Rotherham Metropolitan Borough Council

Health and Well Being Strategy

Priority 5: Long Term Conditions

Improving outcomes for people with a long term condition by delivering integrated services and promoting self-management

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Contents

1. Introduction

The Rotherham Health and Wellbeing Strategy sets out the key priorities that the local Health and Wellbeing Board will deliver over the next three years to improve the health and wellbeing of Rotherham people.

The Health and Wellbeing Board have agreed six areas of priority;

Priority 1	Prevention and early intervention
Priority 2	Expectations and aspirations
Priority 3	Dependence to independence
Priority 4	Healthy lifestyles
Priority 5	Long-term conditions
Priority 6	Poverty

This document focuses on outcomes achieved under Priority 6. It set out the work currently underway and identifies key actions for the next 2 years. There are clear links between these workstreams, particularly between Priority 3 and 5. A lot of the work within these priority areas is focused on maintaining independence and supporting an ethos of self-management among health and social care providers.

2. Shared goals

The Health and Well Being Strategy has identified the following shared goals for the Long Term Conditions workstream.

- Develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual.
- Ensure all agencies work together to make transitions between services for those with long term conditions seamless and smooth
- Work jointly to review our eligibility criteria thresholds and ensure we are able to escalate and de-escalate people through services as their needs change.

The Urgent Care Management Committee, which oversees Priority 6 of The Heath and Well Being Strategy has developed these shared goals to reflect those in the national Long term Conditions Strategy.

- People will be supported to stay healthy and avoid developing a long term condition
- People will have their conditions diagnosed early and quickly
- Services will be joined up, and based around individuals' health and social care needs
- People with long term conditions will be socially included, and supported in work and education
- People with long term conditions will be as independent as possible and in control of their lives
- People with long term conditions will be supported to manage their own condition effectively

3. Joint Strategic Needs Assessment (JSNA)

The local JSNA estimates that 22.4% of the Rotherham population consider themselves to have a limiting long-term illness compared with 17.9% nationally. Rotherham has a higher prevalence of

long-term conditions than the national average and this seems likely to increase as the population continues to age.

63 % of people in Rotherham with a long term condition report that they have had enough support from local services or organisations. This compares favourably nationally and suggests services are working well together to support people. It is estimated that in 2015 there will be 28,199 people over 65 in Rotherham with a limiting long-term condition. 21% of older people are unable to perform one Assisted Daily Living ADL task without help.

The JSNA highlights Intermediate Care, Rothercare and the Expert Patient Programme as vehicles for promoting self management of long term conditions. It emphasises the importance of establishing clear care pathways with a structure in place for coordinated rehabilitation. The JSNA highlights the need for long-term rehabilitation services for specific care pathways including brain injury, stroke and degenerative neurological condition. It supports the development of a key worker role for people with a long term condition.

4. Long Term Conditions Commissioning Programme

Partner organisations from Rotherham's health and social care community have recently participated in a national programme aimed at improving services for people with long term conditions. The programme included 3 workstreams;

1. Risk profiling
2. Integrated neighbourhood teams managing proactive review of high-risk patients
3. An emphasis upon self care
4. Alternative Levels of Care

In Rotherham the Urgent Care Management Committee (UCMC) is responsible for overseeing implementation of the Long Term Conditions Programme. The UCMC includes 3 GPs, Rotherham FT senior management, the Director of Neighbourhoods and Adult Services from RMBC and a Consultant in Public Health. The Committee actively manages the programme to ensure agreed outcomes are met and that there is appropriate and effective engagement with patients and public.

This report will now consider progress so far on each of the workstreams and set out plans for the next 2 years. Currently no recurrent funding committed to many of the initiatives identified in this report. Rotherham CCG is to review and evaluate schemes in October with a view to future funding arrangements

5. Risk Profiling

5.1 Current Status

Rotherham has recently introduced a risk stratification tool which is able identify those people with a long term condition who are at greatest risk of hospital admission in the following year.

There is evidence that effective risk stratification enables appropriate targeting of resources. Combined with a case management approach and appropriate community support, risk stratification can anticipate or pick up deterioration in a condition quickly. By intervening early health and social

care professionals should be able to prevent deterioration, promote self management and reduce likelihood of high cost interventions.

The main function of a risk stratification tool is to analyse individual clinical events and build a predictive risk score for a patient. The most effective risk stratification tools are based on multiple sources of data including both primary and secondary care information. Rotherham's risk stratification tool uses a range of secondary and primary data to help establish risk levels.

