ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Intermediate Care
What is the strategic objective of this scheme?
- To improve pathways of care and outcomes in the community for patients who have an escalating health or social care need, and who would benefit from additional support in either their own home (or usual place of residence) or an intermediate care bed by: o Helping people avoid going into hospital unnecessarily o Helping people to be as independent as possible after a stay in hospital and o Preventing people from having to move into a residential home until they really need to. o Facilitating a transfer from hospital to avoid any unnecessary delays - To contribute to a 3.5% reduction in emergency admissions across Lincolnshire by ensuring that the range of resources available at the intermediate tier is robust and flexible thus facilitating easy ongoing patient referral by health and social care professionals.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Background and current position: In the Spring of 2014 a full review of Intermediate care across Lincolnshire was commissioned by the Proactive Care Board (a joint commissioning forum). For the purposes of the review, both bed based and community based services were analysed. This demonstrates that Lincolnshire has a high diversity of intermediate tier services across the region, comprised of bed based and community based services. However there is a degree of fragmentation of provision. Largely commissioners are supportive of the ongoing developments by providers, and have a good working relationship with them, but there are some issues around the scope, definition and number of services available which causes confusion - particularly amongst GPs hoping to make referrals into the service as an alternative to hospital admission. Intermediate Care bed based provision in Nursing and Residential homes is not consistent across the County and bed occupancy is low compared to benchmarked data from the National Audit 2013/14. Bed availability in the South West (SW) is reported as being poor which has a knock on effect on patient flows from acute care

in that area.

30 Day beds are provided as a means of providing positive, goal orientated pathways of care for patients in the post acute period, but the report demonstrates failure to adhere to these referral protocols. Data demonstrates an average of 14% of patients die in 30 Day beds - and hugely escalating costs over the last 2 years, with a 20% increase to £2.9m for 2013/14. Most patients (55%) stay exactly 30 days; with a further spike in discharges at day 60 – indicating a reactive response to moving patients through the system, rather than proactive management with clearly defined care planning.

Development of Community based services has proceeded at pace over the last few years, however, it is imperative that these pathways of care are developed in line with an overarching strategy, as it is perceived that there are local variations in provision, which cause issues with patient flows and performance.

The emerging strategy for Intermediate Care will thus be closely linked to resilience plans for Urgent Care, and particularly supporting the planned changes in bed stock at ULHT to manage and actively support a reduction in emergency admissions.

To facilitate this, a series of proposals and recommendations are currently being discussed by the Proactive Care Board, and the outline strategy is presented below.

Headline performance issues:

- ULHT were able to demonstrate a net reduction in acute beds over the winter period 2013/14 by around 80 beds; which was supported by the increase in the range of community services supporting admission avoidance and facilitating earlier discharge (e.g. Rapid Response and Independent Living Team(ILT)). However, the increase in the number of 30 Day bed placements during that period demonstrates that discharge into these beds has clearly offset the ULHT bed base.
- A total of 1250 placements into Rapid Response services since its inception in November 2013 to date is encouraging, although this now needs to increase if we are to use it as a real means of admission avoidance. Around 50% of these patients were discharged from the service into no other ongoing service, with only a very small percentage requiring eventual admission to acute care. This caseload of patients would otherwise have required an alternative pathway, usually emergency admission to acute care. The total number of patients expected to go through the Rapid Response service on an annual basis is approximately 2,000, which will equate to 1900 avoidable emergency admissions.
- Call volumes through the Contact Centre continue to increase with extremely good performance in terms of target abandonment rates. GPs and other health and social care professionals are clearly more confident about the service with an increased number of calls now being taken for admission avoidance, although the majority of calls still originate from acute hospital wards for assistance with discharge planning, usually through the Independent Living Team.
- Recent performance data for ILT is encouraging with 174,759 contact hours and 5,823 service user episodes and both figures represent an increase on

current performance levels. A recent LCC performance board meeting reported the in-month figure for LARS on the percentage of people leaving reablement readmitted to hospital fell to 13.9%. 53.5% of patients using ILT were reabled to no ongoing service requirements which again demonstrates an effective and improving service.

