NHS North Lincolnshire Clinical Commissioning Group

NHS England

JOINT COMMISSIONING COMMITTEE

MEETING DATE:	Thursday 9 April 2015
AGENDA ITEM NUMBER:	Item 6.0
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JOB TITLE:	Director of Commissioning
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ELDERLY CARE FUND

PURPOSE/ACTION REQUIRED:	Decisions for: To Receive & Note/Approval For Next Steps
CONSULTATION AND/OR INVOLVEMENT PROCESS:	
FREEDOM OF INFORMATION:	*Is this document releasable under FOI at this time? If not why not? (decision making guide being developed)* **Public**

1. PURPOSE OF THE REPORT:

This report provides an overview of progress made to date on implementation of the Elderly Care Fund during 2014/15.

The report then asks the Joint Commissioning Committee to approve finalisation of an enhanced service specification to be discussed with the LMC. In addition the Committee is asked to approve further work to establish the feasibility of the suggestions contained within this report for commissioning services at scale to support primary care in care of the elderly.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:

Continue to improve the quality of services	**X**
Reduce unwarranted variations in services	**X**
Deliver the best outcomes for every patient	
Improve patient experience	**X**
Reduce the inequalities gap in North Lincolnshire	**X**

3. ASSURANCES TO THE JOINT COMMISSIONING COMMITTEE

4. IMPACT ON RISK ASSURANCE FRAMEWORK:

Yes		No	X

5. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:

Yes		No	X

6. LEGAL IMPLICATIONS:

Yes		No	X

7. RESOURCE IMPLICATIONS:

Yes	X	No	

The services described within the paper will be funded in entirety by the Elderly Care Fund if approved.

8. EQUALITY IMPACT ASSESSMENT:

Yes		No	X

9. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:

Yes		No	X

10. RECOMMENDATIONS:

The Joint Commissioning Committee is asked to:

- Receive and note the up-date on the progress of the Elderly Care Fund during 2014/15
- Recommend finalising the ECF enhanced service specification and discuss with the LMC
- Approve further work to establish the feasibility of the suggestions for commissioning services at scale to support primary care in care of the elderly

Report to the Joint Commissioning Committee
North Lincolnshire Clinical Commissioning Group (NL CCG)
Elderly Care Fund (ECF) 2014-15

Introduction

In December 2013, NHS England published 'Everyone Counts: Planning for Patients 2014/15 to 2018/19. This document detailed the government's commitment to a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. The new GP contract for 204/15 secured specific arrangements for all patients aged 75 and over to have a 'named accountable GP', and for those patients who need it, to have a comprehensive and coordinated package of care developed.

This paper provides an up-date on progress made to date on implementation of the Elderly Care Fund (ECF) in North Lincolnshire.

National Context

Changes to the GP contract 2014/15 stated that:

'The named accountable GP will take lead responsibility for ensuring that all appropriate services required under the contract are delivered to each of their patients aged 75 and over, where required (based on the clinical judgment of the named accountable GP) they will:

- *work with relevant associated health and social care professionals to deliver a multi-disciplinary care package that meets the needs of the patient*
- *ensure that the physical and psychological needs of the patient are recognised and responded to by the relevant clinician at the practice*
- *ensure the patient 75 years and over has access to a health check as set out in section 7.9 of the GMS contract'*

(General Medical Services Contract 2014/15: Guidance and Audit Requirements page 9)

In order to support the contract changes relating to care of the elderly, the planning guidance stated:

'CCGs are expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This

funding should be at around £5 per head of population for each practice which broadly equates to £50 for patients aged 75 and over'.

This resource has to be used to:
'Commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people…... Practice plans should be complementary to initiatives through the Better Care Fund. In some instances, practices may propose that this funding is used to commission new general practice services that go beyond what is required in the GP contract and the new enhanced service (with NHS England involvement)….. In other instances practices may propose that this money be invested in other community services to secure integration with primary care provision. Practices should have the confidence that, where these initial investment plans *successfully reduce emergency admissions*, it will be possible to maintain and potentially increase this investment on a recurrent basis'

('NHS England Everyone Counts: Planning for Patients 2014/15 to 2018/19': pages 14-15).

Local Context

Following Engine Room and Governing Body discussions, North Lincolnshire CCG made the decision to commit the total £5 per head of population ECF budget to GP Practices for 2014/15. In the first instance practices were asked to submit proposals on what new or additional services they felt needed to be commissioned on their behalf by the CCG to support the role of accountable GP, improve care for those patients aged 75 and over, and achieve a reduction in reducing emergency admissions amongst this group of patients[1]. Based upon these proposals, an enhanced service specification was developed for 2014-15. The service specification was flexible in order to encourage practices to be innovative, try new ways of working to improve outcomes, and support delivery of the role of 'accountable' named GP'.

