Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Long Term Conditions Year of Care' JSNA Chapter Summary Update '2014-15'

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Kent Long Term Conditions Year of Care Commissioning Model JSNA Chapter Update 2014

Context

The long term conditions (LTC) Year of Care (YoC) commissioning model is a national support and improvement programme led by Martin McShane, Domain 2 Lead, NHS England. It is designed to enable local health economy teams to deliver change in a measured and supported way.

The task requires pragmatic implementation solutions to change the current care system to:

a Service provision that is centred on patients need and responds in a holistic manner (patient's eye model).
b A commissioning model that eliminates silo working, whilst commissioning for comorbidities and working as a co-ordinated unit.
c A fiscal model that supports health and social care teams to integrate care in a more successful and sustainable way, better aligning the funding flows and incentives with people's needs. This will support, rather than inhibit, organisations working together (LTC Year of Care commissioning model) for people living with long term conditions, alongside achievement of efficiency savings.

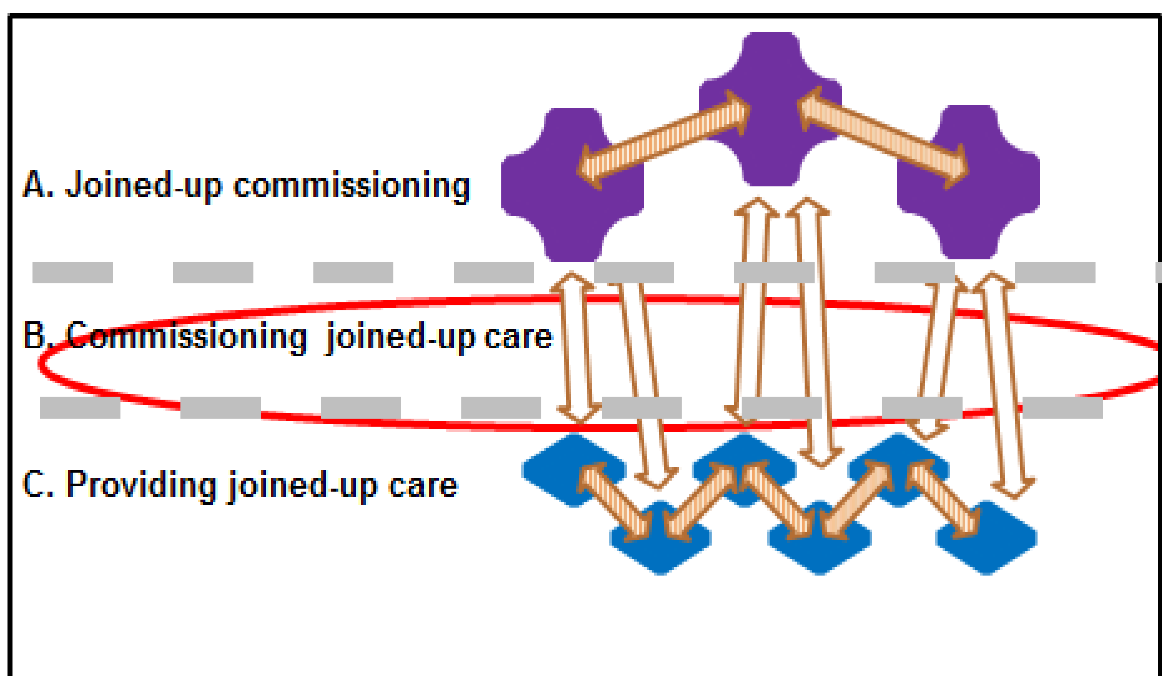
The long term conditions Year of Care commissioning model programme (LTC YoC) is a four year national programme which commenced in June 2012. Its aim was to develop a currency for patients with one or more long term conditions. It was originally led by Sir John Oldham under the Quality, Innovation, Productivity and Prevention programme (QIPP). The original programme consisted of a national team and seven early implementer sites with a number of fast followers. Since June 2012, the LTC YoC commissioning model National Project Team has been working with seven early implementer (EI) sites to test and refine new models of commissioning and contracting for integrated care by developing a capitated funding model.