- Our bed utilisation figures (to March 2014) benchmarked against national data indicates that bed utilisation is low; with 71.3% occupancy in community hospital beds and 62.7% in NH/RH beds. The national occupancy rate is 85%. This demonstrates that, despite ongoing issues with patient flows from acute care, our usage of intermediate care beds is inefficient.
- The 2013/14 cost for the LCC commissioned beds was around £1.5m, with a -6% variance on the previous year. The 2013/14 cost for LCHS commissioned beds (in NH/RH) was approx. £750k, with a 2% variance on the previous year.
- The cost of admission avoidance schemes delivered in the community (SPA, Rapid Response and extended community teams) for 2013/14 (NR pye) has been in the order of approx. £2.5m and the anticipated full cost of all schemes on a recurrent basis is in the order of £5m pa.

Emerging outline strategy:

To support and maintain a 3.5% reduction in emergency admissions across the health and social care system, the way that we provide both 'step up' and 'step down' care in Lincolnshire needs review. The number of current providers of Intermediate Care, and the range and fragmentation in the number of services and pathways, creates confusion and inefficiencies both in terms of quality, outcomes and VFM. Current options and proposals include:

- Adopt the principle of **"home first"** for all our patients, where possible, unless this is clinically inappropriate or functionally impossible to achieve. This shifts the focus away from bed-based care to providing care in the patient's own home wherever possible, through an enhanced range of community services. Ensure that all patients identified (through predictive risk planning) as having an increasing risk of deteriorating health have an **individualised care plan**, and, if admission to hospital is required, that **integrated discharge planning** is commenced on day one of admission.
- Streamlining the way that services are commissioned by moving to a **lead provider model** for Intermediate Care, with a range of subcontracted services, which will eliminate duplication and improve efficiencies. The Intermediate Care service would need to be retendered against a service specification with very clear performance outcomes and within or below the current cost envelope. This model has been successfully utilised in other areas of the UK with extremely good outcomes.
- Explore the potential for **recasting a number of beds at ULHT from acute to intermediate / step down provision**. It would be imperative that use of these beds was ring fenced for step down care immediately following an acute admission. However, this would have the following benefits:
    - Vastly reduce the requirement for discharge into expensive 30 Day beds, where quality outcomes for patients are poor, thus enabling the potential reinvestment of that funding (£2.9m for 2013/14) to other community based services;

    - Enable the current NH/RH beds commissioned by LCC and LCHS to be significantly reduced or even eliminated, thus affording a cost saving (currently contract value £2.3m), and the potential for reinvestment into other community based services;
    - Ensure continuity of care for patients in a safe environment which is accessible to their families and where on-going and active care, including therapies, can be maintained to improve their clinical outcomes, and chances of discharge to their own home environment;
    - A reduction in the number of acute beds available and used for emergency admissions will prompt the system to manage patients in a different way but this can only be achieved if safe and robust community services exist as an alternative to admission, and the use of step down beds in ULHT wards is ring fenced to protect their use and maintain patient flows.
- Explore the **current use of community hospital beds** (*currently 151 beds in total although some beds are used for end of life care*) for step up care, to further increase the capacity for admissions avoidance, to ensure that adequate resource is available to those beds (e.g. therapies) for patients who do not have an acute care requirement and that admission protocols for step up care are protocol driven with protection of those beds to be used for that purpose only. Referral into community beds for short term step-up care (e.g. IV therapies, rehabilitation, intensive nursing) by primary and community care professionals needs to be quick and easy to facilitate.
- We have committed as a health and social care economy to the rollout and **development of Neighbourhood Teams**. However, these teams will only be successful if access to intermediate tier services is improved and referral processes are streamlined to cut out duplication and thus inefficiency.
- Maintenance and **development of the single point of access**, as a means for busy health and social care professionals to make a speedy referral for their patient is critical.
- Development of the **Rapid Response Service** across Lincolnshire to be even more responsive and take a greater case load than currently exists, which will improve and support our admission avoidance protocols;
- A full review of the **Independent Living Team**, as a good example of integrated working, across Lincolnshire with a full workforce assessment to determine what type of resource is required in the different areas of Lincolnshire. The geography of the county presents a series of challenges in terms of provision of this service but current capacity is poor especially in the West of Lincolnshire and this needs urgent review.

Anticipated benefits and outcomes:

In order to achieve the total target 3.5% reduction in emergency admissions - **2515 patient journeys** - (of which the intermediate care scheme will attribute a total of 450 during 2014/15, and 1250 during 2015/16) with a subsequent shift in the activity to community and primary care based services, beds in acute care at ULHT will have to be decommissioned. On an average length of stay of 6 days, this equates to around **40 beds**. Closing these beds to emergency admissions will ensure that the system responds differently during times of rising pressures, and that newly commissioned services in community and primary care will be used more effectively.

