Rutland County Council

Project Business Case

Community Agent Scheme

Version 0.2 November 2014

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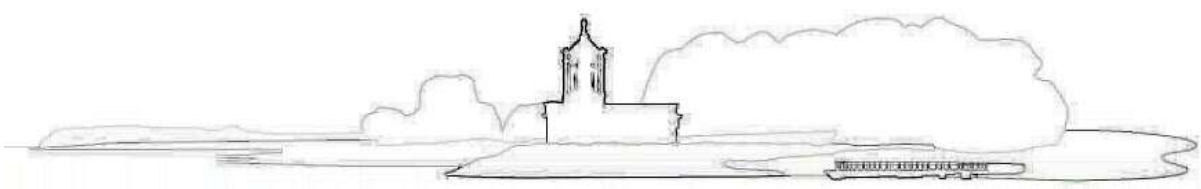


DOCUMENT CONTROL

Change Control History

Version	Change Summary	Change author	Date
0.1	Initial document production	Karen Kibblewhite	29/10/14
0.2	Amended documentation following Integration Exec, meeting with CCGs and outcome of cabinet	Katy Lynch	20/11/14

How would this scheme be described to the service user?

The Community Agent service will provide local coordination and a single point of contact for providing information and signposting to other types of local support including services, peer support and community resources.

A network of community agents will be working flexibly and providing consistent county wide cover so that they are accessible to those in need.

The service will aim to reduce social isolation and increase social contact for all age groups but particularly for older people.

1 Description of Project

Indicate business need including strategic/national local contexts and current organisational approach

1.1 Project Objectives

To create a universal information and advice service for all age groups developed with the council and community, voluntary and faith sectors to build community capacity.

The 7 day information and advice service will improve health outcomes, provide support to carers, and create networks, including peer networks, to promote social interaction and increase wellbeing. Timely and locally provided information will ensure: earlier identification and prevention of escalation of need; greater use of community services and low level service provision; and provision of advice and information for people on keeping safe and well, managing their long-term health conditions, including avoiding falls.

1.2 Key Deliverables

Include key deliverables for the Project lifecycle

Project Deliverable	**Delivery targets**
Compliance with Care Act to deliver information and advice	April 2015
Community Agents in place and engaging with local communities	April 2015
Signposting into targeted and specialist services made in line with pathways and models of care	May 2015
Systems in place to ensure confidentiality and data protection compliance as appropriate	April 2015
Local intelligence regarding services available in the community improved and coordinated	Ongoing

1.3 Project Milestones

Identify the significant milestones (phases, stages, Attach the work stream Plan. This should outline the main stages of the work stream, milestones and any interdependencies

Activity	**Milestone**	**Dependency**	**Responsible**	**Start Date**	**End Date**
Recruit Coordinator and Community Agents	Staff in post by 1st April 2015	Job evaluation process. Outcome of lottery bid	Karen Kibblewhite	Dec 2014	Mar 2015
Mapping of resources and services	Comprehensive list available of where to refer to and how to refer	Mapping to be undertaken as part of the Care Act information and	Information Development Officer Becky Hoyles	Oct 2014	Mar 2015

Activity	Milestone	Dependency	Responsible	Start Date	End Date
		Advice work stream			
Develop policies and procedures for scheme operation	Policies and procedures agreed and signed off	-	Karen Kibblewhite	Jan 2015	Mar 2015
Update Cabinet on the outcome of the Rural Community Council Bid to the Lottery Fund	-	-	Helen Briggs	Jan 2015	Jan 2015
Community Agents start engaging with local communities	Signposting made to a range of support services; social groups set-up and/or linked with.	Community Agents in post Training completed Resource mapping completed	Community Agent Coordinator	April 2015	Mar 2016
Evaluation	Quarterly performance reports collected and analysed	Performance measures for monitoring service agreed	Karen Kibblewhite	April 2015	Mar 2016
Develop specification and tender exercise	Provider for the Community Agents Scheme procured	In-house interim service up and running	Karen Kibblewhite	April 2015	Mar 2016

The development of the scheme is dependent on the outcome of the Rutland Community Council Lottery bid for a similar scheme. Should the Lottery bid be successful then the scheme will be developed in partnership, which may impact on the elements of work delivered by directly by RCC.

