Open Report on behalf of Martin Samuels Executive Director - Adult Care and Community Wellbeing	
Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**24 April 2024**
Subject:	Intermediate Care: Review of Winter 2023/24 (Adult Frailty and Long Term Conditions)

Summary:

This report provides a review of Winter 2023/24 and explores the actions to be undertaken moving forward and in preparation for Winter 2024/25.

Actions Required:

To note outcomes and successes of the services in place over Winter 2023/24

1. Background

The Winter of 2023/24 has been extremely challenging across the Lincolnshire System including Adult Social Care with a significant impact being felt due to both Consultant and Junior Doctors Industrial Action. However, a joined-up approach between the hospital social work teams and area teams led to a continuous flow of discharges from acute and community hospital settings and a focus was placed upon admission avoidance ensuring Lincolnshire residents remained either in their own homes or alternate settings preventing the potential for long waits in the emergency department (ED).

In September 2023 as per the request from the Department of Health and Social Care (DHSC) the Lincolnshire System agreed to focus on four specific High Impact Interventions to ensure the services offered to Lincolnshire residents were seamless and maximised independence. The areas agreed to focus upon were Intermediate Care, Virtual Wards, Acute Respiratory Infection and Frailty. As committee were advised in October 2023, the DHSC also requested an additional three priority areas to be addressed: System Single Point of Access, Hospital Discharge Processes (timely discharge) and High Intensity Users (High Volume Service User).

In support of the System, Adult Social Care fully engaged with partners to achieve positive outcomes from the identified areas for specific focus and from an Adult Social Care perspective a high level of success was achieved, especially in relation to the High Impact Intervention of supporting Hospital Discharge Processes (timely discharge). Through the utilisation of services such as Active Recovery Beds, Home Based Reablement, St Barnabas Community Care Nurse Specialists and working in partnership with the voluntary sector, Adult Social Care have successfully navigated through the Winter of 2023/24.

2. Review of Winter Services.

Active Recovery Beds

Active Recovery Beds (ARB) continue to promote and maximise independence. However, during Winter there has been a slight drop in the number of people leaving the service with no ongoing support. It has been recognised that the identified needs of people in hospital have been higher, which reflects a national picture of admissions to hospital reflecting high acuity. Despite pressures from the hospitals, Adult Social Care have continued to monitor all referrals for ARB's to ensure that those transferred to ARB's are appropriate and meet the ethos of recovery through active engagement and participation. Appendix A. provides the ARB information for the month of February 2024. (Appendix A).

Moving forward ARB'S will remain in place with funding from both LCC and the Integrated Care Board (ICB) and work with LCC Commercial Team is currently underway to ensure the right number of beds, in the right places, are available throughout 2024/25 to promote and maximise independence for Lincolnshire residents.

Hospital Discharge Reablement Service

The Home Based Reablement Service (HBRS) offers the opportunity for Lincolnshire residents to maximise their level of independence from completely independent, through to a reduction in packages of care. Given our practice model and philosophy HBRS is always the hospital teams first consideration for supporting discharges home. Appendix B demonstrates there has been a steady increase from 383 in March 2023 to 572 in January 2024. Of those referrals 98.2% of referrals were accepted into the service. Moving forward, work will be undertaken with health colleagues to reduce the number of failed starts of which a third related to the resident not being ready for discharge from the ward for reasons such as transport and medication not available. (Appendix B).

We are though mindful of the change in the level of enduring need for support that is being seen in our performance data regarding rehabilitation outcomes. Whilst we always work towards maximising potential our focus on choice and supporting people, where possible and safe, to return to their own home the level of acuity of need is inevitably impacting on long term demands for support. We will continue to monitor this activity and work with the provider to ensure that we are optimising outcomes for individuals. In the longer term we may review this indicator in tandem with others regarding discharge routes.

HBRS also support discharges from ED to residents' home and offer support for up to 48 hours. This service is especially effective for residents who may have fallen and lost

confidence in returning straight home. Over the past four months this service has supported 209 residents of which 75 (36%) did not need any further service after 48 hours and 26 (12%) continued to be supported by HBRS for more than 48 hours thus almost half of the residents supported by this service regained their independence and left the ED in a timely manner. Evidence highlights that the longer someone remains in an ED the more likely they are to be admitted thus this is a vital service to keep in place for Winter 2024/5.

St Barnabas Community Care Nurse Specialist

St Barnabas Community Care Nurse Specialists (CCNS) continue to offer support to people in the last 12 months of their life. Supporting them and their families to have difficult conversations at distressing times the CCNS ensures that a person centred- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is in place, so that people are not automatically brought to hospital when their wish may be to remain at home.. In addition, the CCNS supports ASC staff to challenge health colleagues, particularly in relation to fast-track funding, so that the correct funding streams are applied. This year the ASC team at Lincoln County Hospital welcomed CCNS Alice Lee into the team.

Integrated Therapies

Integrated therapies have played a crucial part in Hospital Discharge Processes (timely discharges which was another agreed area of focus as a High Impact Intervention). Throughout the Winter a Lincolnshire County Council Occupational Therapist participated in daily discharge hubs and liaised directly with health professionals to enable safe and timely discharges. An example being a health OT discussing discharge options and direct referrals for moving and handling assessments which are more appropriate to be undertaken in the person's own home, rather than in a hospital setting. This collaboration has had a positive impact upon people and for Prime Providers who are able to be in attendance when the moving and handling plan is designed.

