freeing up hospital beds across England. The government recognised the significant progress that Councils had already made in tackling delayed transfers of care (DTOC), achieving a 39% reduction in DTOC attributable to Adult Social Care since February 2017, as well as recognising the good relationships between colleagues across the Health and Social Care system which meant that local systems worked together towards common aims.

The expectation was that this money would be spent with a focus on further reducing DTOC, helping to reduce extended lengths of stay, improving weekend discharge arrangements so that patients are assessed and discharged earlier and speeding up the process of assessing and agreeing what Social Care is needed for patients in hospitals. The expectation was that health providers and local authorities would monitor improvements in these measures through local jointly agreed monitoring, comparing improvements in each of these areas of impact. The total additional funding awarded in total was £240 million divided between local authority areas in the UK. Lincolnshire County Council received £3,367,950 of this funding.

The key areas we focused on fell broadly into the following two categories:

Supporting Hospital Discharges with a focus on flow through the hospitals

- Ensuring we had enough capacity in a struggling Home Care sector to meet the demand.
- Ensuring we had alternative care pathways available for when home support was not available.
- Ensuring we had the resources available to assess people earlier to enable a discharge home when a person was ready to leave hospital.
- Ensuring that we could provide a service over 7 days for the completion of assessments, the procurement of care and any equipment a person may need to return home.

Admission Avoidance

- Providing support at the Emergency Departments across the hospital sites to support a person to be returned home.
- Investment in services that would reduce the number of service users who required hospital treatment and admission, for example, falls prevention.
- Development of digitalisation and technology to support people in their own home and to support care homes.
- To support care homes so that the people who live there remain doing so even at the end of their life, so they are not taken to a hospital where they are frightened but supported to live at the care home.

See Appendices for a full list of schemes supported.

This report is to provide an update of the schemes and the successes of these and learning which we will take forward for winter planning for 2019/2020, which has already commenced.

Summary of Individual Schemes

Winter Room Scheme

The purpose of this scheme was to provide funding and a process to approve low level spend on an ad-hoc basis to remove blocks to discharge. The money allocated to this scheme has not been fully utilised to date and will continue to support complex discharges over coming months.

Case study 1– Mrs A was unable to return home when she was medically fit as she was unable to access her bedroom upstairs. This scheme enabled the home to be made safe by providing downstairs living at home ready for discharge and avoiding a delay.

Step Up/Discharge to Assess (D2A) Residential Beds

The purpose of this scheme was to provide intensive reablement / D2A care beds on a block basis for six months. The scheme enabled a multi-agency, community response for people who had ongoing complex needs to be discharged from hospital.

Initially eight beds were procured and due to feedback and concern from NHS partners an additional four beds were commissioned to support acute flow. Whilst all of the money has been committed the usage of the beds has been less than expected. Based on usage eight beds will be extended until 14 May to support the Easter and May Bank Holiday period and the remaining four beds have been decommissioned

To date the scheme has provided 70 additional bed days within the acute trust delivering £28k in avoided acute costs. The D2A beds have also delivered improved outcomes for individuals.

Case Study 2 – Mr J was unable to be discharged from hospital when medically fit because of concerns raised with regards to the poor condition of the property, due to hoarding. Assessments and tasks completed while in D2A bed:

- *Deep clean of the property prior to returning home. (Environmental Health)*
- *Full Continuing Health Care assessment (CHC) with regards to eligibility for healthcare funding. Environmental Health were involved. Checklist completed and agreed Decision Support Tool (DST) required as potentially eligible for full funding from CHC.*
- *Safeguarding investigation – due to concerns raised with regards to partner.*
- *Occupational Therapy home assessment*

Mr J was admitted to D2A bed on 24.1.19 and discharged on 07.02.2019.

Case Study 3 – Mrs S was unable to be discharged home due to level of confusion and concerns regarding Mental Health. There were concerns that Mrs S may require a long term residential placement. During the stay in the D2A bed an assessment of night-time needs was established, assessments were completed by the Older Adult Mental Health Services and additional Social Care assessments undertaken with regards to longer term care needed. Mrs S was successfully discharged to her own home.

Mrs S was admitted to a D2A bed on 7.2.19 and discharged home 21.2.19 with Reablement support. Following this period of support longer term services were not required.

Case Study 4 – Mr T was assessed as not having capacity due to a lack of insight into care needs, but had expressed a strong wish to return to his own home. A further period of assessment, and possible best interest meeting, was required to assess long term care needs and establish if a return home was achievable. Adult Care assessed in D2A bed and determined that Mr T needs could be supported in his own home, and he was successfully discharged home with a package of Home Support.

Mr T was admitted to D2A bed 20.2.19 and discharged home on the 3.3.19.

The purpose of this scheme was to test the model of an integrated out of hours co-located offer for CAS to support admission avoidance and discharge through winter. Social work posts to support this went out to advert twice. Unfortunately due to the temporary short term nature of these posts there has been little to no interest. However, as this money is committed to staffing the programme we will be utilising the underspend to advertise these for a 12 month period.

Homecare Trusted Assessors (Domiciliary)

The care home trusted assessor model is already well embedded in Lincolnshire. This scheme was to roll out a proof of concept for domiciliary care mirroring the programme we have in situ for care homes.

All monies have been committed and staff are in place across the acute sector.

Case Study 5 – Mrs B was initially deemed to require a homecare package of 2 carers, 4 times a day. The assessor observed Mrs B walk independently and get in and out of bed independently. The assessment was revised to require only one carer and enabled a timely discharge from hospital.

Extend Hospital Avoidance Response Team (HART) provision from 72 hours to 5 days

The funding was passed to Lincolnshire Community Health Services NHS Trust (LCHS) as the lead commissioners for this service to bolster and improve available capacity. HART were commissioned to increase their capacity by 25% initially and then to 50% by the end of winter.

Between January and March 2019 the HART service has accepted on average 164 cases per month, saving the NHS £54,000 in admission avoidance and £88,800 in hospital discharges (hospital discharge savings have been based on each case being open for 3 days). Case studies are available in Appendix A.

Homecare Restart Extension.

The purpose of this scheme was to enable home care providers to keep complex packages of care open following hospital admission. This would ensure that large packages of support, where a short hospital stay was expected, would remain open from the contracted 48 hours to a maximum of seven days. Where this was applicable it enabled people to return home quickly with a restart of the existing package of support rather than having to commission a new one.

98% of cases restarted within 0-1 day of request received by brokerage. As a result 1100 additional hours of homecare were delivered by the Council. It is estimated that this reduced the length of stay in hospital by two days per client at a saving of £72k to the acute sector.

Winter Induction Bursary plus 6 month bonus/DBS

The purpose of this scheme was to support and develop additional market capacity. The scheme was developed in conjunction with LinCA to maximise the number of new employees to the Care Sector.

