Attachment 5

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| **Report to:** | NEL CCG Joint Co-Commissioning Committee  |
| **Presented by:** | Julie Wilson, Assistant Director Co-Commissioning  |
| **Date of Meeting:** | 1st September 2015 |
| **Subject:** | Future commissioning of services to ensure tailored care for vulnerable and older people (Over 75s) |
| **Status:** | [x]  OPEN [ ]  CLOSED |
|  | [x]  Complies with latest CCG Strategy for Primary Medical Services, if not, please give a brief reason why: |

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| **OBJECT OF REPORT:** |
| This report has been prepared to provide an update to the Joint Co-Commissioning Committee regarding strategy, implementation, delivery outcomes and proposals for future funding of the Ensuring Tailored Care for Vulnerable and Older People (Over 75s) commissioned services within Primary Care.  |

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| **STRATEGY:** |
| The proposal contained within the attached paper is consistent with the primary care strategy presented to the Committee at the meeting on 23rd April 2015. |

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| **IMPLICATIONS:** |
| The attached paper provides overview of the background and strategy deployed by NEL CCG following ‘Everyone Counts: Planning for Patients 2014/15 – 2018/19’ requirement for specific focus during 2014/15 to be on those patients aged 75 and over and those with complex needs.The paper also provides a high level overview of the audit outcomes achieved by the schemes in line with the quality measures determined for the initiative. Based on those outcomes, the paper includes recommendations to realign funding to other services which are detailed within.  |

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| **RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT:****The Joint Co-Commissioning Committee is asked to agree in principle to cease funding the specific Practice level services, and realign funding to other services as outlined in the attached paper.**  |

|  |  | **Yes/****No** | **Comments** |
| --- | --- | --- | --- |
|  | Does the document take account of and meet the requirements of the following: |  |  |
| i) | Mental Capacity Act | N | This will be considered as services develop |
| ii) | CCG Equality Impact Assessment | Y | A full equality impact assessment has been undertaken for each service and further assessments will be considered as services develop.  |
| iii) | Human Rights Act 1998 | N | This will be considered as services develop |
| iv) | Health and Safety at Work Act 1974 | N | This will be considered as services develop |
| v) | Freedom of Information Act 2000 / Data Protection Act 1998 | Y |  |
| iv) | Does the report have regard of the principles and values of the NHS Constitution?[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613) | Y |  |

**Ensuring Tailored Care for Vulnerable and Older People (Over 75s) Outcome Report
Prepared for the Joint Co-Commissioning Committee, 1st September 2015**

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| **Introduction**‘Everyone Counts: Planning for Patients 2014/15 – 2018/19’ outlined a requirement for specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. The new GP contract secured specific arrangements for all patients aged 75 and over to have an accountable GP, and for those who need it, a comprehensive and coordinated package of care. Although the guidance does not specify which provider should deliver services, NELCCG took the decision to invest the funding in General Practice by offering £5 per head of practice population for a fixed period of 12 months. The aim of the service commissioned from general practice is to transform the care of patients aged 75 or older for them to feel supported in remaining as well and as independent as possible, enabling them to enjoy the best possible quality of life, and reducing avoidable admissions and attendances to Accident & Emergency services.  |

**Service Development and Delivery**In July 2014 Practices were invited to submit an outline business plan proposing how they, either as an individual practice or working collaboratively with other practices, would utilise the £5 per practice population to target and improve outcomes for vulnerable and older people. The contract for this service ran from 1st September 2014 to 31st August 2015, and it clearly set out that there would be an evaluation at the end of the period, based on data as at 30th June 2015. Practices have been advised to continue, pending a decision regarding the on-going arrangements, and that they will be given a suitable notice period should the decision be taken to cease this service.

The GP Development Group was the review engine of the plans and following deliberation, feedback to Practices and revised submissions of plans, schemes began to commence in September 2014. Due to the requirement for additional infrastructure to support the schemes, commencement dates have varied spanning from September 2014 – January 2015. Practices that had plans to recruit additional staff for this scheme were advised to do this on a fixed term basis. To date we have spent £549,000 on this scheme.

An over-arching service specification was developed for the service with quality requirements included to validate the outcome objectives of the service based on the SMART objectives of what the Practices articulated their schemes would achieve. Practices were required to complete an audit of the service to identify improvements in several specified areas which are set out in detail in below (figure 1). The period for this audit was from service commencement date to 30th June, 2015.

