Rutland County Council

NHS
East Leicestershire and Rutland Clinical Commissioning Group

Business Case

BCF Priority: Crisis Response, Discharge and Reablement.

This Priority level Business Case combines two separate workstreams from the Better Care Fund Plan: CRDR1: Integrated Urgent Response and CRDR2 Integrated Hospital Reablement and Transfers of Care

Date completed: 10th May 2016

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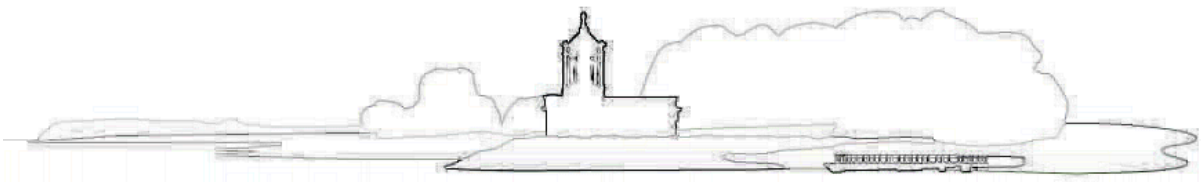


DOCUMENT CONTROL

Change

Control History

Version	Change Summary	Change author	Date
0.1	Initial compilation of business case	Emma Jane Perkins/Neil Lester	10th May 2016
0.2	Second draft including aligned elements	S Taylor	June 2016

How to briefly describe this Activity to a Service User

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.

The scheme will also seek to enable timely transfer of care in to the community for Service Users thereby releasing hospital beds.

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 an interim bed based facility may be required for part of the programme.

By working closely with our health partners and by putting our resources together, we will have an integrated pathway which supports people more effectively within their own homes. Services will be available seven days a week to enable urgent response to any health / social care crisis.

1 Description of Priority

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

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

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 into the community is likely to lead to worse outcomes for older patients/service users.

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.

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.

To enable this to happen, a whole system response is required to ensure a fully coordinated and integrated service is developed, to truly prevent adults and older people from experiencing unnecessarily protracted admissions and for them to have the greatest opportunity for recovery so as to be able to return to their own homes. By bringing our resources together we will establish an integrated pathway which supports people more effectively within their own homes.

We will measure the reduction in 'non elective' admissions, proportion of 65+ year old remaining at home 91 days after discharge from hospital and number of people who are not delayed in hospital.

Services will be available seven days a week to enable an urgent response to crisis. This will include the night nursing service provided by Leicestershire Partnership NHS Trust and an out of hour's social care response provided by Rutland County Council.

Seven day working will be available to enable timely discharge. This will include ICS, an enhanced Reablement service, social work and district nurse capacity to support hospital discharge as well as shared posts to support joint assessments.

This work is also aligned to the BCT project around falls prevention and managing falls and incorporates locally the strategies being developed by this group across Leicester/Leicestershire and Rutland (LLR).

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.

1.1 Priority objectives

- The overall aim of the scheme is to make the pathways between services simple but effective and wherever possible to consider and implement community based care options.
- Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness.
- Service users are able to stay as well as possible for as long as possible in their own home.
- Reassurance for the service user and their family that there is effective support closer to home reducing likelihood of being admitted to hospital.
- If they do have to be hospitalised, patients return sooner to a community setting/home, rather than being delayed in a hospital bed.
- People can more easily resume their normal lives on their return home, maintaining independence.
- End of life patients are given the choice to remain at home.
- 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 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.
- Patients/service users receiving services say they are satisfied with the outcome of the care they receive and have had 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 demonstrate value for money by continually evaluating the structures and processes and making recommendations for future service models to meet the needs of the Rutland community

1.2 Key deliverables

Scheme deliverable	**Delivery targets**
Reduce the number of non-elective admissions to acute hospitals..	BCF metrics achieved.

