ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
UP4
Scheme name
Integrated Care Model
What is the strategic objective of this scheme?
The model aims to deliver proactive community based support, including referral to health and social care services where appropriate, in order to: • Help people understand their conditions • Help people live healthier lives • Help people stay well for longer • Improve patient experience • Avoid hospital and care home admissions • Improve integration of health and social care
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The integrated care model is proactive approach to target services and interventions for people with long term conditions and frailty. The aim of the model is to implement a new way of working between health and social care to deliver more targeted and effective services and interventions to people with long term conditions. The risk stratification tool attributes a risk score to individual patients, which is derived from a computer generated analysis of the interaction of different health conditions. The score is based not on the past experiences of the patient, but on their future likely use of NHS services. Three initial criteria were used in the pilot to generate lists of patients from the risk stratification tool, as follows: • three or more long term conditions • five or more prescribed medicines on repeat prescription • over 60 years of age
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Integrated Care Pathway model begins with a process called risk stratification. This computer tool enables a GP practice to interrogate patient population data to make informed decisions about which patients to invite into the service. The intention of the pilot was to target patients that were 'living well with long term

conditions'.

The Care Co-ordinator, having produced the prospective participant list, meets with the lead GP in the practice to consider the patients on the list, as they are likely to be known to practice staff, and this enables a 'sense check' to take place before inviting patients to take part in the service. An assessment of the patients' needs and outcomes are agreed using the Outcomes Star. The Outcomes Star is based on well recognised method of collating and providing comparison data of the patient's view as to how the patient's view to how they think they are managing their condition. A care plan is then agreed with the patient.

A Multidisciplinary team meeting is convened, including the lead GP, representative from the district nursing team, pharmacist (as required) and the care co-ordinator. The care-coordinator presents their findings from the assessment and the care plan in order to agree MDT actions and then develop the MDT action plan. The MDTs take place monthly where the patient's MDT action plans are reviewed and the new cases are discussed. Formal reviews take place at 3 months and 6 months to review care plan and review outcomes and then patients are discharged from the programme at 12 months with the care plan reviewed through primary care.

The primary care element of risk stratification and MDT implementation is commissioned by ELR CCG provided through primary care.

The Health and Social Care Co-ordinator is commissioned by Rutland LA and provided by the local authority – clinical line management is provided to the co-ordinator from Leicestershire County Council.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The following evidence used to develop the model:

- Cochrane review – use of risk stratification tools in effective care and case management of 'high-risk' patients with long term conditions
- Nuffield Trust Predictive Modelling for social care
- John Hopkins University – predictive risk modelling system
- King's Fund – Integrated health & Social Care

Investment requirements

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

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

KEY PERFORMANCE INDICATORS

1. Everyone with long term care needs that require a health or social care response will be guaranteed a written care plan encompassing health, social and preventative care and the right to access a named coordinator.

2. There will be evidence that patients have been involved in developing the care plan, understand it, and have confidence about who to approach when they need support.

3. Supported self management – people with long term conditions can manage their condition appropriately because they have the right opportunities, resources and support.

4. Commissioners and providers will work together to use a risk model/register to pro-actively find people at high risk of developing chronic and life threatening conditions and offer them targeted screening and other interventions to encourage behaviour change.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key deliverables are:
Quality

- Better patient and carer experience
- Better patient safety
- better integrated health and social care approach
- better developed and trained workforce
- improved access and response rates.

Innovation

- creates integrated services
- creates services sitting between primary and secondary care, health and social care and physical and mental health care
- services operating without unnecessary referral and administration
- incorporates best evidence form controlled trials and good practice sites into a whole-system change and puts patients and carers before administration.

