Bexley Clinical Commissioning Group

ENCLOSURE:	**L**
Agenda Item:	**32/13**

Governing Body (Public) Meeting

DATE: 28th March 2013

Title	**INTEGRATED CARE FOR OLDER PEOPLE**
Recommended action for the Governing Body	That the Governing Body: **Approve** the commissioning intentions and proposed contractual model for developing integrated services for older people. This work forms a key part of the agreed transformational priorities in Bexley CCGs Commissioning Intentions for 2013/14 and an integral part of the Community Based Care Strategy as part of the TSA's recommendations.
Executive Summary	The Integrated Care for Older People's business case sets out the proposals for the redesign of older peoples services in Bexley. This involves delivering system-wide change to more closely integrate the work of healthcare providers and social care services, in order to provide more efficient and streamlined services that are centred around the patient. The business case focuses upon the proposals to ensure that the required community provision is in place that enables older adults to be better managed at home, avoiding the need for hospital admissions and the rapid deterioration that often follows. It also seeks to ensure that when a hospital admission is necessary, patients can be discharged home as quickly and as efficiently as possible. The Integrated Care for Older People's business case was approved by the Executive Committee of Bexley CCG on 6th December thereby authorising the following: • That the CCG designates £1.52m in 2012/13 and £2.02m in 2014/15 of upfront investment from the strategic change fund to purchase the required integrated, community-based services that will improve services for older people in the borough and enable the decommissioning of acute activity with a commensurate reduction in acute capacity achieved • The establishment of a Risk Reserve Fund between Bexley CCG and the London Borough of Bexley

	• To fund approximately £37k of upfront capital/project set up costs in 2012/13.	
Which objective does this paper support?	**Patients:** Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders	✓
	People: Empower our staff to make BCCG the most successful CCG in (south) London	✓
	Pounds: Delivering on all of our statutory duties and become an effective, efficient and economical organisation	✓
	Process: Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience	✓

Organisational implications	Key Risks (corporate and/or clinical)	That the scale of change cannot be achieved leading to financial pressures
	Equality and Diversity	Proposals seek to improve services for vulnerable groups including the elderly and those with dementia.
	Patient impact	Strengthened and more responsive community services that enable patients to be managed more effectively at home with high quality hospital care only sought when necessary
	Financial	Upfront investment required in community health and social care services in order to disinvest in acute non-elective activity.
	Legal Issues	Contractual variation to be agreed
	NHS constitution	The principles of the NHS Constitution have been considered when preparing this report.
Consultation (Public, member or other)	Patient and public consultation has been sought throughout the development, together with briefings and engagement with key stakeholders	
Audit (Considered / Approved by Other Committees / Groups)	Finance Working Group- 6th December Executive Management Committee - 6th December. Business case was approved with conditions Finance Working Group – January – Approved with conditions Health & Wellbeing Board – January Meeting – Supported Council's Executive Management Team – 13th February - Approved Executive Management Committee – 21st February 2013 - principles agreed	
Communications Plan	Communication and stakeholder engagement plan in progress	

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Date	13th March 2013	

Integrated Care for Older People

13th March 2013

1.0 Introduction

1.1 Purpose of Report

1.1.1 The Integrated Care for Older People business case sets out the proposals for the redesign of older peoples services in Bexley. This involves delivering system-wide change to more closely integrate the work of healthcare providers and social care services, in order to provide more efficient and streamlined services that are centred around the patient. The business case focuses upon the proposals to ensure that the required community provision is in place that enables older adults to be better managed at home, avoiding the need for hospital admissions and the rapid deterioration that often follows. It also seeks to ensure that when a hospital admission is necessary, patients can be discharged home as quickly and as efficiently as possible.

