Scottish Borders

Integrated Care Fund Project Brief

Project Name	Transformational proposal to develop and embed a rehabilitation model for individuals with long term conditions that includes Pulmonary Rehabilitation (PR).		
Project Owner	Alison Wilson, Director of Pharmacy	**Application Main Contact**	Kenny Mitchell, GM, PACs Gareth Clinkscale, GM Unscheduled Care
Main contact email	Alison.Wilson@borders.scot.nhs.uk	**Main Contact Telephone**	01896 825585

Guidance on Project Brief

The purpose of this form is to give a brief outline on the key aspects of the proposal to the Integrated Care Fund.

1 Outline project description

The paper presents the case for investment of £98,734 to develop and embed a robust rehabilitation model for individuals with long term conditions that includes PR as a core element. The model would be delivered across all five localities, in order to improve clinical outcomes, reduce admissions/re-admissions, support early discharge and enhance a self management approach. Current figures state that in 2016, patients coded with a respiratory condition was 10,962, approximately 10% of Borders population; however phase 1 (this funding) will focus on individuals with a diagnosis of a respiratory condition, estimated at 3,000 in Borders. Priority in the first year would be to individuals identified to be most 'at-risk' of admission / re-admission, from GP practice lists.
(see appendix 1 for funding outline)

PR, a well proven cost effective intervention, that can be offered to individuals with other long term conditions, has been proven to have a significant impact on quality of life, and the avoidance of unnecessary hospital admissions.
The PR programme is made up of two, 2 hour sessions per week for a period of 7 weeks. Offering a 42 week service, it would run 6 times per year and run 4 programmes concurrently. Twenty-four programmes a year would be run in the first 2 years, reaching approximately 1,000 patients. This is based on a class of 15 'attend-in-person' participants and up to 5 additional participants attending via video link-up remotely.
To reduce clinician travel time, sessions would run concurrently - morning and afternoon in the same venue. One full-time respiratory physiotherapist would lead on the delivery of the PR programme and additional support will be provided by a respiratory specialist nurse, a clinical support worker or a physiotherapy assistant. Support from other agencies/specialists would be co-opted when appropriate for example – Pharmacist, LASS adviser, Community Capacity facilitator, GP, Occupational Therapist or Psychologist.

By 2019/20 it is envisaged that PR will be offered as part of rehabilitation model for suitable individuals with multiple long term conditions for example – Heart Failure, Stroke, at risk of falling, and/or who may be frail. The Scottish Health Survey 2016 reported that 31% of people, in Borders, over 16 years, had a limiting long term condition.(see appendix 2)
Currently we know that 60% of all deaths are attributable to long term conditions and they account for 80% of all GP consultations in Scotland. Furthermore people with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionally longer and account for over 60% of hospital bed days used. While within the social care sector most peoples who need long term residential care have complex needs usually arising from their multiple long term conditions.

It is important to note that Scottish Borders is the only region in Scotland **not providing** Pulmonary Rehabilitation for its citizens'.

2	Project's alignment to H&SC Strategic Plan Objectivs

Improve the health of the population and reduce the number of hospital admission
The redesigned respiratory care pathway (then other LTC) will ensure that services are integrated to support individuals with complex needs, to enable them to manage their condition to live healthy, active and independent lives as long as possible. The number of people living with a respiratory condition in Borders is 3,000 presenting a significant and currently unmanageable challenge to improve the quality of life for those individuals.

Improve the flow of patients into, through and out of hospital
We expect fewer patients to be admitted to the acute hospital, thus reducing pressure and increasing its capacity. Through a better ability to manage their conditions we also expect the length of stay of patients with copd to be shortened.

Improve the capacity for people to better manage their own conditions and support those who care for them
This programme directly relates to enabling patients to manage their condition. The programme has already been tested with very good results, there is a high degree of confidence that this work will reduce admissions and re-admissions of patients.

