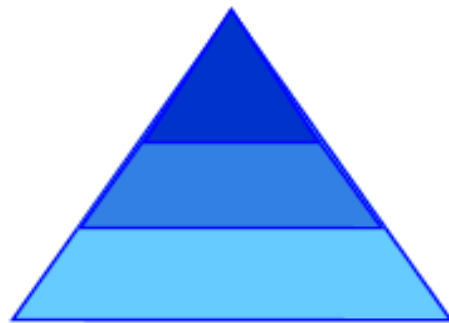


**Proactive, Planned and Coordinated:
Care Management in Scotland**



Practical guidance developed by Long Term Conditions Collaborative Programme teams in Lanarkshire, Ayrshire and Arran and Greater Glasgow and Clyde

June 2009

Aim

The purpose of this guidance and the tools within it are to provide Long Term Conditions programme teams and Community Health Partnerships with practical support to implement a Proactive, Planned and Coordinated approach to the care of people with complex, or frequently changing health and social care needs.

Background

Scotland is faced with a declining but ageing population. Over the next 25 years the proportion of the population aged over 80 years will increase to one in twelve, and one in four will be over the age of 65 years. In general the older a person becomes, the more likely they are to suffer ill health and have a higher prevalence of long term conditions.

At present, care for people with long term conditions, particularly older people, is reactive, episodic and fragmented. NHS Scotland recommends system change to deliver an integrated, coordinated and preventative health and social care system, especially for people with long term conditions.

Within the document *Better Outcomes for Older People (Scottish Executive 2005)* care management is defined ***“as a process whereby an individual's needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented, services are provided and needs are monitored and re-assessed. The individual will usually have complex or frequently or rapidly changing needs”***.

The term case management is defined by the Department of Health as *“a proactive approach focused on high-risk patients with a combination of medical, nursing, pharmaceutical care and social care needs”*.

Although there has been much debate surrounding terminology, it is clear that both terms share a prime objective of **providing the best care and support for people with complex health and social care needs.**

Good quality practice that supports holistic assessments and user and carer participation are the key to better outcomes and the first step in developing appropriate care and support plans. Regular discussions at multi-disciplinary team meetings within GP practices or other settings enable health and social care practitioners to reassess individual care plans, address any gaps in a collaborative way and make more effective use of the local team and services.

Instead of reactive or crisis care, people and their carers will receive an improved service through a more proactive assessment and care planning approach.

Delivering continuous, supportive care with a single point of co-ordination improves patient and carer experience, supports care at home and may prevent avoidable hospital admissions.

Guiding principles

The concept of proactive, planned and coordinated care management is not just about a change in the way we deliver care. It's also about a change in our way of thinking, our behaviour and culture as we move towards providing truly holistic and integrated care that focuses on outcomes.

A national Long Term Conditions Collaborative workshop was held in March 2009 to explore the core elements of a care management approach for people living with long term conditions and complex needs the output from which may be found in Appendix 2.

The participants identified some key principles that underpin the approach:

- Person centred care
- Adopting an enablement approach
- Proactive care that is multidisciplinary
- Integrated working
- An anticipatory approach to assessment, care planning and review
- Coordination of care
- Clarity about responsibility and accountability
- Communication with patient, carer, care team and all agencies
- Patient reviews that are carried out systematically, multidisciplinary and multi-agency
- Collaborative working
- Focus on people who have complex or rapidly changing health and social care needs
- Providing the most intensive care in the least intensive setting (at home if safe and appropriate)
- Ensuring access to appropriate services when required.

Participants also identified a number of critical steps and enabling actions for successful delivery of proactive, planned and coordinated care management:

- Clear eligibility criteria for the service
- Proactive case finding and use of risk prediction tools
- Protocols that enable data sharing across partners and support from practice managers to access records and prescribing information
- Timely access to a range of services to enable early interventions that improve health, provide support and care and, where safe and appropriate, help people remain or return home
- Shared protocols and pathways which empower care managers to **directly** access specialist resources such as day hospital, Allied Health Profession assessment and rapid response / falls prevention services
- A directory of relevant resources, pathways, protocols / referral templates
- Opportunities to plan and review care at multidisciplinary team meetings
- Communication with Out of Hours and interface with Acute Services.