Proportion of 65+ year old remaining at home 91 days after discharge from hospital.	BCF metrics achieved.
Reduction in delayed Transfer of Care (delayed bed days) from Acute Hospitals.	Number of DTOC on sitrep resulting in no reimbursement charges
Timely assessments for Continuing Health Care will be undertaken in the community after discharge once patients have had a period of reablement	Appropriate DST confirmed at panel
Evaluation of this model of integrated working in terms of effectiveness and value for money. Recommendations for future service design.	Validation exercise to be undertaken Oct 2016
To support a 7 day service delivery model which provides broadly consistent service levels by working alongside EDT, ICS, Night Nursing Service and Crisis response in the delivery of out of hours services.	Review performance of the ASC on call process, ICS and Crisis Response Services to highlight systems are in place to evidence comparable service delivery across 7 days
Ensure robust data capture systems are established that allow trends in delayed transfer of care are identified and addressed	BCF Metrics dashboard matches local information
Increased integrated working between health and social care services locally to ensure a seamless transition of care.	Staff are clear about their roles and responsibilities and have positive relationships with colleagues that support the way services are delivered to their patients/service users.
Clear pathway referral routes into services to assist referrers and prevent duplication for services and service users.	Reduction in DTOC numbers.
The service will ensure that the Wellbeing of Service Users is at the forefront of service delivery and that Service users are consulted, where possible, in the care they receive. This is in line with both the Care Act and the Personalisation agenda.	A personalised support plans developed in a person centred way.
In line with the BCF/BCT plans handovers between services will feel seamless and carried out so that the service user feels empowered to manage their ongoing service with choice and control.	Service user feedback/survey

1.3 Scheme milestones

Integrated urgent response

Admission avoidance - Metric 1. Non-Elective Admissions (General & Acute)

Aim	Actions	Start	Finish	responsible
People diverted from acute beds	• Continuing delivery of ICRS crisis response admissions avoidance service in Rutland	Ongoing		Rachel Dewar LPT
	• Integrated work with Peterborough City Hospital (PCH) emergency diversion team to ensure Integrated Care Service is fully utilised	May 2016	June 2016	Neil Doverty
	• The Preventing Avoidable Readmissions Project PARP (2016) being piloted in Leicester City to be analysed to see if it could be used for Rutland patients in PCH & Leicester hospitals (UHL)	May 2016		Srikunar Arun
	• Integrated care coordinator working in Rutland GP surgeries to offer additional support to people identified by GPs as frequently admitted to hospital.	May 2016	Mar 2017	Vicky Hughes
	• Explore ways to facilitate information exchange, including with GPs, to have a complete wraparound approach of the patient. Urgent response needs to be joined up with prevention and LTC management – GP hubs could deliver this.	May 2016	Sept 2016	Neil Lester
	• Work with care homes to raise profile of alternatives to acute response – e.g. ICS/REACH/Crisis response /respite – through the Provider Forum	May 2016	July 2016	Neil Lester

Patients prevented from ill health that requires acute health service intervention	• Deliver Hub project in GP surgeries	June 2016	Jan 2017	Neil Lester
LD patients diverted from Assessment & Treatment Units	• Develop a Transforming Care Partnership and plan • Introduce an avoidance blue light risk register • Embed Outreach team • Review effectiveness of current respite provision in place	Jun 2016	Oct 2016	Kim Sorsky

Systems to monitor and manage patient flow - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Patients are tracked to ensure they are moved efficiently and quickly through and out of acute to community	• Introduce new systems to monitor patient flow • Analyse metrics used for UHL Vanguard patient monitoring	June 2016 June 2016	July 2016 July 2016	Angie Essom

7 day services - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Discharges taking place 24/7	• MDT staff contracts to include flexible and weekends working if required will also ensure 7 day services could be an option	June 2016	Sept 2016	Rachel Dewar & Emmajane Perkins
	• New EDT arrangements from April 2016 of a new staff team structure for the community care response. Planned care will see the tie up of the LPT ICS and RCC reablement (REACH) services to provide recovery and reablement. The rapid response services will see the tie up of RCC crisis response, LPT rapid response and night nursing service. This will include an out of hours community care worker.	May 2016	June 2016	
	• Align REACH team with relevant LPT sections to integrate in a later part of the plan.	June 2016	Jan 2018	
	• Coordinate activity with Vanguard OOH GP, Urgent care centres & 111 service review	June 2016	Jan 2017	

Enhanced health in care homes - Metric 1. Non-Elective Admissions (General & Acute)

Aim	Actions	Start	Finish	Responsible
Reduce number of people admitted to hospital	• Enhance workforce development through OT/reablement/ provider forum	Mar 2016	Mar 2017	Emmajane Perkins
	• Continue to fund Leicestershire Social Care Development Group (LSCDG) to ensure training and care certification for all staff	April 2016	Mar 2017	
	• Provide Moving and Handling Training	April 2016	April 2016	
	• Review the effectiveness of GP link to homes and implement improvements	August 2016	December 2016	
	• Improve admission monitoring by individual care home			

