PAPER E2

DRAFT

Appendix 1

Project Business Case

Integrated Care for people with long term health conditions (GP care Coordinators post)

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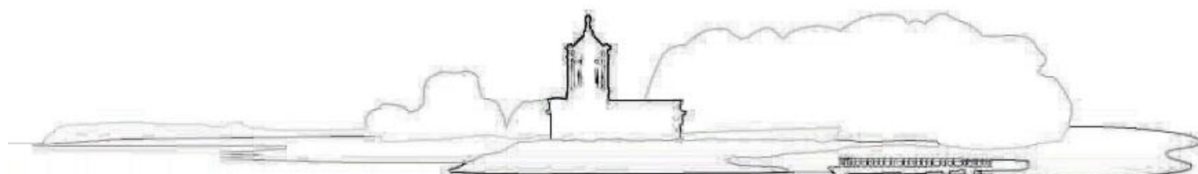


DOCUMENT CONTROL

Change Control History

Version	Change Summary	Change author	Date
0.1	Initial document production	Katy Lynch	31.10.2014
0.2	Amendments following the integration executive	Katy Lynch	7.11.2014
0.3			

Reporting Schedule:

This Business Case was presented to the Integration Executive on 6th November 2014. This will be presented to the Health and Wellbeing Board on 24th March 2015 for approval.

How would this scheme be described to the service user?

The Integrated Care Coordinator supports all 4 GP practices in Rutland, providing advice and information on wellbeing and maintaining good health for people to a carefully selected cohort of people aged 60 plus with long term conditions.

Summary of the role of the Integrated Care Coordinator:

- *A contact that will assist the patient to make use of other health and social care services including the voluntary and community sector.*
- *Ensure that assessments for an individual are coordinated*

1 Description of Project

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

The following evidence was 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
- report from Rutland pilot

About 15 million people in England have a long-term condition[1]. Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.

Long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40) and in more deprived groups (people in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease).

Projections for the future of long-term conditions are not straightforward. The Department of Health (based on self-reported health) estimates that the overall number of people with at least one long-term condition may remain relatively stable until 2018. However, analysis of individual conditions suggests that the numbers are growing, and the number of people with multiple long-term conditions appears to be rising.

Demographic changes and other trends, mean that there will be an increased demand for both acute and community care services for older people, with Rutland projected to see a 49% increase in it's over 65 population having a limiting long term condition by 2030.

Disease prevalence rates significantly higher than the England average in Rutland are as follows[2]:

	April 2012-March 2013		**April 2013-March 2014**		**Trend** (↓= worsened ↑=improved)
Disease	**Registered counts**	**Disease Prevalence**	**Registered counts**	**Disease Prevalence**	
Atrial Fibrillation	808	2.28%	883	2.47%	↓
Coronary Heart Disease	1,321	3.72%	1,337	3.74%	↓
Cardiovascular Disease Primary Prevention	1,026	2.89%	1,322	3.69%	↓

[1] Department of Health (2012)
[2] Quality and Outcomes Framework (QOF) – number and percentage on register

	April 2012-March 2013		April 2013-March 2014		Trend (↓= worsened ↑=improved)
Heart Failure	384	1.08%	381	1.06%	↑
Hypertension	5,839	16.45%	5,917	16.53%	↓
Stroke or Transient Ischaemic Attacks (TIA)	712	2.01%	748	2.09%	↓
Cancer	979	2.76%	1,064	2.97%	↓
Diabetes Mellitus (Diabetes) (ages 17+)	19,17	6.66%	1,967	6.84%	↓
Hypothyroidism	1,264	3.56%	1,316	3.68%	↓
Palliative Care	168	0.47%	305	0.85%	↓
Dementia	239	0.67%	266	0.74%	↓

The Integrated Care Coordinator role is fundamental to the successful delivery of integrated care and better long term outcomes for patients and service users.

The Kings Fund notes that there is no one model of care co-ordination, but evidence suggests that joint commissioning between health and social care that results in a multi-component approach is likely to achieve better results than those that rely on a single or limited set of strategies (Singh and Ham 2005; Powell Davies *et al* 2008; Kodner 2009). Some of the key components (The King's Fund 2011) are:

- a move to community-based multi-professional teams based around general practices that include generalists working alongside specialist
- a focus on intermediate care, case management and support to home-based care
- joint care planning and co-ordinated assessments of care needs
- personalised health care plans and programmes
- named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey
- Clinical records that are shared across the multi-professional team.