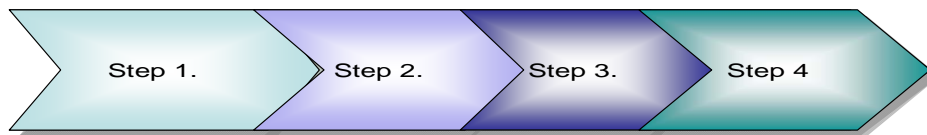
Service improvement tools and techniques to help you get started

Implementing care management is a complex and far reaching development that will involve changes to the way we deliver care and how we share and manage information flows. This guidance provides practical advice and examples of tools and techniques that will support you and your team to implement and spread care management. Appendix 1 provides an example of a detailed implementation plan.

Every project has certain phases of development and implementation – i.e. initiating, planning, motivating, executing, directing, controlling and completing.

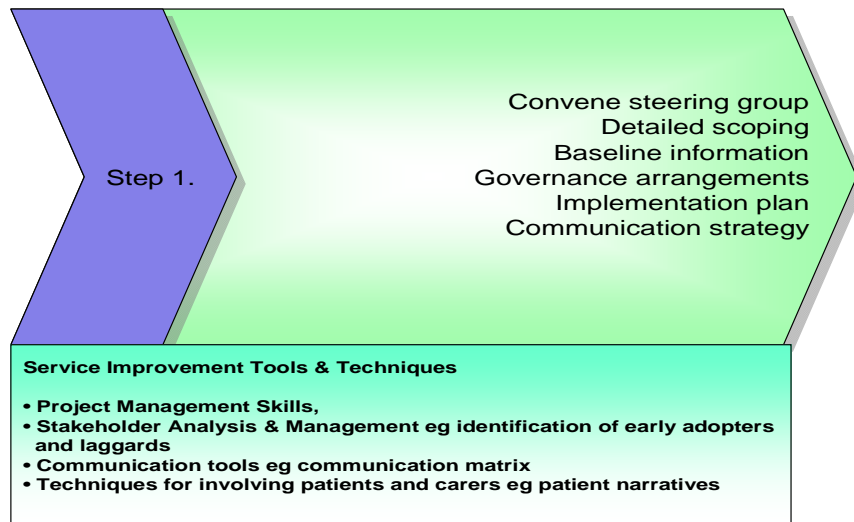
To get started, break your care management work plan into 4 manageable steps:

- Programme Governance
- People
- Processes
- Information Management



Step 1: Programme governance

Implementation may require re-organisation of groups and will involve staff training and development, all of which will require careful programme governance.