Set out below are the 5 key commitments of this project:

1. Prevents admission to hospital
2. Supports early discharge
3. Deliver a sustainable rehabilitation model for long term conditions, using technology as a key component
4. Robust engagement and support plan for Carers
5. An exit strategy to transfer to BAU will be included within the implementation plan

Admission Avoidance (COPD)	Outcomes within the 12 month timeframe of the project: 10% Reduction in rates of admission for patients who have a main diagnosis of COPD (342 / 34) Reduction in the instances of patients being readmitted to hospital with 28 days of discharge by 10% (83 / 8) Reduce unscheduled bed-days in hospital by 10% (OBD 2,306 / 230) Reduce Length of stay by 2 days (6.6 / 4) (Data source ISD April 2017 – March 18)
Supporting early discharge	Delivering PR as part of an integrated care pathway for individuals diagnosed with a respiratory condition, in combination with new and existing initiatives for example: • Technology: has the potential to speed up the discharge process by providing key information across the whole system; we will explore Attend Anywhere to link GPs, Health & Social care staff, Patients & Carers to have informed discussions / virtual clinics. Test the use of mobile apps for example, 'Florence' to increase support in the community • Hospital 2 Home: provides an avenue for early discharge and working with HCSW to support and motivate respiratory patients discharged from hospital to comply with their self-management plan • ACP: Part of a PR programme, and supported by - SAS paramedics undertaking home visits / clinics in practices, and practice nurses completing a respiratory patients 'MOT' has the potential to review or initiate conversations regarding an ACP By combining these and other work-streams provides assurance to Patients, Families, and Professionals to support early discharge and reduce length of stay.
Sustainability	The PR programme will become embedded within a long term conditions pathway, as business as usual, delivered in any locality by a range of individuals. A PR training pack will be developed to ensure that the quality, safety and reliability of the programme are sustained. The pack will create the ability to deliver PR as a hub-spoke programme:

	• Utilising capacity within the H2H project • Utilising technology, for example Attend Anywhere and Phone Apps ('Florence') - for individuals who are harder to reach • Develop capacity from within the PR groups to lead and support continuation of the group • Locality facilitator(s) as part of the Community Capacity building programme, personnel from CHSS and Red Cross will work with the PR groups (post-programme completion) in order to sustain and enhance skills to prevent admission to hospital. Overall by introducing this model it will build both capacity and capability of key individuals in the community.
Engagement & support plan for Carers	The Carers (Scotland) Act 2016 states, 1 in 6 adults have caring responsibilities for someone with a longstanding illness or disability and within Borders unpaid carers 9-9.5% in 2011 census. It is also well recognised that nearly half of carers have long-term conditions themselves and many carers are aging. It is within this context that this project will undertake to deliver 4 support 'clinics' for individuals who care for an individual with a long term condition.
Exit Strategy	By transforming the pathway for managing patients with a respiratory condition it is envisaged that: • A robust and efficient rehabilitation model will be produced and embedded as business as usual • 'Savings' from the project will be re-invested to enhance capability from within the community, to spread the model to other long term conditions, for example Stroke and Heart Failure patients. • By linking with Community Capacity Programme Facilitators, Carers Centre, H2H and Red Cross assurance, has been given that ongoing support post-programme, will be provided.

3 Project Aims

The investment will enable Scottish Borders:

1. To deliver a Borders-wide rehabilitation model that can be replicated for many long term conditions.
2. To empower individuals to be in control of their health condition by providing the necessary skills to maintain independence.
3. To introduce a whole system pathway model of care, including PR that aims to move away from a largely reactive episodic hospital model to a pro-active community based and patient – centred pathway of care.
4. To provide evidenced based interventions at key touch points for individuals as they experience the various stages of their long term condition.
5. Improve patient flow into and out of hospital, by having robust community support in place, self-management plans offering alternatives to hospital admission.
6. The House of Care model will be used as a framework to enhance the quality of life for people with Long Term Conditions, no matter what their condition (see appendix 3)

4 Project outcomes and benefits

The benefits of this rehabilitation model include:

- Personalised exercise regime - re-ablement approach with the aim to maximise the early rehabilitation potential of the person during the early weeks of care
- Educational component supporting self-management by assisting lifestyle and behaviour change
- Increased number of individuals with an active Anticipatory Care Plan
- Increased engagement with community based activities in each locality
- Delivered in a community setting – schools, care centres and day hospitals
- Supports delivery of other key local initiatives such as Hospital to Home, Supported Early Discharge

and reduce avoidable admissions by providing support in the community (current evidence demonstrates that participants within a PR programme evolves into a self-support group, after the programme ends)

- It supports individuals to develop their confidence and skills so that they can carry out activities themselves to enable them to continue to live at home.
- It is envisaged that through Attend Anywhere technology support will be available to a group or individual
- There will be a reduction in attendances / admissions to hospital
- Support early discharge from hospital
- Strengthening links with Red Cross, Community Capacity Builders, Carers Centre and H&S Care partnership initiatives.
- Reduction in the number of SAS conveyances to hospital with patients experiencing exacerbation of their condition
- Enable discussions and possible pilot to develop Community Rehabilitation Team as single point of contact

Patient opinion from individuals with COPD who have attended a PR programme:
"Really feel the rehab class has benefitted my health mentally & physically"
"My OT found out about the rehab group and the water-based exercises, to be honest it has been a lifeline as it has helped to stop isolation & helps your depression"
" I think the exercises & losing weight has done the power of good and kept me out of hospital"
"Before I would have said I was dying from COPD. Now I feel like I'm living with it."

5 What areas of the Borders will the project cover

Pulmonary Rehabilitation programme when resourced will be delivered across all five Borders localities.

6 Which care groups will the project affect?

In the first 12 months PR will focus on those individuals diagnosed with a respiratory condition, those that are in the top 5% of most 'at-risk' of a hospital admission, and meet the eligibility criteria for PR. Thereafter when the model is established it will be spread to include individuals who have had a stroke, diagnosed with diabetes or have a heart condition.
In Scottish Borders approx 3,000 individuals have a confirmed primary diagnosis of COPD with a further 30% having an additional chronic health condition with a secondary diagnosis of COPD or Asthma. Metrics from the Public Health service predicts that a further 25% are currently living with a respiratory condition, which as yet, has not been formally diagnosed.

7 Estimated duration of project

When funding is secured for PR, the project will be delivered over a 12 month period to develop and embed a robust Border wide PR programme.

8 How much funding would the project need and how would it be spent?

In order to develop and embed a robust rehabilitation model funding of £98,734 (see appendix 1)
Over this period the project board will collate and review the necessary data to develop a self-reliant funding model that can be delivered within existing services.

9 What would happen if ICF didn't invest in the project?

- Inequity of care for individuals with long term conditions
- Fragmented, complex systems of care would remain
- Financial and workforce pressures would remain
- The level of admissions & re-admissions would increase
- The cost to health care and pressure on community services would increase as the number of individuals with LTC's is diagnosed.
- This project assists in the delivery of recommendations from CHSS, Dr A Murray's report and the Carers Act,

Integrated Care Fund Project Brief

10	**How would the project release resources in order to sustain the project?** *What services would no longer be provided or would be provided in different ways*

Predicted saving based on:	
Length of stay Reduction 2 Days (30%)	106,000
Admission rates reduced by 30%	137,000
Sub-total saving	243,000
Less cost of new PR service	(77,000)
Predicted annual saving overall	166,000

11	**How would you identify/recruit staff to support the project?**

Local / external advertisement and a discussion with General Managers for Primary & Community Services, Unscheduled Care and Clinical Directors to explore re-organising capacity from within acute care.

