Havering
LONDON BOROUGH

OVERVIEW & SCRUTINY COMMITTEE

REPORT

27 09 2011

Subject Heading:	Integrated Case Management (ICM)
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Policy context:	Department of Health - NHS Support For Social Care

SUMMARY

The aims of the Integrated Case Management programme (ICM) are to avoid unnecessary hospitalisations, to reduce dependence on the acute care, to maintain independence in the community, to promote self care and self control over individuals' own lives and to reduce disabilities and disadvantages arising from chronic illnesses.

There are existing links between Health and Social Care and these are being strengthened through Integrated Case Management and other Health and Social Care developments.

Major transformations include expanding the ICM care-pathway where the existing Community Matron's service is transferred directly across to the ICM pilot programme. The scheme will involve multi-professional approaches and refocus adult community nursing resources to include developing integrated care teams with case management and social care alignment including remodelling of existing community nursing teams.

The remodelled community matrons service will mean that all new individuals accepted on the ICM programme will follow a standard treatment programme and will be discharged after 12 weeks from initial referral but this process will be regularly reviewed to ensure individuals are sufficiently managed.

The team will bring together multi-agency, multi-disciplinary person centred support for adults with complex health and social care needs to enable them greater independence in the community. This will reduce the reliance on hospital admission.

RECOMMENDATIONS

Members are asked to note the content of this report.

REPORT DETAIL

1. Background

Integrated Case Management (ICM) is based on research led by Kings College. It aims to reduce demand on health and social care services through providing suitable individuals with intensive support for a 3 month period. At the end of this period individuals have increased confidence in managing their own conditions, better awareness of support available and decreased social isolation.

2. What the Team Does

ICM is for individuals who have a high risk of an Accident and Emergency (A&E) admission. The service consists of a team of Community Matrons and Social Workers who provide support to individuals in their own home, coordinate other interventions and help individuals develop a capability to support themselves. The aim is to reduce use of acute services/social care and allow people to live independently in their own homes for as long as possible.

The key to this working is identification of the right people at the right time. This is done with case finding software. GP list data is matched with data on use of hospital services. This stratifies the patient list, identifying very high risk and high risk individuals who are then clinically prioritised for referral to ICM.

When a person has been identified as suitable for ICM, an initial assessment visit is undertaken and a care plan developed. Individuals then receive intensive support for a period of up to 12 weeks, after which current experience shows that understanding and capability of managing their health and social care needs improves and they are able to live

independently with reduced use of health (both primary and secondary care) and Social Care services. Evidence also suggests improvements in quality of life and patient reported health and social outcomes.

The data (GP and acute services) is uploaded monthly to give change in use of hospital services and allows evidence to reduce cost of the acute contract. The impact will be tracked through the analysis of SWIFT data.

The project is formally supported by the GP Consortia and the Health and Well Being Board. It has also been approved by the Adult Transformation Board.

3. Method of Approach

The Integrated Case Management project (ICM) originally commenced in October 2010. However, it was introduced with a significantly lower capacity than originally proposed and the structured approach for identifying individuals (risk stratification) was not implemented. In addition no systematic collection of evidence of impact was applied. This has now been addressed through additional funding from the NHS Support for Social Care (funding made available through the Department of Health)

There is strong national evidence that ICM reduces admissions by between 25% and 50%. However, it is essential that Havering collects data of local impact to enable savings to be taken out of contracts with acute hospital providers. To enable this, the following actions have been taken:

- Structured risk stratification implemented;
- Pre ICM and post discharge Quality of Life and Patient Reported Outcome Measures tool completed by individuals;
- Audit of case notes for individuals supported by ICM to identify impact for those not identified through risk stratification;
- Monthly data extracts of hospital data to allow assessment of reduced demand for hospital services;
- Tracking of use of Social Care services through SWIFT.

4. Deliverables

The project team will have capacity to manage an annual case load of between 1575 and 2000 individuals. It will provide short term intensive support to individuals identified as being suitable for the service (through risk stratification and joint (GP/ICM) clinical prioritisation). It is expected to deliver improved quality of life, increased independence reduced demand for social care (residential and home care) and a 50% reduction in hospital admissions.

