CASE MANAGEMENT for Long Term Conditions and Health Reviews for those aged 65 and over and on the enhanced frailty index
Local Enhanced Service (LES)

Rotherham Clinical Commissioning Group
SERVICE SPECIFICATION YEAR 10~~9~~

Service	**Case Management Local Enhanced Service Y10~~9~~**
Commissioner Lead	**Dr Avanthi Gunasekera, SCE GP**
Provider Lead	
Period	~~From 1st April 2020 until 31st March 2021~~1 April 2021 to 31 March 2022
Date of Review	2022~~1~~
Author	Rachel Garrison / Dr Avanthi Gunasekera
Date signed off by Primary Care Committee	

1. Summary

This document gives details of the Case Management Local Enhanced Service for Year ~~9~~10. The only changes made at this time have been to reduce the threshold for clinical judgement from 3% to 2%, and remove the specified nursing qualification. This specification will continue to be reviewed in the coming months and revised in time for the ~~2019/20~~ 2021/22 contracting round, following feedback from practices and engagement with the LMC.

1.1 Overview of the scheme

There are two distinct elements to this enhanced service:

1. **Full Case Management**
2. **Annual Health review under enhanced frailty index**

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

1. Full Case Management

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 2% of patients must comprise solely of patients identified using the RAIDR (Reporting Analysis and Intelligence Delivering Results) Healthcare Intelligence tool (excluding those patients who are currently within a care home and are part of the Care Home LES). Once this 2% is reached, the further 3% can be a combination of patients selected from the RAIDR Health Intelligence tool and those which the GP deems to be clinically appropriate (irrespective of risk score, including patients on the palliative care register).

NB End of life patients can be added to case management regardless of the percentage currently covered by the practice (provided the 5% is not exceeded)

2. Annual Health Review

This will be for all those aged 65 and over and on the enhanced frailty index who are not included in the full case management cohort are palliative or in a care home, as the national priority is to identify a named GP for everyone aged 65 and over and on the frailty index.

1.2 Important points to note about the service

Practices are required to report quarterly numbers for each of the levels and the categories of patient (i.e. risk level and clinical judgement, aged 65 and over and on the enhanced frailty index).

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 in Appendix 1 point 16.

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
- Identification of the appropriate patient cohort using clinical systems, RAIDR Health Intelligence tool and clinical judgement.
- 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.[1]
- Promotion of self-management.

Annual Health Review for those aged 65 and over and on the enhanced frailty index **(not already being case managed)**
- Identification of patient cohort using the Electronic Frailty Index (EFI)
- Population of the 'aged 65 and over and on the enhanced frailty index review template (recommendations of how this is done are given in Appendix 1)
- Interview with patient to create a comprehensive patient care review including a named GP or suitably qualified nurse
- Review on a yearly basis

There may be instances where patients move into the full case management cohort. For those aged 65 and over and on the enhanced frailty index 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 2% they can add a further 3% 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

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

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

Patients who currently reside within a care home (Elderly nursing/residential and EMI) who are covered by the Care Home LES.

There may also 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. Each practice will need to have a GP at a monthly meeting for 10 of the months of the year. Meetings should be held virtually where appropriate.

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.

Practices are no longer required to send in evidence of these meetings, but should keep a record for audit purposes.

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 109 will be available from ~~1st April 2020 to 31st March 2021.~~1 April 2021 to 31 March 2022

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 109 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 within the template must to be used to facilitate reporting and claims.

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.

For case management patients only - 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 65 and over and on the enhanced frailty index, the 'clinician' here should be a suitably qualified and experienced GP or nurse.

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.

3.5 Note on the Risk Stratification tool

Practices will continue to use the RAIDR Health Intelligence 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 RAIDR Health Intelligence 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 into rankings. Very high and high risk patients should provide enough to fulfil the top 5% of Rotherham patients.

The LES requires that part of the first 2% of the practice's LES patients are selected using the RAIDR Health Intelligence 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 2% of their patients in level 3 and 2 they should discuss this with the GP for Primary Care.

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.

