Health and Care in the Community Programme

Presented by: Briony Sloper
Deputy Director – Health and Care in the Community-
NHSE London

Health and Care in the Community- What we do

We support Londoners to receive treatment at home when they experience a health crisis; avoid unnecessary hospital stays; progress through any necessary hospital stay as efficiently as possible by improving patient flow; return home as soon as it is safe to do so, then stay healthy at home.
The HCIC programme achieves this by:

- Supporting community and social care services to keep people well and out of hospital
- Share knowledge & best practice **across London's health and care system**
- Identify unwarranted variation in access to services and outcomes

The functions and benefits of our work

Key functions

- ✓ **Develop** resources for teams and **promote** successful initiatives
- ✓ **Create** and **convene** networks to share best practice
- ✓ **Deliver pilots** to test improvements to services
- ✓ **Provide oversight, assurance** and **feedback** for plans to ensure delivery of high quality services
- ✓ **Conduct data analysis** and **monitor** performance and outcomes
- ✓ **Support teams** develop and implement services, working in partnership with national and local stakeholders
- ✓ **Identify** opportunities to improve services
- ✓ **Identify** Unwarranted variation in access to services and outcomes
- ✓ Act as **key point of contact** between national teams and local teams in order to **disseminate** policy proposals and guidelines, and **share feedback** with the national team.

Key benefits

- + **Improve relationships** between regional, national and local stakeholders as well as different health and social care providers. Ensuring that regional and local stakeholders are represented and have a voice in national policymaking
- + Reduce **hospital admissions**
- + Improve **health outcomes** and **patient experience**
- + Improve **equity of access** to healthcare and reduce **health inequalities**
- + Further develop **evidence base** for proactive, integrated care in the community
- + Reduce **pressure on services**, including 999 and A&E
- + Improve **data quality**
- + Reduce **costs** of healthcare

Our Programmes

- **The Better Care Fund-** partnership and integration programme
- **2 hr Urgent Community Response teams**
- **Proactive Care- identifying those most at risk of hospital admission to provide support at home**
- **Enhanced Health in Care Homes and Home Care- Improved access to health services for care providers- care homes and home care**
- **Community services –** workforce, activity, reporting, waiting lists, productivity
- **Digital transformation in community and social care settings-** shared care records, remote monitoring, technology enabled care
- **Reducing in-hospital length of stay** and improving discharge
- **Intermediate care** – access to rehabilitation, reablement and recovery services

National Ageing Well Programmes

What is the Better Care Fund?

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

It represents a unique collaboration between:

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS England

Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination from various NHS and Council funding sources.

Where are we now?

There are **33 local BCF plans in London** (1 per Health & Wellbeing Board) totalling **£1.6bn in 23/24 and £1.7bn in 24/25**.

In Feb/March of 2025, local teams submitted BCF plans for 25-26. Primarily the focus is on agreeing:

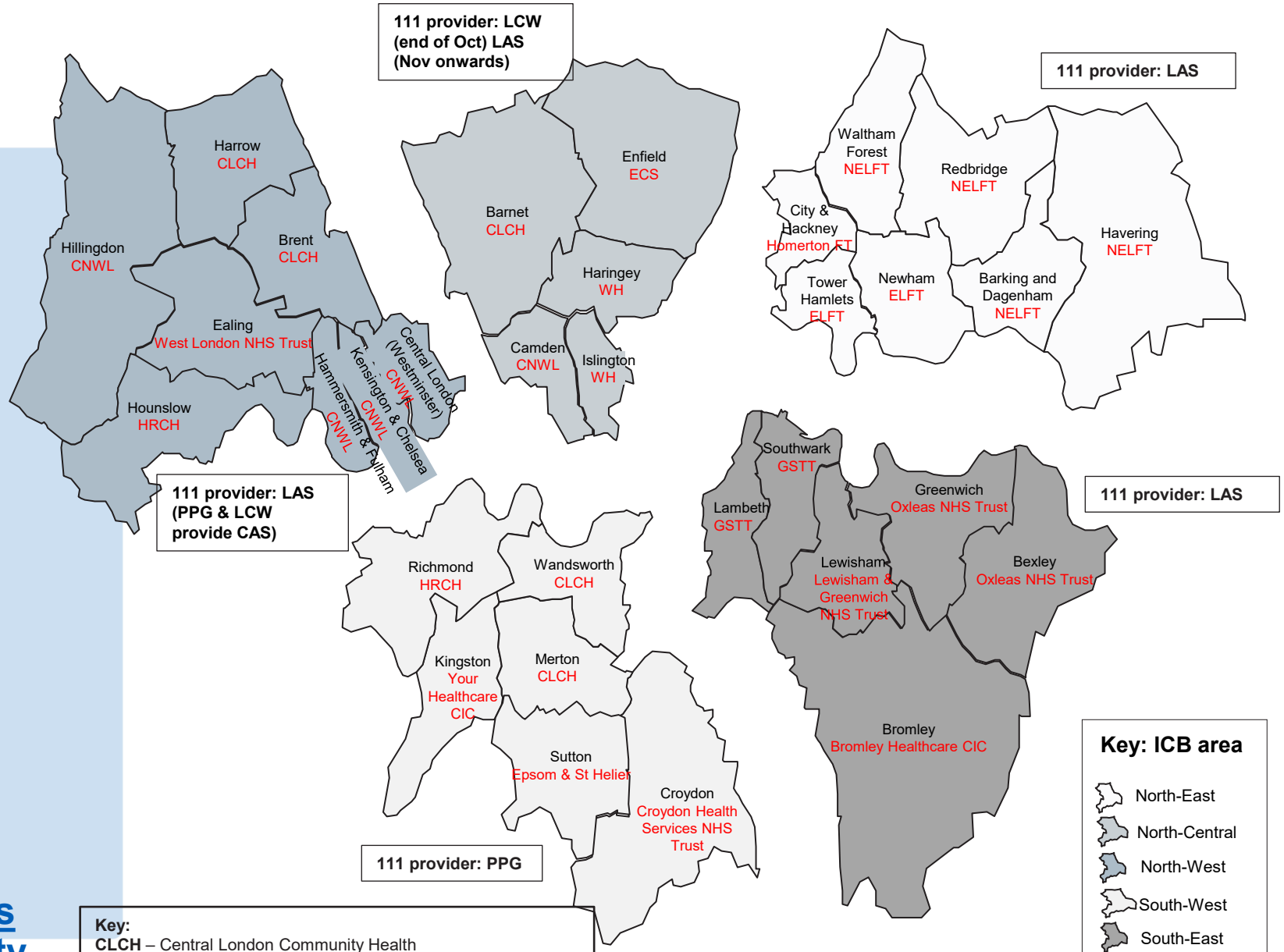
- Capacity and Demand plans
- Spend plans
- Metric ambitions
  - **Avoidable admissions >65s**
  - **Discharge to usual place of residence and reducing permanent admissions to care hor**
  - **Discharge delays**

All funding is agreed in collaboration across health and social care partners, schemes funded are wide ranging and provide shared learning across London
Insight into local, integrated priorities- frailty very dominant this year

London Urgent Community Response Service Provision

London has UCR services in place for all 32 boroughs:

- **16 UCR service providers across the 5 ICBs**
- **All providers deliver a minimum 7 day a week service 8am to 8pm (75% provide extended service hours)**
- **In place formally since the 2021 NHS England [Community health services two-hour urgent community response standard guidance]**



Key:
CLCH – Central London Community Health
CNWL – Central & North-West London NHS Foundation Trust
ECS – Enfield Community Services
ELFT – East London Foundation Trust
GSTT – Guy's & St Thomas' NHS Foundation Trust
HRCH – Hounslow & Richmond Community Healthcare
NELFT – North-East London Foundation Trust
WH – Whittington Health

UCR Service Parameters

Patient criteria

- Adult patients, over 18 in crisis in their own home or residential/care home setting
- Need intervention, within 2-hours to stay safely at home/usual residence, and avoid admission to hospital
- Not for:
  - acutely unwell or injured, require emergency care intervention and admission to acute hospital bed;
  - need acute/complex diagnostics & care; experiencing mental health crisis
  - require referral/ assessment by specialist mental health team.

