Annex 1 – Scheme Detail Summary

SCHEME 1 - Providing an Integrated Health & Social Care ‘Step-up/Step-Down’ Service as an alternative to Hospital Care

SCHEME 2 - Support into Care Homes and Extra Care Housing

SCHEME 3 - Integrated Care (ProMISE)

SCHEME 4 - Dementia

SCHEME 5 - Self-Management

SCHEME 6 - Carers support

SCHEME 7 - Resilience Schemes

SCHEME 8 - Integrated Care Record

SCHEME 1

Providing an Integrated Health & Social Care ‘Step-up/Step-Down’ Service as an alternative to Hospital Care

Scheme ref no.

1

Scheme name

Providing an Integrated Health & Social Care 'Step-up/Step-Down' Service as an alternative to Hospital Care.

What is the strategic objective of this scheme?

- To provide a genuine alternative to an ED attendance; hospital admission or readmission or long hospital stay
- To provide slow stream rehabilitation, reablement or care prior to the commencement of rehabilitation to prevent a hospital readmission
- Strengthen the integration of health and social care and building additional capacity in the community
- Commissioning services in the community to support ambulatory care and the de-escalation of a health and social care crisis in the community, through the provision of community reablement and rehabilitation services.

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?

What is the model of care and support

This scheme will support the delivery of a multi-disciplinary integrated health and social care system by making available the following services

1. Increase the current capacity of step down from hospital rehabilitation service offered in a residential environment or people's own homes.
2. Make available step up rehabilitation service offered in a residential environment such as an extra sheltered unit, a dedicated area in a care home or other residential care environment.
3. Establish an Integrated Discharge Team to reduce hospital admissions of 0 length of stay and reduce delayed transfers of care from the hospital to the community
4. Increased Medical Response Team capacity to respond to acute illness in the community
5. Extend the duration of the current home based rehabilitation program from the current 10 to 20 days

The key objective is to ensure people are receiving a joined-up and personalised care at home or closer to home. We adopt a 'Whole System' approach to bring together organisations (health and social care, care providers and voluntary organisations) and move to a more collective way of working to achieve a reduction in total emergency admissions, prevent hospital readmissions and support independence.

These services will work in partnership with other services described in the Better Care Fund plan schemes.

Which patient cohorts are being targeted?

- Patients/users with existing chronic long-term conditions such as COPD and Stroke, or people with disabilities, or have mental health needs, where the primary concern is not their mental health. Patients/users are likely to be over 65 years, but not exclusively.
- People requiring community based care to complement the emerging ambulatory care pathway
- Patients/users who have had a fall (with or without fracture)
- Patients who have been discharged from hospital but are at risk of readmission.
- Patients at risk of an admission to hospital or long term care
- Patients who require additional services to complement their end of life care plan.

The delivery chain

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

Commissioners: Bromley Clinical Commissioning Group, London Borough of Bromley

Services to be purchased from:

- Existing providers using contract variations (MRT, Step down beds and Step down home based services, Integrated Discharge Team)
- New providers on a spot purchase arrangements
- New Procurement of larger service

The method of procurement will follow the CCG and LBB procurement policy and may in some cases involve the preparation of full business cases.

The procurement of other services will be by variation of existing contracts and the revision of existing service specifications.

All projects will have initiation documents and project plan and will use the disciplines of project management to ensure timely implementation.
A joint commissioning post will articulate and coordinate this project linking with the local authority Head of Care and Assessment Services and the CCG lead for Community Commissioning and Urgent Care.

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

To support the selection and design of this scheme

Evidence suggests that it is not the presence of community services per se that is critical,

but how they operate. Where they are part of an integrated and well-targeted system of care, hospital bed use tends to be lower.

The King's Fund has offered advice and recommendations to achieve better health and social care integration (2013), maximising the better care fund (2014).

A number of organisations have evaluated the impact of community- based alternatives to hospital admissions (Purdy 2012), The Nuffield Trust (Bardsley 2013), The Care Quality Commission (CQC) 'State of Care' report (2013)

Analysis suggests that better management of ambulatory care could achieve savings of more than £1.42 billion (Tian and others, 2012), (PSI 10-05 Pringle: Avoidable Acute Admissions research report).

Intermediate care services, including rehabilitation and reablement, have the potential to reduce length of stay by facilitating a stepped away out of hospital (Step-down) or preventing deterioration that could lead to a hospital admission (step-up). Reablement can enable people to stay in their own homes for longer, reduce the need for home care and improve outcome for users (Social Care Institute for Excellence 2013).

Rehabilitation and re-ablement provided at home are more cost effective than rehabilitation and re-ablement provided as bed-based care (NHS Benchmarking Network 2013)

Assumptions about impact and outcome

We expect to achieve a reduction of 191 non elective admissions for Ambulatory Sensitive Conditions in the first year of the plan (308 full-year effect)

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

At this stage an all-inclusive financial sum has been provided to support this scheme (composed of existing investment and estimated new investment) and is summarised in order to protect commercially sensitive information.

The commissioners are in the process of contract negotiations with potent service providers and final costings have not yet been confirmed.

Service Description	**Investment required**
Increase the capacity of step down beds	£1,658,00
Increase the capacity and duration of home based intermediate care	
Make available step up beds	
Establish and Integrated Discharge Team	
Increase the Medical Response Team capacity	
Joint commissioning role (fixed term)	

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?

Monitor

- non elective spend against plan
- non elective admissions against plan
- Community bed utilisation plan
- Community home based service utilisation against plan
- MRT utilisation against plan
- Long term care admission against plan
- Qualitative KPIs to test integration (to be agreed)

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

- Procurement of additional community based beds available to alleviate the pressure on acute care provision i.e. Hospital care)
- Attracting sufficiently experience staff to provide the home based services
-
- Management of risk within new and existing community beds
-
- Gaining and sustaining a system wide commitment to the delivery of integrated care
- Achieving early and sustained results

SCHEME 2
Support into Care Homes and Extra Care Housing

Scheme ref no.
2
Scheme name
Support into Care homes and extra care housing
What is the strategic objective of this scheme?
- To commission a service for the supply of medical services available to residents of care homes and tenants of extra care housing. - To increase the access and scope of provision of medical services available to residents of care homes and tenants of extra care housing. - To support workforce development in care homes and extra care housing to enhance their ability to sustainably manage patients with complex needs - To reduce unnecessary emergency conveyances to hospital resulting in fewer admissions. - To increase the quality of care for patients in nursing homes, residential homes, and ECH through enhancing the medical support directly available.
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?
<u>Increasing the offer of medical support to care homes</u> In collaboration and consultation with current providers and local care homes, the CCG will review the existing VMO service, and develop a model of enhanced medical support to care homes that will support patients to be managed in their residency. The current service has been in place for a number of years, and a new model of medical care is proposed that meets current and future local and national priorities, as well as integrating with other local services to support relevant pathways and admissions avoidance activities. Patients who are residing in care homes or ECH have increasing health needs and multiple co-morbidities that need anticipatory and emergency care planning. In order for the patient to be maintained out of hospital these care plans need to be regularly reviewed and implemented. **<u>Workforce Development (training)</u>** This model proposes training and upskilling of care home and extra care housing staff, to both improve the quality of care provided in these facilities for patients with ever growing complex co-morbidities and to reduce the number of unplanned conveyances to hospital. The training packages educate the staff in best practices being used, focussing on specific conditions that have been shown to be a concern in the Bromley area.

There are two elements to this scheme:

1. Training for Care Homes and Extra Care Housing linked to a SE London collaborative training project supported by investment from Health Education South London (HESL), but with sufficient funds to target only a limited number of care homes within each SEL CCG, and by other schemes that constitute the Bromley Better Care Fund Plan (where referenced)
2. 'Six Steps to Success' training specific to effective end of life care

Under 1, the following areas have already been identified as priorities for training locally:

- Dementia (note this is referenced and costed in scheme 4)
- Falls (note this is referenced and costed in scheme 3)
- Urinary Tract Infection (note this is referenced and costed in scheme 3)
- Pressure Sores
- Management of Peg feeds
- Catheter competency
- Other priority areas for training to be identified through SEL collaborative training needs analysis

Under 2, the DoH End of Life Care Strategy (2008) highlighted the need for providing good quality end of life care in all settings. The 'Steps to Success' programme is adapted from the National End of Life Care Programme's 'Route to Success in End of Life Care – achieving quality end of life care in care homes' (NEoLCP 2010).

The programme requires each residential home to work through six steps over the period of a year, supported by an electronic toolkit and care home facilitator, who works with the homes help them implement and role model where required.

The key objectives for the programme are that:

- care home staff are able to recognise dying residents and plan care accordingly
- care home staff have increased confidence to care for dying residents in the residential care home setting
- care home staff develop improved collaboration with their GP's and DN's
- residents and families are given the opportunity to discuss preferences and wishes/Advance Care Plan
- tools to improve quality of life e.g. pain assessment are implemented

The training modules included are:

Step 1: Assessment, planning and review

- Monthly coding meetings in the homes with manager and staff.
- Use of Prospective Prognostic planning Tool
- Attend GP GSF meetings

Step 2: Discussions about the end of life

- Advance Care planning Discussions
- IMCA meetings
- Resuscitation decisions - DNaCPR

Step 3:

- Anticipatory medication
- Awaiting outcome of Liverpool Care Pathway review. Training given to staff around care in last days of life.

Step 4:

- Reflective debriefing after each death for support and learning.

Step 5

- Pain assessments
- Depression scales

Step 6

- Encouraging GPs to use Coordinate My Care

This model supports the investment of 0.5 to 1.0 WTE Band 7 Clinical Facilitator to train 5 or 10 care homes within a 12 or 24 month period. If a two year programme, in year two, the trainer will sustain the initial 5 care homes and implement training in 5 new care homes. Due to issues of staff retention, the facilitator is required to continually sustain the training in the earlier homes to ensure all staff continue to use the learning from the training, with the aim of improving quality, standards and clinical knowledge of specific conditions and end of life.

