1. Highlights

Vision

“As a patient with a Case Manager coordinating my care, I shall receive the right care, in the right place and at the right time. I will feel confident that I shall have access to dedicated and skilled health professionals who will advise me on my health condition and the decisions necessary for my treatment/care plan.

As a General Practitioner, patients registered with my practice who have a long-term condition, will have the opportunity of receiving a coordinated care plan from a Case Manager. Through close liaison with the patient and their Case Manager, I will be able to manage those individuals more effectively at their home, only admitting them to an acute hospital bed where appropriate.

As a Case Manager, I shall coordinate the care of patients on my caseload and devise a care plan in agreement with the patient’s general practitioner and the multi-disciplinary team. I will work in collaboration with other health and social care professionals to deliver the right care, in the right place in order to maintain and enhance the quality of life for those patients living with multiple/advanced disease states and related complications.”
# Background:

The Trust has an integrated programme of targeted care that selects patients based on their risk of unplanned care due to their complex health conditions. The care delivered is holistic, meaning that it is not limited by purely examining health care delivery; instead, it incorporates physical, mental, emotional, social and environmental aspects of care.

Looking forward, on any given day the PCT will be providing a case management approach that allows the stakeholders to say:

As a patient I have:
- a co-ordinated approach to the care that I need;
- the information is available so I can do as much for myself as possible;
- the support of an experienced practitioner who I know I will stay with for as long as I need; and
- a case manager who notices and understands the importance of small changes in my condition and provides early intervention.

A case manager has a case load of patients who are:
- identified through predictive modelling;
- approached using a standard personalised procedure leading to a personalised intervention plan;
- intervention plan delivered by those with necessary skills and experience; and
- Recipients of fully co-ordinated care by integrated teams.

This programme contributes to the PCT’s commitment in supporting their population to:

1. **Get Healthy**
2. **Stay Healthy**
3. **Live with Disease**

Staff involved in this project will be the current community matrons and district nurses. The end of the project will result in 2 levels of case manager: one who will have a caseload of those patients who have the most complex needs and the second level who will have caseloads identified by a secondary screening tool. The Business Case will clarify job responsibilities and bands. Patients will move from a series of intensity with the level of case management that they require as well as move from one level to another, as their health needs change. This will ensure that integrated teams have the most appropriate patients on their caseloads to match their level of skill and knowledge and those patients are receiving the most appropriate level of care to meet their needs.

The case managers will work in teams built around patient populations and patient needs to ensure that the appropriate support is provided to them.
Vision – Integrated Case Management Process focused around the Patient

- Case Manager and GP (Co-coordinators of Care)
- Intermediate Care
- Mental Health
- Equipment Services
- RBHFT and Community Geriatrician
- Voluntary Sector
- Hospice
- Community Nursing
- Social Care
- Nutritional Services
- Podiatry Services
- Nursing/Rehab Homes
- Specialty Nurses
- Therapies (PT, OT, SALT)
- Diagnostic Services
- Private Agencies
- OOGP/ Ambulance Trust
- Pharmacists
### Need for change

<table>
<thead>
<tr>
<th>What are the threats of not changing?</th>
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<tbody>
<tr>
<td><strong>Impacting Effectiveness</strong></td>
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<tr>
<td>Quality</td>
</tr>
<tr>
<td>- Continued increased risk for multiple unplanned admissions and increasing deterioration in health status.</td>
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<tr>
<td><strong>Impacting Efficiency</strong></td>
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<tr>
<td>Cost</td>
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<tr>
<td>- Continued lack of early intervention required to reduce the need for unplanned admissions, resulting in the PCT continuing to incur cost for these patients, which potentially could have been avoided. This can be evidenced locally by the Utilisation Management Programme Report findings (2008).</td>
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<tr>
<td>- There will be continued inefficient utilisation of resources.</td>
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<tr>
<td><strong>Service delivery</strong></td>
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<tr>
<td>- Continuation of silo work leading to the duplication of input and less optimal outcomes</td>
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<tr>
<td>- No change in current practice which tends to be transactional and reactive, does not meet the changing needs of the PCT’s patients’ expectations</td>
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<tr>
<td>- Patients will continue to access services inappropriately as they are unable to self manage effectively.</td>
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<td>- Risk of diminished recruitment of new practitioners into our services, if Berkshire West is not progressive in implementing new models of care</td>
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<td>- Lack of sharing of learning and development of staff to better support patients</td>
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<td>- Risk of being left isolated as other organisations transform service delivery</td>
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<tr>
<td>- Fail to take advantage of the additional service opportunities and service development presented by Practiced Based Commissioners. PBC will be unable to reduce secondary care admissions, due to lack of coordination of care, giving them cause to develop their own services for support</td>
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</table>

<table>
<thead>
<tr>
<th>What are the opportunities if we do change?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td><strong>Aim</strong></td>
</tr>
<tr>
<td>- Improve patient satisfaction by 10% in the 12 months after implementation of the Community Nursing Case Management Programme throughout NHS Berkshire West.</td>
</tr>
<tr>
<td><strong>Historical/Literature Review Facts:</strong></td>
</tr>
<tr>
<td>- Approximately 30% of people report they suffer with a Long Term Condition and currently this group accounts for 72% of all in-patient bed days (DH 2008). Longer spells increase the recovery time of the patient and increases the risk of health deterioration for patients with complex and multiple conditions. This results in an increase in dependency and need for health care services. (Berkshire West Utilisation Management Report 2008, DH 2008)</td>
</tr>
<tr>
<td>- Improved outcomes and patient satisfaction based on improved quality of care and better self-management of complex conditions. Effective case management leads to reduced inpatient stays and avoidable emergency admissions, as well as a decrease in the risk of health deterioration.</td>
</tr>
</tbody>
</table>
Earlier identification of those patients with long term conditions ensuring early intervention and aiming to keep patients at home longer if that is their request. Patient ownership is increased and they are empowered.

Cost

**Aim:**

- Avoid 2 admissions per month for each Band 7 nurse in the 12 months (approximately 745 admissions) post implementation of the Community Nursing Case Management Programme
- 20% reduction in A&E attendances
- 20% reduction in readmissions

**Historical/Literature Review Facts:**

- The average cost of a single inpatient admission for patients with complex conditions is £2200 (this figure is based on the mix of tariffs for long-term conditions, and excludes the Market Forces Factor). The current reactive approach to case management does not achieve early interventions required to reduce the need for unplanned admissions. As a result, the PCT incurs cost for the patients that could have been avoided. This is evidenced locally by the Utilisation Management Programme Report findings (2008). In addition, utilisation of resources remains inefficient.

- Patients in the top 0.5% of the population experienced an average of 1.9 unplanned admissions in the prior year, and have risk scores ranging from 12.4 to 37 times the average risk for the population of an unplanned admission for a chronic condition. The average risk score for this highest risk population is 18.5. Through work undertaken in other PCTs, UnitedHealth UK have developed Return on Investment models that utilise two approaches:
  1. A model that predicts reductions in unplanned admissions based on the historic utilisation of the highest risk population
  2. A model based on reports from case managers of admissions avoided. Case manager’s reports are audited by an independent GP to confirm or challenge the avoided admission.

- In other PCTs, these models have shown similar results. Additionally, recent reports in the Journal of Managed Care (February 2007) reported a 38% reduction in admissions for patients in a complex case management programme. This study was undertaken by Carnegie Mellon University.

- Based on this experience and the characteristics of the patient population, in order to achieve the £500,000 savings, the programme will need to result in 250 avoided admissions per year. This assumes that 10% of the savings from admission avoidance will be spent in other health services that would otherwise be bundled with the tariff for the inpatient spell.