Service provision

- 8am-8pm, 7 days a week at a minimum
- Patient contacted within two hours of referral
- Supported for up to 14 days with monitoring and treatment to ensure they stay safe at home

UCR referrals accepted

- NHS 111 and 999 and Emergency departments
- General practice/GPs
- Social care providers (such as care homes) including personal assistants and care workers
- Clinical hubs in ambulance control rooms & patient facing ambulance clinicians
- Specialist services & local authorities
- TEC/Pendant alarm services
- Self-referrals from individuals and their carers also accepted.

Conditions/Clinical Areas Covered

These conditions/clinical areas can be covered by UCR services

They are not an exhaustive list, rather aspects of common clinical conditions or needs that may lead to a person requiring a two-hour response in a crisis.

- Falls
- Urgent catheter care
- Reduced functioning / mobility
- Urgent support for Diabetes
- Unpaid carer breakdown
- Palliative / end of life crisis support
- Decompensation of frailty
- Urgent equipment provision
- Confusion / delirium

Enhanced Health in Care Homes Framework (EHCH)

3 principal aims:

1. Deliver high-quality proactive, personalised care within care homes
2. Care home residents have access to the right care at the right time in their place of choice
3. Enable effective use of resources by reducing unnecessary conveyances and admissions to hospital, whilst ensuring the best care for residents

What does it do?

1. Sets out **contractual requirements** for Primary Care Networks (PCNs and NHS standard contract
2. Describes **evidence-based best practice**. Other than the contractual requirements, there are no defined standards or expectations for what care home residents should be receiving.

Contractual requirements (PCN DES) & NHS Standard contract, to enable the EHCH model

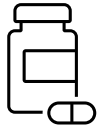
Every care home:

- Aligned to a Primary Care Network
- Has a named Clinical Lead (who is responsible for overseeing implementation of the framework)
- Has a weekly home round or ‘check in’ supported by the MDT
- Care home residents to have structured medication reviews (SMRs) , but no minimum contractual numbers set

Every resident within 7 working days of admission or readmission:

- Has a comprehensive assessment of need undertaken by a member of the MDT
- Has their proactive, personalised care and support plan(s) developed by a member of the MDT

EHCH health and wellbeing focus areas



Structured medication review
People who live in a care home are likely to be taking multiple medicines (polypharmacy) and risks can outweigh benefits

Learning disability and autism
third largest setting that people with learning disabilities reside

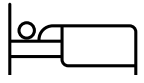
Nutrition and hydration
higher prevalence of over-nourishment and undernourishment – which can lead to greater risk of falls, wounds, infections and catheter issues

Falls, Physical Activity, Strength & balance exercise
Greater prevalence of frailty and chance of falls (i.e. greater +65 yos; and those with LD have similar risk for falls)

Mental health
Complex conditions and ageing can negatively impact mental health

Dementia
>70% of people living in care homes have dementia or severe memory problems

Deterioration
Care home staff can recognise when a person may be becoming unwell before the person exhibits obvious clinical signs of a deterioration –prevents escalation of care



Palliative and end of life care
Caring for people who are at the end of their lives is a large part of what care homes provide

Proactive Care

National Framework

Proactive care: Providing care and support for people living at home with moderate or severe frailty https://www.england.nhs.uk/community-health-services/proactive-care/

Proactive care Providing proactive care for people living in care homes

https://www.england.nhs.uk/long-read/providing-proactive-care-for-people-living-in-care-homes-enhanced-health-in-care-homes-framework/

The specific aims of proactive care are to improve health outcomes and patient experience by:

- delaying the onset of health deterioration where possible
- maintaining independent living
- reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care.