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 contact virtually (via telephone or video) with the GP responsible for their care and/or the relevant case manager, with a face to face meeting being held if the GP considers it appropriate or necessary
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 65 and over and on the enhanced frailty index**:**

5. The relevant template has been completed
6. All patients will have had contact virtually (via telephone or video) with the GP responsible for their care and/or a suitably qualified nurse, with a face to face meeting being held if the GP considers it appropriate or necessary

4.3 Data

Practices will receive an electronic survey for completion by the 10th of the month after quarter end, to provide the following data for monitoring and payment purposes: *(Please refer to minimum dataset for relevant codes and report numbers).* 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 for Primary Care 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

Where necessary and appropriate, the CCG will arrange up to two Rotherham-wide meetings each year where discussion will take place regarding issues relating to the service such as templates, risk stratification tools and practice outputs. All practices participating in the service will be expected to send at least one representative to these meetings and the dates will be confirmed in-year.

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

To assist the CCG with financial planning, practices may be asked 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

Full case management care plan completed & delivered	**£111.65**
Per Review	**£30.45 (x2)**
Health review (those aged over 65)	**£43.14 per review**

The LES will offer funding of up to **£172.72** per annum for each new patient enlisted onto the full case management scheme (£111.65 & £30.45 & £30.45).

Reviews of existing patients can be claimed at £30.45 each; however the maximum number of reviews that the practice may claim for is set at the 2015/16 figure of 2 per new and 3 per follow up.

For those aged 65 and over and on the enhanced frailty index the LES will offer £43.14 per patient for a yearly case review.

Practices will be reimbursed for the reasonable cost of yellow paper and red folders, by claiming directly from the CCG. 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 via the Over 65 Frailty Assessment tick box within the template. Reviews are paid when the relevant read code is completed.

Consequences for late submission of activity data:

- 1 – 7 days: 5% of payment
- 8 – 14 days: 10% of payment and payment won't be released until the next payment run
- 15 – 21 days: 50% of payment and payment won't be released until the next payment run
- Submissions received after 21 days (3 weeks) will receive no payment.

If the CCG makes a payment to a practice under the LES and :

a) The practice was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment **or because the payment was calculated incorrectly** (including where a payment on account overestimates the amount that is to fall due);or
b) the CCG was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money is already been paid,

then the CCG is entitled to repayment of all or part of the money paid.

Any suspicions of fraud will be referred to the CCG's Counter Fraud Specialist for further investigation.
It is important to recognise that claiming for procedures that do not fall within the service specification may constitute fraud and will be referred to the CCG's Counter Fraud Specialist for further investigation.

Termination of agreement

This service forms part of the basket of enhanced services of the Rotherham Quality Contract, and is therefore subject to the terms outlined in the Quality Contract.

Following the recent publication of the 'Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan' the CCG acknowledges that further guidance may influence the future delivery of Local Enhanced Services.

All Local Enhanced Services will be subject to regular review in line with the development of Primary Care Networks (PCNs). Three months' notice will be given to Providers if services are to transfer to PCN delivery and/or payment.

The Practice and/or CCG may give three months written notice to terminate the service for reasons other than those outlined above.

Appendix 1

Full Case Management Procedure

N.B 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 2% select from RAIDR list. If >2% can be risk tool or clinical judgment*). Occasionally, some patients might be considered unsuitable (see 2.2.2 exclusion criteria) – code as such.

2. Enter 'Work started and date' code entered on clinical system for that patient (read codes are on the template).

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 SystmOne / EMIS Web 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).*

Reviews

16. **Review of plan** (more often, if deemed appropriate by the Case Manager, but not longer than 6-monthly):

    If a patient is no longer on your practice list; ensure that they are coded correctly i.e. 'care ended' as per the minimum dataset; no further action. For those patients still on the practice list:

    - Confirm if still on RAIDR Health Intelligence tool at relevant level (i.e. top 5%); If the patient is still within the top 5% on the list, continue 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 patient 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.

    Discharge from the scheme. The aim of case management is to see the cohort of patient selected by RAIDR Health Intelligence 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 65 will need to be discharged to the annual health review element of the LES and offered a yearly review.

Multidisciplinary Team Meetings

17. *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 65 and over and on the enhanced frailty index

N.B. 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', e.g Nurse/HCA

A suitable template is available in both SystmOne and EMIS Web to capture the relevant data

1. The Electronic Frailty Index (EFI) can be used to produce a list of patients aged 65 and over and on the enhanced frailty index 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 aged 65 and over and on the enhanced frailty index list.

2. Enter 'over 65's frailty index codes, Moderate frailty Xabdb or Severe frailty Xabdd code', as per the minimum dataset on clinical system, will pull through from the template.

3. Clinician (GP/Nurse/HCA) 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

    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)

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

10. **For those** aged 65 and over and on the enhanced frailty index **the case review will only be undertaken annually.**