Rutland County Council

Business Case

Step up Step down

(HDR1 hospital discharge, HDR2 Reablement, IUR1 Integrated Crisis Response)

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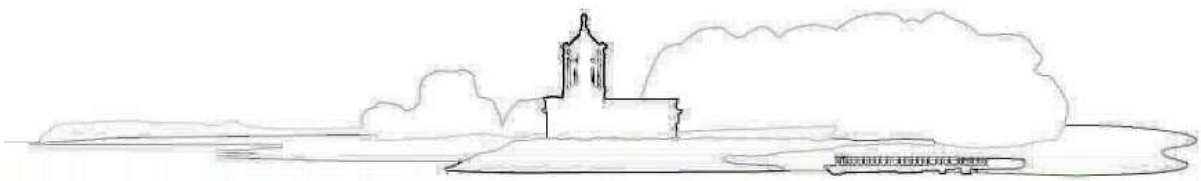


DOCUMENT CONTROL

Change Control History

Version	Change Summary	Change author	Date
0.1	Initial document production	Julia Eames	14/11/14

How to briefly describe this scheme to Service Users

The aim of this scheme is to prevent admissions to hospital or residential care where avoidable by providing services at home, minimise the length of stay for those who do need to go into hospital and help people to regain their maximum level of independence and wellbeing. Reablement helps people to gain or regain the skills necessary for daily living which have been lost through deterioration in health. Reablement ideally takes place in the person's own home but if the person is unable to be at home safely then a bed based facility may be required for part of the programme. Hospital stays are expensive to the public purse and an unsettling experience for individuals and pose particular risks to the elderly.

1 Description of Scheme

Indicate business need including strategic/national local contexts and current organisational approach

This scheme is key to the objectives of the Better Care Together strategy to redesign service pathways to support independence and wellbeing, provide services closer to home, reduce hospital and residential care admissions and support transfer back to the community.

An emergency admission to hospital is a disruptive and unsettling experience, particularly for older patients/service users, exposing them to new clinical and psychological risks and increasing their dependency (Glasby 2003; Hoogerduijn et al 2007; Lafont et al 2011). Any delay to transfer from acute hospital care is likely to lead to worse outcomes for older patients/service users.

The use of acute hospital beds for older patients/service users can be reduced through avoiding emergency admissions and/or reducing excessive lengths of stay. The Scheme will provide discharge options for a comprehensive multi-disciplinary health and social care assessment of need and rehabilitation to take place.

Age UK 'Understanding the Lives of Older Patients/service users Living with Frailty (March 2014), said that the objectives for supporting patients/service users living with frailty should be:

- Maximising capacity and capability
- Personalising care goals
- Managing risk.

In addition there is evidence that;

- shared and comprehensive assessment of needs and personalised care plans, based on shared information and protocols between health and social care partners to address physical, social and psychological needs of patients/service users
- Reablement can enable patients/service users to stay in their own homes for longer, reduce the need for home care and improve outcomes for users.

This Scheme is a combination of Better Care Fund Schemes, that includes a range of health and social care services that work in an integrated way to prevent people's level of care being increase (Stepped up) to the level of requiring an admission to hospital or residential care, or where that level of care has been needed for the services to be reduced (Stepped down). Services to prevent an admission may be low level interventions, including advice or information or intensive multi-disciplinary services provided at a time of crisis. Step down may be in one step or a number of steps e.g. from an acute hospital to a community bed based service, to a supported service at home back to baseline level of independence or on-going support.

This work is align to the BCT work around falls prevention and managing falls and incorporates locally the strategies being developed by this group across LRR. The intention of this piece of work is to consolidate existing activity, ensure clear and appropriate referral routes are in place and ensure practice is evidence based. The scheme will help to deliver more integrated working and inform best value models for the future delivery of these services.

See annexes attached for further details and evidence relating to these plans.

1.1 Scheme Objectives

List scheme objectives

- The overall aim of the scheme is to make the pathways between services simple but effective and wherever possible to consider "Home first" options.
- To maximise the capacity within the acute sector for those who really need it.

