



Rutland County Council

Integrated Care Programme Evaluation

September 2014

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Executive Summary

Peopletoo were commissioned by Rutland County Council to undertake a high level 5 day review of the integrated care programme that currently operates within Rutland. The objective, to determine whether the model was achieving its agreed aims, establish if positive outcomes were identified to all patients and what changes if any are required to make the programme deliver its goals.

Semi-structured interviews were undertaken with multiple stakeholders and where available referral data was analysed. A very small sample of patients were interviewed, but given the size of the sample, this cannot be regarded as representative of patients on the pathway as a whole.

The aim of the integrated care programme is to deliver proactive community based support in order to:

- Help people understand their conditions
- Help people live healthier lives and stay well for longer
- Improve patient experience
- Avoid hospital and care home admissions
- Improve integration of health and social care

The core themes emerging from the evaluation are:

- **Patient outcomes and satisfaction** – The view of the programme as a whole was seen positively by staff and patients, but there were disparities as to whether the pathway actually benefitted patients. Stakeholders and patients agreed that the programme will be/has been of benefit to patients, but may not have been of benefit to others.
- **Risk Stratification** – Differing opinion among clinical staff involved as to whether it should be focusing on those with higher needs or should have its scope broadened and expanded so more people could potentially benefit from the programme that may have been excluded previously. To help inform future decision making and in line with concerns raised from GPs, intelligence exercises such as a review of patients being admitted to residential care can be undertaken to see what the reasons for admission are, and using these findings to inform the risk stratification and ensure that patients that would benefit the most from the programme are being targeted.

- **Evidence** – There is an abundance of ‘soft’ evidence, however very little ‘hard’ evidence to demonstrate if the programme is meeting its intended aims. This needs remedying with robust intelligence needing to be gathered to inform the criteria for the risk stratification and also see if the programme is meeting its intended aims.
- **Sustainability** – We believe and a view echoed by the GPs and patients is that 3 month reviews are inadequate in showing if sustainability of outcomes has been achieved. Patients and staff would like further follow ups as contact with the programme ends after the 3 month review. Follow up contacts can be carried out by the voluntary sector or community agents who can play a vital role in providing much need capacity and who can check to ensure outcomes are being met over the long-term.
- **Care coordinator** – Stakeholders would like the coordinator role developed further, with increased training and more empowerment to ‘direct’ referrals to other services.
- **Knowledge transfer**- Health staff have indicated that they have an increased awareness of the social care services due to the coordinator being based at the practices and would like this maintained.

Introduction

Peopletoo have been commissioned to carry out a 5 day evaluation of the Integrated Care Pathway programme. This paper has been developed for Rutland County Council (RCC) in line with the agreed Project Outline, the contents of which has been progressed following receipt and analyse of appropriate data that is available and meetings and discussions with key personnel involved in the programme and patients. We would like to take this opportunity to thank staff who have taken the time to meet with us and provide information as requested, which we appreciate is difficult when on top of their existing 'workload'.

This exercise has been carried out in parallel with a number of Peopletoo diagnostics across the country, allowing us to bring additional learning, ideas and experience from other authorities, who are exploring similar integrated pathways.

Background

Rutland is the smallest unitary council in the country and one of the most rural counties with a very low population density. In 2011 the population was recorded at 37,369 with almost a third aged 65 and over. The population is expected to rise to 46,400 by 2033. RCC faces many of the same complexities and problems as it bigger counterparts across the country but also unique problems due to its smaller size.

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. As part of a wider strategy the Government created the "Better Care Fund" (BCF) to foster greater integration between health and social care and improve patient outcomes.

Using BCF funding, East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) and Leicestershire County Council (LCC), undertook an integrated care programme as a pilot in January 2013, which was then rolled out to cover Rutland.

The purpose of integrated care is to bring health and social care closer together with the aim of delivering more proactive targeted care to older people with long-term conditions. The aims of the programme are:

- 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 the integration of health and social care

With agreed Key Performance Indicators for Rutland being:

- 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.

