Rutland
County Council

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Business Case

BCF Priority: Long Term Condition Management

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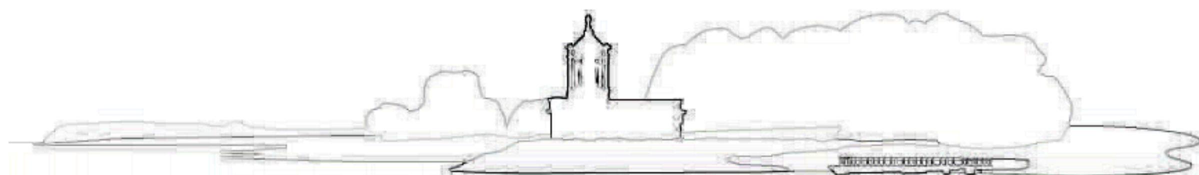


DOCUMENT CONTROL Change Control History

Version	Change Summary	Change author	Date
0.1	Initial compilation of business case	Emmajane Perkins/ John Morley	10/5/16
0.2	Alignment of common sections	S Taylor	June 2016

How to briefly describe this Activity to a Service User

This priority aims to help people who have one or more long term conditions to stay as well as possible so that their health remains stable and does not deteriorate unnecessarily. This enhances their quality of life and reduces their need for health and care services. This could include by monitoring key indicators, minimising symptoms or reducing their impact, and undertaking reablement to maintain mobility. It is also about giving people the tools to support their own health and wellbeing.

People with several long-term conditions have more complex health and care needs and tend to experience poorer quality of life, poorer clinical outcomes and longer hospital stays. Therefore, this priority also aims to help health and care professionals to coordinate their activities better in support of patients with complex needs. There may be a need for different or enhanced care models targeting this group.

Whilst the majority of those with long term conditions are older people there are other sections of our community who are affected by long term conditions that would benefit from a more coordinated approach to their care and support such as those with learning disabilities, dementia and mental health problems. For our citizens and their families it will mean they have access to a consistent

1 Description of Priority

This scheme is key to the overall objective of the Rutland Better Care Fund Plan 2016-17:

''By 2018 there will be an integrated social and health care service that has significantly reduced the demand for hospital services and puts prevention at its heart."

This objective summarises the main direction of travel nationally for health and social care as highlighted in the Better Care Together, (BCT), strategy to redesign service pathways to support independence and wellbeing, provide services closer to home, reduce hospital and residential care admissions and support the transfer of care back to the community. The business plan is also in line with the LLR/BCT Programme for 2016/2017

A core part of this priority is to build up an integrated community health and social care service that is well coordinated and tailored to local needs

Life Expectancy

Life expectancy in Rutland continues to improve year on year and in the 10 year period from 2000-2002 to 2010-2012 there has been an increase in life expectancy of 1.4 years for men and 2.3 years for women. Life expectancy in Rutland is significantly better than the England average for both males and females at 81.0 years and 84.7 years respectively.4

Healthy life expectancy for 2010-12 is 65.8 years for males and 70.3 years for females. For both males and females, a significant proportion of the population will already be affected by poor health before they reach retirement age.

Health of the population

Keeping people healthy for longer is a key goal. The last few years has seen a steady increase in prevalence of a range of long term conditions – but these are largely preventable and closely associated with a range of lifestyle factors. These include increased levels of obesity, lack of exercise and smoking. 2016 Public Health Outcomes Framework report for Rutland

This unprecedented increase in the older population will lead to increases in the number of people living with long-term conditions.

