Better Care Fund Underspend Proposals May 2016

1. Looking After Each Other Pilot

Funding is sought to support delivery of the next phase of the joint NCC. CCG and NCVS sponsored LAEO programme, targeted at enabling citizens and communities to do more to look after each other and themselves, and by doing so significantly reduce the cost of, and demand for, health and social care services.

The main focus of LAEO to date has been piloting specific projects aimed at helping to tackle loneliness and reduce the flow of children into care. A number of these, including Befriending, Social Prescribing, Community Navigators and Safe Families for Children are showing very clear signs of having a positive impact and are now being considered for wider roll-out. These have however been largely "bottom-up" approaches. The plan now (as agreed through CEG) is to shift LAEO to focus at a more strategic level, including implementing a city-wide volunteering plan and linked communications strategy. This in turn will support delivery of related city-level priorities, for example, reducing loneliness and isolation (one of the key priorities in the revised HWBB strategy). LAEO activity will align with the objectives of the BCF.

The LAEO will deliver a volunteering strategy and a communications strategy. A draft volunteering strategy has already been approved by Programme Sponsors, including the Lead Executive councillor. This includes targeted activity to: increase levels of informal volunteering; drive behaviour change so people help each other more as the norm; much better align volunteering efforts of businesses around city priorities; break down the barriers which stop people helping others. If successful, this has the potential to significantly reduce the demand for formal health and social care support. Linked to this, and central to success, we are requesting an amount of funding to develop and deliver an overall communications strategy, including targeted social marketing activity, designed specifically to drive a change in behaviour so that people's default behaviour going forward is to look after each other and themselves more, and to access formal health and social care support much less.

Outcomes

- Reduction in demand for health and social care services
- Reduced costs
- Reduction in levels of loneliness and social isolation
- Increase in informal volunteering levels

Costs

Resources to support and drive delivery of agreed Volunteering Strategy over next 12 months	£45k
Resources to fund overall LAEO Communications strategy/social marketing campaign	£50k
Total	£95,000

2. Hospital Discharge Service Proposal – CityCare

1. Background and context

The Hospital Discharge Service (HDS) is a proactive telephone-based follow up service aiming to reduce emergency readmission to hospital within 28 days of discharge. Launched in February 2013 the service was originally a winter pressures initiative funded through Transformation Funding aimed at identifying and supporting frail/ elderly citizens at risk of readmission to following discharge from hospital. This funding has now ended and therefore the service is currently not commissioned and therefore unsustainability within further investment.

In 2015 it was announced that the Hospital Discharge Service had been shortlisted in the 'Care of Older People' category of the 2015 'Patient Safety' awards and the 'HSJ Awards' in recognition of the demonstrable service outcomes.

2. Executive summary

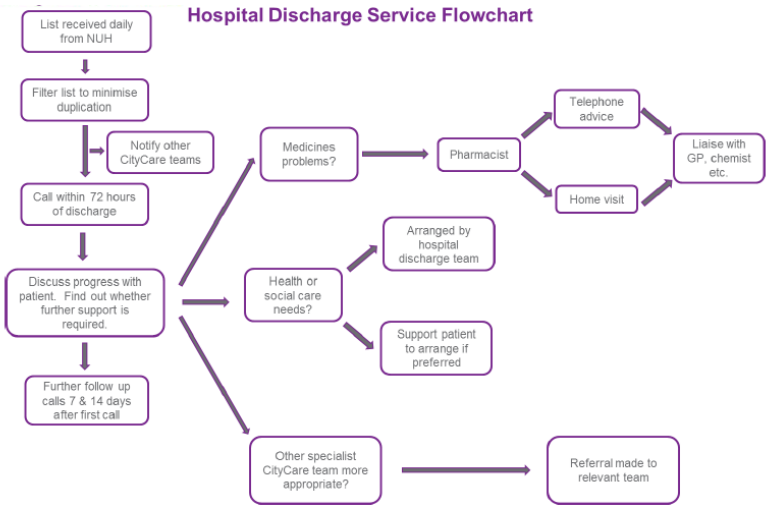
The hospital discharge service continues to support large numbers of patients: proactive post-discharge telephone follow up has helped 292 patients this quarter.

