Leeds West CCG Business case for Recurrent or Non Recurrent Funding request.

Proposal Title: Improving Care to the Over 75s by enhancing pro-active case management

Transformation Workstream: Primary Care Transformation

Accountable Lead Officer/ Lead Director: Susan Robins, Director of Commissioning

Lead Clinician: Dr Chris Mills

Lead Finance officer; Judith Williams

Theme:
Proactive case management of patients at high risk of admission

Responsible Transformation workstream or CCG programme as applicable:
Primary Care Development Steering Group

Approval Group:
Governing Body

Business case Author:
Kirsty Turner

Recurrent or Non Recurrent funding required?:
Non-recurrent ( will transfer to BCF recurrently from 2016/17)

1.0 Description of Proposal

An enhanced service for unplanned admissions has been implemented in primary care with effect from 1 April 2014. The enhanced service places a number of additional processes on primary care but does not take into account the time or skills needed in order to effectively undertake pro-active case management.

This proposal aims to support primary care in filling the gaps within individual practices and their neighbourhood teams that will enable pro-active case management to be undertaken which is both effective and outcome driven.

The proposal funds additional nurse time so that each practice has an identified clinical care co-ordinator to deliver effective care and case management: The posts will be practice based and hosted but link out into the community working closely with the neighbourhood teams and primary and community services.

The Clinical care coordinators will:
- Be responsible for the initial assessment of patients and the formulation and review of a personalised care plan
- Collecting data relating to specific patient outcomes - these will be dependent on the patients requirements
- Key contact along with the named accountable GP for the patient
- Key person for relationship between practices and neighbourhood teams
- Attend case management meetings
- Identifying when patients have been admitted / attended A&E and review care plan accordingly
- Support discharge planning for patients who are admitted

For clarity the roles of the associated integrated team in delivering care management are:

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<th>Role</th>
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| GP                        | Clinically responsible for the care patients receive during the process of pro-active case management  
                          | Selecting cases for case management  
                          | Medical input around diagnosis, treatment planning and medicines management |
| Community Matron          | Managing and coordinating the care of complex patients relating to physical, social and psychological functioning. As well as achieving patient defined goals. |
| District Nurses / Therapists / Specialist Nurses | Providing treatment of specific conditions or problems as identified by the GP, CM or Clinical Care Coordinator in conjunction with patient defined goals |
| Neighbourhood Team Coordinator (Admin) | Ensure MDT meetings run smoothly  
                          | Assist in signposting and scheduling care across health and social care  
                          | Admin function to neighbourhood team  
                          | Non-clinician (do not take blood or perform any basic clinical assessment) |

LCH are reviewing their workforce as part of the Better Care Fund to ensure the right proportion of matrons, specialist nurses and therapists form part of the neighbourhood teams.

An alternate approach for Leeds Student Medical Practice is in development. They are developing a scheme aimed at providing acute Primary Care Mental Health Support for the Student Population.

**2.0 Rationale for Proposal**

There is an expectation nationally that CCGs will provide additional investment to support improving the care to patients aged 75 or older.

Within the Planning Guidance “Everyone Counts – Planning for Patients 2014/15-2018/19” it stated that

"CCGs will be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice, which broadly equates to £50 for patients aged 75 and over."
Practice plans should be complementary to initiatives through the Better Care Fund. “

Guidance contained within Publications Gateway Reference 01414 “A Programme of Action for General Practice” stated that; “CCGs should be using this funding to commission additional primary care services or community health services (over and above those provided under the new enhanced service) that you and other practices in your area have prioritised. It is important that you work closely with your CCG to make the best use of this £5 per patient. Any practice plans should complement the initiatives planned through the Better Care Fund for 2015/16, for which one of the criteria is an accountable professional for integrated packages of care.

The Leeds wide decision has been to put the £2.36 clinical commissioning money and add £2.64 from reserves to create a recurrent £5 per head fund.

The use and make-up of the £5 per head of population has been the subject of discussion at four Locality Development Sessions (April, May, June and July 2014). All options for utilising the funding have been explored (see options appraisal).