Whilst the majority of those with long term conditions are older people there are other sections of our community who are affected by long term conditions that would benefit from a more coordinated approach to their care and support such as those with learning disabilities, dementia and mental health problems. For our citizens and their families it will mean they have access to a consistent co- ordinated support system that is responsive to their changing needs, and that they and their carers receive timely and appropriate advice and support. 7 day services will be available in primary care, coordinated by GPs across Rutland, targeted to frail and vulnerable people. Integrated health and care services will be available in Rutland, combining the expertise of adult social care services from Rutland County Council and the community nursing and therapy teams of Leicestershire Partnership Trust, working hand in hand with a cluster of GP practices. Shared care records and care plans will be in place using the NHS Number to help the integrated team manage care more effectively across organisational boundaries

1.1 Priority objectives

This priority addresses the support offered by primary and community health and social care for patients with long term conditions and the frail elderly, including through:

- Enhanced approaches to care management and support planning (building on the care coordinator approach), including anticipating and reducing needs.
- A review of care pathways.
- An integrated system spanning primary care and community based health and care services in and out of hours.
- Consolidating, integrating and extending a number of Rutland's community health based services into one 24/7 service operating across health and social care – to focus on maintaining independence in the community for as long as possible.
- Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness.

- Service users feel in control of their care.
- Service users feel supported and that their needs are understood.
- Service users are better able to manage their condition(s).
- Service users are able to stay as well as possible for as long as possible.
- To promote social inclusion and utilise community capacity where appropriate
- To enable the development of individual capability in self directing their care and self-managing their conditions
- To enable and support individuals at end of life to be cared for in the place of their choice
- Through enhanced co-ordination and community facilities to assist and support informal carers

1.2 Key deliverables

Scheme deliverable	Delivery targets
Everyone with long term care needs that require a health or social care response will be guaranteed a written care plan encompassing health, social and preventative care and the right to access a named coordinator.	Within 6 weeks a detailed plan is available from referral
There will be evidence that patients have been involved in developing the care plan, understand it, and have confidence about who to approach when they need support.	Each plan is personalised Access to information
Supported self-management – people with long term conditions can manage their condition appropriately because they have the right opportunities, resources and support reducing the admission to residential homes.	More people in their home living independently in the community. Wellbeing
Commissioners and providers will work together to use a risk model/register to pro-actively find people at high risk of developing chronic and life threatening conditions and offer them targeted screening and other interventions.	Less non elective hospital admissions
Reduce the number of non-elective admissions to acute hospitals.	BCF metrics achieved

1.3 Scheme milestones

Activity	Milestone	Dependency	Responsible	Start Date	End Date
Integrated case management	Refresh provision of Integrated Care Coordination service (link from GP to social care for patients identified as with additional needs)	Wider engagement across ELRCCG	Neil Lester	May 16	
	Agree the plan to meet the national condition relating to joint	Dependent on partners	John Morley	June 2016	Sept 2016

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	assessments, care planning and accountable professionals. Case management approach.	engaging			
	Align RCC teams to primary care structures and explore colocation possibility with GP staff and integrate case management	All partners engaging	John Morley	May 16	May 2017
	Develop link worker roles with specialisms such as LD OP across primary care group for specialist input	All partners engaging	John Morley	June 2016	May 2017
	Embedding of senior social work staff attending GP MDT sessions	All partners engaging	Tracey Webb	June 2016	May 2017
	Formulate governance structure for information sharing around NHS number with health colleagues/surgeries.	All partners engaging and national remit	Sandra Taylor	Aug 2016	June 2018
	Establish ASC clinic times within GP practices around Rutland.	Gp buy in and times allocated	Neil Lester	May 2017	Dec 2018
Integrated community care for LTCs and high needs	Incorporate current developments into a new 3 year 'Health and Social care integration plan' To include: • Development of local multi-speciality teams • Models of integrated management and oversight of teams explored and trialled • Permanent model of operational and	Integration across asc & health teams	John Morley	Mar 2017	March 2019

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	management integration delivered				
	ASC teams to adopt Care Management approach to workforce delivery to widen opportunities to recruit operational staff	Availability of suitably qualified and experienced staff	John Morley	Dec 2016	May 2017
	Embed integrated risk stratification for Long term conditions	All partners engaging	Kim Sorsky	SEPT 2016	Mar 2017
LTC management - innovation fund	Agree and deliver projects to trial innovative initiatives that support the management of LTCs (eg. telehealth, condition monitoring, support groups)	Partners engaging	Kim Sorsky	Oct 2016	Aug 2017
Integrated dementia services	Embed provision of Alzheimer's Society person-centred services to individuals with dementia and their carers, helping them to live well	Service user and family engagement	Kim Sorsky	Mar 2016	Mar 2017
	Embed promotion of Alzheimer's friendly communities and high streets	Community involvement	Kim Sorsky	Mar 2016	Mar 2017
	Integrate Alzheimer's Society dementia support workers in Long term and review team	Office space for staff to colocate	Kim Sorsky	Mar 2017	Mar 2018
Care Act - carers	Embed Carers support in Prevention and Safeguarding team	Staff integrated into team	Tracey Webb	Jun 16	Sept 2016

