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| **Report to:**  Attachment 8 | Description: CCG logoNEL CCG Joint Co-Commissioning Committee |
| **Presented by:** | Nicola McVeigh |
| **Date of Meeting:** | 16th February 2016 |
| **Subject:** | Support to Care Homes & those with Multiple Long Term Conditions (Top 2% of Users) |
| **Status:** | OPEN  CLOSED |
| Complies with latest CCG Strategy for Primary Medical Services, if not, please give a brief reason why: | |

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| **OBJECT OF REPORT:** |
| To give the NEL CCG Joint Co-Commissioning Committee a progress update on the Support to Care Homes & those with Multiple Long Term Conditions (Top 2% of Users) Project. |

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| **STRATEGY:** |
| **Aim**  To offer support for those with complex long term conditions residing in the community or in nursing or residential care, in which primary care, social care, mental health, allied health professionals, pharmacy and the third sector work together to provide a co-ordinated and proactive response to the individual’s needs. This will include regular care reviews, an urgent (same day) response for deteriorating individuals, and support following a hospital stay/ period of re-enablement in intermediate care to facilitate an earlier discharge than would otherwise be possible. Support will include use of new technologies and telemedicine to ensure fast, effective clinical input.  **Background**  The Support to Care Homes & those with Multiple Long Term Conditions (Top 2% of Users) Service Specification was agreed at Council of Members (CoM) in September 2015. CoM requested that a multi-disciplinary Implementation Group be established to drive the project forward and develop the model and implementation plan.  The Implementation Group is now well established, covering a range of professionals including GPs, Nurses, Social Workers, Mental Health professionals, Practice Managers and Commissioners. Research has been undertaken looking into other area’s services to glean best practice; research has also occurred locally into resources and understanding what works well and what could be improved.  A stakeholder meeting with Care Home providers was also hosted to gather information on how these providers felt the model could be implemented, the areas of strength locally and areas for improvement.  It is clear from the research that many services and support mechanisms interact with the cohort of residents the project aims to cover; however this project seeks to ensure a greater integration, coordination and consistency of input from contributing providers. We know from intelligence gathered that many professionals from the same organisation/ professional body visit the same care homes, often on a daily basis, e.g. Several nurses attending a care home to administer flu jabs to several different residents, often from the same surgery. In addition, we know that different professionals may well communicate different messages about their clients which are not consistent; these mixed messages lead to inconsistent and sometimes poor care.  Care Homes  There are 43 care homes across NEL, 37 registered for older people (including 6 with nursing), 2 for those with mental health conditions and 5 for those with learning disabilities. The quality of care and overall quality of service delivery at the care homes is monitored via the Quality Framework, The Market Intelligence Failing Services Group, and intelligence from the Customer Care Team and via the Portal. Externally, the Care Quality Commission registers and monitors long term care providers. There are varying degrees of quality in care homes; these are locally rated as Basic (9 care homes), Bronze (12 care homes) Silver (12 care homes) & Gold (4 care homes). Six care homes are currently working towards completion of the Quality Framework.  Evidence from the system has demonstrated that poor quality of care in care homes, coupled with an un-coordinated system, lead not only to negative outcomes for those residents, but also to significant issues for the wider system. These include increased A&E attendances and acute admissions, duplication of effort from community services and higher costs in social care due to increased dependency levels; for example:   * 625 people attended A&E from NEL care homes (Q1 15-16) costing over **£68,000** in A&E tariff, at least a third of which was felt to be unnecessary. In addition by the end of Q2 15-16 the 625 has risen to 1,025 attendances * The Q1 A&E activity is generated by **474** unique individuals – some repeat presenting up to 5 times during the 3 month period, with 376 of these residents arriving by ambulance (costing circa **£70,000**) * In the last 12 months, residents in NEL care homes (18+yrs) have had 11,213 hospital bed days * From 01.02.2014 to 31.01.15 there were 33 hip fractures from NEL Care Home residents admitted to A&E, accounting for a total of 483 acute bed days   Current Resource  The table below describes the current resource deployed across the cohort the project seeks to cover.   |  |  |  |  | | --- | --- | --- | --- | | **Discipline** | **Contract End Date** | **Resource Funded** | | | Primary Care (SIPS) | 31/03/2017 | Backfill for 1 GP session p/w  Backfill for 2 GP sessions p/w  1 x wte Community Nurse Manager  5 x wte Community Matron  1 wte Practice Nurse  0.5 x wte Nurse Practitioner  1 wte HCA (also supports the over 75 initiative)  1.0 x wte HCA  0.5 wte HCA | SIP part funds time of a Practice Nurse and HCA  0.5 wte Diabetic Nurse 0.5 wte COPD Nurse  0.37 wte Complex Case Manager  0.25 x wte Audit Clerk 0.25 x wte Medical Administrator | | 31/03/2018 | 1.0 wte Community Matron  1.0 wte HCA  1.0 wte Mental Health Co-ordinator |  | | Primary Care | On-going | All residents in care homes and those in the top 2% have a GP | | | Community Nursing | On-going | The community nursing functions cover all residents with a need for the service | | | ASC | On-going | A focus member of staff is aligned to each of the 43 Care Homes  Those with complex ASC needs in the community will have a named social worker and those with less complex needs will be assigned to an ASC team. | | | Mental Health | On-going | Team based at The Cedars - 1 X Band 7 Clinical Team Lead (Angie), 2 Band 6 Mental Health Practitioners (MHP), 1 Band 5 MHP & 3 Support Workers.  Currently recruiting for another B6 and B5 to replace staff vacancies.  Due to part-time work, currently have a qualified ratio of 2.9 WTE.  Team supports all 3 enhanced dementia units with weekly reviews by qualified staff & monthly MDT’s including a medic within Psychiatry.  Any requests for placement assessments within the enhanced units and all other Older People’s Mental Health Service referrals for Care Home residents are dealt with by this team in conjunction with FOCUS.  The team have just introduced a new model of working (Newcastle Model).  This model will offer more advice and education sessions to the homes to try and improve quality of care and understanding. | | | Allied Health Professionals | On-going | All therapists respond to clients’ needs via a referral across NEL, whether clients are in Care Homes or the top 2%. | | | Falls Project | 31/7/16 | Offer targeted support relating to Care Homes [Falls Accreditation Scheme], the falls awareness and prevention programme, community based exercise programmes and sheltered housing scheme interventions.  The Falls Accreditation Scheme would formalise and structure an expectation of standards within Care Homes and ensure frequent updates and access to clinical staff so that issues are resolved early before the need for secondary care intervention.    The scheme includes staff training, standardised Care Home falls assessments, yearly walking aid and equipment evaluation and maintenance and exercise groups / activities to reduce falls risk, as well as fast track referrals to the clinical falls service. The programme targets the Care Homes that have the highest rates of attendances at A&E from falls and those with high rates of hip fractures over the last year. | | | Third Sector | Various | Various Third Sector contracts (Alzheimer’s Society, Carers’ Support Service, Red Cross) are in place that can support this project to ensure residents’ wellbeing is maintained or enhanced if at all possible. | |   A project is currently underway to ascertain the number, type and duration of professional visits/ interventions to care homes to support residents and in which care homes these occur, over a period of 1 week (7th-13th December 2015 inclusive). This will be used to gauge the current support into care homes from external health and social care professionals across the year. Initial findings have shown that an extensive amount of resource from all areas above is deployed across each of the care homes in NEL. From the data collected so far, in excess of a total of 251 hours of professional input was spread across the 43 Care Homes. It is felt that this is a significant under estimate of the actual time cost as not all professionals sign in or out during their visit to a Care home.    Work is also currently underway to ascertain how many residents of NEL are categorised in the top 2% of users across primary care, to understand how many of those reside in a Care Home and also how many are housebound.  **Implementation & evaluation**  It is anticipated that this will require 3 years, to ensure full and appropriate implementation and evaluation as follows:  **Phase One (1 April 2016 to 31st March 2018 - Evaluation to commence from 1st April 2018 onwards)**  Co-ordination of the existing services (MH/ SC/ AHP/ Nurse (some prescribing)/ Pharmacy) to enable multidisciplinary working; this will ensure a consistent message and approach for care homes and their residents. Care homes will be provided with support, guidance and training to ensure their own practices also support residents as part of the co-ordinated approach.  The MDT will be co-ordinated by a team leader and be further supported where necessary by a single point of contact (which will be the SPA 01472 256256, for all concerns). Phase One will also include the usual planned primary care intervention from GPs as required to meet their patient’s need.  **Phase Two (Commencement during Phase One)**  Phase Two will build on Phase One and also include the ‘ad hoc’ emergency/ crisis response to residents from the MDT (GP/ Nurse/ AHP/ SC/ Pharmacy), within an agreed appropriate timeframe over 7 days where necessary to meet need. This will commence once phase is fully operational.  **Phase Three (April 2017 to 31st March 2019) – Evaluation to commence and be concluded by 31st March 2019**  The final stage of implementation will see the roll out of the model, adapted appropriately to meet the top 2% of users across the system in NEL.  A further update to CoM was presented on 4th February 2016. CoM agreed the approach and implementation plan. |