Providers were able to access an induction bursary for new starters, new to the care sector, for a maximum of five employees per month over the winter period. Eligible employees would be guaranteed 25 hours full pay in the first two weeks of employment and a £250 bonus if they remain employed after 6 months.

The funding for this scheme is fully committed. All providers have recruited the maximum number of staff to be eligible for the initial payment. The end date for the bursary is six months and therefore the numbers of new starters will not be fully available until later in the year.

The waiting list for homecare across the county has reduced by 37% over the winter period. This is currently estimated to have provided an additional 1500 hours homecare per week and can be confirmed once the six month period is finished.

Investment in Technology

The purpose of this scheme was to invest in technology to support discharge and avoid admissions to hospital

£15k has been committed to LCHS to support Home First principles via enabling video conferencing to avoid admissions. Lincolnshire County Council has supported 62 care homes to meet the NHS Digital Toolkit standards and apply for access to NHS mail. From the 1 April it became possible to bid for additional funds from NHS Digital to support technology in social care. Lincolnshire County Council will be bidding to continue the roll out of the toolkit to all providers in Lincolnshire. The remaining funds will be used to match fund the bid to continue the roll out and support implementation of digital technology for monitoring residents across care homes.

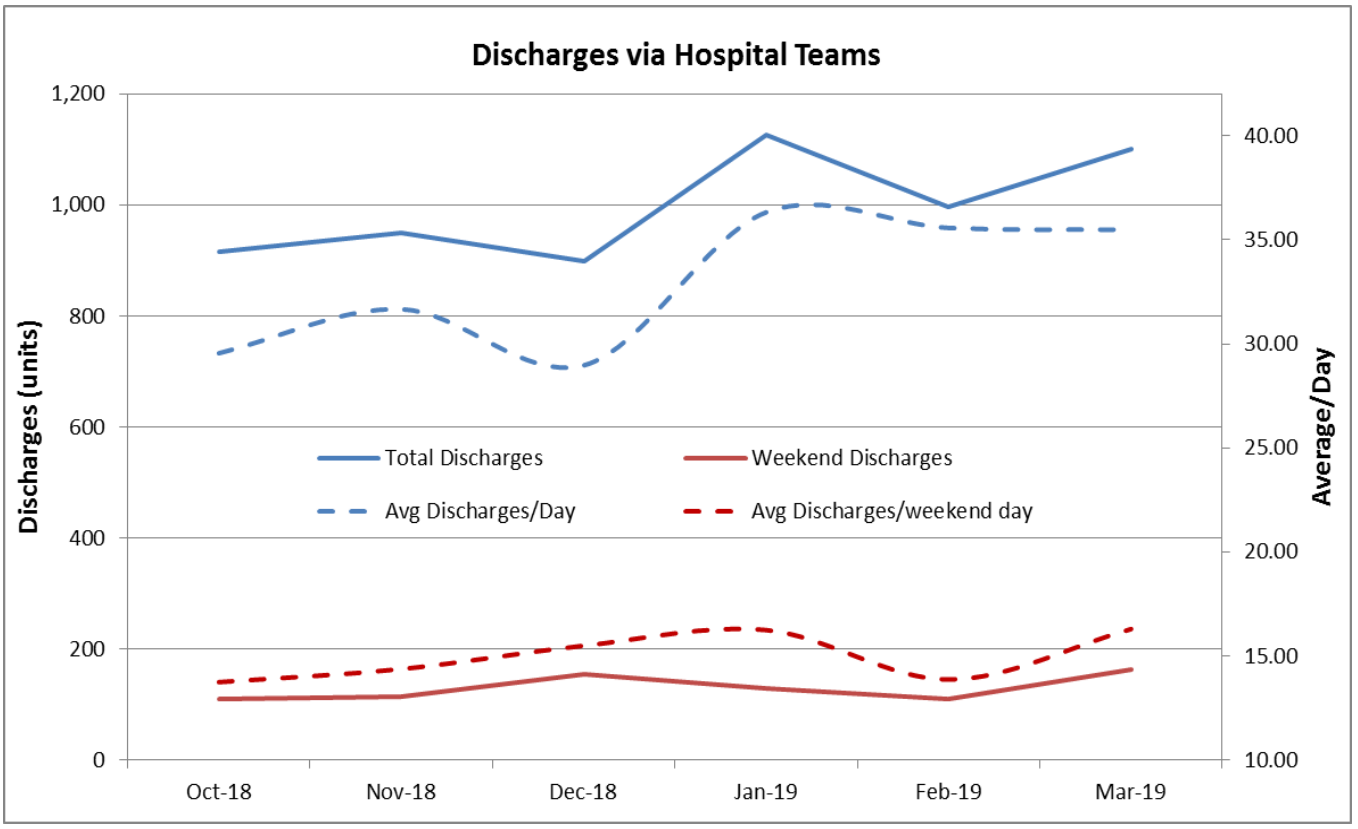
Assessment Staffing for Hospital Teams/ Housing Link Worker

The purpose of this scheme was to minimise delays in discharges and implement good practice on discharge and discharge planning.

- Assessment Staffing for Hospital Teams

The additional agency staff undertook 244 episodes of work to facilitate 97 people to be discharged. The table and chart below show increased discharges completed via hospital teams over the winter period.

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Total Discharges	916	950	898	1,126	996	1,100	5,986
Avg Discharges/Day	29.55	31.67	28.97	36.32	35.57	35.48	32.89
Weekend Discharges	110	115	155	130	111	163	784
Avg Discharges/weekend day	13.75	14.38	15.50	16.25	13.88	16.30	15.08



Data based on Hospital Case Monitoring Forms, where confirmed discharged date entered.

Housing link worker for 12 months

This post will support patients in Lincoln County Hospital whose housing needs could cause a DTOC. The increase in this resource was to mirror the scheme already in place at Boston Pilgrim Hospital. The post holder will be employed by East Lindsey District Council as part of their housing support offer. Recruitment to this post was delayed due to the timing of the funding announcement and the needs for the District Council to seek the necessary agreement to host the role. The role was offered as a secondment, but was not appointed to and is in the process of being advertised externally. The plan is for them to be in post in the summer and be fully operational for the winter of 2019/2020.

Equipment ICES over 7 Days

This scheme was to enable equipment to be delivered seven days a week. All money has been committed to enable NRS (the provider for Lincolnshire Community Equipment Services) to open seven days a week to allow NHS therapists to order equipment over the weekend. Although this service was available no requests were made for deliveries on Sundays. The following have been identified as the most commonly identified barriers to discharging patients at the weekend:

- Decreased levels of staffing in hospitals over the weekend. Reduced provision at weekends naturally inhibit the ability of any of these services to care for patients during that time; whether to assess a new admission and implement a management plan, or to facilitate discharge for a patient who is otherwise ready to leave the hospital.

- Inadequate community support including General Practitioners, Community Nursing Teams, care packages, Multi-Disciplinary Teams and equipment provision.