3.0 Intended Benefits:

- Contribution towards CCG transformation priorities
- Support for JSNA priorities
- Development of Primary Care
- Workforce development
- Quality initiative

Patient Benefits:
- Safer care delivery arising from robust and proactive care planning
- Patients / carers feeling more involved in decisions about their care
- Continuity of care for patients
- Improved management of long term problems
- Reduction in acute episode of illness and unwarranted days in hospital
- Improved patient experience of general practice
- Better and quicker discharge planning
- Remain in their own home for as long as appropriate
- Supports advanced care planning
- Supports the careers role

System Benefits:
- Creates a primary care model which is sustainable for future transformation and supports further integration of care between LCH, ASC and primary care
- Reduction in unplanned and urgent care spend
- Delivery of strategic priorities
- Support Health and Wellbeing Strategy

4.0 Key Functions/Stakeholders affected

Patients
In Autumn 2013, the CCG commissioned comprehensive research with patients, parents
and carers in GP practices to gather their views and experiences of services. The research’s purpose was to develop a tool to measure baseline experiences to allow comparisons to be made over time, and explore ways services might be developed to maintain and improve user experience in the future.

The research highlighted 10 recommendations; which were about behaviours, such as maintaining eye contact and involving patients in consultations but many of the others reflected communication as a particular area for improvement. We have considered each of the areas for improvement and reflected how we can improve the experience for patients within our proposal, for example:

This business case is based on providing additional capacity to identify a ‘care co-ordinator’ that will ensure patients feel supported to manage their condition, provide appropriate education on how to respond proactively to changes in their condition.

**GP members**

Members have been discussing the proposal as part of the last Four Locality Development Sessions (April, May, June and July 2014). We have explored with members the additional resources available (through the new joint NHS / Leeds City Council “Better Care Fund”) to support the accountable GP in improving care to the over 75s and the existing capacity of the neighbourhood teams.

Key messages that have been identified from these members’ sessions are:

- Need for neighbourhood teams to align with practice populations
  - Improve communication
  - Work towards combined team without need for referrals

- Care planning should:
  - Provide organised and pro-active care
  - Emphasis on self care and a holistic approach
  - Person centered care
  - Empower the patient to manage conditions
  - Reduce risks of crisis
  - Improve patient / staff satisfaction

- Outcomes we should expect to see
  - Improved self-management / patient satisfaction
  - Improved quality of life
  - Reduce unplanned admissions & A&E attendances
    - Reduction in falls / UTIs / medication errors
  - Increase in number of patients dying in preferred place of death

**Community service providers**

LCH have been involved in the conversations with regard to the use of the £2.64 and have been supportive of the direction of travel as it provides a key resource for practices to communicate with the integrated teams.

**Out of Hours providers**

We do not envisage any adverse impact on out of hours providers that needs consultation at this stage.
5.0 Equality and Diversity

An Equality impact assessment will be undertaken. It is not expected that this business case would have an adverse impact on equality and diversity issues. Indeed the proposal is aimed at supporting those vulnerable people who will benefit from case management.

The changes may have a positive impact if individual Practices develop approaches that target protected groups.

The Equality and Diversity Impact Assessment can be found at Appendix One.

6.0 Finance

6.1 Key investment requirements

£2.64 / patient to be available to each practice, this would complement existing spend to equate to the required £5 per head.

The total cost to Leeds West CCG would be £864,758.

NB. This only represents 37 practices as Leeds Student Medical Practice is developing a separate individual plan for utilising the £2.64

7.0 Outcomes and Outputs

Impact of Proposal – Activity/ Service/ Quality benefits

Patient
Improvement in the Patient Reported Outcomes Measures (Appendix Two)
Increase in number of patients dying in preferred place of death

Acute Activity
Reduction in A&E, MIU and OOH attendance
Reductions in admission and length of stay

Primary Care Activity
Increase in overall rates of patient contact with changes in the split between; acute and planned interactions; GP to Nurse interactions.