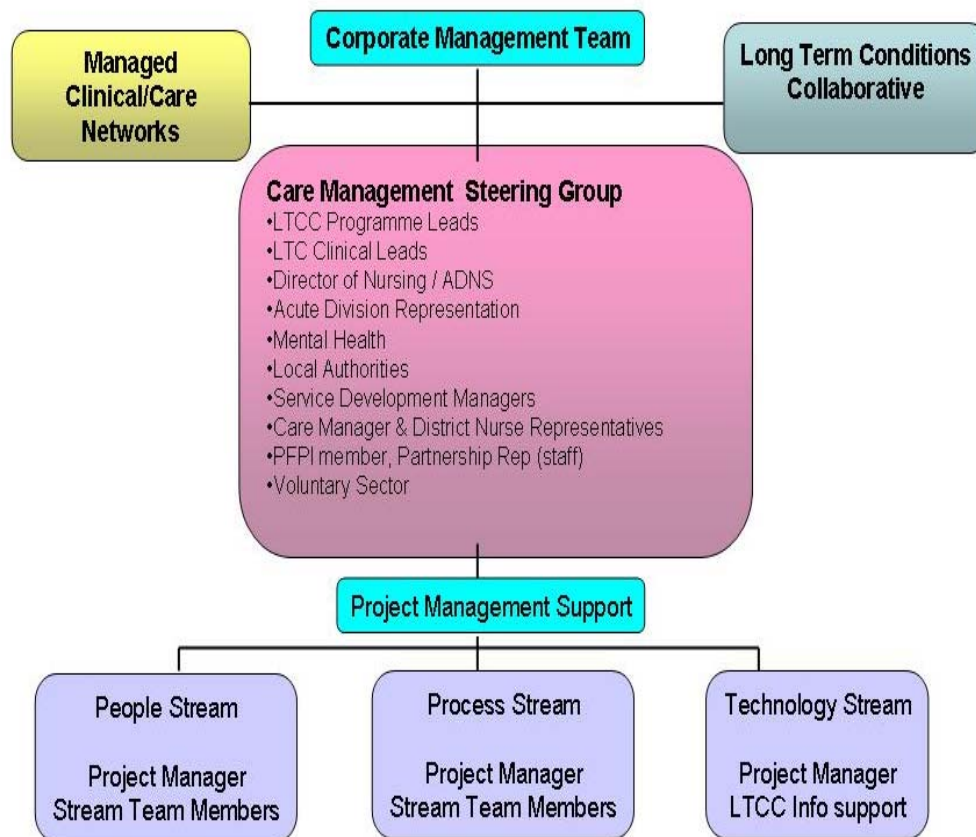


A Care Management Steering Group will help provide the required leadership, guidance and governance to support the implementation process.

This steering group should be framed within existing corporate management teams and health and social care partnership governance arrangements. It should also harness the synergy from related improvement programmes and Managed Clinical or Care Networks.

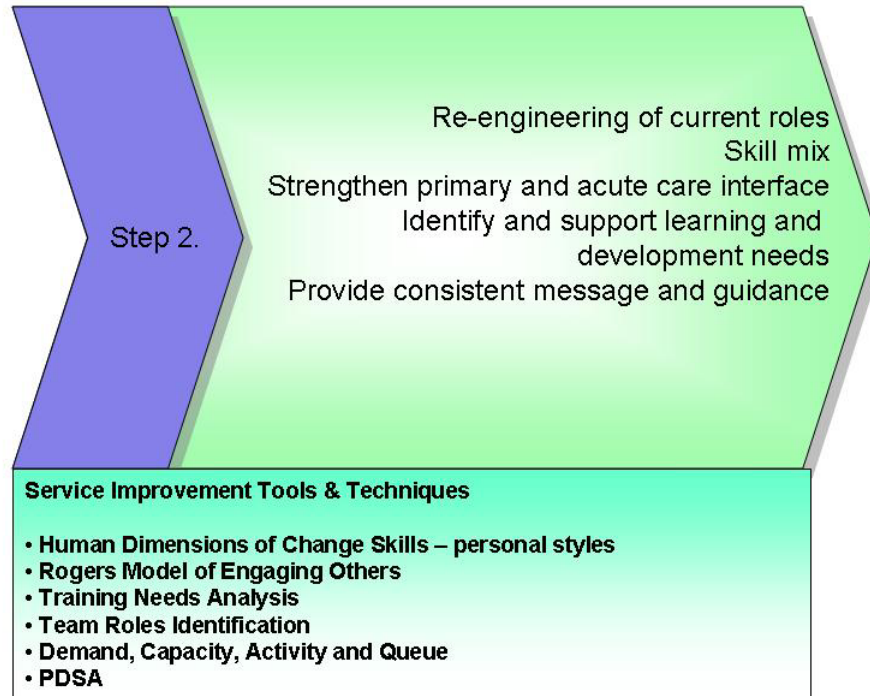
Figure 1 illustrates a possible governance structure for implementing care management and lists key stakeholders that would add value to the steering group.

