Better Care Fund Guidance & Assumptions

Guidance and Assumptions

1 How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?
As a system we are in the process of reviewing our estimates for demand and capacity since our plan was submitted in June. Our estimates in June included our forward schemes and proposals which are discussed later. The system had its NHSE/UEC winter visit on the 10th of October and as part of the feedback following this meeting, we have had a request to remodel and assess the impact of all our current reported capacity and demand figures. There are a range of new schemes that are due to come online over the next few months, along with other schemes that have started and are currently in place and we will now need to model this data. As part of this we are modelling the impact on the acute to determine what the residual capacity gap across the system will be. Due to the timing of the meeting our teams have been working on these estimates since this and we are expecting the first view of this information at the beginning of November. This work is being led by the ICB and unfortunately this means that for Q2 our estimates are the same. In terms of longer-term planning, as part of our intermediate care work we are going to revisit the demand and capacity modeling across the system pathways to also check if there is a residual gap. The work around this is in response to the new national framework for intermediate care and plans will then be made to address any gaps. There are also 4 business cases that we have recently been successful in achieving non-recurrent funding which will support winter planning. Two of these will specifically aim to support demand and capacity, and they are focused on the Increase and extension of existing Homelink D2A pathway 1 offer and increased Active Recovery beds. We are also working with colleagues to utilise the market sustainability and innovation fund that has been released to the LA recently to support UEC and to offer support to our intermediate care and long-term care services offered by the council. The Market Sustainability and Improvement grant is being fully utilised to increase adult social care provider rates and support adult social care workforce aligned to the grant conditions. The second tranche announced in August 2023 has a focus on mental health provision given the increased demand and cost. Due to the increase in demand and therefore the cost of mental health packages of care following discharge we have reprioritized the original homecare allocation to meet this demand and ensure funds are available.

2. Please outline assumptions used to arrive at refreshed projections (including to optimize length of stay in intermediate care and to reduce overprescription of care.) Please also set out your rationale for trends in demand for the next 6 months (e.g. how have you accounted for demand over winter?)

Discharge

As above we are in the process of reviewing our demand and capacity and will be able to provide this data for Q3. Below are some areas that the system is focusing on around capacity and demand.

To support oversight of capacity and demand (including 'blocks' in the pathway), there are twice daily system calls where up-to-date information is share between LCHS (community), LCC (local authority) and ULHT (acute) healthcare professionals with an ongoing MS Teams channel for updates in-between calls. A HomeFirst Power BI dashboard has also been developed to provide insight into capacity and demand across the pathways. A real-time tool to support demand and capacity is also being developed and expected to 'go-live' during the financial year.

The transfer of care policy has been refreshed ensuring that all standard operating procedures are in place along all our discharge pathways with all escalations agreed. We have MADE timetabled in at regular intervals across the acute and community bed base, and regular line by line reviews activated whenever the numbers waiting over 24 hours for supported discharge start to increase. There are daily early morning discharge huddles in place with all operational colleagues from system colleagues to identify any immediate challenges, escalations, and mitigations. We will move to twice daily huddles over the winter period, including an end of day huddle. Information from these feeds into the daily 9.30am system calls run by the SCC. We have met with another acute trust to start conversations around how to better support the patients of Lincolnshire in other acute settings.

We have agreed plans in place to increase the pathway 2 bedded capacity (active recovery beds increase from 40 to 60), increase in short term bridging capacity for care at home for patients awaiting a formal POC to start and community and social care teams located within ED to support admission avoidance by offering both home care and bedded care placements to avoid acute hospital admission. (An additional 10 beds went live during the week 23/10/23 funded by health, by January there will be a total of 70 beds)

The service will support both step up and step-down care achieved through close working with hospitals and community services to ensure appropriate patients are proactively receiving the support they require to ensure they can return to their home safely as soon as possible.

