APPENDIX 2 – PROPOSALS FOR USE OF £4.15M OF NEW MONIES FROM THE BETTER CARE FUND

1.Homecare from Hospital	**Cost £1.5m**	**ENCCG £750k**	**HVCCG £750k**

Proposal: This proposal is a configuration of different packages of Homecare that have been trialled this year. Their focus is on providing quality care to groups with either complex needs, or who are from areas where it is traditionally difficult to source homecare. The patient/service-user groups that these homecare types are aimed at often experience delayed transfers of care at either the acute or community hospitals. Additionally, they are also more likely than most service-users to be directed to costly residential placements. As such, these proposals have clear benefits to both health and social care.

All of these homecare types are free to the service-user and can last up to 4 weeks, allowing fuller assessments to take place where necessary. In each case they give the service-user maximum opportunity to maximise their potential and, ideally, continue to live independently at home. Consequently, the proposal supports the emerging model of 'discharge to assess' being trialled at both East and North Hertfordshire Hospital Trust (ENHHT) and West Hertfordshire Hospitals NHS Trust (WHHT), and aligns to the objectives of both Urgent Care Network.

The specific homecare types that would be delivered with this funding are:

<u>Home from hospital</u>

- A service designed to be as flexible as possible to provide homecare rapidly to patients. The Provider deploys Senior Care Workers to the hospital site to liaise closely with Hospital Staff and Hospital Social Work Staff to ensure that difficult / complex cases are supported out of hospital and back to their own home environment as quickly as possible. A block contract is agreed, and the service will be available between the hours of 7am and 10pm seven days a week and requests for service will come from the Hospital Social Work Team, Hertfordshire County Council Emergency Safeguarding Out of Hours Service (SOOHS). Providers will accept 100% of referrals whilst under their allotted capacity and they will be expected to process the referrals within a four-hour period. The service will also provide an enablement option for those service users which are allocated to the provider and have been assessed as requiring enablement where the existing enablement provider is unable to facilitate.

<u>Complex Care</u>

- A Nurse Led service with a dedicated provider (with a proven track record of specialist support) to support patients with the

most complex health and social care needs, again who will often experience delayed transfer of care

Rural Care

- To block purchase from dedicated provider(s) homecare hours for areas where the market is not developed for homecare, and where delays can result trying to source care

Delirium

- Supporting patients/service-users with delirium, which is a service-user group where it has traditionally been difficult to identify appropriate care. All service-users are reviewed after 3 weeks to understand what ongoing support and advice they will need.

Dementia

- A service that will provide a risk minimisation, assessment, care and support service to people with dementia. The service will support the stabilisation of crisis with care ranging from 24 hours per day through to intermittent calls up to 4 weeks
- People who experience behaviours that are indicative of a dementia, where there is one or more of the following:
  - A change in presenting needs that is making the risks they experience more difficult to manage.
  - The carer is citing an inability to manage their needs and requests support, with management of behaviours associated to dementia being an overwhelming factor.
  - The need for more detailed assessment of need to support future care planning.

The £2.4m (i.e. including carry forward of £900k from last year's allocation, and unspent winter pressure monies) would provide 120 000 hours of care per year, or approximately 60 000 hours per CCG.

Link to National Conditions	**Link to Performance Metrics**
- Protection of social care services (not spending) - 7-day services in health and social care to support patients being discharged (all services can be started 7 days a week, Home from Hospital includes presence of provider in acute trust 7 days a week) - Ensure a joint approach to assessments and care planning. These care packages will be able to be deployed through 'trusted assessment' where the discharge to assess model is being trialled.	- Admissions to residential and care homes – through providing maximum opportunity for service-users/patients to be re-abled in their home environment before any decision on placements are made - Effectiveness of reablement (see above) - Delayed transfers of care – the patient groups targeted with these proposals have care requirements that have in the past led to delayed transfers of care

2. Care Home - Premium	Cost £1m	ENCCG £500k	HVCCG £500k

As the acuity of patients discharged from hospital has increased, so too has the acuity of patients cared for in nursing homes. This presents significant challenges for providers to be able to offer safe care for these patients within the financial resources available to them in their contracts. Where providers are not able to cope with this level of acuity the risk of readmission to acute services increases, as does potential G.P. call-outs, falls, and there can be delays in the provider accepting the patient back into their care following a stay in hospital. Providers are under increased pressure from the Care Quality Commission to evidence clearly that they have sufficient resource and capacity to care for complex patients. To incentivise homes to care for patients with high-levels of acuity, and do so safely without unnecessary transfers to acute settings, a Care Home premium is proposed. The £1m would fund an enhanced weekly rate for the care of service-users/patients of the highest complexity once the relevant home had met a range of accreditation standards. The complexity of patients would be measured using a standard dependency tool. For example, the Rhys Hearn dependency tool, with patients with 'High Dependency (for example is sometimes doubly incontinent, requires assistance or has to be fed, cannot make needs known) would qualify for the higher value payment, as they would be beyond the 'Fair cost model' that is agreed with our care homes. To reach accredited status and be eligible for the premium on higher dependency patients the homes would need to meet agreed criteria, including:

- Appropriate staffing level for High Dependency patients using a model such as the Rees Hearn dependency tool
- 80% of staff trained in the assessment of fallers for injuries that preclude lifting, and the assessment of the requirement for ambulance or GP even if lifted
- The home has equipment to lift residents from the floor and has trained 80% of staff in its use. A member of staff trained in its use is on duty over the full 24 hours
- the home guarantees to admit from hospital/community within 24 hours if a bed is available
- Use of nutritional assessment tools where indicated. Appropriate engagement with dietetic service
- Staff trained in four layer bandaging, PEG feeding, syringe drivers etc

The expected health benefits would be issues such as:

- Reduced unplanned call-outs for GPs for repeat prescriptions
- Reduced ambulance call-outs
- Reduced percentage of ambulance calls which do not result in conveyance
- Residents who fall are assessed for injuries and if safe lifted to bed or chair

- Reduced delays in hospital discharge to care homes

It is likely that 10% of current service users (321) in nursing homes would qualify for this funding. So the estimated cost of the scheme would be £1m per annum countywide.

