East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 30 March 2017

BY: Chief Officer

SUBJECT: Delayed Discharge Fund and Integrated Care Fund

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1 PURPOSE

1.1 This report updates the Integration Joint Board (IJB) on utilisation of the Delayed Discharge Fund and the Integrated Care Fund in 2016/17 and presents propositions for their use in 2017/18.

2 RECOMMENDATIONS

2.1 That the IJB note the range of initiatives made possible by the Delayed Discharge Fund (DD) and the Integrated Care Fund (ICF) which have improved the way care is provided across East Lothian through a focus on community based support and care delivery at home or in a homely setting.

2.2 That the IJB supports the continuing development of the initiatives into the next financial year.

2.3 That the IJB supports the incorporation of the Delayed Discharge funding into the baseline operational budget to continue the services it supports.

3 BACKGROUND

3.1 Building on the success of the Change Fund, the Scottish Government made available additional funds to support Delayed Discharge work and the Integrated Care Fund to support transformational development. In East Lothian these funds were £528,000 and £1.7m respectively. It was agreed that the IJB would provide governance on the use of these funds and oversight of the investments and the outcomes.

3.2 This investment has provided clients with care in their own home or in a homely environment such as a care home or residential home. Support has been delivered through a variety of arrangements and organisations:

- Hospital to Home
- Care Home Team
- Hospital at Home Team
- Dementia – Post Diagnostic Link Worker
- Royal Voluntary Service (RVS) patient transport service
- Strive Link Workers.

3.3 In 2016/17 the planned use of the funds was:-

	2016/17 Planned		
	ICF	**DD**	**Total**
	£000's	£000's	£000's
Available	**1760**	**528**	**2288**
Commitments			
Hospital to Home		370	370
Winter		161	161
Coagucheck	56		56
Care Home Nurse		37	37
ELSIE II	800		800
Respite & Rehab	99		99
Carers Strategy	25		25
Physical Activity	60		60
Clusters	48		48
Day Centres			
Vol Orgs	382		382
	1470	568	2038
Net Position	**290**	**-40**	**250**

3.4 **Delayed Discharge Fund**

The key role of the Delayed Discharge Fund is to reduce delayed discharge by improving the process of discharge. The largest element of investment has been in the Hospital to Home service

Hospital to Home was set up to support the discharge of patients into the community who would otherwise have spent a long time in an acute hospital bed waiting on a care package. Since its inception in 2014 the team has grown to meet demand.

The team's service uses a flexible re-ablement model, under which patients' visits are provided at varying times, with staff working with each patient to support their care needs while ensuring that patients do not become unnecessarily dependant. As a proactive service it can

match input to each patient's changing needs, altering and stopping the package where indicated.

Carers are closely involved, with the outcome of regular weekly reviews of care plans communicated to all carers. As part of the review process, carers' needs are also assessed.

The service receives excellent feedback from patients, relatives and from professionals. The most recent patient satisfaction audit scored 96.7%.

The winter element has provided additional capacity in hospital to home.

The Care Home nursing element has provided educational and clinical support to care homes across the County.

It is proposed that in 2017-18 the Delayed Discharge funds are allocated to the baseline operational budget to continue these services.

3.5 **Integrated Care Fund**

The key element of this work has been further development of the ELSIE (East Lothian Service for the Integrated Care of the Elderly) services.

ELSIE was formed in early 2014 and has evolved to include several teams who work together in partnership to prevent unnecessary hospital admissions, reduce the need for patients to be in hospital when they no longer need to be and provide more care in the community. ELSIE provides care at home to people mostly aged over 65 in East Lothian who would otherwise be in hospital.

The multi-disciplinary teams which make up ELSIE include the Hospital at Home and Hospital to Home teams as wells as Discharge to Assess and Care Home teams. The integrated service is led by a medical consultant and a range of staff including a GP, nurses, advanced nurse practitioners, social workers, occupational therapists, physiotherapists, and care workers. The team liaises closely with GPs and district nurses as well as acute hospitals.

