CASE MANAGEMENT for Long Term Conditions and Health Reviews for those aged 75-65 and over and on the enhanced frailty index
Local Enhanced Service (LES)

Rotherham Clinical Commissioning Group
SERVICE SPECIFICATION YEAR 8

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<th>Service</th>
<th>Case Management Local Enhanced Service Y7-Y8</th>
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<td>Period</td>
<td>From 1st September 2018-2019 until 31st March 2019-2020</td>
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<td>Date of Review</td>
<td>2019-2020</td>
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1. Summary

This document gives details of the Case Management Local Enhanced Service for Year 82. 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 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 for those aged 75 and over

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 Dr Foster (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 Dr Foster and those which the GP deems to be clinically appropriate (irrespective of risk score).

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 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 65 and over and on the frailty index 75 and over.

2.3 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, over aged 65 and over and on the enhanced frailty index 75a).

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**
- Identification of the appropriate patient cohort using clinical systems, Dr Foster 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.
- Promotion of self-management.

**Annual Health Review for those aged 65 and over and on the enhanced frailty index 75 and over (not already being case managed)**
- Identification of patient cohort using current clinical systems
- Prioritisation of reviews using Dr Foster and frailty index.
- Population of the aged 65 and over and on the enhanced frailty index 75 and over 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 (the specifications for this nurse are shown in section 3.3)
- 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.
- 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 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 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**

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

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.

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 2019/20 will be available from 1st April 2018 to 31st March 2019.

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 2019/20 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 65 and over and on the enhanced frailty index aged 75 and over, 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 Dr Foster 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 Dr Foster 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 Dr Foster 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 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 65 and over and on the enhanced frailty index 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.
7. A copy of the template/care plan will be offered to the patient to keep at their home
8. An appropriate mental health assessment  

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
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 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

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<thead>
<tr>
<th>Basis of Contract</th>
<th>Price</th>
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<tr>
<td>Full case management care plan completed &amp; delivered</td>
<td>£110</td>
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<tr>
<td>Per Review</td>
<td>£30 (x2)</td>
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<tr>
<td>Healthy review (those aged over 75/85)</td>
<td>£42.50 per review</td>
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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).

Reviews of existing patients can be claimed at £30 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 over 75 the LES will offer £42.50 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

2 Unless this is covered by an existing LES
full case management) or offered to the patient (for annual health review). 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.

Any suspicions of fraud 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. Either party may withdraw from this agreement with 6 months written notice.

6 months written notice is required by either party if they wish to terminate this agreement.

Costs to the CCG/Annual income to practices

Practices are able to calculate their income based on the numbers of patients under review and the new patients anticipated for case management. The Dr Foster tool can also be used to ascertain the numbers and levels of risk for patients aged 65 and over and on the enhanced frailty index aged 75 and over.

Appendix 1

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 2% select from Dr Foster list. If >2% 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 for that patient (read codes are on the intranet).
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 / 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 Dr Foster 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 Dr Foster 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, 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 aged 75 and over

1. **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’, 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.

2. A suitable template is available in both SystemOne and EMIS Web to capture the relevant data

3. **Dr Foster and the frailty index** can be used to produce a list of patients aged 65 and over and on the enhanced frailty index 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 list.

4. Enter ‘over 75.65’s frailty index codes, Moderate frailty Xabdb or Severe frailty Xabdd health check code’, as per the minimum dataset on clinical system, will pull through from the template.

5. Clinician (GP or suitably qualified nurse) reviews patient records and discussions take place with other professionals currently involved.

6. Update Problem Lists (Active/Past/Significant/Minor) and also medication lists and disease linkages.

7. Identify any current monitoring and clinical follow up actions outstanding

8. Remember to compare current management to ‘best practice’ (NICE/QOF/top tips – available on the CCG intranet site.)

9. 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 aged 65 and over and on the enhanced frailty index 75 and over the case review will only be undertaken annually.