Lancashire and South Cumbria VCFSE Alliance

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UEC winter funds VCFSE Managing Agent brief

Context.

- LSC ICB allocated £420k in FY 2024/25 for the VCFSE to support efforts with Winter Planning. See submission from page 3.
- One of the Alliance's roles is to create these kinds of opportunity through engagement with partners in the ICS, in this case the UEC programme board, and the ICB.
- We did this through VCFSE Assembly task & finish groups in late 2022/23, taking that work into system meetings and discussions about NHS winter planning.
- The VCFSE Alliance on behalf of the LSC UEC Board is looking to commission a managing agent to manage funding to deliver UEC work described from page 3.
- A working group, made up of Alliance members and T&F group members, has agreed the high-level parameters of the plan in line with ICB expectations.
- The ICB's expectations of this are not unreasonable, they are aware that £420k is not going to solve the pressure in UEC. They are looking to learn as much as we will on how to work in this way through this project.
- If this works well, and we can work effectively together, the likelihood is that more investment will follow in coming years.

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Expression of interest form.

https://forms.office.com/e/vm15dLR5ja

Contact.

joeh@communityfutures.org.uk

Managing Agent – Aims.

- With VCFSE Partners, create/enhance interventions to positively impact A&E attendances and admissions within the period of the funding (09/2024-03/2025) working closely with community teams, NWAS and others.
- Test new ways of working between the ICB and VCFSE Alliance/sector (referencing back to the Partnership Agreement).
- Delivering a proof-of-concept to new approaches for managing demand for UEC services with wider VCFSE partners in future.

Managing Agent – Requirements.

- Experience of successfully managing successful, collaborative partnerships – including the ability to sub-contract with multiple partners, and relevant legal accountability e.g. liability insurances.
- Connectivity to existing networks of partner VCFSE groups and organisations providing relevant services in BwD & Blackpool.
- Existing links with PBP & PHM team, PCNs/INTs and ideally other area specific community teams / MDTs.
- Project monitoring systems software capable of tracking and aggregating partner activity and generating useful reports.

Managing Agent – Activities.

- Mobilise partners by September 2024.
- Demonstrate collective impact and individual outcomes with a variety of media including reports and “before and after” case studies.
- Manage grant payments and reporting to the accountable body - LSC’s ICB UEC Board, with oversight from the VCFSE Alliance.
- Contribute to monitoring reports required by LSC ICB’s UEC Programme Board.

Lancashire and South Cumbria Integrated Care Board

UEC Capacity Investment Scheme Proforma 2024/2025

NOTE: this proforma should be completed in conjunction with the scoring tool

Lead Organisation:	*LSC VCFSE Alliance on behalf of VCFSE providers*
Scheme Lead:	***VCFSE Alliance***
Contact email address:	
Contact telephone number:	
Funding amount requested:	*£420,000 (2% investment in VCFSE led schemes)*
Duration of the scheme:	*12 months*
Mobilisation date:	*Q1*

1. Scheme overview:

This proposal seeks investment in VCFSE led schemes to provide integrated and person-centred approaches to admission avoidance and safe & timely hospital discharge. The investment will ensure that evidence-based and high impact interventions are delivered consistently and equitably across the Lancashire & South Cumbria footprint. There will be a focus on individuals and communities who are more likely to use emergency care services including those living in priority wards and older people. The proposal seeks to strengthen the role of the sector in integrated approaches to discharge and admission avoidance and recognises the essential role that it can play in identifying individuals that need help and support, focusing on earlier intervention and holistic support that promotes greater independence for individuals and families.

The investment will be used to embed Link Worker roles in parts of the system to enable individuals and families to be connected to community-based support that will help them to remain independent, in their own homes and better able to manage their own health and care needs. This will include input to:

- Integrated Discharge Teams / Transfer of Care Hubs- liaison with patients and families to enable individuals to be discharged home in a timely and safe manner and ensure support is in place to avoid readmissions. (The investment will be used to ensure a levelling up across L&SC so all residents have access to the appropriate support)
- Integrated approaches within Urgent Community Response Teams and Virtual Wards to connect individuals and their carers to appropriate support that will enable them to remain at home. This will include support in the of use digital technology for those who are struggling with telehealth and telecare.
- Integration will also be with NWAS who can connect people in with the link workers when they identify them.
- The extension of Community Champion volunteers to support those who have recently been discharged from hospital or are at risk of a hospital admission and identified as socially isolated with a focus on priority wards.

