SERVICE SPECIFICATION

MCH FINAL DRAFT

Service	**Active Case Management Service North District**
Commissioner Lead	**Nancy Ryalls/Moneeza Iqbal**
Provider Lead	**Judith Sellars**
Period	**1st April2009 to 31st March 2012 with the possibility to extend to 31st March 2014**

1. Purpose

1.1 Aims and 1.4 Objectives

- To reduce the impact of long term conditions by providing anticipatory care and working in partnership with individuals identified with medium to high risk of unplanned hospital admissions.
- To reduce the rate of unscheduled care requirements of patients with long term conditions.

To improve the quality of life for patients with complex long term conditions and their families and carers.

1.2 Evidence Base

- National Service framework for Older People DH (2001).
- NHS Improvement Plan (2004), five percent of patients who are admitted to hospital for forty two percent of bed days.
- National Public Sevice Agreement DH (2004).
- National Service Framework for Long Term Conditions DH (2005).
- Our Health, Our Care, Our Stay – A new direction for community sevices, white Paper DH (2006).
- Our NHS, Our Future DH (2007).

Nice Guidance for the management of COPD, Diabetes, CHD and other long term conditions.

1.3 General Overview

- The active case management service (ACM) was established in January 2005 to support patients with long term conditions (LTCs). The ACM service is an integral part of community and primary car esevices in North Manchester and works in partnership with the wider health economy.
- The ACM service works specifically with secondary care and GP practices to prevent unnecessary admission to hospital and to facilitate early discharge from hospital.
- The aim of the service is to proactively manage patients with complex needs, through the utilisation of case management, advanced clinical skills and expert knowledge, to develop care programmes that achieve person centred care and positive health outcomes.
- The patient and their family and or carer works with the ACM team to develop management plans to achieve optimum health levels.
- The Advanced Practitioners/Community Matrons and Case Managers are co-located with other community services including the District Nursing service in 4 Health Centres in the north District.

1.5 Expected Outcomes

- Improvement of the quality of life for patients with long term conditions.
- Reduction in emergency medical admissions.
- Reduction in emergency bed days.
- Reduction in average length of stay.
- Reduction in GP home visits.
- To educate and support patients and their carers about their long term conditions to enable them to manage their condition reducing the need for acute amangement and admission to hopsital.

2.Scope

2.1 Service Description

- The Active Case Management service ACM was established in January 2005 to support patients with long-term conditions (LTCs). The ACM service is an integral part of community and primary care services in North Manchester and works in partnership with the wider health economy.
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- The patient and their family and or carer works with the ACM team to develop management plans to achieve optimum health levels.
- The Advanced Practitioners/Community Matrons and Case Managers are co-located with other community services including the District Nursing service in 4 Health Centres in the North District.
- The advanced Practitioners/Community Matrons work across the whole ACM caseload and utilise advanced clinical assessment skills to recognise and diagnose the symptoms of disease exacerbation and acute illness. They work autonomously and have conditions and complex co-morbidites.
- Case managers, who have not completed appropriate and acredited education in advanced assessment and clinical skills, work alongside the Advanced Practitioners/ Community matrons. Case managers lead and coordinate care for those patients deemed to have one dominant unstable complex long term condition. The patients may also have several co-morbidities but these are deemed stable and not complex. Case Mangers are aligned with specific GP practices.
- A full time case finder works alongside the entire ACM team supporting the identification of new referrals and the production of performance data and team statistics.
- Utilising case mangement and leadership skills ACM team members liaise across multi agency boundaries both in primary and secondary care ensuring that the service is delivered within a clinical goverance framework. Patients are assigned to the appropriate team member based on their acuity. Patients may move between the caseloads of Advanced Practitioners/Community Matron and a case manager depending on their individual condition and need.
- The ACM service is available Monday to Friday 08.30- 17.00 excluding Bank Holidays. Urgent nursing/medical care and advice outside normal working hours will be dealt with via the out of hour's service and instruction for callers is available on the individual ACM mobile phone or automatic diversion to colleague.