We have an ambitious system wide intermediate care plan to transform and increase our intermediate care capacity and address the capacity gaps linked to our increasing demand profile from our ageing population. We have a long-term transformational programme encompassing all supported pathways and have an agreed priority 'quick win' list for implementation prior to winter to ensure we have surge and super-surge capacity and maximise the use of all available capacity. All plans to increase both bedded and home care are all developed jointly with the local authority and we have fortnightly BCF discharge meetings with relevant operational, commissioning and finance leads to ensure we are delivering what we agreed within the agreed financial envelope of BCF discharge fund between the ICB and the LA.

All our plans are agreed, signed off and on track to be delivered funded from within the current resource available and have been used to inform our BCF submission. If more funding is made available to support discharge through the BCF route we have very clear operational and commissioning mechanisms between the ICB and LA to quickly agree and implement plans jointly.

Plans already in place include increasing the Active Recovery beds from 40 to 60 beds over the Winter months. If necessary, and in line with the business case submitted, additional beds can be considered. The National capacity tracker identifies high levels of available beds for alternate bedded settings if required.

Capacity.

As above the provision of 40 Active Recovery Beds is already in place with an additional 20 beds (60 in total) becoming available on 1st January. There is potential (linked to a recent business case) for a further 14 beds (10xARB and 4x CHC/Care home) to come online ahead of Q4. LCC Commissioning and Contracts team will ensure capacity is available for Pathway 1 and 3 discharges. Additional capacity will be commissioned as and when necessary.

Part of the LA homecare discharge funding is being planned to fund a Hospital Discharge Extended Assessment pilot. This pilot aims to improve timeliness of discharge by providing the individual with up to 6 weeks funded care whilst their longer-term care needs are met. In addition, a deep dive is being carried out into HART services provided by Age UK. This is to review outcomes of the pilot service to inform future commissioning arrangements. In addition, a review of additional reablement capacity on discharge will commence to inform commissioning arrangements.

As part of our Lincolnshire intermediate care operational work programme and the frailty strategy we have clear plans to improve how we use our community hospital bed capacity and intermediate care capacity (health and social care) which includes increasing our therapy offer, increasing the frequency of MDTs and having agreed discharge plans in place with the patient and their family within 24 hours of admission to a community bed.

We already have a therapy led pathway 1 discharge to assess service, commissioned 2 years ago and recurrently funded, run by our community provider which we are looking at expanding through innovative use of our therapy work force. Our system ambition is to streamline all our pathway 1 offer – working to agreed system outcome metrics across all providers. That is within our 24/25 ambition. Our 23/24 intermediate care workplan includes an ambitious relook at how we jointly (health and care) combine our resources to ensure that all patients receive a comprehensive therapy led offer when moved into pathway 2.

3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?

(LICB) and (LCC) are committed to exploring joint commissioning opportunities by moving towards a system-wide and outcome-based model, preventing unnecessary acute hospital admission, supporting timely discharge, and maximising independent living. Current focus includes scoping a pilot to mobilise an agile allocation referral layer which improves referrals into intermediate care services, a cultural and behavioural science accelerator to support cross-organisational working and the development of the future bed-based intermediate care model and commissioning roadmap. We are also working with colleagues to utilise the market sustainability and innovation fund that has been released to the LA recently to support UEC and to offer support to our intermediate care and long-term care services offered by the council.

The system has several planned interventions that are in place to improve capacity and demand management.

- Frailty SDEC: This is an initial 3-month pilot to commence on 4/9 to provide 7-day Frailty SDEC, virtual ward and consultant in ED for both Pilgrim and Lincoln sites. This has been part of the wider UEC Programme development in year and will be online ahead of winter.

- A primary development to help people stay closer to their own home whilst receiving health and care was the introduction of the Virtual Ward model during 2022. We will continue to deliver on our commitment to further develop virtual wards, where patients can receive specialist led care within their homes. So far, we have launched virtual wards for cardiology, frailty, respiratory, complex neurology and general medicine equating to a plan of 145 acute beds, we are committed to this model of care and continue to explore ways we can continue to expand and enhance this service. A capacity of 172 beds is planned by March 24.
- For this Winter we have implemented Acute Respiratory Hubs in 3 locations across Lincolnshire that that will provide timely and appropriate care for service users with suspected acute respiratory infections. The key objectives of the Acute Respiratory Hubs being to provide same day access, treatment and advice as needed to service users and reduce pressure across the system by reducing demand for ambulance conveyance, GP appointments, Emergency Department attendances, and hospital admissions, for patients who can be appropriately managed in the community.
- The Lincolnshire system has recently completed a piece of work on Bed Rightsizing and the outputs of that are just being finalised and shared. This will help to understand what capacity is where in the system, as well as what space is available for escalation and quantify the opportunities. This work will feed into the modelling to identify gaps in capacity.

