North Lincolnshire Clinical Commissioning Group

NHS England

JOINT COMMISSIONING COMMITTEE

MEETING DATE:	13 August 2015
AGENDA ITEM NUMBER:	Item 5.1
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JOB TITLE:	Relationship Manager/Director of Commissioning
DEPARTMENT:	CCG

ELDERLY CARE FUND UPDATE

PURPOSE/ACTION REQUIRED:	For approval
CONSULTATION AND/OR INVOLVEMENT PROCESS:	This should identify each key Committee/Group which has led prior involvement/consultation in developing the recommendations in the paper Papers to JCC - 11 June 2015 Engine Room – 16 July 2015 Council of Members – 25 June 2015
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:

Background – Elderly Care Fund Community Geriatric/falls prevention service

At the meeting held on Thursday 11 June 2015, the Joint Commissioning Committee approved further work to finalise a service specification for a comprehensive community based geriatric/falls prevention service to be funded through the Elderly Care Fund budget , along with consideration of how best to achieve deliverability of the service outcomes.

The attached report provides an update on progress made to date on the development of the comprehensive community based geriatric/falls prevention service specification; it also details the preferred option to achieve deliverability of the proposed new service model and outcomes.

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	x
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	x	No	

Providing access to comprehensive assessments in the local community has the potential to reduce travel for patients which may benefit the environment.

6. LEGAL IMPLICATIONS:

Yes		No	x

7. RESOURCE IMPLICATIONS:

Yes	x	No	

The service is to be funded through the Elderly Care Fund budget which is approximately £5 per head of population. This budget has to targeted to support care of the elderly (aged 75 years and over) in primary care settings. The budget for this equates to £2 per head of population; the remaining £3 per head of population funds the enhanced service specification for ECF in primary care which all practices have signed up to.

8. EQUALITY IMPACT ASSESSMENT:

Yes	x	No	

The EIA highlighted potential positive impact in relation to the protected characteristic of age. This will be monitored and reviewed in March 2016.
A Sustainability Impact Assessment has also been completed.

9. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:

Yes		No	x

Consideration of the key messages to arise from patient insights as part of the ELC process has been considered in the development of this service specification. Some of the key concerns raised through ELC consultation were around people having access to care and support closer to home to enable people and their families and carers to access the right support, in the right place, at the right time, with the aim of enabling people to manage their own health and stay independent in their own homes as long as possible. These principles underpin the development of the service.

10. RECOMMENDATIONS:

The Joint Commissioning Committee is asked to:

- Note and receive the update
- Approve the award of the Comprehensive Geriatric Service contract to Safecare Network Limited

13th August 2015

Report to the Joint Commissioning Committee

Elderly Care Fund Up-date – Community based Comprehensive Geriatric/Falls Prevention Service

Introduction

At the Joint Commissioning Committee in June 2015, the committee approved further work to finalise the service specification for a comprehensive community based geriatric service to be funded through the Elderly Care Fund and for the CCG to give consideration to the best way to achieve deliverability of the proposed service model and outcomes

This report provides an up-date on progress made since the last Joint Commissioning Committee meeting.

Up-date – August 2015

A service specification for the comprehensive community geriatric service has been developed and approved in principle at the Engine Room on 16th July 2015 (with acknowledgement that further work was required to further define the referral criteria into the service; this work is on-going). Once the referral criteria has been refined and approved the service specification will be ratified at the Engine Room.