Figure 1
Proposed Governance Structure



Step 2: People workstream

This builds on your stakeholder analysis and engagement and takes a systematic approach to communicating, marketing and spreading the concept of proactive, planned and coordinated care management. It will involve identifying and addressing training and education needs, developing supporting documentation, clarifying roles and responsibilities, skill mix and staffing requirements.



The National Training Framework for Care Management, published in 2006, highlights the critical role of the lead practitioner in delivering continuous, supportive care through a single point of co-ordination.

The most appropriate lead practitioner for an individual may be drawn from a range of professionals already contributing to their care (e.g. District Nurse, Community Psychiatric Nurse, Allied Health Professional, Social Worker or Care Manager). Opportunities for regular multidisciplinary team discussions within a GP practice or local area allows practitioners to work in a collaborative way, to share knowledge, identify the ‘best placed’ lead practitioner for an individual and make effective use of the local health and community care team.

Health and social care professionals require a range of competencies, skills and behaviours to support them to deliver a proactive, coordinated care management approach for people with complex or frequently changing needs. This approach should be based on the principles of enablement, self care, self management and the promotion of independence.

The National Minimum Information Standards for all Adults in Scotland (NMIS) support a holistic and outcome focused approach to assessment, care planning and review and provide a useful platform for training and development support for care management. A range of useful competencies can be found within existing frameworks :

‘National Training Framework for Care Management’ (Circular CCD2/2006):
<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/Publications/CCD0206>

Visible, Accessible and Integrated Care

Capability Framework for the Advanced Practitioner: Nursing in the Community
www.nes.scot.nhs.uk

Capable, Integrated and Fit for the Future

A Multiagency Capability Framework for Intermediate Care
www.nes.scot.nhs.uk
www.skillsforhealth.org.uk

Skill mix: Appropriate skill mix generates an efficient, flexible team able to work more effectively and in a more interdisciplinary way. Achieving the right staffing and skill mix balance within a professional discipline can free skilled practitioners such as care managers from inappropriate duties.

For example, although the whole community nursing team will be involved in managing people with complex needs, District Nurses (Band 6 and Band 7) working closely with their social care and mental health team colleagues, will have a pivotal role in delivering care management. They should be consulted and engaged throughout the implementation process. Their current role as caseload holder and team leader should continue but the orchestration of care for those eligible for care management should be considered an explicit requirement of their role. This is in line with the principles of *Visible, Accessible and Integrated Care* and can be implemented without changes to their current job description.

You can create the capacity for skilled District Nurses to provide care management by delegating particular aspects of care according to the skill mix and competencies within the community nursing team, aligned to three levels of care:

Table 1, Adapted from Supporting People with LTCs, Dept of Health 2005

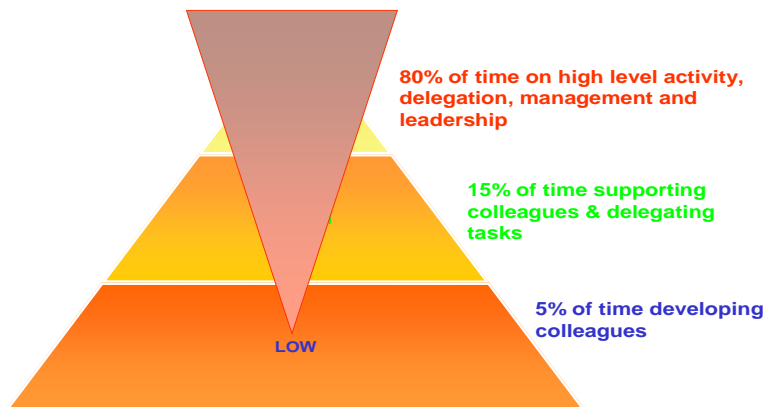
Level of Care	Definition
High	District nurses working at an advanced level of knowledge, skills and competency focusing on patients with complex needs and co-morbidities and their carers.
Medium	Community nurses with generalist knowledge, skills and competency focusing on patients who require support with disease management, from multidisciplinary teams and by liaising with specialist nurses where necessary to promote optimal condition management.
Low	Clinical Support Workers educated to SVQ level who focus on supporting people and their carers with self management

A nursing framework that supports care management

District Nurse / Care Manager

The evolving role of the District Nurse (DN) as care manager is an opportunity to make best use of the advanced level of knowledge, skills and competencies that District Nurses have developed. As a care manager, 80% of the DNs time would be focused on high level activity for patients with complex needs, promoting interagency working, delegation and supervision as appropriate (see Figure 2).