1.1.2 This report provides an overview of the business case that was prepared on behalf of NHS Bexley Clinical Commissioning Group (CCG) and the London Borough of Bexley (LBB). The business case was approved by the Executive Committee of Bexley CCG on 6th December thereby authorising the following:

- That the CCG designates £1.52m in 2012/13 and £2.02m in 2014/15 of upfront investment from the strategic change fund to purchase the required integrated, community-based services that will improve services for older people in the borough and enable the decommissioning of acute activity with a commensurate reduction in acute capacity achieved
- That a joint Risk Reserve Fund be established between the CCG and the London Borough of Bexley
- To fund approximately £37k of upfront capital/project set up costs in 2012/13.

1.1.3 This approval was subject to the following conditions:

- Ensuring that the risk pool arrangements are tied down detailing who contributes what, how is it monitored, what the mechanisms are for accessing the pool, what are the baselines etc. This will need to be agreed and go back to the Executive Committee for approval.
- That the acute capacity is removed and that the acute contractual negotiations specify this
- That Bexley CCG receive a credible implementation plan from LBB and Oxleas
- That we define the contractual model and ensure that it includes the right incentives to drive the required change.

1.1.4 This paper provides a summary of the business case and notes progress made in terms of responding to the conditions of approval detailed above. The

Health and Wellbeing Board confirmed their support for the Integrated Care service proposals at their meeting on 28th January and recommended to the Governing Body of the CCG that they approve the Integrated Care service proposals.

1.2 Background

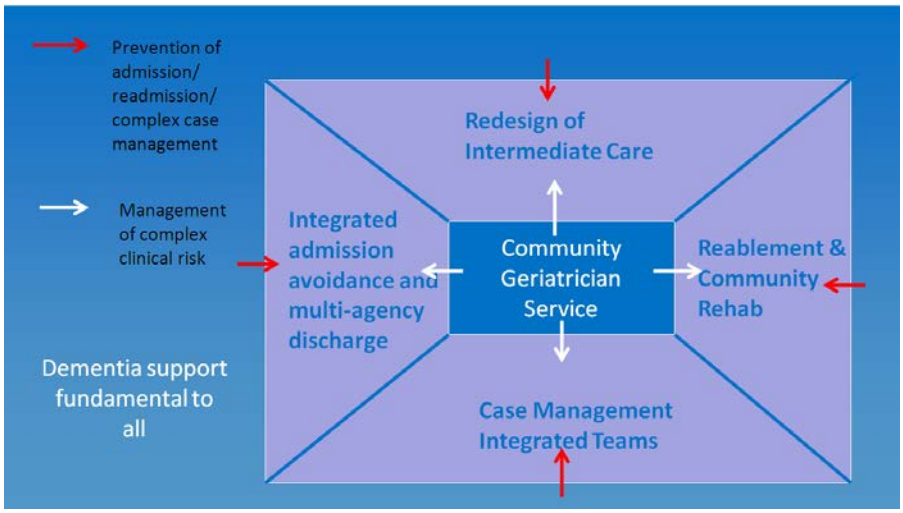
1.2.1 The system wide redesign of older people's services in Bexley is a longstanding priority with widespread commitment from local health and social care commissioners and providers. It has been selected as a priority area for strategic focus and commissioning effort for 2013/14. It is identified as a transformational priority within the JSNA whereby the provision of community services will be commissioned to ensure that there is sufficient resource in place that results in fewer older people ending up in hospital.

1.2.2 The integration agenda has gathered momentum over the last year through national level reform that requires NHS and Local Authorities to integrate their services. The NHS Operating Framework identifies dementia and care of older people as a priority area requiring particular attention during 2012/13 including the need for organisations to work together to achieve a number of aims. The recent Care and Support White Paper released in July 2012 sets out a mandate for Local Authorities to promote the integration of services, where it is considered that this would improve the well-being of adults and carers, contribute to preventing or delaying the need for care or support, and improve the quality of care provided, through more joined up service models. The development of an integrated model of care for older people aligns with the principles of the agreed Community Based Care Programme originating from the Trust Special Administrators (TSA) work. These proposals are therefore critical to the success of the TSA's recommendations to deliver a sustainable healthcare system across South East London.