Methodology

Semi-structured Meetings and telephone calls were carried out with all stakeholders, including:

- 3 Lead GPs
- Care Co-ordinator
- Team Senior
- A practice nurse from Oakham medical practice

- A team manager from adult social care (team 8)
- The manager of the duty team
- Members of occupational therapy
- The Assistant Director for Personal Care and Support from Leicestershire County Council.

The purpose of these interviews was to gain their views of the Programme and how this has been implemented to date to date. In addition interviews were held with 3 patients who are currently on the programme in order to ascertain their thoughts and experiences.

Where available, anonymised data on referrals, outcomes and 3 month reviews was provided and analysed in order to develop quantitative data to be taken alongside the qualitative data.

The Pathway

The pathway at a high level follows the following basic process:

1. Risk Stratification to generate patient list based on agreed criteria.
2. Coordinator and GP further scrutinise list to exclude some patients and invite others.
3. Invitation sent out to patients asking them to participate
4. Assessment carried out following response of invitation, with those accepting being brought forward in to the programme.
5. Health and Wellbeing plan co-produced with the patient.
6. MDT meeting held to discuss patients and agree actions.
7. Referrals made to appropriate services following the results of the MDT.
8. 1 month review to ensure actions are being/were carried out.
9. 3 month review to review progress.

Four GP practices are involved with the integrated pathway in Rutland, Oakham Medical Practice, Uppingham Surgery, Empingham Medical Centre and Market Overton & Somberby Surgery (satellite practice of Oakham) with a practice population totalling 35,506.

Each practice had a dedicated Health & Social Care Coordinator who is allocated to cover a population of around 35,000, coincidentally Rutland's population matches this allocation so one coordinator is assigned to cover all of the practices in Rutland.

Evaluation of the Pathway

Risk Stratification

The coordinator will use the risk stratification tool on HERA, which will create a list of potential patients based on the following criteria:

- 60 years of age or older
- 3 or more Long Term Conditions
- 5 or more repeat medications
- Not on an active cancer pathway

This list is checked in conjunction with the lead GP to ensure the patients identified are appropriate and to remove those currently on palliative pathways or in residential/nursing care.