Which patient cohorts are being targeted?

- People residing in care homes or extra care housing
- Patients with existing chronic conditions and likely to be over 65 years, but not exclusively.
- Patients who have had a fall (with or without fracture)
- Patients who have been discharged from hospital but are at risk of readmission
- Patients at risk of an admission to hospital or long term care
- Patients who require additional services to complement their end of life care plan, dementia
- Patients who have nursing needs that may require additional support not provided routinely in low level bed based care

The delivery chain

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

Bromley Clinical Commissioning Group, London Borough of Bromley, all associated residential homes and extra care housing, Oxleas Foundation Trust, Bromley Healthcare

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

Evidence suggests that it is not the presence of community services per se that is critical, but how they operate. Where they are part of an integrated and well-targeted system of care, hospital bed use tends to be lower. There is, also evidence that better integration of services impacts in appositive way on the quality of care for those with long-term

conditions and end of life care.

Increasing numbers of very frail older people are resident in nursing homes. They have complex medical needs which cannot be met by primary care contracts to the level required to ensure good quality of care. Community services have never been commissioned specifically to support nursing homes, as they have their own nurses, and residential patients were expected to be able to travel to their places of treatment. However this patient group has increasingly complex needs requiring specialist support.

Everyone counts; Planning for Patients provides a focus on the management of patients over 75 years and those with complex needs. The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. CCGs are able to provide additional funding to commission additional services that support the accountable GP, in improving quality of care for older people and reduce avoidable admissions. The new service model will acknowledge, support and enhance this.
A King's fund review in 2012 concluded that here was little systematic evidence of what works in terms of community- based alternatives to hospital admissions (Purdy 2012). The king's fund have offered their 16 steps to integrating care (King's Fund 2013). Following this St Christopher's Hospice have developed a training package – Six Steps to Success- which is currently being assessed for accreditation.

http://www.stchristophers.org.uk/care-homes/residential-care-homes

Pilots and early adopter case studies evidence a change in practice for care homes, post implementation of training. Whilst it is too early to provide any meaningful emergency admissions avoidance evaluation, feedback from care homes supports that staff are more empowered to not only manage the patient themselves, but through identification of other services available within the wider integrated care teams, exacerbations or concerns are being referred to these teams rather than conveyed to hospital.

Investment requirements

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

Investment required for the new VMO scheme :

There are approximately 2500 patients residing in care homes and ECH. Schemes for additional nursing home care cost approximately £200 per bed, and based on this the total cost of the scheme would be £500,000.

2500 beds @ £200 per bed per year	£500,000 per annum
Review and development of model	£5,000
Communications & engagement	£5,000
Implementation	£20,000
Total	**£530,000**

Training costs to be supplied by Health Education South London who will commission training in partnership with Bromley CCG and the London Borough of Bromley.

Six steps to Success - 0.5 to 1.0WTE Band 7 Facilitator Post	£32K to £64K per annum
Initial Training Proposal: - Dementia (See Scheme 4), Falls & UTI (See Scheme 3) - Hydration and nutrition - Medicines management; prevention, recognition and management of infections - Management of Peg feeds - Catheter competency - Assessment and decision making skills, risk assessment and communication across the system - Other SEL identified priorities from training needs analysis	Up to £100K
Grand Total (VMO and training)	**£694k**

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?

Monitor and evaluate

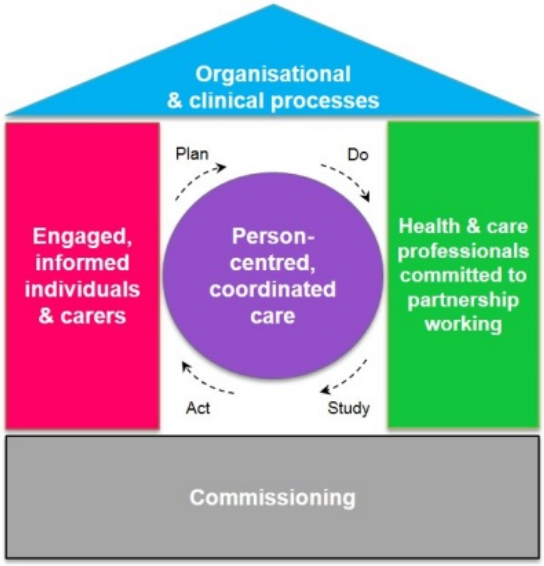
- Trainee evaluation and feedback
- LAS conveyance monitoring, cut by care facility to assess trend changes
- Quality assessments - CQC
- Programme Monitoring

Reduced Emergency hospital admissions/readmissions, LOS & spend for 65 years and over.
Reduced Emergency A&E attendances & spend for 65 years and over
Reduced planned hospital admissions, LOS & spend for 65s and over (by HRG)
Reduced planned activity (OPD first & follow-up) & spend for 65 years and over
% of activity associated with advice and support (Local Authority)
% of patients requiring assessment (Local Authority)
% of assessed patients that require complex care support (Local Authority)
% of assessed patients that require reablement (Local Authority)

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

- Improved level of quality outcomes in care homes and extra care housing
- Reduction in conveyances to A&E from these facilities
- Reduction in emergency admissions relating to care home or extra care housing
- Improved concordance with best practice in care homes and extra care housing
- Feedback from trainees which evidences improved empowerment

SCHEME 3
Integrated Care (ProMISE)

Scheme ref no.
3
Scheme name
Integrated Care (ProMISE)
What is the strategic objective of this scheme?
• to develop and support an integrated approach to care across Bromley that reduces the reliance on secondary care and maintains patients in the community • providing additional capacity within these teams to support patients within the community • take a proactive, collaborative and holistic approach to supporting patients and carers in the community • developing and providing capacity to support services which ensure parity of esteem • developing new processes and methods of working to reduce duplication within the system
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?
Risk Stratification and Care Planning This model of care is based on that specified with the House of Care, in which providers, commissioners and systems are deemed more effective when working in an integrated fashion.      Whilst the workstream will be applied to all Bromley patients, given the older demographic of the area, those with LTCs are predominantly over 65; circa 17.6% (75,000, 2011), as evidenced in our JSNA.

This investment scheme focuses specifically on:

a. Increasing community matron capacity to support proactive home based-assessment and case management of patients risk stratified by GP practices; and increasing Physio and OT capacity to support such patients, as the evidence from a pilot identified this as an area of unmet need;
b. supporting the ongoing development, training and role development of integrated teams: this includes investment in developing trusted assessor roles and joint assessment framework to expedite processes between health and social care, supporting team development initiatives and supporting integrated working and change management approaches.
c. support services that offer enhanced integrated working across primary, community and acute care- this will include Falls, Diabetes, End of Life.

End of Life: The scheme proposes to expand the commissioned 24 coordination service which provides patients identified in the last year of their life with direct access to their keyworker, specialist palliative nurses and the wider St Christopher's Hospice services. Patients are referred in to the service and are assessed for basic nursing, social care provision and specialist palliative input. Advanced care planning is undertaken to ascertain their wishes with regard to their preferred place of death and packages of care and treatment plans are discussed and put in place. Patients, their families or carers are provided with an ongoing keyworker who will continue to manage their case and provide 24 hour support should a change or crisis happen. Equipment and palliative drugs can provided through expedited pathways and all additional services such as community teams, primary care and social services can be liaised with and coordinated through this service.

The calendar year-end caseload in 14/15 is anticipated to be 650 patients. Through this scheme the provider will be expected to increase its caseload to 800, thereby further reducing hospital admissions in the final year of life.

A separate investment in the Dementia scheme will offer the end of life team an improved ability to manage dementia in the final year of life, improving their ability to avoid deaths in hospital if that is the preference of the patient/carer.

Falls: The service will be fully operation in April 2015. It will provide comprehensive and cross-cutting interventions designed to detect osteoporosis and prevent the first or subsequent falls. The new pathway consists of:

- Expanded consultant input offering diagnosis, medication reviews, interventions and onward referrals.
- A fracture liaison nurse case finding within A&E and fracture clinics and conducting DXA scans, training and education including to younger age groups and post-menopausal groups to maximise prevention strategies.
- A community based falls service consisting of Falls Coordinator, nurse, physiotherapy and occupational therapy offering diagnosis, medication use reviews, home assessment, balance and exercise therapy plus training and education including in-reach into care homes.
- Enhanced linkages across social services, podiatry, pharmacy, Rapid Response (Plus) and LAS to ensure patients are offered a holistic and streamlined service.

Diabetes: the scheme will support an enhanced primary care service, which alongside a respecification of the community and acute services will effect a shift from an acute/crisis driven service to a largely primary and community based service helping patients to manage their diabetes effectively and avoiding exacerbations and associated complications that can lead to high cost interventions

The delivery chain

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

Bromley CCG, Bromley Healthcare, Oxleas, London Borough of Bromley Social Care Division, St Christophers Hospice, Bromley Care Partnership, Primary Care providers throughout Bromley, Acute providers- chiefly the Princess Royal Hospital and Kings College Hospital.

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

Integrated Care:

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

Falls:

Age UK (2012), Breaking Through: Building Better Falls and Fracture Services in England, http://www.ageuk.org.uk/PageFiles/22486/Article/breaking_through_building_better_falls_and_fracture_services_in_england_2012.pdf

Age UK (2010), Stop Falling: Start Saving Lives and Money, http://www.ageuk.org.uk/documents/en-gb/campaigns/stop_falling_report_web.pdf?dtrk=true

End of Life: Model is innovative and new; evidence to date is that there has been a marked reduction in deaths in hospital as a proportion of all deaths and Bromley has moved from a lowly position to number 1 or 2 in London for patients registered in the Coordinate My Care register against expected prevalence.

Investment requirements

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

Case Management and Integrated Care Teams (ICT)

Community Matrons	£0.4m (a)
OT and Physio capacity	£0.3m (a)
ICT development	£0.2m (b)
Total	**£0.9m**

Service specific

End of Life Coordination Service	£0.3m (c)
Falls	£0.3m (c)
Diabetes – Enhanced Primary Care	£0.5m (c)
Total	**£1.1m**

Total Investment £2m

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?