Through the fund:

- Coagucheck funding has enabled all general practices in East Lothian to carry out near patient testing for patients on warfarin, so improving convenience for patients and patient safety
- In Respite and Rehab physiotherapists were supported to work in discharge to assess
- Preparatory work for the Carers' Strategy and for the introduction of the Carers' Act has progressed along with

development of tools to pilot carers' assessment and benchmarking against other areas

- Physical Activity for Older People has been delivered through support to Ageing Well
- Support was provided to the GP Cluster Quality Leads.

Further investment with third sector partners (vol orgs) has allowed the development of services which support the IJB's strategic goals. Supported services are: Link Workers in medical practices, post diagnostic dementia support, Dementia Friendly East Lothian and the RVS patient transport service.

3.6 **Out-turn for 2016/17**

Although the final year-end position is not yet available, the projected out-turn for the use of the Delayed Discharge and Integrated Care Funds is as follows :-

	2016/17 Projected Expenditure		
	ICF	**DD**	**Total**
	£000's	£000's	£000's
Available	1,760	528	2,288
Expenditure			
Hospital to Home		370	370
Winter	100	121	221
Coagucheck	56		56
Care Home Nurse		37	37
ELSIE II	536		536
Respite & Rehab	99		99
Vol Orgs	313		313
	1,105	528	1,633
Balance	**655**	**0**	**655**

There has been an element of slippage in some of the planned investments and these funds (the balance above) have been used to support other operational pressures within the partnership.

The use of the £313,000 marked as 'vol orgs' is as follows:-

Vol Orgs 2016/17	£000's
RVS	53
Volunteer development	166
Carers of East Lothian	64
Action on Dementia	10
Alzheimer Scotland	20
Total	**313**

3.7 **Proposal for 2017/18**

In summary terms the proposal for 2017/18 is as follows:-

	2017/18 Proposal		
	ICF	**DD**	**Total**
	£000's	£000's	£000's
Available	1,760	528	2,288
Commitments			
Hospital to Home		370	370
Winter	100	121	221
Coagucheck	56		56
Care Home Nurse		37	37
ELSIE II	800		800
Respite & Rehab	99		99
Carers Strategy			0
Physical Activity			0
Clusters			0
Day Centres	215		215
Vol Orgs	392		392
	1,662	528	2,180
Net Position	**98**	**0**	**98**

(note, the extra £10k is to allow £20k for Action on Dementia)

This is largely a continuation of the current plans and development but with the additional of further investments in Older People's Day Services as agreed by the IJB.

Work will also continue to develop and enhance the link worker programme with Strive and extend this programme to the east of the county. The Scottish Government have announced that (nationally) additional funds will be made available for such programmes.

4. POLICY IMPLICATIONS

4.1 There are no policy implications of this paper.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy. There are no equalities implications of this paper.

6 RESOURCE IMPLICATIONS

6.1 There are no new resource implications of this report.

7 BACKGROUND PAPERS

7.1 Appendix 1 – Details of DD and ICF Investments and Outcomes

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Appendix 1 – Details of DD and ICF Investments and Outcomes.

Hospital to Home Team (HtH)

Hospital to home was set up to support the discharge of patients into the community who would otherwise have spent a long time in an acute hospital bed waiting on a care package. Since its inception in 2014 the team has grown to meet demand. As part of ongoing development, it is planned that one team will specialise in clients who need assistance from two staff on each visit.

The team consists of:

- 1 Band 7 SCN
- 1 Band 6 Co-ordinator
- 1 Band 5 Staff Nurse
- 14 WTE Band 3's
- 6 Part time Band 3's

The team's service uses a flexible re-ablement model, under which patients visits are provided at varying times, with staff working with each patient to support their care needs while ensuring that patients do not become unnecessarily dependant. As a proactive service it can match input to each patient's changing needs, altering and stopping the package where indicated.

Carers are closely involved, with the outcome of regular weekly reviews of care plans communicated to all carers. As part of the review process carers needs are also assessed.

The service receives excellent feedback from patients, relatives and from professionals. The most recent patient satisfaction audit scored 96.7%.

Further development is planned to enable the staff to carry out simple dressings and to take clinical observations.