1.1 Project Objectives

Provides advice and information on wellbeing and maintaining good health for people to a carefully selected cohort of people aged 60 plus with long term conditions

Focusses on early intervention- providing advice, information and practical assistance to help people stay well for longer

Provides an integrated health and social care service

Reduces admissions to care and to hospital for people with long term conditions

1.2 Key Deliverables

Include key deliverables for the Project lifecycle

Project Deliverable	**Delivery targets**
1 Health and social care coordinator recruited and based in Rutland GP practices	Recruit Coordinator ASAP (Post vacant as at March 2015)
High risk patients with health and social care needs identified and supported to better manage their health and wellbeing. Agreed between coordinator and each GP practice	20 per month
Risk stratification tool (computer generated analysis) allocates risk score to potential patients who may be eligible and cohort agreed	Patients chosen through monthly Multi-disciplinary team meeting
Eligible patients receive advice, assistance and intervention through a care planning process led by the coordinator	20 new patients per month
Patients are involved in developing the care plan, understand it, and have confidence about who to approach when they need support.	1 care plan per patient
Care Coordinator is able to undertake case work to encourage independence; which prevents the need for ongoing referrals to other health and social care services.	Only appropriate referrals are made to specialist teams
The programme is clearly communicated with GPs	Article developed and sent to GPs
All Rutland GPs clearly understand the purpose of the programme	As above
<u>Specific patient outcomes:</u> Better understanding of their long term condition(s) Treated with dignity and respect "I feel positive" "I feel safe"	Positive outcomes for all patients

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**
1. Recruit health and social care coordinator based in Rutland GPs	a. Re-advertise Care Coordinator		Team Manager	Feb 2015	March 2015
	b. Shortlist candidates for interview	Activity 1a	Team Manager	March 2015	March 2015
	c. Interview potential	Activity *1a & b*	Team Manager	March 2015	March 2015

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	candidates				
	d. Appoint	Activity 1c	Team Manager	April 2015	
2. New Care Coordinator in post	a. Induction (shadow coordinators in Leicestershire)	Activity 1	Team Manager	End of April 2015	May 2015
	b. Competencies identified to ensure framework in place for the coordinator to work from.		Team Manager	March 2015	May 2015
	c. Training against the competencies		Team Manager	May 2015	May 2015
3. Communication with GPs to plan the programme			Head of Service	April 2015	April 2015
4. Undertake initial case load	a. Working with own case load of patients	Activity 1 & 2	Integrated Care Coordinator	June 2015	Ongoing
	b. Develop outcome measures	Activity 1 & 2	Integrated Care Coordinator/ Team Manager	April 2015	June 2015
5. Care Coordinator to ensure key links in place with other services	Referrals to community agents	Activity 1	Integrated Care Coordinator	June 2015	Ongoing
	Referrals to Memory Advisor	Activity 1	Integrated Care Coordinator	June 2015	Ongoing
	Referrals to Assistive Technology	Activity 1	Integrated Care Coordinator	June 2015	Ongoing
	Undertake falls prevention assessments and carry out	Activity 1	Integrated Care Coordinator	June 2015	Ongoing

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	relevant interventions				
	Use of online directory to make patients aware of the range of services available	Activity 1	Integrated Care Coordinator	June 2015	Ongoing
6. Review	a. Undertake quarterly evaluation reviews to monitor effectiveness of the role	Activities 1-4	Team Manager and Aidan Neaves, working with Coordinator and GPs	June 2015	April 2016
	b. each patient reviewed at 3 months to review their progress		Integrated Care Coordinator	Every 3 months	Ongoing

1.4 Exclusions

Clearly state any areas that are out of scope and whether these are to be delivered by another area/at a later date/not at all, etc.

- People that do not fit with the risk stratification criteria e.g.
  - 60 years of age or older
  - 3 or more Long Term Conditions
  - 5 or more repeat medications
  - Not on an active cancer pathway

  N.B As this is a trial it is acceptable for different thresholds to be piloted to ensure that the model is flexible and works for Rutland
- Specialist dementia support/advice (covered by the memory advisor)

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

How far has work progressed? What is to be done? Milestones

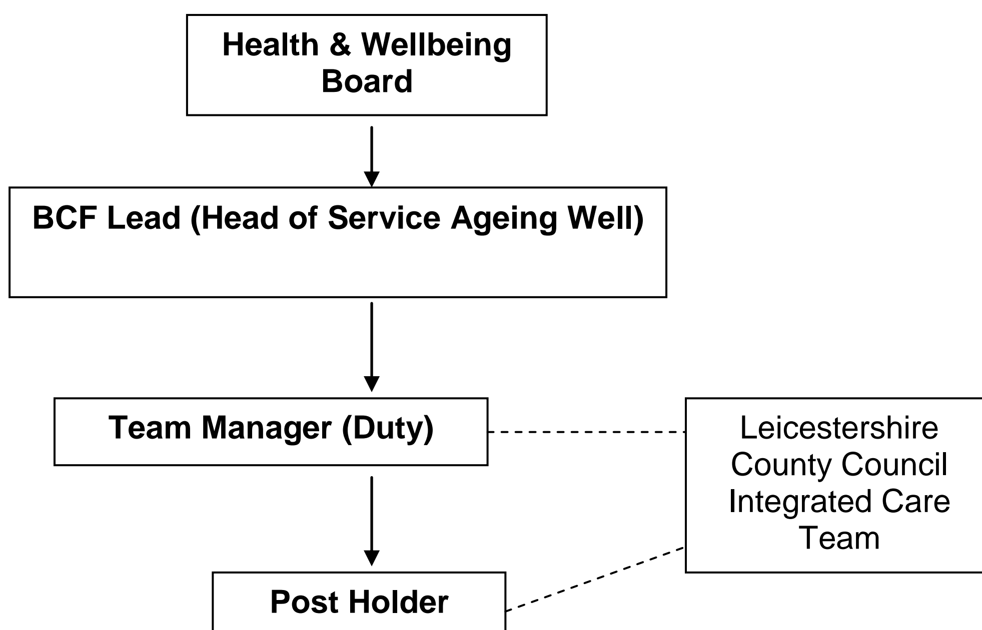
An external evaluation was undertaken in autumn 2014 before the previous Care Coordinator left. Key findings from the evaluation will be considered in further development of the model so that the tool is fit for purpose, key findings include:

- Consider broadening of the criteria/ trial new criteria for example include issues such as frequency of incidents, frequency of falls, adding in so called ‘frequent fliers’.
- Ensure risk stratification identifies those at high risk of admission to hospital and falls.
- Further training and development of the Care Coordinator to ensure referrals direct individuals to services which will allow them to help themselves where possible (prevention)
- Mixed understanding from professionals regarding the role of the Care Coordinator; clear communication with GPs and other partners to clarify the role and expected outcomes.
- Engage pharmacists and bring them on board with the programme

Previous coordinator has left the post therefore there is currently a vacancy; the post is currently out for advert for the second after failing to recruit in January 2015.

Service links in with established service in Leicestershire which will provide professional and peer support for the coordinator.

2.2 Work stream structure



2.3 Work stream metrics

BCF Metric	Description of Impact as set out in BCF Significant/moderate/other
Metric 4 –avoidable hospital admissions	Significant impact; change in activity: FY 14/15 – 8 FY 15/16 - 27
Metric 6 – admissions due to falls	Significant impact; change in activity: FY 14/15 – 1.6 FY 15/16 – 2.1
Local Key Performance Indicators	
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.	
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.	
Supported self-management – people with long term conditions can manage their condition appropriately because they have the right opportunities, resources and support.	
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.	

2.4 Work stream metrics recording

Information being collected	At what stage in the patient pathway is the information being collected?	Information collected by whom	Database on which information is collected / captured/ stored
Spreadsheet of activity: No. of people seen Breakdown of patients per practice	At end of intervention	ICC	Spreadsheet
Service placements of interventions undertaken	Ongoing	ICC	Social Care Case Management system

The no. of patients signposted or provided with information and advice (including the use of community agents and the information portal)	At the beginning of the intervention	ICC	Spreadsheet
Referrals made to other appropriate health and care services		ICC and Team Manager	Break down of which health and which care services an individual has been signposted to
The number of recipients of the service suspected or diagnosed as having dementia	At the beginning of the intervention	ICC	Spreadsheet

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**At what stage is the patient pathway is the information collected**	**Reporting dates**	**Reporting timeframes**
Outcomes report sent to Team Manager	End of each patients intervention	Monthly	Supervision

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**
Health and social care coordinator (new recruit)	Delivery	Better understanding of objectives of role	Supervision
Health and Wellbeing Board	Oversee	Inform of commissioning intentions	HWB highlight reports
Patients	Inform development of service	Receipt of service	Customer satisfaction survey via CCG & feedback re. outcomes

GPs	Support Care Coordinator	Save time	MDT meetings
RCC staff	Understand project support	Reduce referrals	Team meetings
Line manager for Coordinator	Recruitment & Supervision	Inform service development	
Carers	Inform delivery service	Better information & enable to continue their caring role	Correspondence & signing posting information
Pharmacies	Support Care Coordinator and patients with medication issues		Involve and engage in the programme, invite to MDT meetings

3.2 Project Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
Status report	Quarterly	Integration Executive	Work stream Lead	Integration Executive and Health and Wellbeing Board

4 Risks

3.1 Key Risks

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	10.2014	John Morley	Inability to recruit	**Low**	**High**
2	10.2014	John Morley	Poor support from stakeholders	**Low**	**High**
3	10.2014	John Morley	Don’t deliver metric targets	**Medium**	**Medium**

5 Costs

5.1 Project Costs

Include all direct and indirect costs

Description	2014/5(£)	2015/6(£)	Total (£)
Recruitment costs (Health and Social Care Coordinator)	1,000	-	1,000
Health and social care coordinator salary and on costs (Scale 6 – community health worker salary)	31,000	31,000	62,000
Evaluation	3,600	-	3,600

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 (£)	Totals (£)
BCF funding	H	-	39 000	39 000
S256 funding	H	39 000	-	39 000
Total Funding	H	39 000	39 000	78 000

6 Exit Strategy

The post will be recruited as a fixed term position. If further evaluation demonstrates the scheme is delivering anticipated outcomes then a discussion will be necessary to discuss how this position would be funded permanently.