• Integrated hospital transfer and reablement

• Early discharge planning - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Reduced DTOC Timely and safe discharge	• Refresh analysis of the causes of DTOCs in order that solutions and interventions can be sought. • Ensure case reviews to better understand the opportunities to prevent DTOC and monitor patient flow	June 2016 June 2016	Renew as required Renew as required	Angie Essom
Patient planning for discharge on admission	• Earlier planning for discharge to take place from admission for PCH patients in line with pathway established at UHL.	June 2016	Dec 2016	Angie Essom
Planned care patients arranging to come home even before they have gone to hospital. Mentally prepared.	• Planned pre-hospital engagement for patients	June 2016	Dec 2016	Hilary Fox
Prepare patient for hospital through ‘pre-hab’ (stronger patient, reduced recovery period, reduced length of stay, less need for follow up support)	• Investigate potential for 'pre-hab' prior to planned admissions	June 2016	Mar 2017	Hilary Fox

Multi-disciplinary discharge team - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Well-resourced MDT hospital discharge team Work in more integrated ways around the patient using voluntary sector/health/social care/private providers	• Recruitment by LPT of a new band 6 nurse, a phlebotomist and technical instructor	June 2016	July 2016	Rachel Dewar Yasmin Sidyot Emmajane Perkins
	• Introduce use of the minimum data/assessment	May 2016	May 2016	
	• Deliver phase 2 of integration: RCC Hospital and Discharge team with LPT health colleagues continues with the start of a system leadership course	June 2016	April 2017	
	• Co-locate the RCC therapist and social workers to. (A proper licence to occupy RMH will need to negotiated involving RCC estates department.)	June 2016	Sep 2016	
	• Alignment of key staff across health and social care in Rutland. Models of integrated management and oversight of teams explored and trialled	June 2016	Dec 2017	
	• Work with GP's to explore primary care involvement as part of discharge planning.	June 2016	Sept 2017	

Home first and discharge to assess - Metric 1. Non-Elective Admissions (General & Acute) & Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Safe interim discharge solution to those Non-weight Bearing/Discharge to Assess/Reablement	• Pilot the use of vacant residential home placements to assist in providing interim respite to facilitate discharge from acute back into the community.	Mar 2016	May 2016	Emmajane Perkins Rachel Dewar
	• Train care home staff in reablement	Apr 2016	April 2017	
	• Introduce Pathway 3 (Reablement) project with 60 beds	June 2016	Nov 2016	

	• Agreement of pooled budget/commissioning arrangement or charging/invoice agreement when patient triggers a positive CHC checklist but DST to be completed which may cause a DTOC if not agreed	June 2016	June 2016	
	• Integrated hospital team manage all CHC and social care discharge and care packages from acute to community based/home beds and from community beds to home on an agreed health and social care integrated pathway	June 2016	June 2017	
	• Exploration of incorporation of third sector workforce as a possible step down from REACH (from care to support) and a continued monitoring based on risk of readmission.	June 2016	April 2017	
Develop the market for reablement/domiciliary care providers to ensure patient choice can be accommodated	• Concern over the lack of capacity available in the REACH service and local Domiciliary Care providers needs to be assessed to establish how to increase capacity to meet high level of demand seen at present time	June 2016	Sept 2017	Karen Kibblewhite

Trusted assessors - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
CHC FastTrack is used effectively	• Embed in place in UHL and ensure Arden Gem will accept PCH trusted assessor	July 2016	July 2016	Sue Allen
Patient information is shared to ensure timely and safe discharge	• New Minimum data set paperwork being used by Health/Social care/providers	June 2016	June 2016	Angie Essom Yasmin Sidyot
	• Introduce LiquidLogic ASC case management system	2015	May 2016	

- **Focus on choice - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)**

Aim	Actions	Start	Finish	Responsible
Person centred discharge	• Embed clear patient choice protocol is in place in line with the	June 2016	July 2016	Angie Essom

planned and in place when patient is medically fit to move from acute to community	new NHS national policy guidance			
Patient pathway clear	• Develop pathways 1,2,3,4,5 across both PCH & UHL	June 2016	Dec 2016	Tamsin Hooton
Patients in control of commissioning according to identified need	• Increase awareness and communications of Personal Health Budgets and Direct Payments	June 2016	Sep 2016	Neil Lester
Self funders are supported to prevent DTOC	• Develop further communications around Rutland Rapid Responders for housing repairs	May 2016	Dec 2016	Angie Essom
	• Ensure Coordination by integrated hospital team for all self-funders	May 2016	May 2016	
	• Ensure Assistive technology packages open to self-funders	May 2016	May 2016	
	• Develop further the links with the voluntary sector, for example: linking the Community Agents with discharge	May 2016	June 2016	
	• Improve links between discharge and carers assessments	May 2016	April 2016	

1.4 Exclusions

- There is a wider Vanguard project for Urgent Care which is funding a range of complementary measures. This is also the case for Better Care Together.

