

APPENDIX 1

CASE MANAGEMENT for Long Term Conditions and Health Reviews for those aged 75 and over Local Enhanced Service (LES)

Rotherham Clinical Commissioning Group SERVICE SPECIFICATION YEAR 4

Service	Case Management Local Enhanced Service Y4
Commissioner Lead	Dr Jason Page, SCE Primary Care Lead
Provider Lead	<Practice Name>
Period	From 1 st April 2015 until 31 March 2016
Date of Review	October 2015
Author	Dawn Anderson / Jason Page
Date signed off by Governing Body	1 April 2015

1. Summary

This document gives details of the Case Management Local Enhanced Service for Year 4. Changes from 2014/15 are based on the following:

- Feedback from member practices and the results of the evaluation event held on October 22 2014.
- Feedback from practice-wide case management meetings
- Feedback from the LMC Liaison meeting
- Alignment with other strategic areas of commissioning, such as GP Workforce planning.

What are the changes to this year's scheme?

- The main amendment to the scheme for this year is the increased level of payment for the ¹care home cohort of patients. **These patients are currently included in the scheme until such time as a new separate enhanced service is implemented.**
- There has also been clarification about the way that the annual health review (for those aged 75 and over) can be delivered.

Overview of the scheme

There are two distinct elements to this enhanced service:

1. **Full Case Management**
2. **Annual Health review /check for those aged 75 and over**

Practices will be expected to deliver both elements of the scheme.

1. Full Case Management

¹ 'Care home' here refers to those patients in elderly residential and nursing homes and those in Elderly Mentally Impaired homes (EMI). A full list of those homes is provided in the useful information.

It is anticipated that up to 5% of the practice's population will require **full case management**. This initial cohort of patients must be identified as follows:

The first 3% of patients must comprise of all of the practice's nursing home and residential home patients plus patients identified using the risk tool. Once this 3% is reached, the further 2% can be a combination of patients selected from the risk tool and those which the GP deems to be clinically appropriate (irrespective of risk score).

2. Annual Health Review/Check

This will be for all those **aged 75 and over** who are not included in the full case management cohort, as the national priority is to identify a named GP for everyone aged 75 and over.

Important points to note about the service

- Practices are required to report numbers for each of the levels and the categories of patient (i.e. risk, nursing/residential home and clinical judgement, over 75s).
- Case management is the active management of a changing cohort of patients, for new patients to become eligible some existing patients need to be 'discharged'- see Review section.
- To increase the impact of the Case Management LES, practices are required to make the summaries available to any clinicians directly involved in the care of the patient (including TRFT clinicians)- see section 3.2.

2. Scope

2.1 Aims and Objectives of the LES

The objectives of the LES are summarised below:

- To reduce the unnecessary utilisation of secondary care services and therefore cost
- To facilitate improved quality and co-ordination of care in the community setting
- To improve the quality of care for older people
- To improve self care by patients

The approach being taken by this LES is as follows:

Full Case Management

1. Identification of the appropriate patient cohort using clinical systems, risk profiling/stratification and clinical judgement.
2. Multidisciplinary team working to create an integrated case management plan made visible to all relevant services electronically and a paper copy to be kept in the home of the patient.²
3. Promotion of self-management.

Annual Health Review/check for those aged 75 and over (not already being case managed)

1. Identification of patient cohort using current clinical systems
2. Prioritisation of reviews using risk tool
3. Population of the '75 and over' review template (recommendations of how this is done

² The trigger for payment for a new case management patient is the plan being placed in the patient's home

are given in Appendix 1)

4. Interview with patient to create a comprehensive patient care review including a named GP or suitably qualified nurse (the specifications for this nurse are shown in section 3.3)
5. A copy of the Health review to be offered to the patient in a folder to be kept in the patient's home. *If declined, this should be kept on the clinical system*
6. Review on a yearly basis

There may be instances where patients move into the full case management cohort. For those 75+ who may be deemed as needing full case management the justification must be clearly documented but then the higher payment can be claimed. *If this occurs within one month of the review, then the higher payment only will be payable.*

2.2 Service Description

The Case Management LES arrangements will:

- Be for the provision of services over and above core services.
- Be available to all practices for up to 5% of their practice population (if patients meet the required criteria).
- Where practices reach the 3% (all nursing/residential home patients plus risk tool patients) they can add a further 2% which can be a combination of patients identified using the risk tool and those judged by the GP to be at risk of admission.

The key principle of this LES is that the GP takes on the care 'conductor/co-ordinator' role.