Proactive Care

Core Principles

Identifying the target cohort for whom there is the greatest potential impact on health and system outcomes –

- Those living with severe/moderate frailty
- Those living alone
- Those recently bereaved
- High Intensity Users – Primary Care, Social Care, Urgent Care

MDTs to deliver:

- Carrying out holistic assessments, such as a Comprehensive Geriatric Assessment
- Developing a personalised care and support plan
- Delivering co-ordinated multi-professional interventions to address the person's range of needs
- Providing a clear plan for continuity of care, including an agreed schedule of follow-ups

National Frailty Improvement collaborative and the development of Neighbourhood working INTs will be key

Community Services

- Waiting Lists- unwarranted variation, validation and long waits, performance reporting, sharing best practice for specific pathways such as musculoskeletal (MSK)
- Self-referral pathways- 7 x pathways,
    - Falls services
    - MSK
    - Audiology
    - Weight management services
    - Community podiatry
    - Wheelchair services
    - Community equipment
- Activity reporting and **data quality** - community services data set (CSDS) and Faster data Flows (FDF)
- Workforce- safe staffing levels, competencies, recruitment and retention, e-learning, digital access
- Productivity and standardisation

Community Services

Waiting Lists

- Work closely with national to understand the new requirements/metrics and to provide feedback from our London ICB group
- Continue running ICB waiting list group and share best practice, peer support and regional support
- Amend the current granular monthly waiting list report to reflect the 2024/25 requirements
- Provide targeted support to ICBs/providers to improve data quality and management of lists
- Evaluate and feedback on the 2025/26 waiting list plans

Self-Referrals

- Evaluate the impact of increased self-referrals on waiting lists as directed in PCARP1
- Support ICBs to ensure that healthcare staff and patients understand the availability of self-referral pathways
- Use national data to provide tailored analysis for each ICB to help them improve their data quality and flow
- Offer more intensive/targeted support to those ICBs which are under target in-year
- Share best practice, case studies and webinars

Data Quality

- Following initial meeting, establish bi-monthly BI leads forum with agenda driven by ICB. This can be used to identify the core CSDS/FDF issues for their providers and enable mutual aid
- Work with PIR to deliver data quality improvements
- Working with the UCR workstream in HCIC, focus on improving referral reason and referral source coding

CSDS/FDF

- Liaise with ICBs every month to inform them of providers not submitting CSDS
- Encourage improvements in CSDS. Develop routine data quality reports so that ICBs can compare their performance
- Ensure GSTT consistently submits CSDS and starts to submit waiting list data
- Support NECS onboard FDF in cohort order

Additional Projects

- Support team members, as needed, with improvement in;
  1. Community Equipment
  2. Community OPEL Processes
  3. Community Workforce
  4. Community Performance Monitoring
  5. Community Productivity