There is then the potential to create some step down care on acute sites which is managed and run by community teams. These beds would be clinically managed by GPs and would have the advantage of having therapies, and better nursing input than patients currently expect to receive in nursing and residential home intermediate care beds. This will improve patient outcomes, and also enable the system to release cost savings through reduced reliance on 30 day beds, and potentially decommissioning intermediate care beds in NH and RH.

Additionally, further increases in resource into our Rapid Response service (as described in the Resilience Plan), our Independent Living Team and also increased resource in the Contact Centre making it more capable of responding during times of high pressure will serve to create an intermediate tier of services which can meet the higher demand created through shifts in acute care capacity as described above. This will also be supported by the Neighbourhood Teams, the Wellbeing Service and an increase in the range of services provided on a 7-day basis – please see additional annexes for more detail about these services.

The Rapid Response service will anticipate to take a further **160 patients / month during 2014/15,** equating to a potential **960 avoided admissions (and A&E attendances**). In addition, further service developments described through the resilience planning exercise include additional integrated therapy teams which anticipate helping to **avoid a further 60 admissions / month** and the integrated discharge team, which aim to save **150 bed days / month (or 25 actual patient journeys** based on an average length of stay of 6 days). This equates to a reduction of **150 delayed transfers of care over the 6 month period Sept 2014 – Mar 2015.**

For the whole tier of services – Intermediate Care, Wellbeing, Neighbourhood Teams and 7 day services – we expect to see the following benefits (***this does not include Specialist Services or Women's and Children's***):

	2014/15	**2015/16**
Reduction in the number of Emergency Admissions	639	2342
Reduction in A&E Attendances	?	?
Reduction in delayed transfers of care	691	702
Reduction in length of stay in an acute hospital bed	150 bed days	300 bed days
Increase in number of patients seen through Rapid Response and discharge to no service	480	960
Increase in the number of patients reabled to no service for social care	457	257
Reduction in the number of patients admitted to permanent long term care	13	43

Key milestones and timescales:

Given the non-recurrent nature of the funding for the schemes described in the Resilience Plans during the remainder of 2014/15, Commissioners will confirm the transition from NR funding to respecification and recurrent funding arrangements of the intermediate tier of services during the Autumn of 2014.

While there are opportunities for making some improvements to the intermediate care service during 2014/15, and indeed our resilience planning to support winter pressures will depend on our doing so, many of the benefits described above will materialise during 2015/16 and beyond as we make whole system changes to the way that we commission these services.

Certainly during late summer / early autumn 2014 further detailed planning around the workforce requirements to boost our community based teams, i.e. rapid response, ILT and our Neighbourhood Teams will be required to determine the subsequent investment required to maintain these services and take us forward into the whole system service change during 2015/16.

Further detailed analysis around potential changes to our bed stock across the whole system, and recasting of beds at ULHT for use as step down care immediately post acute could potentially be piloted during autumn / winter 2014/15 with a view to being re-commissioned during 2015/16.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The services described above are jointly commissioned by the four CCGs in Lincolnshire and the County Council:

- Lincolnshire West CCG,
- Lincolnshire East CCG,
- South West Lincolnshire CCG,
- South Lincolnshire CCG and
- Lincolnshire County Council.

These services are provided by:

- Lincolnshire Community Hospital Trust,
- Lincolnshire Partnership Foundation Trust,
- A range of independent Nursing and Residential Homes,
- East Midlands Ambulance Service and
- Primary care providers.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

We have referred to and used extensively the National Audit of Intermediate Care Report 2013 (*NHS Benchmarking Network – NAIC2013*) in reviewing and developing our intermediate tier of services across Lincolnshire. We have

participated fully in the 2014 study to provide a robust benchmarking of our own intermediate care delivery against national data.

The NAIC study was extended in 2013 to include crisis response and social care re-ablement services, as well as the bed based and home based services covered in the 2012 study. The key findings from the audit remain the very wide variation between service configuration, size and performance in different localities. With the focus of service provision in the 2013 study, two Patient Report Experience Measures were developed for use in bed and home based / re-ablement services.