In June 2013, (year two of a four year programme), Kent, a fast follower, was invited by the LTC Year of Care commissioning model national programme to become an early implementer site. This invitation was prompted by Kent Public Health Observatory's risk stratification analysis work, looking at whole-population utilisation of health and social care services.

The Long Term Conditions Year of Care Commissioning Model Programme

The primary objective of the LTC Year of Care commissioning model programme is to develop a currency for patients with more than one LTC. It aims to do this by "Shifting the focus away from reactive, episodic care, towards a proactive, person centred model of care, irrespective of organisational boundaries and disease based pathways of care". Martin McShane at NHS England is the sponsor of the programme.

Figure 1



Year one of the national programme was focused on testing the hypothesis that “risk score is a good proxy for health and social care need”. This hypothesis was not proven but the data collected provided direction to develop a currency model based on numbers of LTCs.

Year two of the national programme was focused on data collection to support a currency model, in preparation for testing of the currency model in year three. This data collection included a longitudinal study of a cohort of 550 patients looking at service utilisation and a detailed, hospital based RRR audit (rehabilitation, reablement, recovery) of 100 patients. This data collection was designed to help the national programme identify possible information gaps and develop a data quality improvement plan (DQIP). Kent identified 1,650 patients from risk band 1. Risk band 1 represents the top 0.5% of people who have very complex health needs and use the most services.

Year three and four of the national programme is focused on shadow testing the currency and capitated budget approach by collecting and linking the data across a range of providers to test a potential tariff for each currency group. This intelligence will support the development of the strategic framework and contracting model to support implementation. This may result in new ways of working across providers.

The Kent Programme

Kent and Medway Primary Care Trust cluster had originally applied in 2012 to become a fast follower of the LTC YoC commissioning model national programme. South Kent Coast Clinical Commissioning Group (CCG) was the lead organisation representing the East Kent cluster. In early 2013 a number of integrated commissioning initiatives were beginning to realise some benefits and receive

national attention. At the same time, the Kent whole-population risk stratification report was produced and Kent was invited to become an early implementer site. It joined the LTC Year of Care commissioning model programme in early July 2013. The stakeholders comprised all seven CCGs, Kent County Council (KCC), Kent Community Health Trust (KCHT), Maidstone and Tunbridge Wells NHS Trust, East Kent Hospitals Trust, representatives from the hospices across Kent and the University of Kent. All agreed to support a Kent wide programme. Kent and Medway Partnership Trust (KMPT) joined later.

The Kent Structure

Thanet and South Kent Coast CCGs are the sponsor organisations for the programme and Hazel Carpenter, Accountable Officer for both CCGs, is the senior responsible officer (SRO) for the programme. In order to reflect the variety of commissioning and service provision across Kent, the LTC Year of Care commissioning model programme agreed to proceed with the following approach:

- a Kent would adopt a systems approach to reflect the key strategic health economies in Kent (East, West and North) so each health economy has its own implementation group.
- b Each system would follow the programme model concurrently to support currency development. In practice this means 550 patients from each area (cohort 1650).
- c KCC/Public Health would provide programme management support to co-ordinate the three areas.
- d Accountable officer/CCG clinical lead/CCG Commissioning Lead support would be sought in each system.
- e Each system would provide oversight within their health economy to the shadow implementation of the LTC Year of Care commissioning model.
- f The SRO would utilise the CCG Accountable Officer and Kent County Council structures to communicate the key messages associated with the model.
- g Having been granted EI status, Kent was also awarded pioneer status. To avoid duplication of effort it was agreed the SRO for the Year of Care programme would also, through the Integrated Pioneer Steering Group, provide information to the Health District Management Team and the Kent Health and Wellbeing Board.

So What Exactly is a Tariff and How Does "The Long Term Conditions Year of Care Commissioning Model" work?

The LTC Year of Care commissioning model is designed to be an annually risk adjusted, capitated funding model. The model focuses specifically on patients with multiple long term conditions and seeks to commission an integrated case management model of care. The model works by supporting commissioners to change the way they purchase services, thereby encouraging the various service providers to come together to provide services around the patient. The current model is explained below.