(See Appendix D for additional information)

Prevention of Nursing De-registration

The purpose of this scheme was to maintain capacity and availability in nursing placements over the winter period. The funds were transferred to the CCGs as the responsible commissioners for nursing care.

No nursing homes have been deregistered over the winter period.

End of Life Care

The purpose of this scheme was to ensure that the end of life pathway was improved both in and out of hospital, with nurses acting as community / acute liaison, and support hospital and community staff to facilitate and promote end of

life pathways. The nurse would also support advanced planning and support to enable people to remain in preferred place of death.

The money for this scheme is fully committed to St Barnabas. Although recruitment was initially hoped to coincide with the recruitment of Admiral Nurses, this did not prove successful. We have extended this scheme to 2021, as it is felt that a longer term employment opportunity will attract nurses into the post. Work is currently underway with St Barnabas and the hospital social work teams to map out how we will work together for this project to be successful. (Please see Appendix B for details of the scheme.)

Lincolnshire Partnership NHS Foundation Trust

This additional funding was put in place to ensure continued performance of the Lincolnshire Partnership NHS Foundation Trust (LPFT) DTOC, and to ensure flow through the in-patient units supporting a timely discharge. DTOC attributable to LPFT has remained consistently low over the winter.

LPFT Delayed Transfers of Care

	Social Care	*Both*
Oct-18	*0*	*53*
Nov-18	*0*	*5*
Dec-18	*0*	*28*
Jan-18	*0*	*31*
Feb-18	*0*	*28*

Wellbeing Increased Capacity

This scheme was to increase the capacity of the Wellbeing Service over the winter period. The aim of the Wellbeing Service is to promote independence and support people to remain living independently in their own home.

The winter monies delivered additional assessment capacity.

Measure	*Quarter 1*			*Quarter 2*			*Quarter 3*			*Quarter 4*		
	Apr-18	***May-18***	***Jun-18***	***Jul-18***	***Aug-18***	***Sep-18***	***Oct-18***	***Nov-18***	***Dec-18***	***Jan-19***	***Feb-19***	***Mar-19***
Total number of Trusted Assessments	*344*	*387*	*339*	*393*	*337*	*291*	*496*	*497*	*376*	*597*	*491*	*329*

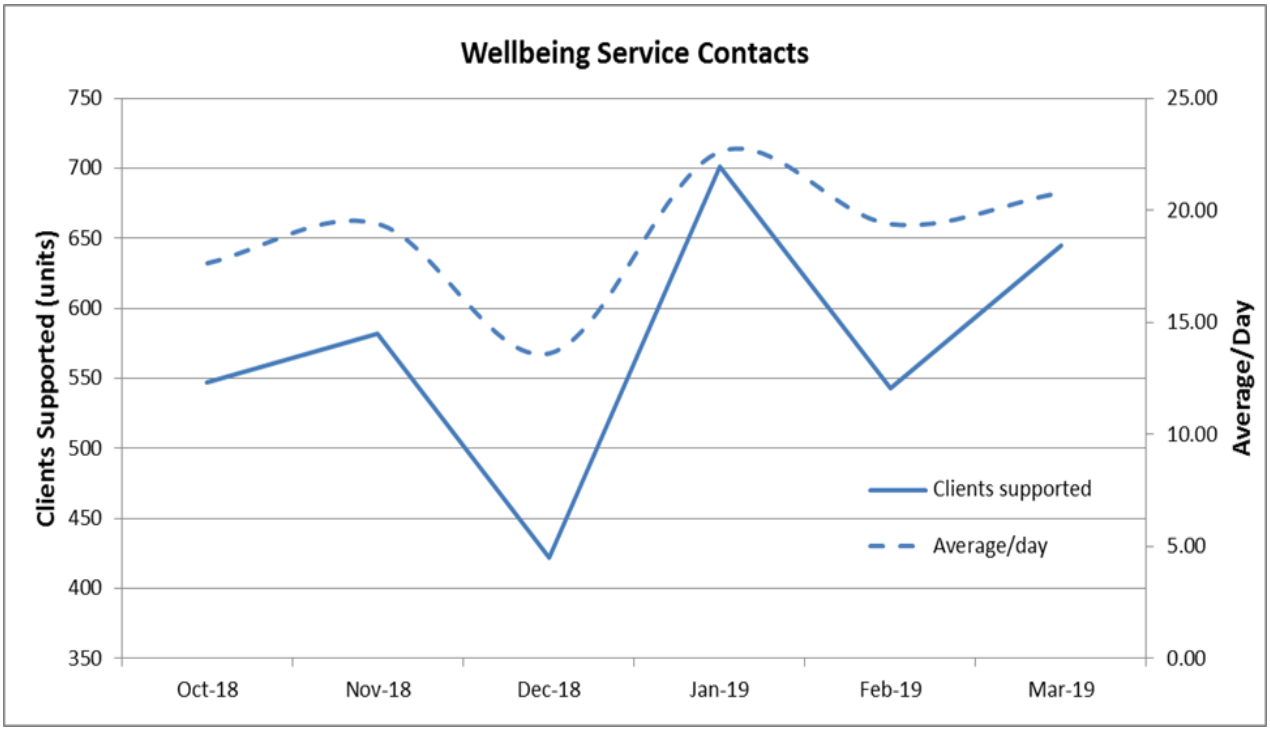
Work has already begun with the Wellbeing Service to determine how the service can support winter pressures for the forthcoming winter. Initial suggestions are for an urgent next day assessment to support DTOC and falls patients, and additional capacity being added to the urgent equipment provision part of the service.

Outcomes of the Wellbeing Service:

- 98% of customers beginning support within 10 days of assessment.
- 96% of customers have been successfully supported to achieve an overall improvement in their outcomes.
- 77% of all call outs in 2018-19 have been to support customers following a non-injury fall or to attend to a no-response activation of a telecare alarm.
- Non-injury falls accounted for 45% of all responses and are consistently the highest reason for dispatching a responder each month.
- To date responders have supported customers on over 330 occasions following a non-injury fall at home.
- Responders have also supported customers on over 60 occasions whilst awaiting an ambulance attendance providing updates on customer's condition and offering reassurance.

Case Study 6 - In January 2019 the Wellbeing Hub received a Wellbeing referral for Mr Y who needed help and support to deal with his current situation at home. The referral stated in the referral document that the gentleman was increasingly stressed by his situation and he had expressed thoughts of suicide.

During a telephone call with Mr Y he disclosed that his daughter had died on the 9th December 2018 following a RTI and throughout the conversation Mr Y was increasingly distressed. After completing the triage questions and talking to Mr Y for approximately 40 – 45 minutes, the Wellbeing Officer was concerned about his welfare. The Wellbeing Officer requested a welfare check by the Police. The Police later confirmed that Mr Y had made an attempt on his life but was found and sent to hospital via ambulance and was being assessed by Mental Health professionals.



Data based on the number of Wellbeing contacts made; Clients supported/opened (or other similar).