Monitor and evaluation

- Activity levels for members of the ICT across both Integrated care team contracts and Community contracting (local Performance Dashboard)
- Outcomes: Emergency attends including ED, UCC; Emergency admissions
- Activity data specific to new pathways (local Performance Dashboard)
- Programme Monitoring
- Local Patient/carer surveys
- National GP practice patient survey

Reduced Emergency admissions/readmissions, LOS & spend for 65 years and over.
Reduced Emergency A&E attendances & spend for 65 years and over
Reduced planned hospital admissions, LOS & spend for 65s and over (by HRG)
Reduced planned activity (OPD first & follow-up) & spend for 65 years and over
Deaths in hospital as a proportion of all deaths
CMC register against expected prevalence

- Qualitative KPIs (Community, specific services and primary care)

Did the patient/carer report that they were treated with dignity and respect?
Does the patient feel more equipped to cope?
Does the patient feel better supported?

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

- Recruitment of additional staffing capacity and embedding of new ways of working by provider(s)
- GP practice engagement
- Acute provider engagement and support
- Effective liaison between services (multi-disciplinary working)
- Stability in community services provision

SCHEME 4
Dementia

Scheme ref no.

4

Scheme name

Dementia

What is the strategic objective of this scheme?

The aim of the this scheme is to develop and improve the existing Dementia service provision, pathway and co-ordination within Bromley, through:

1. Improving awareness and early identification of Dementia through training.
2. Increasing capacity to Assess, Diagnose and mange people with Dementia
3. Developing a range of community support services 'Living Well with Dementia'
4. Increasing support to Carers.
5. Increasing Liaison Services within the PRUH/Kings
6. Improving services for people with Complex and Challenging Dementia.
7. Improving Advanced Dementia Care and End of Life Care
8. Commissioning Project Support

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?

1. Improve awareness and early identification of Dementia through Training

To expand and develop the training programme for care professionals, carers, other workers and public in the Borough to improve awareness and early identification of Dementia, as well as expanding specialist training within care homes to reduce the need for higher cost care or transfer to acute services.

This would expand existing training provision, and provide a coordinated approach to delivery and outcome monitoring. The range of training proposed is as follows:

- Workshops including: Understanding Dementia, Delivering Person-Centred Care for people with dementia, managing the challenges of supporting people with dementia, Successful Communication in dementia care.
- Specialist Training to GPs via a range of education events, masterclasses, practice based seminars etc
- Expand specialist training to care homes, PRUH (Wards & A&E), Extra Care Housing etc.

It is proposed that the training would be delivered by existing local service providers, Oxleas, Alzheimer's Society and Bromley and Lewisham Mind, all of whom have a track record locally.

2. Increased capacity to Assess, Diagnose and mange people with Dementia

To ensure that individuals referred receive a timely and responsive service. Increase capacity working towards the National Target of 67% diagnostic rate (Bromley is currently reporting 45%). Memory clinics in Bromley are currently working at maximum capacity; therefore any increase in referral rate will require additional diagnostic capacity to ensure that referrals are processed in a timely manner.

The model of care would be an expansion of existing services provided by Oxleas NHS Foundation Trust.

3. Develop a range of community support services

Enabling individuals and their carers to access information, support and advice following diagnosis – 'Living Well with Dementia'. Presently, there are minimal post-diagnosis advice and support services in Bromley for individuals and their carers. It is proposed that this will include the introduction of Dementia Advisors and support workers that will be able to work along side the memory clinics, as well as providing support to the community integrated care teams and GPs in the 6 locality teams.

Two potential service models have been put forward by existing service providers (Bromley & Lewisham Mind and Alzheimers Society), each providing the same core components to support individuals and their carers through:

- Provision of Information, relevant to each individual, to help them understand their diagnosis and identify the support they need
- Advice to help people address their practical and social issues, and make informed choices
- Signposting to other sources of appropriate support and community resources that may be of benefit, and supporting people to engage with these
- Personalised Individual Support Planning to help people identify and achieve their personal goals

4. Increase support to Carers (see scheme 3)

5. Increase Liaison Services within the PRUH/Kings

Increase capacity within the liaison services between A&E, acute wards and mental health services. The current service is being expanded as part of resilience planning; it is proposed that this increase is maintained. The liaison service provides assessment and support within A&E and the acute hospital wards to improve 24/7 availability. This increased support will improve the responsiveness in A&E as well as supporting the timely and appropriate discharge of individuals with Dementia.

6. Improve services for people with Complex and Challenging Dementia

Presently a number of individuals with the most challenging and complex presentations remain in the mental health Dementia Inpatient service beyond their acute phase of treatment due to difficulties to place in appropriate nursing homes. Additionally some individuals are placed are in very expensive placements with 2:1 / 1:1 nursing. Work is underway to review if services could be improved to improve throughput within the acute Dementia Inpatient service, and in turn, improve the Dementia service's responsiveness to the acute hospital.

The initial phase of this work will require a review and potential redesign of existing services and investment, to provide a more coordinated and cost-effective approach, involving continuing health, social and mental health older adult inpatient care.

7. Improving Advanced Dementia Care and End of Life Care

The provision of dementia expertise in to the existing palliative care services will help patients with advanced dementia to live at home for as long as possible in the last year of life. Support will be provided during times of crises and/or deterioration to prevent unnecessary hospital admissions where possible and reducing the likelihood that patients are placed in residential care.

8. Commissioning Project Support

Additional commissioning project resource to support the development and implementation of the above individual schemes to ensure successful and timely delivery of each of them. In addition, the role would be responsible for providing specific support to the development of a co-ordinated training programme with the various providers (project 1), liaising with other projects with regard to support to carers (project 4) completing analysis and options for the review of services for people with complex and challenging needs (project 6), and the development of a Dementia Road map for the Borough by end 2015/2016.

The delivery chain

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

Commissioners: Bromley CCG, London Borough of Bromley, Public Health

Providers: Oxleas NHS Foundation Trust, Bromley & Lewisham MIND, Alzheimer's Society are all existing local providers with the skill and knowledge to deliver the above schemes. (Note: a process may be required to decide on the provider where more than one provider is able to deliver the scheme).

In addition: St. Christopher's (Links with the existing palliative care service) and Kings/PRUH (Links with the wider hospital via the Liaison Teams)

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

1. Improving awareness and early identification through training

- NICE guidance (CG42) Health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities
- NICE Guidance (CG42) Primary healthcare staff should consider referring people who show signs of mild cognitive impairment (MCI)[10] for assessment by memory assessment services to aid early identification of dementia, because more than 50% of people with MCI later develop dementia.
- NICE Guidance (CG42) Health and social care staff should be trained to anticipate behaviour that challenges and how to manage violence, aggression and extreme agitation, including de-escalation techniques and methods of physical restraint.
- Oxleas Dementia Care Tool has been developed based on NICE Guidance to reduce distress and the need for antipsychotic mediation. Training to date has demonstrated reductions in the use of antipsychotics.
- Feedback from the Oxleas GP Training CQUIN 2013/2014 identified positive outcomes from the limited number of practices where this was carried out, including, including increased knowledge and confidence, as well as higher rates of referral to the memory services.
- Bromley Dementia Needs Assessment 2012 support the need for further training locally.

2. Increasing capacity to Assess, Diagnose and mange people with Dementia

- The NHS England ambition is that two thirds of the estimated number of people with dementia should have a diagnosis and post diagnostic support.NICE Guidance (CG42) Memory assessment services (which may be provided by a memory assessment clinic or by community mental health teams) should be the single point of referral for all people with a possible diagnosis of dementia.
- NICE Guidance (CG42) Memory assessment services should offer a responsive service to aid early identification and should include a full range of assessment, diagnostic, therapeutic, and rehabilitation services to accommodate the needs of people with different types and all severities of dementia and the needs of their carers and family. Memory assessment services should ensure an integrated approach to the care of people with dementia and the support of their carers, in partnership with local health, social care, and voluntary organisations.
- Improving the diagnosis and care of patients with dementia has been prioritised by the Department of Health and by NHS England through its planning guidance for clinical commissioning groups (CCGs) – target 67%.
- Living Well with dementia: A National Dementia Strategy

3. Developing community support services, 'Living Well with Dementia'

- The aim of high quality support is to ensure that people can live well with dementia and the importance of high quality support is recognised in the National Dementia Strategy (NDS) and the Prime Minister's Dementia Challenge.
- Department of Health evaluation provides positive evidence on the value of these services. It shows that dementia advisers and peer support networks have benefits to the wellbeing and quality of life of people with dementia and their carers. Both the dementia advisors and peer support had resource saving implications for the local health and social care economy. In addition, they played a key role in raising awareness of dementia and tackling stigma.
- NHSE is committed to raising the numbers of people with a formal diagnosis of dementia and to encourage commissioners and others to make sure that there is an appropriate level of high quality post diagnostic support available.

4. Increasing support to Carers (links to Scheme 6)

5. Increasing Liaison Services within the PRUH/Kings

- NICE guidance (CG42) Acute trusts should ensure that all people with suspected or known dementia using inpatient services are assessed by a liaison service that specialises in the treatment of dementia. Care for such people in acute trusts should be planned jointly by the trust's hospital staff, liaison teams, relevant social care professionals and the person with suspected or known dementia and his or her carers

6. Improving services for people with Complex and Challenging Dementia

7. Improving Advanced Dementia Care and End of Life Care

- NICE Guidance (CG42) Dementia care should incorporate a palliative care approach from the time of diagnosis until death. The aim should be to support

the quality of life of people with dementia and to enable them to die with dignity and in the place of their choosing, while also supporting carers during their bereavement, which may both anticipate and follow death.[20]

- NICE Guidance (CG42) Palliative care professionals, other health and social care professionals, and commissioners should ensure that people with dementia who are dying have the same access to palliative care services as those without dementia

Bromley Dementia Needs Assessment 2012 – Highlighted these as areas for future service development.