In addition, we have also referred to examples of national best practice in other regions in the UK, and have listened to various presentations detailing successful implementation of some of the early implementers of integrated care (e.g. Devon and Torbay, North West London, Leeds).

Some of the key findings from the 2013 NAIC report are as follows, and this has been used as evidence to support our own planning activities:

Variation in commissioning:

Nationally, the average investment in 2012/13 in health based intermediate care services was £1.9m /100,000 weighted population, and re-ablement services £0.7m per 100,000 weighted population, with large variations. The 2013 audit has highlighted wide variation in the extent of multi-agency commissioning, the scale of services provided and how intermediate care sits within the full range of health and social care services within each local area.

Patient experiences of intermediate care services:

PREMs (Patient Reported Experience Measures) were used for the first time in the audit and deemed to be very informative. Presented in the form of "I" statements as recommended by National Voices, it suggests setting the bar at 95% of patients reporting positive experiences, and reports that against this standard, IC as a whole is not yet delivering the type of service experience patients hope for.

Intermediate care capacity:

The NAIC report argues that instead of using the term "the hospital is full", "the community and social care is full" is arguably a more truthful statement. In a whole system we are vulnerable to the weakest link. The audit has demonstrated that the current provision of intermediate care is around half that required to avoid inappropriate admissions and provide adequate post acute care for older people. The 2013 audit also demonstrates that capacity is "stuck" with no change compared to the 2012 audit. It argues that the long waiting times to access the services by patients (3.4 days for bed based services; 4.8 days for home based and 4.2 days for enabling services) are caused by weak local planning.

In 2012 it was calculated that IC capacity needed to approximately double to meet potential demand, and there is little evidence to suggest that investment and capacity has increased in 2013. The pressure to fill existing IC capacity with people

leaving hospital appears to have worsened in 2013. Step up bed-based capacity aimed at avoiding hospital admissions is even more limited than highlighted in 2012.

Integration:

It is fully recognised that the current situation of silo working and fragmented health and social care services must be rectified. The audit demonstrates that a mixed picture was presented nationally, which is a fair reflection of some progress, but that there is more work to do. Crisis response teams and home based services appear to be well integrated into the wider health and social care systems with referrals received from primary, secondary and community and social care services. There are opportunities for re-ablement services to become more integrated with the whole system.

Integration at the strategic/commissioner level shows an increase across the health and social care system. In the 2013 audit sample IC services were jointly commissioned in 74% of health economies compared to 58% in 2012 and the use of formal Section 75 pooled budgets has increased from 21% 5o 32%.

Mental health provision seems woefully lacking – the proportion of mental health trained staff in any of the service models audited is very small, and only half the staff have received training in dementia care.

Diversity of provision:

The NAIC report suggests that IC services were typically delivered by small local teams – the average number of services per provider was 2.6 but the range was up to 22 different services. The audit covered approximately half the country, and identified 535 different services at the registration stage. Quality assuring all these services is thus challenging and raises concerns about the fragmentation of these services, potentially unclear routes in and out of services and lack of economies of scale.

Links between IC services and acute hospitals:

In research studies, most of the effective models for preventing people being admitted to hospital involved identifying potential patients in hospital emergency departments (ED) yet only 3% of home based intermediate care referrals, 1% of reablement and 18% of crisis response referrals came from EDs in the audit. Further, 20% of bed-based services reported an average waiting time from referral to commencement of service of 4 days or more with two-thirds of service users waiting in wards in acute hospitals.

Appropriateness of staff mix to clinical needs:

Nationally, the nursing skill mix is in line with RCN recommendations for basic, safe care but below those levels recommended for ideal, good quality care. Mental health workers are rarely included in the establishment of intermediate care teams. In addition only 51% of home based services report that all members of the team have received training in mental health and dementia care and only 34% of re-ablement services have “real and quick access” to specialist mental health skills.

The proportion of home based services relying on the service users own GP for medical cover appears high (71%) when reviewed against the levels of care being provided by these services.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Key performance indicators have been described above, and in the HWB Benefits Plan, however, additional anticipated outcomes may be described using the "QIPP" (Quality, Innovation, Productivity and Prevention) framework used extensively in NHS planning and provides a means of segregating outcomes and outputs for means of benchmarking against best practice:

Quality:

- Improving clinical and social care outcomes – as per measures detailed in the NHS OF, ASCOF, PHOF – by offering a greater range of services and interventions targeted at individual patients;
- Enabling patients to feel better supported in the management of their own health;
- Improving independent – Health and Wellbeing strategy.