- There is overlap between aspects of this priority and the priority for long term condition management. Any crossover between priorities will be managed through coordinated working.

2 Approach

2.1 Operational Readiness

The Operational Delivery Manager- Integration & Care Act is now in place with a remit to ensure that strategic decisions taken in both areas are embedded into practice. This role will also enable a conduit to feed back issues faced by teams to senior managers.

The Operational Delivery Manager will act as a liaison between health and social care organisations, including the voluntary sector.

It is anticipated this will allow Rutland County Council to identify any obstructions to discharge pathways/ Service User/Carer support and work in partnership to remove those obstructions.

A Quality Assurance Framework, (QAF), is being compiled which includes an assessment audit tool. This will allow line managers to review performance of staff against the core principles of the Care Act.

A new Social Worker and an Inreach Nurse for Peterborough Hospital are already in place and working effectively. A further Inreach nurse and Technical Instructor are currently being recruited.

There are a number of initiatives currently ongoing such as Preventing Avoidable Admissions and Discharge Planning working groups.

There is now an RCC ‘Out of Hours’ EDT service working in partnership with other agencies to provide support where care and/or social needs are required.

The Rutland ICS has been operational since the 1.9.14 and has accepted a number of referrals with successful outcomes.

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 its role to act as the main Broker of domiciliary care for the Adult Care Team.

The Team is having successful outcomes with consistently over 85% of people discharged from hospital who have received reablement remaining at home 91 days after discharge, and approximately 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.

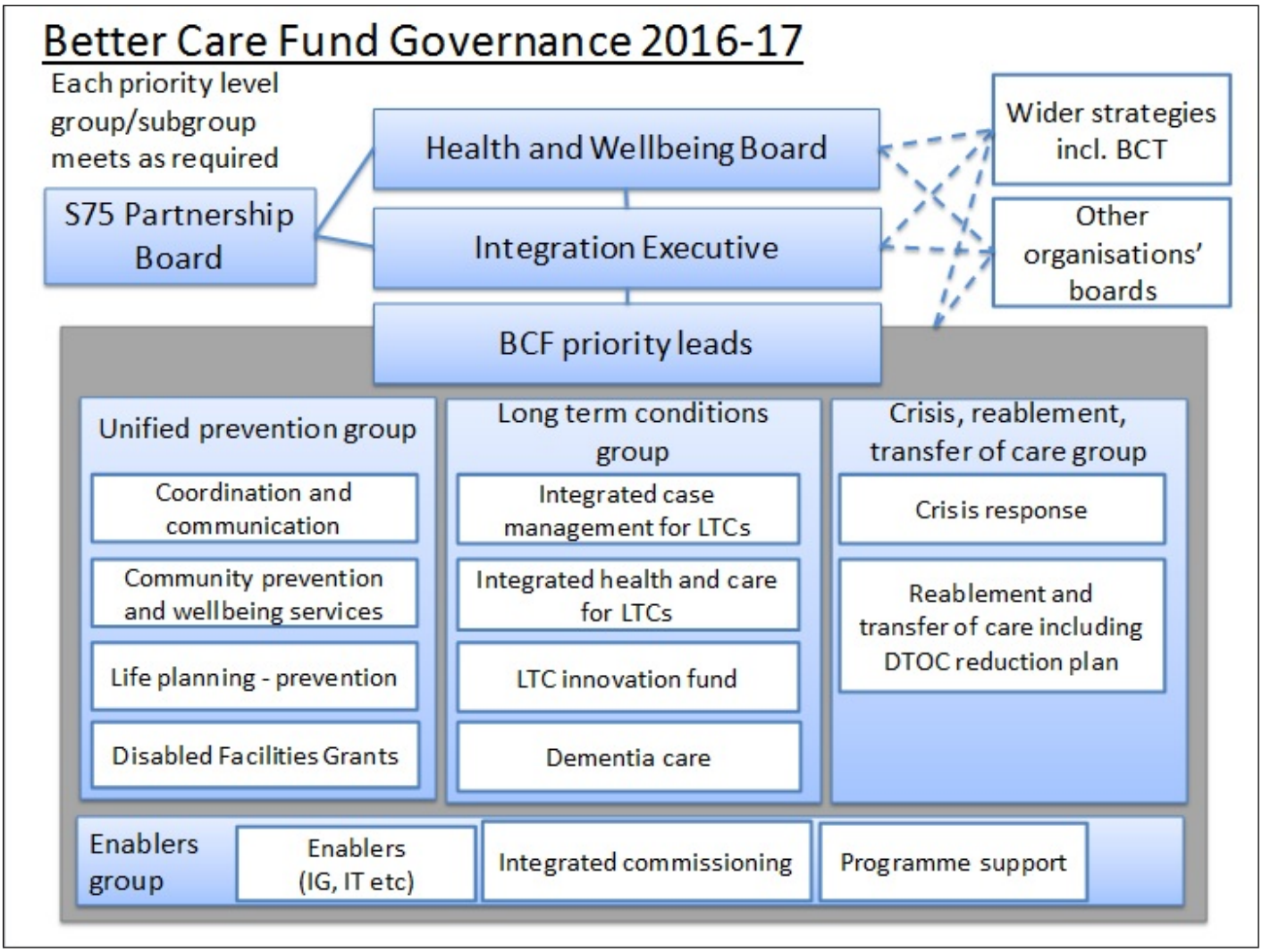
The use of Just Checking has been used by the REACH service to with evidence of positive outcomes, assessment and provision of other assistive technology is regularly utilised.