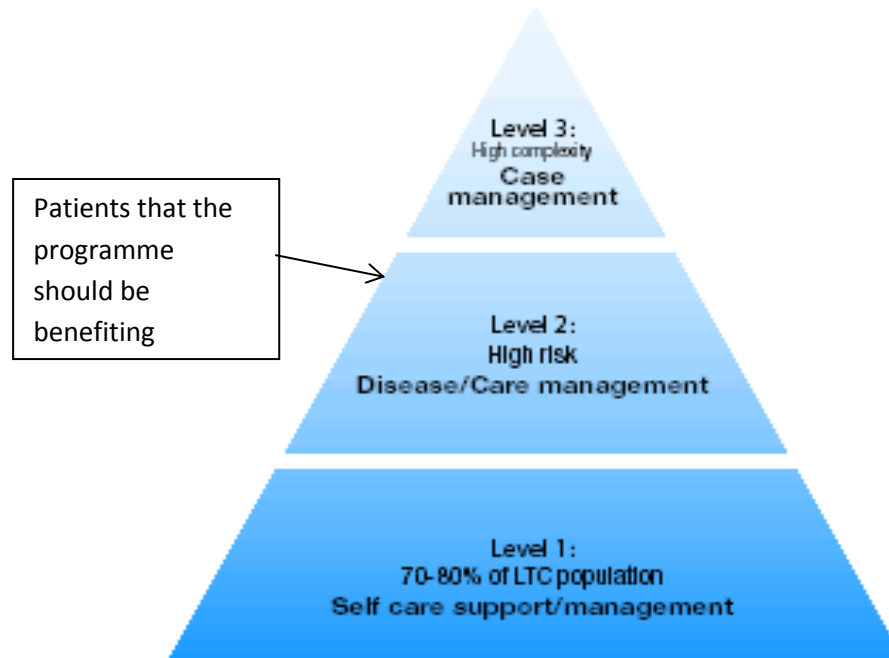


Fig1. Triangle of care

There were mixed views on the risk stratification tool with one GP indicating they felt the tool was set at too low a level and that it should be targeting those with a higher need (see fig.1). It was this GP's view that this is the general direction the CCG would like the programme to go, targeting more complex patients with a focus on the elderly and those with long-term conditions. Two GPs felt that the tool was too restrictive and that many patients that could benefit from the pathway were excluded, and so would like the criteria broadened to include issues such as frequency of incidents, frequency of falls, adding in so called 'frequent fliers'. One GP stated that the risk stratification judged patients based on their likely cost rather than the risk of admission.

The REACH manager and a member of occupational therapy believed patients with lower needs who are currently not identified by risk stratification could benefit from the program and reablement and think the current criteria should be expanded or lowered. The practice nurse and a GP indicated

that the patients list that arose from the risk stratification sometimes fell in to two extremes, those with highly complex needs, and those whose needs were not complex enough that the programme would be beneficial to them.

One GP expressed concern that there was no flexibility in the system and those patients they feel could benefit from the pathway could not be referred in, while two other GPs acknowledged there was room for patients to be recommended to the pathway but accepted they could not do this for everyone they wanted.

The team senior manager and the coordinator indicated that they do allow flexibility in allowing in recommendations to the pathway, but still have to stick to the criteria. An example case load comprising of 75% from the risk stratification and 25% from GP recommendations was given as being appropriate.

A review of what the programme is hoping to achieve and how it will be developed in the future needs to be carried out to inform the risk stratification criteria, with this clearly explained to GPs. If the risk stratification was raised and targeted patients with a higher need, there is a risk that rather than being proactive in managing the needs of patients, this pathway will become yet another reactive service and it was commented that those with a higher need were already known to services. Conversely broadening the criteria will produce bigger lists of patients of which many this service would not be of a benefit as the scope of what is required far outreaches what the programme can actually do.

Recommendation 1: The criteria used for risk stratification should be reviewed in consultation with GPs and the future aims of the project.

Recommendation 2: GPs should be encouraged to recommend patients on the pathway that they think would benefit. It should be communicated that recommended patients must be able to benefit from 'proactive' treatment rather than 'reactive'.

Peopletoo has already undertaken a detailed analysis of the reasons older people are admitted to residential/nursing care in another local authority with similar levels of affluence. The 3 primary reasons identified were:

- Carer breakdown accounted for 30% of admissions
- Deterioration of physical health accounted for 26% of admissions
- Deterioration of mental health accounted for 22% of admissions - mostly relating to dementia

The analysis also highlighted dementia as having a large impact on care home admissions. It is suggested that any future change to risk stratification take into account the above. RCC may wish to undertake their own analysis of reasons for admission to residential with the findings being used to inform the risk stratification (Recommendation 1).

Invitation

After risk stratification, the coordinator will write out to patients asking if they would like to participate in the pilot. One of the GPs expressed concern that the wording of the letter created an over expectation of what the service would provide, leading some patients expecting a bigger service or increase in their care provision. Indeed this may be occurring, following an interview with one patient who had recently benefitted from some adaptations to their home, they indicated that not much had changed in their life, and they would be in the same position without the programme, despite being having adaptations made to the house.

Recommendation 3: Consider rewording the invitation letter emphasising the objectives of the programme and its proactive nature and modify the pilot leaflet to make it more specific for the services offered in Rutland.

Assessment

The Care Coordinator carries out an integrated assessment that was developed jointly between social care and nursing. One GP said that they felt the coordinator was extremely thorough in their assessments and had identified all possible solutions and outcomes, a view that was echoed by the patients interviewed. Concern was raised that the coordinator may raise expectations to patients of the services that can benefit them, and that a better understanding of treatments and services may be needed (see Recommendation 7).