- To contribute to providing 24/7 services as required.
- To contribute to the LLR wide target of reducing conveyance rates to hospital by EMAS.
- To contribute to a reduction in the number of permanent admissions to residential care.
- For services to work in an integrated way that reduces duplication and ensures services are provided in a timely way, are safe, comprehensive and effective and that provide individuals with opportunities to maximise their independence.
- To maximise the involvement of voluntary and community services to contribute to supporting the objectives of preventing hospital or residential care admissions and supporting people to return home and to regain their maximum level of independence following an admission.
- To ensure that patients/service users receiving services as part of these schemes are satisfied with the outcome of the care they receive and have a positive experience.
- To ensure Carers involved in the delivery of these services are satisfied with the experience they receive and the outcomes for the person they care for.
- To ensure staff involved with the delivery of these services feel satisfied.
- To ensure people making referrals to the scheme are satisfied with the response they receive and outcome of their referral.
- To demonstrate value for money by evaluating the structures and processes and making recommendations for future service models to meet the needs of the Rutland community.

1.2 Key Deliverables

Include key deliverables for the scheme lifecycle

Scheme Deliverable	**Delivery targets**
Reduce the number of avoidable admissions to acute hospitals and residential care. Prevention of readmissions to hospital.	BCF metrics achieved and receipt of reward grant.
Reduction in delayed bed days from Acute Hospitals, thus freeing up beds for those with priority needs, reducing the clinical risks for people of being in hospital, reducing the overall cost of acute care and to prevent reimbursement charges to the local authority. Ensure reasons for delays are understood and addressed for individuals, through appropriate tracking and planning and any trends are identified and addressed.	No reimbursement charges
Evaluation of this model of integrated working in terms of effectiveness and value for money and evidence as to the need for a night nursing service. Recommendations for future service design.	External evaluation to be completed by June 2015 Local evaluation and recommendations by Sept 2015
To inform the review of Emergency Duty Team services out of office hours	Plans in place post April 2015 to manage crisis referrals to health and social care.
A range of step up step down options/pathways will be available to meet people's needs in a personalised way.	Efficient use of beds at RMH

Will result in fewer people requiring on-going health and social care services and more people being maintained/cared for at home rather than being admitted to hospital or residential care. Timely assessments for Continuing health care will be undertaken.	At the end of Reablement 60% of people will have no ongoing need for the provision of social care services. A falls risk assessment will be undertaken for all people receiving Reablement and as required they will receive advice and information to help prevent falls and know how to manage appropriately if a fall occurs. Service users will be aware of how to access a range of advice and information and community services that enables them to self manage their condition/needs.
Increased integrated working between health and social care services locally.	Staff will feel clear about their roles and responsibilities and have positive relationships with colleagues that supports the way they feel services are delivered to their patients/service users.
Will streamline referral routes into services to assist referrers and prevent duplication for services and service users.	Positive feedback from people referring to these services.
The service will improve the individual's perceived quality of life.	One page profiles will be completed and support plans developed in a person centred way. Reablement Workers will be able to provide a range of interventions to help individuals to achieve their Reablement goals. Audit tools and outcomes measure to be developed.
Handovers between services will feel seamless. Handover to ongoing providers when required will be brokered and carried out so that the service user feels empowered to	Service user feedback/survey

manage their ongoing service with choice and control.	

1.3 Scheme Milestones

Identify the significant milestones (phases, stages, Attach the work stream Plan. This should outline the main stages of the work stream, milestones and any interdependencies

Activity	Milestone	Dependency	Responsible	Start Date	End Date
Develop culture of joint working between relevant services including ELRCCG, RCC, LPT, Lincolnshire and Cambridgeshire CCG, Peterborough Hospital, UHL, Kettering Hospital, RMH, other hospitals used by Rutland residents, Provider services, voluntary sector, neighbouring authorities.	Joint meetings and training Develop use of single referral form/shared minimum data sets. Develop shared IT systems Develop links with MHSOP	Engagement from workforce and capacity to work differently	Operational Integration steering group (Julia Eames) Katy Lynch, Jason Haynes	July 2014	0ngoing
Promotion of current service to potential referrers	Initial and on-going communications	Influencing referrers amongst the many new initiatives they need to be aware of.	Rutland operational integration steering group	August 2014	ongoing
Establish current baseline activity for DTOC	Identify systems for recording and analysing data Identify demand over 7 days		Performance Team BCF leads		
Define demand for different options for step	Link to joint Commissioning strategy between		Karen Kibblewhite Paul		

