Item No: 4.2 Enc No: 2

South Staffordshire NHS
Primary Care Trust

REPORT TO THE PBC GOVERNANCE COMMITTEE TO BE HELD ON: 10th March 2010

Enclosure:						
Subject:	South East Staffs Community Matron pilot					
Lead Director:	Sue Price					
Lead Officer:	Frances Sutherland					
Recommendation:	**For Approval**	**X**	**For Discussion**		**For Information**	

PURPOSE OF THE REPORT:
To request approval to invest in the development of a community matron service to support patients with Long term conditions in the South East Staffs locality.

KEY POINTS:
A six month pilot was undertaken in the locality with five practices in the Tamworth area. The outcome indicated a reduction in admissions to secondary care in the pilot practices. The pilot produced a net saving of £81,258 for the six months across five practices with a practice population of £44,000. The consortium wishes to mainstream this pilot across the district. This will require pump priming investment of £185,384. This is subject to Executive team approval to release LDP funding from care outside of Hospital.

CORPORATE OBJECTIVES:
CP 11 a - 4,748 more patients treated closer to home, rather than in Secondary Care from a secondary baseline of 59,963.

RESPONSIBLE COMMITTEE:

NAME:

APPROVED at Cmte: /NO Date of Cmte:

IMPLICATIONS:

Legal and/or Risk	If not undertaken the risk is increasing numbers of admissions into secondary and suboptimal care for patients
Standards for Better Health	2 Clinical and cost effectiveness 4 Patient focus 5 Accessible and responsive care

Patient Safety	Patients receive proactive case managed care
Patient Engagement	Reviews form the pilot
Financial	Requires investment to save admissions
PBC	PBC lead project
Training	Will require the team to have a high level of training in disease management and prescribing
Workforce	Increase in front line staff

RECOMMENDATIONS / ACTION REQUIRED:

The PBC Governance Committee is asked to: Agree the invest to save.

Service Provision Business Case Template

TITLE OF PROPOSAL	Community Matrons for patients with Long Term Conditions
ORGANISATION/ COMMISSIONING BODY	South East Staffordshire Consortium
LEAD NAME FOR PROPOSAL	Frances Sutherland
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Document Control

Document Version	Date of Revision	Summary of Revision

Section 1: Compliance with the PCT Commissioning Framework

This business case complies with the following priority areas as outlined in the PCT Commissioning Framework:

PCT Commissioning Framework Priority Areas: *PCT to complete PCT Commissioning Framework priorities as outlined in the PCT LDP and ISIP.* *Full details of each of these areas are available from your PCT*	**This business case relates to the following** *(Proposer to tick as appropriate):*
PCTS have specific targets on all of the following areas in line with national directives regarding achievement thereof, and practice are expected to work within these priorities as practice based commissioners. With regard to your specific service proposal, please tick all appropriate boxes served by your scheme.	
1. National priorities	
1.1 Improving health of the population	
1.2 Supporting people with long term conditions	X
1.3 Access to services	X
1.4 Patient/user experience	X
1.5 Achieving financial balance	X
1.6 Implementing reform	
1.7 6 key service priorities:	
- health inequalities	
- cancer 31 and 62 day waits	
- 18 week wait	
- MRSA	
- Patient Choose & Book	
- Sexual health & access to GU medicine	
1.8 Links with Integrated Service Improvement Plan	
(ISIP) & Benefits Realisation Plan (BRP)?	
2. Local priorities	
Development of pre referral systems	
Care closer to Home	X

Section 2: Outline of the Proposed Service Provision

Introduction
Give a brief out line of the background (i.e. current service provision and demonstration of need for improvement. Include Health Needs Assessment)

Within South East Staffs a small team of two community matrons and a nurse (3 WTE) covered a population of 154,000 and 24 practices. Originally the aim was for this team to support people with long term conditions. However, they were not having the impact that they should as they could not work closely with practices and spent a great deal of time travelling. The Consortium GPs also felt that this was a wasted resource.

A pilot was therefore undertaken and the team (2.05 WTE) worked with five practices in the Tamworth area over a six month period from July to December 2009. These practices had a combined population of 44,000. The team worked with the pilot practices, attending GSF meetings and working with specific patients referred to them. Referrals were not taken from practices outside of the pilot.

The objective of the pilot was:-

- To measure the value of community matrons working closely with practices to proactively case find and then manage high risk patients.
- To ensure value for money from this resource.