5. Project Outcomes

The ICM project is expected to deliver reduced admissions, reduced demand on Social Care, together with improvements in Social Care related quality of life and improved patient reported outcomes.

Based on an annual caseload of 1575 individuals, the net FYE savings will be £1.7m. As in 2011/12 the team will be expanded from its current size to full compliment. Monthly monitoring of the Health Analytics data will be undertaken to ensure that savings in 2011/12 are fully understood and used to inform negotiations with BHRUT.

The savings for 2012/13 will be less than the FYE as the full team will take time to build and the savings will have a time lag between validating reduced demand and changing contracts to reduce cost.

The savings will be reviewed monthly to ensure confidence of them being realised as cash releasing, allowing sustainable investment beyond the end of the project.

It is also expected that Integrated Case Management will deliver savings in Social Care by reducing demand for support packages and reduction in residential care admission. Additional evidence will be sought to validate a prediction of impact, but a conservative estimate is that full year effect savings of £150k will be realised.

This is summarised below:

Description	Health			Social Care		
	Saving 2011/12	**Saving 2012/13**	**Saving 2013/14**	**Saving 2011/12**	**Saving 2012/13**	**Saving 2013/14**
Reduced demand	£200,000	£900,000	£850,0000	0	£100,000	£150,000
Total	**£200,000**	**£900,000**	**£850,000**	**0**	**£100,000**	**£150,000**

6. Governance

The project will be monitored through the ICM Steering Group that includes representation from key stakeholders. In addition, there is an operational implementation meeting. The project will also be reviewed by the Health and Wellbeing Board.

7. Budget

The project costs are in addition to existing baseline costs of the pilot funded through the block contract with ONEL CS. Annual figures are:

Item	Baseline Budget 2011/12*	Additional Budget 2011/12	Total
	£	£	£
Totals	**218,148**	**604,274**	**822,422**

*PCT allocation to ONEL CS

It should be noted that the budget estimate for 2012/13 and 2013/14 is subject to review dependent on progress of the project and end year evaluation. In 2011/12, it is assumed that the new staff will be in post between October 2011 and December 2012. The budget requirement for the project is as follows:

Item	Additional Budget 2011/12	Additional Budget 2012/13	Additional Budget 2013/14
	£	£	£
Totals	**232,000**	**604,000**	**374,000**

8. Progress

A revised service specification has been completed and agreed through the steering group.

Community Matrons are being given direct access to Health Analytics to allow timely patient identification and measurement of performance.

GP clusters have been developed to allow allocation of named teams to each cluster.

A contract variation has been signed to allow operational implementation by ONEL CS.

Agreement reached with other ONEL PCT's to undertake shared review of services in each Borough and converge projects into a single specification to allow shared learning and simplify operational delivery of service through North East London Foundation Trust (NELFT) (ONEL CS will be transferring to NELFT in 2011).

Current performance suggests that admissions are being reduced by around 60%.

9. Next Steps

The service will be extended to all Havering residents from 1st September 2011 (the pilot was restricted to 10 pilot practices. Monthly monitoring will take place to allow for informed review in December 2011 of service effectiveness.

IMPLICATIONS AND RISKS

Legal Implications and Risks

There are no apparent legal risks or implications in noting this Report.

Hunan Resources Implications and Risks

There are no direct HR implications or risks coming from the information contained in this report.

Financial Implications and risks

The Councils MTFS contains £100k from 2012/13 rising to £150k from 2013/14 in respect of the ICM programme. There will also be savings to the NHS as a result of this strategy.

The project is funded partly from existing resources but also by Department of Health monies, of which funding levels are only as yet announced until 2013/14. Beyond such time it can not be assumed that the DoH funding will continue to be available, so appropriate strategy will need to be in place to manage the eventuality that this funding will cease. The additional budget levels as quoted within this report are indicative.

BACKGROUND PAPERS

Developing Integrated Case Management Programme – Institute for Health and Human Development, University of East London, June 2009.