down services Develop home based and bed based step down options in RMH, residential care and in an extra-care type facility to fulfil need.	CCG and RCC Link to the Better Care Together pathways work for LLR and Peterborough and Lincolnshire. Include options for people in 'holding' situations e.g. those who are NWB or in PoP (suggested 1 bed in summer, 2 in winter) Options for people who are end of life.		Phillipson (Places directorate) Integration Executive.		
Developing systems for evaluation of the service	Local data collection. Engagement with external evaluation		Julia Eames Step Up step down board	1.10.14	
Develop market for provider services – domiciliary and residential and extra care schemes to support hospital discharges.	Need to consider use of voluntary sector, personal health budgets and Direct payments, role of housing etc.		Karen Kibblewhite		
Incorporate recommendations from the Falls redesign BCT work book.			Julia Eames Caroline Kirkpatrick		
Evaluation of the service and making recommendations for future service delivery	Model for people living in Rutland with a LLR GP Model for people living in Rutland with a non LLR GP				

1.4 Exclusions

Clearly state any areas that are out of scope and whether these are to be delivered by another area/at a later date/not at all, etc.

Mental health,

Integrated health and social care pathways being evaluated separately (IUR2)

See separate standing operating procedures for Night Nursing Crisis Response and ICRS – not safeguarding, not sitting in residential or nursing homes, not people with serious health conditions requiring immediate (999) attention, things that don't need a response within 2 to 4 hours to prevent admission and can be dealt with in normal operating hours, people who do not have a LLR GP.

2 Approach

Indicate what impact the proposed work will have on business as usual. E.g. will it fit naturally with an existing service? Will an existing service need to change in order to accommodate the maintenance or on-going delivery of the products or services? Does this work stream fall within the Better Care Together work stream?

2.1 Operational Readiness

How far has work progressed? What is to be done? Milestones

The Social Worker for Peterborough Hospital and Link Nurse at RMH is already in place through previous winter pressure funding and working effectively so posts need to be reviewed and made permanent.

Work is underway through BCT; integrated transfer - care and support in the community (Tracy Yole) and Falls redesign pathway.

The Rutland ICRS has been operational since the 1.9.14 and has already accepted a number of referrals with successful outcomes. The services are still being developed in anticipation of an increased demand over the winter period. Further work is required to integrate the elements of the service between day and night and between health and social care but there is a strong commitment at all levels to achieve this.

There has been some delay in the external evaluation commencing as anticipated.

The REACH Team has undergone a major re-structure over the past 3 years to develop the role of Co-ordinators and Reablement support Workers. Therapists and a Review Officer are now integral to the Team. Over the past year the Team has developed it's role to act as the main Broker of domiciliary care for the Adult Care Team.

Process Maps have been developed to clarify roles and responsibilities within Adult Social Care and within the REACH Team.

The use of One page profiles and handover checklists have been introduced. The Risk Assessments for new starters with the service have been radically reviewed and streamlined, including a falls risk assessment.

The Team is having successful outcomes with approx. 60% of people requiring no on-going social care at the end of their Reablement period. The average time on Reablement is 4 weeks. The service is 'all inclusive', accepting people considered to have limited potential for improvement but needing the opportunity for their needs to be properly assessed and a package of ongoing care established.

The use of Just Checking has been used by the REACH service and assessment and provision of other assistive technology is regularly utilised.

Close working links with the Discharge Social Worker for Peterborough Hospital and the wider adult social care team are well established.