*Fig 1:*

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| **Quality Requirement** | **Threshold** | **Method of Measurement** |
| Reduced attendances to Accident & Emergency department for patients accessing this service.  | Previous year as baseline. | Performance Audit. |
| Reduced emergency admissions for patients accessing this service.  | Previous year as baseline. | Performance Audit. |
| Increased patient contact with the practice by way of the most appropriate medium.  | Previous year as baseline. | Performance Audit. |
| Patients accessing this service will have a named General Practitioner.  | 100% | Performance Audit. |
| Where applicable, patients feel they are able to manage their diagnosed condition more effectively due to self-management, education and signposting.  | 70% of returns. | Patient Satisfaction Survey. |
| Patients accessing this service will be satisfied with the care received and will provide feedback in order for the provider to assess effectiveness.  | 50% response rate.80% minimum satisfaction rate. | Patient Satisfaction Survey.  |

The service realised 3 Practices who chose not to participate and 4 collaborative service delivery models. Out of the 30 NEL Practices, 21 services commenced spanning a patient population of 163,092, 14,592 of which are aged 75 years or older.

 **Audit Results**

**Response Rate**Out of the 21 schemes, the CCG received a return of 20 audits.

**Criterion 1:**

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| **Quality Requirement** | **Threshold** | No of services which **achieved** measure | No of services which **did not achieve** measure |
| Reduced attendances to Accident & Emergency department for patients accessing this service.  | Previous year as baseline. | 6 | 14 |
|  | Practice population affected (over 75s) | 4047 | 10545 |

Impact of scheme to attendances to Accident & Emergency trends (highlighted in red for scheme period) for the over 75s:

**Criterion 2:**

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| **Quality Requirement** | **Threshold** | No of services which **achieved** measure | No of services which **did not achieve** measure |
| Reduced emergency admissions for patients accessing this service. | Previous year as baseline. | 8 | 12 |
|  | Practice population affected (over 75s) | 4329 | 10263 |

Impact of scheme to emergency admission trends (highlighted in red for scheme period) for the over 75s:

**Criterion 3:**

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| **Quality Requirement** | **Threshold** | No of services which **achieved** measure | No of services which **did not achieve** measure as no data was collected |
| Increased patient contact with the practice by way of the most appropriate medium. | Previous year as baseline. | 6 | 14 |
|  | Practice population affected (over 75s) | 5585 | 9007 |

**Criterion 4:**

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| **Quality Requirement** | **Threshold** | No of services which **achieved** measure | No of services which **did not achieve** measure as no data was collected |
| Patients accessing this service will have a named General Practitioner. | 100% | 17 | 3 |
|  | Practice population affected (over 75s) | 10829 | 3763 |

**Criterion 5:**

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| **Quality Requirement** | **Threshold** | No of services which **achieved** measure | No of services which **did not achieve** measure as no data was collected |
| Where applicable, patients feel they are able to manage their diagnosed condition more effectively due to self-management, education and signposting. | 70% of returns | 5 | 15 |
|  | Practice population affected (over 75s) | 4114 | 10478 |

**Criterion 6:**

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| **Quality Requirement** | **Threshold** | No of services which **achieved** measure | No of services which **did not achieve** measure as no data was collected |
| Patients accessing this service will be satisfied with the care received and will provide feedback in order for the provider to assess effectiveness.  | 50% response rate.80% minimum satisfaction rate. | 9 | 11 |
|  | Practice population affected (over 75s) | 4826 | 9766 |

Only one service (a partnership between 3 Practices) achieved all 6 criteria.

**Options for on-going service**

Based on the reported achievement of the outcomes, as detailed above, the current service model does not appear to have had the impact that was anticipated, with the exception of one provider. In particular, there appears to have been minimal impact in relation to reducing the Accident & Emergency attendances and emergency admissions for this cohort of patients.

Given the need to ensure the delivery of outcomes for this cohort of patients, and the need to direct the limited resources available to the most effective services, the CCG could consider realigning this resource to an alternative model – providing tailored support to people in care/residential homes, the housebound and the top 2% of service users; however, we would need to consider whether this would be necessary in the individual case where all criteria have been achieved. General practice could still be a provider within this alternative care model, and this is highlighted as a way of working in the future for primary care within the Primary Care Workforce Commission’s 2015 publication “The future of Primary Care; Creating teams for tomorrow” which states that “*Care for people in nursing and residential homes should be organised so that all patients in a home are cared for by one GP practice”.*

General Practice also have other sources of funding to support this cohort and there is notable overlap between this current over 75s scheme and other schemes currently commissioned, such as NHS England’s Avoiding Unplanned Admission DES.

It should be noted that if a decision is taken to cease the service as it currently operates, some Practices may have a risk in terms of staff employed to deliver this service, although the funding was not committed on a recurrent basis and Practices were advised to employ staff on a fixed term basis. If they were to be included within the commissioning of the alternative model, they may be able to redeploy their staff internally to support this service.

**Recommendations**

**The Joint Co-Commissioning Committee is to consider whether to cease the funding of the specific Practice level services, and agree in principle to re-align funding to support to care and nursing home services, the specification for which will be on the agenda for the October Joint Co-Commissioning Committee.**