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

Seven day services – Increasing the capacity of the Independent Living Team particularly focused at the weekends.

What is the strategic objective of this scheme?

Seven day service provision is about equitable access, care and treatment, regardless of the day of the week. The overall strategic objective for seven day services is to ensure that the patient / service user has a seamless pathway of care when accessing services no matter what day of the week.

The strategic objective of this scheme is to support patients being discharged from hospital and prevent hospital admissions at weekends, with four main drivers:

- Reducing mortality which is generally worse at weekends
- Increasing efficiency in the system
- Moving with the times, weekends should be no different to a week day
- The compassionate argument, service users/patients should be entitled to receive the same standard and quality of care regardless of the day of the week.

The case for need for this service is that discharges from acute care are low at weekends. Whilst A&E attendances and emergency admissions do not vary significantly by day of the week, this is not the case for discharges. There appears to be little difference between the mean number of discharges and the 85th centile on Monday to Thursday when compared with Friday at Pilgrim Hospital; however for Lincoln County Hospital, the mean is 32 more on Fridays, with 13 more at Grantham Hospital and 8 more at Peterborough Hospital. In summary, there are raised numbers of discharges on Friday and very few on Sunday. It is well known that the lack of availability of in-patient beds increases waiting times and breaches in A&E. By increasing discharges at the weekend, not only does this improve patient experience and reduce unnecessary hospital stays, it will also improve the flow of patients through acute care. This scheme will “pull” patients into the community.

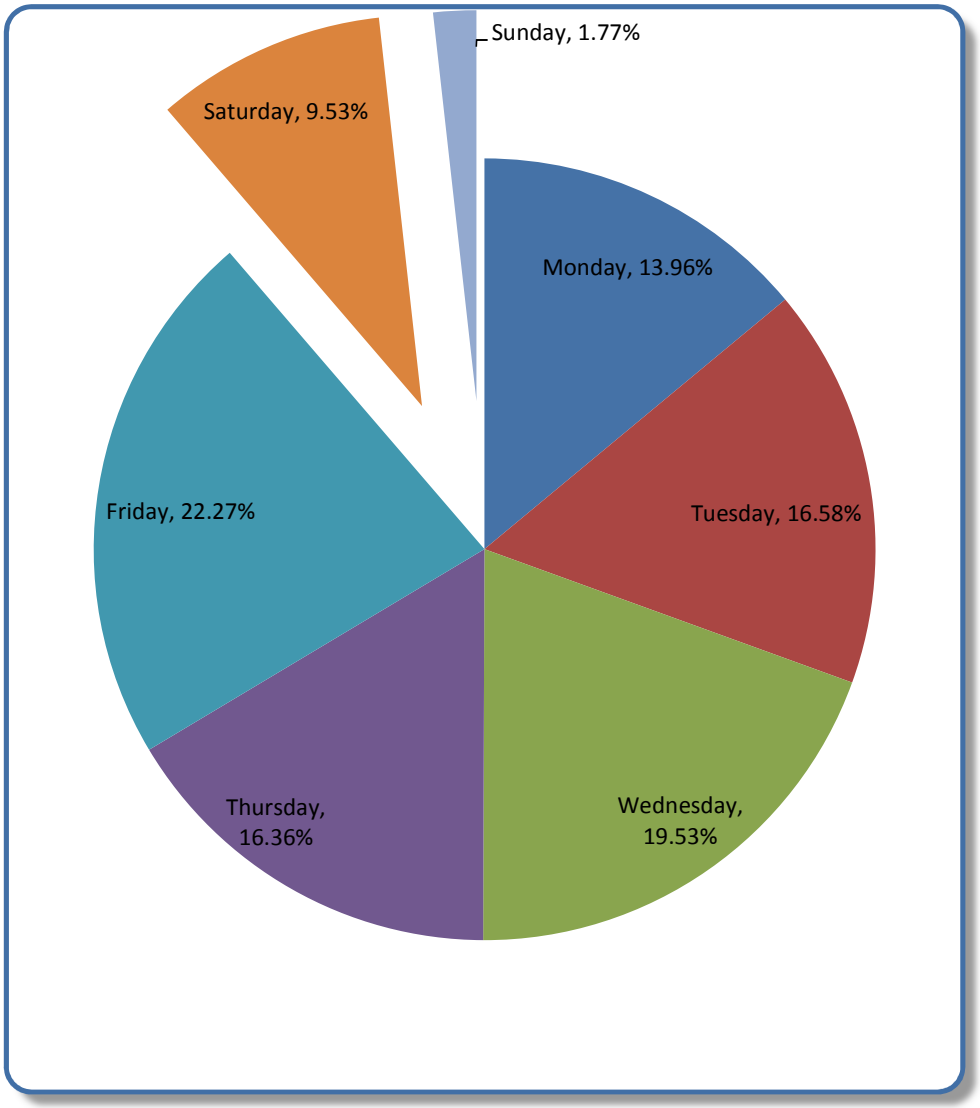
Under the current grant agreement, Lincolnshire County Council has set the following activity targets for the service over the lifespan of the agreement.

