NHS National End of Life Care Programme[i] **End of Life Care Modelling Tools**

YH Co-Design Model (formerly Yorkshire and the Humber Commissioner Financial Model)

CASE STUDY

Lancaster, Morecambe, Carnforth & Garstang Clinical Commissioning Consortium (The Consortium)

The National End of Life Care (NEoLC) Programme supports the early adoption of modelling tools, designed to help achieve the NEoLC Strategy[ii] and the NHS QIPP agenda of improving quality and productivity with innovation.

Key points:

Lancaster, Morecambe, Carnforth & Garstang Clinical Commissioning Consortium are located in the North West of England. There are around 120 local GPs involved, and the registered population is around 160,000. Being an early adopter of the YH Co-Design Model (The Model) has enabled them to:

- Understand and interrogate local data on how we currently treat our frail elderly population in the last year of life.
- Work collaboratively based on data to reach agreement quickly, on the number of people who could benefit from service change and the local alternative care pathways
- Increase partnership working with the local hospital; develop service and financial plans that are owned by clinicians to support agreed priorities for patients
- Have genuine informed engagement with existing providers on potential solutions, as the basis for a business case to develop end of life care services.

What did the Model tell us?

The Model is not a clinical decision-making tool. At a local population level it provides estimates of the number and scope for care to be delivered in Community rather than Hospital setting.

In a local cohort of 450 there were 899 hospital admissions, the Model indicated that 41% of admissions in the six month period at the end of life were potentially avoidable. These are identified as Type 2 and 3 admissions. The Model allocated these to Alternative Pathways of Care costed according to the level of patient need and related level of workforce skill; with Pathway B providing a Supportive Level of Care and Pathway C Intermediate level of care. Using the Hospital Length of Stay, the Model calculated the potential Bed Days Saved.
59% of the funding continues to flow to the Hospital as before. These are identified as Type 1 admissions.

What did we do about it? We recognise that re-design and investment in new services may not save our CCG money in the first instance. We are committed to ensuring that patients are transferred to hospital only when they need to be there.

In the **immediate term** we used the Model to get better engagement to find solutions across primary and secondary care.

Level of change	**What was the objective?**	**How did we measure it?**
1 Reaction/ engagement	Named stakeholders are willing and ready to review and change services	Reaction and degree of commitment to change
2 Learning	Using local data to build common understanding and knowledge between clinicians, commissioners, data coders and performance analysts	Learning and confidence after workshops
3 Application to their job	Using the outputs of the Model to consider local patient flows including reasons for admission and alternative local care pathways.	Application of the learning through agreed action plans

Plans to be taken through **over time to support future service planning**

4 Service Impact	Changes to practice that result in better end of Life Care.. % of deaths in usual place of residence	Impact on services
5 Target financial ROI	Financial Return on Investment (ROI) % (monetised impacts only). Payback/ value for money	Financial Impacts
6 Service improvement	Affordable better end of life care for clients as measured by their outcomes	Non financial impacts, including use of ELQuA

How easy was it to do? The web-site estimated 10 days of an analyst, 6 days of commissioner time and 2 days each of other workshop attendees to create your first version, spread over upto 12 weeks. Then using the model over a period of months to properly understand and direct local decision-making.

In practice the first version using our local data was created quite quickly. We found it helped a great deal to have senior service and clinical lead, working together. With telephone and email support, the local analyst populated the model with our local information ready for the first workshop.

86% of participants at the workshop rated the quality of the discussion as Good or Excellent. It is the use of local data focused on the care received, that creates high quality and practical discussion of what is possible. Everyone considered the workshops to be Significantly or Completely relevant to the organisation and to their role.

It required everyone to attend three three-hour workshops over a 12 to 16 week period plus the commitment of a core team of three throughout.

CASE STUDY – DETAILED REPORT

1 Context

The Consortium is well established, having been set up as a formal "Practice Based Commissioning Consortium" under the previous Government strategy to involve GPs in decisions about health services. The Consortium has moved forward under the new Government White Paper proposals and is a "Pathfinder" consortium. Throughout, the Consortium has had full support from the North Lancs Primary Care Trust, and has been appointed as a formal sub-committee of the PCT since 1st April 2011 to lead commissioning for the area.

What attracted the team – need and expected benefits?