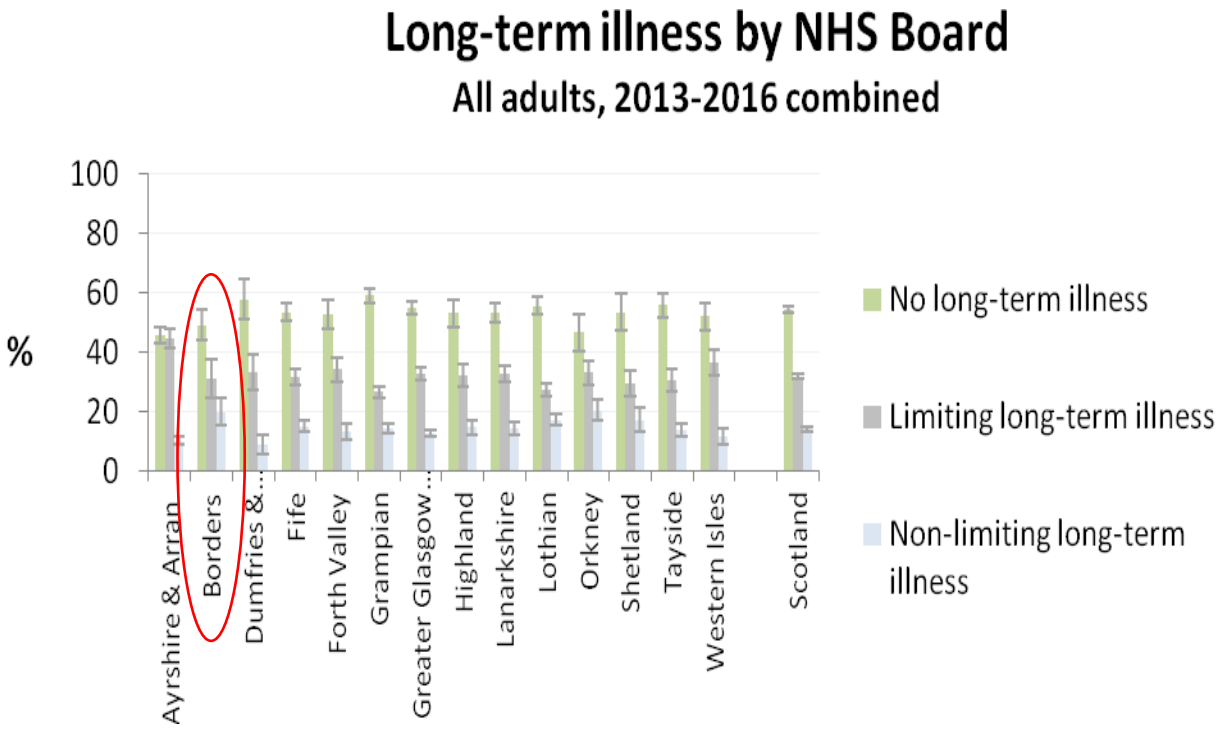
12	**Would the project require dedicated project support from the programme team**

Project support would be provided by the BB transformational change team.

Appendix 1

Staffing costs						
Team member	Grade	Number of sessions per PR programme	Cost per hour	Cost per session (session = 3.75 hours)	Cost per 7 week block (4 programmes running concurrently)	Cost per year (cost per 7 week block x 6)
Respiratory Physiotherapists x2	7	Full-time	£28.41 (£56.82)	£106.54 (£113.64)	100 sessions	£44,746.8 (£68,184)
Support Worker	3	10	£14.80	£55.50	70 sessions	£23,310
Respiratory Specialist Nurse	6	4	£15.68	£58.80	40 sessions	£2,352
Practice Nurse		1 half-day /month				£1,000
Administrator	3	4	£14.80	£55.50	16 sessions	£888
Red Cross support						£2,000
Equipment & Sundries						£1,000
	Total					£98,734

Appendix 2



Appendix 3

The House of Care model (HoC), shown below will be used as a framework to enhance the quality of life for people with Long Term Conditions, no matter what their condition. At its core is listening to experiences and feedback from people coping with Long Term Conditions, to inform how care should be designed and implemented.

The framework describes the building blocks that need to be in place to enable effective care delivery for individuals with one or more Long Term Condition.

The future model will demonstrate that we have listened to patients who universally say that they wish to be treated as a whole person and for the NHS and social care to act as one team.

As we move to implement change we will modernise our workforce to develop the skills required to meet future requirements.

Integrated Care Fund Project Brief