The service also supports a number of other CityCare teams by case finding and discharge notification. An additional 246 patients have been helped indirectly through notification by the hospital discharge service to other CityCare teams. Some details from this quarter:

- 27 new patients referred to the care homes specialist nurses.
- 28 new referrals for falls assessments (falls and bone health or CNRT).
- 23 referrals to the CityCare compliance review service.

Patients, relatives and carers continue to indicate a high level of satisfaction with the service, with 98 % saying they would be likely or extremely likely to recommend it to their friends or family.

3. Service model



Every week day the HDS receives a list detailing patients aged ≥ 60 discharged from NUH. This list is filtered:

- To remove patients outside our area of coverage (those with a non-City GP).
- To enable targeting those at greatest risk of readmission to hospital:
- Emergency admissions
- Admitted to certain wards (assessment wards)
- Discharged from certain specialties

The list is also cross matched with SystmOne to identify citizens known to CityCare teams, to alert the team of the need to contact and potentially review the citizen, supporting the delivery of co-ordinated care as well as minimising duplication. In Q3 15/16 246 patients (41 % of those not suitable for a call) were helped by notifying other teams. Examples include:

Community Matrons
Notifying CityCare community matrons of their patients' discharge from hospital enables the matrons to reinstate their visits to patients promptly. This improves patient care and could reduce the risk of readmission to hospital. There were 197 such notifications made this quarter.

Care Homes Specialist Nurses
CityCare care homes specialist nurses are informed of patients discharged to a care home. This benefits patients by ensuring they have a holistic assessment when they move to a care home. There have been 27 notifications of first time transfers to a care home this quarter. These are patients that the care home specialist nurses would not otherwise have known about.

Primary Care Cardiac Service
This quarter saw the introduction of discharge notifications to the primary care cardiac service. This enables the service to get back in contact with their patients promptly after discharge. An average of 11 notifications are made per month.

If not know to an appropriate community service citizens are identified as eligible for the service then go on to receive up to three telephone follow ups, the first within 72 hours of discharge (an average of 56 % of patients contacted in Q3 received their first call within 24 hours of discharge) at 7 days intervals after the first. During these calls service advisors use an algorithm to identify on going needs with a specific focus on medication compliance. Citizens identified as at risk are then referred for a formal medication review (tel or face to face). All other needs identified are referred/ signposted as appropriate.

During Q3 15/16 telephone follow up was offered to 530 eligible citizens. Over the same period, 292 (55 %) received our full package of 3 follow up calls.

4. Outcomes

Medicines management
- 219 citizens were identified as in need of a medication review in 14/15. Of these:
- 29% (63) resulted in a reduction in medicines-related risk that could have required a hospital admission if allowed to continue.
- 19% (41) resulted in a reduction in medicines-related risk that could have required a GP appointment or home visit if allowed to continue.

The most common cause of medicines-related risk identified by this service appears to be breakdowns in communication (about medicines) between the hospital, GP, community pharmacist and patient. Based on these figures, this service has avoided 63 medicines-related hospital admissions and 41 medicines-related GP consultations. These figures above can be used to attribute a potential cost saving from pharmacist intervention.

Supporting Independence
In addition on average each month 45 patients receive care referrals and 68 patients receive signposting as a result of this service.

5. Cost analysis

Comprehensive analysis of costs saved and revenue generated by the hospital discharge service is challenging. For some areas of activity within the service, it is possible to detail estimated & potential costs saved.