Currently commissioners receive a fixed pot of monies to provide services for their registered population. They commission (purchase) services from different service

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providers using different contract models. This way of commissioning often appears disjointed and does not support integrated working. The main types of health commissioning are:

a **Health Resource Groups (HRGs):** hospitals (acute services) are funded by HRGs which identify the interventions by conditions and charge accordingly. The price for the HRG is set nationally (national tariff) and is per person. So the more they see, the more they earn. Commissioners sometimes set limits (a cap) on the numbers seen to try and keep costs down. This care is reactive and episodic.

b **Block contract:** most community providers (KCHT, KMPT) are funded in this way. Essentially the commissioner purchases capacity from the organisation using a fixed pot of money. Once the capacity is used up the service cannot see anyone else until some capacity within the organisation is released (usually through discharge or death). The gap in service capacity is normally managed by creating waiting lists. The funds allocated are reviewed every year. The care model tends to focus on people with LTCs for long periods of time and, in some cases, many years.

c The services mainly interact with each other when crises occur.

d Each organisation has a separate contract and there is often limited opportunity or incentive for organisations to work together.

GPs and local authorities are funded from a different pot of monies and any services they provide are outside those mentioned above.

The LTC Year of Care commissioning model is trying to join up commissioning and combine the reactive provision of hospital services with the ongoing support of community services to develop “a proactive, person centred model of care, irrespective of organisational boundaries and disease based pathways of care” for people with long term conditions.

The recently published Five Year Forward View states that people with long term health conditions now account for 70% of the health service budget. The older we get the more likely we are to develop more than one LTC. To make sure individuals with multiple LTCs receive care in the most appropriate environment, therefore, we need to change the way we contract for services.

The LTC Year of Care commissioning model is testing the creation of a currency to help identify the people with multiple LTCs and the development of a tariff divided between hospital and community services to incentivise them to work together in the best interest of the patient.

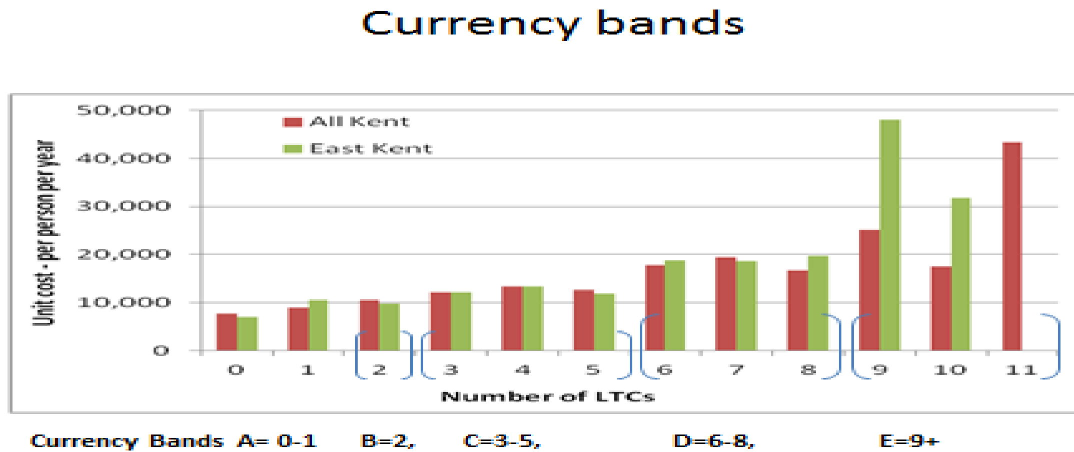
Developing a Currency

Kent used the data from the pilot cohort to develop its LTC Year of Care multi-morbidity currency. In Kent we have categorised the currencies as:

- currency group A 0-1 long term condition
- currency group B 2 long term conditions
- currency group C 3-5 long term conditions

- currency group D 6-8 long term conditions
- currency group E 9+ long term conditions.