Falls Prevention/ Co-responders Scheme

This scheme supported the introduction of falls advisory service in residential homes and additional investments for "LIVES" service to attend falls within 45 minutes of a call.

The overall aims of the project are to:

1. Reduce the length of time people are on the floor following a fall (typically this can be up to 4 hours normally and the longer someone is on the floor the worse their outcomes are likely to be); and

2. Reduce the numbers of people conveyed to hospital following a fall (through referring them into community based services that can help keep them safe and well at home).

The project is delivered through a partnership of core organisations including East Midlands Ambulance Service, LIVES, Lincolnshire County Council, Lincolnshire Community Health Services and Wellbeing Lincs. Between 19 December 2018 and as of 17 March 2019 the project has:

- supported 164 people who have experienced a fall.
- 73% of these were successfully discharged at the scene and not conveyed to hospital (this is compared to a baseline of approx. 50% conveyance rate).
- dispatched LIVES to attend a fall within 45 minutes in approximately 70% of cases.

Case Study 7 – Mrs T sustained a head injury following a fall and was attended to by the LIVES service. The LIVES responder noticed that Mrs T's walking frame was not suitable and as a result she has been measured for and received a new frame. Mrs T was also referred to an Occupational Therapist to assess her needs. Mrs T passed on her thanks for the prompt help and her appreciation of everything the project has done for her.

Quote from feedback provided via LIVES website:

LIVES attended today for my Mother who had had a fall. What a fantastic service they provide. They are such a caring, efficient and supportive incident response team. They were extremely thorough, empathetic and they took time with my Mother and explained every step of her care. We are so very lucky to have this service in our area. Simon and Debbie provided incredible care today. Thank you. Please can you make sure this is passed on in recognition to both Simon and Debbie so they are aware of the great work they are doing.

£300k has been committed to falls prevention and the co-responders scheme via LIVES over the winter period. The remaining £100k will be used to extend the existing LIVES scheme to allow for a full evaluation of impact to be completed by Lincoln University.

2. Conclusion

The schemes on the whole have been successful and supported the system through the winter with additional services to support timely discharge and reduce non-elective admissions. Some of the schemes that did not start or started very late were due to the lateness of the notification of the additional funding award. Lincolnshire County Council has been informed that the same level of additional funding has been awarded for 2019/20, which will enable us to ensure all of the additional winter pressure schemes are fully operational ready for winter. Lincolnshire County Council will work with the support of our system partners to ensure this funding supports the people of Lincolnshire going forward.

3. Consultation

a) Have Risks and Impact Analysis been carried out??

No

b) Risks and Impact Analysis

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Hospital Avoidance Response Team Increased Capacity Report November 2018 - March 2019
Appendix B	St Barnabas Hospice Anticipatory Care Nurses - Business Case
Appendix C	Falls Response Partnership - Progress Report 16.4.2019
Appendix D	NRS Seven Day Opening for Winter Discharge of Care 2.4.2019

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Tracy Perrett, who can be contacted on 01522 554375 or tracy.perrett@lincolnshire.gov.uk.

APPENDIX A

Reporting Month: November 2018 to March 2019

Hospital Avoidance Response Team Increased Capacity Report

Wendy Humphreys
FOR AGE UK LINCOLN & SOUTH LINCOLNSHIRE ON BEHALF OF THE LILP CONSORTIUM

Contents

1. Key Performance Indicators

In November 2018, the team were asked to increase capacity from 130 acceptances per month to 150. Following notification of additional funding, in order to increase capacity, we recruited the following additional staff;

- Temporary Recruitment Officer in our HR department to deal with increased recruitment activity
- Temporary Call Handler to free up capacity of Team Leaders to deliver care and support
- Temporary Responders within the HART Team to meet increased capacity

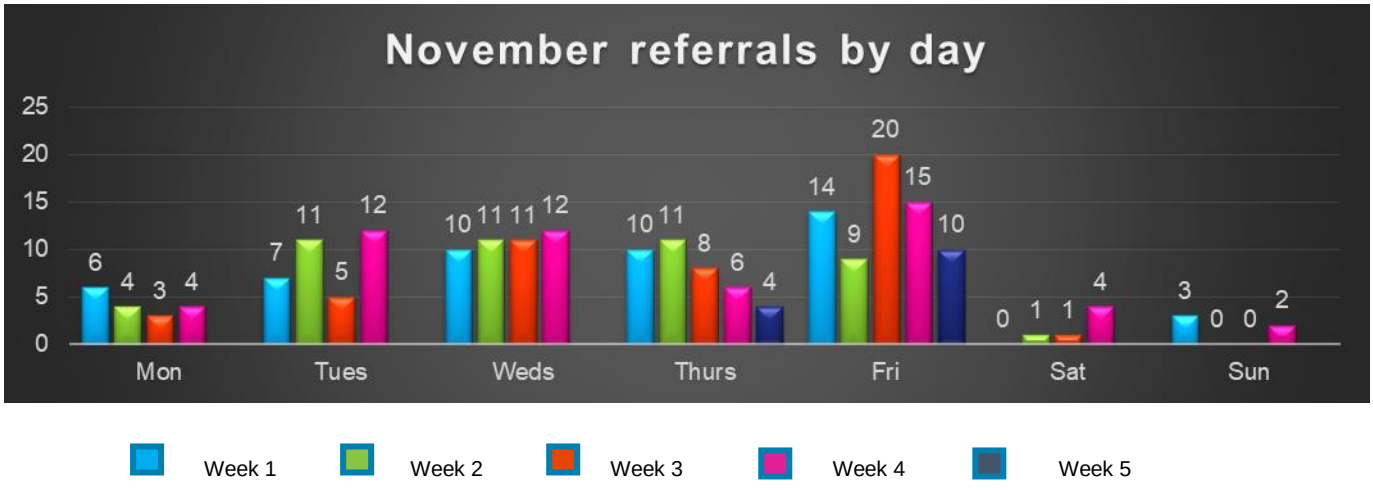
Recruitment takes up to 8 weeks. Following this, it is approximately 6-8 weeks before Responders can lone work. This enables us to have received a clear DBS and for the staff member to have undertaken the Care Certificate training, if required, along with any other mandatory training we provide.