To date the use of the HtH team has allowed:

- 50 Home Care packages to be discontinued
- 28 Home Care packages to be reduced in size
- 7 palliative patients to receive end of life care at home

Total cost of care packages delivered from HtH: £188.946.12

Reduced cost of care packages, HtH has reduced: £4.358.56

East Lothian Care Home Team

The team, which was established in 2014 covers three strands of operation, with staff working collaboratively and providing cross-cover in the:

- Care Home Liaison strand
- Nurse Practitioner strand
- Nursing Home strand

The team currently comprises:

- 1 WTE Band 7 Care Home Team Manager
- 2 WTE Band 6 Care Home Liaison Nurses
- 2 WTE Band 6 Nurse Practitioners
- 2 WTE Band 5 Staff Nurses.

The Care Home Liaison strand (CHT) aims to:

- Promote and enhance quality standards of care and clinical practice through education and clinical support
- Prevent admission and facilitate earlier discharge
- Improve communication between primary care, secondary care, community and specialist services
- Enhance partnership and integrated working
- Improve uptake of and access to educational resources/opportunities

The CHT's education work to date has provided:

- 45 formal education sessions on various topics including pressure ulcer prevention, nurse verification of expected death, anticipatory care, and catheterisation
- Allowed 233 staff (including care workers and registered nursing staff) to attend training sessions
- Facilitated flu vaccination training programme in 13 care homes

Care Home Liaison Activity Levels

Individual referrals:

- 253 individual patients seen since January 2015
- 73 patients seen since September 2016
- 153 contacts with patients since September 2016

The CHT are now recording all individual contacts on TRAK.

Benefits

Regular visiting to each care home along with responding to requests for intervention which aims to pro-actively support staff within care homes.

Recently conducted a survey of all the homes to find out what training will be required in the coming year and also what training would be most useful but may not currently be being offered – this will form the basis of the structured educational programme but will also inform educational developments that will need to be put in place or facilitated.

Links with the education team continue to be strengthened to ensure that the governance around the delivery of specific educational sessions is robust. This approach means that staff within the care homes is able to access education at local level which enhances their skill level and enables them to be more able to care for more complex patients e.g. VAC dressings.

Nurse Practitioner Strand

The Nurse Practitioner led service in Eskbridge is now embedded within the Practice and is the lead contact for five care homes in Musselburgh. Provides holistic assessment, diagnosis and treatment for approximately 135 patients/clients registered with Eskbridge medical practise. This team is now able to offer a more comprehensive service with regard to anticipatory and preventive care whilst continuing with its routine visiting. The service continues to be the first point of contact between 8am-6pm for any acute periods of illness within this care home population. A recent questionnaire elicited positive results with some areas of improvement highlighted. One of the Nurse practitioners has completed an independent prescribing course and the second NP is nearing completion of the course (March 2017).

Nurse Practitioner Activity Levels:

1003 contacts December 2015 – August 2016
1118 contacts August 2016 – February 2017.

Benefits
The benefits of the Nurse Practitioner (NPs) service are that it is holistic and very responsive in its approach to prevent hospital admission and facilitate discharge whenever possible. The NPs are very accessible and will respond within a short timeframe when a patient is acutely unwell. The numbers of patients in care homes covered by this service is rising and this is as a result of the care home managers choosing to register new patients with Eskbridge to ensure that they can be covered by the NP service.

Nursing Home Strand

The CHT has most recently started to work more closely in partnership with one independent provider in employing a Band 5 Staff Nurse who works as part of the CHT but is based within a nursing home.

The role of this Band 5 is to provide direct patient care to the residents in the home but also to provide leadership, clinical teaching and role modelling to staff within the home. The role, although in its infancy, has been welcomed and initial feedback is positive.

Benefits
This involvement is partly enabling this particular nursing home to remain open and functioning to ensure that the 23 beds within the home can be accessed by patients from East Lothian The continuity of this member of staff enhances the care provided for patients whilst also improving the skills and clinical practice of the staff in the home. Working in close partnership with this independent care home provides challenges but also offers a chance to develop this relationship.

Hospital at Home Service (H@H)

The H@H service seeks to support the twin goals of avoiding unnecessary Hospital admissions, and where an admission is necessary, to support the patient's prompt discharge from hospital back to home.