Service delivery

**Aim:**

- 10% Improvement in recruitment and retention in first 12 months post implementation of the Community Nursing Case Management Programme

**Historical/Literature Review Facts:**

The project will enable us to integrate the best practice in case management within the wider community teams. This will lead to improved outcomes for patients who will be enabled to better self manage their condition. This will be achieved through working in partnership with our patients and partner organisations. Integrated teams will be developed and roles clarified, leading to improved morale and staff recruitment and retention.
### 2. Description of change

**Current process / state**

| NHS Berkshire West has three localities, which have various levels of nursing staff under different management models creating the environment for overlooking the most costly patients for case management. Within the three localities, each has put community nursing as the focal point for managing these patients, however, the patients targeted for management and the skill set of the nurses in place varies by locality. There are highly skilled professional disciplines, however these resources are arranged and managed in silos. This is not conducive to providing a collaborative team approach to the delivery of care that is required to maintain the patient in the community setting and to enable team members to be valuable and contributing members of the care team. |
Current Community Matron Workflow

Referral to Community Matron

Reading—Falls not appropriate for CM referred to Kim Parsons Team

Research information on Pt. Telephone Pt. If not suitable will sign post

Referral to GP or Social Service

CM Assessment with Home Assessment

Driven by Pt as to what is biggest problem: CM perception

Nomination Criteria
- >18
- ≥2 or more admissions within 1 year
- ≥8 medicines
- cognitive impairment
- recent bereavement
- major change in treatment in last 30 days
- lives alone

Top to Toe Assessment if Pt is very frail and ill

CM Collates information and decides what is the best course of action

Health and Social Care IC SS Acute Unit GP

Reading SS—Response Access Team—telephone referrals

Leave Pt contact information and establish flu visit

Care Plan developed

All information is documented on FACE, Dudley and GP system

Complex Pt’s Meetings at hospital, i.e., case conferences

Meetings in Pt’s home

Meeting w/Pt GP as required

Joint visits

Do not discharge

2nd CM visit—delivery of person held record care plan

Community Matrons—Band 7 Avg Case Load 45 Matron

GPs—Majority DNs Social Service Specialist Nurse Palliative Care Discharge Team (most recent discharge letter) Pts Family/Caregiver (Informal) Pharmacists RBH Consultants Discharge Letters

Prepared by: Julia Bliss, Barbara Johnson & Kelly Birch
### Strengths
- Case Management (CM) philosophy developing in NHS Berkshire West, some localities further along than others
- Some have embraced CM programmes and are progressing in implementation
- Community Matrons presently in Wokingham and Reading
- The current Community Matrons have very strong clinical skills including advanced assessment, prescribing and management.
- Community Matrons in place know what they need to deliver a successful care plan, however have a difficult time getting committed resources
- Committed Consultant Geriatrician widely respected with in NHS Berkshire West.

### Weaknesses
- Disjointed structure
- Not all networks have same resources available
- Various skill sets exist within the nursing staff at the same band level
- Lack of direction as to the roles and responsibilities for District Nurses and how they work in conjunction with the Community Matrons/Case Manager
- Variance in discipline capabilities/capacity to support a case management programme
- Variance in referral privileges and admission rights across NHS Berkshire West and Community Nurses by title and location
- Lack of direct access to Social Worker, Occupational Therapist, Adult Mental Health
- Lack of support for acquisition of funding for a patient with in Continuing Care
- Lack of a full-time Community Geriatrician for each of the localities (Currently only in West Berkshire (Newbury) area
- Need for uniformed service access across NHS Berkshire West, i.e. Rapid Assessment Clinic for Older People (RACOP)
- Lack of clinical Leadership, current managers are not aware of the difficulties that patients with complex conditions present and the work involved
- Historical lack of IT support for Community Nurses
- Lack of access to patient record unless GP practice based
- Lack of Admin support for the Community Nurses
- Lack of marketing available services in each area to practitioners
- Inconsistent, inefficient recordkeeping practices
- Loss of staff to other PCTs who are perceived as more progressive

### Opportunities
- Capitalise on the programmes currently in place to structure a consistent programme which identifies the patients most at risk for repeat hospitalisation based upon data analysis and GP/carer knowledge
- Develop more organized way to document care plan, care delivered, roles and responsibilities of care team and other disciplines
- Embrace the risk analysis model for the identification and management of patient at risk for frequent admissions
- Provide equipment for advance skilled nurses to allow appropriate diagnostic assessment
- Development of career advancement opportunity through encouraging nurses to take advantage of upskilling course.
- Evaluation of the appropriate office location of Community Nurses, GP Practices vs. NHS Berkshire West locations
- Provide business cards and promotional marketing materials to Community Nurses

### Threats
- Each locality implementing their own version of a case management programme with different selection criteria for the population to manage
- Lack of staff capacity with in nursing as well as other disciplines
- Lack of collaboration of all the disciplines to manage the care of the patient in a case management model
### Design changes to address weaknesses and capitalise on opportunities: (See future state process maps)

1. Single point of access for Case Management assessment
2. Structured Roles & Responsibilities and required skill set for the CM and DN staff by grade band
3. Development of consistent process for referral/evaluation and acceptance into case management
4. Appropriate use of Community Nursing resources for the delivery of patient care based upon the present needs of a patient.
5. Development of a Care Planning process to assign and monitor the effectiveness of a multidisciplinary care team
7. Continued process for care plan evaluation and improvement of the delivery of care by the multidisciplinary team.
Future process / state

NHS Berkshire West commissioned a single coordinated case management model across all localities, which work to consistently identify and manage the population most at risk for repeated hospitalisation. The Case Management model will utilise the present nursing staff in the most efficient and effective manner dependent upon their skill set. The model will introduce specific roles and responsibilities by nursing band to capitalise on all skill sets currently available within the organisation and identify areas where skill sets are lacking or need to be advanced. If necessary, the appropriate resources will be brought into NHS Berkshire West in order that the Trust can implement the goal of ensuring that Patients will receive the right care in the right place at the right time by the right person.

The Case Management and District Nurse structure will have the following components:

Component 1 – Definition of Community Nurse role and responsibilities and required skill set by band

In today’s environment each locality has several levels of Community Nurses (Band 7 and below) with different skills set per band and different responsibilities for care delivery Each locality utilises titles such as Community Matrons, advanced skilled District Nurses to deliver care at defined skill level.

**Required Action** – The PCT has the need to align the nurse bands with a defined skill set which further defines roles and responsibilities regarding the delivery of patient care.

<table>
<thead>
<tr>
<th>Nurse Band</th>
<th>Required Skill Set</th>
<th>Roles and Responsibilities</th>
<th>Tier(s) Assignment</th>
<th>Case Load Maximum</th>
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<tbody>
<tr>
<td>Band 7: Note: In Current review with HR based upon the Agenda for Change initiative, this chart will be completed after further development through this initiative.</td>
<td>• Advanced clinical examination skills  • Detailed medical history skills  • Independent and supplementary prescribing skills  • Case management theory and management training  • Care Coordination/Liaison training with Health and Social Care Professionals  • Long-term condition diagnostic training  • Biometric monitoring and evaluation skills  • RISC analytic tool training</td>
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<td>3</td>
<td>50</td>
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**Other Duties of Band 6/7 DNs**
- Team Management
- Team development/ appraisals
- Recruitment
- CPTs (serve as subject matter experts on projects and mentor students)
- Performance Management
- Additional leadership responsibilities
<table>
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<tr>
<th>Nurse Band</th>
<th>Required Skill Set</th>
<th>Roles and Responsibilities</th>
<th>Tier(s) Assignment</th>
<th>Case Load Maximum</th>
</tr>
</thead>
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<tr>
<td><strong>Band 6</strong></td>
<td>• Case management theory and management training</td>
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<td>3,2</td>
<td>75</td>
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<td></td>
<td>• Clinical examination skills</td>
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<td>• Long-term condition diagnostic training</td>
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<td></td>
<td>• Detailed medical history skills</td>
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<td></td>
<td>• Biometric monitoring and evaluation skills</td>
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<td></td>
<td>• RISC analytic tool training</td>
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<tr>
<td><strong>Band 5</strong></td>
<td>• Case management theory training</td>
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<td>3,2,1</td>
<td>100</td>
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<td></td>
<td>• General body systems/examination skills</td>
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<td>• Dressing changes and wound assessment skills</td>
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<td></td>
<td>• Medication administration skills</td>
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<td></td>
<td>• Biometric monitoring</td>
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<td><strong>Band 4</strong></td>
<td>• Home care task training</td>
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<td>3,2,1</td>
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<td></td>
<td>• Personal Care skills</td>
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<td>• Activities of daily living skills</td>
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<td></td>
<td>• Dressing changes and wound assessment skills</td>
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<td>• Medication administration skills</td>
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<td></td>
<td>• Biometric monitoring</td>
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<td></td>
<td>• Mobility training</td>
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<tr>
<td><strong>Band 2</strong></td>
<td>• Home care task training</td>
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<td>3,2,1</td>
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<td></td>
<td>• Personal Care skills</td>
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<td></td>
<td>• Activities of daily living skills</td>
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<td></td>
<td>• Medication administration skills</td>
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<td>• Rehab Programme training</td>
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<td></td>
<td>• Toileting skills and Mobility training</td>
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### Future process / state

**Component 2 – Case Management Patient identifications process**

**Case Management Criteria:**
- > than 18 years of age
- Multiple pathologies/diagnoses
- 2 or more unplanned admissions in less than 1 year
- Medication non-compliance
- History of recent Case Management
- Cognitive impairment/medically instability

**Required Action:**
- Establish consistent process for referral for evaluation of case management
- Establish criteria for acceptance as an appropriate referral into case management
- Establish process for referral into other levels/disciplines of care when case management criteria are not met.
Component 2 – Patient Identification Workflow

1. RISC
2. Discharge Planning
3. Referral from GP/ Social Care

CM Assessment - includes health risk assessment

CM Criteria Applied/Met

See Workflow for Component 4

Case load validation criteria
- 18 y/o
- Multiple pathologies / diseases
- 2 or more unplanned admissions
- Medication history of non-compliance
- Falls history
- Cognitive impairment / medically unstable
Component 3 – Alignment of staff with identified risk level

The aim of this component is to ensure that patients are being managed at the appropriate level by the appropriate level of staff.