Figure 2



LTC Community Nurse (Band 5)

Most of the activities of community nurses will be focused on continuing to provide generalist support and care for people within their own homes. However as assessment is key to quality nursing care there is an opportunity for community nurses to support District Nurses in their role as care managers.

Band 3 Nurses / Clinical Support Workers (CSW)

Clinical support workers have an important role in supporting the DNs and community nurses by undertaking specific competency based, planned and predictable tasks. The current CSW development programme presents an opportunity to develop this role further.

Patient and carers

Active participation of patients and their families in managing their condition(s) can improve their health and wellbeing and help enablement. Therefore the care management approach should incorporate resources and education to support people to self manage. This can be promoted through joint agenda setting, person centred goal setting and the development and use of a tailored self management plan. Self management plans which address individual needs have been shown to improve outcomes such as self efficacy, knowledge of the condition and improve confidence in the management of that condition.

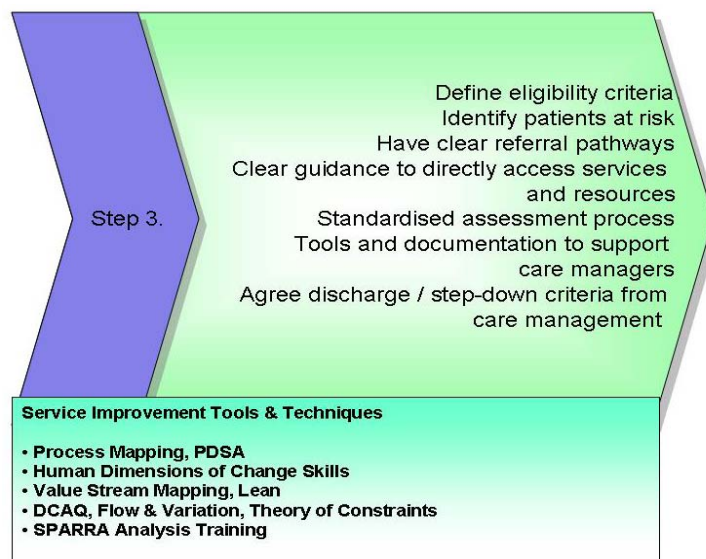
Step 3: Process workstream

This stream of work will support you to adapt nationally agreed core elements of care management to your local structures, processes and circumstances.

Collaborative or **integrated working is one of the critical success factors** for care management. The purpose of integrated working is to improve the experience and outcomes of care for people who use joint services and for their carers. Having local commitment to integrated working across organisational and professional boundaries is essential for successful implementation of care management.

This workstream will prompt you to review, redesign and streamline pathways for care management and the appropriate supporting services. This will require mapping of your processes and pathways, and identification of any gaps, waste, duplication or non value added steps. You will need to jointly agree eligibility and exit criteria for care management and negotiate timely (ideally direct) access to resources and services across acute and primary care settings and across health, local authority and voluntary sector partners.

Each local area should identify or establish a 'knowledge sharing' meeting or forum that supports a partnership approach to case finding, screening and assessment. In some local areas you may be able to use existing forums such as established multidisciplinary team meetings for older people's care, rehabilitation or palliative care services. These multidisciplinary groups will help you share knowledge, develop care plans, protocols and tools to support care managers.