2.0 Integration of Older People – Service Proposals

2.1 Structure and Determining Priorities:

2.1.1 Integrated governance structures have been in place since June 2012, whereby senior strategic representation from LBB, Bexley CCG, South London Healthcare Trust, Dartford & Gravesham NHS Trust and Oxleas have come together in an Integrated Care Collaborative that reports to each organisations respective groups and up to the Health & Wellbeing Board. Through this forum the transformation of the following service areas was agreed to be the most immediate priority for delivery in 2013/14.



2.2 Service Scoping & Design:

2.2.1 The scoping of each service area has been worked up over the last few months through extensive stakeholder engagement with clinicians and service managers involved with the delivery of services for older people. Patient engagement events have also helped inform the development of the proposals. A summary of what is proposed includes:

- **Community Geriatrician Service** – use of traditionally acute based expertise, to support patients in the community, breaking down organisational boundaries to contribute expert advice to community teams so building confidence in the system as a whole. Some key features of the service will include:

  - Clinical advice and support to intermediate care services
  - Participates in Multi-disciplinary Team meetings for patients with very complex health issues where the community case management needs their expertise
  - Provides anticipatory planning for patients who are in residential care or nursing care and are declining, ensuring there is a communication stream with the GP to facilitate learning and knowledge sharing
  - Includes mental health resource to aid decision making where there is a mental health co-morbidity such as dementia
  - Provides nursing homes with the plan/advice/support that is required for patients who are frequently being admitted to hospital from nursing homes.
  - Providing advanced care planning and confidence for the community/care homes to instigate new pathways, i.e. end of life pathway
  - Be available by telephone to advise GPs and community teams.

  This service is integral to the overall model for elderly care and will support all areas of the system to ensuring older people get the necessary expert advice so they are well managed in the community. This expertise will enable the effectiveness and productivity of all other parts of the system to improve.

The benefits include:

- improved quality of care for patients
- reduced admissions from care homes to hospital
- reduced readmission rates from reablement services into hospital
- reduced lengths of stay for intermediate care beds
- provision of clinical expert advice to GPs and community services.

- **Case management** – GP led model of an integrated multi-disciplinary team approach using innovative models of communication, to planning care for patients with complex needs, and monitoring outcomes. This seeks to encourage a more proactive approach to managing patients across the system so they remain well managed in a community setting. Key features of the approach involve:

  Holding multi-disciplinary team meetings to plan patients care in an integrated and holistic way whereby effectiveness is maximised through:

  - Greater use of risk stratification to identify patients to be discussed
  - Involving the social workers
  - Enabling all professionals to identify patients that they are concerned about
  - Circulating/sharing the patient list prior to the meeting so that professionals have the opportunity to review their own care records
  - Using conference call facilities to enable professionals to dial in when they are unable to attend meetings

  The benefits of this approach include:

  - better coordinated care for patients
  - avoidance of admissions to care homes and hospital
  - improved medicine management

- **Integrated admission avoidance and multi agency discharge** – breaking down organisation barriers to create an integrated health and social care "front-door" and "back door" team. These teams will provide a rapid response to a crisis situation to avoid a hospital admission/emergency placement and ensuring flexibility in the approach to a safe hospital discharge across the system. An Integrated rapid Response and Assessment Team will perform the following key functions:

  - To provide rapid assessment, triage and support to prevent A&E attendances, unnecessary hospital admissions and facilitate safe timely discharges from assessment units
  - Respond to situations where vulnerable adults require a form of urgent intervention (health and/or social care) to avoid further deterioration via referrals from LAS, GPs and other community services.
  - Assess, plan and organise ongoing support for a safe discharge and prevention of readmission for up to 5 days.
  - Work closely with LAS to avert patients being taken to hospital

The Integrated Discharge Team will be responsible for:

- Assisting in the safe and timely discharges of Bexley patients from hospital.
- Assessing clients on the ward and ensuring that their needs and the carers needs are taken into consideration on discharge.
- Form part of the multi-disciplinary team to ensure a responsive service is delivered to enable patients to have ongoing support outside of hospital
- Proactively support the ward team to effectively plan ongoing care and support in a timely manner ensuring that patients do not stay in hospital beyond their medically fit date.