This will incorporate the following:

1. The GP to act as care co-ordinator: Proactive role. The GP should be 'conducting' the patient's care at all times.
2. The GP to understand the role of all other parties involved in the care of the individual patient and to be pro-active in communication

N.b: Tasks may be delegated, but co-ordination role cannot. The role of Case Manager for individual patients may be allocated within the wider team at any particular time.

Services over and above core services-

This LES will not attempt to define core service. Practices are required to demonstrate a proactive case management approach to the selected cohort of long term conditions patients.

2.2.1 Population Covered

This LES has been offered to all practices in Rotherham and the relevant subset of patients.

2.2.2 Exclusion Criteria

There are no exclusion criteria however there may be some patients with a high risk score for whom the practice feel case management would be inappropriate because they are already receiving comprehensive care (e.g. renal patients / anti-coagulation patients).

Where this is the case, practices may choose to exclude these from the case management LES.

2.2.3 Interdependencies with Other Services

Evidence shows that integrated care teams can enhance existing care arrangements, reduce unscheduled hospital admissions and help patients manage their own conditions. Multi-Disciplinary Team meetings should contain a mix of staff relevant to the patients being discussed such as practice, community, Social Work and voluntary sector. Practices may also invite other services to attend the meeting as they deem appropriate, such as Physiotherapy, Occupational Therapy, Drugs & Alcohol or Mental Health.

Practices must organise the meetings with a regular schedule shared at least 4 weeks in advance to

allow all members to organise their attendance (a central diary will be held on the CM website for this purpose). Each practice will need to have a GP at a monthly meeting for 10 of the months of the year.

Many practices already have Gold Standard Framework meetings. It is acceptable to run the MDT meeting on the same occasion, but there must be two separately minuted discussions and a separate patient group discussed for the CM. The MDT meeting CAN be used to discuss patients from the Case Management LES.

Some case management patients may be or become End of Life Care patients in which case the case management plan should be amended to include additional details such as advanced directives and preferred place of care.

2.2.4 Geographical Population Served

This LES is open to all patients registered at Rotherham practices who are taking part in the LES.

2.2.5 Timescale

Funding for Year 4 will be available from 1st April 2015 to 31st March 2016.

2.2.6 NHS England national contract

This agreement is separate and in addition to any agreements between the practice and NHS England.

3 Service Delivery

3.1 Service Model

The service model for Year 4 can be found in Appendix 1.

3.2 Record Keeping and Confidentiality

Practices should work with the reporting tools and templates that have been provided for their current medical system. In particular the specified READ codes must to be used to facilitate reporting and claims. A minimum dataset is included at appendix 2. **Practices should ensure that those patients who are on the scheme have consented to the sharing of their data with relevant members of the multi-disciplinary team and other clinicians involved in direct patient care such as the Care Co-ordination centre** and are aware that their anonymised plans may be audited by members of the Clinical Commissioning Group (CCG). Once patient consent has been given, **this should be done immediately**, by setting the relevant sharing protocols in the practice's clinical systems.

A copy of the current plan/review must be kept in a red folder, at the patient's home/residence. As agreed with SY Emergency Services, the front two pages of the care plan, containing the key relevant information should be on yellow paper.

3.3 Workforce

The lead for the LES must be a suitably qualified and experienced GP. With specific reference to the annual health review for those aged 75 and over, the 'clinician' here should be a suitably qualified and experienced GP or a nurse with one of the following qualifications:

- *Specialist Practitioner General Practice Nursing recorded on NMC register*
- *Primary Health Care Diploma*
- *Cardiovascular and Respiratory Diploma*

If a practice experiences difficulties in delivering the LES, such as staffing shortages they should

contact the Project Lead as soon as possible to discuss and agree a solution such as temporary withdrawal from the LES.

3.4 Service User Engagement

Promotion of self-management is a key component of the LES. Practices should show evidence in the case management plans of having promoted self-care and also taken account of the patient's views. In addition, to assist with the evaluation of the LES, practices must ensure that the feedback questionnaire is distributed and a minimum of 10 responses are received. The questionnaire will be distributed to practices in April (questionnaire to be supplied; practices will need to select patients who have been on the scheme for a minimum of 3 months, and either email a link to the survey or send to patients with an SAE for their direct return to the CCG).

3.5 Note on the Risk Stratification tool

Practices will continue to use the Risk Stratification tool as the main method of identification of the patient cohort. Any change of supplier for the risk stratification tool will not be made without consultation with practices.