Investment requirements

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

1. Improving awareness and early identification through training.

To include a selection of the following:

i. Training Workshops to Include:-
   a. Understanding Dementia
   b. Delivering Person-Centred Care for people with dementia
   c. Managing the challenges of supporting people with dementia
   d. Successful Communication in dementia care

ii. Dementia skills training and consultancy to staff in Extra Care Housing and Care Managers. This package includes a range of training sessions, consultancy to individual staff and teams and support to help the transition of new referrals with a dementia diagnosis.

iii. Specialist Dementia Training Programme for Care Homes, GPs, PRUH.

Total £70,000

2. Increasing capacity to Assess, Diagnose and mange people with Dementia.

The additional resource to expand existing clinic capacity:

- WTE Consultant Psychiatrist
- WTE Band 6 Memory Nurses
- WTE Administrator Band 3
- WTE Clinical Psychologist Band 7
- 2.0 WTE Assistant Psychologist Band 4
- WTE Occupational Therapist Band 6
- Non-pay costs

Total £453,000

3. Developing a range of community support services 'Living Well with Dementia'

Service models have been suggested by Bromley & Lewisham Mind and the Alzheimers Society, although they have slight variations, both are of similar financial

value. Staffing to include Dementia information / Dementia Support Workers / Dementia Advisors

Total £248,000

4. Increasing supporting to Carers (see scheme 6)

5. Increase in Liaison Services within the PRUH/Kings

Continuation of agreed additional organisational resilience funding

Total £200,000

6. Improving services for people with Complex and Challenging Dementia.

Re-model existing investment with support from commissioning project support.

7. Improving Advanced Dementia Care and End of Life Care

- 0.6wte Band 6 Nurse
- 0.2 wte Consultant Psychiatrist
- Non-pay inc. emergency prescriptions

£65,000 (Estimate)

8. Project / commissioning support
1.0 wte Band 7

£48,000

Summary costs

Training & Development	£70,000
Diagnostic Clinic Expansion	£450,000
Community Support	£248,000
Expand Liaison PRUH	£200,000
End of Life Care	£65,000
Project Support	£48,000
Total	**£1,081,000**

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

1. Improving awareness and early identification through training

- Programme of Workshops could be developed over a 12 month period to deliver training for up to 600 people.

- The existing programme of training support to extra care housing (due to end Sept 2015) could be extended until March 2016, enabling continued support and skills development for staff.
- Provision of GP seminars and training to staff in the community and PRUH will improve detection and referral for assessment, as well as provide more information to avoid unnecessary admission and improve the management of challenging behaviours.

2. Increased capacity to Assess, Diagnose and mange people with Dementia

- Increased diagnostic capacity of at least 217 additional assessments per year (20% increase) to achieve prevalence target of 67%

3. Developing community support services 'Living Well with Dementia'

- An estimated 600 people and their carers could be supported with 1:1 support and advice per year. In addition, specialist dementia input could be provided to the 6 primary care locality 'integrated care teams', supporting individuals to remain at home.
- A range of dedicated community activity groups for people with dementia could be established.
- A range of community information and support resources could be developed, available to all.

4. Increasing support to Carers (see scheme 6)

5. Increasing Liaison Services within the PRUH/Kings

- Reduce length of stay and unnecessary delays in discharge from A&E and Acute Hospital Wards.

6. Improving services for people with Complex and Challenging Dementia.

- Reduce length of stay and unnecessary delays in discharge from Acute Older Adult Mental Health Wards.

7. Improving Advanced Dementia Care and End of Life Care

- Reduce unnecessary admission to hospital. Support individuals to die in a place of their choice.

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?

Each of the schemes would have a set of measurable objectives and outcomes agreed. Each project would be expected to report back on a regular / monthly basis against the agreed activity and outcome measures.

The existing mental health programme framework (programme implementation

group and programme Board) would be used, along with a dedicated Dementia steering group, to ensure that all areas of the programme are effectively integrated.

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

1. Improved awareness and early identification of Dementia through training.

- More people with memory problems are appropriately referred to the Memory Service for a diagnosis of dementia and access to support services and treatment
- Staff have more confidence in working with people with dementia following awareness training
- Specialist training enables staff to reduce distress in dementia and delays the need for higher cost care / reduces the use of acute health services
- Bromley is able to be a more Dementia friendly Borough

2. Increased capacity to Assess, Diagnose and mange people with Dementia.

- Increased early detection of Dementia by GPs
- Increase in dementia diagnosis to assist with GPs' QOF
- Early support for clients and carers
- Improved pathway for clients

3. Developing a range of community support services 'Living Well with Dementia'.

- Individuals are more aware of the support available post diagnosis
- Improve well-being and quality of life for individuals and their carers

4. Increasing supporting to Carers (see scheme 6)

5. Increase in Liaison Services within the PRUH/Kings (as per resilience plan)

6. Increase Home Treatment for people with Dementia

- Reduction in the number of admissions to both the acute hospital and mental health wards for older people with Dementia
- Reduce the average length of stay for those admitted to acute and mental health wards with Dementia.
- reduce the usage of antipsychotic medications
- The investment would need to save an estimated 1,500 bed days to be cost neutral. (£600,000 / £400 estimate OBD)

7. Improving services for people with Complex and Challenging Dementia.
There are a number of individuals in acute older adult Dementia beds, that are past their acute phase of assessment and treatment, and with appropriate service provision could be moved to specialist

8 Improving Advanced Dementia Care and End of Life Care

SCHEME 5
Self-Management

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
5.
Scheme name
Self-Management
What is the strategic objective of this scheme?
Bromley CCG and Bromley Council are committed to creating an environment which enables and encourages residents, their carers and families and wider community, to take control of and make well-informed choices about their health, care and wellbeing. Well researched, developed and publicised integrated sources of trusted and reliable information and advice is fundamental to supporting people to make good choices about their health and wellbeing, and to empower them to take control over their lives through the self-management of their health and care needs. This is also a vital component of preventing or delaying the need for accessing health and care support and services, including: • reducing unnecessary GP appointments • reducing hospital A&E attendances • reducing hospital admissions • improved discharge planning • better management of care and support needs in the community • reducing inappropriate referrals and initial contacts to Adult Social Care Services • encouraging the development of a well-supported and trained network of informal care and support within the community • better informing people about their health and care so that they are empowered to manage their own needs
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?
This scheme will develop and implement a better integrated community network of support to enable people to better self-manage their health and care needs through strengthened education and training, enhanced information, advice & guidance and extended utilisation of telecare. This will include a number of interlinking elements: 1. Twelve patient Self-Management for Life education programmes (£55k) and four equivalent programmes for carers (£18k) 2. Targeted education and prevention work through GP practices of patients deemed to be at high risk of developing diabetes encouraging improved behaviours and promoting self-management. Maximum investment £100k 3. Linked to 1. above and 6. below working with Self-Management UK to develop a local, self-sustaining programme of patient and carer education in living effectively and confidently with long-term conditions. Estimated cost of £50k to encompass identification of local coordinating/provider organisation, training of facilitators, communications and engagement, development of local resources and course

materials, and a self-management network.

4. The commissioning of health coaching training for care professionals to promote self-care, support the role of 'accountable professional' and truly collaborative care planning with patients and carers. Ceiling for investment set at £50k.
5. A single point of entry into a network of enhanced advice and support from the third sector via telephone and/or face-to-face sessions and online. this will require a maximum investment of £100k.
6. An extended single point of information, advice and guidance online via the expansion of the Bromley MyLife website to cover health and social care, as well as community area and locality based 'sub sites' developed around the borough's 6 local clinical networks, and enhanced integration with the national NHS Choices website – this will require an investment of £100k comprising of additional staffing (£40k), developments to the MyLife website (£30k), development of self-assessment tools (£8k), promotional material (£2k), content development and management (£5k), and purchase and installation of terminals within GP surgeries (£15k)
7. The creation of a retail/shop in the borough's busiest shopping centre through a partnership of statutory and voluntary & community sector organisations as a public access point for integrated information, advice & guidance, health promotion and volunteer recruitment – this will require an investment of approximately £100k
8. The expansion of the borough's Health Champions programme to increase both the number of Health Champions and their skills & knowledge to expand the informal network of support and social capacity across the community, with anticipated recruitment of a number of Health Champions from participants in the Self-Management for Life programme – this will require a maximum investment of £50k comprising of a coordinator, promotional materials, training and support, and the development of a virtual network and hub (not confirmed)
9. Expansion of the existing Florence Telecare (text messaging) scheme commissioned by the CCG to include the development of new clinical protocols; training; licensing and text bundles; purchasing of self-monitoring equipment such as oximeters, spirometers, blood pressure monitoring kits; and incentives for GP practices to participate. The latter to compensate practices for the time in recruiting patients, registering patients and monitoring; similar to the Remote Monitoring Direct Enhanced Service scheme since discontinued. The maximum investment will be £200k.
10. Participation in the London-wide Digital Mental Health and Wellbeing project as set out on the business case for London developed by project managers within Public Health England and the Office of London Councils. Estimated costs £70k over two years.
11. Dedicated project management and project support to manage and coordinate this programme of work. Estimated at £100k

Although most of this scheme will be universally available for residents across the whole of the borough, the different elements are most likely going to be used by people who are on the cusp of accessing health and care services due to a long-term health condition, illness, disability or old age. It would also be expected that the carers and families of these residents would also access and use the different elements of the scheme to better support them.

Elements of the scheme have been identified from intelligence gathered from a number of different engagement activities with residents of the borough who are both within and on the cusp of using the services. The intelligence has informed the view that there should not be one single provision of this service. Instead there should be a coordinated and integrated delivery of the provision across multiple channels – online and hardcopy;

face-to-face, telephone and online; trusted local sources of information and advice which is informed by national/international information; and services and support for both service users and their carers, alongside information for professionals and volunteers.

