RightCare CASEBOOK

Slough CCG

Developing a Complex Care Case Management Service within Primary Care

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The setting

NHS Slough CCG is responsible for commissioning health services for its population of approximately 150,000 across its 16 GP practices. The CCG has had access to the Johns Hopkins Adjusted Clinical Groups (ACG®) System[1] for 3 years and had been using it mainly to identify the top 2% of individuals most at risk of an unscheduled admission.

The situation or problem

The CCG and local GPs wanted to improve their understanding of what factors are the key drivers of cost and hospital activity. Analysis of the Slough CCG patient population demonstrated that 5% (7,500) of people consume 43% of healthcare resources. In an attempt to realise cost savings and improve quality of service, efforts were made to target those at higher risk of an emergency admission or A&E attendance.

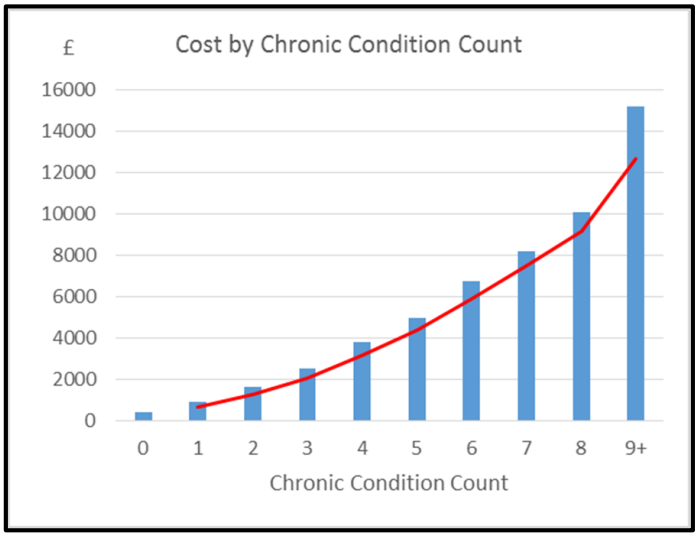
What action was taken?

Where to Look

Utilisation of the ACG System within the population of Slough CCG demonstrated that there was a clear relationship between multi-morbidity and cost. People associated with the highest costs were those with 7 or more chronic conditions, with costs consistently high in pharmacy, unscheduled attendances and admissions (Figure 1).

Although there is a relationship between number of co-morbidities and age, not all old people have multiple chronic conditions. Multi-morbidity also occurs across the whole of the adult population, particularly in the 45-64 year olds.

Figure 1.



[1] Starfield B, Kinder K. (2011) Multi-morbidity and its measurement. Health Policy 103:3-8.

What to Change

Clinicians analysed the probability of emergency admission associated with single chronic conditions and also with 2 co-morbidities (congestive heart failure (CHF) with chronic renal failure (CRF) and CHF with chronic obstructive pulmonary disease (COPD)to understand what conditions have the most significant impact on future risk,. Patients with either of these co-morbidities had a much higher risk of emergency admission than those with any single chronic condition.

Analysis to assess commonality in different risk groups showed that those at high risk of emergency admission were not always the same population as those at risk of high cost:

- 40% of high-cost patients did not have an emergency admission
- There was only a small overlap between those at high risk of emergency admission, those at risk of high costs and those flagged as frail elderly

These analyses suggested significant opportunities for delivering clinically effective and value for money services when the patient population is stratified according to co-morbidities. The stratification further illustrated and quantified that some GP practices have a "sicker" population than others.

How to Change

Local GPs discovered that multi-morbidity is the norm and that chronic conditions rarely exist in isolation.

The GPs agreed they could make a difference within the primary care setting for a cohort of people; multi-morbid patients with a base disease that was unstable in nature and prone to exacerbation. Each member of this cohort had one of four combinations of disease:

- CHF and CRF
- CHF and COPD
- Diabetes, CHF and CRF
- Diabetes, Ischaemic heart disease and CRF

Clinicians in Slough GP practices reviewed the case notes of 750 individuals within this cohort. Baseline data was gathered prior to the implementation of the changes (for a 12 month period), including primary care, secondary care and pharmacy costs. 172 individuals were receiving acute secondary care interventions at the start of the service change and were therefore excluded from the study until their condition had stabilised.

What happened as a result?

The remaining 578 patients were selected to receive a primary care based "Complex Care Case Management Service" (CCCMS). Each patient had an initial GP review followed by a series of appointments every 3 weeks. These are aimed at designing, with the patients, individual care plans and proactively managing patients' needs in a holistic way, including education of the

patient and their carer(s), improving the coordination of care provided by health and social care professionals, and by the involvement of the 3rd sector.

The CCMS was launched in October 2015, and all 16 GP practices within Slough CCG are engaged in its delivery. Progress is monitored to ensure that the service is being delivered as commissioned, and data relating to performance and outcomes, including patient feedback, are gathered to identify and share best practice.

