Developing the role of primary care Clinical Care Coordinators with Leeds West CCG

‘It’s All About the People’

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A bit about Leeds West CCG

37k population
38 GP Practices
National Context

A need for Primary Care Transformation

- Ageing population, increased multi-morbidity & frailty
- Older people majority users of many health & social care services; frequently move between services & organisations
- Need for better integration btw health & social care

NHS England Avoidable Unplanned Admissions (AUA) direct enhanced service for primary care 1 April 2014
- Most ‘at risk’ population to have proactive co-produced care plan (top 2%)
- Placed additional processes on primary care
- Didn’t account for time/skills needed to undertake pro-active case management

Then 5 Year Forward View: Everyone Counts – Planning for Patients 2014/15-2018/19
- CCGs expected to support practices to transform care of patients over 75 yo
- Funding @ around £5 per head of population for each practice

Leeds West CCG

38 Proactive Care Microsystems

Leeds West GP engagement exercise:
- Need for better alignment
- Need for improved communication with wider health & social care teams
- More simple referral pathways

Patient GP Satisfaction Survey 2014-15 indicated need for:
- Improved behaviours i.e. involve patients in consultations
- Better communication with other services

Decision to pilot 38 Clinical Care Coordinators (CCC):
- Funded additional nurse time to support proactive care
- Hosted by primary care
- Fill the gaps within individual practices
- Enable pro-active case management
- Link out into the community
- Working closely with the Integrated Neighbourhood Teams (INT)
Care Coordination Definition (n=40)

Care coordination reflects a process that occurs most often during & in response to care transitions; and involves activities or approaches that bridge gaps arising from those transitions (AHRQ, 2014)

Care Coordination key components
(The King's Fund 2013):
• A move to community-based MDT teams
• Based around general practice
• Include generalists working alongside specialists
• A focus on intermediate care, case management & support, home-based care
• Joint care planning
• Co-ordinated assessments of care needs
• Personalised health care plans
• Named care co-ordinators who act as navigators & retain responsibility for patient care
• Clinical records that are shared across the multi-professional team.

Care Coordination

Delivery Challenges

• Different ways of coordinating clinical care are reported in research (Health Foundation, 2011)

• No comprehensive list of interventions improve coordination

• Not possible to directly translate what working in one context to another

• Evidence lacking as to optimum set of skills/qualifications required
Care Coordination in Primary Care: A Community of Practice

What works for care coordination in Leeds West?

Find answers to:
- What CCC interventions actually make a difference?
- How can Leeds West CCCs show they are making a difference - which measures?
- Are quantitative measures a valid way to measure impact?
- Does care coordination approach add value for patients?
- What are the unintended consequences of CCCs?
- How do we spread what works?


The Proactive Care Microsystems
The Patients

Proactive Care Population not easily defined

Different clinical systems: SystmOne & EMISWeb; different case finding tools

Microsystem specific case finding approaches:
- drilling down i.e. by age (>80 year old) or risk profile (LTC count)
- Needs based inclusion of patients < 75 years old
- Clinical profiling: anxiety, recent discharge, dementia, falls history, recent bereavement
- Intra- and inter-team referrals: GPs, Community Matrons, INT

Case load interplay – double counting on registers/funding streams i.e. AUA

Case load determined by CCC skill set: exclusion of complex patients (COPD, Diabetes, CCF patients)

The Patients

Practice I patients:

‘Care Coordinators find their own case load in several different ways. These include referrals from GP, referrals from outside agencies including Age UK, Community Matrons, and self-identifying vulnerable patients using the Risk Strat tool or the 3 day post discharge phone call.’

Case finding in this way [using the CCG risk stratification tool] is labour intensive and complex. We generally search for patients that are over 75, have more than 2 medical conditions and highlighted as vulnerable. We include patients on the AUA register if they need proactive care coordination.’
The Patients

Practice P patients:

We try to make the initial "care planning" review coincide with their chronic disease review. However, because ‘K’ doesn’t do Diabetes/COPD/Asthma reviews, she only does the "care planning" for patients without these conditions.

Longer term our nurses will get more involved with doing the "care planning" for the Diabetes/COPD/Asthma reviews. We have not included the 2% register patients, so these are completely separate.”