The benefits of these teams include:

- more responsive services outside core hours
- fewer hospital admissions and emergency placements
- patients be discharged from hospital once declared medically fit
- reduced admission length
- patients not having to make a decision about their long term care from a hospital bed

- **Redesign of intermediate care** – provision of 24 hour, bedded support to the whole model of care by commissioning a limited capacity of beds to challenge traditional methods of care by enabling community based teams to care for patients in their own home. Currently there are 24 beds in the Step-up, Step-down ward at Queen Mary's and a further six reablement beds in a care home. An additional 6 beds will be purchased with the intention to consolidate all community beds in a single location. The criteria for admission into the intermediate care beds will be changed so that it can support more complex patients such as those requiring IV therapy, who are immobile or have dementia. The service will also provide rehabilitation to patients so that they are able to regain their independence and maximise their functional abilities when they return home.

  The benefits include**:**

  - Enables patients to not make a decision about long term care from a hospital bed
  - Reduction in length of stay in hospital
  - Enhanced independence and functional capacity of individuals following a period of illness

- **Integration of reablement and community rehab services** – An integrated model of delivering community based rehabilitation and reablement providing more streamlined, integrated working by sharing of skills and challenging traditional ways of working and providing efficient use of services. The key functions of these integrated team will be to:

  - Provide community based assessment, rehabilitation and prevention services for adults in the home, residential or nursing homes and other appropriate community settings.

- Set appropriate rehab goals, and provide rehab programmes for up to 6 weeks initially to maximise each individual's independence.
- Ensuring that patients are discharged from inpatient or community rehab with improved function or ability
- Holistic care planning
- Offering innovative strategies to patients such as telecare, telehealth in order for them to self-care
- Assess and provide appropriate equipment
- Coordinate case management teams across all practices, providing link between community geriatrician service, CAR Teams, GP practices and core community services.

The benefits of this service include:

- Improved quality of care resulting in one decision, one care plan
- Maintains patients independence and function for as long as possible
- Reduction in admissions to permanent care

2.2.2 The delivery plan for each scheme is summarised in the table below. The intention is to have all services up and running from July 2013.

Service	Q4 2012/13	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Case management	Pilot ongoing with 6 practices	Evaluate, plan roll out at locality level	Implementation of case management for all practices		
Community Geriatrician	Further scoping or options for resourcing the service on a pilot basis	Commence service on a pilot basis.			Evaluate and extend or competitively procure service
Intermediate Care	Fund additional 6 reablement beds from winter monies. Re-specify intermediate care capacity requirements jointly with LBB.	Recruitment / sourcing of additional staff	SUSD able to deal with more complex rehab needs, IVs, assessment for fallers, dementia and other common mental health conditions		
Integrated Rapid Response & Assessment Team and Integrated Discharge Team	Existing resource realigned to support new integrated team structures	Recruitment / sourcing of additional staff	All staff in post. Service commences operation		
Community Assessment & Rehab Team	Existing resource realigned to support new integrated structures	Recruitment / sourcing of additional staff	All staff in post. Service commences operation		

3.0 Activity and Financial Impact

3.1 Comprehensive activity modelling has been undertaken to identify the level of acute disinvestment that can be realised as a consequence of the new and redesigned services. This modelling has been based upon 2011/12 non-elective activity data for Darent Valley and SLHT, with clinically based assumptions being applied in relation to the proportion of ambulatory sensitive non-elective admissions that can be prevented. Assumptions have also been made in relation to the proportion of remaining activity where the length of stay is reduced to trim-point. The outcome of this modelling has demonstrated the following full year impact:

- 1,867 admissions can be prevented (approximately 5 per day)
- 13,130 acute bed days saved (reduction of approximately 37 beds) from preventing hospital admissions and reducing the length of stay
- Disinvesting £4.02m from the acute sector.