The investment proposal recognises the need for co-ordinated 'wrap around' support for individuals and families who experience complex interacting problems that can increase the risk of a hospital admission or delay discharges from hospital to home. These include carer breakdown; income and debt; legal issues; and housing insecurity. There is significant evidence to show that individuals and families who disproportionately use emergency care often need support in navigating services and that community-based support can provide positive benefits which impacts on hospital admissions, readmissions and A&E utilisation. (*British Red Cross, Getting Discharge Right)* A lack of practical support or somewhere to turn for help in a crisis is associated with higher risk of an adverse health incident. Older people living alone are more likely to access urgent and emergency care services or have frequent contact with GP services. Social isolation is a strong predictor of being admitted to hospital (or readmitted within 30 days) or a care home. During the winter months, high levels of isolation coupled with increased health risks can amplify this effect. (*Age UK, 2023, A Co-ordinated Response to Winter Pressures*)

The Alliance is aware that some schemes are already in place within the L&SC health and care system, but that they are not operating consistently across the 4 places or within our 5 NHS Trusts. This leads to inequitable provision for our population and will place increased demand and pressures on certain parts of the system. Further work is needed to identify where gaps exist and where the intervention model could make the most significant impact. If the proposal is supported this would take place within 2 weeks of confirmation through discussions with key delivery partners and Place UEC Boards.

The attached case studies provide an illustration of the benefits that the investment could deliver to the system and individuals and their families.

2. Capacity created:

Schemes supported by this investment will use evidence-based approaches to create additional capacity within the system through high cost activity avoidance, namely:

- Avoiding A&E attendances;
- Reducing hospital admissions;
- Improving timely discharge thereby improving flow and releasing bed capacity (with a focus on pathways 0 & 1)
- Reducing readmissions to hospital

3. Impact of the scheme:
Of the areas of focus detailed below, please select the most appropriate priority area the scheme will impact, and provide a baseline/ and anticipated impact trajectory and associated performance data to demonstrate delivery

The interventions outlined in this proposal will be part of an integrated approach to ensure earlier intervention and personalised, holistic care is provided to reduce hospital admissions and support timely discharge. The impacts will therefore be seen across a number of the areas of focus as outlined below, but will be part of a cumulative effect that would require a more sophisticated approach to understanding combined impacts against baselines to provide an improvement trajectory over a 12 month period.

76% of patients being admitted, transferred, or discharged within 4 hours

The proposed interventions will contribute to earlier intervention and targeted support for individuals and communities who are more likely to rely on emergency services, thus impacting on this target by reducing demand and providing alternative support in the community.

Category 2 ambulance response times – average of 30 minutes over 2023/2024

In reducing the number of people re-admitted to hospital due to having the necessary support in place at home to stay well, this scheme will have a positive impact on ambulance response times. Evidence from other areas indicated that readmissions could be reduced by 76% within the target cohort.

92% G&A bed occupancy

Over the 12 month period the interventions will impact on demand by providing earlier intervention and community based support thus reducing admissions amongst the target cohort. The investment will also impact on length of stay by improving discharge, particularly for pathway 0 and 1 patients.

5% of patients not meeting criteria to reside

Holistic support will be made available to all patients as part of discharge planning, thus enabling people to return home in a safe and timely manner with the appropriate support infrastructure in place.

Reduction in twelve hour breaches e.g. (10%, 7% or 5%)
Please outline the baseline, trajectories and timeline

Reduction in length of stay
Evidence from similar schemes indicates that the average length of stay can be reduced by an average of 4.3 days where VCFSE partners are engaged in integrated discharge teams or Transfer of Care Hubs. [i]

Admission avoidance
The scheme will result in less people being readmitted as the necessary support will be in place within the community. A similar VCFSE led scheme delivered in Cheshire & Merseyside showed that 76% of the cohort supported through the programme did not utilise emergency services in the 12 month period under review despite being made up of 'high risk cohorts' with previously high levels of utilisation. [ii]

4. Quality Impact Assessment:

*Please outline the benefits to patient safety and experience and confirm that a Quality Impact Assessment/*Equality Impact Risk Assessment has been completed.

The proposals have been developed in line with the LGA's High Impact Change Model on preventing hospital admissions and the evidence contained within multiple papers outlining the core aspects of successful discharge processes for individuals, their carers and families. The benefits that will be delivered include person centred services that meet the holistic needs of individuals.