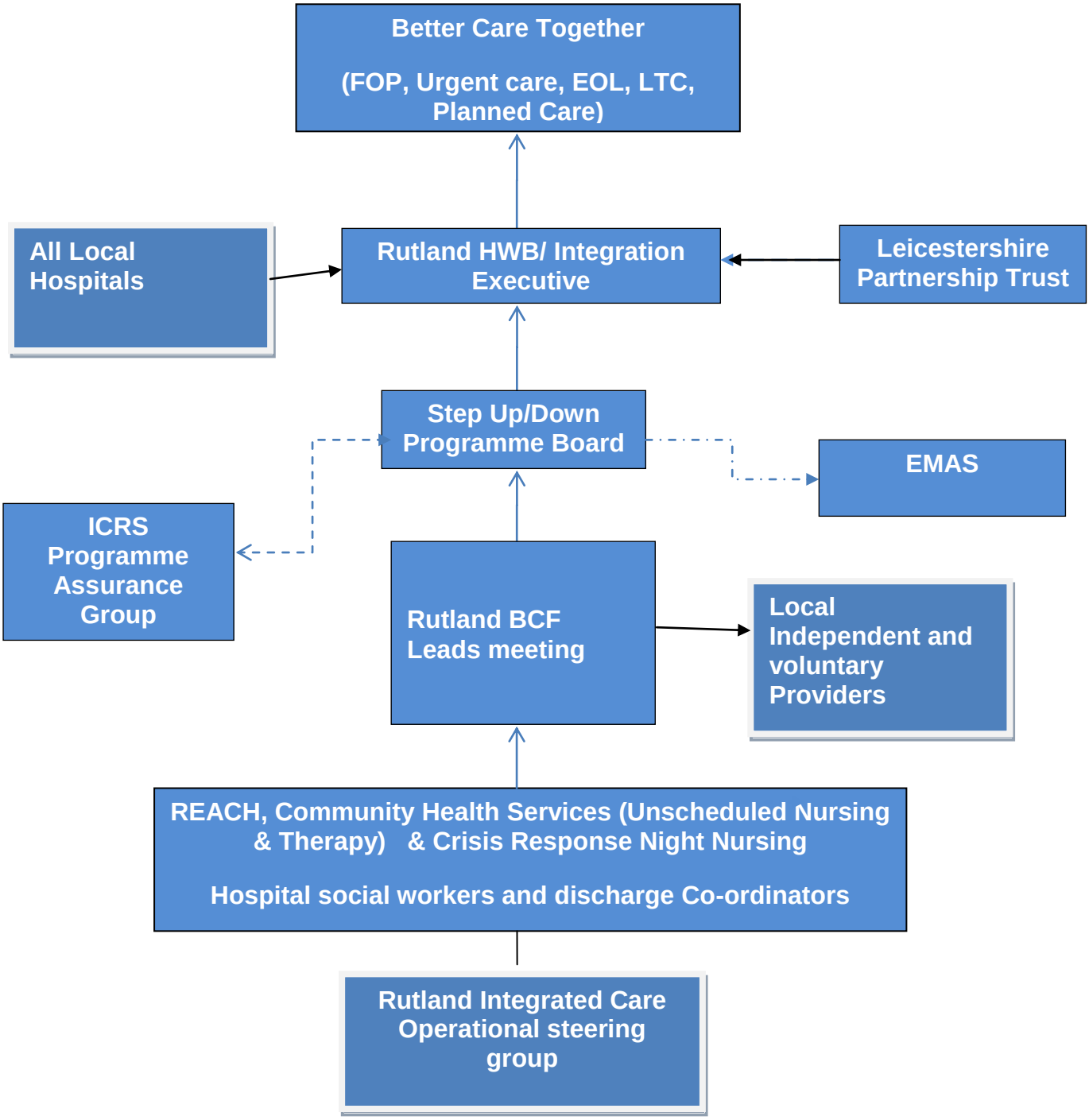
A pilot project for the Reablement team to work more closely with a Pharmacist is due to commence in November.

More recently joint meetings with the Intensive Community Support Service have commenced. However currently there is no formalised information sharing or shared IT in place for the services to work in an integrated way. The services have separate referral points and processes for assessment, recording etc etc

2.2 Work stream structure

Consider key Business areas such as procurement, IT, workforce and delivery into Service.