The Risk Stratification tool is used because there is evidence that computerised prediction tools are more accurate than clinical opinion at predicting the risk of admission. The tool calculates the risk of all patients across Rotherham and puts them in 3 rankings. Level 3 (the highest risk) and level two patients make up the top 5% of Rotherham patients.

The LES requires that part of the first 3% of the practice's LES patients are selected using the Risk tool. For the vast majority of practices all these patients will be level 3 and level 2 patients. If there are any practices that have less than 3% of their patients in level 3 and 2 they should discuss this with the CMP lead GP.

3.6 Additional supportive information on the CCG Intranet

Information to support the scheme can be found on the intranet here:

<http://intranet.rotherhamccg.nhs.uk/case-management.htm>

4. Outcomes and Outputs

4.1 Outcomes

The key demonstrable outcome of the LES must be a reduction in non-elective activity across all patients of practices which are part of the LES, which is attributable to the scheme. Practices will be provided with a regular report showing their secondary care activity against other practices.

The 15/16 scheme will be reviewed in October 2015 on the basis of its contribution to keeping hospital admissions within affordable levels and its delivery.

4.2 Outputs

The deliverables for the LES are:

Full case Management:

1. Each patient under full case management has been discussed at an MDT meeting (if appropriate)
2. All patients will have had a face to face meeting with the GP responsible for their care and/or the relevant case manager
3. A care plan has been created and a copy of the care plan will be left at the patient's home
4. An appropriate mental health assessment

Annual Health Review for those aged 75 and over:

5. The relevant template has been completed
6. All patients will have had a face to face meeting with the GP responsible for their care and/or a suitably qualified nurse (see section 3.3)
7. A copy of the template/care plan will be offered to the patient to keep at their home
8. An appropriate mental health assessment³

4.3 Data

Practices will receive an electronic survey for completion by the 15th of each month, to provide the following data for monitoring and payment purposes:

(Please refer to minimum dataset for relevant codes and report numbers)

- Number of new care plans done for residential and nursing home patients
- Number of new care plans done for patients at practice discretion
- Number of new care plans for the over 75s
- Number of plans reviewed (one claim per patient every 4 months) separated into those for care home (nursing and residential) patients and other
- The total number of care plans the practice currently has in place in patient's homes subdivided into: patients identified on basis of risk tool, nursing home & residential patients, other patients identified by clinical discretion
- Claims for red folders and yellow paper.

In addition, practices will be required to submit evidence of peer review meetings at a locality level (see 5). Details of the patients discussed and a signed attendance sheet, should be kept by the practices for audit purposes.

4.4 Audit – Compliance with the Scheme

Practices will be selected at random for audit (and also if the GP Case management Lead identifies any potential irregularities). Practices selected for audit are required to work with the auditors to demonstrate to them that all parts of the scheme have been complied with, including electronic records that patients have been seen on the dates claims have been made, multidisciplinary team meetings have been held and that copies of care plans have been left in the patient's home.

5. Quality Indicators

There will be two Rotherham-wide meetings each year where discussion will take place regarding issues such as templates and practice outputs. There will also be updates from Social Prescribing and Social Services. These meetings will take place at 1pm on the following dates:

- Wed 8th July 2015
- Wed 13th January 2016

Each practice will be required to be part of a further **four peer review** meetings throughout the year. These should be held at locality level. It is the responsibility of the practices to ensure that the meetings take place. Notes from these meetings, including a signed attendance sheet should be forwarded to the CCG so that best practice and recommendations can be shared.

6. Activity Plan

³ Unless this is covered by an existing LES

To assist the CCG with financial planning, practices are required to supply predicted activity projections and inform the CCG if they deviate from these (for example temporarily reducing activity due to staff unavailability or if predicting a surge of year end activity).

7. Prices and Contract Value

Basis of Contract

Unit of measurement	Care patients	Home	All other case management patients
Full case management care plan completed & delivered	£150		£110
Per Review (4 monthly)	£40 (x2)		£30 (x2)
Health review (those aged over 75)	£50		

For care home patients (until such time as the care home LES is launched) :

The LES will offer funding of up to **£230** per annum for each new patient enlisted onto the full case management scheme (£150 & £40 & £40).

The LES will offer funding of £120 per annum (£40 & £ 40 & 40) for each patient kept under follow up by the scheme.

For all other case managed patients:

The LES will offer funding of up to **£170** per annum for each new patient enlisted onto the full case management scheme (£110 & £30 & £30).

The LES will offer funding of £90 per annum (£30 & £30 & 30) for each patient kept under follow up by the scheme.

