ANNEX 1 – Detailed Scheme Descriptions

Long Term Conditions

Scheme ref no.
LTC
Scheme name
Integrated, Proactive Care for People with Long Term Conditions
What is the strategic objective of this scheme?

Case for Change

Our rationale for changing the way care is delivered across LLR over the five year period for people with long term conditions (LTCs) is based on the following challenges:

- There will be an increasing number of people with LTCs /multiple LTCs over the next 10 years.
- There is a high level of health inequality between different areas of LLR leading to different outcomes for people with long term conditions.
- We need to work to increase screening and prevention for LTCs in response to current low detection rate for LTCs and some cancers.
- Too many people are being admitted for conditions that could be treated outside of hospital – we need to improve ambulatory care in support of these conditions and focus proactive care at this group of people.

Desired outcomes

The outcomes we are seeking to achieve across LLR over the five year period are as follows:

- An increased number of care plans in place and people on disease registers.
- More people reporting higher personal resilience and support for self-management.
- More people with LTCs supported by telehealth and telecare services.
- A reduced number of admission and readmission associated with LTCs.
- Shorter inpatient stays for LTCs across LTC and Frail Older People this would equate to 30% of bed days with continued length of stay greater than 15 days (delayed transfers of care – DTOCs' ambulatory care sensitive conditions – ACSC).
- Reduction in dependency on access to care in acute settings for people with LTCs.

BCF Plan Response to the Long Term Conditions Case for Change

Leicestershire's BCF plan focuses on providing proactive, integrated care for those with long term conditions, including targeted case management. This will be achieved by:

- Risk stratification of GP practice populations
- Extending the risk stratification tools/ analysis to align social care and public health data
- Case management by an accountable professional for those with complex needs and/or the over 75s
- Integrated health and care Locality Teams working together to maintain independence in the community
- Improved community based information, advice and support through the unified prevention offer (BCF Theme 1)
- New integrated urgent response services when care needs escalate (BCF Theme 3)

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

LTC1 - Integrated, Proactive Care (Risk Stratification and Case Management by Accountable Lead Professional)

Both local Clinical Commissioning Groups in the County have developed effective models of care to support people with long term conditions to maintain the maximum level of independence and self-care possible.

This involves risk stratification and care planning, with primary and community based support planned around the patient, carer and family.

Risk stratification identifies those individuals most at risk of being admitted to hospital or those who are likely to experience a health crisis.

A proactive, integrated approach is followed where the individual and the health and care team work together to agree the support needed to manage their condition and identify the specific help they need. The engagement with the individual is ongoing and ensures the health risk is kept at bay while supporting the individual to self-manage their condition.

Care plans "step up" care when needed to support through a period of crisis or increased need and "step down" care when the person stabilises or needs decrease.

The model is in its fourth year of delivery and has been successfully developed through the creation of "Virtual Wards" – these are locality based teams working with General Practice as an integrated service, using the established community and social care resources within each locality.

Further integration of pathways, data, records, technology and, where appropriate, services, are the key to improving our local service offer to patients with Long Term Conditions and we have identified some enabling schemes in support of this work within our BCF plan.

Releasing time for primary care to undertake a co-ordinated multidisciplinary approach to patient care is also a key enabler to improved system management of patients that are complex and have multiple health and social care issues. The early implementers of seven day services in primary care in Leicestershire will examine the impact on patients with LTCs as part of this approach,

LTC Deliverables by CCG Per CCG Operating Plan

WLCCG	EL&R CCG
• Between 2014/15 and 2015/16, the number of Personalised Care Plans for people with Chronic Kidney Disease, Dementia, Diabetes, COPD, Heart Failure, and Palliative Care will increase by 30%. This will lead to nearly 12,000 additional care plans • Increase from 1% to 2% from each practice population those at risk of admission identified through risk stratification and on a	• The 2014/16 GP Support and Investment Framework focuses on end of life care, care homes, COPD and atrial fibrillation. • During 2014/15 palliative care registers will increase by up to 1% and have a care plan in place. • 95% care home patients to have a care plan in place.

case management register • Increase and optimise the bed occupancy of the "Virtual Ward" from 82% to 90%, which will reduce emergency admissions for ambulatory care sensitive conditions by 161 spells, and length of stay by 970 days based on 2012/13 baseline activity • Increase utilisation of the First Contact Scheme by 30% on 2013/14 baseline • Increase the number of people reporting confidence to manage their conditions from 6% to 15% based on the 2013/14 baseline • Increase patients who are anti-coagulated, and avoid 1 stroke per 37 patients supported in this way by quarterly review commenced April 2014.	• 2% of patients identified as at risk of admission (which would include EoL and Care home patients) to have a care plan and be case managed in line with the NHS England admission avoidance des. • Over all care plans are expected to rise to over 4839 • Increase in COPD prevalence rates by 1.5% to expected prevalence of 3.1% • Increase patients who are anticoagulated and avoid strokes. Plan is for minimum of two patients per practice to be anticoagulated effectively.