Care management is most effective when applied to people who will benefit most from proactive, planned and coordinated care. The Scottish Patients at Risk of Readmission and Admission (SPARRA) tool identifies people at all ages who have entered a cycle of repeat admissions to hospital in the previous three years and predicts their risk of future hospitalisation. You can identify other people who may benefit from care management by sharing local intelligence at GP practice

and locality multidisciplinary and multi-agency team meetings and by using other community risk prediction tools. For example, the Indicator of Relative Need (IoRN), Single Shared Assessments (SSA), GP Practice disease registers and prescribing information contain useful data to identify people at greater risk.

Through discussions at multidisciplinary and interagency meetings, at practice or local area level, you can agree the most appropriate lead practitioner to follow up the assessment and care planning for each person identified on the SPARRA list. Engaging community mental health practitioners can be valuable given the prevalence of mental health issues associated with complex health and social care needs.

Not all of the people on the SPARRA list will require to be care managed. Some people, for example those who need less intensive interventions and those in low to medium SPARRA risk groups, will benefit more from other targeted approaches from a range of practitioners with the skills to support self managed care. These targeted approaches include information, education, advice and support from the practice nurse, community rehabilitation team and from local community and voluntary sector partners.

A decision about the most appropriate intervention and arrangements for review will be made following multi-disciplinary, multi agency discussion and assessment. The decision regarding care management and the appropriate level of support required should be made in partnership with the patient and carer, shared at the multi-disciplinary team meetings at GP practice and local area level, and communicated to all other partners involved in the person's care.

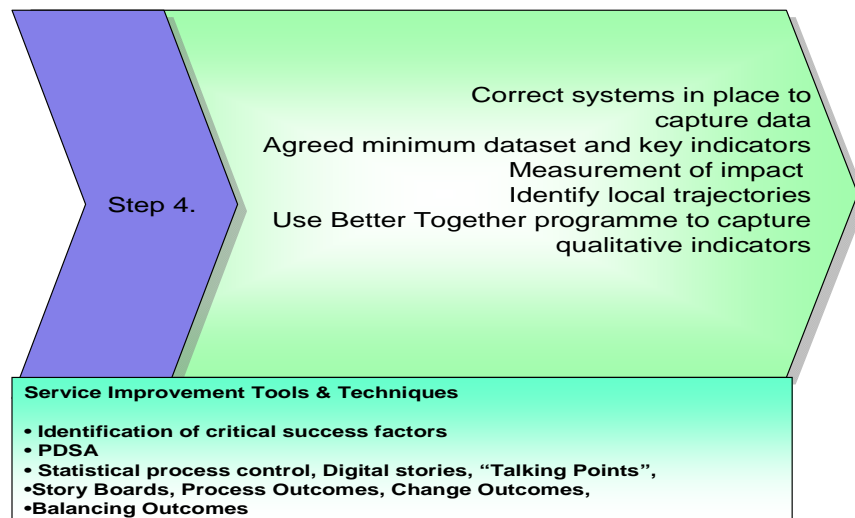
Care planning

Personalised care planning is based on a holistic process that puts the individual at the centre of their own care and focuses on helping them and their carers achieve the outcome they want for themselves (Department of Health 2009). Care planning involves discussion and reflection about goals, values and choices. It covers a continuum from self management support, care and treatment preferences and carer support to 'thinking ahead' anticipatory care planning for potential flare ups or unexpected deterioration.

Advanced care planning is a process of discussion and reflection about goals, values and preferences for future treatment when facing anticipated deterioration.

Step 4: Information management

This workstream builds on the guidance and protocols already developed by local data sharing partnerships. It focuses on the support required from information services in order to define and monitor improvement and outcome measures for care management and to share these locally and nationally. Basic requirements include an agreed minimum dataset and a list of people being intensively care managed. Benchmarking information should be agreed and information captured prospectively. The Long Term Conditions Collaborative has agreed an initial suite of improvement measures, including a care management measure, with national reporting arrangements.



Impact and Benefits

It is important to evaluate care management in terms of its effectiveness, impact on other community and acute services and benefits to patients and carers.