The Professionals

The CCG

- Clinical Lead GP – encouraged different ‘Proactive Care’ models
- Day to day leadership from CCG Locality Manager - supporting model (across 38 GP Practices) alongside ‘day job’
- No formal CCG evaluation plan or additional resources
- No CCG standardised guidance re: processes e.g. caseload/data quality
- Opportunistic quality improvement support – frontline focus
- Clinical Lead declined foundation level QI training for all CCCs at start up
- CCG Manager & myself – conduit for sharing & learning among CCCs & across 38 Microsystems (CoP & site visits)
The Professionals
The Clinical Care Coordinators

A single generic job description:
• Assessment of patients & care planning
• Data collection
• Key contact along with the named accountable GP for the patient
• Key to relationships between GP Practices & INTs
• Attend GP case management meetings
• Identify patients admitted / attended A&E & review
• Support discharge planning for those admitted

CCC approach adapted to needs of Microsystem:
• A variety of staff grades
• Not all qualified nurses - support workers, administrators, ICU nurses
• Clinical vs. non clinical roles depending on experience
• Different capacities: wide range of WTEs, job shares, enhanced Practice Nurse role vs. admin supporting Practice Nurse

Proactive Care Microsystems

Different models

Practice T:
‘So our model is using ‘J’ as the admin care coordinator who does a lot of the ringing around/booking patients in/signposting over the phone.
Then the clinical care coordinator role is shared out between our nurses and HCA - it’s whoever the patient has seen the most historically (e.g. a diabetic patient would have the diabetes nurse as their clinical care coordinator.
‘J’ will look for patients due their chronic disease review, and when she rings them up to arrange their review she will assess if they are suitable for "care planning" too.
We have not included 2% patients (these are on a separate caseload) and we have excluded all care home patients as we get paid for these under the enhanced care home scheme.
Practice H

‘The care coordinators work with the 2% case management register only. I work 37 hrs a week and visit patients in their own homes as it give us a greater understanding of the home dynamic, environmental set up, and other social issues. I have an active working case load of 53 patients I see on a regular basis and the responsibility of reviewing and contacting anyone on the 2% register following discharge from hospital.

The Processes

- Care Coordination in Primary Care CoP events (monthly)
- No central repository - CCCs declined virtual forum in favour of group emails
- Staff development aligned to their Microsystem approach: prescribing courses (equipment), phlebotomy, Year of Care
- Different referral processes:
  ‘GP’s refer into the service by sending an EMIS task. They will have reviewed the patient prior to our involvement We then contact the patient and arrange a visit with the patient and their family.’
- Different assessment & discharge processes:
  ‘The Care Coordinator has her own assessment template in the practice. This is a rough guide to highlight the issues that the patient has. When there is no further requirement for the Care Coordinator we stop seeing the patient but do not discharge from the 2% case management register.’
- Different care planning approaches: experience determined, templates varied
The Patterns: Quantitative

Underpinned by Measurement for Improvement

- **Decided collaboratively @ CoP events**: what felt CCCs could influence, what they could measure/already collected routinely

- **Outcome Measures**:  
  - Weekly number of hospital admissions  
  - Weekly number of A&E admissions  
  - Weekly number of primary care clinician contacts  
  - Weekly number of out-of-hours consultations

- **Process Measures**:  
  - Number of patients on care coordinator case load with a care plan

Quantitative Measurement

The Challenges

- Data quality inconsistencies e.g. read coding A&E admissions  
- CCC/Practice Staff clinical system skills – data extraction  
- **Human factors**: data capture/analysis not their role to collect & analyse data; only exposed to measurement for performance ('CCG should do this centrally')  
- Right people not around the table i.e. Data Quality Support  
- Leadership presence/support limited  
- No set up phase - no baseline data pre CCC implementation  
- **No control group**: how know the change is an improvement?  
  - decision to compare ‘provision of proactive care’ caseload with '>75 year old’ case load
Run charts – Practice P

The Patterns: Qualitative

- Individual CCC narrative & tacit knowledge shared via CoP events
- Individual CCC Learning Logs & Significant Event Analysis
- Patient satisfaction surveys: on discharge from CCC (unless only telephone contact; patient unable)
- Staff feedback – questionnaire, post implementation only
- CCC value creation stories
- Patient stories requested for each Microsystem – not mandated
- Team Safety Climate & Culture Survey - to measure & drive team working improvements (intra- & inter-microsystems)
Patient Satisfaction

Q2: Do you have a named Clinical Care Coordinator who co-ordinates your care and support?

- Yes: 38
- No: 10
- Not Sure: 29
- (Blank)

Practice T

Patient feels she could be supported better by the surgery in the care and treatment of her COPD. She also feels that she should be given an appt to be seen (F2F not telephone) if her chest is bad as she has COPD.

Happy with the care she received from HCA, said she thinks of her not just as a Nurse and co-ordinator but as a friend. Proving J was the perfect choice of co-ordinator. said she “could not receive better care from a surgery anywhere else in the world”!!!