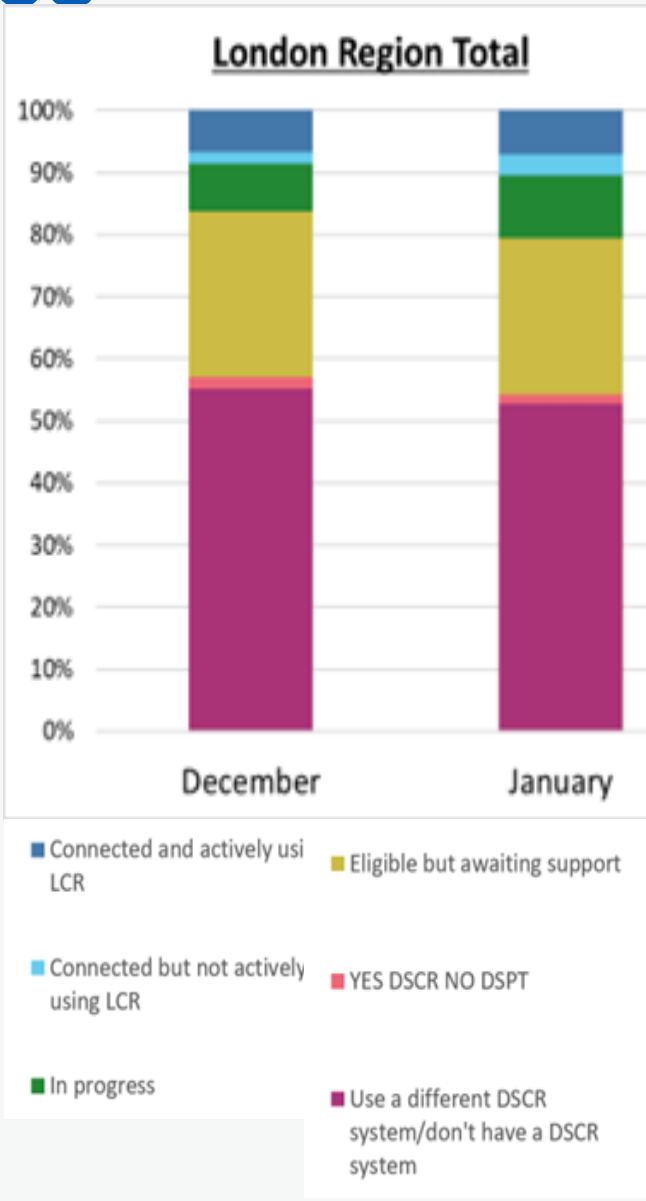
Digital: London Care Record in care homes

- **Progress:**
- Connecting care homes to the London Care Record (LCR) via an in-context link in Digital Social Care Record systems (DSCR) has made steady progress.
- >160 care homes (15% of total London care homes) are now connected, a 100% increase over 6 months. Of those, 90 are actively using LCR. A further 130 care homes are currently being actively supported to connect.

- **Impact:** 2000+ views in January led to time saved and better decisions made in care homes such as timeliness and quality of discharge, visibility of assessments, care plans, prescriptions, appointments, test results.

- **Challenges:** Delayed technical development by DSCR suppliers and a complex on-boarding process for care homes have been barriers to further progress.

- **Next steps:**
- Planning to enable access to the LCR to care homes using different systems to ones already engaged, and those who remain paper based , via a web-portal.
- **Also focus on technology enabled care, artificial intelligence, cyber security, resident outcomes and benefits, shared learning and digital summits- falls technology a high priority**



Reducing in-hospital length of stay and discharge

Key metrics

- Discharge Ready Date – days delayed between discharge ready and actual discharge
- % of bed base occupied by +7, +14, +21 days
- % bed base occupied by patients assessed as not meeting the criteria to reside (ready for discharge)
- Daily discharge numbers – including weekends, pre and post 17:00
- Discharge across different pathways:
    - Pathway 0 simple discharge- not ongoing health or social care needs
    - Pathway 1 discharge where some element of health or social care is required at home
    - Pathway 2 rehabilitation and reablement
    - Pathway 3 long term care placement
- Number of delayed discharges and associated causes, hospital only (awaiting decisions, tests, medication transport etc), reablement/rehabilitation capacity, community and home care capacity, residential/nursing home capacity
- >12 hr episodes in Emergency Departments

Reducing in-hospital length of stay and discharge

- Integrated Care Board/Local Authority discharge leads forums fortnightly
- Weekly data analysis and reporting identifying ICB and provider level performance, variation and improvement/deterioration in position

Improvement programmes

- Discharge Lounges & Weekend discharges
- Criteria to Admit
- Long length of stay reviews/Missed Opportunity Audits
- Improvement visits and shared learning – e.g. Clinical Site Management, Board Rounds
- Criteria Led Discharge
- Care Transfer Hubs and repatriation pathways
- Community Providers LoS (intermediate care, rehabilitation and reablement)
- Tier 1 specialist rehab centres LoS, waiting lists and referral pathways
- Trusted Assessors
- Patient Choice
- Care Home discharge pathways
- Health Inequalities
- Voluntary Sector partnerships
- Best practice guidelines co-produced for common pathway challenged such as homeless health

Intermediate Care

National framework

Oversight and implementation of the newly published intermediate care framework for rehabilitation, reablement and recovery following hospital discharge to help ensure high quality step-down care.