**Target Population:**
- Individuals who are identified as Level 3 or Level 2 risk for repeat hospitalisation or increase utilisation of services

**Required Action:**
- Proactively identify and assess an individual’s risk based upon established criteria, health risk assessment and data analysis
- Based upon the identified risk, assign the patient to the appropriate risk level and the appropriate health professional for case management or self care education regardless of the location they call their home environment i.e. nursing or residential home, rehabilitation, own home, carer’s home, etc.

### Level 3: Case Management
- Identification of high risk individuals
- Case management process followed and case management carried out by a nurse with advanced practice skills
- Case management process requires anticipation and coordination of the patient’s care via an interdisciplinary care team
- Requires the development and ongoing evaluation and updating of the patient’s care plan
- Patient’s are never discharged from the case management service, however they may require less intensive care at various times

### Level 2: Disease-specific case management
- Identification of individuals with a single disease state or multiple disease states that requires case management to maintain the present state of wellness for their disease
- Case management processes are followed and the case management is carried out by a highly skilled district nurse
- Case management process requires anticipation and coordination of the patient’s care via an interdisciplinary care team
- Requires the development and ongoing evaluation and updating of the patient’s care plan.
- If discharge criteria are met, patient can be discharged from case management

### Level 1: Supported Self-Care
- Provide multidisciplinary support to a patient, their family or carer to develop skills and confidence to provide self care in the home and maintain their current state of wellness for their age or disease states.
- Short-term nursing care will be provided by the appropriate level of community nurse, i.e., wound care, medication monitoring, until able to self manager.
Component 4 – Proactive Care Planning and Case Management by Multidisciplinary Care Team

The aim of this component is to proactively assess and anticipate the needs of the patient in order to put care and services in place in the home to prevent hospital admission, A&E attendances and to improve the quality of life for the patient, their family or carer.

**Target Population:**
- Individuals who are at risk for repeated admissions, A&E attendances due to chronic medical conditions and their co-morbid conditions, polypharmacy, safety, social care issues, etc.

**Required Action:**
- Proactively identify and assess the individual’s needs for ongoing support in the community prior to any future hospitalisation.
- Arrange for the required community care and services to be in place to stabilise and maintain the patient in the community regardless of the patient’s home environment i.e. nursing or residential home, rehabilitation, own home, carer’s home, etc.
- Assess the patient for their appropriateness for case management and assign a case manager if criteria are met.
- If the client does not meet criteria, then refer the patient to the appropriate health and or social care service for short-term care intervention or to the appropriate District Nurse for disease state case management.
Component 4 – Level 3 Case Management Process Workflow

1. Referral to Case Manager
2. CM Assessment
3. Candidate for CM?
   - YES
   - NO
4. Care Plan developed in conjunction with GP
5. Referrals to other discipline to deliver plan of care
6. Can care be delivered at home?
   - NO
   - YES
7. CM reassesses every 3 months or as indicated due to new condition, life events
   - All disciplines report Care Plan progress via report to CM

Options discussed with GP & appropriate setting of care determined/arranged

Implement Care Plan

Update Care Plan & review with GP

Make appropriate referral for care to other discipline

Contact GP for short-term plan for PT

Prepare by: Julia Bliss, Barbara Johnson & Kelly Birch

BWPCT Community Nursing Case Management 1.doc

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Component 4 – Level 2 Case Management Process Workflow

1. Referral to Level 2 Case Manager
2. CM Assessment
3. Candidate for CM?
   - YES
     - Care Plan developed in conjunction with GP
   - NO
     - Contact GP for short-term plan for PT
4. Update Care Plan & review with GP
5. Can care be delivered at home?
   - YES
     - Implement Care Plan
   - NO
5. Review with GP
   - Options discussed with GP & appropriate setting of care determined/arranged
   - NO
     - Discharge
   - YES
6. Review of CM
   - Discharge Criteria Met
   - NO
   - Make appropriate referral for care (to other discipline)
   - YES
7. All disciplines report Care Plan progress via report to CM
   - CM reassesses every 3 weeks or as indicated due to new condition, life events and discharge eligibility

BWPCT Community Nursing Case Management
Prepared by: Julia Bliss, Barbara Johnson & Kelly Birch
Birch
Proposed scope

**Component:** The proposed Community Nursing Case Management Programme
Component 1 – Definition of Community Nurse role and responsibilities and required skill set by band
Component 2 – Case Management Patient identifications process
Component 3 – Alignment of staff with identified at risk population
Component 4 – Proactive Care Planning and Case Management by Multidisciplinary Care Team

**Description:** This Community Nursing Case Management Programme will provide a structured process for the early identification of individuals at risk for repeated hospitalisation, establish care and support services to minimise the likelihood of admission. To introduce a process to support collaborative and timely care by a multidisciplinary team, in order to maintain the patient in their home environment and improve their quality of life and that of their family and carer.

**In scope**

**Component 1:**
- Development of Roles and Responsibilities ‘rules of engagement’ document to ensure the right band level nursing staff attending to the right patient risk and clinical need
- Development of skills based training requirements by band level of nursing staff to ensure consistent professional proficiency at each band level
- Ensure integration with the Single Assessment model across health and social care.
- Training and development of appropriate staff on the programme engagement, delivery and outcomes. Nine days of mentoring provided post training.

**Component 2:**
- Process of identifying patients over 18 that should be case managed.
- Clear strategies for patients who currently receive a service and who would not qualify under the new operating model.
Proposed scope

**Component 3:**
- Process by which the patient’s clinical needs are assessed and through the care planning process the determination of the right band of nurse to care for the patients identified short and long-term needs

**Component 4:**
- The production of the full working process for the service (Operating Model) including documentation and a Return on Investment model. (See Appendix III)
- Development of a documentation system for the care planning ongoing evaluation and care plan updates

**All Components:**
- Production of programme guide materials for patients and staff.
- Production of programme KPIs.
- Work in conjunction with the Change Programme Management Group and its timescales.
- Ongoing literature production

**Out of scope – All Components**
- Staff training based upon the skills sets required, i.e., Advanced Assessment Skills
- Process for identifying patients under the age of 18.
- For the first 6 months of the programme, patients in Nursing Homes will not join the programme.
- Ongoing mentoring by UHUK staff to ensure that the programme is embedded in the PCT. This service available at any stage during implementation at additional cost, and generally requires a total of 12-18 months support.
- West Berkshire NECAAP (Newbury Elderly Community Admission Avoidance Project) which includes the Amber Project
3. Stakeholder management

Stakeholder map

![Stakeholder Map](image)
Stakeholder Impact Map

* See Appendix I – Key Stakeholders for details
### Benefits matrix

<table>
<thead>
<tr>
<th>Benefit / Stakeholder group</th>
<th>Patient / Carers</th>
<th>Community Nurses</th>
<th>Therapies</th>
<th>Social Care</th>
<th>GPs</th>
<th>Intermediate Care</th>
<th>Care Homes</th>
<th>Ambulance Services</th>
<th>OOH</th>
<th>Acute Care</th>
<th>Voluntary Sector</th>
<th>Pharmacists</th>
<th>Private Agencies</th>
<th>HR</th>
<th>Community Geriatricians</th>
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<td>Better for patients</td>
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<td>Named Health Care professional</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proactive Management of Patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widen Access to Care</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreases over-prescribing of Drugs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simpler for provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Communication</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cheaper for health economy / provider</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiencies Improvements</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 4. Financial appraisal – Cost benefit analysis - You will need to complete a separate analysis for each option

<table>
<thead>
<tr>
<th>Bid reference number(s) in Operating Plan</th>
<th>Bid 19 &amp; Bid 49</th>
</tr>
</thead>
</table>
| Agreed with finance manager | Name: Audrey Ward  
Date: 09/05/08 | Agreed with finance manager  
Name: Audrey Ward  
Date: 09/05/08 |

### Current costs

The current budget for bands 5, 6, and 7 includes 152 whole time equivalents at a total cost of $5,210,924. At the present time, there are 11.47 WTE positions vacant. This model identifies **increases** in cost from the current budget levels.