- The total general practice population of North Manchester district is approximately 165 000 and there are 35 GP practices. The ACM service targtes patients who are over 18 and who are registered with a North Manchester GP. Patients are identified at highest risk of unplanned emergency medical admissions (EMA's) by utilising the combined Patients at Risk of Readmission (PARR) tool and through a triage system for direct referrals using the early Admission Risk Likelihood Index (EARLI) scoring tool devised by Castlefields Health Centre to prioritise.

- Proactive case finding is facilitated through the combined utilisation of the PARR1 and PARR2 tools.The office manager is responsible for seeking PARR data every two weeks. Screening and allocation case by case is performed by a community matron/advanced practitioner.
- Patients at risk of re-hospitalisation (PARR) score explanation below:

"Predicting who most at risk of an emergency admission is is a complex task. A high degree of accuracy is required if we are to ensure that the services are directed at those who most need them to ensure we do not waste resources in the rong areas." The PARR case finding algorithms use prior hospital discharge data to identify patients at risk from re-hospitalisation in the last 12 months following their identification. PARR was developed by the Kings Fund, DOH and New York University and is robust tool for identifying patients to whom ACM would make a difference. The PARR approach to case finding builds on a review of literature and has several important characteristics:

1. Use of hospitalisation as a triggering event:
   There are two basic PARR algorithms that diffeer in terms of the characteristics of the triggering condition.

   - **PARR 1** – focuses on triggering admissions for specific reference conditions where improved management can often help prevent/avoid future hospitalisations.
   - **PARR 2** – uses any emergency admission as a trigger and in not limited to admission for a reference condition.
2. Designed to be used in real time or with archival analysis only.
   As effective discharge planning is likely to be an essential component of many intervention strategies, the algorithms are designed for application in real time while the patient is still in hospital.
3. Use of a broad range of variables to help predict risk
   - Data on hospital utilisation – diagnostic codes for current hospitalisation; any admission in the previous three years provides data on whether the patient has a chronic condition or other co morbidity; hospitalisation frequency; day case utilisation; consultant treatment speciality; demographic characteristics.
   - Community charactersitics – demographic data; underlying sex/ age adjusted rates of hospitalisation for conditions that are sensitive to GP practice style.
   - Hospital of current admission – practice style of the physician at the hospital of current admission.

   Both PARR 1 and PARR 2 produce a risk score showing patient's likelihood of admission within the next 12 months. Risk scores range from 0 – 100, with 100 bieng the highest risk. The tool operates in a relatively simple database in Microsoft Access. PARR 1 and Parr 2 A brief Guide, DH (2006).

2.2 Accessibility/acceptability

The values and principles that underpin this sevrvice specification are detailed below and it is expected that the provider makes special provision to make staff aware of the principles and also demonstrate this in their application and service delivery (proven by performance data and audit):

- Equal access to the service will be provided for all the people who meet the service criteria and to be able to demonstarate this with monitoring information about race, disability, age, gender, sexual orientation and religion or belief.
- Patients will not be excluded an thr grounds of race, disability or gender in line with; race relation (Ammendment) Act 2000; Disability Discrimination Duty 2005; Equality Act 2006 (Gender Duty).
- The service will not engage in any discriminatory practices, this includes dealings with the general public and recruitment of staff.
- All staff have a responsibility to work in partnership with secondary and community providers to develop, improve and deliver the service.
- Patients will be impowered to exercise their rights to choose and given sufficient information which enables them to make informed decisions about their future long-term care arrangements.
- Patients are treated with dignity, respect and as individuals; these will be given high priority of all points of service delivery. This is a key priority for the NHS measured by the Health Care Commission.
- The service provider will ensure that patient views are incorporated into the development of future services.
- There will be effective communication and information sharing between agencies involved in the provision of care and with patients and their carers.
- Information and records will be kept confidential and in accordance with the data protection legislation and Caldicott principles. Record keeping. Information and confidentiality policies will follow NHS standards must be available and adhered to by all staff.

2.3 Whole System Relationships

- The ACM service acts as as the patients care co-ordinator, working in partnership with the patients GP, secondary care, all community services, therapy services, intermediate care, social services, voluntary and independent sector services.

