

# Improving healthcare services for patients in Lincolnshire

June 2022

## What is Care Closer to Home?

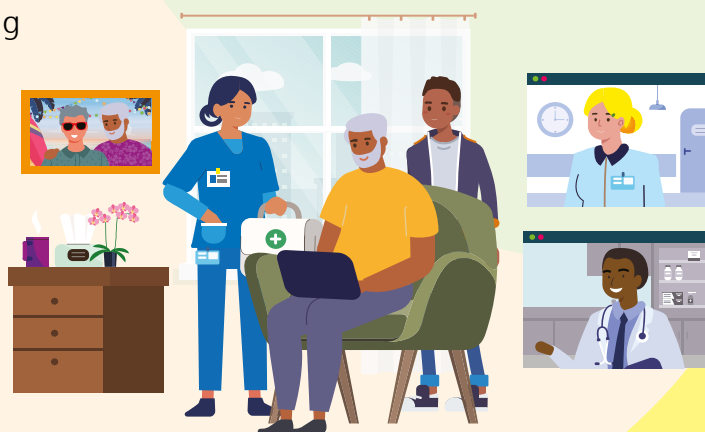
Providing co-ordinated care for patients in their home or in their local community that enables our residents and patients to keep themselves well, take charge of their own health, whilst maintaining access to high quality care at the right time, with the right specialist support.



**Submission sent to the HSJ Awards in the "Primary and Community Care Innovation of the Year" category for Lincolnshire Care Closer to Home programme to showcase the excellent work being delivered across our county**

The Lincolnshire system has developed a **Virtual Ward Strategy**, setting out the model of care and identifying additional specialties to support the development of virtual care. This strategy was supported by the Urgent Emergency Care partnership board and will be rolled out across the county.

The strategy builds on the excellent collaborative work already undertaken across frailty and heart failure, and will see expansion into palliative and end of life care, respiratory, and same day emergency care bringing a holistic approach to the care people in Lincolnshire receive.



Planning continues to launch (softly) the **Integrated Discharge Hub** at the end of June. Working with local partners, new processes have been agreed and equipment for both hub sites has arrived to be installed. The launch of the new hub will help support patient flow and help local people to get the right health care support in the right place.

This month, system **Multi-Agency Discharge Events (MADE)** have taken place to assist discharges across the county. Local partners will work together with the aim to support as many discharges as possible for people who do not require hospital care and would be cared for more appropriately at home or in a community setting.

Following the **successful recruitment of seven registered therapists**, who will deliver initial therapy assessments to all patients triaged through the Discharge to Assess Health Team service, we will see an increase in activity to help support patient flow and signpost patients to the most appropriate care setting for them.



Lincolnshire Community Health Services received **91 referrals via the Discharge to Assess team and supported 54 discharge patients** over the past seven weeks.

**ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)** creates a summary of personalised recommendations for a person's clinical care in an emergency if they don't have capacity to make or express choices. This enables them to express how they wish to be treated and, in particular, can avoid them being taken to hospital if they do not wish to do so.



The latest version of the ReSPECT form can now be ordered directly online via Ruddocks. This has been successfully piloted with Primary Care Networks (PCNs) and care homes and is being rolled out across Lincolnshire.

For further information on this work please contact [jenny.fryer3@nhs.net](mailto:jenny.fryer3@nhs.net)

We are focusing on co-producing solutions to support the challenges identified by patients and their families.

- **Self-Management:** focus on developing an approach to the self-management of palliative care.
- **Palliative discharge:** following completion of the survey on their discharge experience, we are now addressing some of the challenges identified - particularly communication, practical support and signposting as part of the discharge process.
- If you wish to help or to get further information about this work, please speak to either [kay.howard@nhs.net](mailto:kay.howard@nhs.net), [cgent@nhs.net](mailto:cgent@nhs.net) or [david.reed7@nhs.net](mailto:david.reed7@nhs.net).



The new **virtual multi-disciplinary system** for community cardiology has launched and is being used by staff to review patient health needs and the virtual ward continues to provide support and benefits including out of hospital appointments.



A total of **148 referrals were made to the Urgent Community Response (UCR)** service in May, helping local people to get the urgent care they need and avoiding hospital admissions.

The UCR team continues to raise awareness of its service, most recently **engaging with Primary Care colleagues** at a number of events and will be attending the Integrated Working Event to **showcase the service to other healthcare stakeholders** in June.



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