The service brings together the multidisciplinary team (MDT) and integrates this around the needs of the patient, setting goals and implementing a care plan to reach these goals through continuous review and a monitoring and review process that takes place each day at a 'huddle'.

The team consists of:

- 0.50 WTE Clinical Lead.
- 3.00 WTE Advanced Nurse Practitioners.
- 3.00 WTE Nurse Practitioners.
- 2.20 WTE Staff Nurses.
- 3.00 WTE Clinical Support workers
- 0.50 WTE Occupational Therapists.
- 0.50 WTE Physiotherapists.
- 0.50 WTE Clinical Pharmacists.
- 0.50 WTE Nurse Specialist (Mental Health)

Adult social work also attends the daily huddles every day at 08.15.

Using a 'virtual ward' approach, the H@H team discuss and review the care plan for each patient who is being supported at home. This is with a view to agreeing the next step in a patient's journey and the best member/s of the team to provide care and treatment.

The team is supported by a delayed discharge co-ordinator who can facilitate access to a bed as necessary and the home care advisor who will interface with the team if a patient from any care home is admitted.

There are two categories of patients within the H@H service:

- Those being supported to avoid inappropriate admission
- Those being supported to achieve early discharge from hospital.

For admission avoidance the H@H service accepts referrals from:

- GP's across East Lothian.
- District nursing teams in consultation with the team and the patients GP.
- Community Hospitals.
- Acute Hospital consultants and medical staff.
- Nurse Specialists. Specialist Palliative Care Teams.
- Accident and Emergency.
- ECAT – Royal Infirmary of Edinburgh
- Team 65 – Western General Hospital.
- Psychiatrist.
- Care Homes across East Lothian, via GP's.

The H@H service then provides an urgent assessment that is responsive and able to provide intensive monitoring and intervention for the patient with an acute episode of illness that would otherwise require an acute hospital admission.

This nurse led multidisciplinary team will provide care within 12 hours of referral as required, working with other members of the multidisciplinary team to get the patient seen in the right place at the right time and by the right person who's care is reviewed on a regular basis.

For early discharge H@H accepts referral from acute care medical physicians, Ward Senior Charge, Therapist's, Frail Elderly Teams and other acute care Consultants. The aim is to allow a timely advanced discharge for patients in secondary care who have had acute intervention or treatment and who require ongoing treatment, monitoring, nursing care and therapy support, and who would otherwise remain in hospital without this active and necessary intervention.

To date the team have supported over 774 patients since February 2014, the average length of stay depends on the patients presenting condition this can be from 1 day to up to 50 days. The team will support the patients in the community to remain in their own home and environment.

Patient satisfaction is excellent, patients and relatives have expressed that they feel that the service is patient centred allowing patient to be supported within their own environment through their acute episode or exacerbation of a chronic condition.

Benefits:

- Patients remain in their own home, surrounded by their family and carers.
- Patients are not admitted and therefore do not lose their package of care and have a further delay of having to be reallocated a package further down the line when available, if a complex package of care patients can wait some considerable months.
- Reduced bed days allowing the service to close 13 beds.
- Allows the service to ensure that the patient receives the right treatment in the right place at the right time.

- Patient benefits from a multiprofessional approach to care.
- Strengthened links with social care and mental health.

One downside that will need consideration is: Feedback, demonstrates that some relatives feel that they do not benefit from an opportunity of a rest whilst their relative is in hospital therefore increasing carers stress.

Older People's Day Centres

IJB members will recall that a paper was presented at its meeting on 26 January 2017 which details a review of Older Peoples Day Services and two recommendations which were:

- The IJB is asked to support the development of an improvement programme approach to older people's day services in line with the strategic priorities as set by East Lothian's Health and Social Care Partnership and the Integrated Joint Board. Para 3.1 in the January 2017 paper
- And to agree that the additional investment needed in order to achieve the improvement programme as detailed in the resource framework 7.1 Appendix 1 should be funded from the Integrated Care Fund subject to final budget decisions by the IJB in March 2017. Para 3.2 in the January 2017 paper

Both recommendations were agreed including further investment of £215 K.