LTC 2 Implementation of NHS Number and Electronic Shared Records

The implementation of electronic care plans and shared care records is being undertaken through collaborative working with the LLR Information Management and Technology (IM&T) Steering Group.

The milestones for the implementation of the NHS number are as follows:

- September 2014 – the NHS number loader will be installed on the adult social care (IAS) system and the connection to the Health and Social Care Information Centre's data matching service will be enabled
- October 2014 – a full extract will be performed for current service users including those with an existing NHS number, as a one off initiation exercise.
- November 2014 onwards – a routine process will be implemented, with handover from the strategic information and technology group into business as usual in adult social care, this will be supported by a technical solution to enable a regular batch update to be performed.

Alongside the above work continues on data cleansing.

The Primary Care Records Sharing Project (Stage One) looks at enabling a view of the GP patient record to local health providers who have appropriate authorisation and permission within the LLR Health Economy. This will enable better sharing of information between Primary Care into Secondary Care and will support both TPP SystmOne and EMIS Web.

The scope of the Stage One project is to implement the technical framework for this view to be accessible by LLR NHS Providers, using a standalone viewer. The project will connect TPP SystmOne Primary Care and EMIS Web Primary Care systems into the viewer for access by secondary care staff. As is required, appropriate Information Governance and IT Security processes and protocols will be developed to ensure effective delivery, and this will form part of

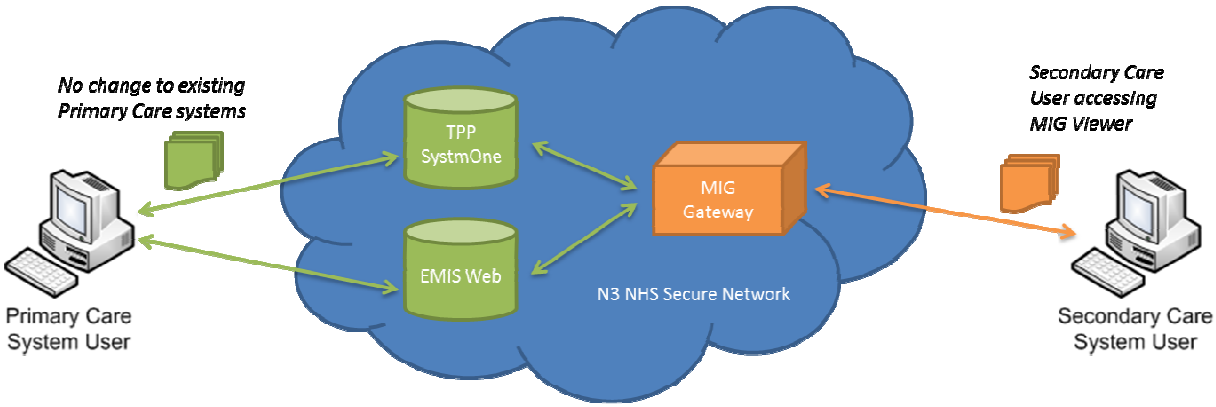
this project also.

It is envisaged that Phase One will be delivered within a 12 month period from approval of funding.

Key deliverables for this project are as follows;

- Definition and agreement in LLR NHS of appropriate IG and IT Security Controls in relation to primary care records sharing with secondary care
- Technical implementation of the MIG Gateway solution, connecting TPP SystmOne Primary Care and EMIS Web Primary Care systems into a locally assessable MIG Viewer to be used by Secondary Care
- Testing and Monitoring of the MIG Gateway for usage
- Planning for Phase Two, future deployment to wider audience including Social Care

Solution Overview



(Proposed implementation aspects shown in Orange)

A business case has been produced with the project is governed by the LLR IM&T Better Care Together working group. This is expected to be approved by the end of September 2014

Following the implementation of phase 1 which is expected to take up to 12 months, Phase 2 will entail further integration including with adult social care.