Social Care Activity
Increase social work input
Reduction in long term placement

Elective Activity
Secondary Care Services – neutral or reduction in outpatients and planned treatment
Community Services – increased use of nursing and therapy services

Process Measures
How cohort chosen and how and when it changed over time
Rate of turnover in the cohort
Number of care plans completed and review rate
Actions and goals set and achieved

It has been projected that if the city were to continue on its current trajectory and in five years' time the city would be spending over £163million on emergency admissions. The city has set itself a target of reducing the number of emergency admissions to hospital by 15%.

8.0 Metrics

We would use the metrics from the Better Care Fund who have identified 5 national measures, which are:

- National Measure 1: Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population
- National Measure 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- National Measure 3: Delayed transfers of care from hospital per 100,000 population
- National Measure 4: Avoidable emergency admissions
- National Measure 5: Patient/service user experience

We will also complement the above list of high level outcomes with a local metrics dashboard. Please see Appendix Three.

9.0 Impact of Proposal – Cost Benefits

We cannot currently identify who is on the 2% list of each practice and therefore we are unable to map that against current activity levels.

We are able to benchmark non-elective activity against other CCGs nationally through the NHS Better Care, Better Value Indicators. Through this the Opportunity Locator has identified that by moving to the 50th percentile, will release £1,156,863 savings (527 admissions) for admissions purely relating to ambulatory care sensitive conditions (based on Quarter 4 13/14).

We aim to have an impact on admissions relating to ambulatory care sensitive conditions due to the effective and pro-active case management of patients with long term conditions and ensuring that admissions are avoided (due to the presence of emergency care plans etc).

10.0 Key Risks – to success of the proposal

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<th>Mitigation</th>
<th>RAG</th>
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<tr>
<td>Timescale for implementation / sustainability; If approved the proposal will be</td>
<td>Leeds West CCG is in the process of commissioning extended primary care and therefore the future sustainability of this scheme</td>
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established from Quarter 3 2014/15 and will run for a period of 12 months, this may not be sufficient time to be able to demonstrate effective outcomes in order to guarantee the future commissioning via the BCF could be incorporated within the longer term development of devolved budgets.

Leeds West CCG through the Primary Care Transformation agenda will also look to co-commissioning the Enhanced Service for Unplanned Admissions with the Area Team to develop a scheme which is outcome driven

**Workforce;** There is a risk that the appropriate workforce is available with specific skills

The scheme has been discussed at a number of locality development sessions and practices have been identifying the appropriate skills within practices. Many practices have already gone at risk and recruited additional staff either through increasing hours or through temporary contracts.

A number of practices have already agreed to share staff across practices.

**Delay in implementation;** due to the level of engagement in the development of the business case, practices have already developed care plans in order to meet the enhanced service deadline of 30 September

The focus of this business case is to develop the quality of the care plans and therefore we would ensure that all practices, once they have identified the care co-ordinator review the care plans to ensure these have been co-produced with patients effectively

**Links to other providers;** LCH/ASC may have already developed their plans (as part of the BCF) and General Practice may be excluded

The CCG is actively engaged in the LCH CQUIN Implementation Group and is ensuring that primary care is appropriately represented to ensure that all plans support integration.

### 11.0 Mitigation against Risks

As above.

### 12.0 Options appraisal

**Option 1 – Proactive case management of patients at high risk of admission (preferred option)**

Develop a scheme which is open to all 37 practices to support pro-active case management which is effective and outcome driven by funding additional nurse time so that each practice has an identified **clinical care co-ordinator** to deliver effective care and case management: The posts will be practice based and hosted but link out into the community working closely with the neighbourhood teams and primary and community services

*Strengths of Option 1:*

- Equitable to all practices and patients – developed in consultation with member practices through locality development sessions
- Supports improved working relations between member practices and LCH/ASC to
further develop integrated care

- Provides protected time for practices to implement case management in a pro-active way, allowing practices to develop their systems internally
- Provides a point of contact for LCH/ASC and ensures practices are represented at the MDT case management meetings
- Provides practice focused resource to support the 2% and over 75’s
- Provides practices with an opportunity to commission additional Community resources directly (if they wish to do this)

**Weaknesses of Option 1:**

- Workforce availability to support case management
- May not be able to easily unpick and describe cost savings from elsewhere in the system
- Measuring outcomes is more of a challenge

**Option 2 – Invest in additional Community Services**

Practices had initially identified that they would like to see additional investment in community services to support practices directly.