2.2 Work stream structure

The priority lead will coordinate delivery of this priority, working with scheme leads, partners, 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.

This priority is the most focussed on hospital use and must maintain tight coordination with the activities of the wider Better Care Together strategy (frail older people, urgent care and urgent care Vanguard, planned care, end of life, long term conditions.), with the Urgent Care Vanguard and with wider Discharge Steering Groups.

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 contribution to key BCF metrics

BCF Metric	Rationale	Likely Impact (significant/ moderate/ none/ other)
Admissions to permanent residential and care homes avoided	Reduced hospital stays, prompt hospital discharge then reablement help to prolong independence	Significant
People who have had reablement still at home 91 days after release from hospital	Delivering reablement to restore strength/condition.	Significant
Delayed transfers of care avoided or reduced	Main priority addressing barriers to timely transfers of care. Also reducing length of hospital stays.	Significant
Non elective admissions avoided	Crisis response services avoid hospitalisation where appropriate.	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
Collection of 'Live' DTOC statistics to avoid time lag of official DTOC reporting.	Daily	RCC ASC	Sitrep RCC local DTOC monitoring logs
Data relating to Rutland DTOCs (nights, causes, sector, Trust)	Monthly	Arden & GEMCSU	Unify
Local data collection for Reach	Reach Team	At referral, at discharge	Liquid Logic
Local data collection for night nursing service	Night nursing team	ICRS	LPT Database
Customer satisfaction surveys	To be developed jointly with patients ASCOF Letters of compliment	Steering group	

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
	and complaints		
Numbers of referrals to Reablement	Start	REACH Admin Information Management team	Liquid Logic
Outcomes of Reablement	End	REACH Admin	Liquid Logic
Number of people remaining at home after 91 days	Monthly	Performance Team	Liquid Logic

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting timeframes**
ICRS reports on admissions avoided in crisis	LPT	Monthly
Reablement outcomes	Performance Team	Monthly
'Live' DTOC monitoring	Designated ASC managers	Monthly
Reports to RCC Leadership Team/Elected members	Emma Jane/Neil Lester	As required

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	Expectations regarding the level of support they require will determine their	Shorter stays in hospital and/or interventions provided at home or in different settings	Detailed and consistent communication/information given to Service Users and their families/carers.

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
of the public.	level of engagement with the service. Feedback on the effectiveness and satisfaction with the services.	closer to home. They will require services to respond in a timely and effective way.	Why the move from acute services Reassurance regarding the level of support/care in the community once discharged. To supply information to all involved to help them understand what Reablement aims to achieve based on their identified outcomes. 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.	The level of support by the '3rd sector' will grow as new discharge pathways are established. The sector will become an integral part of those pathways providing support in the community	Promote engagement with the sector through a variety of mediums including: • Provider forums • Newsletter • Local Interaction on an ad hoc basis
Partners who will want to refer to the service e.g. GP's, Emergency departments, EMAS, other health and social care services.	Required to understand the options available within the community and to utilise them appropriately	Will provide options 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.	Any changes to processes/pathways to be communicated to all stakeholders Review of service through established working groups.
Members of the REACH Service	Support values and behaviours required to facilitate successful Reablement and 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
Intensive Community	Need to work closely with the	May affect job roles and responsibilities	Need to keep involved through regular joint meetings.