An application has been made to the national Integrated Digital Care Fund for further funding to accelerate phase 2 of the project and the outcome of that bid should be known by October 2014

LTC 3 Improving Quality in Care Homes

Historically Leicestershire County Council (LCC) has taken an integrated approach to contract monitoring and improving quality in providers. This has been achieved through the work being undertaken by compliance officers.

Homes that were subject to an improvement plan or essential actions have been offered support and advice when the need arose on an ad-hoc basis; however, this support was limited due to limited resources.

It was recognised that a more proactive approach to quality improvement was required and to

support this shift, the department used resources transferred from the NHS to develop a team of officers that work with providers of residential and nursing care services to support overall improvements in the quality of services in Leicestershire.

The Quality Improvement Team was established in May 2012. By raising the quality of services provided by residential and nursing care providers the expectation was that the Adults & Communities department would see a reduction of instances of institutional safeguarding investigations.

The reductions in safeguarding incidents since the introduction of QIT are shown below:

Safeguarding Incident	Pre QIT	Post QIT	Route of Referral	Pre QIT	Post QIT	Outcome of Investigation	Pre QIT	Post QIT
Neglect	105	74	Anonymous	10	0	Substantiated	70	28
Physical	55	21	ASC Staff	29	15	Partly Substantiated	21	6
Financial	6	2	CQC	11	6	Unsubstantiated	54	53
Discriminatory	0	0	Home	61	58	Unsubstantiated – Signposting/Advice	2	1
Sexual	1	7	NHS Staff	41	18	Not Determined	29	9
Institutional	6	5	Police	2	0	On-going		17
Psychological	3	5	SU Family	20	17			
			Victim	2	0			
Total	176	**114**		176	**114**		176	**114**

Of the 30 care homes there are 5 care homes with the highest number of safeguarding incidents reported to LCC prior to QIT involvement which account for 85 of the 176 incidents (Table 2 below). QIT are now monitoring the sustainability of improvements made at these 5 care homes.

LTC4 – Protected LTC Services

- **Nursing care packages**
  Ongoing provision of c300 nursing care placements enabling these service users to stay outside of the acute sector.

- **Sustaining community care packages**
  To support service users' increased dependency for home care and other community based services enabling more people to remain in, or return to their homes, following discharge from hospital. Sustaining community care packages will fund c500 service users during the year

- **Increasing demographic pressures**
  Provision of care packages resulting from increased demographic pressures with increasingly complex needs and dementia in older people. This is an addition to the £21m being funded by Leicestershire County Council. Increasing demographic pressures will fund c400 service users.

Provision of care packages are long established services that are provided/commissioned by Leicestershire County Council. The care packages are available to all FACS eligible service users.

LTC 5 - Integration of Locality-based health and social care services

Leicestershire County Council and Leicestershire Partnership Trust are undertaking joint work to align their locality services. These include district nursing, therapy and other community health services alongside local social care teams, in order to provide a coordinated care and support service which delivers deliver seamless care to patients and service users. Key elements of the model are:

- Geographical alignment across primary care, community services and social care
- A common model of delivery
- Single care plans
- Joint care pathways
- Good relationships and communication
- Co-location where possible

The model has been based on the national voices and King's Fund principles of effective integrated care the model aims to reduce silo working and tackle the barriers that impact on the service user experience of good quality integrated care and support.

LTC 6 Enabler: Developing Personal Budgets (text needs reviewing/updating)

Leicestershire CCGs are also working with local authorities and other health partners to establish effective systems to deliver personal health budgets to individuals eligible through the NHS Continuing Health Care (CHC) process, with a view to the extension of this approach to those with LTCs in line with national policy implementation timescales.

An LLR steering group has been established to plan and develop policies and procedures for implementation for on-going management of personal health budgets. Membership includes health and social care representatives.

National timeline:

- *April 2014 - those in receipt of CHC have the right to ask for a personal health budget*
- *October 2014 - those in receipt of CHC have the right to have a personal health budget*
- *October 2015 - those with long term conditions will be able to have a personal health budget (further guidance pending).*

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

LTC1 – Integrated, Proactive Care (Risk Stratification and Case Management by Accountable Lead Professional)

Proactive care

- Commissioned to Leicestershire Partnership Trust (LPT)
- Commissioned by West Leicestershire CCG

Integrated care model for long term conditions

- Commissioned to Leicestershire County Council

- Commissioned by East Leicestershire and Rutland CCG

LTC3 – Improving Quality in Care Homes
The services provided by the Quality Improvement Team and Safeguarding Team are delivered in-house by Leicestershire County Council

LTC4 – Protected LTC Services
All services are either commissioned directly by Leicestershire County Council or can be purchased by the service user, via a direct payment, for the community services.