- 2014/15: 174,759 face to face contact hours
  5,823 unique service user episodes
- 2015/16: 192,133 face to face contact hours
  6,405 unique service user episodes
- 2016/17: 192,133 face to face contact hours
  6,405 unique face to face episodes

The aim is for LPFT to deliver these targets based upon a whole service redesign,

although the current service provision provides for a seven day service, the bulk of the weekend working is focussed upon follow up interventions to aid re-ablement. The service can and does take new referrals at weekends but this impacts on the delivery schedule; the consequence of it being difficult to take on new referrals at weekends is discharges from hospitals are significantly reduced.

The following pie chart provides a breakdown of the days when re-ablement services commence the chart clearly demonstrates a significant reduction in commencement of re-ablement at weekends. The Data covers the period of April to July 2014.



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
Grand Total	**331**	**393**	**463**	**388**	**528**	**226**	**42**	**2371**

Percentage	13.96%	16.58%	19.53%	16.36%	22.27%	9.53%	1.77%	100.00%

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?

Context of seven day services in Lincolnshire

Before describing the scheme, below are details of other schemes that are targeted at seven day service provision. This has been provided so the whole system is described and the context / rationale for this scheme is explicit. All these schemes will be required to improve access, care and treatment, regardless of the day of the week.

- **Acute Care**
  Through the operational resilience plan for 2014/15, the following schemes will be funded;
  - Integrated Discharge team working within acute care with hospital, community and adult social care staff that work seven days a week. Staffing includes social workers and brokerage staff to support weekend discharges with the identification of care packages at the weekend. Investment is £411,595 PYE.
  - Therapy services in acute care at weekend to support weekend discharges and a reduction in acute length of stay. Investment is £217,589 PYE.
  - Therapy services in the community rapid response team (new service seven days per week) and the A&E departments (extension of current service into weekends) to prevent hospital admissions. Investment is £367,795 PYE.
  - MRI diagnostics on a Saturday and Sunday to reduce hospital admissions for a diagnostic test only and reduce waiting times for patients. Investment is £155,100 PYE.
  - Pharmacy working at the weekend to increase level discharge by 5% every day over 7 days, reduce missed and omitted medications with associated improved patient outcomes and reduction in acute length of stay. Investment is £602,155 PYE.
  - Ambulatory Emergency Care Services are being expanded to open at Pilgrim Hospital and Grantham Hospital at the weekend and an additional 3 hours in the week at Pilgrim. The objective being to reduce the number of admissions and reduce acute length of stay. Investment is £785,843 PYE.

- **Community Care**
  The impact of the Neighbourhood teams and the Intermediate Care Service will need to be fully understood in order for further investment to be decided from 2016/17 onwards in terms of seven day services.

- **Primary Care**
  Through the operational resilience plan for 2014/15, the following schemes will be funded:
  - Minor Injuries Unit in Sleaford is being expanded to operate at the weekend to reduce A&E attendances and admissions. Investment is £195,262 PYE.
  - Lower acuity pathway is being developed at Lincoln and Pilgrim Hospitals which will provide GPs in A&E seven days per week to reduce paediatric

admissions and admissions for the frail elderly. Investment is £446,659 PYE.

Collectively these schemes will either prevent hospital admissions or increase discharges at the weekend from acute care with impact starting September 2014 and continuing to the end of March 2015. Impact will be measured through the Lincolnshire System Resilience Group. The projected impact is currently being modelled into trajectories and will be available by the time this BCF is submitted. Depending on impact, each service will either have an exit strategy to stop the service or a plan to sustain the service from April 2015.

The above schemes will mean that people will be rapidly assessed and will either receive their care in the community or experience a rapid discharge from hospital when they are medically fit for discharge. Therefore additional resource is required in the community to support these people and promote their independence. Hence the scheme below.

Increasing the capacity of the Independent Living Team
Lincolnshire Partnership NHS Foundation Trust is currently conducting a whole systems service redesign for the ILT support service. The objective being to shape the service and structure to exert the greatest amount of efficiencies as possible, this will include creating capacity with the introduction of new shift patterns, reducing the amount of downtime, and allowing home support workers to work across a number of different patches which will provide the critical mass required to meet the demands for the service.

With the introduction of new technology, this will release the home support workers' time to concentrate on service delivery. The creation of a countywide roster, underpinned by clear criteria, will ensure that the right level of re-ablement can be delivered to the right person, and also provide an administrative function to the whole service. The Service User will continue to receive an assessment and subsequent reablement at home and onward signposting to the brokerage service. The ILT support service will continue to work in a fully integrated way with the ILT health service and the contact centre. The service provision will continue to be provided at the service user's home and will be fully focused on short term interventions/support which allows the individual to remain at home or be discharged from hospital.