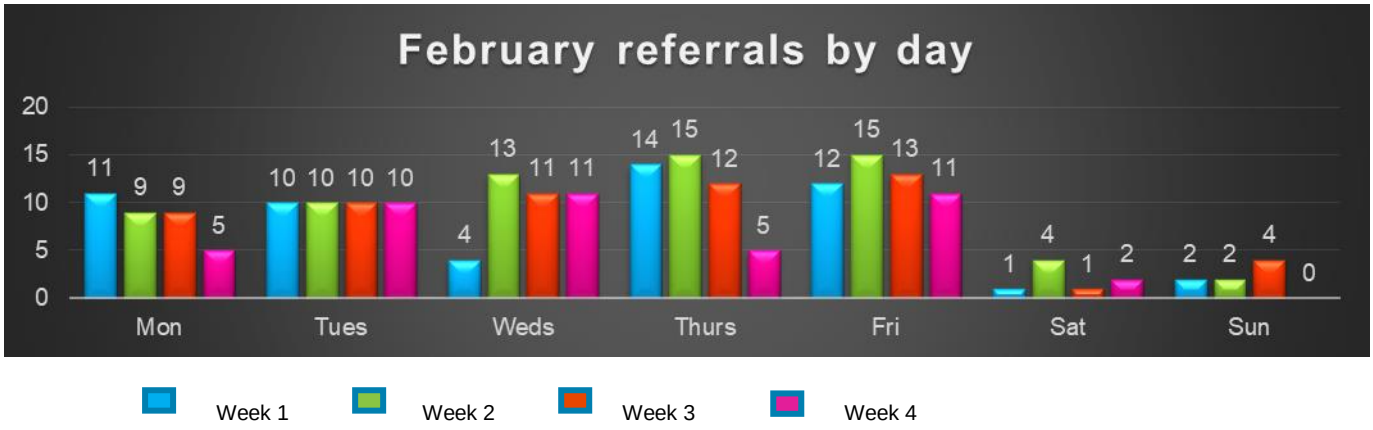
In the interim, whilst recruiting and training, we offered overtime at higher hourly rates of pay to existing staff, which resulted in immediate additional capacity and demonstrated the flexibility of the service to be reactive to increased demand.

Historically, there has been an influx of referrals towards the end of the week, with very few during weekends and the early part of the week.

Over more recent months, referrals have become more evenly spread throughout the week, allowing us to accept more and balance our capacity. The charts below demonstrates the change in referrals.

Weekend referrals remain low.





Number of HART referrals

Figures below show the number of referrals, acceptances and rejections.

	Actual Referrals	Total Acceptances	Rejections	Acceptance %	2017/2018 Comparison	
					Referrals	Acceptances
Nov 2018	**239**	**150**	**89**	**63%**	**127**	**106**
Dec 2018	**185**	**125**	**60**	**67%**	**129**	**109**
Jan 2019	**245**	**164**	**81**	**67%**	**180**	**127**
Feb 2019	**245**	**163**	**82**	**67%**	**156**	**116**
Mar 2019	**246**	**164**	**82**	**67%**	**182**	**126**
Years Total	**2454**	**1661**	**793**	**68%**	**1648**	**1260**

Our performance has achieved target number of referrals with the exception of December. This was due to the low number of referrals received – acceptance percentage of referrals was 67%, which was 3% higher than the previous month.

Reasons for Referral Rejections

	Actual Rejections November 2018	Rejections as a % of all referrals (239)	Actual Rejections December 2018	Rejections as a % of all referrals (185)	Actual Rejections January 2019	Rejections as a % of all referrals (245)	Actual Rejections February 2019	Rejections as a % of all referrals (245)	Actual Rejections March 2019	Rejections as a % of all referrals (246)	Actual Rejections Service Total	Service Total Rejections as a % of all referrals (2454)
No Capacity in the Area	70	29%	53	29%	68	28%	68	28%	69	28%	671	27%
No - Inappropriate	2	0.5%	1	0.5%	0	0%	0	0%	2	1%	15	0.5%
No - V2 Capacity	17	7%	6	3%	13	5%	14	6%	11	4%	107	4%
Yes but unable to make contact with referrer to confirm	2	0.5%	1	0.5%	2	1%	1	0.5%	1	0.5%	7	0.5%

A total of 401 referrals which were declined between November 2018 and March 2019.

328 of these referrals were declined, due to a lack of capacity in the area and 61 declined due to requests or for two person visits. Lack of capacity occurs when there is an influx of referrals, with support required on the same day as the referral is received. By the time the referral is received, staffing has already been organised. The solution to this would be to overstaff each day in order to allow for last minute referrals.

There is also a large proportion of instances where the referral is cancelled by the referrer at short notice. This has an impact on capacity as the calls have already been allocated at this stage. Only 5 of the referrals were classed as inappropriate and were declined for that reason.

Admission Avoidance

	Actual Acceptances	Percentage of Acceptances
November 2018 (150)	39	26%
December 2018 (125)	43	34%
January 2019 (164)	51	31%
February 2019 (160)	36	22%
March 2019 (164)	41	25%
Total YTD (1661) from April 2018	373	22%

Between November 2018 and March 2019, we have accepted a total of 210 admission avoidance referrals from GP's, clinicians in the community, Accident & Emergency departments or assessment wards. Whilst this makes up a 22% percentage of overall acceptances for the HART service, we continue to work on increasing this referral area by engaging more closely with neighbourhood teams.

Supported Discharge from Hospital

	Actual Acceptances	Percentage of Acceptances
November 2018 (150)	111	74%
December 2018 (125)	82	66%
January 2019 (164)	113	69%
February 2019 (160)	124	78%
March 2019 (164)	123	75%
Total YTD (1661) from April 2018	1288	78%

During this period, the HART service accepted 553 referrals for support so that people could be discharged from hospital. At present, the majority of referrals are received for this purpose with many hospital ward staff referring into the service to enable a safe discharge with onward support for the individual.

2. Funders Return on Investment

Bed Day Savings

On hospital discharge alone, based on an average of 3 days per case, a saving of **3,864** bed days has been made.

Admission Avoidance cannot be calculated in the same way but if we were to apply the same reasoning and an average of 3 days per case, a saving of **1,119** bed days has been made during the year.

Financial Savings

A £540,200 saving was made over the year by the service supporting clients to bridge the gap between hospital discharge and their package of care starting. We can prove this saving because without our support in place they would have not been discharged from hospital.

The service has also saved the NHS £44,100 through supporting customers to build their confidence leading to an independent pathway, however the person may have been discharged without our support. This is extra added value that the service brings to the NHS.

Savings based on calculations of £2,000 per Admission Avoidance and £400 per day of Hospital Discharge.

Service Cost April 2018 – March 2019	£480,000
Extra Funding for Winter Pressures November 2018 – March 2019	£50,000
Year proven savings to NHS	£1,048,200
Year unproven savings to NHS	£44,100
Return on investment	£562,300

The below table demonstrates the return on investment of the additional pressures funding. During the period of increased capacity, between November 2018 and March 2019, we accepted 121 additional referrals.