The pilot was evaluated in two ways:-

1. A case note review by a Consortium clinician to decide where admissions had been avoided. All of the patients where there was admission avoidance had either COPD and/or Heart Failure.
2. A review of the SUS data for hospital admissions over the six months of the project. The admissions for Heart failure and COPD were compared to specific non pilot practices with a similar population of 44,000 over this time frame.

Findings

The case note review undertaken indicated 25 saved admissions within the six month pilot. The clinician did feel that this was the minimum number of saved admissions and the number was probably higher.

The admission data (see Appendix 1 for further details) indicated a reduction in admissions from the pilot practices for COPD (30 % reduction) compared to the non-pilot practices (32% increase). For patients with CHF the pilot practices saw an 18% decrease in admissions compared to a 25% increase for the non-pilot practices. If the pilot practices had seen the same level of increase as the non-pilot practices, there would have been 31 more patients admitted with COPD and 13 with CHF.

Savings

The average cost of a COPD admission is £2,721 and for CHF is £3,097. As all patients go through A&E, there would be an additional cost of £80 per attendance.

Condition	Reduction in admissions during the pilot	Average cost	In patient costs	A&E attend at £80 per patient	Total saving for pilot practices

	COPD	31	£2721	84,351	£2,480	£86,831
	CHF	13	£3097	40,261	£1040	£41,301

This gives a total cost reduction in admissions of £128,132.

Costs

The team to undertake this pilot cost £46,874.

This produced a net saving of £81,258 for the six months.

Conclusion from Pilot

The pilot indicates that Community matrons working closely with practices and focusing on COPD and Heart failure appears to avoid hospital admissions. The caveats to this are that the practices in the pilot and control are different ie some are rural some urban. The commitment of the community matrons may also influence the outcomes

Taking this into account it does appear that the service is value for money and improves the quality of care for patients with long term conditions. The net savings to pilot practice in Tamworth over one year would be £162K.

Outline of Proposal
How does this link to PCT & Local priorities?

The Consortium wish to increase the numbers of community matrons to cover the districts of Tamworth, Burntwood and Lichfield.

The community matron teams would focus on patients with COPD and Heart Failure, working very closely with GP practices and district nurse to ensure patients improve their self management, increase in confidence and are supported in the palliative stage of their illness.

The Consortium wish to mainstream the pilot in each geographical area and will need an increase of four WTE with oncosts. This would require an additional investment of £187,496 per year.

Potential Savings

If the same effect was achieved across the districts the potential net savings could be £486K. However other schemes already commissioned will support the reduction in COPD admissions eg Pulmonary rehab. Therefore a more realistic figure would be £194K for CHF and £334K for COPD (2008/09 admission figures using pilot practice reduction and average cost) giving a net saving of £248K.

Aims & Objectives
(Please expand on the brief outline that you gave in the Commissioning Proposal)

To improve the care for patients with COPD and CHF.

To decrease the admissions for these Long Term conditions and therefore make savings.

To support patients to die at home if they wish.

Management of the Service *(Explain how the service will be managed i.e. receiving referrals, appointments, outcomes and waiting list requirements)*	Within the Provider Arm of the PCT. Referrals from the practices to which the matrons are attached. The community matrons would be part of the primary health care team.
Scope of the Proposed Service	Patients registered with practices in South East Staffs districts. Patients with complex health problems focusing on COPD and CHF
Clinical Effectiveness *(What evidence is there of the clinical effectiveness of the proposed service?)*	NHS Improvement Plan (2004) Department of Health. Caring for patients with Long Term conditions (2006) Department of Health Local pilot evidence.

What will be the benefits to Patients? (*e.g. How will this link in to Choice/Choose & Book?)*	Supported by clinicians when concerned about their long term condition. Some to provide education so better informed patients.
What will be the benefits for Clinicians/Staff?	Work within the primary health care team. Supporting and educating patients.
What will be the anticipated benefit area for the PCT *(i.e Number of Reduced Admissions / Avoided Out Patient attendances)*	Reduced number of acute hospital admissions. Reduced number of A&E attendances. More patients supported to die at home.