2.4 Interdepenencies

- The service works closely with the patients GP to ensure access to appropriate health care and diagnostics to maintain the patient's independence and prevent unnecessary hospital admission. The service works in collaboration with secondary care sevices including secondary consultants to facilitate timely discharge from hospital and access to diagnostics.
- The service utilises MCH intermediate care services to prevent unnecessary hospital admission.
- In order to achieve the service aims, referrals are made to all the services listed above.

2.5 Relevant networks and screening programmes

The service works in collaboration with patients secondary care providers to prevent unnecessary hospitalisation of ACM patients and to facilitate early discharge when appropriate.

2.6 Sub-contractors

There are currently no directly sub contracted elements of the North ACM services.

4. Service Delivery

3.1 Service Model

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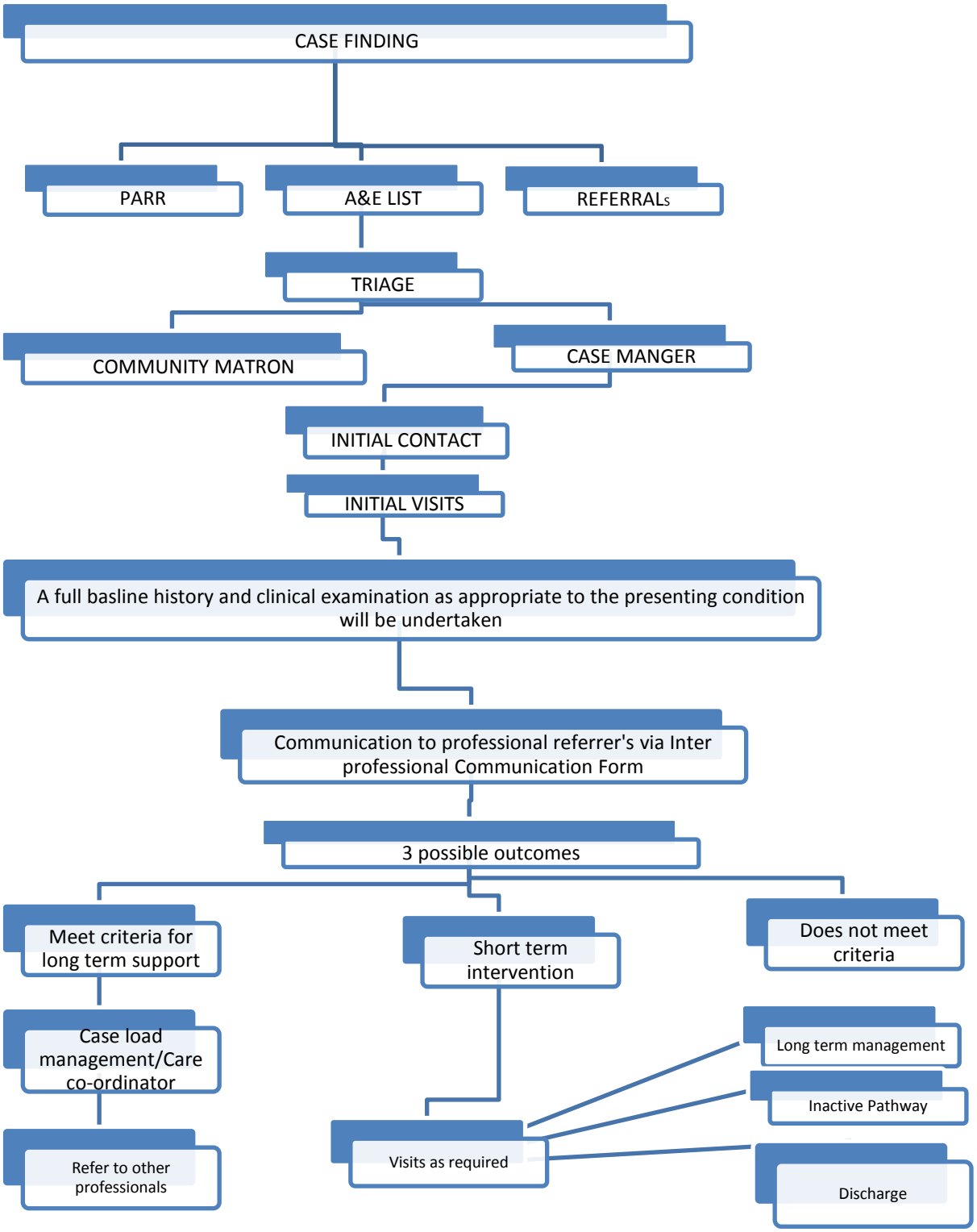
- The team will complete assessments and progress interventions for each patients considered to be appropriate for the ACM service and who consent to work with the ACM service to achieve jointly agreed goals set in the care plan. Initial contact with the parent/carer following referrla will be made via the telephone, to untroduce the service, further assess the priority of need for intrevention and to arrange a convenient time to visit. If the patient carer has no telephone initial contact will be made by letter.
- The use of the Adult Personal Held Community Record (APHR) is mandatory across the trust and is utilised to communicate with all professionals involved in the patients care. During initial patient visit, the ACM team member will explain the reason for referral and role of different members of the team. If the patient is deemed appropriate for the service they will be asked to sign the information sharing consent form cotained in the APHR. In addition a full baseline history and clinical examination as appropriate to the presenting condition will be undertaken and documented in line with the ACM approved assessment forms.
- The progress of patients will be discussed with the GP and/or another relevant practitioner as appropriate and referrals will be made to other professionals as appropriate following assessment on an ongoing basis.