The delivery chain

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

The scheme will be delivered by the following providers – split into commissioners and providers:

Commissioners:

- Bromley CCG
- London Borough of Bromley

Providers:

- Bromley Advice and Information Network – consisting of five independent advice giving organisations: Age UK Bromley & Greenwich; Bromley Citizens Advice Bureau; Bromley Mencap; Bromley & Lewisham Mind; and Carers Bromley
- Bromley Healthcare
- Community Links Bromley
- intu Bromley
- OLM Systems

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

Self-management is considered effective in improving health outcomes, 'Evidence suggests that supporting self-management works. Supporting people to look after themselves can improve their motivation, the extent to which they eat well and exercise, their symptoms and clinical outcomes and can even change how they use health services.'[1]

The following extracts and references to a report by the Kings Fund, articulate the case for change and the associated policy context and also recognises the value of self-management courses to help some people become effective or more effective self-managers:

- People with long-term conditions are managing their health on a daily basis, but they may need additional help to develop their confidence in fulfilling their role as a self-manager. This may include support to enhance their ability to manage their tests or medicines, to make changes to their lifestyle or to cope with the emotional and social consequences of living with a long-term condition (Corbin and Strauss 1988).

- The call for a more person-centred, better co-ordinated approach to managing care for people with long-term conditions has been embraced by … National Voices – a coalition of more than 140 UK health and social care charities – developed a first-person narrative to explain what the gold standard of care looks like. This requires

[1] Health Foundation (2011)

making the patient perspective (or that of the service user) the organising principle of integrated care, and can be summarised as follows: 'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me' (National Voices 2013).

- A report by the Richmond Group of Charities and The King's Fund (2012) outlined the service components needed to achieve this:

    - patients engaged in decisions about their care
    - supported self-management
    - co-ordinated care
    - prevention, early diagnosis and intervention
    - emotional, psychological and practical support.

- The government's Mandate for NHS England requires it to 'ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment' (Department of Health 2012b). This includes the aspiration that everyone with a long-term condition, including those with mental health problems, should be offered a personalised care plan that reflects their preferences and agreed decisions

- … six-week generic self-management courses such as those run under the auspices of the Expert Patients Programme (nb now Self-Management UK)…can help people to develop practical skills and strategies for dealing with the emotional and psychological impact of living with a long-term condition. In addition to the educational impact of courses, many patients value the social support gained from meeting other people who are living with a long-term condition.[2]

- A study by the Health Foundation[3] estimated the potential savings to the healthcare system of self-management as follows:

Use of Healthcare Services	% decrease
GP consultations	7%
Outpatients attendances	10%
A&E attendances	16%
Physiotherapy Services	9%

- Various studies have found that peer-led self-management programmes are both cost-effective (an average saving of £452 per patient per year) and help to reduce the burden on healthcare professionals by providing patients with the skills, confidence to be more actively involved in their own care and to better manage their own symptoms. Many of those who participate in self-management programmes go on to provide peer support and play more active roles in their local communities and it is estimated that for every £1 invested some £6.50 of social care value is created.

[2] Delivering Better Service for People with Long-term Conditions, The Kings Fund (October 2013)
[3] Helping people help themselves: Evidence about supporting self-management, the Health Foundation (2011)

During the past few years, the CCG and the LBB have undertaken a number of engagement activities – including consultations and surveys, conferences, focus groups and informal intelligence gathering exercises – to identify the information, advice and guidance needs of the borough. These activities has enabled both partners to hear directly from over 3,400 people – including residents of the borough who are both within and on the cusp of using the services, those who have very low level health and care needs, and their carers and families, alongside professionals from across the workforce and volunteers.

The number of unique visitors to the Bromley MyLife website has grown significantly since the website was launched in May 2011 as illustrated below:

- Number of unique visitors from 1 May 2011 to 30 April 2012: 6,642
- Number of unique visitors from 1 May 2012 to 30 April 2013: 9,888
- Number of unique visitors from 1 May 2013 to 30 April 2014: 18,524

This illustrates the increasing reliance within the borough on people accessing and using online information, advice and guidance.

Recent research indicates that over 38 million people across the country now access the internet every day. Between 2006 and 2014 the percentage of people aged over 65 who used a computer everyday increased from 9% to 42%, reflecting the increasing usage of computers by people who are likely to be beginning to experience health and care needs.

LBB has developed and launched a specific 'sub-site' within the Bromley MyLife website for one particular community area – the Cray Valley Community – which has had approximately 2,000 unique visitors and over 4,400 page views between November 2013 and August 2014. The Council is currently working with Bromley CCG and Bromley Healthcare to develop a specific 'sub-site' within the Bromley MyLife website for the community served by a health clinic in the Chislehurst & Mottingham Community. Since the start of the development of this 'sub-site' in May 2014, the pages have been viewed by approximately 700 unique visitors who have viewed nearly 1,900 pages.

The Council's initial contact point for adult social care - Bromley Social Services Direct - receives approximately 45,000 contacts a year and, of these, around 2,000 are logged on the social care information system as referrals and passed to the Contact and Assessment Team (COAT). The remainder of the callers are either logged as enquiries related to open cases, or provided with information and advice or signposted to other organisations. Of those that are referred to COAT, 44% are then screened out as not being eligible for social care services. This suggests that if residents and professionals were better informed through an enhanced information, advice and guidance system this could significantly reduce the demand on local services.

Furthermore, recent research from Nesta indicates that CCG's could save on average £21 million through better engagement and involvement of people with health and care needs – especially those with long-term conditions – in the organisation and delivery of their care and support. The research also states that one-third of the population will have a long-term condition and that these residents account for a significant number of contacts and pressures on both primary and secondary care services – including GP appointments, outpatient appointments and inpatient bed days.

Investment requirements

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

Summary:	
Self-Management for Life	£223k
Health Coaching	£50k
MyLife website development	£100k (includes web developer post)
Volunteer hub	£100k
Health Champions	£50k
Telecare	£200k
Digital Mental Health	£70k
Project support	£100
Total	**£993k**

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

The measures that will used to monitor the impact of the scheme, include:

- A reduction in the number of inappropriate presentations at A&E
- A reduction in the number of inappropriate GP appointments
- A reduction in the number of inappropriate Out of Hours contacts
- An increase in the number of people who self-manage their health and care needs
- An increase in the number of people engaged with self-management support groups
- An increase in the number of unique visitors to the Bromley MyLife website
- An increase in the number of referrals dealt with the Bromley Advice and Information Network which are dealt with and are not inappropriately signposted to the Council
- The footfall within the retail/shop in the intu Bromley shopping centre
- An increase in the number of volunteers who are working with the health and social care sector
- An increase in the number of Health Champions
- An increase in the number of 'conversations' and interactions logged by the Health Champions
- An increase in the proportion of 'informed people' who contact local health and care services

There is a growing body of evidence to suggest that integrated health and well-being services can realise significant financial benefits - in particular, studies have illustrated that integrated early intervention programmes can generate resource savings of between £1.20 and £2.65 for every £1 spent (POPPs, LinkAge Plus, Supporting People, self-care schemes) However, a focus on early intervention and support is designed to prevent needs escalating in years to come, and so the real benefits will be realised over time.

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 above measures will be regularly and routinely measured as part of an integrated Performance Management Framework. Feedback will also be continuous gathered via

the borough's existing partnership and engagement framework.
What are the key success factors for implementation of this scheme?
• Agreement to recruit the required project management support • Clear and timetabled implementation plans with breakpoints linked to benefits realisation reviews • Capacity and capability of the third sector to respond to commissioning challenges • Agreement to lease a suitable and affordable retail unit in Intu Bromley • Agreement to invest in the development and enhancement of Bromley MyLife website • Strong provider engagement (at individual practitioner level) to promote and encourage self-management participation • Effective communications to promote self-management among patients/.carers and representative groups

SCHEME 6
Carers support

Scheme ref no.
6
Scheme name
Carers support
What is the strategic objective of this scheme?
To increase the levels of support to carers specifically to avoid carer breakdown and the consequent need for high cost acute interventions or long term care packages where the outcomes for the service user are often poorer.
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?

Cohort Targeted: Carers

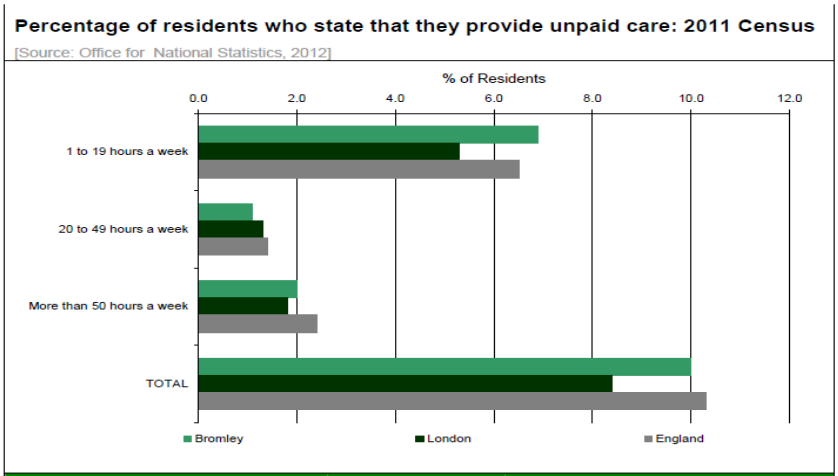
"*someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems"* Source: Department of Health, 2008

Carers do not include people who volunteer or paid workers as they are referred to as 'care workers'. Carers play a huge, unpaid role in supporting people with their health and social care needs. Without this support, there would be far greater pressure on both health and local authority services.

The numbers of carers

The initial findings from the 2011 Census [Source: Office for National Statistics, 2012] indicate that:

- around 5.4 million people (10.3%) of the population in England were unpaid carers
- around 31,000 people (10%) of the population in Bromley were unpaid carers
- Bromley has a significantly higher percentage of carers than across London (8.4%).