### Revenue costs

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3 (onwards)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td>£251,139</td>
<td>£430,523</td>
<td>£430,523</td>
</tr>
<tr>
<td><strong>Non-staffing</strong></td>
<td>£118,227</td>
<td>£11,610</td>
<td>£11,610</td>
</tr>
<tr>
<td><strong>Overheads</strong></td>
<td>PCT General Overhead Not Included</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Revenue implications of capital costs</strong></td>
<td>Not Applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gross costs</strong></td>
<td>£369,366</td>
<td>£422,133</td>
<td>£422,133</td>
</tr>
<tr>
<td><strong>Miscellaneous income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net costs (affordability measure)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Change Programme Management Group
### Business case

<table>
<thead>
<tr>
<th>Estimated savings</th>
<th>£1,020,348</th>
<th>£2,040,695</th>
<th>£2,040,695</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net costs (VFM measure)</td>
<td>£650,982</td>
<td>£1,598,562</td>
<td>£1,598,562</td>
</tr>
</tbody>
</table>

### Key Assumptions
- Estimated Savings Assumes 20% reduction in emergency readmissions and 20% reduction in A & E attendances associated with emergency admissions for patients 65 years of age or greater.
- This number equates to approximately 2 avoided admissions per month per Band 7 nurse.
- Assumes that 5% of this amount will be spent on additional services and supplies beyond that included in programme budget.
- Assumes that savings begin to accrue one month after staff is deployed.
- Assumes that this number is an increase over the number of admissions currently avoided by the 5 community matrons.

### Sensitivity Analysis
If the actual avoided readmissions and A & E charges are 10%, the VFM is reduced to £140,808 for Year 1 and £578,214 in years 2 and 3.

### Project Costs

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3 (onwards)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td>£50,108</td>
<td>Included in Revenue Costs</td>
<td>Included in Revenue Costs</td>
</tr>
<tr>
<td><strong>Non-staffing</strong></td>
<td>£150,000</td>
<td>£50,000</td>
<td>£50,000</td>
</tr>
<tr>
<td><strong>Overheads</strong></td>
<td>PCT General Overhead Not Included</td>
<td>£50,000</td>
<td>£50,000</td>
</tr>
<tr>
<td><strong>Gross costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Key Assumptions</strong></td>
<td>Non-Staffing includes UHUK fees and training costs. Staffing costs, with the exception of £5,000 and for staff currently in post.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sensitivity analysis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Capital costs

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3 (onwards)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None required</td>
<td>None Required</td>
<td>None Required</td>
</tr>
</tbody>
</table>

### Key assumptions

### Sensitivity analysis

### Metrics

*We will use the UH UK Return on Investment model to identify savings associated with the Community Nursing Case Management Programme.*

### Leading indicators

<table>
<thead>
<tr>
<th>Programme Component 1, 2, 3, 4</th>
<th>Name</th>
<th>Baseline (Current value)</th>
<th>Target value</th>
<th>How will you measure it?</th>
<th>When will you measure it?</th>
<th>How often / starting when?</th>
<th>Who provides the data?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2,3</td>
<td>Number of patients in case management programme</td>
<td>Number of patients currently in case management programme—<strong>242</strong></td>
<td>100% of patients in case management</td>
<td>Required reporting by case manager</td>
<td>Weekly</td>
<td>Weekly, upon Programme implementation</td>
<td>Julia Bliss/Kelly Birch</td>
</tr>
<tr>
<td>1,2,3</td>
<td>Number of patients from RISC list in programme</td>
<td>Comparison of current case management patients and RISC analytics tiering</td>
<td>Comparison of 100% of patients currently in case management</td>
<td>Monthly comparison of RISC analysis data vs. patients currently under case management</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Julia Bliss</td>
</tr>
</tbody>
</table>
## Lagging indicators

<table>
<thead>
<tr>
<th>Programme Component 1, 2, 3, 4</th>
<th>Name</th>
<th>Baseline (Current value)</th>
<th>Target value</th>
<th>How will you measure it?</th>
<th>When will you measure it?</th>
<th>How often / starting when?</th>
<th>Who provides the data?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ROI-modelled</td>
<td>% of patients in case management programme who are level 3--unknown</td>
<td>To be determined</td>
<td>Actual Caseload vs. RISC Analysis Level 3 patients</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Julia Bliss</td>
</tr>
<tr>
<td>1, 2, 3, 4</td>
<td>Audited emergency admissions avoided</td>
<td>Current savings projection model – 162 admissions avoided September 2007 to February 2008 (not audited)</td>
<td>To be audited/validated to develop benchmark</td>
<td>Case note review against admission data</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Julia Bliss</td>
</tr>
<tr>
<td>1, 2, 3, 4</td>
<td>Patient, GP and carer satisfaction</td>
<td>Develop baseline</td>
<td>10%</td>
<td>Survey Tool</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Julia Bliss</td>
</tr>
<tr>
<td>1, 2, 3, 4</td>
<td>Staff satisfaction</td>
<td>Develop baseline</td>
<td>10%</td>
<td>Survey Tool</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, inception of programme implementation</td>
<td>Julia Bliss</td>
</tr>
</tbody>
</table>
### 5. Project management

#### Key deliverables

This programme consists of three general phases:

1. A comprehensive evaluation of the current programme design and operating models, along with revisions to the models to incorporate best practice.
2. A training and mentoring programme for existing case managers.
3. A training programme for district nurse managers so that case management practices are incorporated into the care model used by district nurses. Need to evaluate the capacity for train the trainer programme through Learning and Development within the PCT. If no capacity, will look to utilise the contracts that NHS Berkshire West has with Thames Valley University and Oxford Brookes University for training modules.

More specifically, the deliverables are:

1. Identify target patients using various methods including: a predictive modelling risk tool, confirmed with a Health Risk Assessment, discussions with GPs and acute referrals:
   a. 18+ identified at Level 3 – 1st priority
   b. 0 – 17 – 2nd priority
2. Development of the case management programme to enable the integrated community teams and patients to access services appropriately and avoid inappropriate admissions
3. Documentation and completion of operating model components.
4. Creation of a stakeholder engagement plan and strategy.
5. Provide training, development and implementation support team. UH UK and NHS Berkshire West staff resources to be evaluated. Training will be ongoing as new Case Managers are recruited.
6. Project management of programme implementation for 6 months.
7. Provision of programme KPIs that will allow for better measurement of patient outcomes, hospital admissions and those admissions that have been avoided.
8. Monitoring and feedback on project progress against plan after implementation has been in place for 12 weeks.