Dementia –Post Diagnostic Link Worker

Background

Improving post diagnostic support has been a key part of the Scottish Government's " National Dementia Strategy: 2013-16' , Commitment 2 states 'we will transform the availability, consistency and quality of post-diagnostic support by delivering the new post-diagnostic HEAT target.' This is detailed in the strategy as '...by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a Link Worker, including the building of a person-centred support plan.'

Existing Provision

The current Service Level Agreement (SLA) between East Lothian Council/NHS Lothian and Alzheimer Scotland has been in place for the last two years (started February 2015). The SLA provides for the provision of a full time Post Diagnostic Support worker. A total of £40,000 annual funding was secured: in the first year East Lothian Council funded £22,000 and NHS funded £18,000. Year two has been funded wholly by the Integrated Care Fund.

It has been agreed that funding will continue via the ICF for 2017/18.

At present the demand is exceeding capacity and the Post Diagnostic Support (PDS) guarantee of every person having a diagnosis of Dementia, receiving 1 year of PDS is not being met. .

The Link Worker is employed, managed and monitored by Alzheimer Scotland. The Link Worker is based within the Community Mental Health Team and works closely with team members, sharing knowledge, expertise and excellent joint working.

The Link Worker carries a live case load of 50 people and there is a current waiting list of 66. Longest waiting time has been 5 months.

Total number of referrals is 214 (11 inappropriate referrals;14 declined post diagnostic support: 34 declined after first visit and 28 died or went into long term care

Proposal from Alzheimer is to have two full time workers to ensure demand is met currently, as well as allow for some future growth. Additional funding to be offered for at least two years if not three. There is historically, difficulty in trying to recruit to a one year post. **.**

In the *Services for Older People in East Lothian, Joint Inspection of Adult Health & Social Care Services Inspection Report,* May 2016, Page 6 "The partnership rightly acknowledged it needed to continue to improve the provision of support for older people following a diagnosis of dementia", and Recommendation 5 "Ensuring people diagnosed with dementia and their carers receive post-diagnostic support in line with the National Dementia Strategy"

Alzheimer Scotland would recruit to the post swiftly, interview panel of representatives from Alzheimer Scotland, and East Lothian Health and Social Care Partnership East Lothian Council and NHS, full training will be provided and opportunities given for learning and development.

Increasing for a single handed to a 2 WTE support workers is detailed in the following table

OUTCOMES	OUTPUTS
The person with dementia and their family and carer will: Be better informed and equipped with skills to manage the challenges of living with dementia Have legal and financial arrangements in place for the future. Be in a position to take control, now and in the future, of services to support them to live at home as independently as possible. Maintain community links & build peer support networks for both carers and people with dementia at all stages. Benefit from sharing experiences, tips and coping strategies. Build on existing support networks. Benefit from timely, relevant and responsive information & advice from the point of diagnosis and throughout the duration of the illness. Statutory supports will be phased in at a pace and time that is acceptable to both the person with dementia and their carer Carers will feel confident and well supported in their caring role Finish the one year support with a Personal Support Plan in place.	To achieve this we will……. Dementia Link Workers: • Continue to identify and support new families during the next year for one year's post-diagnostic support, keeping an active caseload of at least 50 families per full time equivalent link worker The new proposal will increase this figure to a case load of approximately 100 families per year at any one time (with up to an extra 10 families receiving 'light touch' support) At 6.3.17 there is a waiting list of 66 people with a diagnosis of dementia waiting for one year's post diagnostic support and the figure is constantly rising as the CMH Teams are referring from 3 months of diagnosis if receiving memory treatment and at date of diagnosis if not receiving memory treatment. The proposal is to increase our staffing levels from 1 full time equivalent position to 2 full time equivalent

Royal Voluntary Service - Transport Service for Patients

This service is scheduled for review in the course of 2017/18.

The intention is to maintain the service as currently provided with the same level of funding into the next financial year.

It provides a service to take patients to and from Primary Care appointments, when they don't have access to transport. This enables early intervention and potentially stops a condition worsening to the extent that it requires Secondary Care.