There are approximately 209 providers delivering community care and nursing packages.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local Evidence	National Evidence
Scale of opportunity to avoid emergency admissions: **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data These collectively demonstrated the opportunity to avoid 13 of 100 emergency department admissions per day and achieve a 25% reduction in converted admissions from emergency department. **The Director of Public Health Annual Report** (NHS Leicestershire County and Rutland, Leicestershire County Council and Rutland County Council, 2012). States that the increase in the ageing population will drive an increase in the number of people living with long term conditions. http://www.leics.gov.uk/dphannualreport.pdf **Leicestershire JSNA** chapter on long term conditions 2012: http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna_2012_full_length **Leicestershire's Health & Wellbeing Strategy** [Available online at http://politics.leics.gov.uk/Published/C00000135/M00003397/AI00033271/$FFAppendixD.doc.pdf]. Leicestershire Scrutiny Review Panel on the Referral Pathway for Older People with Anxiety or Depression, 2014.	**Scale of opportunity to avoid emergency admissions:** Quality Watch, The Health Foundation, Nuffield Trust: Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' Making our health and care systems fit for an aging population. **The Kings Fund (2014)**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population Includes a section on living with simple or stable long term conditions and co-morbidities. The role of GPs in personalised care of older people is set out in the Government policy **Transforming Primary Care**: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf **Care co-ordination report by The Kings Fund (2013)**: 'South Devon & Torbay: Proactive case management using the community virtual ward and the Devon predictive model' **Case management report by The Kings Fund (2011)**: 'Case management: what it is and how it can be best implemented' Roland M (2012) Reducing emergency admissions: are we on the right track?, *BMJ Sep 2012 345.* Depression in adults with a chronic physical health

	problem: NICE Guideline 91: http://www.nice.org.uk/guidance/cg91 *No health without mental health: a cross-government mental health outcomes strategy for people of all ages: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.** http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on primary prevention, managing ambulatory care-sensitive conditions (which account for 15.9% of England's emergency admission in 2009/10) , risk stratification, care coordination, care management, intermediate care, re-ablement and rehabilitation, managing emergency activity, discharge planning and post-discharge support, mental and physical health needs and delivering integrated care.
	Integrated, Proactive Care (Risk Stratification & Care Management) The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' Naylor C et al. (2012) Long term conditions and mental health – the cost of co-morbidities. King's Fund and Centre for Mental Health. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf] [Accessed on 22/08/2014]. • 30% of people with a long-term condition have a mental health problem (approximately 4.6 million people) (page 5) • 46% of people with a mental health problem have a long-term condition (approximately 4.6 million people) (page 5) • Including a psychological component in a breathlessness clinic for COPD in Hillingdon Hospital led to 1.17 fewer A&E presentations and 1.93 fewer hospital bed days per person in the six months after intervention (Howard et al 2010). This translated into savings of £837 per person – around four times the upfront cost.(Page 14) • In the year following a CBT-based disease management programme for angina, patients needed 33 per cent fewer hospital admissions – saving £1,337 per person (Moore et al 2007). (Page

	14) De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation. [Available online at http://personcentredcare.health.org.uk/sites/default/files/resources/helping_people_help_themselves_0.pdf] Accessed on 22/08/2014] A NICE Local Practice example is available at: Self-care support for long-term conditions The King's Fund: Naylor et al, 2013. Transforming our health care system. Ten priorities for commissioners. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf]. Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The integrated, proactive care for people with long term conditions will be measured by:

- Reducing the total overall number of admissions to hospital.
- Contribution to bed capacity reductions in the acute sector
- Numbers of people with an accountable lead professional
- Numbers of people with active case management
- Numbers of people with care plans
- User Experience – especially with regard to how supported and involved people feel in managing their LTC(s)
- (insert reference to any clinical audit/statistical process control/evaluation etc.)

What are the key success factors for implementation of this scheme?

- Clinical expertise to develop the model of care
- Robust business cases
- Effective impact assessment
- Clear KPI's and evaluation approach
- Realistic trajectory for implementation
- Recruitment timelines

- Risk mitigation plans
- Clear project management and SRO roles
- Performance management of delivery via the Integration Executive
- Relationship management and joint leadership across agencies
- Maintaining alignment with the 5 year plan
- Relationship management between County, City and Rutland BCF.