A QIA/EIRA has not yet been completed for this scheme, but the VCFSE has these for other provision that can inform the development of these assessments. In terms of equality impact, this scheme will support people who are disadvantaged by poverty as it aims to put in place practical measures to ensure people have a warm home and food to return to when they leave hospital.

5. Finance: (Invest to Save)

Please outline if there will be any savings made as a result of the investment

The full impact of the investment on releasing capacity will need to be worked through once the delivery settings are agreed. It should also be noted that the ambition is for Link Workers to embedded within existing teams, therefore financial savings need to be considered collectively to avoid double counting. Evidence indicates that by including Link Workers within teams, the benefits realisation will be greater and more sustainable.

The following examples are indicative of the capacity that could be released though the investment based on evidence from similar schemes:

4 Link Workers co-located in Trusts where there is a current VCFSE gap within Integrated Discharge Teams/ Care Transfer Hubs. Able to support 480 individuals and families per annum. Assumption of interventions contributing to an average reduction of length of stay by 3 days- **1,440 bed days** (cost avoidance of £498,240) [iii]

6 Link Workers aligned with Community Based Teams (including Virtual Wards) supporting 720 individuals per annum (plus carers and wider family). Assumes baseline readmissions of 15.5% for this cohort (likely to be higher due to demographics and risk factors) and 76% reduction in those requiring an emergency readmission. 82 less readmissions providing an estimated cost avoidance of **£288,869** [iv]

The likely savings associated with admission avoidance are likely to be much higher if interventions are targeted appropriately either within priority wards or by working in an integrated way within Virtual Wards and Urgent Community Response Teams. Case studies from other areas have demonstrated activity avoidance costs in the region of **£77,000** per individual over a 12 month period [v] ('

If successful in progressing the proposals, the Alliance would work with local research institutions to understand the true impact of schemes and provide local evidence of effectiveness to guide future investment decisions.

6. Key Performance Indicators: (SMART)

Please detail the key performance indicators which will be measured to demonstrate delivery and impact linked to priority areas in section 3.

- Number of patients discharged early as a result of interventions.
- Number of beds made available as a result of interventions
- Number of individual support plans completed
- Case study examples will be used to provide evidence of changes in emergency services utilisation pre and post intervention

Risks:	Mitigations:

Unable to embed Link Workers within existing teams	Further development of proposals with acute trusts and community teams (health & social Care) to deliver integrated responses
Unable to deliver system wide impacts due to level of investment	Rapid assessment of current provision and further discussions with partners (including those within the VCFSE sector) to ensure UEC capacity investment adds value and addresses current gaps in provision
A lack of resources across the VCFSE at each Place to enable the support and care for people in the community	Interventions will be delivered as part of a wider strategic drive to focus on personalised care and preventative approaches that empower individuals and enable them to remain independent for as long as possible

Exit strategy

Please provide details of the exit plans once the funding ceases

This investment is intended to provide a basis for earlier intervention and preventative approaches that support demand management and the most effective use of resources to meet the health and wellbeing needs of L&SC's population. We would envisage that the interventions developed would provide the basis for a future model of integrated working between VCFSE and statutory organisations. The evaluation of the scheme impacts could be used to inform future commissioning decisions to redirect investment where it can make the greatest impact as part of the ICBs transformation agenda.

Please complete and return this form to the Urgent and Emergency Care Team at lscicb-bd.urgentandemergencycare@nhs.net by midday **Monday, 5 February 2024**

[i] Future Hosp J. 2017 Feb; 4(1): 30–32 provides evidence from a discharge to assess model implemented in Sheffield.

[ii] Healthy & Home – Reducing length of stay and supporting patients by fully embedding the Voluntary, Community & Social Enterprise (VCSE) Sector in the discharge process. VSNW, April 2023

[iii] Health Foundation Report (Tim Horton) Improving hospital discharge in England: the case for continued focus and support. Indicated average length of stay reduced by 4.3 days as a result of integrated discharge to assess schemes. Estimates the cost to the system of additional bed days beyond the end of treatment as £346.

[iv] Based on data provided by the Kings Fund NHS: Key Facts And Figures | The King's Fund (kingsfund.org.uk) Assumes cost avoidance per person of ambulance conveyance, A&E investigations and average length of stay of 8.3 days

[v] *Healthy & Home – Reducing length of stay and supporting patients by fully embedding the Voluntary, Community & Social Enterprise (VCSE) Sector in the discharge process' VSNW, March 2023*)