Item	**Number/year**	**Estimated costs saved per year with justification**
Referral and signposting for falls assessment	112	£59360 2 % of people falling each year suffer a hip fracture (data from Marie Ward, CityCare Falls and Bone Health service). We are referring people who were admitted as a direct result of a fall and/or have had more than 1 fall in the last year. Multidisciplinary falls assessment and intervention by the CityCare falls and bone health service reduces falls, fracture rates, ED attendance, hospital admissions and GP appointments. Data from the service show a baseline fracture rate of 0.4 per patient per year [1]. This is reduced to 0 at 6 months after patient discharge from the falls and bone health service. Medical and social care costs around £26,500 in the year following a hip fracture [2]. Assuming referral and signposting these 112 patients for a falls assessment prevents 112 x 2 % = 2.24 hip fractures per year, this is a potential cost of £59360 saved.
Pharmacist referral reduces risk that would otherwise	12	£546 Pharmacist interventions with a

have required allied healthcare professional involvement		consequence score of 2 are deemed to have an average cost of £45.54 based on costs of ambulance, district nurse, pharmacist costs.
Pharmacist referral reduces risk that would otherwise have required GP appointment or home visit.	41	£4,018 Pharmacist interventions with a consequence score of 3 are deemed to cost £98 on average, based on the costs of GP appointments and home visits [3] and assuming ⅓ of consultations would be at the surgery and ⅔ would require a home visit.
Pharmacist referral reduces risk that would otherwise have required hospital admission	63	£92,894 Based on 50 % of these interventions preventing medicines-related hospital admissions, using a cost of £2949 per hospital admission, this being the average cost from 2014 for ambulance treatment plus long stay non-elective admission [3].
Total predicted savings: £156,818		

Please note these figures do not include any estimations of potential health or social care savings attached to signposting/ referrals to any services other than falls and medicines management.

Proposed cost **£152,370**

based on an establishment of:

- 4 WTE x B3 Administrators
- 0.5 WTE x B2 Support Administrator
- 0.5 WTE x Team Manager

2. System Wide Approach Adult Social Care

Aim: Appropriate management of flow in and out of the acute hospital by providing sustainable homecare support services in the community

2a. Embedding "Is one to One Care Right for You"

Within Nottingham City a significant number of citizens receiving homecare support are perceived to require more than a single carer to support them with personal care

and daily tasks of living. National research has indicated that citizens can be enabled to have single handed care in 43%- 52% situations The aim of this approach was not only to reduce ongoing cost but also to improve outcomes for citizens by promoting independency, choice and dignity. The average cost of installing the new specialist equipment was approximately £700 per citizen and cashable savings were accrued six weeks after the reduction of the homecare support.

A pilot run by Nottingham City Council in 2014/2015 supported the above research with the same outcomes achieved. (3 Occupational Therapists within Nottingham City were upskilled to complete this work with 40 citizens).

A key learning factor from the pilot was the earlier the introduction of this approach i.e. when a citizen had only been receiving care from 2 care workers for a short time, the more successful the move was to single handed care. A further small pilot run by Nottingham City in 2016 linked one of NCC Occupational Therapist trained in this approach with a small number of Occupational Therapists within the hospital setting. 8 citizens were involved in the pilot and 2 citizens are now receiving single handed care instead of care from 2 care workers.

Given the current pressures on the homecare market, this approach would create additional capacity for other citizens requiring homecare support.

The aim now is to upskill all Occupational Therapists across the Health and Social Care system to use this approach with a one day training course. Further it is suggested that an agency Occupational Therapist be employed to release capacity within Nottingham City's Occupational Therapists so a colleague can be released to work with the private homecare sector to screen, identify and work with citizens who would benefit from this approach.

<u>Outcomes</u>

- Increased dignity and privacy of care for citizens
- Additional capacity created to meet increasing demand for homecare services in the Community

<u>Costs</u>

- 1 Agency Occupational Therapist
- 1 day training for all Occupational Therapists across the system
- Equipment

<u>Cost:</u>

Total: £50, 838k

2b. Creation of NCC Generic Homecare Team

Within Nottingham City the demand for homecare support continues to grow, not only from demographic pressures but also the recognition that citizens are better cared for within their own homes where ever possible rather than the acute hospital sector. Third sector providers continue to struggle to meet demand and find responding to either requests for urgent homecare support in the community or hospital discharges problematic. Currently in the ReAblement service is responding to these requests but again has insufficient capacity to meet demand. At any one time 45 citizens are inappropriately placed within the system. The market over a 2 year period has been unable to expand to sufficiently to meet this demand. The proposal is to create a NCC generic homecare team to care for 50 citizens at any one time to meet this demand. Recruitment will be at Care Level 1 with existing management structures being used to run the services.