**Strengths of Option 2:**

- Promotes the value of Community Services within General Practices and could further help support integration
- Utilises the expertise of Community services

**Weaknesses of Option 2:**

- Additional investment in community services had already been identified through the BCF
- Practices requested a workforce plan for LCH to understand where gaps currently exist and the overall plan for investment
- Lack of (practice) control over the resources with competing priorities
- Lack of confidence in ability to deliver, practices already feel frustrated with community services not turning up for meetings
- IT Logistics i.e. inability to access EMISweb

**Option 3 – Integrate Pro-active Case Management with the Extended Hours Business Case**

The CCG has developed a business case to support extended access in general practice which is being progressed through the relevant processes through a separate business case. There is an opportunity to increase the value and outcomes for this business case by incorporating the two schemes.

**Strengths of Option 3:**

- Simplifies internal processes
- Enables more effective evaluation – as similar outcomes will be sought

**Weaknesses of Option 3:**

- The two schemes are being funded differently; it is envisaged that the £2.64 is made recurrently through the BCF
- Lose credibility as members have asked that this is kept separate
An analysis of the strengths and weaknesses of the above options indicate that on balance option 1 is the recommended course of action and that options 2 and 3 should be disregarded.

13.0 Procurement

Consideration was given to a requirement to tender this service, as required now for all community services from 2014/15. The exception is where a service needs to be list based. We propose that this service, as an extension to an existing list based general practice core service, fully meets the definition of needing to be a list based service. Tendering for procurement of this service is therefore not required.

14.0 Workforce

The role of a ‘clinical care coordinator’ has been identified as a gap for practices in terms of delivering high quality case management. We have estimated that for a practice of around 8,000 patients they will require at least 20 hours of clinical care co-ordination per week, it is likely that practices will identify this role from within existing resources (increase hours of existing employed nursing staff) or through recruitment of additional staffing.

Workforce and recruitment has been identified as a particular risk and practices are already taking action to mitigate any risks with regard to this.

We will encourage practices to work together when looking at recruitment and identify opportunities for the joint appointment of staff and appropriate skill mix of the clinical workforce.

15.0 Evaluation plans

It is anticipated that this proposal will contribute to the citywide indicators and overall achievement of the overarching outcome of the Better Care Fund (BCF).

Through the BCF, the CCG will assess whether Leeds as a health and social care system is working towards achievement of the system and BCF outcome as quantified through the citywide indicators below. It is not possible to attribute a direct causal link between individual practice-level interventions and the achievement of citywide indicators. Practices will however be required to use information and data to evaluate the extent to which the planned intervention or service have achieved what they set out to achieve.

16.0 Exit Strategy

The 2014-15 planning guidance makes reference to a £5 per head to be spent specifically to focus on the over 75 year olds. In Leeds there has been agreement that the funding would be put into the Better Care Fund recurrently from 15-16 and evaluated as part of the Better Care Fund arrangements.
The success of this scheme will therefore need to be agreed through the Better Care Funding arrangements and therefore practices will need to be clear when recruiting staff with regard to the risk to the continuation of the service.

Leeds West CCG is in the process of commissioning extended primary care where we envisage that the longer term sustainability of that scheme will be supported by practices choosing to enter a risk sharing arrangement across groups of practices and eventually taking ownership of delegated budgets for elective, non-elective and prescribing expenditure. Therefore the future sustainability of this scheme could be incorporated within the longer term development of devolved budgets.

Leeds West CCG through the Primary Care Transformation agenda will also look to co-commissioning the Enhanced Service for Unplanned Admissions with the Area Team to develop a scheme which is outcome driven and rather than having two separate schemes (the enhanced services and this scheme) look to have one overall scheme which is qualitative driven.