3.2 Care Pathways



4. Referral,Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The ACM service is contracted to all patients registered with a North Manchester district GP Practice; the team follow the patient across geographic boundaries.

4.2 Location(s) of Service Delivery

- Case Managed patients are cared for in their own home or in an acute hospital setting as appropriate.

4.3 Days/Hours of operation

- The service operates Monday to Friday from 08.30 to 16 :30 excluding Bank Holidays.

4.4 Referral criteria & sources

- Patients are identified from PARR see data 2.1 for a brief explanation of the PARR tool and please see care pathways 3.2.

Referral Criteria

The Patient is required to be registered with a GP in the North Manchester district and where the GP agrees to maintain overall medical responsibility for care.

The patient is over 18 and meets either criteria 1, 2, or 3:

1. Two or more emergency admissions in the previous 12 months
2. Two or more diagnosed chronic long term conditions
3. Taking four or more prescribed medications

And 1 or more of the following:

4. Frequent out of hours contacts and/or frequent requests for domicilliary visits
5. Frequent A+E attendences

Referral criteria & information for referrers regarding appropriate patients for the service and documentation required is available and can be sent to referrers in the form of Guidance for referral to the ACM service.

4.5 Referral route

- Please see service description 2.1 and care pathways 3.2

4.6 Exclusion criteria

- **Referral exclusions**

In order to ensure appropriate patients continue to be referred/identified through the use of PARR data, a list of exclusions has been developed. Patients deemed not appropriate for the service include:

- Those with current obstetric problems
- Current substance abusers and/or patients currently under treatment, eg.

  Alcoholism with no other long term medical conditions
  Patients on methadone programmes

- Acute mental health diagnoses (with no other long term conditions) excluding dementia

  Schizophrenia

  Major depression

  Bi – Polar

Should a referred patient fall into an exclusion category, the referrer will be contacted in writing and notified in writing of the decision. Additional information will be obtained as necessary and a decision made, regarding the acceptance of the patient onto the ACM service caseload, during the triage process. Outcomes will be documented in the triage log.

4.7 Response time & detail and prioritisation

- Triage takes place each day before 4.30pm. Triage will be completed by asuitably competent member of the ACM team. Pateints received as direct referrals and those identified by PARR are discussed, priority of care is determined and the appropriate grade of staff is assigned based on the patients overall condition and needs. If additional information is required to make a decision, a member of the ACM team will contact the referrer for additional information.

- **Response times**

  A priority level (high/low) for referral patients will be determined during the triage process. Referrals which require a high priority response will be contacted within two working days. Patients who are classified as high priority will have one or more of the following:

  - Fequent A&E Attendances
  - Frequent GP callouts
  - Frequent hospital admissions
  - Repeat falls
  - Increasing shortness of breath
  - Have recently become house bound

Lower priority patients will be contacted according to a Case Manager's individual caseload and initial assessment visits will be prioritised accordingly and seen within 5 weeks from date of referral or identification for case amanagement.