Health and Wellbeing Plan

The coordinator co-produces the health and wellbeing plan with the patient which enables the patient to gain a greater understanding of their condition and social needs as well as any treatments that are available. One of the GPs indicated that patients were telling the coordinator about conditions that they had not previously disclosed to the GP, the GP felt that this was because the patients themselves were unsure if the disclosed condition was of such a priority that the GP should be informed. However one of the GPs indicated that patients liked having the coordinator around, as they would tell them all their problems whether they were medically significant or not.

MDT Meeting

A Multidisciplinary Team meeting is held to consider and approve actions for patients. Attendance comprises of lead GP (mandatory), a District Nurse (mandatory), the Care Co-ordinator (mandatory), practice nurse or other relevant stakeholders (invited). All staff indicated that MDT was extremely beneficial and useful in the co-ordination and delivery of patient care. The biggest weakness highlighted though was that other invited professionals rarely attended and their valued specialist input was missed.

One GP indicated that they were no longer attending MDT team meetings due to having no cover at their practice. They had said that their enhanced service (DES) payments had stopped and could no longer afford to hire a locum to stand in to cover for them. In the initial pilot GPs were paid some remuneration for their time, however in the expanded role out there is no monetary contribution.

While the integrated programme can aid GPs and their practices achieve some of the goals as set out by the new enhanced service agreement, particularly avoiding unplanned admissions, it cannot be solely relied on to deliver the requirement set out by DES. There is a clear overlap between the programme and the DES and these should be communicated effectively to participating practices so that there is a clear understanding of where the programme can aid in the DES

Recommendation 4: Ensure the programme is clearly communicated to GPs so that they understand the overlaps of the programme with the DES but also know that it cannot be solely relied on to deliver the DES.

Recommendation 5: Ensure there is enough capacity in services so that invited members can attend the MDT. This would likely have significant benefits as the MDT process was widely seen as a positive step and an integral part of the pathway, and an OT or social worker attending these meetings (when invited) would provide a valuable contribution to the discussion and overall provide better outcomes for patients and in the long-term reduce the demand for statutory services.

In the initial pilot that took place in Leicestershire, pharmacists were engaged and included as part of the pilot and was seen as quite beneficial to the programme, this was not carried forward when the programme expanded in to Rutland.

Recommendation 6: Engage pharmacists within Rutland and bring them on board as part of the programme.

Referrals

Following the MDT the co-ordinator makes referrals to various services in accord with the Health and Wellbeing Plan and the outcomes of the MDT meeting.

Interviews with staff indicated that they believed the majority of referrals were for falls management, occupational therapy, sensory loss, referral back to the GP, and district nursing.

One of the GPs commented that this was increasing their workload and most stakeholders agreeing that district nursing had seen an increase in their workload also. This increase in workload and referrals should be expected, but as the programme continues this increase will hopefully bottom out and a reduction will be seen instead, as the programme would have put in place services that reduce use of services over the long term at the cost of an initial spike to put said services in place. Robust intelligence from data would be needed to see if this is the case and whether alternative pathways of care could have been considered.

Below is an overview of the services referred to for 3 of the practices involved in the programme and has been pulled from their computer systems, the data represents a period that covers the programme from its start to August 2014. It should be noted that patients may have been referred to multiple services but were recorded as being referred to one service on the GP system.

| Oakham Medical Practice | | Market Overton | | Empingham | |
|---------------------------|-----|-----------------------|-----|---------------------------|-----|
| Total Patients | 136 | Total Patients | 28 | Total Patients | 39 |
| Self-help support | 6% | Self-help support | 5% | Self-help support | 10% |
| Social Services | 10% | Social Services | 7% | Social Services | 10% |
| Pharmacist | 1% | Pharmacist | 4% | Mental Health | 3% |
| GP | 9% | GP | 7% | GP | 8% |
| Fall Service | 2% | Fall Service | 4% | Fall Service | 3% |
| Occupational Health | 3% | Drug and alcohol team | 4% | Occupational Health | 3% |
| Clinical Nurse Specialist | 2% | Dietician | 4% | Clinical Nurse Specialist | 5% |
| Benefits Advisor | 4% | District Nurse | 11% | Physiotherapist | 5% |
| Exercise Therapy | 1% | Other Care | 7% | Exercise Therapy | 3% |