Outcomes:

- Citizens supported within the right place
- Additional capacity created in the community by increased homecare support

Cost:

Total: £303, 000

2c. Integration of the Council's and CityCare's Reablement and Urgent Care Services

Nottingham City Council and CityCare have been asked to integrate their services in order to deliver an enhanced offer for all citizens requiring support at home to maintain their independence both at times of health and social care crisis and also following hospital discharge. There are a number of costs associated with this integration and it has been agreed that all recurrent costs will be met through the delivery of efficiencies in the integrated service following a review and service redesign in 2017/2018, however the costs for 2016/2017 cannot be delivered in this financial year and this proposal recommends funding of these costs for one year.

CityCare's Community Triage Hub will integrate with Nottingham City Council's Care Bureau in order to deliver a responsive triage to all referrers and to co-ordinate all visits completed by care workers. This measure will provide increased capacity for triage, the demand for which has increased significantly due to a number of discharge schemes being delivered in partnership by CityCare, Adult Social Care and NUH. There appears to be a significant delay currently from citizens being identified as needing long term support by CityCare to the point at which their packages are passed to the Care Bureau for processing out to external providers. This integration will prevent this from happening as citizens' packages will be added on a daily basis to the spreadsheet which is submitted to all external providers as soon as a long term need is identified. The is currently no capacity in the care bureau to process these additional packages in a more timely way and, therefore, funding for one additional advisor is proposed for a 12 month period.

Co-ordination of all care worker visits will maximise the number of face to face care hours available to citizens through the use of CM2000 to geographically patch runs thereby reducing travelling time and distance. Currently, CityCare does not use any software to co-ordinate visits and individual colleagues book visits into their diaries which can lead to inefficiencies. CM2000 also enables the service to be responsive to new demand and add additional care calls into existing programmes. There is no capacity within the current funding of the care bureau to take on this additional function for the 80 CityCare staff in the integrated service and funding for additional posts to deliver this is requested for one year. Mobile telephones compatible with CM2000 are required for a number of CityCare colleagues in addition to CM2000 licenses, RFDI tags & 2 days of project support to establish the 80 additional staff on CM2000.

Systm1 will be used as a clinical record for all citizens in the new service with relevant information also copied and saved to Liquid Logic. This will enhance communication between the service and referring clinicians and social care colleagues who will be able to access relevant information without unnecessarily contacting the integrated service. Currently, Nottingham City Council colleagues cannot access Systm1 from their PCs and, therefore, several laptops with this function, licenses and NHIS RA smartcards are required to enable the use of Systm1 as a clinical record.

Currently, CityCare and Nottingham City Council care workers wear different uniforms; a single uniform for all care and clinical staff in the integrated service is recommended in order to avoid any confusion for citizens and carers using the service.

Outcomes

- Maximise the availability of triage function available to the health and social care system
- Maximise the number of face to face care hours available to citizens
- Reduction in travelling time & distance
- Improved responsiveness of service to meet new demand
- Improved offer for all citizens requiring a reablement or urgent care service as all citizens will have access to a clinician should they need this
- Enhanced communication with health and social care partners
- Consistent visible image for integrated service

Costs

Item	Individual cost	Number required	Duration	Cost
Uniforms	£62.51	315	Non-recurrent	£19,691.25
Handsets compatible with CM2000	£102	10	Non-recurrent	£1020

Monthly cost of new handsets (minus existing monthly rental paid by CityCare)	£330	N/A	12 months	£3960
Advisor	£19,742	1	12 months	£19,742
Co-ordinator	£23,109	2	12 months	£46,218
Reconditioned laptops	£253	5	Non-recurrent	£1265
NHIS RA smartcard	£25	22	12 months	£550.01
Systm1 license	£106	22	12 months	£2332
CM2000 project fee	£742	2	Non-recurrent	£1,484
RFDI Tag	£1.03	150	Non-recurrent	£154.50
CM2000 license	£61.80	16	12 months	£11,865.60
Total cost				**£108,282.36**