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| **IMPLICATIONS:** |
| There will be positive implications of this project as well as some challenges; these are as follows:  Positive   * Improved resident outcomes, quality of care, efficiency and use of resources.   Challenges   * There will be a requirement to change working practices across all disciplines to ensure appropriate coordinated intervention to the cohort the project seeks to serve. * Agreement from the care homes will be required to launch the project, and also to accept and embrace the training to be delivered. * Agreement from GPs is necessary for the MDT to support their patients; GPs will need to work in partnership with the MDT   Additional cost will be required for some roles, for example administration and a team leader post to support the co-ordination and execution of the project. |

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| **RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT:**  It is recommended that the project is implemented as above and in the attached action plan. |

|  |  | **Yes/No** | **Comments** |
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|  | Does the document take account of and meet the requirements of the following: | | |
| i) | Mental Capacity Act | YES | The services/ project will require compliance against the Mental Capacity Act. |
| ii) | CCG Equality Impact Assessment | YES | The specification will have a robust EIA undertaken. |
| iii) | Human Rights Act 1998 | YES | The services/ project will require compliance against the Human Rights Act. |
| iv) | Health and Safety at Work Act 1974 | YES | The services/ Project will require compliance against the Health & Safety at Work Act. |
| v) | Freedom of Information Act 2000 / Data Protection Act 1998 | YES | The services/ project will require compliance against the Freedom of Information Act. |
| vi) | Civil Contingencies Act 2004 | N/A |  |
| vii) | Most Capable Provider | YES | The project draws on a range of multi-agency professionals, ensuring those with the correct specialist skills are utilised to support those residing within a Care Home/ in the Top 2%. |
| iv) | Does the report have regard of the principles and values of the NHS Constitution? | YES | Yes, the specification and service being delivered takes account of the NHS Constitution |