| Oakham Medical Practice | | Market Overton | | Empingham | |
|-------------------------|-----|----------------|--|----------------|-----|
| Practice Nurse | 1% | | | Practice Nurse | 3% |
| District Nurse | 8% | | | District Nurse | 18% |
| Physiotherapist | 1% | | | Dietician | 3% |
| Other Care | 23% | | | Other Care | 10% |

Below is a breakdown of referrals made since June 2014 to August 2014 for patients on the programme that the care coordinator has kept a record of. The data for this period was more thorough and reflects some of the new changes implemented to the programme recently. There were 67 patients during this period with outcomes recorded; those with no recorded outcomes are not included in the table.

| Referral | % of patients | Referral | % of patients | Referral | % of patients |
|----------------------|---------------|-----------------------------|---------------|-----------------------|---------------|
| GP | 31% | Other | 15% | Social Services | 6% |
| Occupational Therapy | 28% | Deaf and Hard of Hearing | 9% | Clinical Lead | 7% |
| Physiotherapy | 6% | Speech and Language therapy | 1% | Exercise Therapy | 1% |
| District Nursing | 12% | Information and advice | 73% | REACH | 1% |
| Medication Support | 18% | Carer's team | 4% | Practice Nurse | 7% |
| Falls Clinic | 18% | VISTA | 6% | Mental Health Team | 1% |
| Benefits Advisor | 12% | Social Groups | 1% | Social Inclusion Team | 3% |
| Patient Pack | 60% | Rutland Community Spirit | 1% | Befriending Service | 9% |

As evident from above there is a significant amount of referrals which end with information and advice (73%) and patient pack (60%), with lots referrals also to the GP (31%) and occupational therapy (28%). While this is useful as a reference for activity data, it cannot be interrogated further in isolation and would need to be looked at against a backdrop of baseline data and data from other services (recommendation 13) to see if outcomes are having their intended aims.

It was noted that on very rare occasions referrals to occupational therapy, particularly for equipment were inappropriate and that coordinators knowledge of equipment was lacking. It was felt that the coordinator would benefit from spending some time with occupational therapy and the promoting independence work stream to gain a fuller understanding of their service. A 'Trusted Assessor', when trained, will be able to assess for and prescribe a simple solution or a basic piece of equipment to meet the needs of an individual. This will help alleviate some of the demand for occupational therapy and reduce waiting lists.

Recommendation 7: Care coordinator to be trained as a trusted assessor.

Recommendation 8: Schedule sessions between the Coordinator, Occupational Therapy and members of the promoting independence work stream.

Nearly all stakeholders liked that the coordinator was based at each GP practice, and believed this aided in knowledge of transfer of social care to the practice which they previously would not have had. There was some concern that the coordinator may be too embedded within the practices and would benefit from some time in other areas (see Recommendation 8).

Where referrals had taken place, there was no formal reporting mechanism back to the coordinator to monitor and track outcomes. Similarly if a patient was to have an incident after being seen by the coordinator there was no procedure in place for the services that responded to the incident to inform the coordinator, the coordinator would either have to chase up the outcomes or hope the services concerned informed them.

One GP raised concern that the programme did not actually help integration at all as patients were still referred down singular care pathways that are not integrated.

Recommendation 9: Develop and formalise reporting mechanisms to referred services so outcomes can be captured.

One GP expressed disappointment that the coordinator could not refer directly in to more services particularly health related services and would require the GP, practice/district nurse to make these referrals. This is very dependent on the background of the coordinator, with different view considered. In the West and City Leicestershire CCG the coordinators are Band 7 nurses who can do these referrals, but the concern of the model implemented in those areas is that it was very health focused and missed out on the social care element.