Local health and community care information systems can provide data on emergency admissions, bed days, homecare resource use and out of hours contacts. Some of this data will be collected routinely for the purpose of HEAT and Community Care Outcomes reporting.

Qualitative assessments of service users, carers and staff experience add another dimension to the evaluation.

Talking Points: A personal outcomes approach, previously known as UDSET (user defined service evaluation toolkit) can be used to capture the experiences of people who are care managed and will also collect outcomes data (Cook et al 2007).

Evaluation is also important to help continuously improve the system so in future you can provide even better care for people with complex needs.

Continuous Quality Improvement is a cycle of :

- Testing improvements
- Measuring and reporting on outcomes
- Analysing and reflecting on what worked or on lessons learned
- Testing more changes through Plan Do Study Act cycles
- Measuring again

You could use a Care Management monitoring template similar to the one below to report the outcomes from the quarterly SPARRA list:

Locality/Team		
Date range		
Section 1	Number	Comments
No of new patients identified from SPARRA		
Deceased		
Live outwith the area		
Live in Care Home		
Currently care managed		
Total number of patients remaining.		
Section 2		
Number eligible for a care management assessment		
Number of care management assessments carried out		
Variance		
Care management not required following assessment		
Care Managed following assessment		
Total number of new patients being care managed		
Section 3		
No of patients identified as eligible but had no assessment carried out		
Not housebound attends surgery		
Refused/moved away		
Being assessed for long term care		
Variance		

Appendix 1 Sample detailed implementation planning tool

	Key Actions	Proactive, Planned and Coordinated: Care Management in Scotland Timeframe –											
		June 2009	July 2009	Aug 2009	Sept 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010
1	Recruit local project manager												
2	Obtain local authority agreement, support and membership to Care Management Implementation Group												
3	Identify members and schedule meetings of the Care Management Implementation Group												
4	Identify lead GPs and Practice Manager of each practice, Out of Hours services etc.												
5	Identify members of DN teams and care managers												
6	Introduce Care Managers forum for peer support and communication												

Appendix 1 Sample detailed implementation planning tool

7	Identify number of people eligible for Care Management using SPARRA and local information systems												
8	Set up knowledge sharing groups at locality level: Interrogate local intelligence												
9	Acknowledge core elements of national care management model and apply locally												
10	Agree pathways to care management and discharge from care management												
11	Agree pathways to access specialist services												
12	Review competencies and identify training needs of care managers and wider teams to support care management approach												
13	Identify sources for training, agree costing and implement training schedule												

Appendix 1 Sample detailed implementation planning tool

14	Identify tools & documentation to support care managers												
15	Develop and distribute care management resource kit – consider different formats												
16	Ensure care management is addressed within the community nursing workforce review to minimise any risks												
17	Consider the impact the introduction of care management may have within the development of any workforce plans												
18	Hold a number of roadshows with stakeholders to secure buy-in												
19	Agree and produce communication strategy: provide regular progress reports and feedback												
20	Set up meetings with Senior Nurses in Acute care setting to strengthen interface												

Appendix 1 Sample detailed implementation planning tool

21	Continue to interrogate and gather intelligence from Information Services and ISD and use with local knowledge sharing groups												
22	Identify outcome criteria and agree ongoing data capture												
23	Agree and produce evaluation												
24	Add Local action												
25	Add Local Action												
26	Add Local Action												
27	Add Local Action												