4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?

There are no specific capacity concerns or support to raise for the winter ahead however like other areas in the country our biggest risk is for our workforce. To ensure we keep adequate staffing levels the system has modelled its workforce with a focus on attraction and retention thereby reducing our reliance on agency and bank.

Organisations have introduced regular monitoring of recruitment pipelines and have created plans for each vacancy. Workforce Planning systems and processes have improved thereby leading to improved use of workforce data in a timely manner to help inform clinical and operational decision making. We have been successful with both local and international recruitment campaigns and have also seen a downward trajectory in our turnover rates since June 2022.

5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data)

As above there are certain data issues we have when recording our planned capacity for social support (pathway 0), as we are unable to split out data to provide accurate information. Due to this our BCF 23-25 submission had this number at 0.

There is a time lag for recording permanent admission information on to our case management system. This means that the number of permanent admissions is likely to be higher than the 163 showing on the system at the end of quarter 1 2023/24.

Around the reablement metrics the data combines Lincolnshire Community Health Data and Adult Social Care Libertas Reablement data. Some people cannot be traced to a case management system (Mosaic) number so these people are then classified as Not at Home. This accounts for 45 Persons, if these people were at home the measure would be 92%.

6. Where projected demands exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge

The Lincolnshire System winter operating plan continues to be developed, led by the ICB and in conjunction with the SCC and system partners.

The revised UEC governance includes strategic leaders and clinical leaders groups, meeting weekly and including nursing directorate input and led by the UEC SRO. The clinical leaders and strategic leaders will be used as points of escalation, assurance and decision making to avoid any delays in agreement actions and full consideration of risk. The addition of a winter plan delivery group for the winter period will further support delivery on plans.

When we are experiencing demand over our planned G&A beds, it is clear that there is capacity still in other parts of the system, which is demonstrated in the VW and UCR modelling, and we have the opportunity to escalate by almost 25% on existing core community bed provision (some of this is subject to the recent business case submitted). There are also a number of initiatives due to come online ahead of winter that will further support a reduced reliance upon G&A beds and instead focus on maximising existing out of hospital care, and full utilisation of the new capacity.

The Lincolnshire whole system escalation plan is in development and will include break-glass options focussed on expansion of existing service and use of existing contracts to increase capacity. This might be options that the system wouldn't ordinarily consider, but would directly support de-escalation and balance of risk.

The existing UEC plan does already include a number of initiatives that are due to come online during winter including:

- Additional Active Recovery Beds
- Additional Community Hospital Beds
- Additional P1 capacity
- Additional CAS capacity to support alternatives to ED
- Rapid implementation of phase one of a single system SPA to support alternatives to ED and support a reduction in HCP calls to EMAS
- Increases in Primary Care Capacity

The Lincolnshire SCC lead on monitoring demand, capacity and pressure within the system as follows:

- Daily system calls 0930 and 1300hrs – early warnings of current and potential issues that are logged and actions raised for that day.
- OPEL levels for each provider discussed on system calls – reasons for level and how we can work as a system to de-escalate.
- Extra system calls added if continued high demand
- Monitoring demand using SHREWD – looking at trends for early warning and working with Vital Hub to develop more visual data for monitoring demand.
- MS Teams daily chat set up with SCC Ops, acute Clinical Site Managers, EMAS and Acute Tactical to monitor, planning and pre-empt delays.
- Monitoring of EMAS arrival screens to monitor demand and pre-empt delays in off loads – liaising with Clinical Site Managers and Tactical in the acute.
- Transport issues being flagged on the system calls to pre-empt any discharge delays due to transport.
- Operational/Clinical improvement work monitoring day to day issues and working with providers on solutions to improve re-occurring issues