5.Discharge Criteria and Planning

- **Discharge process**

Certain patients may remain on the caseload through to the palliative and terminal phases of their lives.Others may be discharged if deemed appropriate. The decision to discharge will be made foloowing a full discussion of the case and circumstances with a senior member of the ACM team. All conversations, decisions and rationale will be documented in the patients office based notes. Patients/carers will be given a contact telephone number and encouraged to phone for advice if required. All other professionals in the patients care will be notified of the discharge.

- Patients will be considered for discharge, if:
    - An episode of care has been completed, the reason for referral has been comprhensively dealt with and the patient is coping well.
    - The patient is under the care of another service, eg. District nurse and the reason for referral has been addressed; there will be a discussion with the other service and handover of the patient prior to discharge.
    - The patient has moved out of the area and registers with a GP from another PCT.
    - The home environment has become unsafe for service delivery and all options have been explored.
    - The patients discharge themselves from the service.
    - The patient is non concordant leading to ineffective or unsafe practice.
    - The patient has died.

6.Self care and Patient Carer Information

- Education and training is provided to patients and carers as appropriate about their condition. The team develop anticipatory care plans in collaboration with the patient, carer and specialist teams as appropriate to the patient's long term condition. Leaflets and information is supplied to the patient about their condition as deemed appropriate for the individual.
- At the initial visit patients are given an Active case management service leaflet which outlines the role of the Advanced Practitioner/Community matron and case manager and the scope or their practice, as well as giving the patient information relating to what is expected of them within the period of intervention and involvement with the service. This will enable the patient to make an informed choice as to their willingness to contribute to the intervention being offered.

7.Quality and Performance Standards

Quality Performance Indicator	Threshold	Method of measurement	Consequence of breach	Report due
Infection Control	100% of staff receive training and education re: infection control	Attendance on 'Clean your Hands 'training		Annually
Service user Experience	Patients will be handed out a satisfaction questionnaire to assess satisfaction with overall quality of service and satisfaction with privacy and dignity in care provided.% of patients surveyed to be determined	Patient satisfaction Questionnaire results.		Annually
Improving Productivity	Average number of patients per wte Community Matron/Advanced Practitioner/Case Manager. Threshold to be agreed	Service database		Quarterly
Access	% of patients admitted to ACM service in one year threshold to be agreed	Lorenzo data collection		Annually
Care Management	All patients will have an individualised care plan documented in their adult record.	Audit of sample of records		Annually
Outcomes	% of patients discharged from the North ACM service in one year threshold to be agreed	Lorenzo data collection		Annually
Outcomes	Reduction in hospital admissions for patients on North ACM service. Threshold to be			Quarterly

	agreed.			

Additional Measures for Block Contracts:-

Staff Turnover rates	To be agreed	Electronic staff record system		Annually
Sickness levels	To be Agreed	Electronic staff record system		Annually

8. Activity

Activity Performance Indicators	Threshold	Method of Measurement	Consequence of breach	Report Due
Number of Community Matrons	To be confirmed on a citywide basis (National Targets)	Service database		Quarterly
Number of Case Managers	To be confirmed on a citywide basis (national target)	Service database		Quarterly
Number of case managed patients	To be Agreed	Service database		Monthly
Number of patient contacts face to face and telephone	To be agreed	Service database		Monthly
Number of No Access visits	To be agreed	Lorenzo data collection		Monthly
Activity Plan				

9. Continual Service Improvement Plan

- The North ACM service will be monitored against the annual key performance indicators identified within the community contract as above.
- In addition to this the North ACM service and adult division have a planned programme of improvement related to service and divisional specific key indicators that aim to demonstrate continuous service improvement.
- The North ACM service has an annual governance plan that develops practice and demonstrates continuous improvement in all aspects of goverance. This plan requires the service to monitor and continuously improve the following areas, risk management, training and development, patient and public involvement, service

improvement, health inequalities, adherence to PCT policies and procedures, best practice and audit and information goverance.

10. Prices and Costs

Basis Of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block/cost & volume/cost per case/other *		£		£
Total		£		£

*delete as appropriate

10.2 Cost of service by Commissioner

Total cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£