Milestones & Timescales	Milestone	Timescale
	Business case approved	? March 2010
	Recruitment process commence	April 2010
	Team in place	July 2010
	Working with practices and patients	August 2010

Initial Risks Associated with the Service Provision Proposal and Strategy for managing those risks (Countermeasure)	**Risk**	**Countermeasure**
	If these patients not admitted others maybe to fill the beds	Closure of acute hospital beds across the health economy
	Community matrons may not be as committed as present team	Ensure present team work with newly recruited staff. Ensure recruitment process positive.

Section 3: Financial Implications

Annual Expenses (Cost of New Service) *List a breakdown of all expenses, remembering to add on-costs to staff costs*	**Year 1**	**Year 2**	**Year 3**
Capital Costs			
computers	2,000		
Staffing Costs, *including backfill for clinicians running new service provision*			
Additional			
3.10 WTE band 7 plus on costs 22%	£92,345 + £20,316		
1. WTE band 5 plus on costs	£24,013 + £5,282		
18% top up for 52 weeks a year	£25,552		
Training supervision etc			
Equipment & Materials (short term in addition to loan store)			
Other Expenses			
Travel	£3960 per member of staff (lease car plus 0.11 per mile at 500 miles per month)		
Total Cost of New Service Recurrent	**£183,348**		
Capital	£2,000		
Anticipated Revenue reduction in admissions	**£353,760**	**£**	**£**
Profit Element for Service Provider		**£**	**£**

Anticipated Financial Benefit to	**Year 1**	**Year 2**	**Year 3**

PBC Budgets			
Anticipated freed up resources achieved through avoided secondary care activity. *Please specify:*	**£353,760 (against additional resource only)**		
Less Cost of new Service Provision to users of the service	**£183,348 plus £2,000 non recurrent**		
Surplus to PBC Budgets	£170,412 (this is against the additional investment only)		

How much funding is being requested & identification of purpose	£185,348 year one. Subject to executive agreement to release funding from LDP for Care outside of Hospital.

Section 4: Corporate Governance

Please note that some contracting methods will entail certain liabilities, for example a Limited Company option under APMS. It is therefore essential specialist advice is taken to understand clinical/personal liability, medical indemnity etc.

On which contracting basis do you intend this service provision to be based? *e.g. LES, PMS, SPMS, APMS, PCT GPSI Commissioned Service, please explain.*	Community Contract Provider services
Which National, NSF and PCT Targets will this service provision deliver against?	Long Term conditions Care closer to Home
Patient, Public & Front-line Staff Involvement. *Please describe how you have involved Patient, Public and front-line staff in this proposed development.*	Appendix 2 Patient feedback GP feed back Patient stories

Section 5: Quality & Corporate Assurance

Please note there is value in discussing your proposals early on with your PCT Clinical Governance Lead

Clinical Governance Assurances	
Please provide details of how the intended provider location meets Health & Safety and other Clinical Governance Assurance standards	As provider arm contract
Please Specify Audit arrangements ie, patient satisfaction surveys, reduction of hospital referrals & admissions	As provider arm contract
What Quality Checks will be in place?	As provider arm contract
What information will you supply to the PCT and with what regularity?	Patients contacts by the team monthly basis
Outline Contractual Arrangements (To be detailed in the Service Level Agreement)	
Proposed period of Contract	**3 years**
Proposed Notice Period	**6 months**
What Contract Review arrangements do you envisage?	As provider arm contract
How will Complaints be managed?	As provider arm contract

To be Completed by PCT:

Comments received:	**Date**
Practice Based Commissioning practice/consortia	
Clinical Governance Lead	
Executive Directors	
Professional Executive Committee	

Outcome of Application	**Name**	**Date**
Approved – on the basis of:		
Rejected - Reasons for Rejection:		
Passed for Payment:		

Appendix 1

Non Elective LTC Admissions by ICD-10 code FY2008/09 & FY2009/10

Source: CBSA SUS data 0809 & 0910; Master DB; FS LTC admissions by ICD-10 0809 & 0910

Updated 4/2/2010; HIS Warehouse New CBSA Tables; FS LTCs by ICD-10 v2 0910 query
Information based on months 4-9 data for FY2008/09 & FY2009/10, and ICD-10 codes from attached list
LTC ICD-10 code list

Provider_ID_Description	(All)	
CareTypeDescription	Non Elective	
PBC	South East	
Duration_of_Spell	(All)	
month_of_end_of_spell	(Multiple Items)	
organisation name	(Multiple Items)	