For those over 75 the LES will offer £50 per patient for a yearly case review.

Practices will be re-imbursed for the reasonable cost of yellow paper and red folders, by stating amount to be claimed on the electronic survey. Receipts/invoices for yellow paper/red folders should be kept at the practice for audit purposes.

In all cases the trigger for payment for new patients is when the plan is either placed in the patient's home (for full case management) or offered to the patient (for annual health review). Reviews are paid when the relevant read code is completed.

The exact payment will be dependent upon the activity delivered each month and will be paid monthly in arrears on the basis of activity recorded in the data survey. Any survey returned later than the 15th will not be paid until the following month. Any activity that is not claimed for within THREE months will not be paid.

Costs to the CCG/Annual income to practices

The total value of the contract available for practices is £2.1 million (recurrent).

Practices are able to calculate their income based on the numbers of patients under review and the new patients anticipated for case management. The risk tool can also be used to ascertain the numbers and levels of risk for patients aged 75 and over.

DRAFT

Full Case Management Procedure

Nb The following is a guide to the selection of patients and capture/completion of the relevant information. It is not prescriptive about the model in which this is done- some of this information may be completed in advance by admin staff or nursing staff.

New Patients

1. Select the next patient according to the level of patient reached (*i.e. if less than 3% nursing/residential home or from RISC tool list. If >3% can be risk tool or clinical judgment*). Occasionally, some patients might be considered unsuitable (see 2.2.2) – code as such.
2. Enter 'Work started and date' code entered on clinical system & also 'Started' and date on comments box of RISC list for that patient (read codes are on the intranet). It is essential that the RISC tool is updated so that we can map the activity for this cohort of patients.
3. Clinician reviews patient records and discussions take place with other professionals currently involved.
4. Update Problem Lists (Active/Past/Significant/Minor) and also medication lists and disease linkages.
5. Identify any current monitoring and clinical follow up actions outstanding
6. Remember to compare current management to 'best practice' (NICE/QOF/top tips – available on the Case Management LES intranet site.)
7. Capture this in a clinical entry in records
8. Inform patient of LES scheme and obtain their consent to share their information (provide information leaflet). Ensure that the relevant 'sharing' protocols are set.
9. Arrange case review with patient/family/carers to discuss/agree above and add **patient agenda/goals** regarding priorities, desired outcomes, and actions to be taken and by whom.
10. Unless no wider action required, discuss patient's needs with appropriate members of Multi Disciplinary Team to identify any actions required
11. Agree who will be the Case Manager until next review (could be any member of the practice or wider team, as agreed with them, as appropriate to patient's current needs)
12. Produce a Case Management Plan which highlights:
 - Patient details
 - Medical conditions, treatment (in line with current best practice), involved parties
 - Relevant social factors – relevant involved parties/carer details
 - Exacerbation plans for known conditions (e.g. COPD, asthma, diabetes, falls)

- Other details of note such as DNAR/place of care preferences,
- Patient-identified needs (e.g. stopping smoking, more social contact, weight loss, more information for self-help) and plan to help them meet current priority.
- Baseline observations (pulse, BP, peak flow, oxygen saturation, known AF – such as would be of value to clinician attending in emergency)
- Use of the Care Plan template provided for SystemOne/ EMISWeb will give a good starting point for this, especially if data has been entered onto the system using the LES Data Entry Template, but each will need further editing prior to printing/saving

13. Agree the plan with patient/relevant carers/family as per patient wishes/consent

14. Commence agreed actions (referrals, medication or management changes)

15. Plan to be placed in a **red folder** in patient's home and shared with all relevant parties (with patient consent) – e.g. GP records, with Out of Hours service if applicable, with relevant community services. First two pages containing key information (patient details and clinical information) to be printed on **yellow paper** as per agreement with emergency services.

(NOTE: EOLC folders are also red and also left in homes, where a patient is both an EOLC LES patient and a CMP patient the two folders can be merged into one, as long as the two yellow pages are still at the front).

16. Add 'plan complete' code on clinical system and put **'complete' and date in comments box on RISC list for that patient, and name of Case Manager in relevant column.** Ensure that the relevant code has been completed for residential/ care home patient or clinical judgement.

NB 'plan complete' means that the patient has been discussed at an MDT (where appropriate) and that the care plan is in the patient's home.

Reviews

17. **Review of plan every four months** (more often, if deemed appropriate by the Case Manager):

If a patient is no longer on your practice list; ensure that they are coded correctly ie 'care ended' as per the minimum dataset; no further action.