Progress to date

The proposed new service builds upon the service model of community geriatric/fall prevention clinics developed by Winterton Medical Practice as part of the 2014/15 ECF funding allocations. Evaluation of the services has suggested positive outcomes that compliment primary care practice and improve patient experience and outcomes. The service also reflects the British Geriatric Society best practice guidelines on improving outcomes for patients aged 75 and over, in particular in relation to improving identification and management of frailty in the over 75s. The service will support the role of named accountable GP for patients aged 75 and over, in improving care of the elderly in primary care

The overall aims and objectives of the service are:

The aims of the service will be to provide community based, comprehensive geriatric assessments for patients referred into the service, to include:

- Community based, Geriatrician led one stop clinics
- Individualised care and support planning for patients, including family/carers where possible (advanced care planning where appropriate) – to be shared across Multi-Disciplinary Teams/social care etc…
- Reversible medical conditions are considered and addressed
- Undertake evidence based medication reviews to focus on poly-pharmacy for older people with frailty (STOPP START criteria)

- Include signposting carers for independent assessment/support services
- Review previous diagnoses and management of long term conditions
- Holistic Falls prevention (primary and secondary prevention)
- Advice and support to primary care for on-going management and risk reduction for care of frail elderly (e.g. impact of medication changes/risk of falls)
- Key worker identified (links to named accountable GP)
- Integrated clinical pathways developed
- Referral pathways into FEAST[1] when appropriate

Service Objectives

- Provide access to comprehensive geriatric assessments delivered in community and residential settings for patients aged 75 and over who have been identified by their GP as at risk/having frailty
- Proactive onward referral to appropriate support services/additional services to support identified needs
- Improved management of frailty in primary, community and residential settings
- Holistic falls prevention assessments (primary and secondary prevention)
- Reduce poly-pharmacy
- Improved outcomes for patients with frailty
- Contribute to reduced emergency admissions for patients aged 75 and over
- Closer working relationships with locality/community teams
- Integrated pathways developed to ensure multi-morbidities are managed within a holistic framework (i.e. links to dementia support, LTC management, physical activity, nutrition review)
- Improved self-management of frailty
- Development of high quality care and support plans (based on BGS guidelines)
- Exit strategies for patients and family cares (linked to care and support plans)
- Education/training for GP/primary care staff on care and support needs associated with frailty
- Link with FEAST referral for acute assessment when appropriate

The service will be monitored and evaluated against the following Key Performance Indicators (KPIs) included in the specification:

[1] Frail Elderly Assessment Team

KPIs:

- Number of patients referred for geriatric comprehensive assessment
- Number of patients referred for holistic falls prevention assessment
- Number receiving a holistic falls prevention assessment
- Number receiving a comprehensive geriatric assessment
- Number of patients with diagnosed level of frailty (level to be recorded)
- Number of onward referrals (include referral route/provider/service)
- Number of patients referred to FEAST for acute assessment
- Medication review data (STOPP- START) (include details of medications stopped and started/dosage reduced)
- Emergency admissions for patients aged 75 and over
- Length Of Stay for patients aged 75 and over
- Number of patients aged 75 and over referred into emergency ambulatory care sensitive pathways
- Number of care and support plans produced –(to include advanced care planning where appropriate)
- Minimum of 75% completed patient satisfaction surveys (completed following assessment)

Deliverability

Following consideration of the best way to achieve deliverability of the proposed service model and outcomes, a single tender waiver was approved by The Chief Officer and the Lay Member of the Governing Body on 2nd July 2015; Safecare Network Ltd. (NL GP Federation) is the preferred identified provider. As Safecare Network Ltd are representative of all GP practices across North Lincolnshire, the service model will ensure continuity of care for patients aged 75 and over, deliver improved access to additional care and support for those patients registered with GP practices, and so further support the role of accountable GP in care of the elderly (as required by the 2014 Everyone Counts Planning Guidance).

It is also anticipated that commissioning the service at scale will provide efficiencies, reduce variation in outcomes and improve quality of care of the elderly.

Next Steps:

Finalise the referral criteria into the service with the aim of having access to the service from September 2015, building to have North Lincolnshire wide service in place.

Award the contract to Safecare Network Ltd on finalisation of the service specification with expectation that the service will expand the current model being delivered, at pace, to achieve a North Lincolnshire wide service by October 2015.

Recommendations:

The JCC is asked to:

- Receive and note the up-date.
- Approve the award of contract to Safecare Network Limited

Julie Killingbeck
06/08/20154