REPORT NO: 138/2015 – Appendix A

Rutland County Council

Project Business Case

Integrated Health and Social Care Pathways and service delivery

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DOCUMENT CONTROL

Change Control History

Version	Change Summary	Change author	Date
0.1	Initial document production	Yasmin Sidyot	1.12.14
0.2	Additional milestones added	Julia Eames	26.5.15
0.3	Alterations made following Integration Executive feedback to clarify delivery times and dependency on organisational developments	Julia Eames	15.6.15

Reporting Schedule:

This draft went to the Integration Executive of the Health and Wellbeing Board on 4th December 2014

Next draft due to go to the Health and Wellbeing Board on 23rd July 2015

How would this scheme be described to the service user?

Individuals will be supported to live more independently in their own homes through the provision of joined up, co-ordinated health and social care services, designed to meet individual need and delivered at local level.

1 Description of Project

Business need:

Evidence from cross-cultural examples indicates that:

- integration is most effective when it is targeted towards people with severe, complex and long-term needs
- it is best suited to frail older people, those with long-term chronic conditions and mental health illnesses and those requiring urgent care
- it is most effective when it is population based and approaches the holistic needs of a patient, rather than being based on the patient's condition
- Condition-based approaches to integration can create silos and thus lead to different types of fragmentation. [1]

Locally, as nationally, there is an ageing, frail population and an increasing prevalence of chronic disease.[2]

The result of engagement in across Leicester, Leicestershire and Rutland tells us that people want joined up care closer to home and a wellness service, not just an illness service. This will only be possible if sustainable community solutions are in place.[3]

The Project is in line with ELRCCG's Two Year Operational Plan and Integrated Community Services Strategy and the LLR wide Better Care together; Five Year Strategic Plan, all of which recognise the need to move towards integrated services provided by multi-disciplinary teams of primary, community and social care services which can be wrapped around the individual; promoting and sustaining independence in a home based setting.

The Better Care Together; Five Year Strategy Plan summarises the delivery of care under eight service pathways delivered across six settings of care (see below). This Project will contribute to service pathways for '*frail older people'* and '*long term conditions'* delivered in the settings of care '*self-care, education and prevention'*, *'community and social care services'* and*' crisis response, Reablement and discharge'*.

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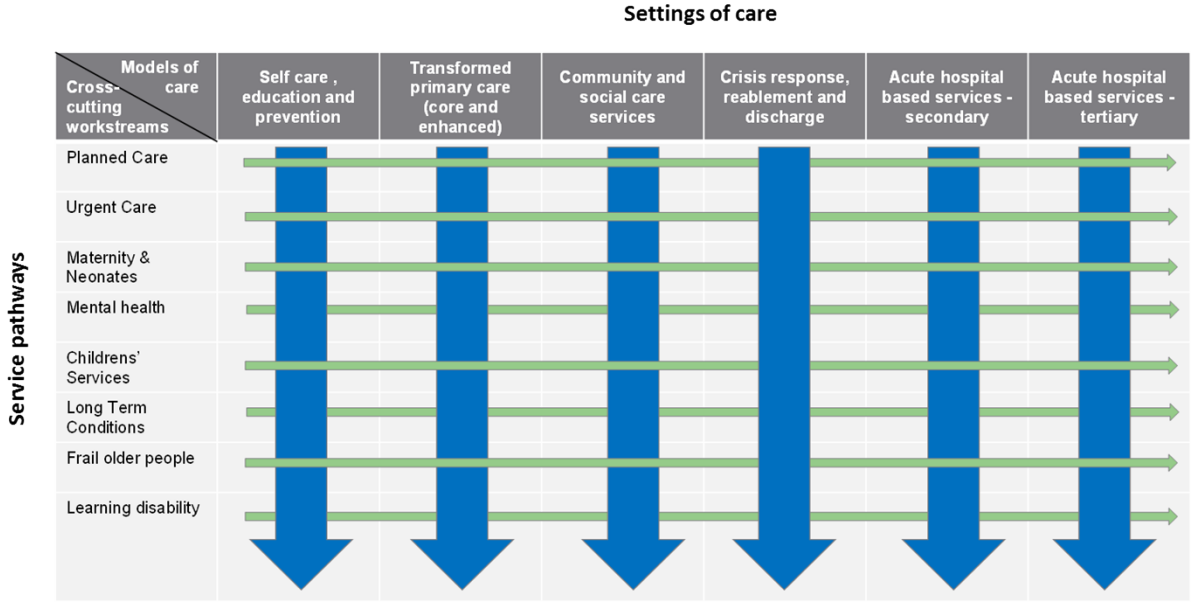
[1] The King Fund – case for Integrated care 2011; Nuffield Trust – preventing hospital readmissions; The King Fund – making our health and care systems fit for the ageing population 2014; Safe and Compassionate care for frail older people – using an integrated pathway practical guidance for commissioners, providers and nursing, medical and allied health professional leaders NHS England