Provide a diagram of the proposed scheme structure and brief details of the governance approach



2.3 Work stream metrics

BCF Metric	**Description of Impact as set out in BCF** **Significant/moderate/other**
Avoiding admissions to hospital	ICRS FY14/15 2.7 FY 15/16 9.0
Reduce delayed transfers of care	Hospital discharges FY 14/15 34.2 days FY 15/16 104.1 days
Increase the number of 65's still living at home 91 days after discharge.	Reablement FY 14/15 0.7 FY 15/16 1.0
Reducing admissions to hospital due to injuries sustained because of a fall	ICRS FY 14/15 0.5 FY 15/16 0.7 Reablement FY 14/15 1.6 FY 15/16 2.1
Other metrics	

2.4 Work stream metrics recording

Information being collected	**At what stage in the patient**	**Information collected by whom**	**Database on which information is collected /**

	pathway is the information being collected?		**captured/ stored**
Peterborough and Cambridge CCG data about activity relating to P'boro hospital	monthly	CCG	
Data relating to LLR DTOC	monthly	GEM Jason Underwood	
Local data collection for Peterborough scheme	Point of referral	Lauren Reed and Claire Haines Julia Eames	spreadsheet
Sitreps	Weekly	Angela (Team Manager) form P'borough and Leicester	
Local data collection for Reach	Reach Team	At referral, at discharge	Spreadsheet
Local data collection for night nursing service	Night nursing team	At referral and discharge	
Customer satisfaction surveys	To be developed jointly	Steering group	
Staff satisfaction surveys	To be developed jointly	Steering group	
Referrer satisfaction surveys	To be developed jointly	Steering group	
External evaluation quantitative and qualitative data			
Numbers of referrals to Reablement	Start	REACH Admin Information Management team	CM2000 and Raise
Outcomes of Reablement	End	REACH Admin	Spreadsheet
Number of people remaining at home after 91 days	Katherine Ayton	Monthly	

Patient Experience	ASCOF Local survey to be developed Letters of compliment and complaints	TBA	Annually
Reduce number of falls	Jason Haynes		

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting dates**	**Reporting timeframes**
Report to BCF leads meeting, Integration executive meeting, Step up Step down Board	BCF lead, Julia Eames, Caroline Kirkpatrick		

3 Communication and Engagement

3.1 Stakeholder Analysis

Stakeholder Name	**How they will impact on the scheme**	**How they will be impacted by the scheme**	**Communication requirements/methods**
People receiving/needing a service and their families and carers. Members of the public.	Expectations they have about the sort of support they want and expect will determine their level of engagement with the service. Feedback on the effectiveness and satisfaction with the services.	Shorter stays in hospital and/or interventions provided at home or in different settings closer to home. They will require services to respond in a timely and effective way.	Information sharing so have realistic expectations and understanding of why not remaining in acute bed for as long as might expect or feel need and reassurance that their outcomes will be successful. Need information to help them understand what Reablement aims

			to achieve and the reasons why it is helpful for individuals and necessary to the wider public purse. Promotion of the service to reassure people that they will get a safe and effective service, that is a better option for them than being admitted to hospital or residential care. Positive publicity about individual success stories.
Voluntary sector and wider community	To understand how to use preventative services, advice and information systems and universal services to support self management and wellbeing.		
Partners who will want to refer to the service e.g. GP's, Emergency departments, EMAS, other health and social care services.	Need to understand the service to be able to make use of appropriately	Will provide an option for them rather than admitting/conveying people to hospital or residential care Will free up capacity of workers in other teams to deal with new and more on-going cases.	Information for health and social care staff has already been circulated to key referrers. Further rollout of information needs to be considered. Follow-up contact with referrers to give feedback regarding individual cases and service in general.
Members of the REACH Service	Support values and behaviours required to facilitate successful Reablement and service changes.	May effect job roles and responsibilities, work location.	Need to keep involved through staff meetings and newsletters and individual supervisions and PDR's
Intensive Community Support Service	Need to be prepared to work closely with the Reach team .	May effect job roles and responsibilities and work location.	Need to keep involved through regular joint meetings.
Acute Hospitals	Providing appropriate referrals and information using agreed minimum data set and trusted assessments. Effective partnership	Will help with speedier and smooth discharges and free up capacity in acute sector. To actively identify people who will	Need to ensure are aware of referral pathways. Need to ensure they are confident about community services being able to deliver high quality services, so are not risk