Building on work of eight discharge frontrunner sites (Croydon was one) to test new approaches, this best practice guidance focusses on a number of recommended actions that systems should consider in partnership with their intermediate care services.

There is also a new community rehabilitation model published alongside the framework and aims to ensure that the individual (and their families) is at the centre of discussions and that any transition points will be as seamless as possible.

Intermediate Care

Priority area 1: Improve demand and capacity planning

Priority area 2: Improve workforce utilisation

Priority area 3: Implement effective care transfer hubs

Priority area 4: Improve data quality

Focus regionally:

Best practice models for home based reablement, rehabilitation and recovery

Workforce skill mix, models and productivity

Bed based models – community bed audit, variation in length of stay, post discharge outcomes

Capacity and flow – admissions from home alongside discharges form hospital

Pathway specific: Catheters

- London Region UEC Board identified priorities for winter and catheters and reduction of utilisation of emergency pathways was agreed as a regional improvement focus:

  No referral or conveyance to the ED (via 111 or 999) for clinically well patients with an isolated catheter problem without being referred and assessed by a UCR/community clinical team.

Detailed data insight programme undertaken by the national CLEAR programme (Clinically-Led workforce and activity Redesign programme)

- **31.7 ambulance attendances** related to catheter problems per day most between **10-11am** and **4-5pm (during core UCR operating hours)**
- Generally comprising of patients with **low NEWS2** and in **no pain**
- **Average wait time: 96 min, Average time with patient: 126 min**
- **75% are conveyed to hospital, 88% of Care Home attendances are conveyed**
- **For all catheter presentations to ED**
  - **Majority are self-referrals (70.5%)**
  - **Average time in ED is 11 hours**
  - **35.9% are admitted (at least 65% of these were assessed as avoidable)**
  - **Average length of stay: 16 days for patients coded with urinary retention of which 52.4% spent 7 or more days in hospital**

Key themes and agreed deliverables

A system wide task and finish group was established in November 2024 including representatives from national Nursing directorate, ICBs, ambulance, 111, community, primary, social and urgent care alongside subject matter experts in urology/catheter management, digital and BI leads.

National nursing directorate has established a group to focus on catheter pathway improvement, with representation from all regions to share good practice and

.

- **PCNs, deep dive into identifying those patients with indwelling catheters – Urgent Care Plan (UCP), catheter reviews undertaken**
- **Self-Care/self-management tools (NHS App)**
- **Catheter passport – developing a London wide passport in collaboration with T&F group**
- **Collation of education and training materials – scale and spread.**
- **Best practice discharge guidance documentation (GIRFT/Urology CLG)**
- **111 NLP identification tool to fast-track redirection**
- **Identify and resolve UCR teams' variation in service models supporting catheter response**
- **Identify areas with highest volumes catheter related calls including those with highest volumes of care home catheter related activity**
- **Call before convey urology specialist (Clinical Nurse Specialist)**
- **LAS/Care home/home care education modules**
- **Single LAS Alternative Care Pathways for catheters**
- **Perfect week- catheter focussed**

Other HCIC improvement focus areas

Looking at Pan London step changes in:

- Falls pathways
- Frailty services
- Same Day Emergency Care (SDEC)/Virtual Wards (VW) interfaces with 111/999 improved utilisation of community services to increase care closer to home
- Home Care/Domiciliary Care providers access to services and health support
- Care Coordination Hubs/Single Points of Access (SPOAs)
- London Ambulance Service (LAS) interfaces and referral numbers- Health Care professionals , Care Homes, pendant alarms, training and education, Urgent Community Response
- 111- upstream identification and frailty flagging, natural language processing (NLP)
- Focus across all on **unwarranted variation in access to, and support provided** across Health and Well Being Board/LA/ICB footprints. Link closely with extensive range of regional programmes to avoid duplication of effort and join up improvement programmes

Thank You!!!

Briony.Sloper1@nhs.net