Hospital Avoidance Response Team

The Hospital Avoidance Response Team (HART) consists of both ASC and LCHS staff working together within ED or the Discharge Lounge to facilitate discharge using the response team provided by Age UK staff. In addition, the HART service can bridge gaps between the date the resident is ready to leave hospital and the date the Prime Provider is able to commence packages of care. Whilst this service has been beneficial, the increase in capacity provided by HBRS and quicker responses from Prime Providers, this service has not been utilised to the same degree as previous Winters but in turn that has led to more capacity for the Urgent Community Response team led by Lincolnshire Community Health NHS Service (LCHS).

Community Connector Scheme

The Community Connector scheme provided by Age UK and based with the ASC teams at Lincoln County Hospital and Pilgrim Hospital Boston offer advice and guidance to Lincolnshire Residents regarding benefits and other services available in the community. Referrals can be accepted from across the System and of the 1171 referrals in 2023/24, almost 30% came directly from the ASC hospital teams. In addition, the Community

Connectors complete the applications for the Hospital Discharge Home Recovery Scheme (HDHRS) fund as described below. (Appendix C).

Hospital Discharge Home Recovery Scheme

As noted, applications for this fund are completed by Community Care Connectors based within the ASC teams at Lincoln County Hospital and Pilgrim Hospital Boston. The funds are used to support hospital discharge by undertaking tasks such as arranging for deep cleans to properties that could otherwise prevent a discharge home or for equipment outside the statutory obligations to improve a resident's quality of life. Over the last 12 months, minus the grant value, this has averaged a bed saving cost for both health and social care of an estimated £565,593. (Appendix C).

Lincolnshire Intermediate Care

At the end of October 2023 and in discussions with the ICB it was agreed to 'pause' the Intermediate Care project and to take time to reflect on what had been achieved and to have time to identify exactly what was needed to meet the current needs and future needs of Lincolnshire residents. The introduction of the 'group model' (alignment of LCHS with ULHT) and Industrial Actions by Consultants and Junior Doctors significantly impacted upon a relaunch but the project was relaunched in March 2024, jointly led by Julie Davidson (Interim Assistant Director ASC) and Rebecca Neno (Interim Assistant Director Urgent and Emergency Care) as joint Senior Responsible Officers. The implementation of this framework is starting to move at pace, with work being completed on Demand and Capacity to identify which services are needed now and in the future. The project will focus not just on population needs but upon listening to Lincolnshire residents through public engagement.

Care Transfer Hub

The third priority in the Intermediate Care Framework, the Care Transfer Hub was not paused over the Winter and continues to promote a joined up, fully integrated approach to discharge and flow. A team manager for the hub has recently been appointed by United Lincolnshire Hospitals Trust but the manager will be line managed by Catherine Paterson (ASC Area Manger for Hospital Social Work Teams). The integrated ownership and responsibility of the care transfer hub is however being closely monitored so that it does not get subsumed into the new 'group' model being designed by health colleagues as this will diminish the trusted assessor model and strengths-based approach which the integrated team utilises to ensure the most appropriate service, that promotes independence, is provided to all Lincolnshire residents.

3. Other Areas of Priority as agreed by the System:

Frailty

ASC have fully participated in the design and implementations of the Lincolnshire Older People's Strategy and recently supported the System when visited by the DHSC to discuss Lincolnshire's strategy. ASC are a member of the Frailty Strategy Board. This joined up

approach was recognised by the DHSC as evidence of best practice taking place in Lincolnshire.

Acute Respiratory Infection

The Hospital Trust are extremely well supported by LCC Public Health colleagues who provide weekly updates of trends and areas of concern. Fortunately, over the Winter the concerns regarding Acute Respiratory Infection did not impact as it might have. However, ASC had planned through the use of the services mentioned above to be able to support the System and most importantly Lincolnshire resident to remain well and at home.

System Single Point of Access

This service is now live and provides an opportunity for professional staff to discuss residents before agreeing the next steps and to ensure residents are not unnecessarily transferred to ED. Still in its early stages, commentary is that the service is successfully ensuring the wellbeing and safety of residents.

High Intensity Users (High Volume Service User)

This work will remain ongoing throughout the year and not just over the Winter months. ASC have throughout the Winter and will continue, through the coming year to support the System and work with residents to provide the right services, at the right time, in the right place.

4. Conclusion

Winter 2023/24 has been a challenge but one that ASC has met and surpassed with the utilisation of the schemes described above. All these schemes support ASC to ensure timely discharge with a Home First approach, with transfers to long term Care Home settings reserved for those for whom home is no longer an appropriate setting to ensure identified outcomes are achieved.

Throughout the coming months and the Winter of 2024/25, for which planning is already being considered, the hospital teams will continue to deliver positive outcomes for Lincolnshire residents through efficient and effective support of timely discharges that maximises and promotes independent living with support to have a safe and meaningful life.

5. Consultation

a) Risks and Impact Analysis

N/A

6. Appendices

These are listed below and attached at the back of the report	
Appendix A	Active Recovery Beds Data (Provided by Commercial Team)
Appendix B	Hospital Discharge Reablement Service (Provided by Commercial Team)
Appendix C	Community Connectors and HDHRS

7. 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 Andrea Kingdom, Head of Service – Hospitals and Special Projects who can be contacted on 01522 573109 or andrea.kingdom@lincolnshire.gov.uk.