Innovation:

- Through introduction of a single point of access for all referrals
- Through the introduction of new technology – e.g. telehealth/telemedicine, risk stratification
- By means for integrated commissioning and new shared contractual mechanisms

Productivity:

- Reduction in unnecessary A&E attendances, emergency admissions/readmissions, DTOCs and excess bed days
- Reductions in the number of frequent fallers
- Improvements in primary care productivity
- Reduction in the length of stay of those patients requiring support type interventions
- Reduction of duplication in provision through a range of fully integrated services by means of multiple providers using a single point of access and common pathways of care
- Reduction in the number of patients admitted to long term care

Prevention:

- Improvements in outcomes for patients with long term conditions through better case management and prevention of deterioration of their condition
- Reduction in the number of falls through regular assessment
- Increased number of patients who are reabled to full independence, thus reducing reliance on long term packages of care

Patient experience:

Patient experience will be measured by ongoing participating in the NAIC. The audit introduced PREMS measures for the first time in 2013 and the results were interesting. We have surveyed our patients by means of questionnaires during the summer of 2014 and the exercise will be repeated in subsequent years as a

measure of our ongoing success.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

At a strategic level, the Intermediate Care programme in Lincolnshire is overseen and owned by the Proactive Care Joint Delivery Board (PCB), which is a joint commissioner led forum, and who regularly receive reports and proposals for development. Additionally, the Urgent Care working Group/ System Resilience Group in Lincolnshire, which has membership from all partner commissioners and providers (including acute care) also regularly review the outputs of this programme and its impact and contribution to managing urgent and emergency activity across Lincolnshire.

The PCB commissioned a full review of Intermediate Care Services in Lincolnshire during 2014, and a full baselining report was published in the summer of 2014 which details outputs and outcomes from all our intermediate tier of services, including both bed based and home based services. In addition, an academic review of the Admission Avoidance Schemes in the Spring of 2014 has also provided some evidence and support in terms of our longer term planning proposals, particularly around the contact centre and Rapid Response.

At a tactical and operational level, each CCG regularly reviews the development and oversight of intermediate care services in their own area, for example with the development of Neighbourhood Teams, bed utilisation and other outcome measures determined locally.

What are the key success factors for implementation of this scheme?

Success at a strategic level is dependent upon a number of factors, which have to be jointly owned and continually monitored by the PCB. These include:

1. Transparency in planning activities and full partnership working across the entire health and social care economy, including acute care.
2. A review of bed based intermediate care across Lincolnshire with respect to capacity and also location of provision of services. The 49 beds commissioned by LCC have been subject to a contractual review in August 2014 and it is apparent that capacity needs some urgent review.
3. Evolving Neighbourhood Teams - the development of this as a strategy as part of the Lincolnshire Health and Care Programme needs to build upon the successes - and relative capacity issues - experienced as part of the rollout of the Independent Living Team and Rapid Response services across Lincolnshire.
4. Cutting down on the fragmentation and duplication of description of services across the patch is key to building GP confidence and will help with improving GP referral rates to these services which will contribute to positive outcomes for admissions avoidance.
5. An urgent review of 30 Day Bed provision across Lincolnshire. The baselining report published in the summer of 2014 demonstrates that this service does not provide best value in terms of patient outcomes, and clinical outcomes need to be investigated further. This has to be taken in context with shifts in bed capacity and provision at ULHT.

6. Continued commissioning of the out of hospital / admission avoidance schemes (Rapid Response, Contact Centre, Extended Community Teams) as a means of ensuring that we can build upon these schemes in the future (as a forerunner to the successful rollout of Neighbourhood Teams) and providing further data to evaluate the effectiveness of out of hospital based pathways of care.
7. A regional approach to determining where economies of scale can be achieved around commissioning out of hospital pathways should be coupled with local, pragmatic flexibilities to ensure that geographical and demographic variations in demand can be met effectively.
8. Ensure that ULHT are part of all strategic planning and development of out of hospital pathways so that discharge planning from acute care is built into care planning for each patient from day one of their admission to hospital.
9. A full review of costs and outcomes for each of these services is explored in more detail during 2014.