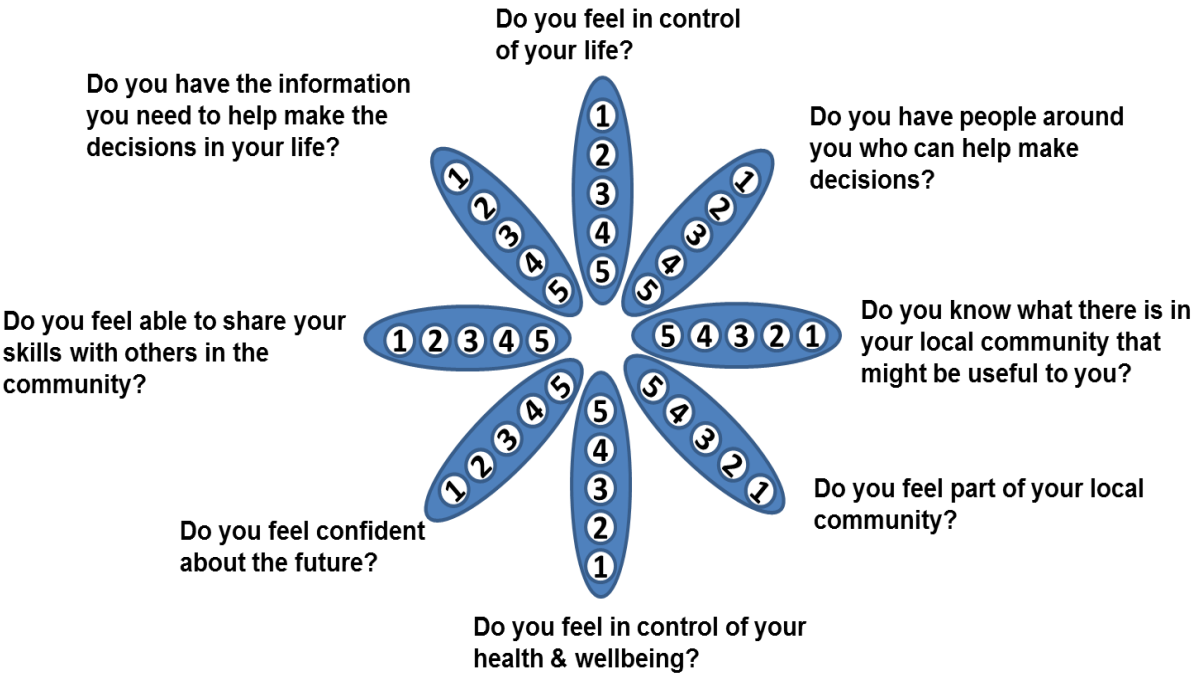
Productivity

- reduced demand for acute inpatient provision
- reduced demand for specialist mental health inpatient provision
- increased discharge rates from acute and specialist mental healthcare to primary care and home support
- bed reduction
- increased response times
- increased diagnosis rates
- increased numbers of people receiving specialist assessment
- more people being seen
- release of resources so that more treatment can be provided in the community and home settings.

Prevention of

- inappropriate hospital admissions
- people having to lose their independence
- admissions to care homes
- inappropriate drug prescribing
- crises
- unnecessary delayed discharges
- complaints/incidents.

Improved outcomes for service users using the outcomes star:



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

The following processes have already been put into place to deliver the model across Rutland:

- Health and social care co-ordinator recruited in 2013 and in place aligned to the practices in Rutland
- Caseload for co-ordinators agreed between Health and social care co-ordinator and the practice – indicative caseload agreed of 20 new patients per month
- All 4 GP Practices in Rutland have signed up to the GP framework as set up by ELRCCG
- Monthly MDT implemented
- Specific integrated care templates and read codes set-up for each clinical system

Factor	Explanation
Partner engagement	The success of the scheme is not just dependent on appropriately communicating with partners, instead the

Assessment criteria and tools	The success of the project depends upon the ability to identify and support the vulnerable individuals in the community (i.e. those who are likely to enter the care system over the next 3- 5+ years). The return on the investment will be helping individuals *who would otherwise have needed acute and secondary care.* Therefore it depends upon successfully identifying these through suitable assessment criteria.
Monitoring & KPI tools	In order to evaluate the progress of the individual and the success of the project, there must be realistic, measureable and agreed KPIs. These should be reported at regular stages to give the project board an understanding of the progress and risks of the project as it develops.
Governance & escalation	Governance is a challenge in any partnership programme. The governance of this programme should enable clear and transparent assessment and escalation of risks. This can be achieved through: Agreement on the KPIs of the programme; Clear routes for issues escalation and resolution; Clear and transparent progress reports; Senior sponsorship from relevant partners; Consistent governance across districts/ areas
Support System & tools	In order for the scheme to be as successful as possible, there must be appropriate supporting systems and processes in place. Part of the role entails advice and signposting of available community assets. The available tools to access these services will be a key enabler to this aspect of the role. Similarly, the availability of user data to establish who the at-risk individuals are, and efficient risk stratification tools.