Month	Additional Referrals	% Admission Avoidance	Admission Avoidance	% Hospital Discharge	Hospital Discharge	Savings - Admission Avoidance	Savings – Hospital Discharge	Total
November 2018	20	26%	5	74%	15	£10,000	£18,000	
December 2018	0	34%	0	66%	0	0	0	
January 2019	34	31%	11	69%	23	£22,000	£27,600	
February 2019	33	22%	7	78%	26	£14,000	£31,200	
March 2019	34	25%	9	75%	25	£18,000	£30,000	
Total	**121**					**£64,000**	**£106,800**	**£170,800**

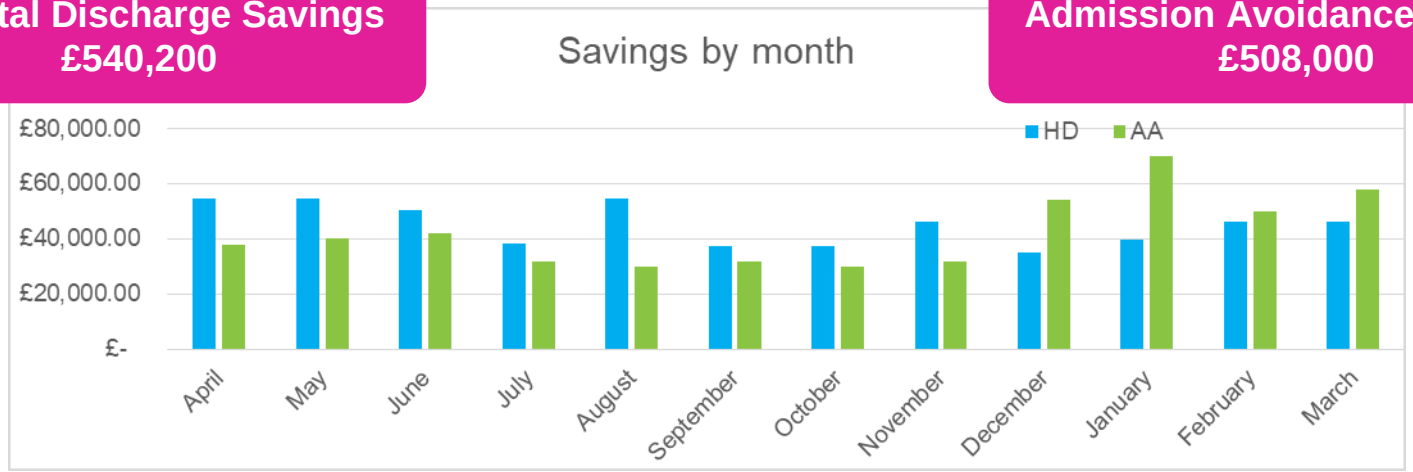
We have calculated this on the percentage split for each month.
Hospital discharge savings have been based on each case being open for an average of 3 days.
Based on the above calculation, there is a net return on investment of £120,800 in relation to the additional funding for winter pressures.

Hospital Discharge Bed Day Savings 3,864

Admission Avoidance Bed Day Savings 1,119

Hospital Discharge Savings £540,200

Admission Avoidance Savings £508,000



3.Case Study

Case Study 1

We were contacted by a GP from Market Rasen Surgery, requesting support for a lady who was recovering from shingles, to avoid hospital admission. The lady was an unpaid carer for her husband who is living with dementia.

The GP advised that the lady was weak and unsteady on her feet and her medication was 'in a mess'. The GP had arranged for the community nurse to attend to organise the medication so that we could support with prompting or administering if necessary.

We supported the lady over a period of 3 days, during which time the team made notes and provided thorough handovers, they liaised closely with other visiting professional such as the GP, as well as obtaining advice during visits from team leaders, and raising any concerns.

On the third day, the Responder in attendance having read the notes from the previous two days, and assessing the lady on arrival at the property, noticed a decline in her condition from the previous day. The lady was refusing food and drink, had become increasingly weak and was complaining of stomach pain.

Our team contacted the GP and highlighted their concerns. The GP arranged to visit that day and the Responder remained at the property until the visit had taken place, to ensure the safety of the lady and her husband.

On re-assessing the lady, the GP agreed that there had been a decline in her condition and stated that he would be organising a non-emergency ambulance to admit her to hospital. The staff member in attendance raised concerns about the husband being left home alone and respite care was arranged for him.

The Responder was at the lady's property for 4 hours ensuring that she received the support she needed. Telecare was left in place whilst the lady was awaiting the ambulance so that she could call for help if needed.

Support Provided

- Planned visits providing care and support
- Additional unscheduled visits
- Medication support
- Encouragement to eat and drink
- Monitoring of deterioration
- Liaising with GP to highlight concerns
- Support whilst waiting for GP
- Telecare equipment installed
- Alerting the GP that husband would need support if his wife was admitted to hospital

This is an example of well supported admission avoidance. Everything was put in place by the GP to use hospital admission as a last resort. Due to their extensive training, staff were

able to support, observe and highlight deterioration and escalate where necessary, on this occasion to the GP.

Case Study 2

A referral was received from Lincoln County Hospital for a gentleman who was being discharged. He had some severe respiratory problems and had a domiciliary care package due to commence the following day. Support from the team was required for that evening and the following morning.

Whilst agreeing a care plan with the gentleman, he told the Responder that his radiators were cold. Upon checking, the Responder found that there was no power to the control box. The Responder checked the fuse box and there seemed to be no problems. The gentleman advised that his neighbour was aware of how the heating system worked and asked the Responder to go and ask him to help.

The Responder remained at the property, getting the gentleman something to eat and drink, whilst the neighbour had a look at the heating.

Unfortunately they were unable to get the system working and the Responder offered to call British Gas to get some help. The gentleman and neighbour advised that they knew a plumber and would contact them.

The Responder arranged an unscheduled call later on that evening to check the gentleman was comfortable and to assist him with getting ready for bed.

Upon arrival for the second call of the evening, the neighbour was still there and had provided a heater, which was set up to make sure that the room was warm. The Responder also offered Telecare, which the gentleman accepted. This was installed the following morning, at his request.

The gentleman was also informed of the funding available for support around the home via the Winter Pressures fund and agreed to some support with his cleaning and shopping.

A plumber attended the following day to resolve the issue with the heating.

Support Provided

- Planned visits providing care and support
- Additional unscheduled visits
- Reactive support provided in relation to the heating
- Preparing food and drink
- Telecare installation
- Referral to Help in the Home funded support
- Liaising with the neighbour according to the client's request

This case demonstrates the commitment of the team to ensure individuals are safe and comfortable in their homes, including putting in additional calls and support, or referring on to additional services, if required. An holistic approach is taken, and support is tailored to the individual circumstances.

Case Study 3

During a visit to a gentleman, the team noticed that he was particularly distressed and seemed to be having difficulty in managing his home. Upon discussion, we found that he was previously provided with the support of a carer full time, which was funded by Adult Social Care. The care service had been withdrawn due to a breakdown in relationship with the carer and he was now not in receipt of any support from carers.

The gentleman disclosed that he had not been eating very much as he was unable to prepare food. He also said that he was unable to clean up and had no clean pots to use. The Responder noticed that the gentleman appeared to be feeling itchy and asked about this and was told that he was covered in bites and he thought it may be because his bed covers hadn't been changed in some time.

The Responder asked the gentleman for his consent to contact other professionals to obtain some more intensive support for him and he confirmed that he would like us to do this.

