Open Report on behalf of Glen Garrod, Executive Director - Adult Care and Community Wellbeing	
Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**06 September 2023**
Subject:	**Acute Hospitals – Admission to Discharge Care Pathway and Winter Planning 2023/4**

Summary:

This report updates on the Acute Hospitals – Admission to Discharge Care Pathway following the April 2023 Report and explores the current winter planning for 2023/4 across Health and Social Care.

Actions Required:

To note progress, outcomes and examine services being developed as part of winter planning 2023/4.

1. Background

A report was shared with the Adults and Community Wellbeing Scrutiny Committee on 6th April 2023 which set out the Pathways available to Lincolnshire residents to facilitate discharge from acute and community hospitals. These services built upon capacity in Pathway 1 thus offering Lincolnshire residents reablement, rehabilitation and recovery in their own homes post hospital discharge.

Since April, the Active Recovery Beds (ARB) (Appendix A), Pathway 1 Hospital Discharge Reablement Service and Pathway 1 Discharge to Assess have continued to thrive. As a result, these services will continue throughout the Winter and therefore the current focus of System partners is on collaborative Winter Planning, to ensure timely discharge and flow with a focus on Home First and independent living.

The winter planning has been led by the Integrated Care Board and focuses upon the Urgent and Emergency Care (UEC) Recovery Plan alongside admission avoidance and discharge and flow. Services for Winter 2023/24 include additional Active Recovery beds, continuation of the Hospital Discharge Reablement Service and a current recruitment campaign for three Team Managers to lead the Care Transfer Hub previously known as Transfer of Care Hub (renamed by NHSE). In addition, workflows such as the Integrated Therapy Service, Increase in Virtual Wards, extension of the Hospital Avoidance Response

Team (HART), continuation of funding to the Hospital Discharge Home Recovery Scheme (HDHRS) led by Age UK, the extension of the Community Connector Scheme and continuation of St Barnabas Community Care Nurse Specialists (CCNS) have been implemented. All of these schemes support Adult Social Care (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.

2.Pathway Updates

Active Recovery Beds

At the Adults and Community Wellbeing Scrutiny Committee on the 6th April 2023, a request was made to return to the Committee in September to ensure the use of 40 beds was sufficient before the introduction of a further 20 beds (60 in total) between 1st January 2024 and 31st March 2024. Due to careful management of the flow in and out of ARB's the current level of 40 beds has been efficient and economic with empty beds at the end of each day averaging around 3. This has ensured availability overnight thus supporting admission avoidance.

Throughout June 2023, a procurement was undertaken to extend the ARB's, with four homes being awarded a contract for 10 beds each between 1st July 2023 and 31st March 2024 and a further two homes were awarded contracts for 10 beds each for the period 1st January 2024 to 31ST March 2024. The first four homes awarded the contract were; Monson Care Home Lincoln, Skirbeck Care Home Boston, Appletrees Care Home Grantham and Meadows Park Louth. The second cohort of beds were awarded to; Foxby Hill Gainsborough and Chevington House Bourne. As demonstrated, the Care Homes are geographically placed across the County, enabling people to recover as near as possible to their own home.

Pathway 1 Hospital Discharge Reablement Service

This service provided by Lincolnshire Reablement Service continues to support discharge home directly from Emergency Departments (ED) thus preventing long waits in ED and potential to be admitted. Offering support for up to 48 hours, since December 2022, the service has supported 243 discharges. Over one third, 91 residents (37.5%) required no further services at the end of the 48 hours.

Pathway 1 Discharge to Assess

As per the Government documents; Hospital Discharge Policy and Operating Model (2020) and Hospital Discharge and Community Support Guidance (2022), the hospital social work teams continue to facilitate discharges 7 days a week by undertaking a proportionate needs assessment which is then reviewed and completed within their own home when actual needs are identified, alongside outcomes to be achieved. This practice ensures that assessments are completed at the right time, in the right place.

Care Transfer Hub

The Care Transfer Hub is a crucial tool in ensuring timely discharges. A integrated facility based within the ASC Departments at Lincoln County Hospital and Pilgrim Hospital Boston, the Hub Team consists of ASC, United Lincolnshire Hospitals Discharge Team, Lincolnshire Community Health Service, Lincolnshire Reablement Service, Age UK, Housing In-Reach Officer, Specialist Palliative Care Team and virtual access is also available to System Partners. The function of the Hub is to triage all patients identified as requiring a service to support discharge home or if necessary to another setting. Utilising a Trusted Assessor Model and a strengths-based approach, the team ensures the most appropriate service that promotes independence is provided within 48 hours.

A recent visit to Lincolnshire was undertaken by DHSC to witness the running of the Hubs and the information gained from that visit has been shared across the Country. Contact has now been received from Derby and Derbyshire, Leicester and Nottingham asking for meetings to share knowledge and skills already being utilised in the Lincolnshire Hubs.

Due to the success of the Hubs, the improvement in discharge and flow and the desire to expand the support the Hubs can offer, 3 Team Managers are to be appointed, funded by the Better Care Fund, to support discharge planning and leadership. The Team Mangers will be recruited by ULHT but will be supervised by ASC ensuring an integrated approach to the service.

3. Winter Planning

As per previous years, the expectations and demand on services will be very challenging and with the additional impact due to industrial action by both Consultants and Junior Doctors, the importance of Winter Planning at an earlier stage has taken precedence over other duties.