Governance	
People	
Processes	
Technology	

Appendix 2: Output from Long Term Conditions Collaborative workshop, March 2009

	Eligibility	Infrastructure and principles	Education	Risk prediction and case finding	Evaluation
Governance	<p>Agree eligibility criteria</p> <p>Define performance management process</p> <p>Need core starting point</p>	<p>Manage strategic context</p> <p>Consider alongside efficiency proposals and targets</p> <p>Communications events</p> <p>Develop local implementation plan</p> <p>Establish project management structure & board</p> <p>Accountability</p> <p>Workforce development & planning</p>	<p>Communication strategy</p> <p>Incorporate Personal Development Planning / Knowledge and Skills Framework</p> <p>Develop pathways</p> <p>Skills for Care</p> <p>Competency / capability development</p>	<p>Disseminate SPARRA data to localities – password protected</p> <p>Agree data sharing</p> <p>Integrated data</p>	<p>Complete report for NHS Boards</p> <p>Complete reports for Long Term Conditions Collaborative Programme</p> <p>Capture care management digital stories</p> <p>HEAT Targets, Community Care Outcomes, High Impact Changes</p>
People	<p>Identify care managers</p> <p>Engage local services</p> <p>Engage out of hours services</p> <p>Engage acute sector</p> <p>Obtain buy-in from GPs</p>	<p>Team approach</p> <p>Consider skill mix</p> <p>Set up multidisciplinary team reviews</p> <p>Extended multidisciplinary teams to include service users & carers,</p> <p>Named link / key person</p> <p>Must be person centred – terms care/case management don't reflect this</p> <p>Focus on person centred outcomes</p>	<p>Develop education material</p> <p>Patient & carer training</p> <p>Communicate with GPs</p> <p>Communicate with Acute Sectors</p> <p>Care Managers Forum</p> <p>Joint/ interagency training</p> <p>Motivational interviewing</p> <p>Care management resource folder / directory</p> <p>Disease specific modules</p>	<p>Interrogate SPARRA</p> <p>Multidisciplinary reviews</p> <p>Use clinical judgment</p> <p>Discuss case finding measures</p>	<p>Care managers focus groups</p> <p>Case analyses</p> <p>Digital stories</p> <p><i>Talking Points</i></p> <p>Questionnaires for GPs and staff</p>

Appendix 2: Output from Long Term Conditions Collaborative workshop, March 2009

	Eligibility	Infrastructure and principles	Education	Risk prediction and case finding	Evaluation
Processes	<p>Proactive case finding</p> <p>Define patient entry/exit criteria</p> <p>One size doesn't fit all</p> <p>40 – 60% variation in eligibility criteria – need consistent thresholds</p>	<p>Use best principles of community care</p> <p>Review skill mix</p> <p>Adapt to local circumstances</p> <p>Set up local multidisciplinary reviews</p> <p>Develop generic pathways for complex care</p> <p>Use rehabilitation framework</p> <p>Defined approaches / one size does not fit all.</p> <p>Partnership working</p> <p>Link with 18 week & Mental Health Collaboratives</p>	<p>Set up care managers forum</p> <p>Joint training</p> <p>Partnership working</p> <p>Training needs analysis</p> <p>Engage Organisational Development</p> <p>Assessment and outcomes training</p>	<p>Use SPARRA with local intelligence</p> <p>Number of people eligible / identified</p> <p>Analyse number of people assessed</p> <p>Capture number of people care/case managed</p> <p>Reporting template</p> <p>Apply to real time event analyses</p>	<p>Carry out programme evaluation</p> <p>Facilitate holistic assessments</p> <p>Review eligibility criteria for appropriateness</p> <p>Audit assessments</p> <p>Partnership assessment</p> <p>Measure of integration</p>
Technology	<p>Change measure to 'targeted proactive intensive care management'</p> <p>Collect numbers of patients intensively care managed</p> <p>Define outcome measures</p> <p>Need national core starting point</p>	<p>Maintain single / central list of people being intensively care managed</p> <p>Update local PMS systems</p> <p>Apply care management coding</p> <p>Directory of Services</p>	<p>Directory of Services</p> <p>Sessions on use of SPARRA</p> <p>How to use excel</p>	<p>Use local intelligence</p> <p>Interrogate other systems</p> <p>IoRN, QOF, SSA</p> <p>A & E info</p> <p>Falls Detectors</p> <p>Link health & social care data systems</p> <p>Improve quality of data across systems</p>	<p>Obtain baseline information / benchmark</p> <p>Data collection</p> <p>QOF, SSA</p> <p>Access admission data</p> <p>Improvement measure template</p>