Link to National Conditions	Link to Performance Metrics
- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	- admissions to residential and care homes - effectiveness of reablement; - delayed transfers of care; - avoidable emergency admissions and; - patient / service user experience.

3. Primary Care Plus / Homefirst	Cost £1m	ENCCG £500k	HVCCG £500k

Both CCGs and the Council are committed to developing integrated health and social care team around G.P. clusters that will:

- Provide wrap around health and social care for patients at risk of hospital admission
- Deliver rapid response to patients to prevent admission, or accelerate discharge, including rapid access homecare
- Case manage patients

The Council have initiated work with HPFT (Hertfordshire Partnership NHS Trust) and HCT (Hertfordshire NHS Community Trust) to help develop a scalable model for teams, based on the Homefirst pilots, and emerging ideas for Primary Care Plus in Herts Valleys.

These monies would be used flexibly to fund the social care capacity needed to deliver this type of service in areas identified as priorities for roll out in 2014/15. The capacity might include:

- Dedicated homecare capacity to be managed within the team, which could replace nursing capacity if necessary, and could also act as a rapid response to facilitate early discharge from acute settings. A new 'hybrid' role could be developed, which has elements of a domiciliary care worker and a Healthcare Assistant.
- Social workers of Care Coordination Officer capacity for the teams.

Link to National Conditions	Link to Performance Metrics
- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends - Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	- admissions to residential and care homes; - effectiveness of reablement; - delayed transfers of care; - avoidable emergency admissions and; - patient / service user experience.

4. Stroke ESD	Cost £100	ENCCG £100k	HVCCG £0
As part of the emerging work on the stroke pathway it is clear that an integrated approach will be beneficial, for example in the delivery of an Early Supported Discharge. National evidence suggests that effective integrated stroke pathways have the potential to reduce social care costs in terms of reduced placements and homecare costs. This funding would be used to fund social work support for the pathway, for example in an integrated community team and some dedicated homecare support where required for a pilot service. Research suggests 0.5 social workers for every 100 patients that go through the service a year, which would necessitate approximately 2.5 social workers.			

Link to National Conditions	Link to Performance Metrics
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	- admissions to residential and care homes; - effectiveness of reablement; - delayed transfers of care; - patient / service user experience.

5. Carer Navigators	**Cost £150k**	**ENCCG £0**	**HVCCG £150**

As part of supporting primary care and focussing on early intervention and prevention there will be an enhancement of our current Care Navigator service that provides 'local navigators' who will be trained on social care services and voluntary sectors in their local areas. This will provide swift access to community support services enabling people to receive the right service at the right time.

The Care Navigator role is taken on by a member of a GP surgery, often a member of the receptionist staff. They are given training in issues relating to social care and support to carers. They can then offer advice to patients and carers when they come to services and thereby improve access to social care, and increase the likelihood that social care will be accessible quicker than it normally would have. This should lessen the risk of carer breakdown and other issues that could lead to an unnecessary admission, or the need for more costly social care support.

The monies are used to allow practices to give existing staff extra hours to enable them to perform these new duties and £150k would double the scale of the existing roll-out of these roles.

Link to National Conditions	**Link to Performance Metrics**
- Protection for social care services - Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	- admissions to residential and care homes; - patient / service user experience. - Avoidable emergency admissions

5. Expansion of 7-day working	Cost £125	ENCCG £67k	HVCCG £58k

Previous investment in 7 day working has enabled hospital discharge teams to be staffed at the major acute sites at the weekend. Further investment (in addition to the existing £125), would make this more robust and allow for greater coverage across the system, e.g. community hospitals etc. Calculations on 7 day working in the NHS assume a 2% increase on staffing costs to pay for it. If this figure is applied to our hospital social work teams, service solutions (the team that identifies and initiates care packages, placements, etc) and relevant management, the total cost would amount to £250k.

Link to National Conditions	Link to Performance Metrics
- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	- delayed transfers of care; - avoidable emergency admissions

6. Programme management for delivering national conditions and rolling out Primary Care Plus	Cost £284k	ENCCG £142k	HVCCG £142k

These monies would be used for funding joint posts to help deliver the ambitions of the Better Care Fund and associated national conditions, specifically:

- dedicated programme management on data sharing across NHS and social care
- dedicated programme management to help roll-out Homefirst/Primary Care Plus
- subject matter expertise to lead on trusted assessment and discharge to assess model

Link to National Conditions	Link to Performance Metrics
- Better data sharing between health and social care, based on the NHS number - Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	- admissions to residential and care homes; - effectiveness of reablement; - delayed transfers of care; - avoidable emergency admissions and; - patient / service user experience.