1.4 Exclusions

There is some overlap between the Unified Prevention priority and that for Long Term Condition Management. It is anticipated that there will be close coordination between schemes under the two priorities, so that there is not duplication of effort. This is a role of the operational delivery manager.

2 Approach

2.1 Operational Readiness

The Local Authority 'Memory advisor' role that was established during 2015-16 will be sustained into 2016-17, offering additional support to dementia patients and their carers in navigating health and care services.

Our 2015-16 BCF plan included a care coordination approach which used risk stratification to identify patients with multiple co-morbidities whose evolving heath situation meant that they might benefit from a more rounded response, including potential social care support and wider (eg. medication review, mobility support, benefits reviews etc). Building on this, local partners want to implement a stronger case management approach in 2016-17 which coordinates primary care, community health and social care around target patients more effectively.

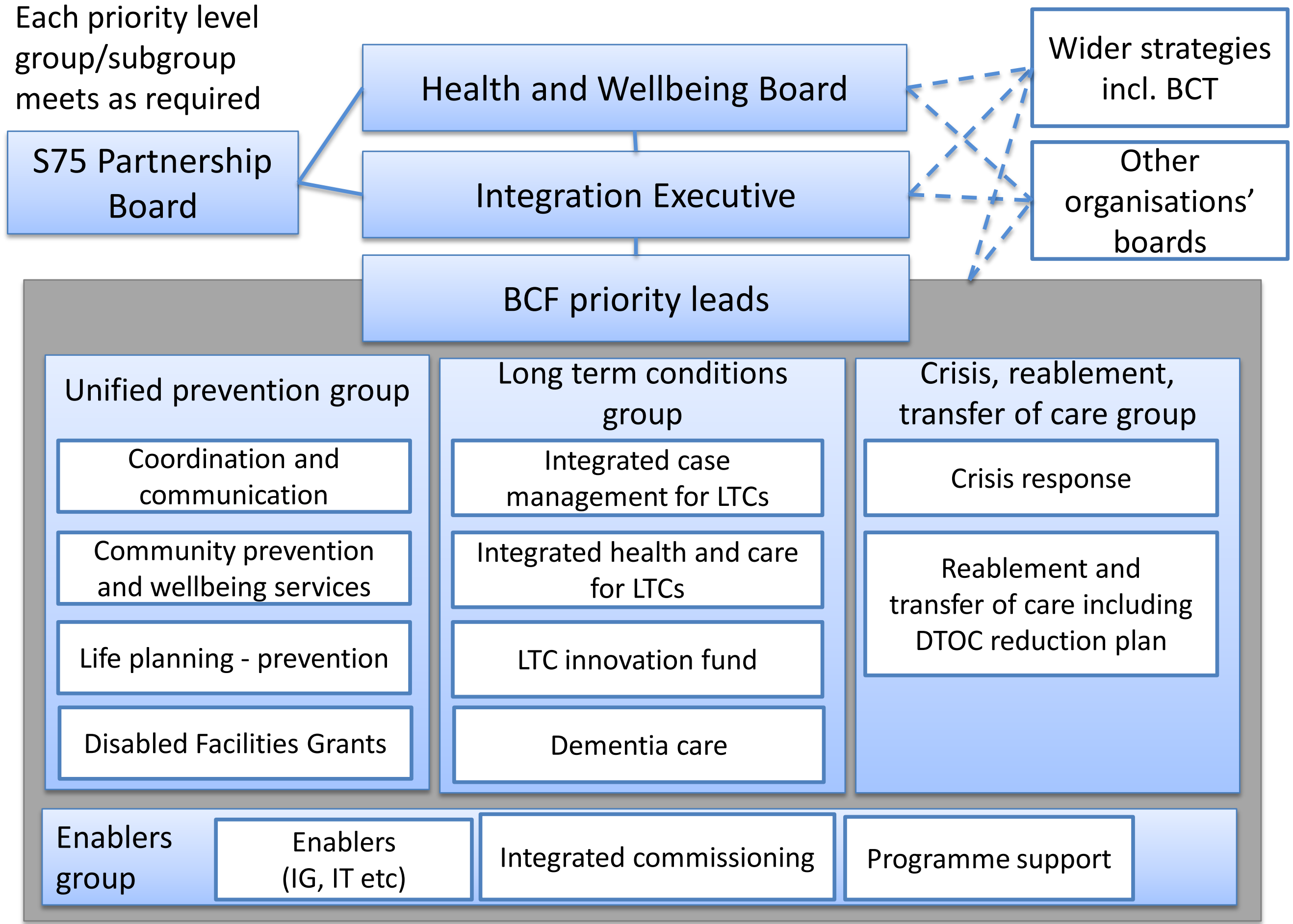
In terms of the model of care ELRCCG continue to focus on the following areas to maximise the benefits for the most vulnerable patients:

- Proactive care planning for all patients at the end of their lives - this would amount to approximately 1% of our population, and as a result increase the number of patients who die in their place of choice
- Proactively work with care homes to improve patient care and reduce unnecessary unplanned admissions
- Combine care for patients with multiple long-term conditions through advanced planning and multi-disciplinary teams (MDT) working to reduce workload and patient visits to practice
- Use of the medicines management team to work on a review of patients relying on multiple medications, medicines reconciliation (i.e. the process of identifying the most accurate list of all medications that a patient is taking), and proactive patient management, as well as improving the quality of prescribing
- Focus on the systems and processes of our healthcare providers to improve the transition towards a primary care model
- A programme of support, advice and education to help GP practices to work closely together.

2.2 Work stream structure

The priority lead will coordinate delivery of this priority, working with scheme leads, stakeholders and providers and using enabler services (IT, commissioning, workforce, etc) as required. The BCF priorities are inter-related, so a priority leads meeting has been established to ensure coordinated progress across the priorities.

Progress across all priorities will be reviewed monthly at the Integration Executive which steers the programme at the more operational level. Information will also be supplied as required to support decision making and plan steering by the Section 75 Partnership Board (quarterly) and the Health and Wellbeing Board (quarterly as required).



2.3 Work stream metrics

BCF Metric	Rationale	Likely Impact (significant/moderate/ none/other)
Admissions to permanent residential and care homes avoided	Enabling people to live independently at home	Significant
People who have had reablement still at home 91 days after release from hospital	Delaying dependency and reduce non elective admissions	Moderate
Non elective admissions avoided	Effective management of one or more conditions and exacerbating factors.	Significant
Delayed transfers of care avoided or reduced	Efficient transfer back into the community with appropriate health and care support to manage conditions.	Moderate
Falls prevention	Support people in managing conditions and sustaining strength/balance. Avoiding medication related falls.	Moderate
Service user satisfaction	Effective engagement of patients	Moderate

2.4 Work stream metrics recording

Information being collected	At what stage in the patient pathway is the information being collected?	Information collected by whom	Database on which information is collected / captured/ stored
ASCOF service user and carer feedback re wellbeing. Service users with control over their daily life. Service users with as much social contact as they would like. Service users and carers who find it easy to get information.	Annually	Adult Social Care	Performance Team
ASC Liquid Logic system referral rate and trends	At referral	Adult Social Care	Liquid Logic
Non elective admissions to acute hospitals	Quarterly	Performance	BCF Metrics
Readmission to acute hospitals within 91 days	Quarterly	Adult Social Care	BCF Metrics
Residential Care placements	Quarterly	Adult Social Care	BCF Metrics
Integrated care coordination and case coordination	TBC	Numbers of patients supported and how (high level)	Regular return by project lead to priority lead. BCF monitoring files.
Posts created or redefined, of which vacancies	n/a	Activity leads	Integrated into priority reporting
Alzheimer's Society services	As required by contract	Dementia care lead	Regular return by project lead to priority lead. BCF monitoring files.
Activities of LTC management projects to be commissioned	TBC	Activity, output and impact measuers to be agreed relevant to the aims of the priority	Regular return by project lead to priority lead. BCF monitoring files.