Reviews

Following the implementation of agreed measures, the coordinator will review patients one month later and then again 3 months after that. There was concern from GPs and all interviewed patients that following the 3 month review they would be left on their own with no further support. An anonymised sample of 10 three month reviews were analysed, it would seem each patient had benefited from being involved on the programme though some did require ongoing support and so were referred on to other services. Given that the reviews are undertaken relatively quickly after referrals are done, enough time may not have passed to adequately show the longer term aims of the programme and demonstrate and sustainability of outcomes, furthermore those patients with more complex conditions and a greater need would benefit from further follow ups to ensure that their needs are still being met.

Recommendation 10: Scheduled annual reviews to take place with participating patients to ensure needs have been met and demonstrate sustainability of outcomes.

Recommendation 11: Consider setting up and formalising agreements with existing voluntary providers to join and be a part of the programme. Given that support for patients effectively ends after 3 months, the third sector can provide much needed capacity in following up on patients to ensure sustainability of outcomes.

Recommendation 12: Community Agents to be put in place and work closely with the coordinator and act as a point of contact for participating patients. Community Agents can be utilised to carry out annual reviews of patients on the programme.

Community agents are part-time locally employed people who operate within specific localities or parishes. They are a vital connection between local people, the council and other third party providers, often being the link between the older person and support services. They accomplish this by becoming an integrated, trusted and an approachable member of the community they serve, by seeing older people as not simply patient in health or social care; by raising the profile of older people and reducing isolation; offering one to one support; and being part of a holistic service delivery and part of an extensive network system.

Recommendation 13: Following from recommendation 9, key performance indicators and metrics need to be revisited and appropriate methods of capturing outcomes are to be developed and implemented. Examples of what could be measured are:

- Interrogate GP systems to baseline and track number of unscheduled visits.

- Baseline OOH information on known patients 12 months prior to service and track 12 months after intervention to detect if there was any reduction in contacts.
- Use CCG admission data to interrogate acute admissions based on GP practice, to see if there are any trends developing to see if there is a reduction in visits.
- Baseline known patients monitoring social care unscheduled reviews 12 months prior to the programme, and track 12 months after to see if there is a reduction in contacts.
- A review of institutionalised bed days in acute or residential/nursing care. Baseline known patient 12 months prior to the programme and track 12 months following the programme to see if there is any reduction.

Patient Feedback

Involved patients were sent feedback forms (see Appendix A) and asked to return them. Below is a snap shot of some of the responses that were provided totalling 32 patients. Many of the free text questions were unanswered, with the tick box questionnaire answered considerably more.

Q1. What is the best thing about being on the pathway?

“Befriend Scheme. Help given through occupational therapy”

“It has helped me get back on track after major heart surgery”

“I was able to talk to someone”

“It has made me see more people but I do feel lonely at times”

“I am not sufficiently involved”

“Access to help and advice if needed”

Q2. What do you feel could be better about the programme?

“Able to contact people when you require”

“Nothing”
“Wasn’t any great help”
“Better communication between professionals”
“More contact with Rebecca”
“It was very satisfactory”

Q3. Please use the space to describe how being on the programme has affected your life.

“It hasn’t affected my life”
“I have become more social”
“Thank you it’s just the little things and nice people that help”
“It has made my life more comfortable”

Q4. Please tell how strongly you agree or disagree with the following statements by placing a mark in the appropriate box.

| Description | Strongly Agree / Agree (%) | Strongly Disagree / Disagree (%) | Don’t Know (%) | No Answer |
|--|----------------------------|----------------------------------|----------------|-----------|
| I feel my life is moving forwards | 44% | 25% | 22% | 9% |
| I feel more well supported by my GP surgery to manage my long term condition or conditions than before the programme | 66% | 25% | 3% | 6% |
| I feel I have more chance of achieving my personal health goals than before the programme | 47% | 22% | 19% | 13% |
| I feel more socially involved than before the programme | 41% | 34% | 16% | 9% |

| Description | Strongly Agree / Agree (%) | Strongly Disagree / Disagree (%) | Don't Know (%) | No Answer |
|--|----------------------------|----------------------------------|----------------|-----------|
| I feel the NHS is taking a pro-active approach to helping me stay well | 72% | 19% | 3% | 6% |
| I feel my quality of life has improved as a result of being on the programme | 44% | 28% | 19% | 9% |
| I feel being on the programme has made things easier for my family / carers | 44% | 41% | 6% | 9% |