#### Indicators of success:

- A successful case management programme for high risk complex patients of all ages which includes the following:
  - Scaleable and measurable
  - Provides return on investment
    - Quantitative
    - Qualitative
- Successfully incorporate case management approaches to district nursing for identified patients.
## Dependencies

<table>
<thead>
<tr>
<th>Project / Area / Service</th>
<th>Delivers to / for</th>
<th>What?</th>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Transformation in Clinical Services Project</td>
<td>To: PCT Provider Services For: District Nursing Service</td>
<td>Evaluation of the productivity and outcomes of the current District Nursing services.</td>
<td>Clinical Services Project Steering Group to discuss managing the interface between Case Management, Falls and Service Transformation Projects</td>
</tr>
<tr>
<td>NECAAP Project - includes the Amber Model</td>
<td>To: West Berks Locality For: Practice Based Consortia</td>
<td>A patient identification and management model.</td>
<td>Out of scope for this project</td>
</tr>
<tr>
<td>Integrate Intermediate Care with UAs Project (Social Care)</td>
<td>To: PCT Provider Services For: Social Care Services</td>
<td>Provides source of referral to Case Management service and savings from in care home service requirement from UA. Will likely also result in additional, less expensive services provided by UA to reduce admissions.</td>
<td>Clinical Services Project Steering Group to discuss managing the interface between Case Management, Falls and Service Transformation Projects</td>
</tr>
<tr>
<td>Falls Prevention Programme</td>
<td>To: PCT Provider Services For: Falls Prevention Care</td>
<td>Provide a structured process for Falls prevention, risk assessment and care planning for those at risk for repeated falls</td>
<td>Clinical Services Project Steering Group to discuss managing the interface between Case Management, Falls and Service Transformation Projects</td>
</tr>
</tbody>
</table>

## Risks and Issues

<table>
<thead>
<tr>
<th>Risk</th>
<th>Status</th>
<th>Owner</th>
<th>Mitigating action</th>
<th>Impact</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three Unity Authorities who are at differing stages of integration. This may impact the possible operating models available</td>
<td>Amber</td>
<td>Anne Owen</td>
<td>Early engagement with the Unity authorities and linking with dependent projects to maintain complementary communications.</td>
<td>High</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
### Change Programme Management Group

#### Business case

<table>
<thead>
<tr>
<th>Newbury PBC cluster who are considering introducing their own Case Management Model</th>
<th>Amber</th>
<th>Anne Owen</th>
<th>Project Manager engage with the cluster to ensure the programmes are complementary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Green</td>
<td>Julia Bliss</td>
<td>Develop clear entrance and exit strategy and communications plan for patients joining and leaving the service so that expectations are clear and explicit.</td>
</tr>
<tr>
<td>Patient concerns about changes in the services that they have previously received</td>
<td>Amber</td>
<td>Julia Bliss, Anne Owen and Kelly Birch</td>
<td>Project Manager to engage with the District Nursing leadership and maintain consistent and open communication</td>
</tr>
<tr>
<td>Not being able to engage District Nursing Staff due to the continuing commitment to developing case management model independently</td>
<td>Status</td>
<td>Owner</td>
<td>Who needs to do what to resolve?</td>
</tr>
<tr>
<td>Issue</td>
<td>TBD</td>
<td>Jan Thomas</td>
<td>EY and UHUK to discuss with Executive Sponsor and PCT leads.</td>
</tr>
<tr>
<td>Number of days required from external resource to complete the programme exceeds number of days available.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Project team

<table>
<thead>
<tr>
<th>Team member</th>
<th>Time requirement (day per month)</th>
<th>Description of role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Owen</td>
<td>1</td>
<td>Programme Sponsor - Project oversight and communication to PCT CMPG and Exec Team and Clinical Champion</td>
</tr>
<tr>
<td>Dr Steven Madgwick</td>
<td>2</td>
<td>GP Champion - Programme Lead to provide local, clinical support for the implementation and development of the programme.</td>
</tr>
<tr>
<td>Jan Thomas (external)</td>
<td>1</td>
<td>Programme Lead</td>
</tr>
<tr>
<td>Kelly Birch</td>
<td>8</td>
<td>Programme Lead</td>
</tr>
<tr>
<td>Julia Bliss</td>
<td>10</td>
<td>Project Manager - work in partnership with the UHUK lead to co-ordinate the ‘on the ground’ delivery of tasks, problem solving and engagement.</td>
</tr>
</tbody>
</table>
### Change Programme Management Group

#### Business case

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
<th>Resource Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara Johnson (external)</td>
<td>1</td>
<td>SME Lead</td>
</tr>
<tr>
<td>District nurse (1 from each locality)</td>
<td></td>
<td>0.25 per team member</td>
</tr>
<tr>
<td>Community Health Nurse (1 from each locality)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Geriatrician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Matron 1 each from Reading and Wokingham RBHFT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Authority representatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Services representatives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Change Programme Management Group

Business case

Governance

Change Programme Management Group
Charles Waddicor
(CEO)

Project Sponsor
Anne Owen
(Director of Clinical Services)

Clinical Services
Project Steering Group
Chair: Anne Owen
(Monthly)

Case Management
Model Working Group
Chair: Julia Bliss

CM Stakeholder
Counsel
(Consultative)
Chair: Julia Bliss

1st Line problem solving
Manages the day to day delivery of the project

2nd Line problem solving
Ensures the delivery of the project on time, in budget and scope

3rd Line problem solving
Removes strategic and operational blocks in the project. Overall accountability for

Escalate

Escalate

Escalate
Change Programme Management Group

Business case

Reports to | Change Programme Management Group | Approve
--- | --- | ---

Internal project governance
Escalation procedure to be used as outline by the CPMG –
Project Support (5d) ->Project Manager (5d) -> Programme Lead (3d) -> Project Sponsor (3d) -> CPMG

Who / Group

CM Stakeholder Counsel | As Needed
Case Management Model Working Group | Weekly
Clinical Services Project Steering Group | Monthly
CPMG | Monthly
Change Programme Management Group
Business case

Timelines

Major Milestones

02/07/2008
Outcome measure in place and being collated

07/07/2008
Set up – Sign off
Business Case & Stakeholder Map

25/08/2008
KPIs Agreed, Commence Recruitment

30/07/2008
KPIs signed off

30/09/2008
First Case Management Activity Report

01/10/2008
Finalize Case Management Report Format

21/07/2008
Go – implementation to commence

01/05/2008
Project Established

30/07/2008
Didactic and operating model training for Community Matrons complete

25/08/2008
KPIs tested and agreed for on-going use

19/11/2008
2 month review of progress

31/10/2008
First Case Management Activity Report

07/04/2009
Annual (6 month) Case Management Report to PEC

07/04/2009
End of Fiscal Year
31/03/2009

Project Plan sign off
07/07/2008

01/09/2008
KPI Sign Off
25/08/2008

07/04/2009
Annual (6 month) Case Management Report to PEC

07/04/2009
End of Fiscal Year
31/03/2009

Clinical reference group formed, meeting schedules in place
30/07/2008

25/08/2008
KPIs tested and agreed for on-going use
01/09/2008

30/07/2008
Didactic and operating model training for Community Matrons complete

01/09/2008
KPIs tested and agreed for on-going use
01/09/2008

31/10/2008
First Case Management Activity Report
31/10/2008

07/04/2009
End of Fiscal Year
31/03/2009

01/09/2008
KPIs tested and agreed for on-going use
01/09/2008

07/07/2008
Set up – Sign off
Business Case & Stakeholder Map

07/07/2008
Set up – Sign off
Business Case & Stakeholder Map

31/10/2008
Finalize Case Management Report Format

## Major Milestone descriptions

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1 Get Ready - PID Sign off</td>
<td>12th May</td>
</tr>
<tr>
<td>M2 Set up – Sign off Business Case &amp; Stakeholder Map</td>
<td>7th July</td>
</tr>
<tr>
<td>M3 Planning – Project Plan sign off</td>
<td>7th July</td>
</tr>
<tr>
<td>M4 Go – implementation to commence</td>
<td>21st July</td>
</tr>
<tr>
<td>M5 Didactic and operating model training for current Community Matrons complete</td>
<td>30th July</td>
</tr>
<tr>
<td>M6 Clinical reference group formed and meeting schedules in place</td>
<td>30th July</td>
</tr>
<tr>
<td>M7 Outcome measure in place and being collated</td>
<td>30th August</td>
</tr>
<tr>
<td>M8 KPIs tested and agreed for on-going use</td>
<td>1st September</td>
</tr>
<tr>
<td>M9 2 month review of progress</td>
<td>30th September</td>
</tr>
<tr>
<td>M10 Project short phase close</td>
<td>30th September</td>
</tr>
<tr>
<td>M11 First Case Management Activity Report/Analysis/Data Validation</td>
<td>31st October</td>
</tr>
<tr>
<td>M12 Finalize Case Management Report Format</td>
<td>19th November</td>
</tr>
<tr>
<td>M13 Annual Case Management Report to PEC</td>
<td>7th April</td>
</tr>
</tbody>
</table>
### Secondary Milestones