Figure 2

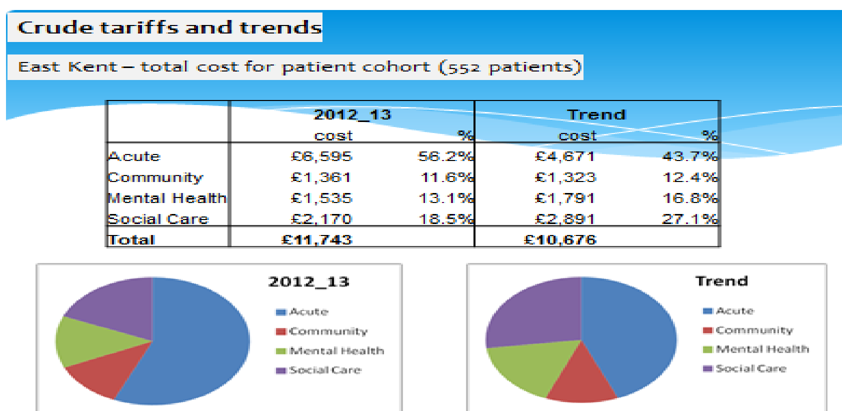


Developing a Tariff

The public health members of the LTC Year of Care commissioning model team have spent the last two years collecting and analysing pseudonymised/anonymised data from across the whole system (hospital, community, local authority, mental health and hospice) to make sure this approach to commissioning is accurate and will meet individual needs. This work has produced an indicative tariff for a mixed cohort of people and we are now trying to use that as a baseline.

The indicative tariff was calculated across the whole 1650 cohort of patients in risk band 1 and produced an annual cost of £11 thousand. This enabled us to identify an indicative budget of £19 million for this group of people.

Figure 3



Crude tariffs and trends

East Kent – total cost for patient cohort (552 patients)

	2012_13		Trend	
	cost	%	cost	%
Acute	£6,595	56.2%	£4,671	43.7%
Community	£1,361	11.6%	£1,323	12.4%
Mental Health	£1,535	13.1%	£1,791	16.8%
Social Care	£2,170	18.5%	£2,891	27.1%
Total	£11,743		£10,676	

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In year three we expanded the currency to include risk band 2 (people at risk of admission) and this means we need to develop a range of tariffs to cover each currency group. We are expanding the cohort to enable us to identify potential risk band 1 patients to help us to achieve greater efficiencies in the system. This was done by identifying those patients with a recent rising risk score (see below)

Testing the Currency and the Tariff

As stated earlier, we have categorised our currencies as bands A-E. Each currency will be assigned a cost (which is the average cost of all the interventions needed). The tariff applies regardless of the level of services used by the individual. It is reviewed annually to make sure that each part of the service is appropriately funded, but also to make sure that services can respond to the individual's need by increasing support to prevent hospital admission if this is in the individual's best interest. It is intended to incentivise the services to work together in the best interest of the patient.

Testing the tariff is about collecting the information to make sure we have assigned the right amount of resources (money) to each currency group and correctly grouped the currencies. The tariff is devised by calculating the actual cost of people within each currency band and producing an average cost per person against each band.

Selecting the Cohort

In year two we worked with patients from risk band 1 (1650 from the top 0.5%) and in year three we identified patients from risk bands 1 and 2 (top 5%) and seek to identify people from within these bands with increasing health needs (approximately 0.8–1.2%). Our methodology is outlined below:

Figure 4

Identifying patients suitable for YoC

- Risk stratification tool applied
- **LTC codes** applied (**18 in total - QoF**)
- **List segmented by LTC currency** (Bands B – E applied - B=2,C=3-5,D=6-8,E=9),
- Risk Score over time mapped (looking for **rise in risk score in last 6 mths** – 4 of 6 show an increase) or
- Rapid Riser in last 3 mths (mthly increase in **risk score over past 3 mths** and overall increase of >15pts).

This method identifies patients "suitable for a LTC capitated funding model approach". It has identified those patients currently on GP LTC registers who have gradual increasing service utilisation and who are likely to require a co-ordinated case management/care co-ordination or multidisciplinary team approach from primary care.