	working – shared information Able to identify patients at the point of admission who are likely to be difficult to discharge so they can refer early to the discharge co-ordinators so the required attention and time to prepare for their discharge can be given. People with alcohol related problems or people who are bariatiric are examples where this should happen.	require social care and ongoing health support following their acute hospital episode. Benefit from timely and effective discharges to free up beds. Reduction in level of services being commissioned	averse/anxious about discharging people. Introduce a traffic light system for identifying people at the point of admission who will potentially be difficult to discharge, linked to section 2's. Understanding of level of information required by step down facilities and appropriate pathways for them to follow. Information about step down options.
Private domiciliary and Residential care providers	Supporting the principles of Reablement to maintain individuals maximum levels of independence. Sufficient availability to pick up cases quickly at the end of reablement or to support cases prior to being ready to commence Reablement.	Will affect the nature of the people they are working with – potentially quicker turnover of some cases and long term cases will be more complex.	Ensure part of commissioning strategy and workforce and training strategy work to develop capacity and expertise required. Contracts to be outcome based to ensure delivering quality services in way required, including staff satisfaction information.
Mental Health services for Older people	Need to explore joint working for people who have a mental rather than physical frailty to ensure services are joined up and individuals benefit from their expertise. Utilise expertise to help facilitate discharges from acute settings for people with dementia who are more complex to arrange a safe discharge for.	A number of people undergoing Reablement will have some degree of mental frailty and may need referring to the MHSOP unless the skills within the Reablement service exist.	Involve in integration steering group and local integration activities.
Hospital Social Worker and Link Nurse for P'borough	Delivery of the service sharing good practice that can be used for	Recognition for what they are doing, direction for future	Supervision arrangements, team meetings.

Hospital	other hospitals.	service development.	
Hospital social Workers for other hospitals and Primary Care Co-ordinator at UHL	Liaise with Link nurse to facilitate best use of step down resources	Have a different profile and resources available to enable them to do their role.	Supervision arrangements, team meetings Establish links with Primary care Co-ordinator to ensure fully integrated with Rutland services.
Team Managers/ heads of service	Help with monitoring DTOC through sitreps and conference escalation meetings.	This reduces demands on their time dealing with delays and fines.	Agreed protocols for managing discharge escalation meeting.
Rutland Memorial hospital	Key step down option for those who can't return home immediately.	Increased demand on their service.	Agreed level of referral information from hospital and trusted assessments. Understanding of need to accept referrals and ensure own processes are maximising throughput.
REACH/ICS	Provide support and ongoing assessment and intervention for people when discharged	Increased demand on service. Need to develop capacity and methods so that they can 'pull' people out of hospital as soon as they are ready.	Agreed level of referral information from hospital and trusted assessments. Understanding of need to accept referrals and ensure own processes are maximising throughput.
Other Step down services	Provide support and ongoing assessment and intervention for people when discharged	Business opportunities for independent sector	
Rutland H&WBB	Will determine future funding and direction of the service	Rewards for achieving targets. Reputation.	Regular reports to keep informed of the service development and activity.

3.2 Scheme Reporting and Communication

Type of communication	**Communication Schedule**	**Communication Mechanism**	**Initiator**	**Recipient**
e.g. Status report	*Every other Tuesday*	*Transformation Board meeting*	*Work stream Lead*	*Transformation Team*

Status report	Quarterly	Verbal or written	Julia Eames	Better Care Fund leads meeting
Exception report	As required	Verbal or written	Julia Eames	Integration Executive
Exception report	As required, linked to other LLR schemes such as ICRS, Falls,	Verbal or written	Julia Eames	Step up step Down board

4 Risks

3.1 Key Risks

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	19.11.14	JE	Clarity regarding finances between competing schemes and service areas. Some of this funding is existing and some is new, to be used to achieve integration. The combined money for these BCF schemes is a significant amount. The anticipated savings for this work is mainly to deliver, enhance or establish pilot services as 'business as usual' and maintain the positive outcomes that are already being achieved as the schemes have already undergone significant changes in recent years.	Med	High
2	15.10.14	JE	External evaluation not having sufficient evidence, due to lack of Rutland focus or lack of referrals to make data viable/statistically significant.	High	Med
3	15.10.14	JE	Capacity within different parts of the service to be able to respond to referrals resulting in referrers losing faith in the service.	Med	Med