- **01/05/2008**
  - Project Established

- **09/06/2008**
  - Stakeholder & PT Engagement

- **29/08/2008**
  - Documentation Tool Deployment

- **20/08/2008**
  - Provider Oversight Cttee

- **02/07/2008**
  - Operational Delivery / KPI Dev

- **30/09/2008**
  - Training Implementation

- **15/07/2008**
  - Operational Delivery / KPI Dev

- **14/11/2008**
  - Stakeholder Meeting - Programme Validation

- **28/11/2008**
  - Stakeholder Meeting - Programme Validation

- **16/01/2009**
  - Stakeholder Meeting - Programme Validation

- **20/02/2009**
  - Case Management Report to PEC

- **21/01/2009**
  - Provider Oversight Cttee

- **22/10/2008**
  - Provider Oversight Cttee

- **29/08/2008**
  - Documentation Tool Deployment

- **22/10/2008**
  - Provider Oversight Cttee

- **14/11/2008**
  - Stakeholder Meeting - Programme Validation

- **28/11/2008**
  - Stakeholder Meeting - Programme Validation

- **16/01/2009**
  - Stakeholder Meeting - Programme Validation

- **02/07/2008**
  - Operational Delivery / KPI Dev

- **09/06/2008**
  - Stakeholder & PT Engagement

- **30/09/2008**
  - Short Project End

- **15/07/2008**
  - Operational Delivery / KPI Dev

- **28/11/2008**
  - November Case Management Activity Report Accuracy Analysis

- **22/10/2008**
  - Provider Oversight Cttee

- **21/01/2009**
  - Provider Oversight Cttee

- **07/04/2009**
  - Annual (6 month) Case Management Report to PEC

- **20/08/2008**
  - Provider Oversight Cttee

- **22/10/2008**
  - Provider Oversight Cttee

- **21/01/2009**
  - Provider Oversight Cttee

- **14/11/2008**
  - Stakeholder Meeting - Programme Validation

- **28/11/2008**
  - Stakeholder Meeting - Programme Validation

- **16/01/2009**
  - Stakeholder Meeting - Programme Validation

- **20/02/2009**
  - Case Management Report to PEC

- **31/03/2009**
  - End of Fiscal Year

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*Prepared by: Julia Bliss, Barbara Johnson & Kelly Birch*
### Sustainability/Business Continuity

The Case Management Programme requires a 1-year programme to measure return on investment. The sustainability of the project after September 2008 is dependent on:

1. Good processes that are clear and owned by the Sponsor and Project Manager.
   - Julia Bliss the PCT project manager has dedicated time for the duration of the 1-year project.
2. Communication strategy that extends beyond September 2008.
   - This will be developed and embedded by the close of Sept 2008.
3. KPIs proven and in-place.
   - In place by the close of September 2008.
4. Ongoing ownership.
   - Case Management Steering Group to continue on a bi-monthly basis for the duration of the year to ensure on-going progress is made.
5. Perceived added value by the stakeholders
   - 1 Year evaluation to be lead by the ongoing PCT Project Lead Julia Bliss.
6. Training and Mentoring support
   - Initial and ongoing support and updating of training materials as the case management Programme matures
   - Initial and ongoing support for case management mentoring for level 3 and level 2 case managers to ensure that they are delivering quality, cost effective care and appropriately anticipating, identifying and addressing patient needs
7. The various projects that interface directly (see dependencies, above) will communicate consistently to assure that patient care is maximised.

### Comments
## Appendix – I

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (H/M/L)</th>
<th>Present mindset</th>
<th>Support needed</th>
<th>Concerns / issues / resistance (with proposed change)</th>
<th>Benefits / what’s good about proposed change?</th>
<th>Actions to resolve concerns / responsibility / date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/Family/Carers of case management services.</td>
<td>H</td>
<td>N</td>
<td>C</td>
<td>Lack of regular and consistent communication with a healthcare professional – don’t know who to turn to for advice and help.</td>
<td>A named healthcare professional who can offer information and support on their specific conditions.</td>
<td>Education Programme for Community Case Management Services</td>
</tr>
</tbody>
</table>
## Integrated teams working within a case management model (e.g. district nursing)

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (H/M/L)</th>
<th>Present mindset</th>
<th>Support needed</th>
<th>Concerns / issues / resistance (with proposed change)</th>
<th>Benefits / what's good about proposed change?</th>
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<tbody>
<tr>
<td>H</td>
<td>R/N/C</td>
<td>C</td>
<td>T</td>
<td>No proactive mechanism for selection of patients&lt;br&gt;Only re-active service model currently&lt;br&gt;Limited resources to provide services&lt;br&gt;Practice varies according to whether or not there is currently a Community Matron in situ or if the District Nurse is undertaking Clinical Upskilling</td>
<td>A named healthcare professional who can offer information and support on their specific conditions&lt;br&gt;Pro-active management of patients to enable them to access services appropriately.&lt;br&gt;Efficiency improvement through integrated service teams</td>
<td>Education &amp; Training Programme for Multidisciplinary team on Case Management Programme&lt;br&gt;Raise Awareness within Multidisciplinary Team of the benefits of Case Management.</td>
</tr>
</tbody>
</table>

## Community Nurses

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (H/M/L)</th>
<th>Present mindset</th>
<th>Support needed</th>
<th>Concerns / issues / resistance (with proposed change)</th>
<th>Benefits / what's good about proposed change?</th>
<th>Actions to resolve concerns / responsibility / date</th>
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<tbody>
<tr>
<td>H</td>
<td>N</td>
<td>C</td>
<td></td>
<td>No proactive mechanism for selection of patients&lt;br&gt;Only re-active service model currently&lt;br&gt;Limited resources to provide services&lt;br&gt;Practice varies according to whether or not there is currently a Community Matron in situ or if the District Nurse is undertaking Clinical Upskilling</td>
<td>A named healthcare professional who can offer information and support on their specific conditions&lt;br&gt;Pro-active management of patients to enable them to access services appropriately.&lt;br&gt;Efficiency improvement through integrated service teams</td>
<td>Education &amp; Training Programme for community nurses on Case Management Programme&lt;br&gt;Raise Awareness within Multidisciplinary Team of the benefits of Case Management.</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Impact (H/M/L)</td>
<td>Present mindset</td>
<td>Support needed</td>
<td>Concerns / issues / resistance (with proposed change)</td>
<td>Benefits / what’s good about proposed change?</td>
<td>Actions to resolve concerns / responsibility / date</td>
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<tr>
<td>Therapies</td>
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<td></td>
<td>No proactive mechanism for selection of patients</td>
<td>A named healthcare professional who can offer information and support on their specific conditions</td>
<td>Education &amp; Training Programme for Therapies team on Case Management Programme</td>
</tr>
<tr>
<td>• Physiotherapy</td>
<td>H</td>
<td>N</td>
<td>C</td>
<td>Only re-active service model currently</td>
<td>Pro-active management of patients to enable them to access services appropriately.</td>
<td>Raise Awareness within Therapies of the benefits of Case Management.</td>
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<td>• OT</td>
<td></td>
<td></td>
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<td>Limited resources to provide services</td>
<td>Efficiency improvement through integrated service teams</td>
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<td>• ST</td>
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<td></td>
<td>Practice varies according to whether or not there is currently a Community Matron in situ</td>
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<tr>
<td>Local Authorities Social Services – Social Workers &amp; Care Delivery Team</td>
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<td>Limited co-ordinated approach to admission avoidance</td>
<td>A named healthcare professional who can offer information and support on their specific conditions</td>
<td>Education &amp; Training Programme for Social Care on Case Management Programme</td>
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<tr>
<td></td>
<td>H</td>
<td>N</td>
<td>C</td>
<td>Some ownership of the long term care issues</td>
<td>Wider access to care for additional support.</td>
<td>Raise Awareness within Social Care of the benefits of Case Management.</td>
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<td></td>
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<td></td>
<td>Limited additional or support services to refer patients.</td>
<td>Increased communication between services.</td>
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<td>Some coordinated communication between the services</td>
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</tbody>
</table>
## Stakeholder Impact (H/M/L) Present mindset Support needed Concerns / issues / resistance (with proposed change) Benefits / what’s good about proposed change? Actions to resolve concerns / responsibility / date

### GPs

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (H/M/L)</th>
<th>Present mindset</th>
<th>Support needed</th>
<th>Concerns / issues / resistance (with proposed change)</th>
<th>Benefits / what’s good about proposed change?</th>
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</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>H N C</td>
<td></td>
<td>C</td>
<td>No proactive mechanism for selection of patients</td>
<td>A named healthcare professional who can offer information and support on their specific conditions</td>
<td>Education &amp; Training Programme for GPs on Case Management Programme Raise Awareness within GP Surgeries of the benefits of Case Management.</td>
</tr>
</tbody>
</table>

#### Reasons:
- No proactive mechanism for selection of patients
- Only re-active service model currently
- Limited resources to provide services

#### Actions:
- Education & Training Programme for GPs on Case Management Programme
- Raise Awareness within GP Surgeries of the benefits of Case Management.