Rotherham's risk stratification tool is an essential vehicle for delivering the GP Case Management Programme, assisting GPs in the effective identification of high-risk patients.

Rotherham's risk stratification tool is easy to use. Access to the tool and its data is quick and compatible with existing primary, community and secondary care data systems. The usability and accuracy of the tool for clinicians has been a primary consideration when choosing the most appropriate model.

The risk stratification tool is a cross-cutting initiative which supports the "Early Intervention" priority, ensuring that we are able to keep people with long term conditions out of hospital.

5.2 Future Development of Risk Stratification Tools

Over the last year commissioners have focussed on procuring and distributing the risk stratification tool. Over the next year we have to establish the current level of use within GP Practices, how this is influencing GP interventions and whether it is having an impact on patients. We will cross check patients who are highlighted as "high risk" against social care systems to see if health and social care teams are working with the same cohort of the population.

6. Integrated Long Term Conditions Teams)

In Rotherham Integrated Neighbourhood Teams incorporate the following key elements

- GP Case Management
- Locality Community Health Teams
- Aligned Social Workers
- Social Prescribing
- Alternative Levels of Care

6.1 GP Case Management Programme

Rotherham CCG has recently commissioned a GP Case Management Programme, which defines the role of GPs within case management and ensures that they have the resources to fulfil this role.

The key principle of this pilot is that the GP acts as the lead professional for the case management of people with long term conditions. Using the risk stratification tool GP Practices are able to identify people who are, or have the potential to be, high intensity users of health and social care resources. This includes people with palliative care needs and those in nursing or residential care. Practices covering over 85% of the the Rotherham population have signed up to this project, and are carrying

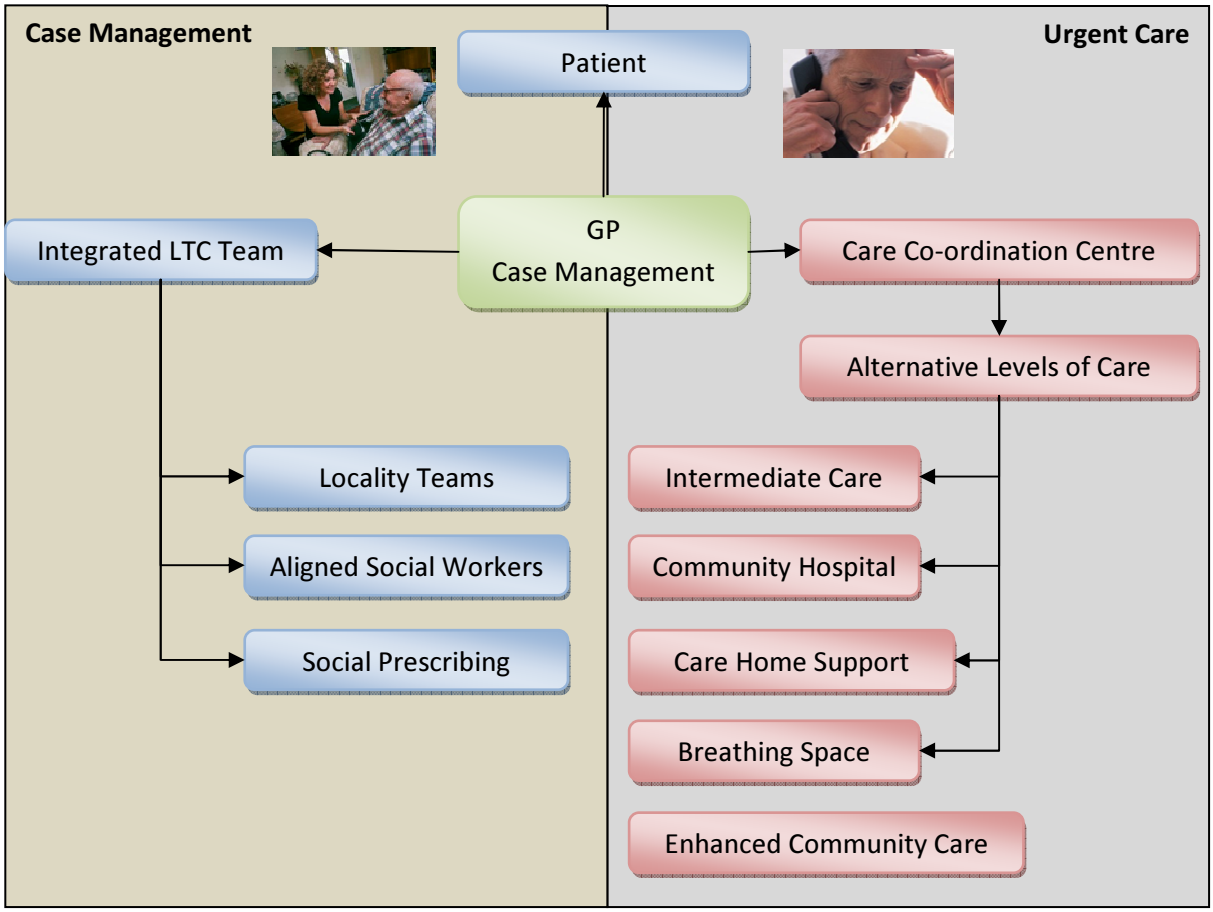
out pro-active patient-centred reviews of patients in the highest 5% of the risk profile. Currently there are 3103 care plans in place for high-risk patients, with an aspiration to achieve 8000.