17.0 Appendices

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Appendix 1. Equality Impact Assessment
Appendix Two - Questions to use in the Care Plan for Older People.

For each of these questions, which answer best describes how you feel. Or can be completed in a questionnaire or during an interview.

1. How is your health these days?
   Overall, my health is very good. □
   I have a few health problems but I am ok most of the time. □
   My health could improve a little □
   My health could improve a lot □
   I am not very well but there is nothing that needs to be done for my health □

2. Self-Care
   I have no problems with self-care □
   I have some problems washing or dressing myself □
   I am unable to wash or dress myself. □

3. Usual Activities (e.g. work, study, housework, family or leisure activities)
   I have no problems with performing my usual activities. □
   I have some problems with performing my usual activities. □
   I am unable to perform my usual activities. □

4. Pain/Discomfort
   I have no pain or discomfort □
   I have moderate pain or discomfort □
   I have extreme pain or discomfort. □

5. How are your social relationships these days?
   I have as much social contact as I want □
   I often visit with friends or relatives but I would like to socialise a bit more □
   I have visitors but I would like a few more people I feel close to □
   I feel lonely some of the time □
   I feel lonely a lot of the time. □

6. How well are you managing financially these days?
   I am living comfortably □
   I am doing alright □
   I am just about getting by □
   I am finding it quite difficult □
   I am finding it very difficult. □

7. How is your home?
   I am very happy with my home □
   My home is good □
   I have a few problems with my home but I manage ok □
   My home needs to improve a little □
   My home needs to improve a lot. □
8. Mobility
   I have no problems in walking about   □
   I have some problems in walking about   □
   I am confined to bed   □

9. How well are you managing your health condition these days?
   I don't have a health condition   □
   I am managing my health condition very well by myself.   □
   I am managing my health condition very well with help from other people.   □
   I need a bit more help to manage my health condition   □
   I need a lot more help to manage my health condition   □

10. In the last 6 months, have you had enough support from local services or organisations to help you to manage any long-term health condition(s) ?
    Please think about all services and organisations, not just health services
    Yes, definitely   □
    Yes, to some extent   □
    No   □
    I haven’t needed such support   □
    Don’t know / can’t say   □

11. How confident are you that you can manage your own health?
    Very confident   □
    Fairly confident   □
    Not very confident   □
    Not at all confident   □

12. Thinking about both the good and bad things that make up the quality of your life, how would you rate the quality of your life as a whole.
    Very good   □
    Good   □
    Alright   □
    Bad   □
    Very bad   □

13. Anxiety/Depression
    I am not anxious or depressed   □
    I am moderately anxious or depressed   □
    I am extremely anxious or depressed   □
APPENDIX 3   METRICS

Acute
Non-Elective Activity
A&E attendances
- Adult
- Children
- Frequent Flyers
MIU attendances
Admissions
- Acute conditions not requiring admission
- LTC hospitalisation rates
- Elderly
- General Medicine
- Respiratory
- CDU
- General Surgery
- Urology
- Orthopaedic
- Children's
- 30 Day readmission rates
- Length of Stay

Other Providers
Shakespeare Walk in Centre
LCD (OOH)
111
Social Care - Long term placements

Acute
Elective Activity
Outpatient Rate
New / follow up

Other Providers
Healthy living services
Physio
OT
Falls
Pulmonary rehab
Cardiac rehab
Structured educational programmes

Patient Experience
Annual patient survey
Patient satisfaction – patient level / patient groups
  - % of all GP appointments on day of request or day of choice
  - % of appointments with preferred GP

Friends and Family Test

Staff
Staff survey
Staff morale survey (transformation appetite)
WTE / numbers employed

Prevalence
LTC / Cancer

Acute
Non-Elective Activity

Primary Care
Opening hours by weekday
Total contacts split by staff group
- Face to face appointments
- Home visits
- Telephone appointments
- Email appointments