A requirement of the ECF enhanced service specification was the submission of an individual 'practice plan'. The practice plans detail how the individual practice would utilise the resource allocated to support the delivery of the accountable GP role and improve care for patients aged 75 and over. The specification also required practices to provide continual feedback throughout the year to the CCG (via CoM/Relationship Manager) to identify best practice in the care and management of patients aged 75 and over; highlight any perceived gaps in local services to support primary care in the delivery of the accountable GP role, and offer suggestions for system wide change/initiatives that will improve the outcomes for this cohort of patients. Practices were also encouraged to share what does not work well and change plans if this was deemed appropriate to secure improved outcomes.

Practices were informed during the course of 2014/15 that a minimum of £3 per head of the ECF budget would be committed to GP practice for 15/16. This was to allow forward planning/recruitment to support the delivery of practice plans during 2015/16.

[1] As set out in NHS England's 'Everyone Counts: Planning for Patients 2014/15 to 2018/19 using this budget.

Overview/Summary of outcomes to date

To date:

- Approximately 15,274 patients aged 75 and over have been informed of their named accountable GP
- Over 1,700 care packages/plans have been developed for patents aged 75 and over
- Over 1,600 patients aged 75 and over have received a health check at their practice

As might be expected given the variability in practice plans submitted, there are variations in ECF specific workload in practice. As an overview of current activity, the following elements are being delivered across practices:

- Practices have informed all their patients aged 75 years and over of their named accountable GP. Practices have established systems to ensure that processes are in place to identify those patients reaching 75 years during each month and inform them of their named accountable GP
- Increased clinical hours to focus on care of the elderly – though the number of hours and length of appointment varies considerably.
- Most practices have introduced 20 minute appointments to review care needs/develop care plans for patients aged 75 and over where appropriate. These are becoming more widespread and a common feature of appointment system
- Same day access to practice staff (as appropriate to need) for high risk patients/home visits for patients not able to attend surgery (blood tests/ECP input at some practices)
- Monthly reviews of patients aged 75 and over with care plans include, where appropriate, Multi-Disciplinary Team (MDT) input
- Proactive care planning to include parity of esteem (routine checks/vaccinations etc/dementia awareness etc.)
- Practices have started inviting patients in for health checks and clinical reviews. Some practices routinely review patients aged over 75 years every 6 months, others are focusing on inviting all patients aged 75 and over in for reviews/health checks
- Recruitment of additional clinical staff (Emergency Care Practioners (ECPS) /nursing input – including locums to back-fill) for GPs to allow time to develop care plans
- New primary care/community services, including, for example, Geriatric Clinics in a variety of locations to suit the needs of the patient (including home visits where appropriate) have been piloted with success
- Falls assessment clinics in community and care homes (have been piloted successfully)

Summary of Progress to date

While it may be too early to have a thorough evaluation on some of the initiatives, best practice is emerging as practices implement plans; this has informed the

development of an outcomes based Enhanced Service Specification for 2015/16 (to be funded through the committed £3 per head of population to practices)
Practices have provided continual feedback to the CCG on any perceived gaps in services (primary/community etc) to support primary care of the elderly and improve MDT working across the health and care system.

At the Council of Members meeting in January 2015, a request was made for volunteers to meet and discuss the development of an outcomes based service specification for the ECF 2015/16. The meeting took place in February 2015 and the discussions were informed by the continual feedback received around perceived gaps in service provision and best practice that had emerged during 2014/15. The meeting also involved discussions around emerging best practice and possible additional services that the CCG may commission to support the delivery of the named accountable GP (with the remaining resource form the ECF).

As a result of this meeting an outcomes based service specification in currently being finalised ready for discussion with the LMC: the following suggestions have been put forward for consideration by CoM and the CCG as possible system wide primary care support services. If approved they will inform the commissioning intentions for the utilisation of the unallocated ECG fund[2] (£2 per head of population).

(1) NL Fall Prevention Service

The proposal would be for a NL wide service that practices can access providing a community based holistic falls prevention service, including working within care homes. A service has been piloted in Winterton has proved successful.

(2) Community Based Geriatric clinics

To provide community based, proactive clinics (with MDT approach including District Nurses/Community Matrons /ECPs/) to support the care and management of the elderly. The service would aim to fill the gap in service provision for these patients and their carers before they reach crisis.

(3) Dementia/Cognitive impairment community support

Following on from perceived lack of community support for patients with Dementia or cognitive impairment and their careers, especially OOHs when they may find themselves in crisis. There are also concerns around lack of adult mental health services support available.

(4) Community Nursing

Complete review of the current service with GP input to ensure that community nursing is responsive to changing needs of primary care.

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[22] *Note: some of the suggestions may overlap with developments within the Better Care Fund initiatives and so would need to be aligned to overall strategic aims for care of the elderly, with potential for efficiencies for commissioning at scale.*

Next Steps:

The Joint Commissioning Committee is asked to:

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- Approve further work to establish the feasibility of the suggestions for commissioning services at scale to support primary care in care of the elderly.