One month after launching the service, initial outcomes demonstrated that there was:

- 24% reduction in A&E activity in November 2015 compared with the same month in 2014 (47 attendances compared with 62) (Figure 2).
- 17% reduction in non-elective admissions (38 compared with 46) (Figure 3)

Figure 2.

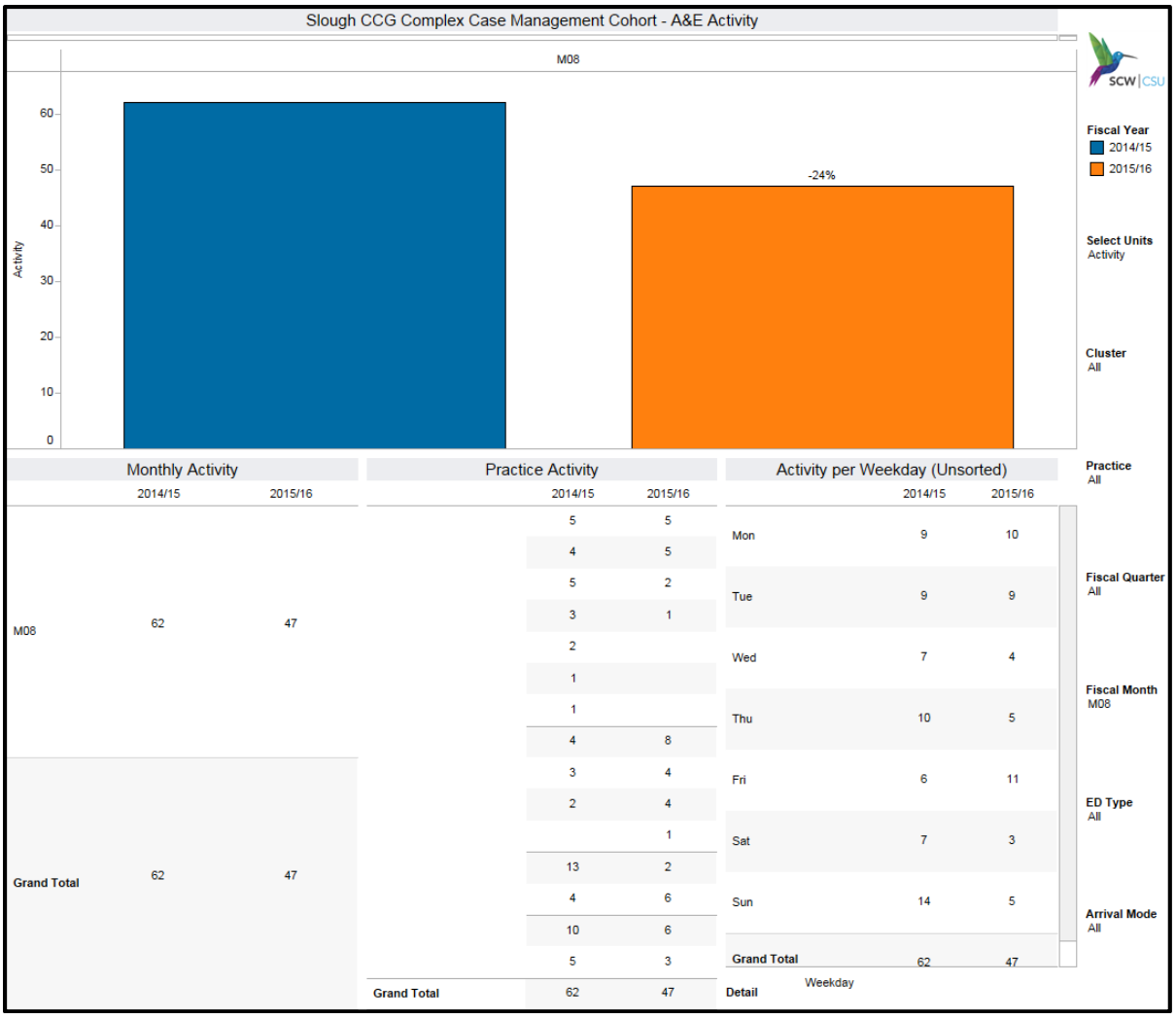
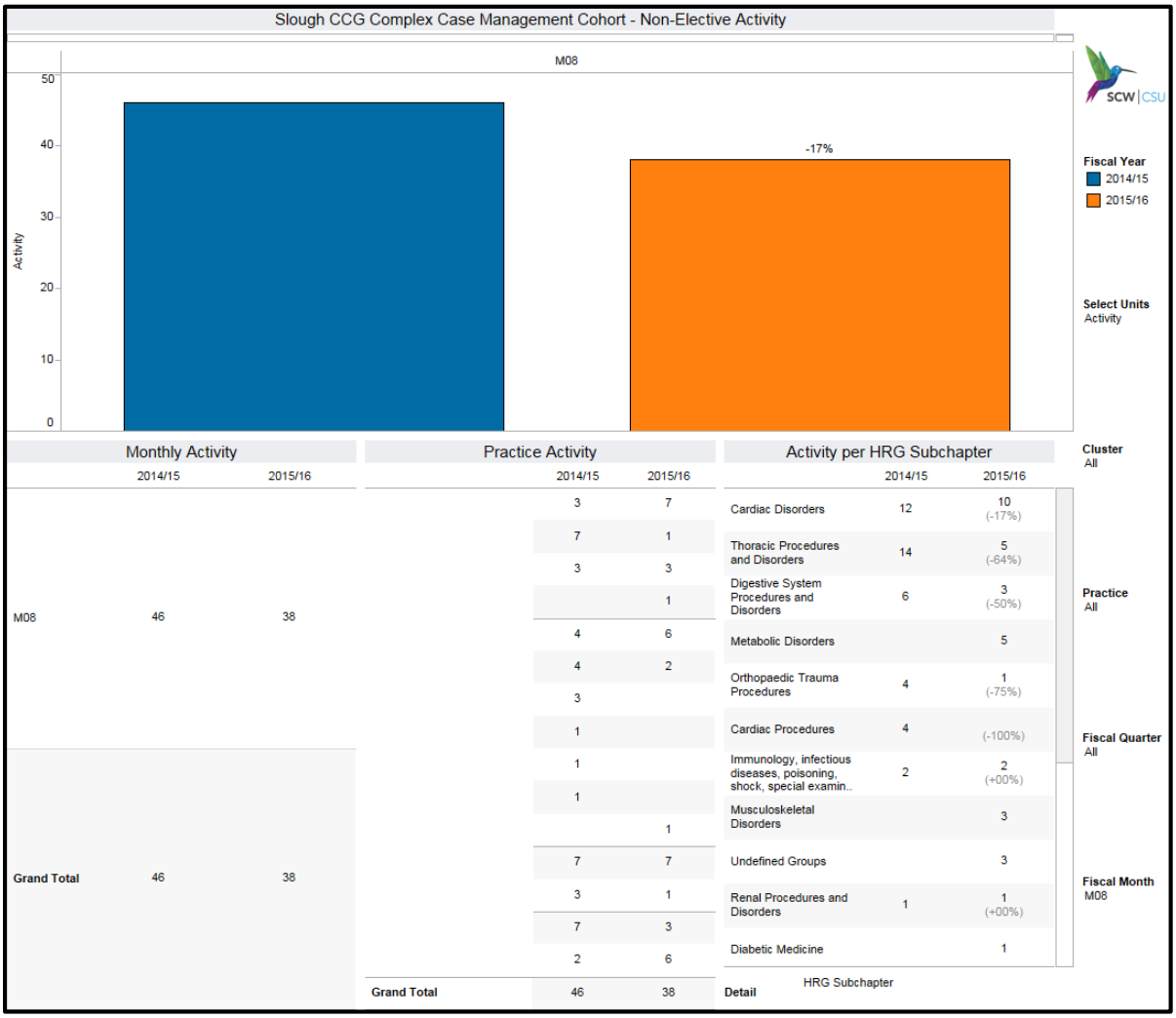