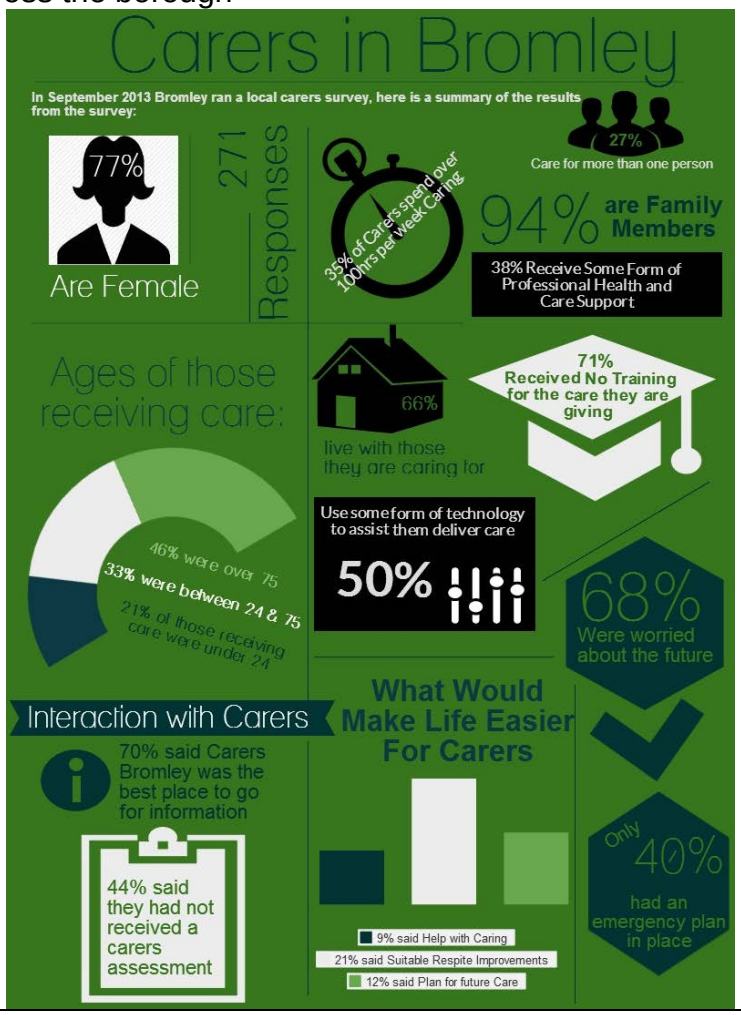
	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides more than 50 hours unpaid care a week	Totals
Bromley	6.9%	1.1%	2.0%	**10.0%**
London	5.3%	1.3%	1.8%	**8.4%**
England	6.5%	1.4%	2.4%	**10.3%**

Supporting carers
Many carers feel that their contribution to society goes unrecognised and they often find that their needs are overlooked; they have to fight for support and that the support available is insufficient or poor quality. Only a small proportion of carers receive any support in their caring role and a many are themselves over 65 years.

Impact
Nationally, carers providing high levels of care are twice as likely to report poor health compared with those who did not have any caring responsibilities. This has implications for health and adult social care as it will increase demand for treatment, respite and social care packages. Those who are already over 65 years and those who live in single households are also at risk from requiring care for themselves.

As this increased need for care clashes with cuts in services resources, will be targeted at the most vulnerable, leaving the majority to take care of themselves. Age UK examined the impact of a 7% real terms cut to local authority funding. They estimated this would lead to 250,000 fewer older people receiving care in their own home (a 38% decline); a 25% rise in the hours of personal care provided by carers and an estimated £8 billion funding gap for local authorities. As the number of carers increase this will also have an impact on businesses as most carers fall into the 45-64 age brackets at the peak of their careers. Their experience may be difficult to replace and their economic contribution will also be greatly reduced.

Carers survey
In 2013, the Local Authority surveyed Carers to get a better picture of demand and the needs of carers across the borough



Current services

The London Borough of Bromley and Bromley Clinical Commissioning Group have jointly commissioned a 'strategic partnership' contract with Carers Bromley. As a strategic partner, Carers Bromley is funded to be the first port of call for all carers requiring information, advice and guidance. Carers Bromley meets the needs of the majority of the carers requiring support, and only refers carers on to statutory organisations when they are likely to meet the eligibility criteria.

In addition to the strategic partnership with Carers Bromley, the Local Authority and Bromley Clinical Commissioning Group also commission respite services and other support services to carers which may be wholly subsidised or which may be subject to a contribution from the service user. Some of the services provide support both to the service-user and carer, for example day services which provide social stimulation to the service-user during the day as well as a break for the carer. These services have historically been commissioned separately by the Local Authority and Primary Care Trust.

Public Health are working with local GP's to identify carers and increase the referral rates to carer support services available in Bromley.

Health and Adult Social Care currently spend £4 million per annum (adult social care contributes £1 million) on services for carers. Services include:

- information and guidance;
- emotional support;
- respite at home services;
- residential respite;
- day services and respite for carers of people at the end of life.

In 2013/14, 1,130 carers were assessed/ reviewed; 62% of whom were aged 65 or over. However, this represents a significant decrease from an average of 2000 over the 5 years previously, and a peak in 2009/10 of 2700. This presents as a gap in provision of assessments seeing as there is no reason to think that the actual number of carers in the borough has reduced, in fact with an ageing population, it is reasonable to assume that the number may be increasing.

It is locally understood that the reasons for reduced carer assessments in recent years is complicated, but principally is founded on the idea of the carer support (service package) offer being insufficiently generous to make a carer assessment worthwhile to the carer.

The service offer for carers can be split broadly into two – a low level/preventative offer and a high level (typically respite) offer.

There are 5000 carers who access the low level and preventative support.

- 4800 Carers Bromley core contract
- 25 Mencap Saturday lunch club
- 50 Pineapple Lunch Club
- 125 The Stroke Association
- Carers supported by MIND's training for carers of people with dementia

The key part of this 'low level offer' is the support provided to people referred to Carers Bromley, which includes information and advice and a very popular 'check in' service of telephone support.

The higher level offer is provided to approximately 1,175 carers.

900 carers of older people, consisting of:

- 150 Respite in residential and nursing homes
- 450 Respite at home – sitting services
- 250 Day opportunities and day centres
- 50 Mencap mutual carer support (where both carer and cared-for have needs)

275 carers of people with learning disabilities, consisting of:

- 160 Day opportunities and day centres
- 100 Respite centre (registered care) – overnight staffed beds
- 15 Shared Lives provision

Volume and cost understanding of this higher level services is a little complicated because of the assumptions that need to be made about day opportunities: *whether the support is in place to principally benefit the carer as respite or to benefit the cared-for by social interaction*, however current modelling suggests an average expenditure per carer of an older person of £1500 per year for these sorts of services.

	Costs	**Users**	**# Breaks**
Residential	£33,564	25	49
Residential dementia	£25,979	34	49
Nursing	£55,971	47	77
Block Heathers	£27,634	15	20
Block Elmstead	£56,311	25	41
Carers Bromley breaks	£86,558	100	46
Carers Bromley sits	£216,395	250	136
MIND respite at home	£116,559	108	167
Day opps mainstream	£358,608	182	279
Day opps Dementia	£295,613	70	141
	£1,273,193	**856**	**1005**
Estimated £ per carer		£1,487.37	

Targets and Growth

This current carer offer reaches 6175 carers. This is 20% of the 31,000 carers who responded to the Census 2011.

Latest modelling for the Care Act projects that there will be 1615 carers receiving services in 2015/16, including over 300 new carers to receive respite support.

Therefore one of the outcomes to be achieved from this BCF carer funding would be an anticipated rise in coverage of the carer offer, perhaps by as much as 25% (although this does depend on carer behaviour and the uncertain effects of the application of the Act).

In addition, significant strengthening of the offer (increase in expenditure per head) is anticipated in order to achieve compliance with the new duty to meet carers' assessed eligible unmet needs, including a currently-estimated 60% increase in the expenditure per head for low level/preventative carer supports, and potential for a 10% increase in the expenditure per head for high level (respite) support.

There is also inadequate support planning on offer to carers which also presents as an opportunity to provide a different sort of assistance to carers – the carer survey indicated a 12% response asking for help with planning care, which indicates demand for this support

and would be preferable to offering a charged-for support planning option (as is allowed under the Care Act).

In order to address these pressures in partnership both eth CCG and LBB belief that there needs to be a dedicated resource and carers commissioning project set up now.

Existing Commissioned Carer Support Services in Bromley:

Service	Activity
Carers Bromley	
Strategic Partnership	Providing information, advice and guidance through multiple channels including face to face, telephone and web based services. Among the services offered to carers are; emotional support, a 'check in' service and an emergency carers card.
Respite at home	The respite at home service allows carers to have a break from their caring role, ranging from 1-2 hour sits up 8 or 24 hour breaks. Carers can self-refer or be referred to the service.
Hospital Discharge Worker	The hospital discharge worker is based within the social services team at the Princess Royal University Hospital, identifying and supporting carers of patients. The worker will complete Carers Assessments and assessments of carers who are caring for someone at the end of their life
Mental Health Worker	Provide information, advice and guidance to carers of people with mental health problems. Raises awareness of carers and Carers Bromley, providing advice, guidance and training to Oxleas staff, increasing the number of carers assessments undertaken with mental health carers.
Back Care Advisor	To promote the health of carers in the borough and to provide carers a risk assessment, training and support in their own homes. To monitor safe back care practice for individual carers and to review, following an initial assessment and training.
Bromley Mencap	
Mutual Carer Support	A project co-ordinator works with and provides advocacy for families in Bromley who are in a mutually caring situation, where the person with a learning disability has started to take on a caring role.
Complex Needs	To provide respite to families of adults with complex needs, who are unable to access traditional building-based respite services. The service allows attendees to undertake a number of group activities and day trips to local facilities which can accommodate the personal care needs of the group.
Buddying Scheme	The scheme provides parents/carers with a short break from their caring role by supporting young disabled adults to access the community and become as independent as possible.
Sitting Service/ Respite at home	This service provides respite of 2-3 hour sits, enabling carers to have a break from their role. Carers can self refer or be referred to the service.
Childminding Networks	A flexible, tailor-made service where disabled children with complex needs up to 16 years of age are carefully matched with registered childminders who are trained specifically to care for them. The childminders are monitored and supported to provide care for as little as two hours or as much as 40 hours each week.
Bromley Mind	
Respite at home	A range of respite at home services, including respite for carers of people with advanced forms of dementia and evening and weekend respite. Also provided is a respite service for carers of people with early onset dementia, aimed to provide greater stimulation to the service user.