The additional funding will allow the service to increase the number of home support workers available at weekends which will allow and support increased discharges or admission avoidance from ULHT beds. The increased capacity will allow the ILT support service to deliver the following projected volumes. An assessment will be conducted by the Home co-ordinator within 48 hours of the referral being received, with subsequent reviews completed during the reablement period.

The projected increase of staffing establishment would be approximately 12 whole time equivalents creating 22,000 additional hours offering services to a further 800-1000 service users. The focus will be primarily on the older adult population.

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

For the scheme, Lincolnshire County Council will commission Lincolnshire Partnership Foundation Trust (LPFT) to deliver the service through the current contract.
In addition, the Independent Living Team works closely as an integrated service with Lincolnshire Community Health NHS Services. This relationship will need to be taken into account not only in terms of care delivery but also in terms of the Contact Centre (24/7 single point of contact) which will receive the referral to the scheme from acute care and the community and deploy the resource as they do currently.

The Contact Centre will continue to be the gateway for all referrals into the ILT support service; the Contact Centre will undertake an initial screening and then warm transfer the referral onto the LPFT's central roster team who will then deploy the resources required in conjunction with the service user.

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

In September 2013 LCC published an evaluation report on the Independent Living team
The results of the evaluation are attached:

Independent Living Team Appendix A.pdf

As part of the service redesign process LPFT held a number of staff engagement workshop events across the county to determine how the service should look going forward. The outputs from the engagement events have been included within the proposed service redesigned model and subsequently LPFT has formally commenced staff consultation on the proposed new service model, on the whole staff are broadly in favour of the proposed changes.

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

Headline metrics – the service will contribute to:
- Increasing the number of discharges from acute care
- Reducing Delayed Transfers of Care
- Reducing re-admissions to acute hospital with 30 days
- Reducing permanent admissions of older people to residential and nursing care homes
- Increase the proportion of older people who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services

- Reduction in unnecessary A&E attendances/readmissions, at weekends

Service outcomes will be:

- Quality
    - Enabling patients to feel better supported in the management of their own health
    - Improving independence – Health and Wellbeing Strategy

- Productivity
    - Reduction in the number of frequent fallers
    - Levelling discharges across the week by increasing discharges at weekends from acute care ULHT would have smoother patient flows, in particular avoiding some of the current pressures on Mondays
    - Reducing length of stay in acute 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 re-abled to full independence, thus reducing reliance on long term packages of health and/or support care

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?

LPFT already collects KPI performance data for LCC, this performance matrix can be added to, to reflect weekend working and include key deliverables that meets the objectives of the service. The Trust already collect service user feedback on the current service provision, again this can be broadened out to include service user views on the weekend provision.

The opportunity to use new technology in collecting data will enable LPFT to generate KPI data electronically through the development of dynamic window and uploaded to the Trusts clinical system.

The National Audit for Intermediate Care 2013 has used PREMS outcome measures for the first time, with some interesting results. Given our participation during 2014 LPFT can ensure that this is built into their planning and auditing of their own services, but in the meantime there are proxy measures which can be used as additional measures of success (or otherwise). Some of the measures used as part of the urgent care /winter pressures evaluation (of which there is a high level of cross over into intermediate / transitional /out of hospital based services, due to the nature of the patient journey).

Key outcome measures, which are whole system and representative of the entire patient pathway, are already being used after being drawn from other major programmes of work – e.g. the evaluation of the ILT.

These are lifted from the various outcome frameworks – e.g. ASCOF, NHSOF and PHOF – and cross mapped to ensure that we are consistently measuring the benefits from

service change.

LPFT intend to use The Better Care programme which plans to use a range of simple output measures which have been fixed nationally to monitor relative success in developing integrated care type services, and these are:

- Admissions to residential care
- Effectiveness of reablement
- Delayed Transfers of Care
- Avoiding emergency admissions
- Patient and Service User Experience

Additional benefits may be described through the "QIPP" (Quality, Innovation, Productivity and Prevention) Framework used extensively in NHS planning, and provides a means of segregating outputs for means of benchmarking against best practice. In addition to those outcomes detailed in the section above, other measures could include:

Quality:

- Improving clinical and social care outcomes – as per measures detailed in 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 independence – Health and Wellbeing Strategy Innovation:
- Through the introduction of new technology – e.g. telehealth/telemedicine, risk stratification
- By means of integrated commissioning and new shared contractual mechanisms

Productivity:

- Improvements in primary care productivity
- Reduction in length of stay of those patients requiring support type interventions
- Reduce 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 residential care

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

Key success factors include:

- Completing the staff consultation and implementing changes with full support of current staff and without a loss of the workforce
- If there is an attrition rate in the current workforce, to be able to recruit and retain new members of the workforce
- There is an interdependency with both the Integrated Discharge Team (and the other acute care seven day services) to identify patients ready for discharge at the weekends and an interdependency with the Contact Centre who will manage the referrals into this service.
- There is a huge support across the health and care system to expand this service so no issues identified with implementing this new resource.