3.2 The table below summarises the CCG's investment and disinvestment profile including the provision of a risk reserve fund (CCG element only referred to as Risk Pool in the below). It is assumed that in year 1 (2013/14), investment will represent 75% of the full year cost with all staff resource being in post from 1st July onwards. It is assumed that they will not start to impact acute activity until 1st August onwards so eight months of acute saving has been modelled. This demonstrates that a QIPP saving of £425k can be achieved in 2013/14 after a risk reserve of £740k has been set aside. From 2014/15 onwards, full year effect will support a QIPP saving of £749k after a £1.25m risk reserve has been funded.

Health Impact	**2013/14 (Part year impact) (£m)**	**Full Year Impact 2014/15 onwards (£m)**
Total CCG Investment in new Integrated Health & Social Care Services for Older People	1.52	2.02
Total Acute Disinvestment	-2.68	-4.02
Risk Pool Fund (contribution by CCG)	0.74	1.25
Net Saving (assuming risk pool spent)	-0.42	-0.75
Council Disinvestment in Care Homes, Emergency placements and home-based care	-0.27	-0.54
System Wide Net Saving (excludes acute saving)	**-£0.69**	**-£1.29**

3.3 LBB Social Care is also anticipating a saving of £270k in 2013/14 with full year impact of £537k being achieved in 2014/15. In addition to the financial benefit to commissioners, there are further savings to the local health economy as the acute providers will save through a reduction in loss making non-elective activity. Due to the financial position of SLHT this would not free up funds to reinvest elsewhere but simply reduce the size of their deficit. This saving has therefore not been defined.

3.4 There would also be a requirement for £37k of project set up costs for the first year of operation to cover IT hardware costs, information governance requirements, communications and evaluation costs.

4.0 Risk Reserve Fund

4.1 Due to the scale of transformation and the risk that new demand emerges elsewhere in the health and social care system beyond what has been scoped in this business case, partners have agreed that a risk reserve fund is required. This has been established for 2013/14 together with the terms of its usage and oversight. The risk reserve fund will serve two main purposes:

- To alleviate any unexpected social care costs pressures as their impact is less well modelled
- To support any acute activity risks if the spend does not reduce to the extent anticipated while the transformation takes effect.

5.0 Update on Contractual Arrangements

5.1 Overview

5.1.1 This paper sets out the proposed contractual model that will operate for the elderly care service model. This proposed contractual model sits against a backdrop of the arrangements that are being developed as part of the TSA process to ensure the long-term viability of the Queen Mary's Campus. It was also informed by a meeting held with the three GP Locality Leads on 19th December where a number of suggestions were made in relation to ensuring that there are contractual levers in place that effectively incentivise providers.

5.1.2 During this first year of operation the teams will have time to develop and the culture change to embed which will inform the service specification and baseline performance for the subsequent year. After an initial period the services will then be procured through a competitive tendering.

5.2 Variation to Existing Contract with Oxleas including Revised Service Specification

5.2.1 The intention is to contract the community services element of the proposal from Oxleas through a variation to the existing community contract. This will specify that Bexley CCG will invest an additional £820,741 (75% of full year) in 2013/14 to provide the elderly care model in an integrated way with LBB. In developing the service model and the care pathways Oxleas have been working with LBB to map how they intend to restructure their teams and the new resource required to deliver the scale of acute disinvestment. As the service model involves an expansion and reconfiguration of existing services (e.g. Care Navigation and Community Rehabilitation) a variation to the existing community contract is the preferred contractual mechanism in the short-term.

5.2.2 Bexley CCG has specified all the older peoples services proposed and the outcomes required which has been shared with the Integrated Care Collaborative for comments. It is also being reviewed by the GP clinical lead for this work, Nikki Kanani. Contractual discussions with Oxleas have commenced.