4	27.10.14	Julia Eames	Capacity with external domiciliary care providers to pick up cases at the end of Reablement	High	High
5	27.10.14	Julia Eames	Capacity of the Intensive Community support Service to work closely with the REACH Team in Rutland	Med	Med
6	27.10.14	Julia Eames	Ability to work with Lincolnshire Independent Living Teams in a consistent way	High	Med
7	27.10.14	Julia Eames	Interest from Residential Care providers to be involved in step down reablement	Med	High
8	27.10.14	Julia Eames	Need to have access to 7 day services including equipment and premises for service to operate from, possible need for some therapy cover at weekends and bank holidays.		

5 Costs

5.1 Scheme Costs

Include all direct and indirect costs

Description	**2014/5(£)**	**2015/6(£)**	**Total (£)**
REACH Team	*Total budget for cost centre 4551* **£637,400**	£637,400	£1,274,800
Physiotherapy secondment 2/7	*£25,000*	£25,000	£50,000
Rutland element of the Single point of access (SPA)Team			
Rutland's element of the Crisis Response Night Nursing Service			

Rutland's ICS service and virtual beds (Pathway 2)			
Seconded nurse from ICS to work in a more integrated way with Reach 2/7		£25,000	
Any funding to support Lincolnshire's Reablement and Crisis response service			
Hospital SW for Peterborough Hospital	£50,000	£50,000	£100,000
Link Nurse for Peterborough/RMH	£50,000	£50,000	£100,000
Contribution to Peterborough Admission avoidance Service – nothing agreed.			
Hospital SW for other acute hospitals	£100,000	£100,000	£200,000
Primary Care Co-ordinator UHL (Is Sarah full time for Rutland? Is this a 7/7 day service?)	£	£	
Beds at RMH (Pathway 3)			
Step down beds at Extra-care/stepping stone or residential care facility (Pathway 3)			

5.2 Funding

Include detail of any potential, or definite, sources of funding. Indicate whether this is likely to come from inside or outside of the BCF approved allocation for this work stream. If external, identify the proposed source.

Funding Source (External - name/Internal)	**Confidence rating of funding being provided (H/M/L)**	**2014/15 (£)**	**2015/16 (£)**	**2016/17+ (£)**	**Totals (£)**
BCF Reablement	Med	£586,000	£536,000		
RCC – Reablement team 2 WTE Social Workers for Hospital discharges at UHL and other hospitals plus part year funding for Peterborough post	Med	£51,400 £125,000			

BCF ICRS			£450,000		
BCF Hospital discharge			£50,000		
CCG Funding for….					
Winter Pressure money		Some for Hospital discharge scheme up to July 2014. Possible funding for extra care scheme Dec 2014 to …..			
Total Funding					

6 Exit Strategy

Describe how this work stream will be sustained e.g. post 31st March 2016[1]

Things to consider:

Will this work stream be transferred to business as usual activity? If so, how? Who will be responsible for this area of work in the long term?

Will some existing services be replaced by the introduction of this service?

What will be the impact (both to the council, health service and to residents) if this service was to cease?

As hospital avoidance schemes begin to have the intended impact on reducing admission to hospital then the number of acute beds and people in acute beds requiring a hospital discharge assessment and planning will reduce. As people's expectations of acute hospitals change and the confidence in community services increases then the pathways out of hospital, for those who do need to be admitted, will become more established. However this change will take some considerable attention and the 'payback' period for the investment is more likely to fit with the BCT timescales of 5 years than the BCF timescales.

[1] As at September 2014 the government has only indicated funding for 2014/15 and 2015/16

It is anticipated that these services could evolve to become a fully integrated mainstream health and social care service that will deliver a range of step up step down options in line with LLR strategies and national recommendations based on research findings for improving service delivery. This scheme will help to shape and inform how this will best be provided locally.

The H&WBB will be responsible for shaping the long term of these services and determining how integrated they become. This will determine the timescales for any changes. In the meantime there will be some transition costs associated with workforce and service developments and changes alongside maintaining the current services.