Figure 3.



Next Steps

- Cases will be referred to, and reviewed by, the multidisciplinary Primary Care Integrated Care Teams (PCICTs) which were set up 2 years ago and which will be redesigned to accommodate the CCCMS
- Further analysis will be undertaken by clinicians to identify additional cohorts that will benefit from this approach
- Additional cohorts may be identified from those at moderate risk of emergency admissions in order to develop a more proactive approach to the delivery of a quality and value for money service
- Qualitative data will be gathered from the patients over a 12 month period to determine the benefits derived from the CCMS in terms of self-management of the medical and psychological aspects of their conditions and their satisfaction with the CCMS

- Quantitative data will be gathered to measure the total financial benefits of this approach to caring for this cohort of patients

What was the learning as a result of this experience?

- Risk stratification within the top 2% of people most at risk of an emergency admission is a useful tool to understand likely care needs and potential interventions to prevent avoidable emergency admissions but this should only be a starting point. Further analysis of the top 5% of the population needs to be carried out and a further stratification of this population needs to take place to identify clinically similar cohorts of people who require different types of intervention to reduce costs and improve the quality of their lives
- Clinical engagement and leadership was essential to identify new models of care within the primary care setting
- CCG leadership ensured that the benefits aligned to the CCG Commissioning Intentions and that capacity and resources were made available within primary care
- Right care methodology works and is transferable
- Significant resources can be released
- Using the Right care tools, Atlas & Commissioning for Value packs helps to create the narrative for all stakeholders to improve the health of the population, not only those patients known to the service
- The Atlas of variation has highlighted another opportunity within the CCG population to undertake a similar risk assessment and thus transfer the learning from this case study to other patient cohorts

Right Care Resource Centre

Right Care has a resource centre where CCGs can find supporting materials describing the Commissioning for Value approach:

- Online learning videos
- Atlases, Spend and Outcome Tools
- Commissioning for Value tools
- Casebooks showing learning from early adopters
- Essential reading lists and glossary

www.rightcare.nhs.uk/resourcecentre