Figure 5

NHS
Improving Quality

Numbers in system at present – Dec14

- EK currently 38 GP practices pop – 352307(of 88 practices pop 752374)
  - Band B = 3549, Band C = 4993 Band D = 562
  - Band E = 22 – total 9129 (cumulative – 1 double count)
- WK – 13 GP practices pop 141,504 (of 64 practices pop 533585)
  - Band B = 1097, Band C = 1702 Band D = 256
  - Band E = 10 – total 3065 (2 duplicates)
- NK –DGS 33 practices pop 250999 (of 34 practices pop 253646)
  - Band B = 2304, Band C = 3401 Band D = 425
  - Band E = 20 – total 6150
- Currently Kent totals are 18568 of 744,810

Will Services be any Different?

The LTC Year of Care commissioning model will not dictate how services are delivered: this will be for local determination. It is building on many of the different service integration initiatives that are already in place in Kent. The programme's focus is on the commissioning model to support these initiatives. So, for example, single point of access, rapid response teams, proactive care and multidisciplinary team (MDT) approaches are some of the ways services have been changing to provide more joined up care to people with multiple LTCs. A similar range of services are being developed within KCC: services like re-ablement, intermediate care beds and tele-care. The LTC Year of Care commissioning model is pulling together all the information to support these developments by joining them up with information in the commissioning arena.

More recently, GPs have been encouraged to become an integral part of the community team with initiatives like the Enhanced Primary Care Team. All of these initiatives will support how we develop the LTC Year of Care commissioning model.

The commissioning model team is developing a system of measuring and reporting that will enable everyone to understand what is being provided: where, to what level and, more importantly, whether it is meeting the patient's needs. We are doing this by identifying areas where information is not consistently collected and developing a consistent approach.

What are the Benefits?

For Commissioners:

- a proactive, planned commissioning model built on intelligent data
- a systematic way of using all the information available to target services to those most in need (with multiple LTCs)
- a contractual model which supports service integration by enabling services to develop incentives across organisations/contracts
- greater transparency in services delivered with agreed outcomes
- a reduction in the non-elective activity in acute (not emergency) services.

For Providers:

- focus is on the patient and their care
- clearer definitions of roles
- incentives to work together across traditional boundaries and pathways
- integrated services with virtual or actual integrated services/teams
- an integrated care management plan which can be accessed by all involved.

For the Individual

- a named care co-ordinator who will liaise with all the other service providers on the individual's behalf
- a care plan that covers all their care (not just specific conditions)
- a proactive care plan that clearly states what the patient wants to happen when they are in crisis (as well as how to keep themselves well)
- regular scheduled reviews of the care to reduce crises and improve wellbeing
- fewer crises that result in trips to A&E/hospital admissions because the care is being better managed by everyone involved.

Where Are We Now?

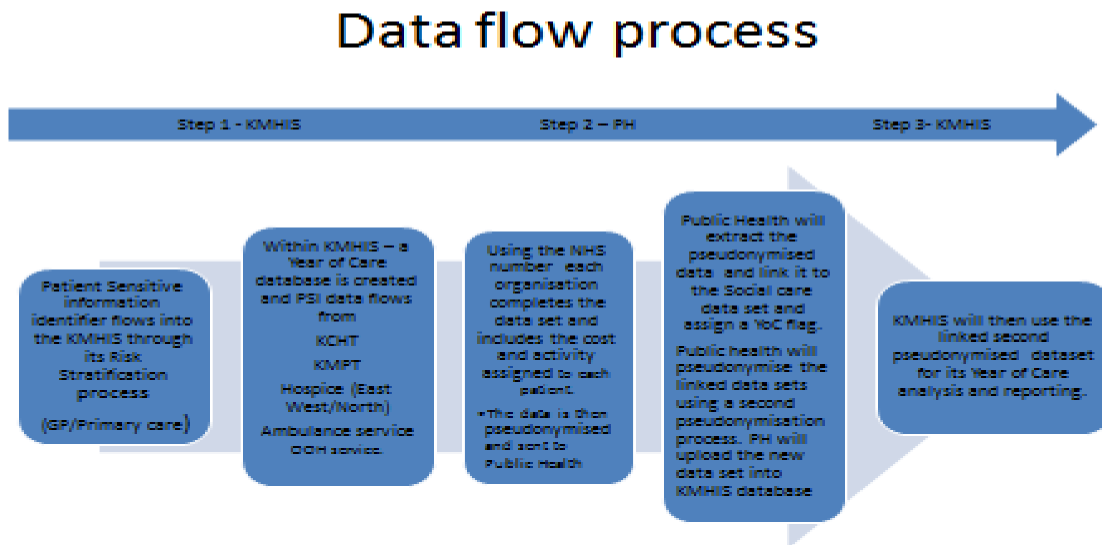
Year three and four of the national programme are focused on shadow testing the currency and capitated budget approach by collecting and linking the data across a range of providers to test a potential tariff for each currency group. This intelligence will support the development of the strategic framework and contracting model to support implementation. This may result in new ways of working across providers.