On 28th July 2023 the Department of Health and Social Care (DHSC) announced a Market Sustainability and Innovation Fund (MSIF) of £600 million to boost social care and workforce capacity alongside a Market Sustainability and Improvement Fund which included funding for further Research. LCC ASC were awarded £5m. Working alongside LincA and NHS colleagues to ensure a whole system approach to winter planning and to put ASC on a firm footing for Winter, careful consideration has been given and continues to be given to Winter Planning by all System Partners thus a number of services are being scoped and considered to ensure the wellbeing of Lincolnshire residents, including those in Out of County Hospitals.

At the same time as the Market Sustainability Funding was announced, the DHSC also advised all Systems of the need to focus on 4 out of 10 identified High Impact Interventions; Same Day Emergency Care (SDEC), Frailty, Inpatient flow and length of stay, Community bed productivity and flow, Care Transfer Hubs, Intermediate Care Demand and Capacity, Virtual Wards, Urgent and Community Response, Single point of Access and Acute Respiratory Infection Hubs. At present any additional funding to meet these priorities is yet to be advised to the Integrated Care Board.

After consideration and moderation by all System Partners, Lincolnshire agreed to focus upon; Intermediate Care, Virtual Wards, Acute Respiratory Infection and Frailty. Acute Respiratory Infection has been selected as initial reports from Countries such as Australia who are currently in their winter months, has shown a significant rise in demand due to these conditions. In addition, the Regional Team working alongside KPMG have also requested 3 priority areas to be addressed: System Single Point of Access, Hospital Discharge Processes (timely discharge) and High Intensity Users (High Volume Service User). Of note, these three priority areas are aligned with the Lincolnshire Intermediate Care work.

Two of the identified priorities have already been identified as workstreams, with planning underway and funding in place to successfully navigate through the winter months such as:

Lincolnshire Intermediate Care (LIC)

In the early stages of development and led by Afsaneh Sabouri (Assistant Director ASC) as Senior Responsible Officer, LIC will be an integrated approach to service delivery for Lincolnshire residents. Currently two main workstreams are underway: Operational Delivery Group which is focusing upon: Agile Referral Allocation Layer (looking into seamless referral routes), Cultural and Behavioural Science (ensuring all partners have the same vison and team ethos leading to a strengths-based approach to personalised care), Digital Enablement (To step up digitally enabled referral routes), Integrated Demand Model (Incorporating population and health needs to underpin strategic resourcing planning) and Developing Operational Requirements for Future LIC Model (developing the future intermediate care model and commissioning). The second workstream is the LIC Finance Group which will oversee the commissioning and funding of LIC.

Virtual Wards: Virtual wards (also known as hospital at home) enables patients to get hospital-level care at home safely and in familiar surroundings which helps speed up their recovery whilst freeing up hospital beds for patients that need them most. Patients are reviewed daily by the clinical team and the 'ward round' may involve a home visit or take place through video technology. Many virtual wards use technology like apps and other medical devices enabling clinical staff to easily check in and monitor the person's recovery. ASC staff are available to support with advice and guidance on services in the community if any areas of concern are identified. ASC are also a stakeholder in the Virtual Ward task and finish group and Virtual Ward Strategic Delivery Group in developing the service moving forward. At present there are three virtual wards; Frailty, Cardiology and Respiratory Wards. Other areas such as Palliative Care are still in the planning stage.

In addition to the priority areas ASC has already implemented or extended service provision as part of winter planning:

Integrated Therapies

This integrated approach involves a collaborative approach of Occupational Therapy Services provided by LCC, LCHS, ULHT and Primary Care Networks who have employed their own Occupational Therapy Staff to work with their patients. Good practice example includes a resident who wished to be returned home before a formal moving and handling assessment could be completed. Thus, ULHT and LCC therapists discussed the case and the resident was able to return home and the LCC therapist visited to undertake the moving and handling assessment in the residents home. This facilitated a discharge home at an earlier point than if the assessment had been completed in an acute hospital setting. This collaborative working improved the quality of life for the resident and freed up an acute hospital bed.

HART

The Hospital Avoidance Response Team 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.

Hospital Discharge Home Recovery Scheme

Led by ASC and Age UK, this service provides a Health Grant to expedite discharge from Hospital to the residents home. For example, a Lincolnshire resident might not be able to return home due to their home needing a deep clean or a particular piece of equipment that is not provided by statutory services such as new bed and bedding but there are no personal funds available to purchase. Since August 2022, 143 residents have been supported through this scheme at a cost of £97,198 which saved an estimated 909 days in hospital. Minus the grant value, this has ensured a bed saving cost of £341,849.

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. In addition, the Community Connectors complete the applications for the HDHRS fund as described above.

St Barnabas Community Care Nurse Specialist

This service is provided by two CCNS's, with one based at Lincoln County Hospital and the other at Pilgrim Hospital Boston. Their primary roles include working with Lincolnshire residents identified as being within the last 12 months of their life. They offer advise, guidance and support with advance planning. Often supporting residents and their families to have difficult conversations at what can be a very distressing time. In addition the CCNS support ASC to effectively challenge decisions relating to fast track funding thus ensuring the correct funding streams are applied. Although based at Lincoln County Hospital and Pilgrim Hospital Boston, the CCNS also offer advice and guidance to the ASC teams at Grantham Hospital and Peterborough City Hospital.

4. Conclusion

The Pathway 1 initiatives continue to deliver efficient and effective support for timely discharges that promote independent living or at least reduce the level of support required through packages of care.

Winter planning is well underway utilising Lincolnshire creative and innovative thinking alongside the requirements of the DHSE. This work will be ongoing and will develop over the coming months.

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)

7. Background Papers

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

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