			PBR_Year			
LTC	**Pilot**	**Data**	**2008/09**	**2009/10**	**Grand Total**	**% change**
Congestive Heart Failure (CHF)	Yes	Spell	28	23	51	-18%
		Cost	67,529.	69,958.	137,487	4%
	No	Spell	20	25	45	25%
		Cost	59,698	78,704	138,402.	32%
CHF Spells total			48	48	96	0%
CHF Cost total			127,227	148,662	275,890	17%
Chronic Obstructive Pulmonary Disease(COPD	Yes	Spell	50	35	85	-30%
		Cost	104,293	88,182	192,475	-15%
	No	Spell	38	50	88	32%
		Cost	71,243	125,069	196,311	76%
COPD Spells total			88	85	173	-3%
COPD Cost total			175,536	213,251	388,787	21%
Total Spells			**136**	**133**	**269**	**-2%**
Total Cost			**302764**	**361913**	**664677**	**20%**

Appendix 2

Please note- All names have been changed to protect patient confidentiality.

Patient Story 1:

David is 61year old gentleman with COPD, insulin controlled diabetes and hypertension. He was referred by his GP as he was regularly accessing our of hours support and ending up in hospital as well as previously requesting hospital admission due to increased anxiety rather than due to his physical symptoms. He lived alone with variable social support.

The Community Matron Team were able to provide education, advice and support about normal variance of COPD symptoms and alert David to early warnings signs of exacerbations where he needed to seek help. David had previously been prescribed oxygen therapy 4 years previously and following monitoring and assessment the oxygen was able to be removed as he did not require it. Initially David stated at every contact that he had a chest infection and required antibiotics. The Community Matron was able to assess each time and provide reassurance that antibiotics were not always required as well as managing the reduction of oral steroid therapy without the need for the patient to visit the GP.

David had been using a nebuliser machine 4 times daily for several years and it was identified it had not been serviced for over 9 years. Replacement equipment was ordered which would be maintained properly.

The Community Matron was also able to arrange joint visits with Diabetes Specialist Nurse to assess current insulin regime, as current COPD medication was affecting diabetic control. Monitoring of his symptoms continued.

6-8 weeks after initial contact from Community Matron Team David started to state that he felt “well”. He has not attended A&E or been admitted to hospital for 3 months now.

Patient story 2.

Winnie is an elderly lady, who lives alone.

She has dementia; COPD; hypertension; arthritis and heart failure.

Her son lives 20 miles away and can only visit once a week due to work/family commitments.

Referred to team for help managing COPD. The team were able to support the care package and reduce GP visits, as we monitor her COPD symptoms.

When Winnie was discharged from hospital earlier in the year, her inhalers we not ordered on repeat prescription, so she only had a nebuliser, which wasn’t sufficient. The community matron arranged for the inhalers to be ordered regularly and requested that the carers prompt Winnie to take them regularly. This improved her breathlessness, so she wanted to start going out again. I referred her to the rehab dept to increase her exercise tolerance.

The community matron saved a GP visit, as Winnie had symptoms of a cold, she was assessed physically for signs of exacerbation and the carer was asked to increase oral fluids and contact the community matron if she felt the cold had deteriorated; as a district nurse I would have requested a GP visit for this.

Plan: monitor COPD and manage exacerbations at home with increased input from the team. Son and carer are able to access team if they are concerned. Winnie is eager to stay at home, so is reviewed regularly at home.

GP Comments regarding the pilot

From: Bowen Yvonne (West Midlands Strategic Health Authority)
Sent: 19 February 2010 18:57
To: Bevan Kathryn (SOUTH STAFFORDSHIRE PCT)
Subject: FW: Community Matron Pilot

Dear Kathryn,

The couple of patients I have shared with the community matron have definitely coped better with their problems, and they and their families have felt supported. At least one of them was able to stay at home when she would otherwise have been admitted, because of the increased confidence of her carers.

Yvonne

Patient comments

'They are always here for me'
'They give you confidence to carry on with life after the lose of a loved one. They help me very much
'The care and professional advice of the community matron which covers many aspects of my disease is invaluable to me'
'It an excellent service'
'Prompt service at all times'
They are first class either by phone- information or service
'I have all the confidence in my matron…. I do phone her when I am worried about anything and she tries to sort me out'
'The quality of care and understanding of my wife's condition is particularly good. The ease with which I and my wife can discuss our concerns with the community matron team is a help to myself as a carer''