For those patients still on the practice list:

- Confirm if still on RISC list at relevant level (i.e. top 5%); If the patient is still within the top 5% on the RISC list, continue with 4 monthly review (even if the risk score has reduced) but see last point
- Update relevant information (medication/ diagnosis etc) and review progress against agreed actions and priorities in the Plan
- Update Plan in patient's residence
- Use the relevant code for a review
- If the patient is no longer within the top 5% the practice has to decide whether there are exceptional circumstances to keep the patient under review. If there are exceptional circumstances continue Case management as a practice discretion patient. If the patients is no longer in the top 5% by risk and not a practice discretion patient discharge the patient from the scheme and code the patient ' admission

avoided care ended (as per the minimum dataset). The patient should be informed and an evaluation questionnaire sent to them. A note should also be put in the RISC tool to say case management ended.

Discharges from the scheme. The aim of case management is to see the cohort of patient selected by the risk tool and on the basis of clinical discretion as being the most likely to benefit from interventions that will avoid admission. This means that practices will need to discharge patients in order to have capacity to accept new patients. Practices can claim for a final review consultation for patients whose risk score has improved. Patients who are over 75 will need to be discharged to the annual health review element of the LES and offered a yearly review.

Multidisciplinary Team Meetings

18. Multi-Disciplinary Team meetings are expected to contain a mix of practice, community and other staff as relevant to the patients discussed, but as a minimum would include:

- *GP (plus Practice Nurse/Practice Manager, if applicable)*
- *Community nurse (DN and/or Community Matron)*
- *Social Work input*
- *Voluntary Sector Co-ordinator*
- *Carers*

Meetings might also include others as relevant to patients discussed – Drug/alcohol team, mental health workers, community physiotherapy/OT, End of Life Care project worker.

Practices must organise 10 meetings per annum with a regular schedule shared at least 4 weeks in advance to allow all members to organise their attendance. The ID of patients to be discussed should be shared with other attendees at least a week in advance of each meeting (method of doing this to be agreed with regular attendees). Date changes and cancellations should be kept to a minimum, and communicated to all relevant parties in good time. A copy of the signed attendance sheet and how many patients have been discussed should be kept by the practice for audit purposes.

Annual Health Review Procedure – Those aged 75 and over

Nb The following is a guide to the selection of patients and capture/completion of the relevant information. It is not prescriptive about the model in which this is done- some of this information may be completed in advance by admin staff or nursing staff. These reviews could also be done opportunistically by a GP during a routine medication review. The 'face to face' element can be 'nurse-led, doctor supported', but the nurse must possess the relevant qualifications (see 3.3). In the absence of a suitably qualified nurse this should be undertaken by a GP.

A suitable template is available in both SystemOne and EMISWeb to capture the relevant data

1. The RISC tool can be used to produce a list of patients aged 75 and over by risk score. Those already being case managed should be excluded; there may also be some patients who are not appropriate for an annual health review. Select the next patient on the over 75s list.
2. Enter 'over 75 health check code', as per the minimum dataset on clinical system.
3. Clinician (GP or suitably qualified nurse) reviews patient records and discussions take place with other professionals currently involved.
4. Update Problem Lists (Active/Past/Significant/Minor) and also medication lists and disease linkages.
5. Identify any current monitoring and clinical follow up actions outstanding
6. Remember to compare current management to 'best practice' (NICE/QOF/top tips – available on the CCG intranet site.)
7. Capture this in a clinical entry in records
8. Arrange 'face to face' with patient (and family/carers if appropriate) to discuss/agree above and add **patient agenda/goals** regarding priorities, desired outcomes, and actions to be taken and by whom.
9. Produce a summary of the health review which highlights relevant details such as:
 - a. Patient details
 - b. Medical conditions, treatment (in line with current best practice), involved parties
 - c. Relevant social factors – relevant involved parties/carer details
 - d. Exacerbation plans for known conditions (e.g. COPD, asthma, diabetes, falls)
 - e. Other details of note such as DNAR/place of care preferences,
 - f. Patient-identified needs (e.g. stopping smoking, more social contact, weight loss, more information for self-help) and plan to help them meet current priority.
 - g. Baseline observations (pulse, BP, peak flow, oxygen saturation, known AF – such as would be of value to clinician attending in emergency)
10. Commence agreed actions (referrals, medication or management changes)

11. A copy of the review is offered to the patient to be placed in the patient's home and the relevant code is completed in the clinical system to show that the review has been done.
12. **For those 75 and over the case review will only be undertaken annually.**

DRAFT