[2] Rutland JSNA

[3] East Leicestershire and Rutland CCG Integrated Community Services Strategy 2014



NHS Planning Guidance 2014 – 2019 identifies that any high quality, sustainable health and care system in England will have the following six characteristics in five years' time:

- A completely new approach to ensuring citizens are fully included in all aspects of service design and change and that individuals are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step change in the productivity of elective care

The Kings Fund document *'Transforming our Health Care System' (April 2013)* states that:

'the ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated'.

The Kings Fund document *'Community Services: How they can Transform Care' (February 2014)* identifies an approach required to develop community services in a way that will deliver transformation. This approach requires locality based teams that are grouped around primary care and natural geographies, with multi-disciplinary teams offering 24/7 services as standard and complemented by highly flexible and responsive community and social care services. These teams need to work in new ways; offering individuals a much more complete and less fragmented service.

1.1 Project Objectives

The overall aim of the project is to develop a whole system response to ensure a fully coordinated and integrated service offer is available for individuals with health and social care needs in Rutland.

The Project will develop pathways, protocols and possibly co-location of health and social care teams to allow the health and social care economy to fully realise its vision of integrated care.

By bringing our resources together we aim to have an integrated pathway of home based support which can enable people to live more independently within their own homes.

1.2 Key Deliverables

	Project Deliverable	Delivery targets	How?
1	Localities will have arrangements in place for aligned clinical leadership of nursing (clinical case managers) and allied health professionals (OT and physiotherapy), with Social Workers and Social Care workers, delivered through multi agency teams, including MHSOP	March 2016	Through workforce and organisational development
2	Localities will include operational management and administrative support	October 2015	Development of existing teams, resources and provider services
3	Multi agency teams will be in place for delivery of planned care, each serving a cluster of GP practices with a registered list of c30-35,000 individuals to: • Deliver planned pathways of health and social care for people with long term conditions, people with Continuing Health Care needs and people at the end of their life; through integrated care plans and case management • Support GPs in delivering care plans for patients aged 75 and over • Work with GPs and Integrated Care Co-ordinators to support risk stratification and care planning • Support self-care and provision of patient and carer information, including patient held records which include a care plan detailing an individual's nursing and therapy needs • Proactively identify and prevent falls for 'at risk' individuals, including advice and training in falls prevention and management for care homes and health and social care teams so that falls awareness and assessment are part of every contact • Rehabilitation and Reablement provision • Explore the use of combined personal health budgets and social care budgets.	March 2016	Development of existing teams, resources and provider services
4	There will be in place a multi-disciplinary and integrated unscheduled care service comprising: • An unscheduled care team containing nursing staff, allied health professionals, social care workers and generic health and social care support workers	November 2015	Development of existing teams, resources and provider services

	Project Deliverable	Delivery targets	How?
	• Intensive Community Support (ICS) • Integrated Crisis Response Service (ICRS) • Reablement		