The GP Case Management Programme is a cross-cutting initiative which supports the "Early Intervention" priority. It is based on the premise that early primary care intervention reduces costs further down the care pathway.

Under the GP Case Management Programme GPs will co-ordinate meeting of the Integrated Long Term Conditions Team. They will identify membership and take responsibility for co-ordinating meetings. The team will ensure that each patient has a clear plan of care which addresses both health and social care needs. They will identify a care co-ordinator for each patient. The GP will act as the interface between the integrated team and the patient.

Figure 1 sets out the service model that has now been build up around the GP case management programme. The integrated team supports GPs on case management. These teams consist of a federation of community health locality teams, social workers aligned to GP Practices and a 3rd sector brokerage service. Urgent care response is provided through the local Care Co-ordination Centre (Sec 8.1)

Figure 1: Service Model for People with Long Term Conditions



6.2 Locality Community Health Teams

Rotherham has reconfigured its community health services so that they deliver a combination of episodic care and case management support. Rotherham now has three integrated locality health teams which work alongside GPs to support people with long term conditions.

The teams provide named key workers for those identified as high risk. They ensure that a comprehensive assessment of health and social care needs is carried out. Alongside GPs they develop and implement personalised care plans for patients.

Locality teams agree self-management plans with patients where appropriate and provide up-to-date information, advice and support on their condition. The teams provide patients with access to assistive technology/equipment to support activities of daily living and more independent lifestyles.

Locality teams provide a comprehensive range of palliative care services, incorporating symptom control, pain-relief, social, psychological and spiritual support in line with the Gold Standard Framework.

6.3 Aligned Social Workers

Rotherham CCG has utilised Reablement Grant monies to ensure that there is social care support within the Integrated Long Term Conditions Teams. Rotherham MBC now employs social workers with specific responsibility for working closely with GPs on the case management programme. Their role is to identify any social care needs, carry out appropriate assessment and co-ordinate any services. Social workers can access domiciliary care provision, day care services, supported housing and respite care where appropriate.

The main benefit to this approach is that the social care package will form part of a holistic package of care and support, promoting self management, increasing independence and preventing the use of more expensive services such as residential care.

6.4 Social Prescribing

Rotherham has developed a Social Prescribing Programme, co-ordinated by Voluntary Action Rotherham and intended to support the work of our Integrated Long Term Conditions Teams.

Social prescribing is an approach that links patients in primary care with non- medical sources of support within the community. It is a mechanism by which GPs as case managers can engage with third sector providers, integrating health and social care support widening the local provider base.

Social prescribing is a cross-cutting initiative which supports the “Health Lifestyles ” priority. It provides support on lifestyle and community integration issues, reducing the need for formal support.

The service can provide the following options to GPs when trying to support patients.

Support with self-management

This can include support with education, managing pain and fatigue, healthy eating, exercise, emotional support, support to self-care and understanding care pathways.

Community Integration

VAR have access to a range of craft groups, interactive music sessions for people with dementia and community gardening projects. They can facilitate access to men's peer support groups, healthy cooking club, walking groups, specialist yoga, chair-based exercise and assistive technology support. GPs will be able to help patients access training opportunities and support with transport.

Emotional and practical support

There are a range of support groups and services located in the community that VAR work closely with. Typical services include peer mentoring, stroke support services, welfare rights advice, befriending, dementia cafes, gym buddies, support with aids and adaptations, handyperson services and language support services.