Links to other Better Care Fund schemes:

The scheme will rely on a directory of services providing good quality up to date information.

The scheme will form part of the integrated dementia pathway by providing a link into dementia services available through health, social care and the voluntary and community sector.

Community Agents will link to the integrated care coordinator based in GP surgeries, providing two-way communication to support individuals in accessing services which will enable individuals to manage their conditions and prevent escalation.

1.4 Exclusions

The service will cover the whole geographic area of Rutland, but will be targeted initially at areas of greatest need.

It will not include:

- Regular transportation of service users as this will have an impact on the limited hours available to deliver advice and information;

- Advocacy. The Community Agents will not be trained advocates. Advocacy is currently provided through several schemes according to service users' needs and will be extended under the Care Act provision separately.

- Individuals requiring a greater level of ongoing support and/or care will be referred accordingly by the Community Agents.

2 Approach

Indicate what impact the proposed work will have on business as usual. E.g. will it fit naturally with an existing service? Will an existing service need to change in order to accommodate the maintenance or on-going delivery of the products or services? Does this work stream fall within the Better Care Together work stream?

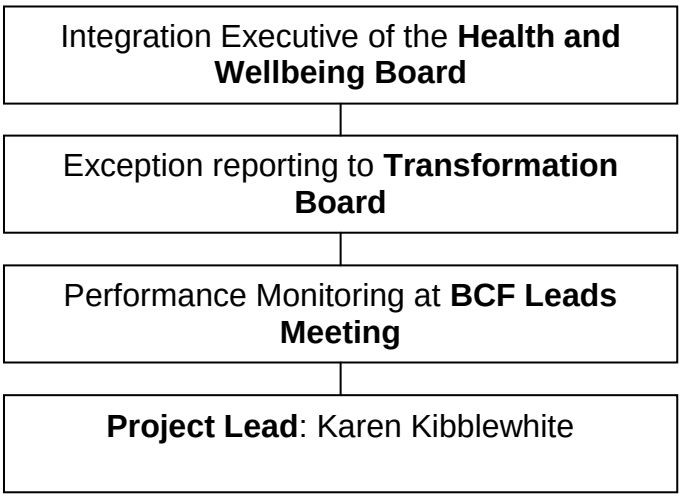
2.1 Operational Readiness

The draft model and staffing structure have been developed by Lynda Bowen (previous lead), along with some draft job descriptions.

2.2 Work stream structure

Consider key Business areas such as procurement, IT, workforce and delivery into Service.

Provide a diagram of the proposed Project structure and brief details of the governance approach



2.3 Work stream metrics

BCF Metric	Description of Impact as set out in BCF Significant/moderate/other
Residential admissions This scheme will contribute to the following change in activity: FY 14/15 – 0.5 FY 15/16 – 1.0	Moderate
Delayed transfers of Care This scheme will contribute to the following change in activity: FY 14/15 – 11.4 FY 15/16 – 34.7	Moderate
Patient experience - do care services/support improve quality of life?	Moderate
Admissions due to falls This scheme will contribute to the following change in activity: FY 14/15 – 1.6 FY 15/16 – 2.1	High

2.4 Work stream metrics recording

Information being collected	By whom	At what stage in the patient pathway is the information being collected?	Database on which information is collected / captured/ stored
Number of individuals engaged with a Community Agent	Community Agent Coordinator		tbc
Number of individuals referred to support services who then present at those support services	Community Agent Coordinator		tbc
Number of individuals who engage in social activity or attend community groups as	Community Agent Coordinator		tbc

a result of Community Agent intervention			
Increase in self-evaluated quality of life criteria	Community Agent Coordinator		tbc
Number of individuals supported by Community Agents to leave hospital	Community Agent Coordinator		tbc
Number of individuals supported by Community Agents to leave residential care	Community Agent Coordinator		tbc
The number of new community groups linked in to the integrated information service	Community Agent Coordinator		tbc

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting dates**	**Reporting timeframes**