"We are motivated to adopt and develop best practice and would value a place on the EoLC Modelling Tools Masterclass". This was the driver to attend the Masterclass in Summer 2011.

"I am confident that this will be interesting and productive work that will move us forward in our plans to build on the excellent work on End of Life care that already happens and would be grateful for you input". This was the invitation to the Early Adopter stakeholders"

They identified End of life Care as one of their priority areas. At the time, all GP practices within the Consortium were undertaking the Going for Gold quality improvement programme through the Gold Standards Framework (GSF)[iii]. The local secondary care provider also planned to register for GSF in 2012, with a number of Care Homes working towards improving End of Life care through GSF and other service improvement initiatives. The use of Liverpool Care Pathway was seen to be embedded in the local health care community and work had begun to increase the numbers of patients with an advanced care plan or discussion as to their preferred place of care. However, they recognised that there was more work to do.

A new End of Life Care board was being established to reflect the new health localities with representation from all key providers who deliver end of life care and who need to work collaboratively to drive service improvement.

2. Range of Provision – who was involved/which stages of EoLC pathway?

The Consortium involved clinicians and managers from North Lancashire Teaching Primary Care Trust (NLtPCT), University Hospitals of Morecambe Bay NHS Foundation Trust, Morecambe Bay PCT.

The core team was led Dr Peter Nightingale, Macmillan GP and Lead for End of Life Care and Helen McConville, Commissioning Manager, Unscheduled Care, with Christine Graham as information analyst

3. Vision of team in taking up offer of EoLC modelling support and Early Adopter status.

The vision was to collaborate across primary and secondary care as stakeholders in the work to determine the future funding of Palliative Care services in The Consortium.

Our strategic aim is to reduce the numbers of expected deaths that occur in hospitals and, whilst we have had some impact on this in recent years, we anticipate that the increase in patients on Palliative Care registers that we achieve through the Going for Gold programme will begin to have an impact on other parts of the healthcare system in the coming year and capacity in community provision will become an increasing problem.

We have undertaken a self assessment of our End of Life commissioning against the Quality Markers and this clearly shows that our Palliative care services do no extend adequately over the 24 hour period. In addition, recent staff changes at the local hospice mean that we need to give consideration to our workforce planning in respect of Specialist Palliative Care Consultant's post.

Once it is run, the tool can produce a range of reports that are used to inform discussion and decision-making of Commissioners and Providers.

4. Model choice – why this one? Who would you say could use it?

We chose the YH Service Co-Design Model because it is focused on practical issues including:

- Change in place of death to usual place of residence, communication across providers, 24/7 care in community, rapid discharge.
- Preferred place of death/workforce/cost analysis
- Enabling choice place of death/early recognition/workforce flexibility/team knowledge/alternative pathways/understanding current spending/service improvement targets . Financial savings whilst delivering quality

The source of these comments is the Workshop Evaluation forms which were gathered at each of the three workshops

5. Data used – details of required data, source, ease of access, data analyst support etc.

The model takes Office of National Statistics (ONS) and Secondary Use Services (SUS) data for the period of one financial year for the given population. The focus is on establishing how many people who died in an Acute Hospital could reasonably have ended their days in an alternative care setting. It identifies those Alternative Pathways of Care and what the costs of that alternative might be. It then calculates Acute bed days saved by the change.

The model is structured to (i) gather data (ONS residence and mortality data and SUS data of current actual episodes and spells in hospital and the related costs of care over a specified period) using the NHS number to match data from different sources and provide a unique identifier for each record, then (ii) apply decision criteria to that data to tag each spell. This tag or Type is used by the model to allocate records to pathways.

As part of the work we are required to develop local Alternative Care Pathways and their costs . The Model will then automatically allocate each record to a Type and thence to a Pathway of Care, using a calculation engine within the model.

We chose the 12 month period to August 2011 as input data. This showed 450 LMGC patients aged 75 and over who died in hospital in that period. We chose a six month period for any hospital admissions for those patients prior to their death. This equated to 899 hospital admission for that

patient group. The projected estimates for the Model are based on population increases between 2010 and 2015 in Lancaster district.

6. Resource implications of becoming an early adopter of the YH Service Co-Design Model – regular and additional time/ money/expertise.