6.5 Future Development of Integrated Long Term Conditions Teams

Rotherham will continue to transform the way people with long term conditions are supported. We will contain the growth in costs of care by intervening early and reducing the need for high-cost services.

We will continue to support the four key components of Integrated LTC Teams; GP Case Management, Locality Teams, Aligned Social Workers and Social Prescribing. We will incorporate the award-winning Community Buddy and Community Partner Services into locality teams. These services recruit volunteer befrienders to support stroke survivors and falls patients once they have been discharged home.

We will continue to develop specific care pathways doing targeted work on those conditions which generate highest cost to the health and social care economy. We will develop integrated teams around these pathways, specifically targeting;

- Stroke
- Neurological Conditions
- Falls and Bone Health
- COPD

We will explore the use of personal health and social care budgets, empowering people to take greater control and enabling them to tailor resources to their needs. We will provide more targeted support for people in care homes by developing a similar approach to integrated case management.

7. Self Management

7.1 What Constitutes Good Self Management

The purpose of this workstream is to ensure that self-management is embedded in all aspects of health and social care. There are strong links here with the "Dependence to Independence" workstream, which requires a similar approach to care and support.

A good system of self-management will support the development of knowledge, skills and confidence in self care support. Health and social care services should support people with LTCs to actively participate in care planning. Care plans should include actions for the person receiving support aimed at improving or maintaining their condition. High-risk patients with long term

conditions should have a person held record, which includes their care plan. Case managers should ensure planned follow up on goals. Scheduled appointments should be in place to plan care, treatment or support.

7.2 Current Status

Some specialist teams such as the Home Care Enabling Service, Intermediate Care , Falls Service, Breathing Space and the Community Stroke / Neurological Conditions Teams and community matrons are built on an ethos of self management. These services have the clinical systems in place to support self care. However many mainstream health services still focus on direct support rather than support with self management.

Rotherham has a range of self care programmes which are routinely used by clinical teams. The Expert Patient Programme delivers a 6 week programme of support for people with long term conditions. This focuses on self management and motivational techniques. Rotherham also commissions a range of services from the 3rd sector which focus on self management; Crossroads Reablement Services, Stroke Community Integration Service and the Care UK COPD Health Coaching Programme.

There is a need to broaden out self care programmes so that they are delivered effectively across all care pathways. Specifically there is a deficit in linking up psychological support services into condition specific care pathways. This would address the impact of anxiety and depression on the ability to self-manage.

7.3 Future Development of Self Management

Rotherham will evaluate the current patient skills programme and reconfigure. We will bring all self management programmes under a single banner “Rotherham Patient Skills Programme”. We will extend the current patient skills programme so that it supports patients on the GP case Management Programme and people receiving social care packages. We will develop specialised psychological support services for people with long term conditions, so that they are better able to self-manage

Rotherham will set up a local self-management network, responsible for promoting self-management and acting as an interface between the statutory, voluntary and independent sectors. We will develop a multi-agency practitioner development programme, equipping works with the skills to assist in self management.

Finally Rotherham will introduce a person held record for people with a long term condition, enabling them to monitor their condition and track the progress of their care plan.

8. Alternative Levels of Care

The purpose of this workstream is to develop a full range of alternative levels of care for people with long terms conditions who experience an exacerbation. The programme has focussed on the following workstreams.

- Realignment of Intermediate Care services, ensuring that they support a broader range of patients
- Introduction of a Community Unit in Rotherham
- The development of an Enhanced Community Care Service supporting patients in their own home
- Better health care support for people in residential and nursing care
- Utilisation of Breathing Space beds, providing discharge support and step-up provision

For people with long term condition, these services are accessed through Rotherham's Care Co-ordination Centre. The Care Co-ordination Centre acts as a single point of access to health professionals, supporting them to identify the most appropriate service for someone with an urgent health need