The Responder fed back to the Team Leader at the office, who organised the following;

Support Provided

- Two Responders attended the property to prepare some food, wash the pots and change the bedding. They also had a general tidy up and moved the food to the front of the freezer so that the gentleman could reach it. One load of washing was completed
- Contact was made with the Complex Care Team who arranged to visit the next day to organise medication and assess for support needed
- Advice was given to contact GP in relation to the itching skin and possible bites
- Referral made to Help in the Home funded support

The HART Team supported this gentleman in order to avoid a potential hospital admission. He was close to the point of crisis and had it not been for our intervention, he would have at risk of falls, infection and becoming undernourished.

APPENDIX B

ST BARNABAS HOSPICE

ANTICIPATORY CARE NURSE

1. DESCRIPTION

Background

Palliative Care is now recognised as an enabler to facilitate high quality person centred care for people with complex needs (1, 2). Early access to palliative/supportive care promotes resilience, self-management and reduces unnecessary admissions to hospital (3) The Ambitions Document (2016) sets out very clearly a national frame work for local action. Indeed, locally in Lincolnshire, commissioners are keen to bench mark current services against these ambitions and influence future developments.

There is a requirement to develop a proactive palliative care approach which would be embedded as part of the Social Services Team within the acute multi-disciplinary team (MDT) to support front door services such as:

- Accident and Emergency
- Medical admissions Unit
- Surgical admissions Unit
- Frailty Unit

The innovation would also provide patient follow up onto the wards and subsequent case management as current practice is dependent on referrals from clinicians to the Specialist Palliative Care Team within ULHT – often leading to the late identification of need, subsequently resulting in the burden of non-beneficial interventions for the patient (1,2), and a limited window of opportunity to support the person and their family to achieve their preferred place of care/preferred place of death. There is evidence that this way of working reduces average length of stay by up to 8.4 days, due to earlier identification. While also reducing future unnecessary admissions to hospital through improved integrated working.

Demographics

- Lincolnshire has one of the most aged populations in England (5)
- 10% of the population in Lincolnshire is over the age of 75 (National Average 7.8%) (5)
- Number of people over the age of 75 is set to double over the next 30 years, Lincolnshire wide (5).
- High levels of deprivation is linked to the development of frailty 10 years earlier than the general population (Oliver et al 2014) and is evidenced in the high levels of admission rates of people under the age of 75 from the East Coast.
- Currently almost half of all deaths occur in hospital in Lincolnshire (5)
- At any one time 30% of hospital beds, nationally are occupied by someone in the last year of their life (2)
- Most deaths occur following a period of chronic illness (2)
- Many people will people will require to spend a proportion of their last months, weeks and days in hospital (2)
- 71 % of acute hospital costs are accrued in the last year of life (6)

Scoping work completed by the St Barnabas Hospice Matron for Palliative and End of Life Care in 2017 within ULHT, reflected national findings that there is lack of identification of people on or during acute admission who would benefit from generalist palliative/anticipatory care resulting in:

- Increased likelihood of inappropriate admissions.
- Increased likelihood of preferred place of care/Death not being achieved.
- Increased likelihood of delayed discharge to preferred place of care/death.

Through proactive working it was identified that 80-90% of the people being admitted to the MEAU acute trust wide has severe frailty and would have been eligible for palliative/ supportive care. That is not to say their admissions were not appropriate due to the acute presenting event, however, identification of palliative/supportive care need on previous admission may have negated the need for subsequent presentation to hospital as an acute event would have been assessed in the context of their chronic condition (7,8,9,10) The literature advises that with appropriate case management 20- 30% of unnecessary admissions could be avoided (7,8,9,10) – this concurs with the observations made: had presenting patients plans of care, prior to admission been optimised.

2. IMPACT (Tick those that apply)

Clinical	√	**Financial**	√	**Risk Management**	√	**IT**	

Describe Impact/Benefit

Benefits: For the people in our care

- Support earlier identification of person centred palliative care needs based on the four pillars of well-being.
- Collaboration with the Adult Social Care Social Service Team and St Barnabas Hospice will enable cross pollination of skills and knowledge resulting improved outcomes for the people we care for.
- Facilitate improved communication with the Adult Social Care Brokerage team brokerage to optimise use community care resource to facilitate preferred place of care/death.
- Opportunity to upskill social care and acute care clinicians regarding the importance of a timely psycho- social approach to palliative care to reduce avoidable admissions to hospital and facilitate person centred outcomes.
- Improve confidence and practice of social care team to recognise people with palliative care needs.
- Enable the people in our care to have access to best practice and high level of skill and competence.
- Enable staff in care and nursing homes to have their learning and support needs regarding caring for people with palliative and end of life care needs to be identified, to ensure ongoing support from St Barnabas Hospice and other community services to achieve person centred outcomes.
- Facilitation of direct communication with Neighbourhood Working, for people with complex needs in order to optimise opportunities for them to achieve their preferred place of care and death.
- Access to SystmOne documentation and communication to enable the people we care for to have their plans of care relayed to Community MDT in a timely manner.
- Enable people from hard to reach groups to access palliative care services: People in nursing residential and care; people the mental illness; people with learning disabilities; people from lesbian, gay, bisexual and transgender community; people from traveller community and people from black and ethnic minority groups.

Benefits continued :

- Increase in number of referrals through the Palliative Care Coordination Centre from across ULHT, reduces workload of the acute trust and promotes seamless care.
- Increase in the numbers of people accessing timely palliative and end of life care.
- Increase in number of carer assessments completed through working in collaboration with Carers First.
- Reduction in average length of stay acute trust.
- Increase in the numbers of people who achieve their preferred place of care.
- Increase in the numbers of people who achieve their preferred place of death.
- Increase in the numbers of people who have their advance care plan recorded within an EPaCCs template.
- Decrease in the numbers of people who experience a non-beneficial admission to hospital.

The project is anticipated to support:

- Up to an average 8.4 day reduction in length of stay in hospital
- Earlier identification of people with severe frailty entering their final stage of life, enabling earlier initiation of appropriate care planning.
- Person centred care planning that promotes quality of life.
- Improved support for people to develop Advance Care Plans based on their preferences.
- Improved support for carers and family.
- 20 - 30 % reduction in inappropriate admissions associated with appropriate care planning (ACP, DNACPR, EPaCCS Care plan)
- Improved access to palliative care for people in care and nursing homes.
- Communication with GPs advising that patient should be registered on their palliative care register.

Key Performance Indicators

KPI	Anticipated Data Source	Anticipated Baseline	Anticipated Outcomes
30% reduction in length of hospital stay	ULHT admissions/discharge data	12.2 days Average Geriatric Medicine 13.48 days	8.54 days 9.436
30% reduction in readmission rates post Advanced Care Planning and establishment and discharge to preferred place of care	ULHT emergency admissions data	Scoping required	
30% Increase in the numbers of people referred to the PCCC from Social Services Team based within ULHT	PCCC Referral Data		

Project Risks

Short term

Inability to recruit short term contract

Impact might not be as anticipated due to lack of capacity in community services.