5.3 CQUIN – Oxleas and SLHT

5.3.1 This will retain 2.5% of the community services contract value as a CQUIN with Oxleas. In year 1, the CQUIN value would only be released if Oxleas can evidence integration through demonstrating that:

- Robust system-wide pathways, procedures and protocols are in place that enable implementation of the redesigned services.
- That the pathways are effectively being maintained as evidenced through a growth in referrals from community sources.
- Comprehensive communication methods are employed that ensure that the wider health and social care system understand the services, are able to access them and that patient expectations are managed.

5.3.2 As there is a significant amount of upfront investment required by providers to get the infrastructure and relationships in place for the model to be effective, the aim of the CQUIN is to reward Oxleas for ensuring that the integration is completed effectively. It attempts to encourage culture change and drive forward a fundamental change in how providers engage with each other and with patients.

5.3.3 At the time of submitting this paper the CQUIN had been shared with Oxleas with their initial feedback being that this required a lot from them with timescales being too ambitious. This will now get picked up in contract meetings to negotiate acceptance by Oxleas of this CQUIN.

5.4 Section 75 with LBB

5.4.1 This will recognise that Bexley CCG is prepared to fund the Local Authority £0.49m in 2013/14 for delivering the older peoples service model in an integrated way with Oxleas. This will fund the extra social care worker resources (e.g. social workers, therapist, OTs etc.) as identified in the business case as being necessary to ensure that adequate social care resource is available to have the planned impact upon reducing acute activity and reducing length of stay in hospital.

5.4.2 The section 75 will reflect the requirements of the service as specified in the contract variation with Oxleas. The risk pool arrangements will also be detailed. Baseline data will be scoped and a statement will be included that requires the Local Authority to share their monitoring activity on a monthly basis.

5.5 Acute Contractual Negotiations

5.5.1 The decommissioning intentions have been shared with SLHT and Dartford & Gravesham NHS Trust as part of the contractual negotiations that have now commenced. The decommissioning intentions have been specified to detail the activity levels in 2011/12 against the modelled impact at a HRG level.

6.0 Stakeholder Support

6.1.1 The service proposals set out in this business case were presented on 9th October 2012 to senior leaders of the local healthcare organisations who are fundamental to the success of this business case. The following was agreed at this meeting:

i. The CEO of Bexley Council, the Chief Officer designate of Bexley CCG and the CEO of Oxleas FT all confirmed their full support for the proposed model of Older People's Integrated Care noting that improved outcomes and experience would be achieved for patients if this integration could be achieved

ii. The CEO of Bexley Council and the Chief Officer designate of Bexley CCG (as the commissioning organisations) agreed that they both felt that the figures and financial assumptions outlined at the meeting could be used as working figures for any submission to the TSA

iii. The CEO of Bexley Council and the Chief Officer of designate Bexley CCG (as the commissioning organisations) both confirmed that the overall proposals could now form part of the submission to the TSA and that further work should continue in parallel.

6.1.2 Since October, the community service proposals have been more accurately scoped by providers and are of a more ambitious scale than previously anticipated. The model developed is robust and is very similar to the model in Greenwich which has evidenced an impact of reducing spend on acute and community services. This has given commissioners the confidence to be more ambitious with the decommissioning intentions and extending the impact from only older people (+64) to adults aged 18-64, thereby capturing those with long-term conditions. While the scale of transformation has increased, the ratio between investment and disinvestment is unchanged since the Chief Executives and QMS Steering Group endorsed the service redesign proposals.

7.0 Next Steps

7.1.1 The key milestones to be achieved over the next two months include:

- Finalising the service specification for the proposals set out in the business case and commencing contractual discussions with Oxleas
- Communication and engagement activities with staff, general practice and members of the public
- Discussions and agreements to be developed with LBB in relation to the transfer of funds required to resource the additional social care staff required to support the service model
- Ensuring the acute contracts reflect the decommissioning intentions
- Establishing all the performance monitoring arrangements with LBB and providers and the governance arrangements that will enact this process.

8.0 Governing Body Approval

The Governing Body are asked to support and approve the developments shown within this paper and the next steps identified above.