Dementia Support Centres	Provides care during the day up to 6 days a week; offering stimulating activities in a friendly and welcoming atmosphere. The 3 Centres are located in the Beckenham and Orpington/ Chislehurst areas.
Domiciliary Care	For those who need help with daily tasks in order to stay in their own homes. Visits, which usually take place 1-3 times a day, can include assistance in and out of bed, personal care and meal preparation.
Dementia training for Carers	Provided through workshops or individual training in people's own homes.
Community Wellbeing Services	A person-centred peer and professional support service aimed at 'open doors' to the wider community. The service also helps people manage their mental health, rediscover lost skills and develop new ones. The service provides a flexible range of opportunities from three Centre bases and a range of community venues.
Working for Wellbeing	Supports people to learn skills to make the changes in their lives that will help them to overcome the effects of low mood and anxiety. The service delivers 'low intensity' interventions, which use evidence based Cognitive Behavioural Therapy (CBT) approaches.
The Peace Outreach Service	Provides individual and group support to women with dependent children who feel the need for support independent of statutory mental health or children and families services.
Stroke Association	
	To support survivors of stroke and their families, providing information, advice and support on adjusting to changes caused by stroke, and optimising the quality of life for the survivor and their families. Ongoing regular contact will be maintained with stroke survivors to ensure they are supported in the most appropriate manner.
Alzheimer's Society	
	Operates a Day Centre open 6 days a week for people with dementia providing much needed support for their carers. Operates a drop in centre weekly, to provide information and advice for anyone affected by dementia. The Society runs monthly support groups which provide an opportunity for carers to network and offer mutual support. The Society also has 2 part time support workers who provide information and advice and will visit families giving individual support as required.
The Pineapple Club	
	Provide respite and culturally sensitive support and advice to carers from the Bromley African and Caribbean Communities.
Somali Well Women Project	
	Operates a drop in centre for Somali Women and their carers, providing culturally sensitive information and advice.
Headway	
	Support to carers caring for someone who has suffered a brain injury. Headway run 2 family and carers support services, including monthly workshops for understanding brain injuries and a bi monthly peer support group for carers and their families.
Residential Respite	
	Overall, a total of 9 respite places are commissioned, including 4 places for residential physically frail respite, 4 places for residential dementia respite and 1 place for nursing dementia respite.

Day Opportunity Services	
	The majority of people attending day services live with a carer and the attendance at a centre provides carers with regular breaks and support. There are 1,500 day centre places per week for older people, 450 of which are for people with dementia. There are also day opportunities for people with disabilities provided both in the community and at Astley centre.

New Scheme

We want to create a one year fixed joint commissioner role to:

- Support increasing carers support capacity using the council's existing contracts in the immediate term
- Reviewing all existing carers services (contracts) for Adults
- Engagement with local providers and service users
- Producing a gap analysis
- Feeding in NICE best practice and other sources of expertise
- Producing a commissioning strategy
- Commissioning Carers services against the recommendations in the strategy

Certain defined outcomes

- Increased support for Carers in Bromley
- Plans to move support to carers onto a spot purchasing model funded through the allocation of Personal Budgets that can be taken, wherever possible, as a Direct Payment, thus supporting personalisation and falling in line with other service modernisations such as day opportunities
- Meet the demands of the new Care Act for carers services which comes into effect in April 2015
- One pooled budget for carers, one jointly commissioned service

The delivery chain

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

Commissioners

This scheme will fund a 1 year placement for a joint Carers Commissioner who will be responsible for delivery of the new scheme set out above.

The project sponsor will be the *Joint Integrated Commissioning Executive* and the commissioning strategy will be authorised and championed through the Health and Wellbeing Board as well as each organisations existing structures.

A pooled budget for Carers will be created within the BCF.

Providers

Both the CCG and LBB have a core contract with Carers Bromley and, as a strategic provider, commissioners would look to work closely with this provider when considering options for remodelling and expanding our collective support to carers.

Other local providers of lower level support include Bromley Mind, Mencap, Age Uk, and Stroke Association. Providers of further higher level support include respite placements for up to a couple of weeks through our local nursing and residential care home providers. To support personalisation, any new commissioning will look to move away from block contracts and as such we would hope to encourage new providers to enter the market.

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

National Policy Drivers

- Health and Care Act 2012
- Care Act 2014

Both call for greater levels of integration between health and care services and put in place levers such as the creation of Health and Wellbeing boards.

They both also recognise the role of informal care provided by carers and the need to have local preventative services out in the community to delay the need for long term care packages and episodes where there is a crisis resulting in an avoidable hospital admission.

They both also call for services to be co-produced and to support personalisation and use of direct payments.

National Carers Strategy
The scheme will need to meet the recommendations as set out by the national strategy. Four key priorities were identified:

- Priority 1 - "*Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages"*
- Priority 2 - "*Enabling those with caring responsibilities to fulfil their educational and employment potential"*
- Priority 3 - "*Personalised support both for carers and those they support, enabling them to have a family and community life*"
- Priority 4 - "*Supporting carers to remain mentally and physically well*"

Local Policy Drivers
JSNA
Carers Strategy Refresh 2012-13

Both documents highlighted that, instead of being supported, carers often feel that their needs are overlooked. Many say they have to fight to get support and that the assistance available is insufficient and of poor quality.

The Strategy Refresh specifically identifies that carers themselves express the need for more choice and control over the support they receive with services that re more flexible and responsive to individual circumstances.

Demand Management
The local Authority's front of house service Bromley Social Services Direct takes over 44,000 calls per year. The vast majority of requests for help and support are met through providing information, advice and guidance and signposting residents to our strategic providers. Without these services our budgets would be overwhelmed.

Demographic Pressures
Bromley's population profile suggests increased demand will be coming through BSSD over the next 5 years, especially regarding support with dementia. Also our increased

requirements to support self-funders will mean that we anticipate an escalation in referrals. (Also see Targets and Growth section above)

Funding Cuts
Funding pressures make it increasingly hard for the Council to directly fund non-statutory, non-eligible services on its own, the important value of low level interventions early in a resident's care journey is well understood. The Council will therefore take every opportunity to support such schemes through other avenues such as the Better Care Fund where we are working closely with our partners at the CCG to develop jointly commissioned schemes that offer early interventions such as carers support that seeks to reduce the need for hospital admissions and a resilience secondary health services as well as residential and nursing homes.

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

- Recruitment jointly of a commissioner for carers for one year fixed (£60k)
- Increase in existing capacity under current contracts for sitting and respite services (£450k)
- Systems changes to support personalisation (£40k)
- Training for staff and communications (£50k)

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

The scheme is one of eight schemes all with the aim of shifting resource away from secondary health care and long term bed based social care out into a community setting. The redirection of funding from secondary care into carers support should delay the need for higher cost care packages.

For example long term care packages have high unit costs

Older people nursing home placement	£700 per week
Older people Residential placement	£600 per week
LD residential placement	£1000 per week
Dom care	£150 per week

By comparison unit costs for providing interventions that allow a carer to continue to deliver their caring responsibilities represents a much more cost effective option to the tax payer with an average cost of £1500 per year and allows the service user to remain at home.

The impact of the extra resources directed through the Better Care Fund will be to redirect services to carer support.

The impact of jointly commissioning services and review existing provision will be to redesign carers support to be more flexible and responsive to needs by moving brokerage away from block contracts with local providers towards a more personalised approach and using a direct payment where the carer wishes to manage their own support.

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?

Monitor and evaluation

- High level Macro Programme Monitoring for BCF as a whole
- Monitoring of SUS data
- Monitoring of Care First (LA) activity data
- Carer Survey

Reduced Emergency hospital admissions/readmissions, LOS & spend for 65 years and over.
Reduced Emergency A&E attendances & spend for 65 years and over
Reduced planned hospital admissions, LOS & spend for 65s and over (by HRG)
Reduced planned activity (OPD first & follow-up) & spend for 65 years and over
% of activity associated with advice and support (Local Authority)
% of patients requiring assessment (Local Authority)
% of assessed patients that require complex care support (Local Authority)
% of assessed patients that require reablement (Local Authority)

Monitoring reported back through JICE and to the Health and Wellbeing Board. Each organisation will also want to see progress and performance reported. At the local authority this will be through Care Services PDS and the Care Services Portfolio Holder. At the CCG, this will be through the Integrated Care Programme Board and Integrated Governance Committee.

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

- Recruitment jointly of a commissioner for carers for one year fixed
- Engagement from providers especially Carers Bromley
- Existing providers able to offer increased capacity
- Better understanding of referral routes into carers services

SCHEME 7
Resilience Schemes

Scheme ref no.
7
Scheme name
Resilience Schemes
What is the strategic objective of this scheme?
• To ensure timely access to equipment over 7 days to support: - Timely discharge when people are medically fit. - Admission avoidance to hospital and long term care - Self-management and self-care of long term conditions - Ill health and crisis prevention - Increase the effectiveness of reablement • Contribute to the maintenance of 7 day hospital working arrangements recently implemented as part of the winter resilience plan.
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?
What is the model of care and support This proposal not only extends the range and volume of equipment supplied in Bromley, but improves the stock control; assessment and supply of equipment to both increase efficiency and reduce delays to supply. This proposal builds upon the winter resilience project that supports timely discharge from hospital in order to maintain patient flows and maximise people's independence following a health "event". **Which patient cohorts are being targeted?** Patients with existing chronic conditions and likely to be over 65 years, but not exclusively. People requiring community based care to compliment the emerging ambulatory care pathway Patients who have had a fall (with or without fracture) Patients who have been discharged from hospital but are at risk of readmission. Patients at risk of an admission to hospital or long term care Patients who require additional services to complement their end of life care plan
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioners: Bromley Clinical Commissioning Group, London Borough of Bromley Purchase additional: therapy staff to complete assessments; technician to fit and deliver equipment.