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	By whom	Reporting timeframes
Liquid Logic reporting	ASC	Coinciding with Integration Executives.
Contract monitoring reports -	Contract lead	Coinciding with Integration

Dementia services		Executives. Monthly.
Reports from projects/workstrands to Long Term Condition Management lead to support Integration Executive reporting requirements	Each project/theme lead or contract lead	Coinciding with Integration Executives.

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
Individuals who may require or use the service	Able to contribute to service design	Will require the service to respond in a timely and effective way	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
Partners (including staff) who will want to refer to services	Need to understand pathways to be able to make use of them appropriately	Will provide an option for them rather than admitting/conveying people to hospital or residential care	Relevant/targeted material to explain pathways, services, referral routes etc.
Existing service staff	Support values and behaviours required to facilitate successful service changes	May affect job roles and responsibilities, work location	Need to keep involved through staff meetings and newsletters and individual supervisions and PDR's

3.2 Scheme Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
highlight report to Integration Executive	To Integration Executive timetable	Send to H&SC Integration Manager for Integration Executive	Work stream Lead	Integration Executive

4 Risks

A contingency reserve has been built up after year 1 from underspends. Any partners experiencing increased activity or the financial consequence of any risk materialising can apply to access the contingency.

The partners recognise that failure of a scheme to achieve targets may have a range of financial impact on others. Given the size of the fund, all partners accept this as risk to be shared equally.

3.1 Key Risks [start by seeing which of the risks in the programme apply]

Risk No.	**Date Opened**	**Risk Owner**	**Risk Description**	**Probability** (High, Med, Low)	**Impact** (High, Med, Low)
1	10/5/16	John Morley	Key partners are not engaged or willing to make the necessary transformation	Low	High
2	June 2016	John Morley	Lack of consensus across partners about changes to be made.	Med	High
3	10/5/16	John Morley	Tools and IT support systems are not able to support transformation	Med	Med
4	10/5/16	John Morley	Staff are not equipped to embrace and deliver change	Med	Med

5 Costs

5.1 Funding

Long term condition management	**£898,000**		**Greater share of funding in 2016-17**
Integrated case management	£40,000 £100,000	Other Carry forward from 2015-16	Funding increased to broaden from care integration to broader case management.
Integrated community care for LTCs and high needs	£405,000 £113,000	Out of hospital services Social care services	The £405k is community health funding. Alongside social care monies to drive health and care integration.
LTC management - innovation fund	£55,000	Carry forward from 2015-16	Investment in schemes and activities supporting long term condition management.
Integrated dementia services	£50,000 £50,000	Social care services Alzheimer's Society	Key & complex area. Needs continuity to deliver sustainable change.
Care Act - carers	£85,000	Care Act monies	As per national guidance, supporting carers.

6 Exit Strategy

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 community based 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 Integration Executive will be responsible for shaping the long term sustainability and delivery 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.

This workstream is already part of core service provision and is recurrently funded by ELRCCG. The purpose of bringing it into the BCF is so that greater integration can be achieved between health and social care provision enabling a fully integrated service offer. It is line with the CCG's Community Services Strategy.

As this is core service provision, the intention is not to cease but to deliver this provision in a different way that enables greater integration ongoing.

The aim of this this Project is to transform existing pathways, services and resources into new business as usual activity.

There is £55k of one-off funding for new approaches to supporting long term condition management. Activities will be commissioned to be coterminous with the programme to minimise financial risk and consideration will be given to how those that are successful in improving LTC management could be continued beyond the lifetime of the current BCF programme.