As part of this evaluation, 3 patients were interviewed with 1 other declining. As well as face to face interviews with these users, they were also asked to complete a separate feedback form (see Appendix B) that was created for this evaluation which drew upon the existing feedback from, the original pilot questionnaire and previous experience. The results are included as Appendix C. Unfortunately due to timescales and the issues regarding data governance relating to knowing which patients to elicit feedback from, a representative sample of patients could not be interviewed.

Based on the patient testimonies and feedback, it would seem that a significant number of patients do benefit from the programme with a large majority feeling more supported by their GP (66%) and feeling that the NHS is being proactive about their care (77%). However we also see that a proportion of patients have felt no significant benefit of being on the programme. This view is backed up by clinical stakeholders who all indicated there were patients that have benefitted on the programme, some more than others, and those who the programme had not had an effect on. This can be down to numerous reasons, with the key question to ask being - Are the right patients being targeted? The patients interviewed as part of this evaluation felt the feedback questions were very generic and vague, with questions not being applicable to them or their needs; this may explain the significant numbers of people who did not answer or responded did not know when providing feedback.

Recommendation 14: Develop new feedback forms with more direct statements which will help inform the qualitative aspect of the programme. Following recommendation 12, community agents could be used to follow up on patients and feedback to the programme in relation to sustainability of outcomes.

Outcomes

No discernible outcomes can be established at present except for the 'soft' evidence indicating that some patients benefitted and some patients did not. As mentioned earlier in this report, key performance indicators and measureable data needs to be revisited, agreed upon, and measures put in place to capture outcomes of interventions so that the effects of the programme can be properly evaluated.

Recommendation 15: Further evaluation to take place 12-18 months from now, at which point it is hoped that measurable data has been captured and in conjunction with data from partner services, trends can be identified.

Summary of Recommendations

At the time that this evaluation was carried out, new process changes had just come in to effect, as a result the interviews and views of patients may not have taken into account the new changes, particularly Recommendations 9 and 8 may have been addressed. Another evaluation should be carried out in the future to see the impact of the new process changes.

It should be said also that sufficient hard data on patients did not seem to have been captured at any point through the programme, this needs addressing so as to identify the needs of the target population, to see if current ways of working are providing the intended benefits and what change if any need implementing. This would require agreeing key metrics to measure the agreed upon performance indicators, which in turn can be used to inform the risk stratification.

Further follow-up contacts with patients to take place after the final 3 month review which can be carried out by community agents or voluntary organisations to ensure sustainability of outcomes.

Develop and enhance the role of the Care Coordinator by linking in with other teams, training and allowing more direct referral routes and options.

Expand the MDT team by adding pharmacists, and ensure that invited services send representatives to participate in the MDT.

Communicate the aims and services of the programme more clearly to patients and GPs to ensure they adequately understand the aims of the programme and what services are on offer.

Future Considerations

Going forward, there is scope for the integrated programme to be developed further and expanded. During the evaluation there had been talk of changing the target group to focus on those with higher needs and one GP commented that the pathway was not integrated as patients were referred to traditional single agency pathways with the coordinator being the only integrated post. RCC and ELR CCG may wish to develop the pathway in such way that offers true integration. This can be achieved by:

- Developing effective anticipatory care planning with care wrapped around the individual with a care plan accessible by all professionals.
- Development of a continuum of multi-agency provision, deploying the right resources at the right time in a holistic manner.
- Develop capacity for effective early prevention in conjunction with the voluntary sector.

Appendices

Attached Appendices are the completed handwritten questionnaires confirming information incorporated into table in Question 4 (page 17)