Year Three of the Kent Programme

As stated earlier, year two was all about collecting the data and creating the structure in each of the systems (East, West and North Kent) to oversee the implementation of the LTC Year of Care commissioning model and currency. The data collected has produced a Kent costing report. The costing report has helped us to develop our currency categories (ABCDE) and we now need to assign a tariff (cost) to each category. In year two we worked with patients from risk band 1 (1650 from the top 0.5%) and in year three we identified patients from risk band 2 whose

needs are increasing (top 2%). During year 3 the programme collected whole population data retrospectively and linked it across organisations using the double pseudonymisation process

Figure 6



Using this data linking method the programme collected and linked a longitudinal data set data from five organisations across the system to produce an interim report which can be accessed here: http://www.nhsiq.nhs.uk/resource-search/publications/population-level-commissioning-for-the-future.aspx

We have now worked out how to link the data at an anonymised individual level and want to look at whether particular combinations of LTCs impact on service demand and help commissioners better understand what they need to commission to meet that need. Being able to look at data in this way will ultimately help commissioners understand individual need and support the personalisation and individual health budget initiative.

To support "testing the implementation" we are working with the Kent and Medway Health Intelligence Service and by developing a dashboard to monitor service models. This monitoring will include making sure the identified benefits are realised.

By understanding the CCG population and segmenting them in this way the commissioners and clinical leads can identify the best way to meet the population need and commission a model of care appropriate for that population. The dashboard presents this complex information in a way that people can see "at a glance" what is happening and support commissioning decisions. Some examples of the dashboard are outlined below.

Figure 7

The intention is to ensure that people who meet the currency criteria and for whom an integrated care plan approach would be helpful will be offered the opportunity to have an integrated care plan. The data being collected is routine administrative data which is collected for contract and performance purposes. If, as a result of the information, a clinician decides to engage in discussion about direct care with an individual it is at this point that “explicit patient consent” will be required as it will impact on direct patient care.

All of our work will be shared with the national programme and we will continuously evaluate the impact this new way of commissioning services will have on the whole system.

The project groups in each of the systems are scheduled to meet quarterly and the five early implementer sites meet to share learning, resolve issues and communicate the work across the wider NHS platform.

Next steps:

- link the data at individual level using the # anonymisation process (April 15)
- report the data at anonymised individual level and track and link specific LTC by cost
- increase the number of GP practices involved and flowing GP data to KMHIS
- increase the number of providers flowing data to KMHIS
- link the work to the different system wide Integrated Care Initiatives across Kent (starting from workshop on 02nd March)
- develop a Data Quality Improvement Plan for each ITC initiative to enable accurate tracking of service initiative

- work with Commissioners and Providers to develop a commissioning model in each system
- work with commissioners and providers to develop the contracting model to support the commissioning model
- develop a standard set of reports and dashboards to support the monitoring of the Integrated Care services across Kent – (similar to the interim report mentioned earlier but with better quality data).
- agree how patients will move between different contracting models – whole population approach.

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References

http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissioning-model.aspx

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