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
Support Service	Reach team.	and work location.	
Hospitals	Providing appropriate referrals and information using agreed minimum data set and trusted assessments and agreed pathways. Effective partnership 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. This will allow for the required attention and time to prepare for their discharge.	Will help with speedier and smooth discharges and free up capacity in acute sector. To actively identify people who will require social care and ongoing health support following their acute hospital episode. Benefit from timely and effective discharges to free up beds.	Need to ensure all partners are aware of referral pathways. Collaborative working/understanding to ensure health partners are confident about community services and their ability to provide care/support. Understanding of level of information required by step down facilities and appropriate pathways for them to follow.
Private Domiciliary and Residential care providers	Supporting the principles of Reablement to maintain individual's maximum levels of independence. Sufficient availability to pick up cases efficiently at the end of Reablement or to support cases prior to being ready to commence Reablement.	Will affect the client group they are working with – potentially quicker turnover of some cases and long term cases will be more complex.	Ensure part of RCC commissioning strategy includes a review of provider workforce and training strategy. Contracts to include outcome based 'Key Performance Indicators' to ensure service delivery is in line with expectations.
Hospital Social	Delivery of the	Recognition for what	Supervision arrangements, team

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
Worker and in reach Nurse for Peterborough Hospital	service sharing good practice that can be used for other hospitals.	they are doing, direction for future service development.	meetings.
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 escalation meetings.	This reduces demands on their time dealing with delays and fines.	Agreed protocols for managing discharge escalation meeting.
Team Managers/Heads of Service	Tracking of cases using Liquid Logic	Allows supervision of cases to ensure they are not 'lost' or prioritised incorrectly	Heads of service team meeting.
Rutland Memorial Hospital/ICS virtual beds/interim beds for D2A and NWB	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 Community based service	Provide support and ongoing assessment and intervention for people when discharged	Business opportunities for independent sector	Promote engagement with the sector through a variety of mediums including: • Provider forums • Newsletter • Local Interaction on an ad hoc basis

3.2 Priority Reporting and Communication

Type of	Communication	Communication	Initiator	Recipient

communication	Schedule	Mechanism		
Highlight report to Integration Executive	To Integration Executive timetable	Send to H&SC Integration Manager for Integration Executive	Priority Lead	Integration Executive

4 Risks

4.1 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	10th May 2016	Neil Lester	External evaluations not having sufficient evidence, due to lack of Rutland focus or lack of referrals to make data viable/statistically significant.	High	Med
2	10th May 2016	Neil Lester	Failure of RCC 'Out of Hours' support to EDT	Med	High
3	10th May 2016	Neil Lester	Failure to establish robust working relationships where these are required to ensure integrated service is consistent and effective	Med	High
4	10th May 2016	Team managers	Wider changes affect the ability of particular partners to contribute to the BCF strategy in the way intended eg. Care Act could affect the number of assessments being requested.	Low	High

5 Costs

5.1 Priority Costs

Include all direct and indirect costs

Description	2016-17 (£)
Integrated Crisis Response	
CCG Posts	£125,000
RCC Posts	£115,000
Transfer and reablement	
CCG Posts	£135,000
RCC Posts	£561,000

5.2 Funding

Funding Source (External - name/Internal)	2016/17+ (£)	Totals (£)
BCF Integrated Crisis Response (ICR)	£240,000	
BCF Hospital Transfer & Reablement (HTR)	£696,000	
Total Funding	£936,000	

6 Exit Strategy

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.

However until the culture shift in peoples expectation that acute services are the only health option available for health crisis then the Non elective admissions will be difficult to reduce completely

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 Exec 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.

It should be noted the most significant driver of health needs for the Rutland is the growing older population

In 2013 the total population for Rutland was an estimated 37600 people 8,540 people were estimated to be 65 years and over, and 1,180 were 85 years and over.

The total population is predicted to grow by 10% and is broken down as follows:

- 85 years + growth 227%, 1,100 to 3,600 people.
- 65-84 growth 49%, 7,100 to 10,600 people.
- 0-24 reduce by 4%, 10,400 to 10,000 people.
- Adult population 25-64 reduce by 10% from 18,300 people to 16,400

It is important to recognise that there will also be a 10% decrease in the working age population (25-64 years).

All of the above will have a significant impact on the delivery of health and social care across Rutland