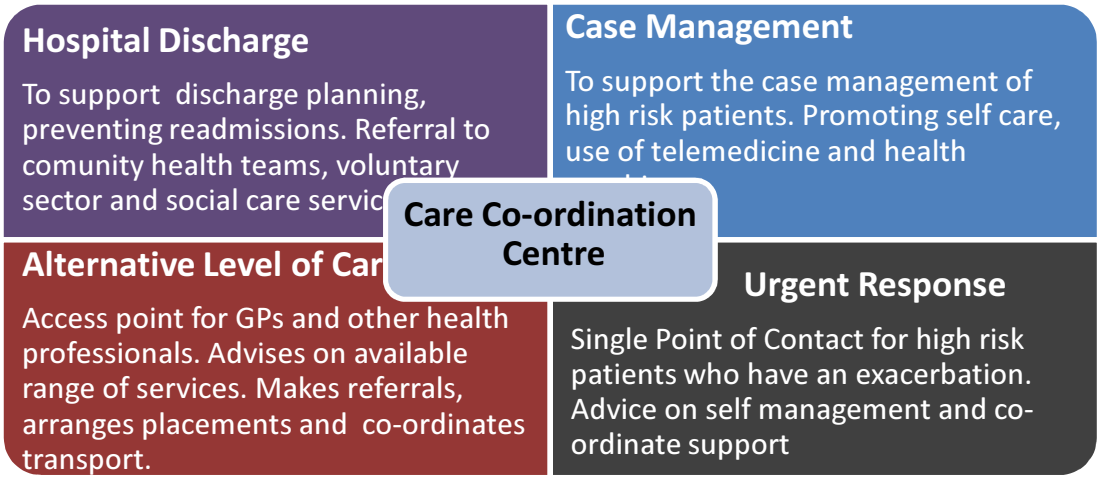
8.1 Care Co-ordination Centre (CCC)

The Rotherham Care Co-ordination Centre has 4 key functions.

1. Support discharge planning, ensuring appropriate and timely community services are in place
2. Single point of contact for GPs and health professionals to support the identification of the appropriate level of care for their patients.
3. Support the case management of patients with long term conditions
4. Single Point of Contact for patients with a long term condition who experience an exacerbation

The first two of these functions are already in operation. Case management support and direct support for patients is to follow next year. Figure 2 provides a diagrammatic representation of the separate functions of the CCC.

Figure 2: Summary of Functions of the Care Enhanced Call Centre



Benefits of Developing a Care Co-ordination Centre

The main benefits of developing a Care Co-ordination Centre are;

- GPs and other clinicians will have a single point of referral for a range of services
- Patients will quickly receive the care they need in the most appropriate setting
- The CCC will provide a single portal into all RFT urgent health care services
- The CCC will ensure that service packages and transfer arrangements are in place
- The CCC will confirm that the agreed care package is in place and provide follow-up information to the GP within 24 hours.

8.2 Realignment of Intermediate Care

The Intermediate Care Residential Service has been reconfigured so that it can accommodate people who require a "step up" facility. People who have a combination of nursing and therapy needs can now be supported within the intermediate care units. This enables intermediate care to support a different cohort of people who would otherwise have been admitted to hospital.

Rotherham CCG has commissioned a new 15 bedded unit at Lord hardy Court which provides a combination of intermediate care and Fast Response beds. The Fast Response beds can provide a place of care for up to 2 weeks while a patient recovers from an exacerbation.

Additional medical cover is now in place for the Intermediate Care Service. The current contract has been enhanced to provide more support to patients with complex care needs. Also, the community physicians are providing direct support to Fast Response patients who tend to be less stable than those being discharged from hospital.

8.3 The Rotherham Community Unit

This facility is used to support patients who need a period of recovery or recuperation that cannot be provided at home or in one of our intermediate care facilities.

Using Interqual, RFT have demonstrated that between 15% and 30% of hospital beds are currently occupied by patients who do not require acute care. At any one time there are over 200 patients occupying an acute hospital bed with a length of stay longer than 10 days. A significant proportion of these are medically stable. They may require observation or rehabilitation but not acute care. Many patients are awaiting recommencement of services or assessment for care packages.

The Community Unit beds will play a pivotal role in facilitating the timely discharge of patients who no longer require acute care in a hospital. They will also be able to support patients who do not require admission to hospital and whose needs can be met in an alternative setting.

8.4 Enhanced Community Care Service (ECC)

Rotherham's Enhanced Community Care Service provides multidisciplinary care co-ordination to high-risk patients who have been identified using the risk stratification tool.

The Enhanced Community Care Service supports GP in the case management of patients who would benefit from risk-reduction interventions. Individual Practices meet with their local ECC co-ordinator to identify patients where there are concerns relating to condition management.

The day-to-day clinical work of the ECC is led by a community matron. The community matron acts as care co-ordinator for all patients on the ECC and is able to pull in support from Locality Community Health Teams. The Locality Teams support the ECC by making available community nurses, allied health professionals and health support workers.