3 Communication and Engagement

3.1 Stakeholder Analysis

Stakeholder Name	**How they will impact on the project**	**How they will be impacted by the project**	**Communication requirements/methods**
Internal staff	Understanding the scheme, referring people to it.	Accepting referrals from. Making use of the Community Agents to provide low level support that would otherwise come	Briefings

		to their teams.	
External providers: *Voluntary and Community Sector* *GPs* *Leicestershire Partnership Trust*	Understanding the scheme, referring people to it.	Accepting referrals from. Making use of the Community Agents to provide low level support that would otherwise come to their teams	Briefings. Written communication. Website
Community groups and local informal networks such as service user groups, faith groups, etc	Understanding the scheme, referring people to it and enabling signposting from	Supporting a wider range of members of their communities, receiving support themselves from the Community Agents	Marketing of the scheme
Individuals within the community	Understanding and making use of the scheme	Receiving support and information that enables them to make informed decisions about their own health and wellbeing	Marketing of the scheme

3.2 Project Reporting and Communication

Type of communication	**Communication Schedule**	**Communication Mechanism**	**Initiator**	**Recipient**
e.g. Status report	*Every other Tuesday*	*Transformation Board meeting*	*Work stream Lead*	*Transformation Team*
Status report	Every other Tuesday	BCF leads meeting	Karen Kibblewhite	BCF leads meeting
Written and Face to Face - Communicate with voluntary sector providers	Letter to those who responded to the consultation on the community agents scheme outlining the position and next steps (November 2014)	Letter	Helen Briggs	Voluntary sector organisations
	VCS event 17th December	Discussion at VCS event regarding Community Agents	Helen Briggs	
Update to Members	Cabinet in January 2015	Cabinet Report	Helen Briggs	Cabinet
Scheme launch	Early April 2015	Launch meeting or written launch release	Community Agent Coordinator	Internal and external stakeholders
Face to Face - Workshops	Held during 2015 to assist and support	Workshops	Helen Briggs	Voluntary sector

	voluntary sector agents to prepare for the shift in moving to outcome focussed services			organisations
Written - Bulletins	Bi-monthly during 2015/16	Bulletins to stakeholders updating them on the emerging specification and how the scheme is developing	Karen Kibblewhite	Cabinet Integration Exec Health and Wellbeing Board Voluntary Sector

4 Risks

3.1 Key Risks

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	29/10	KK	Unable to recruit to staff	Med	High
2	29/10	KK	Resource and support mapping incomplete	Low	Med
3	29/10	KK	Communities do not engage with Community Agents	Low	High
4	29/10	KK	Exit strategy fails due to costs of TUPEing the Coordinator role in March 2016	Med	Med

5 Costs

5.1 Project Costs

Include all direct and indirect costs

Description	2014/5(£)	2015/6(£)	Total (£)
Staffing: 1 fte coordinator 4 fte community agents 0.7 fte Support Officer	-	139,795.80	139,795.80

community agents travel	-	8,000	8,000
meeting/venue hire	-	7,000	7,000
ICT licences and hardware	-	15,000	15,000
stationery, phone and office costs	-	15,000	15,000
Database	-	15,000	15,000
Total		**199,795.80**	**199,795.80**

5.2 Funding

Include detail of any potential, or definite, sources of funding. Indicate whether this is likely to come from inside or outside of the BCF approved allocation for this work stream. If external, identify the proposed source.

Funding Source (External - name/Internal)	**Confidence rating of funding being provided (H/M/L)**	**2014/15 (£)**	**2015/16 (£)**	**2016/17+ (£)**	**Totals (£)**
BCF	High	-	200,000	-	200,000
RCC*	Medium	-	-	200, 000	200, 000
Total Funding		**-**	**200,000**	**-**	**400,000**

6 Exit Strategy

Describe how this work stream will be sustained e.g. post 3st 1 March 2016[1]

Things to consider:

Will this work stream be transferred to business as usual activity? If so, how? Who will be responsible for this area of work in the long term?

Will some existing services be replaced by the introduction of this service?

What will be the impact (both to the council, health service and to residents) if this service was to cease?

The scheme is being designed to set-up and embed a network of community based support structures that will then continue to run themselves and develop with input from local individuals and community organisations.

[1] As at September 2014 the government has only indicated funding for 2014/15 and 2015/16

The initial work of the Community Agents with individuals will run alongside the development of a volunteer network that will also work with individuals and catalyst work to develop micro-enterprises that continue to support vulnerable people within specific geographic or community areas.

The Co-ordinator role will need to continue either in-house or with a local third sector provider beyond March 2016, however it is intended that the rest of the scheme will be self-funding (at least to a degree) via social enterprises.