1.3 Project 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
Map and review existing structures and pathways	Existing services and pathways in and out of services are understood	Partner organisations own readiness for change	Project leads	Nov 14	Jan 15
Explore future delivery model for community based health services in line with Integrated Community Services Strategy	Opportunities for integration, alignment and co-location are identified	Wider engagement across ELRCCG	CCG Adult Social Care	Nov 14	July 15
Agree an information governance protocol which covers all partners linked in to Rutland's health and care system	There will be one Information Sharing protocol which is understood and implemented by all partners from board level to operational staff.	Commitment from partners	CCG to lead	June 2015	Sept 2015
Revised pathways are mapped out, including: • new multi-agency team structures that will support new pathways • role and contribution of community and voluntary sector • role and	Identify opportunities for Social Care Staff to integrate with GP practices. Review the NHS and Social Care Occupational	Partner organisations own readiness for change	Project leads Service Managers	July15	Sept 15

Activity	Milestone	Dependency	Responsible	Start Date	End Date
contribution of other council services	therapy provision to identify plans for joint or aligned posts.				
Develop Integrated Clinical Leadership through a joint programme of workforce development	Leadership style across partners will promote the values of integration and support the right culture and processes.	Funding – proposal to link with workforce development in IUR1	CCG Lead, LPT, Julia Eames	July 2015	Dec 2015
New model for integrated delivery of health and social care services is agreed by key partners	Proposals to be developed and presented to H&WBB	Clear and robust proposal being established	H&WBB CCG Board	17 Nov 2015	26 Jan 2016
New arrangements, pathways and service delivery arrangements established	Timed and resourced plan in place to move to new arrangements	Approval from H&WBB	Service Managers	Dec 15	Mar 16
Review of Continuing Health Care protocols and pathways to deliver a partnership approach to assessment and integrated care plans.	Assessments will be completed at the right time and place with support from relevant professionals. Joint care plans will be managed in an integrated way, facilitating the use of personal health budgets and direct payments where appropriate.		CCG		Mar 16
Develop Multi-agency meeting to jointly review 'high users of services' and people with complex needs	There will be a partnership approach to assessing and	Agreed Information sharing protocol	CCG – GP Practices (one already established at OMP)	July 2015	Dec 2015

Activity	Milestone	Dependency	Responsible	Start Date	End Date
and long term conditions, including GP Practice Nurses.	delivering care with a focus on supporting self directed care and the use of personal budgets.				
Strengthen links with Mental health Services for Older People.	managers and operational staff will participate in relevant strategic and operational meetings	Availability of staff	LPT	July 2015	Sept 2015
Improving care for people at the end of their life by working in an integrated way	Will be delivering National End of Life best practice.	Training for relevant staff groups.	CCG	July 2015	Mar 2016
Establish shared outcome measures to be used across relevant health and social care settings.	Identify a task and finish group	People able to contribute and agree an approach	Julia Eames	Sept 2015	Dec 2015
Review the implementation of the new Health and Social Care Protocol locally, including utilisation by Independent Care providers.	The principles of the protocol will be embedded to reduce duplication	LLR protocol	John Morley	July 2015	Dec 2015
Progress opportunities for joint commissioning and performance managing of domiciliary care and nursing care and joint brokerage.	Appropriate contracts will be joint. The market will be well managed and responsive to demands in a way that provides best value for money	Availability of sufficient providers	Karen Kibblewhite	June 2015	Mar 2016
Strengthen links with Public Health outcomes and activities.	All services will contribute to primary and secondary	Closer working between all partners.	Mike Sandys	July 2015	Dec 2015

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	prevention. Utilisation of the Third Sector to provide early preventative interventions				

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.

Integrated Crisis Response, Hospital Discharge and Reablement services are separate BCF Projects in their own right.

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

Existing health and social care services are in place but this Project will better co-ordinate, align and locate service delivery to reduce duplication and provide more seamless service provision.