8.5 Care Home Support Service

There are currently around 1,600 older people living in 40 residential and nursing care homes in Rotherham, with the provision of around 2,000 beds. The number of older people is predicted to significantly increase to 1,800 by 2015 and 2,100 by 2020. Around 350 older people are admitted to residential care each year.

The main aims of the Care Home Support Service are to:

- Reduce A&E referrals, ambulance journeys and hospital admissions from care homes
- Meet the mental health needs of residents (in conjunction with RDASH via MH pathways)
- Support the case management of residents at high risk of hospital admission
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Review health care provision within care homes and liaise with RMBC

8.6 Future Development of Alternative Levels of Care

The Rotherham health and social care community will increase the number of GP referrals into the Care Co-ordination Centre and divert more patients to alternative care settings. We will maintain current good performance on bed occupancy and length of stay within the intermediate care service.

The CCC will be extended to support the case management of patients who are at high risk of hospital admission. High risk patients will be identified using Rotherham's GP Case Management Programme. The CCC will be able to carry out the following tasks as part of any care plan.

- Provide an access point for patients who require advice and support on self care
- Monitor conditions remotely using telemedicine and responding to these where appropriate
- Delivery of health coaching, improving outcomes through lifestyle changes

The CCC will provide a reactive service to the same cohort of patients when they have an urgent care need.

We will pilot integrated telehealth/telecare packages for patients who currently receive both health and social care support. We will explore the potential of developing an integrated telecare/telehealth hub, linking up the Care Coordination Centre run by Rotherham FT with the RMBC based Rothercare service.

Finally we will ensure full integration between the CCC and NHS 111. We will put in place pathways to ensure that patients with a long term condition who phone NHS 111 will be routed to the CCC for support and advice.

11 Action Plan for Local Long Term Conditions Programme

Table 1 sets out the key actions an action plan for the Long Term Conditions Programme.

Workstream	Responsible Person	Actions	Date
Risk Stratification			
Establish current level of use within GP Practices	DB	Generate reports from the current risk tool to identify high risk patients. Cross check with case management lists	Jul 13
Measure impact of the risk stratification tool	DB	Evaluation report to the Adults Board	Aug 13
Cross check high-risk patients against social care systems	DB/SM	Assess whether there is those receiving social care services are high risk health patients	Aug 13
Integrated Long Term Conditions Teams			
Extend case management pilot across all GP Practices	DT	Evaluation in October of all specially commissioned health initiatives	Oct 13
Explore use of personal health and social care budgets	SM/DB	Identify patients who score high on risk stratification tool. Target those with social care support for personal budgets. Report to Adults Board with list of patients and strategy	Sep 13

Development of specialist integrated community teams across 4 key pathways in	LW/SM/DB	Develop then implement proposals for further integration of the following care pathways: falls and bone health, COPD, stroke and neurological conditions. Include RMBC and 3rd sector as part of a multi-disciplinary approach	Mar 14
Self Management			
Develop an integrated Patient and Practitioner Skills Programme for health and social care	DB/SM	Agree joint workforce development plan for practitioner skills training. Reconfigure existing patient skills programme, extending it to social care customers. Present plans to Adults Board	Jan 14
Develop specialised psychological support services for people with long term conditions	DB/LW	Develop a protocol for delivering psychological support for people on the case management programme	Sep 13
Develop a local network, incorporating statutory, independent and voluntary sector partners to promote self management	DB/SM	Identify membership, prepare terms of reference and set up meeting schedule	Jun 13
Introduce an integrated person held care plan which incorporates a care plan and self-management plan	DB/SM	Review template for a person held care plan for people on the case management programme. Incorporate a self-management plan and flare up plan. Implement new care plan	Jan 14
Alternative Levels of Care			
Pilot integrated telehealth/telecare packages and explore the potential of developing an integrated telecare/telehealth hub	BC/HR DB/SM	Develop a range of integrated telehealth/telecare packages that can be offered to GPs as part of the GP case management programme	April 14

Introduce a programme of telehealth coaching for people with long term conditions, based at the Care Coordination Centre	DH/DB		Jane14
Full integration between NHS 111 and the Care Co-ordination Centre	DH/DB	Develop a system whereby all NHS 11 calls with a disposition for a community service are routed through the Care Coordination Centre	June 13

Key

DB	Dominic Blaydon	LW	Lorraine Watson
SM	Shona McFarlane	HR	Helen Ramsay
DT	Dave Tooth	BC	Ben Chico