" We welcomed the focused approach using a new tool in three workshops. Our analysis was undertaken between November 2011 and February 2012"

In order to use the model we need a key group of stakeholders to commit to attending 3 x 3 hour sessions; Lois Bentley who developed the model facilitated the first session and provided ongoing support to the small core team undertaking the work in between the three larger group meetings.

Tool rating by the local information analyst " Initially a challenge but became easier". It took 30hrs in total of analysts time to input local data before the first workshop and then support use of the tool over a 16 week period.

"The value of the tool came with the more in-depth analysis of the admissions and Types after the 1st workshop. This analysis will vary depending on what comes from the workshops and what the clinicians/commissioners want from it. It's worth spending time at the beginning getting all potentially relevant data into the dataset (not just selecting the fields specified by the model) as this will make it easier to provide detailed analysis later on". Extract from analyst's evaluation of the Model

7. Impact of workshops on attenders, and implications.

Expressed benefit of being an Early Adopter

- A robust model which will progress work started
- Task & finish approach
- EoLC is priority for development by PBC
- Transferable skills - Led by Macmillan GP/PBC – already on "going for Gold". Many will want to learn from this "hands on" approach.

Each workshop was evaluated by attendees. At the first workshop 63% considered the overall experience of attending the workshop to be Good or Excellent. This was immediately as strong score but by workshop 3 that had risen to 100%.

8. Impact on services now.

Commissioners developed an overarching Service Specification based on the findings from the workshops. This has gone to existing providers with a request for them to work together. They were asked to consider how they could re-design services to be better co-ordinated and managed between them, whilst adding capacity. We shared information with them on the additional patients that the model suggested could benefit from 24 hour palliative care services in the community and asked them to offer potential solutions.

9. Impact on future services, including costs.

We recognise that re-design and investment in new services may not save our CCG money in the first instance. However, we are committed to ensuring that patients are transferred to hospital only when they need to be there. We cannot change the landscape of provision without making an investment to change our community services

Measures of Success

A. Increase the proportion of people who die in their preferred place of care/or appropriate surroundings (Measured by QIPP indicators 2 and 4 below the table)
B. Reduction in unplanned attendances by more effective working together (measured by QIPP indicators 1,5 and 6 below

The Return on Investment Method will enable us to measure impact and costs over time. At the time of writing we are at level 2 and have measured engagement and learning with 100% seeing this as significantly or Completely relevant to their role and 71% of attendees confident in using the model as part of a multi-disciplinary team.

Level	What is the need?	Objectives related to:	Timescales for measurement
6 Service improvement	Affordable better end of life care for clients as measured by thier outcomes	Non financial impacts	0-24months Apr 2012 to Mar 2014
5 Target financial ROI	Financial Return on Investment % (monetised impacts only). Payback/ value for money	Financial Impacts	6 -24 months
4 Service Impact	Changes to practice that result in better end of Life Care	Impact on services	1-6 months then 6-24 months
3 Application to their job	People within the existing paid and unpaid workforce need to apply the learning and change what they do.	Application of the learning	1-4 months
2 Learning	Knowledge, skills, personal and integrated capacity building	Learning and confidence	0-3 months
1 Reaction/ engagement	Named stakeholders are willing and ready to review and change services	Reaction and degree of commitment to change	0-3 weeks

Relevant measures include:Links to QIPP indicators

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1. Reduction in number of None Elective Spells (activity and cost) vs baseline and use of new services (e.g. Rapid intervention and end of life service, Care Homes Support Service)
2. Percentage of deaths in usual place of residence)
3. Identifying the 1% of population at end of life (primary care)
4. Reduction in number of people who die in hospital through use of alternative services
5. Reduction in the percentage of patients admitted more than 4 times in last year of life (Matron service)
6. Reduction in A&E attendances- activity and cost

10. Impact on service users – plans to capture and measure this?

Part of our proposed service re-design will include some education programmes that will run for people with long term conditions and their family members; this will include aspects of advanced care planning. In time we expect that we can use this engagement to evaluate people's experience of using the services.

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[i] www.endoflifecareforadults.nhs.uk

[ii] Department of Health (July 2008) – End of Life Care Strategy for England and Wales – promoting high quality end of life care for all adults at the end of life, Crown, London.

[iii] www.goldstandardsframework.org.uk