### Intermediate Care

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (H/M/L)</th>
<th>Present mindset</th>
<th>Support needed</th>
<th>Concerns / issues / resistance (with proposed change)</th>
<th>Benefits / what’s good about proposed change?</th>
<th>Actions to resolve concerns / responsibility / date</th>
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</thead>
<tbody>
<tr>
<td>Intermediate Care</td>
<td>H N C</td>
<td></td>
<td>C</td>
<td>No proactive mechanism for selection of patients</td>
<td>A named healthcare professional who can offer information and support on their specific conditions</td>
<td>Education &amp; Training Programme for Intermediate Care on Case Management Programme Raise Awareness within Intermediate Care of the benefits of Case Management.</td>
</tr>
</tbody>
</table>

#### Reasons:
- No proactive mechanism for selection of patients
- Only re-active service model currently
- Limited resources to provide services

#### Actions:
- Education & Training Programme for Intermediate Care on Case Management Programme
- Raise Awareness within Intermediate Care of the benefits of Case Management.

#### Efficiency improvement through integrated service teams
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (H/M/L)</th>
<th>Present mindset</th>
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<th>Benefits / what’s good about proposed change?</th>
<th>Actions to resolve concerns / responsibility / date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential / Nursing Home</td>
<td>M</td>
<td>N</td>
<td>C</td>
<td>Limited co-ordinated approach to admission avoidance</td>
<td>Wider access to care for additional support.</td>
<td>Education &amp; Training Programme on Case Management</td>
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<td>Limited ownership of the long term care issues</td>
<td>Increased communication between services.</td>
<td>Raise Awareness of the benefits of Case Management</td>
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<td>Limited additional or support services to refer patients to.</td>
<td>A named healthcare professional who can offer information and support on their specific conditions</td>
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<td>Poor coordinated communication between the services</td>
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<tr>
<td>Ambulance Service</td>
<td>M</td>
<td>N</td>
<td>C</td>
<td>Limited co-ordinated approach to admission avoidance</td>
<td>Wider access to care for additional support.</td>
<td>Education &amp; Training Programme on Case Management</td>
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<td></td>
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<tr>
<td>Out of Hours Service Provider – WestCall</td>
<td>H</td>
<td>N</td>
<td>C</td>
<td>Limited co-ordinated approach to admission avoidance&lt;br&gt;Some ownership of the long term care issues&lt;br&gt;Limited additional or support services to refer patients to.&lt;br&gt;Some coordinated communication between the services</td>
<td>Wider access to care for additional support.&lt;br&gt;Increased communication between services.&lt;br&gt;A named healthcare professional who can offer information and support on their specific conditions</td>
<td>Education &amp; Training Programme on Case Management Programme&lt;br&gt;Raise Awareness of the benefits of Case Management</td>
</tr>
<tr>
<td>Acute Hospital Trust</td>
<td>H</td>
<td>S</td>
<td>C</td>
<td>Only re-active service model currently&lt;br&gt;Some coordinated communication between the services</td>
<td>Efficiency improvement through integrated service teams&lt;br&gt;Increased communication between services.&lt;br&gt;A named healthcare professional who can offer information and support on their specific conditions</td>
<td>Education &amp; Training Programme on Case Management Programme&lt;br&gt;Raise Awareness of the benefits of Case Management</td>
</tr>
<tr>
<td>Voluntary Organisations</td>
<td>M</td>
<td>N</td>
<td>S</td>
<td>Some coordinated communication between the services&lt;br&gt;Limited ownership of the long term care issues</td>
<td>Increased communication between services.&lt;br&gt;A named healthcare professional who can offer information and support on their specific conditions</td>
<td>Education &amp; Training Programme on Case Management Programme&lt;br&gt;Raise Awareness of the benefits of Case Management</td>
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<td>Stakeholder</td>
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<tr>
<td>Pharmacists</td>
<td>H N C</td>
<td></td>
<td></td>
<td>Medication review currently in contract but not accessed.</td>
<td>Decrease over dispensing and inappropriate dispensing of medications</td>
<td>Education &amp; Training Programme on Case Management Programme Raise Awareness of the benefits of Case Management</td>
</tr>
<tr>
<td>Private Agencies</td>
<td>H N C</td>
<td></td>
<td></td>
<td>Increased requirement for service capacity</td>
<td>Cost savings on excess drug dispensing</td>
<td>Education &amp; Training Programme on Case Management Programme Raise Awareness of the benefits of Case Management</td>
</tr>
<tr>
<td>Human Resources</td>
<td>H N C</td>
<td></td>
<td></td>
<td>Increase requirement for support</td>
<td>A named healthcare professional who can offer information and support on their specific conditions Pro-active management of patients to enable them to access services appropriately. Efficiency improvement through integrated service teams</td>
<td>Education &amp; Training Programme on Case Management Programme Raise Awareness of the benefits of Case Management</td>
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<tr>
<td></td>
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<td></td>
<td>Increase requirement for support as aligning the correct nursing bands with skill set and roles &amp; responsibilities.</td>
<td>A named healthcare professional who can offer information and support on their specific conditions Access to Named Case Manager for Pts Efficiency improvement through integrated service teams</td>
<td>Education &amp; Training Programme on Case Management Programme Raise Awareness of the benefits of Case Management</td>
</tr>
</tbody>
</table>
## Stakeholder Impact and Concerns

<table>
<thead>
<tr>
<th>Stakeholder</th>
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</thead>
<tbody>
<tr>
<td>Community Geriatrician</td>
<td>H</td>
<td>S</td>
<td>C</td>
<td>No proactive mechanism for selection of patients Only re-active service model currently Limited resources to provide services</td>
<td>A named healthcare professional who can offer information and support on their specific conditions Pro-active management of patients to enable them to access services appropriately Efficiency improvement through integrated service teams</td>
<td>Education &amp; Training Programme for Geriatricians on Case Management Programme Raise Awareness within Geriatricians of the benefits of Case Management.</td>
</tr>
</tbody>
</table>
## Communication plan

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Message(s)</th>
<th>How communicated</th>
<th>When and how often</th>
<th>Feedback mechanism/ follow-up required</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those directly <strong>involved</strong> in implementing the New Case Management Programme</td>
<td>- Overview of current Case Management Programme and services and current usage of healthcare resources.</td>
<td>Introduction to the project and overview of the programme implementation plan via:</td>
<td>Monthly</td>
<td>Ensure Project Team details included on all communications and encourage feedback on proposals.</td>
<td>Julia Bliss and Kelly Birch</td>
</tr>
<tr>
<td>- GPs</td>
<td>- Overview of the new Case Management Prevention Programme including new assessment tools, pathways and services</td>
<td>Chief Execs briefing – Bi-monthly</td>
<td>- Chief Exec briefing</td>
<td></td>
<td>Regular update slots on key groups</td>
</tr>
<tr>
<td>- Other Primary Care based health professionals (e.g. DNs, Case managers, Practice Nurses)</td>
<td>- Review of the quantitative and qualitative benefits of the Programme.</td>
<td>- PCT newsletter</td>
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<tr>
<td>- Residential and Nursing Homes</td>
<td>- Review of the stakeholder’s role and responsibilities in the day-to-day implementation of the programme.</td>
<td>- PBC Leads and Governance meetings</td>
<td></td>
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<tr>
<td>- Unitary Authorities - Adult Social Services</td>
<td>- Review of the stakeholders role in the collection of data and reporting of the programme metrics</td>
<td>- Provider Services newsletter</td>
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<tr>
<td>- Therapists (physiotherapists and OTs)</td>
<td>- Review of reporting process for Stakeholder that occurs on a monthly, quarterly and annual basis. <strong>Not the role of the stakeholders.</strong></td>
<td>- PEC</td>
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<tr>
<td>- SCAS</td>
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<td>- Bi-monthly</td>
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<td>Monthly feedback to key stakeholders on programme implementation/usage and outcomes</td>
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<tr>
<td>- Westcall</td>
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<td>- System Reform Project Board</td>
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<td>- RBHFT</td>
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<td>Others as per existing schedule</td>
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<td>- Intermediate Care</td>
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<tr>
<td>Stakeholder</td>
<td>Message(s)</td>
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<td>When and how often</td>
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<td>Responsible</td>
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<td>Provider Services newsletter, West Call performance review meetings</td>
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<td>GP Newsletter – 6 weekly</td>
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<td>Existing Team Meetings</td>
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<td>Via Berkshire West Case Management Group</td>
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<tr>
<td></td>
<td>▪ Introduction of tools to support the programme</td>
<td>- PEC</td>
<td>- road show approach for GP practices and their staff</td>
<td>- TIPS meetings</td>
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<td></td>
<td>o Case Validation Tool</td>
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<td>o RISC Analysis Tool</td>
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<td>o Health Risk Assessment Tool</td>
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<td>o Referral Tool</td>
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<td>o Reporting Tool</td>
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<td></td>
<td>▪ Review of the feedback mechanisms/follow-up activity that will occur to ensure the successful implementation and continued improvement of the New Case Management Programme.</td>
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</tbody>
</table>