Purchase, distribute and replace additional equipment

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

To support the selection and design of this scheme

There is substantial evidence that the deployment of equipment and minor adaptations reduces costs for more traditional home or residential social care (Manchester City Council 2013).

Supply of items such as: Hoists to enable single cover care; aids and equipment to support falls prevention and to make changes to the home environment; supply of mattresses and beds to reduce pressure risks.

Investment requirements

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

Description	**Investment Required**
(Resilience Plan) Continue the senior clinician in A&E at the Princess Royal Hospital • Additional consultant 5 hour shift, 7 days a week • Additional middle grade doctor 10 hour shift, 7 days a week •	£ 446,000
(Resilience Plan) Continue the 7 day opening of the Ambulatory Unit at the PRUH 7.7 nurses 2.4 Doctors 2.1 Support staff	£ 340,000
Provide fast track access to equipment to stop hospital admissions or support hospital discharges 2 P/T (1 wte) Admin staff 2 wte “flying technicians” 2 P/T (1wte) OT 2 WTE risk assessors Equipment budget – approx. £545,576	£ 800,000

Resilience schemes £ 1,586,000

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?

Monitor

- non elective spend against plan
- non elective admissions against plan
- Community bed utilisation plan
- Community home based service utilisation against plan
- MRT utilisation against plan
- Long term care admission against plan
- Qualitative KPIs to test integration (to be agreed)

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

- Reduce the number of people who are medically stable and fit for discharge who are awaiting equipment

- Enable equipment to be ordered and arrangements to be made to fit the equipment from the Emergency Department

SCHEME 8
Integrated Care Record

Scheme ref no.

8

Scheme name

Integrated Care Record

What is the strategic objective of this scheme?

To support delivery of the Bromley 'House of Care', a transformed, integrated health and social care provision that is:

- Able to identify people's health and social care needs at an early stage and involve them in shaping a personalised care plan to meet those needs
- Defined by collaborative, multi-disciplinary working across agencies and professions that enables seamless, coordinated and person-centred care
- Able to deliver care in, or close to, home where possible

We require a horizontally and vertically integrated and shared care record throughout Bromley incorporating health and social care and real time data sharing.

Overview of the scheme

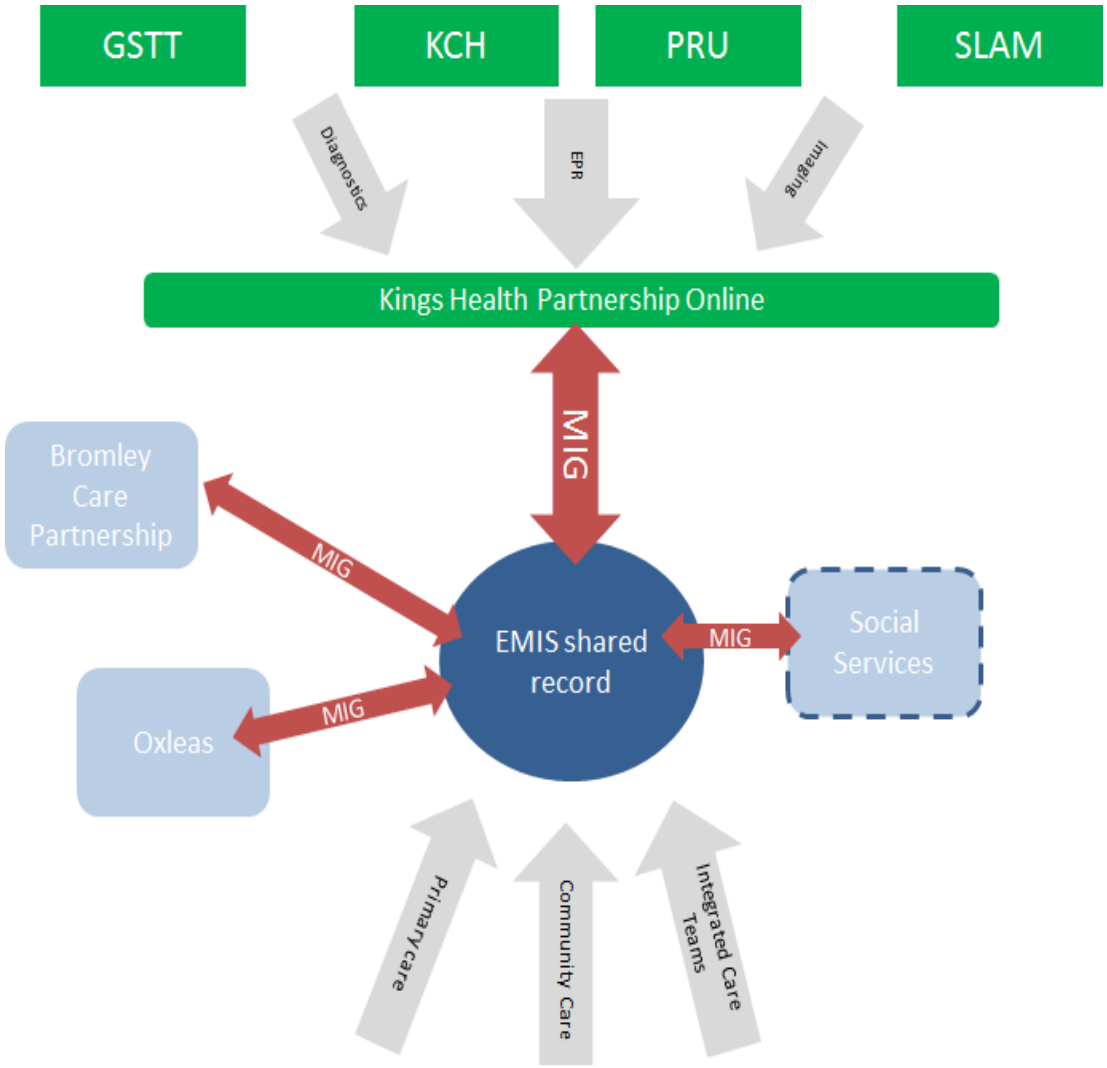
Please provide a brief description of what you are proposing to do including:

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

The proposition includes generating an integrated shared care record system for patients. Delivery encompasses four distinct phases:

1) To link all Primary care and community care records, using EMIS as the central record. All Integrated Care Teams will be able to access the patients' live records on EMIS, using this platform to record care plans, notes, include diagnostics, code information, develop treatment plans. By April 2015
2) To link in other community and local authority providers with the EMIS system either via new procurement of the EMIS or other system for these institutions or by way of using a MIG (medical interoperability gateway) to link the systems; ensuring that the NHS number is the primary identifier for correspondence across all health and care services. By April 2016
3) To connect the acute systems at the Princess Royal Hospital – our key acute site- for purposes of sharing care plans and discharge information.
4) To connect the Kings Health Partnership Online system being delivered with the community and primary care integrated record system. KHP Online includes all acute data from Kings College Hospital, Guys and St Thomas' and South London and Maudsley- inclusive of pathology, imaging and electronic patient records. By Nov 2015

This model of care is based on that specified with the House of Care, in which providers, commissioners and systems are deemed more effective when working in an integrated fashion, supported by organisational processes and systems that effect such integrated working
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf



This key enabling workstream will support effective and collaborative care planning by providing the infrastructure, processes, operations and system interfaces that support the timely and appropriate sharing of information across health and social care landscape. The model assumes that the various components are interdependent and that the combination of these factors generates a meta-outcome. Consequently these workstreams have been combined to give greater clarity around the anticipated outcomes.

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

Bromley CCG, Bromley Healthcare, Oxleas NHS Foundation Trust, London Borough of Bromley Social Care Division, St Christophers Group, Bromley Care Partnership, Primary Care providers throughout Bromley, Acute providers (principally Kings College Hospital NHS Foundation Trust.

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

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

- Central Manchester's Clinical Integrated Care
- Canterbury District Health Board in New Zealand's
- Kaiser Permanente
- North West London Integrated Care
- Torbay- Health & Social Care

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

Shared care, integrated record

Licenses of Q-admissions and Publisher	£50k
MIG conversion	£100k
Project Costs: 1.0WTE @ Band 7	£60k
Training- practice, social care and community staff	£25k
Comms & Engagement	£25k
Total	**£260k**
Respecification and/or procurement of alternative to Care First	£150k
TOTAL	**£410k**

This model has no direct measurable admissions avoidances but acts as an enabler as part of the wider House of Care concept.

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?

Monitor and evaluation
- High level Macro Programme Monitoring

Reduced Emergency hospital admissions/readmissions, LOS & spend for 65 years and over.
Reduced Emergency A&E attendances & spend for 65 years and over
Reduced planned hospital admissions, LOS & spend for 65s and over (by HRG)
Reduced planned activity (OPD first & follow-up) & spend for 65 years and over
% of activity associated with advice and support (Local Authority)

% of patients requiring assessment (Local Authority)
% of assessed patients that require complex care support (Local Authority)
% of assessed patients that require reablement (Local Authority)

- KPI and milestones monitoring
- Auditing

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

- Delivery of an interim solution with the PRU ED and Discharge for integration of all patients, but specifically with value for community managed patients
- Shared care record between primary care and the 6 local care teams
- Wider integrated or shared record system with other providers - including mental health, social services, end of life and acute.
- Integrated record system including pathology, imaging and electronic patient notes between acute and primary/community care.