Lack of willingness of acute staff to engage, (no current evidence of this)

Lack of uplift in roles to cover AL/training

Medium Term

Community Services do not have the skills, knowledge or resources to respond increased identification of need.

Long Term

Increase of 33% of people over the age 85 by 2024 – Any reduction in admissions to acute care absorbed by on-going increased demand on service

APPENDIX C

Report To: **Lincolnshire Urgent and Emergency Response Board**

Subject: **Falls Response Partnership – Progress Report**

Date: **16 April 2019**

From: **David Stacey, Lincolnshire County Council**
Ross Noble, East Midlands Ambulance Service
Nikki Silver, LIVES

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1. Purpose

This report provides an update to the Lincolnshire Urgent and Emergency Response Board on progress made with regards to the Falls Response Partnership project. Information is provided up to 11 March 2019.

2. Background Information

Falls constitute a large proportion of ambulance attendances with delays in attendance leading to worsening of patients conditions, a high rate (estimated to be approx. 50%) of transportation to hospital and a considerable risk of further falls, all of which adds to current pressures on emergency, acute hospital and social care.

Lincolnshire County Council has taken the decision to invest £300k in 2018/19 and 2019/20 to develop a Falls Response project for the county. At a recent meeting of Adult Care and Community Wellbeing Executive Directorate Management Team it was agreed to extend the current project to 30 June 2019. This will allow a further period of time to ensure sufficient numbers of people are supported to achieve a robust evaluation of the project.

3. Report

3.1 Project Performance

Progress to week commencing 11 March 2019 is as follows:

FRP Volumes	Total
Number of calls referred to LIVES	164
Stood down before arrival at scene	24
Number attended by LIVES	140
Number of responses which result in patient discharged at scene	102
Percentage discharged at scene	73%

FRP Volumes	Total
Number of responses which result in an EMAS vehicle being deployed	38
Number of patients conveyed to hospital	36
Time from receipt of 999 call to LIVES response dispatch (Average)	01:59:40
Time from LIVES response dispatch to discharge/conveyance to hospital (Average)	01:48:49

Average numbers are up to 18 per week (last 3 weeks) from 11 calls per week. Capacity is approx. 56 per week. It has recently been agreed to refer all falls calls to LIVES based on the patient's condition and the intensity of support required rather than on the category or code the 999 call is given. This should support increased referrals and also be within the capacity of LIVES to manage.

Percentage of people discharged at scene continues to be good compared to the baseline (73% compared to 50%). Although the time to dispatch is higher than the 45 minutes which the partnership want to achieve. Despite this, data suggests that approx. 70% of calls are dispatched within 45 minutes (67% within 30 minutes).

Prior to the formal evaluation the partnership continues to review cases which have been referred through to LCHS in an attempt to understand the community services which patients go on to receive following discharge at scene.

3.2 University of Lincoln Interim Progress Report

The evaluation has been submitted for ethical approval through University of Lincoln. For the initial data analysis at least 3 months of data is needed so an anonymised dataset for has been requested from EMAS Performance Management Information Team (PMIT) in March 2019 for the period January 2017 to March 2019 including:

- Persons aged 65 years and older with Advanced Medical Priority Dispatch System (AMPDS) coded as fall or Electronic Clinical Record (Patient Report Form) coded as fall
- Physiological measures (pulse, blood pressure, respiratory rate, temperature, AVPU, GCS etc.)
- Initial attendance (CFR vs ambulance or Rapid Response Vehicle)
- Disposition (home, community referral, transport to hospital)

Initial data from LIVES including records of patients attended with falls as part of the service are being collated and entered on a database and surveys are currently being developed or adapted in order to understand the experiences of patients, LIVES and ambulance staff.

The extension of the project to the end of June will help support further, more robust evaluation of the project.

4. Conclusion

The Falls Response Partnership continues to work closely to ensure the project is well-managed.

Work is ongoing to understand the outcomes for individual patients regarding the follow on support they receive in the community. Added to this, work is required to ensure capacity is fully utilised within the project.

The University of Lincoln evaluation has commenced now that we have three months of data which can be analysed.

5. Recommendations

Lincolnshire Urgent and Emergency Response Board is asked to note this report and the progress being made with the Falls Response Partnership project.

APPENDIX D

Report Title:	**NRS Seven day opening for Winter Discharge of Care**
Author:	**Prashant Agrawal**
Date of report:	**02/04/19**

Aim of service:

Following an options appraisal a seven day NRS (Provider for Lincolnshire community equipment Services) opening service was implemented with the aim that provision of equipment can aid in facilitating hospital discharge and potentially reduce delays in transfer of care over the weekend. It is proposed that the current Lincolnshire Community Equipment Service (LCES) contract is reviewed to consider the potential for an enhanced wrap around service. This entailed prescribers having access to NRS ordering seven days a week during winter pressure period (Mid Dec to end of March). Including NRS having adequate capacity required to provide bariatric equipment (two person delivery).

Duration of the trial: 23rd December through to the end of 31st of March 2019.

Cost of service: Any orders received were charged & delivered via the service level chosen but a contribution from LCC was agreed to cover NRS administration cost for providing this service which was charged at £250 for each Sunday worked.
Total Cost 15 x £250 = £3750

Opening times: Sunday between the hours of 10am to 4.00pm excluding bank Holidays
Utilisation of service: There were no orders placed on Sunday during the trial period.
Key stakeholders in respect of uptake of the service were identified as, Discharge Lead from Acute hospitals, Locality Lead and Lead Practitioners (Adult care LCC) for acute hospital, Therapy Leads from ULHT, AHP Lead from LCHS, Lead Practitioners and locality lead covering non acute/ community hospitals and District Nurses.

It is agreed that to increase utilisation of the service that better communication and raising awareness with key stakeholders would be vital. This was done prior, during and following implementation through:

- Internal communication via all key stakeholders;
- Bulletin board information on IRIS (NRS ordering system);
- Face to face meeting with key stakeholders individually or part of a group; and
- Raising awareness in Lincolnshire Partnership board meetings and transformation group meetings.

Possible barriers to Uptake
Most commonly identified barriers to discharging patients at the weekend comprise:

- Decreased levels of staffing in hospitals over weekend: Reduced provision at weekends naturally inhibit the ability of any of these services to care for patients during that time; whether to assess a new admission and implement a management plan, or to facilitate discharge for a patient who is otherwise ready to leave the hospital.
- Inadequate community support including General Practitioners, Community Nursing Teams, care packages, MDT and equipment provision.
- Role of Peripheral stores: Peripheral stores play a vital part in facilitating discharge and avoiding delay in discharges. As these stores allow prescribers to have instant access to above mentioned equipment to aid discharge and rehabilitation.