Stakeholder Message(s) How communicated When and how often Feedback mechanism/ follow-up required Responsible

Provider Services newsletter, West Call performance review meetings
GP Newsletter – 6 weekly
Existing Team Meetings
Via Berkshire West Case Management Group

- PEC
- road show approach for GP practices and their staff
- TIPS meetings
## Stakeholder Message(s) How communicated When and how often Feedback mechanism/ follow-up required Responsible

### Those **partners** who have a high influence and high interest in the successful implementation of the new Case Management Programme

- Voluntary Services
- **BW Case Management Group**
- **PCT Stakeholders**

- Overview of current Case Management Programme and services and current usage of healthcare resources.
- Overview of the new Case Management Prevention Programme including new assessment tools, pathways and services.
- Review of the quantitative and qualitative benefits of the Programme.
- Review of the stakeholder’s role and responsibilities in the day-to-day implementation of the programme.
- Review of the stakeholders role in the success of the programme.

<table>
<thead>
<tr>
<th>How communicated</th>
<th>When and how often</th>
<th>Feedback mechanism/ follow-up required</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Organisation. October, overview and scrutiny with all voluntary services.</td>
<td>Initial overview followed by monthly follow up</td>
<td>Ensure Project Team details included on all communications and encourage feedback on proposals.</td>
<td>Julia Bliss and Kelly Birch</td>
</tr>
</tbody>
</table>
| **BW Case Management Group**
- Regular slot on all meetings & minutes
- Patient and public involvement forum | Meetings currently 6 weekly approx. | Regular update slots on key groups | |
| **PCT Stakeholders**
- - Overview of current Case Management Prevention process along with current statistics.
- - Overview of Berkshire West’s new Case Management Prevention Programme. Including a review of the programme pathways.
- - Review of quantitative and qualitative aims of the programme.
- - Review of the stakeholder’s role and responsibilities in the day to day operations of the programme. | | Monthly feedback to key stakeholders on programme implementation/usage and outcomes | |
| **Patient and Public involvement forum**
- Meeting with all voluntary services | | | |

### Those individuals that play a **consulting** role in the successful implementation of the New Case Management Programme

- Public Health
- **Leisure and Rec**
- **Carers**
- **UHUK**

<table>
<thead>
<tr>
<th>How communicated</th>
<th>When and how often</th>
<th>Feedback mechanism/ follow-up required</th>
<th>Responsible</th>
</tr>
</thead>
</table>
| Patient and Public involvement forum
- Meeting with all voluntary services | Overview and status report provided via Exects briefing/intranet home page/monthly newsletter/regular meetings/Provider Services newsletter, provided on a monthly basis for the first 6 months and then provide 6-month updates thereafter.
- Face to face training delivered 4 weeks prior to implementation via | Perform an audit of all Case Management reported in the first 4 months to ensure the process is followed. Thereafter, sampling of reported Case Management to ensure process is continuing to be followed. Provide compliance reporting to the individual stakeholders as well as the project team. Elicit feedback from stakeholders regarding | Julia Bliss and Kelly Birch |
### Stakeholder: Individuals in the community who need to be informed of the Case Management Programme that is available in the community and how to access these services if required

- Patient/Carers
- Public in General
- Other Health Professionals
- Communicate with BME Groups and other hard to reach groups

<table>
<thead>
<tr>
<th>Message(s)</th>
<th>How communicated</th>
<th>When and how often</th>
<th>Feedback mechanism/ follow-up required</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of the stakeholder’s role in the success of the programme</td>
<td>biweekly 1-hour sessions per week for 4 weeks and then monthly educational</td>
<td></td>
<td>Non-compliance with the programme process and feedback on the tools and easy of use to perform</td>
<td>Julia Bliss and Kelly Birch</td>
</tr>
<tr>
<td>Review of the stakeholder’s role in the collection of data and reporting</td>
<td>reinforcement training for 4 months</td>
<td></td>
<td>process improvement reviews of the process.</td>
<td></td>
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<td>of the programme and reporting of the programme metrics</td>
<td></td>
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<tr>
<td>Review of reporting process for stakeholder that occurs on a monthly,</td>
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<td>quarterly and annual basis.</td>
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<tr>
<td>Introduction and review of how to use the following tools associated</td>
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<td>with the Case Management Programme</td>
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<td>• Referral Tool</td>
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<td>• Reporting Tool</td>
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<tr>
<td>Review of the feedback/ follow-up activity that will occur to ensure</td>
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<td>the successful implementation and continued improvement of the new</td>
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<td>Case Management programme.</td>
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**High level overview of Berkshire West's new Case Management Prevention Programme.**

- Review of aims of the programme that is specific to the community and the improvement in the delivery of care and services available.
- Review of how the public accesses the programme
- Review of the stakeholders role in the success of the programme
- Overview of mechanisms for evaluation and improvement of the programme on an annual basis and stakeholder’s role in this evaluation.

**Attend AGM, 29/30 Sept. Green Park in Reading.**

- Have a stand for all three projects and individuals available to answer questions.
- Consider press release when have new information; need to explain clearly how services will improve, feel different for patients

**Annual satisfaction survey for those who have access the programme in the last 12 months**
## Appendix III

### Case Management Report

<table>
<thead>
<tr>
<th>Case Load per Case Manager</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
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</thead>
<tbody>
<tr>
<td>Case Managers</td>
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</table>

### No Case Managers

<table>
<thead>
<tr>
<th>Expected Unplanned Hospital Admissions if no intervention</th>
<th>Δ £</th>
<th>Δ £</th>
<th>Δ £</th>
<th>Δ £</th>
<th>Δ £</th>
<th>Δ £</th>
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<tbody>
<tr>
<td>Expected Cost in £000 (£2200/admission)</td>
<td>Δ £</td>
<td>Δ £</td>
<td>Δ £</td>
<td>Δ £</td>
<td>Δ £</td>
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<td>Market Forces Factor</td>
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<tr>
<td>Total Expected Cost</td>
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### Expected Results:

<table>
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<tr>
<th>Expected Unplanned Hospital Admissions Avoided</th>
<th>Δ £</th>
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<tbody>
<tr>
<td>Expected Cost in £000 (£2200/admission)</td>
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<td>Expected Total Cost, including MFF</td>
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<tr>
<td>Expected Gross Secondary Care Cost Savings in £000</td>
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<tr>
<td>Expected Other Costs</td>
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<tr>
<td>Expected labour costs £000</td>
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<td>Expected Savings £000</td>
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<tr>
<td>Cumulative Savings (cost)</td>
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</table>

### Assumptions
- Months reflect full month in post after training
- Based on acute data analysis of top 1000 patients with chronic conditions (average number of unplanned admissions)
- Assume average cost of unplanned admission of £2200 based on analysis of top utilisers in acute data
- Expected admissions with skilled case managers reflects training level of nurse as well as the assumption that care pathways are in place
- Reduced Other Expense to 5% of Gross Savings based on experience to date

### Salary Assumptions

| Case Manager Salary Per Year | £ 38,000 |
| Benefits Load                | 22%      |
| Management Load              | 18%      |
| Cost Per Case Manager Per Year| £ 54,705 |
| Cost Per Case Manager Per Month| £ 4,559 |

### Market Forces Factor Assumption:

1.2275

### Average Admissions: Top 1000 patients

5

### Expected Percentage of Avoided Admissions

25%

[Note: Include consideration of knowledge and skill of staff, the availability of care pathways, etc.]

### Expected Other Expense

5%