2.2 Work stream structure

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

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

- Accountable to Health and Wellbeing Board
- Formal performance reporting against work stream progress and metrics as in 3.2 below
- Project leads identified

Better Care Together

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Health and Wellbeing Board/Integration Executive

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Better Care Fund Leads

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ELCCG, LPT and RCC

2.3 Work stream metrics

BCF Metric	Description of Impact as set out in BCF Significant/moderate/other
Metric 3 – Reducing Delayed Transfers of Care	Significant impact – contribute towards the 8.4% reduction in DTOC
Metric 4 – Reducing Avoidable Emergency Admissions	Moderate impact contribution towards the 2.4%
Other metrics: Outcomes	
Contribution to achieving 7 day working	Moderate impact
Improve the patient/service users experience	significant impact
Reduce the number of injuries due to falls	Moderate impact

Other desired outcomes include:

a) Improved partnership working between health and social care partners

b) Reduction in avoidable hospital admissions through the provision of accessible, targeted community based health and social care services which support independence

c) Reduction in admissions to residential care through the provision of support to enable individuals to remain independent in their own home for as long as possible

d) Reduction in delayed transfers of care through improved information sharing, a co-ordinated approach that is able to maximise step down options and resources to support hospital discharge

e) Reduced length of stay through facilitated early secondary care discharge

f) Reduced impairments attributable to long term conditions

g) To rehabilitate individuals to their optimum level of functioning

h) To promote social inclusion and utilise community capacity where appropriate

i) To enable the development of individual capability in self directing their care and self-manage their conditions

j) To enable and support individuals at end of life to be cared for in the place of their choice

k) Through enhanced co-ordination and community facilities to assist and support informal carers

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 feedback	Annually	Adult Social Care	

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting dates**	**Reporting timeframes**
SITREPS and Dashboard Reporting on Metrics to Integration Executive	SITREPS – CCG Contract Management Dashboard – GEM	TBC	Monthly

3 Communication and Engagement

3.1 Stakeholder Analysis

Stakeholder Name	**How they will impact on the project**	**How they will be impacted by the project**	**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
Hospitals	Providing appropriate referrals and information using agreed minimum data sets and trusted assessments	Will help with speedier and smooth discharges and free up capacity in acute sector	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 anxious/risk averse to discharging people.

3.2 Project Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
Status report	Monthly	Highlight Report to Integration Executive	Work stream Lead	Integration Executive
Exception report	Quarterly	Report to Integration Executive	Work Stream Lead	Integration Executive

4 Risks

4.1 Key Risks

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	1.12.14	Yasmin Sidyot/Julia Eames	Key partners are not engaged or willing to make the necessary transformation	Low	High
2	1.12.14	Yasmin Sidyot/Julia Eames	Tools and IT support systems are not able to support transformation	Med	Med
3	1.12.14	Yasmin Sidyot/Julia Eames	Staff are not equipped to embrace and deliver change	Med	Med

5 Costs

5.1 Project Costs

Include all direct and indirect costs

Description	2014/5(£)	2015/6(£)	Total (£)
Core expenditure for nursing and therapy services.		405	405
Workforce development costs		50	50
Total			**455**

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 (£000)	2015/16 (£000)	2016/17+ (£000)	Totals (£000)
ELRCCG – Existing funding for Intermediate care – Unscheduled care team for Rutland and Intensive Community Support - 48 virtual beds (8 Rutland)	H	405	405		810
Transfer of funds from IUR1 towards workforce development costs.					
Total Funding			**405**		

6 Exit Strategy

Describe how this work stream will be sustained e.g. post 31st March 2016[4]

This workstream is already part of core service provision and is recurrently funded by ELRCCG. The purpose of bringing into the BCF is so that the 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.

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

No

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

As identified above this is core service provision and therefore the intention is not to cease but to deliver this provision in a different way that enables greater integration

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

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