Commented that Alzheimer’s dementia diagnosis not on patient’s summary and she has to explain this to every clinician patient comes into contact with.
Practice P

Team Culture
- n=48 replies; 6 Proactive Care Microsystems +/- members of their INT
Team Culture

I have the support I need from other personnel at the GP Practice to care for patients

The GP Practice team here work together as a well co-ordinated team

Respondents
Do we know the change is an improvement?

- Poor response staff satisfaction questionnaire - questionnaire may not be best method
- Staff interviews/focus groups - talked about but not captured
- Should we tape CoP conversations – also need to get narrative from GPs, Practice Managers, INT members
- No Learning Logs or SEA shared by CCCs
- No engagement with patients stories - one case study only
- CCC push back re: measurement emphasis in CoP sessions
- Run charts inconclusive without baseline or new tests of change
- Reluctant to make changes /replicate what others are doing

What has been achieved?

- **CoP supports intra- and inter- microsystem relations**: sharing with the wider health & social care ecosystem e.g. Adult Social Care, Dementia Support Workers
- **Solution focus**  e.g. Adult Social Care referral pathway
- **Primary Care has greater knowledge of what community has to offer** through CCC building relationships
- **CCCs act as a point of contact for outside agencies**: forming a bridge btw GP Practice and community
- **Some CCCs viewed as asset in their microsystem** i.e. MDT meetings, sign posting for other pts
- **Comraderie and peer support** - extended beyond confines of monthly CoP events
- **Staff empowerment** - demand for complex client discussion, learning in CoP aligned to conditions (not just measurement for improvement)
- **Staff development** - quality improvement methodology, prescribing courses etc
Barriers to Successful Change

- Proactive Care Microsystem significant approach & process variation
- Lack formal evaluation framework
- Time spent problem solving around processes to support evaluation – time CCCs would have preferred spent sharing good practice
- CCC identity not established in wider ecosystem
- CCC resisting their role in measurement for improvement – deprioritised next to their other responsibilities
- CCG Leadership - support for QI methodology not visible
- System wide changes disrupting the microsystem - BCF evaluation mandates; Locality Manager on extended period of leave

Reflections

From the Improvement Academy perspective

We wouldn’t have started in this way…

Instead would have ensured conditions for improvement in place - leadership, QI training, implementation & evaluation plans

I attempted to support the CCG to:
- Imbed QI methodology into the Microsystems via the CCCs & CoP
- Change behaviour of frontline staff, specifically the CCCs
- Demonstrate change through measures & run charts plus qualitative data
- Drive change & continuous improvement in Microsystems using simple QI tools i.e. PDSA cycles
- Harvest & share learning across Microsystems
My Reflections

1. We have bad systems, not bad people
2. The Proactive Care Microsystems evolved differently & at different rates – it is no-one’s ‘fault’ that some microsystems don’t appear to work as well as others
3. The CoP was more successful than the measurement & QI
4. Time needed to achieve change: the development of relationships has taken time to nurture; difficulty imbedding QI methods within Microsystems even after 18 months
5. If going to improve the Proactive Care Microsystems, need to change how they do things
6. Don’t always recognise the difference between ‘change’ and ‘improvement’, so, we need to test the changes before we implement them elsewhere
7. We DO need objective ways of measuring the impact of the changes
8. This is going to require measurement & therefore, behavioural change - not just with CCCs but whole Proactive Care Teams

If you want to understand something, try to change it

Goran Henricks

“Every system is perfectly designed to achieve exactly the results it gets.”

Donald Berwick

So ... if you want different results you have to change the system.
How do we get to the PDSAs?

Need to identify opportunities which lead to action…

What’s next?

• CCG endorsement of accredited foundation level QI training for CCCs

• Visible & supportive CCG leadership – QI not performance; CCC role identity

• Work closely with CCG to get conditions right for measurement for improvement – data analysis resource

• Review measures per Proactive Care Microsystem – potential to drive local change through PDSAs; support continuous improvement
More what next…

• Patient stories/narratives – what is important to them?

• Formally capture staff feedback – what works/doesn’t?

• Microsystem impact case studies: which CCC approach/processes stand out? Can these be replicated elsewhere?

• Scale up/spread what works - supported by data

• Opportunity for ‘Silver Training’ for teams – QI capacity build

• Opportunity to re-define ‘Proactive Care’ for Leeds West - Co-Commissioning April 2016

Any questions?
References

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• Wenger et al (2011) Promoting and assessing value creation in communities and networks: a conceptual framework; Ruud du Moor Centrum, Open University
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