*RCC Informal Cabinet recognised the importance of this scheme at its meeting on 28th October 2014; it was indicated that if BCF funding was to cease from 2016/17 RCC would commit to funding the service for 2016/17 and 2017/18. This was approved at Cabinet on 18th November 2014. This will be built into the People Directorate MTFP for these 2 years regardless of how the project will be funded.

Employment of the coordinator and community agents will be on a fixed term basis with the potential for extension.

Appendix 1 – Original Scheme Annexe submitted to NHS England in September 2014

Scheme ref no.
UP1
Scheme name
Community Agents
What is the strategic objective of this scheme?
To create a universal information and advice service for all age groups developed with the council and community, voluntary and faith sectors to build community capacity. The 7 day information and advice service will improve health outcomes, provide support to carers, and create networks including peer networks, to promote social interaction and increase wellbeing. Timely and locally provided information will ensure earlier identification of need, greater use of community services and low level service provision, including advice and information for people on keeping safe and well, managing their long term health conditions, and avoiding falls.
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 scheme will establish a new network of community agents, who will be local contacts across the whole of Rutland, for people requiring health and social care advice and information. Community agents will be points of contact for their local population, and experts at networking to ensure timely and connected information can be available, and used to support people needing services as well as creating community capacity. Through community agents, the population of Rutland (both children and adults) will have access to an accessible source of information and advice with a single point of contact. This signposting service will: • make it easier for those seeking information about services in Rutland to

navigate through existing information and support networks
- improve integration and community capacity building between services, service providers, public, private, Voluntary, Community and Faith sectors
- facilitate a shift from face to face to web based provision, to reflect the changing ways people access information
- Be available 7 days, thus extending existing 7 day service provision
- remove barriers that stop people accessing the right services
- encourage take up of entitlements to benefits and essential support
- enable the area to meet its statutory requirements regarding the provision of information

The agents will:

- Act as a signposting service, they will know their communities and available resources, and potential resources
- Feed their knowledge about their communities into the Rutland information and advice service
- Support their communities to support themselves by acting as a catalyst for community clubs, societies and events within and for the community
- Identify gaps in provision and work with the Public, Voluntary and Community Sectors to address gaps where appropriate
- Know who the most vulnerable are within their community
- Complement the services to support independent living and keeping the vulnerable safe
- Target patients at risk of isolation or breakdown in their health condition – this is a universal service for all ages.
- The service will encourage innovative ways to provide support for people such as local businesses or neighbours providing meals or keeping watch on an elderly neighbour.
- Encourage and enable a resilient community by encouraging volunteering or employment as a personal assistant (employment and volunteering are shown to have health benefits).

The service provider(s) will determine the final model for service delivery but this must include reaching all villages and towns within Rutland, possibly on one or two agents per ward basis – the agents are likely to be part time but the service is expected to cover support over a working week – the information and advice service will be available 24/7 in an online format.

As this is a new scheme we do not yet have the predicted numbers using the community agent service.

A visual for the service is attached at this bottom of this section.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Activity	**Timeline**
Develop Service specification	September 2014
Award contract	February 2015
Service to be in place	1 April 2015

The specification has been developed jointly with the ELRCCG and in consultation with stakeholders within the voluntary sector and colleagues. Commissioning of the service will be led by Rutland County Council.

The service provider will determine the way that the agents are distributed and the network of volunteers needed. They will be closely monitored on their outcomes and contribution to the targets around the Care Act – to provide information – and the emergency admission target by providing timely signposting to sources of support.

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

A number of existing similar schemes are in place nationally that have shown that investment in prevention can mean an increase in self-management and independence and therefore a reduction in unnecessary secondary care activity for the affected user groups.

The scheme envisages this would mean a person would present much further down the line to social care as there is less likelihood of isolation and carer breakdown or need for advice at an early stage.

Isolation and loneliness, particularly for older people has been shown to cause poor health outcomes.

The model within Derby City has demonstrated improved outcomes for users using the outcomes star, similar outcome based measures will be required for the Rutland service. However The Gloucestershire village agents have improved the numbers of people actively involved within their communities and contributed to wellbeing outcomes plus the prevention agenda.

SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes (Social Care Institute for Excellence) By Karen Windle, Jennifer Francis and Caroline Coomber Published: October 2011 found the following:

Key messages

- Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income.
- Social isolation and loneliness impact upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services.
- The interventions to tackle social isolation or loneliness include: befriending, mentoring, Community Navigators, social group schemes.
- People who use befriending or Community Navigator services reported that they were less lonely and socially isolated following the intervention.
- The outcomes from mentoring services are less clear; one study reported improvements in mental and physical health, another that no difference was found.
- Where longitudinal studies recorded survival rates, older people who were part of a social group intervention had a greater chance of survival than those who had not received such a service.
- Users report high satisfaction with services, benefiting from such interventions by increasing their social interaction and community involvement, taking up or going back to hobbies and participating in wider community activities.
- Users argued for flexibility and adaptation of services. One-to-one services could be more flexible, while enjoyment of group activities would be greater if these could be tailored to users' preferences.
- When planning services to reduce social isolation or loneliness, strong partnership arrangements need to be in place between organisations to ensure developed services can be sustained.
- We need to invest in proven projects. Community Navigator interventions have been shown to be effective in identifying those individuals who are socially isolated. Befriending services can be effective in reducing depression and are cost-effective.

Windle, K., Francis, J. and Coomber, C. (2011) Research briefing 39: preventing loneliness and social isolation: interventions and outcomes, London: SCIE

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

Individuals and Families	Communities	Health and Social Care Agencies
• Personalised support • Increased level of independence • Improved health and wellbeing • Single point of access with easier access to services • Improved social interaction & connection with community	• Clearer identification and use of community assets • Support establishing community networks • Improved capacity of voluntary sector and community services • Improved coordination between groups	• Reduced demand for secondary care • Data and intelligence informing integration • User information on unmet need • Step-up based community service • Reduce the amount of time that health and social care staff spend advising people on the support and advice available or in signposting, which allows them to focus on the most vulnerable.

Metric 1 – Reducing Residential Admissions – Moderate Impact

The Community Agents scheme will have a significant impact on reducing residential admissions because:

- Community networks will be developed and customised support designed and given to enable people to remain independent at home.
- Carers will be identified sooner, and given earlier and more targeted support, preventing carer breakdown

Metric 3 – Reducing Delayed Transfers of Care – Moderate Impact

The Community Agents scheme will have a moderate impact on reducing delayed Transfers of Care because:

- Communication channel in place between hospital discharge worker and community agents to support hospital discharge
- Community agents will help put new arrangements in place to enable people to return home sooner.

Metric 5 - Patient experience

In addition the Community agents will make a **Moderate Impact** on improving the individuals quality of life by enabling them to

- Timely access to appropriate information and services
- Access to a local, named contact to assist navigation of information networks
- Creating, sustaining and developing networks of peer and community support
- Creating, sustaining and developing community facilities and networks

Metric 6 – Reducing Admissions from Injuries Due to Falls – Significant Impact

The Community Agents scheme will have a significant impact on reducing admissions from injuries due to falls because:

- Community agents will help act as responders. or resource locators, matching people in need to those who have the facility to assist and support them, thus providing a preventative service
- Earlier identification of people at risk of falls and referral to relevant advice and information

- Community agents will provide support in the community to identify where vulnerable residents need additional support or services to prevent them from falling at home

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?

I**ndividual**

- Individuals receiving an information service will be asked about their service experiences, using a methodology commensurate with the level of advice and information they received. It is envisaged that more than one measure will be in place, ranging from a single question for a simple request to an outcome star model for more extensive community capacity building

Service Level

- Outcome of service level evaluation will be built into the service specification, and robustness tested during the procurement process

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

- Ensuring that the specification is fit for purpose and will produce a service able to meet the KPIs.
- accurate information databases available and up to date for Community Agents
- Engagement with the community and voluntary sector
- Procurement of the service to in line with budget and quality thresholds
- Monitoring and evaluation of the scheme and its users to ensure that it delivers the outcomes required.

Factor	Explanation
Partner engagement	The success of the scheme is not just dependent on appropriately communicating with partners, instead the Council will look to create teams of multi-disciplinary and multi-agency representatives to guide the programme. The lessons learned from Derby and Thurrock emphasise the importance of engaging partners (boards, GPs, residents) early so everyone is bought-in to project before it is operational.
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 or medical 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 and signposting them early to sources of support.
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	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. The information and advice service is an interdependency.

Community Agents Visual