East Lancashire
Clinical Commissioning Group

Agenda Item No: 6.3

REPORT TO:	**PRIMARY CARE COMMITTEE**		
MEETING DATE:	**12 September 2018**		
REPORT TITLE:	**QUALITY FRAMEWORK – Over 75s Element**		
SUMMARY OF REPORT:	This report provides an update position in relation to the Over 75's/Care Home Services which form part of the Quality Framework across all localities and a specific update in relation to the Care Home Liaison Nurse element of the service for Hyndburn.		
REPORT RECOMMENDATIONS:	Primary Care Committee are requested to review the report and: - Agree the proposed extension of the current Over 75s/Care Home Services in the Quality Framework for 6 months (up to 31 March 2019) to bring it in line with the other elements of the quality framework and to allow for completion of an in-depth service review. - Agree the inclusion of the Care Home Liaison Nurse Service in Hyndburn into the Quality Framework to bring it in line with other localities and enable practices to agree service provision among themselves.		
FINANCIAL IMPLICATIONS:	£1,114,000 (6 months) already committed funding (Recurrent)		
PROCUREMENT IMPLICATIONS:	None		
REPORT CATEGORY:			**Tick**
	Formally Receipt		
	Action the recommendations outlined in the report.		√
	Debate the content of the report		
	Receive the report for information		
AUTHOR:	**Rachel Watkin, Hyndburn Locality Manager**		
	Report supported & approved by your Senior Lead		**Y**
PRESENTED BY:	**Lisa Cunliffe, primary Care Development Manager**		
OTHER COMMITTEES/GROUPS CONSULTED:	None		
PRIVACY IMPACT ASSESSMENT (PIA)	Has a PIA been completed in respect of this report?		**N**
	If yes, please attach	If no, please provide reason below Maintenance of current position with a full service review to be undertaken in the coming 3 months	
EQUALITY IMPACT ANALYSIS (EIA)	Has an EIA been completed in respect of this report?		**N**
	If yes, please attach	If no, please provide reason below Maintenance of current position with a full service review to be undertaken in the coming 3 months	
RISKS:	Have any risks been identified / assessed?		**Y**
CONFLICT OF INTEREST:	Is there a conflict of interest associated with this report?		**Y**
CLINICAL ENGAGEMENT:	Has any clinical engagement/involvement taken place as part of the proposal being presented.		**Y**
PATIENT ENGAGEMENT:	Has there been any patient engagement associated with this report?		**N**
PRIVACY STATUS OF THE REPORT:	Can the document be shared?		**Y**

Which Strategic Objective does the report relate to		**Tick**
1	Commission the right services for patients to be seen at the right time, in the right place, by the right professional.	√
2	Optimise appropriate use of resources and remove inefficiencies.	√
3	Improve access, quality and choice of service provision within Primary Care	√
4	Work with colleagues from Secondary Care and Local Authorities to develop seamless care pathways	

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NHS EL CCG Primary Care Committee
12th September 2018

QUALITY FRAMEWORK – Over 75's/Care Home Services

1. Introduction

1.1. In April 2018 Primary Care Committee agreed to continue the 2017/18 service specification for the Over 75s/Care Home Services element of the Quality Framework for 6 months until 30 September 2018 to allow a complete service review to be under taken.

1.2. There is currently a significant amount of work on-going around the Over 75's/Care Home Services specification within the Quality Framework (Appendix 1), looking at the current service offer, the contractual arrangements and the outcomes being delivered.

1.3. In order to enable a robust service review **in line with other community service reviews,** the current service specification needs to be extended until 31 March 2019

1.4. In addition agreement is required to commission the Care Home Liaison Services in Hyndburn through the Quality Framework which will enable practices in Hyndburn to agree the most appropriate service delivery model.

2. Background

2.1. The expectation from NHS England's 'Everyone Counts' planning guidance was that CCG's utilise £5 per head funding to support plans for improving services for older people and those with more complex needs.

2.2. GP Practices had the opportunity to influence how this resource was spent in each Locality. This resulted in a number of schemes to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions, identification of people living with a frailty, a comprehensive geriatric assessment, and medical and nursing cover to support intermediate care, community provision and Integrated Neighbourhood Teams.

2.3. East Lancashire CCG committed £1.842 million to delivering the Over 75s schemes across East Lancashire.

2.4. In addition each Locality in East Lancashire was allocated funding to support the development of a Specialist Care Home Nursing service.

2.5. Funding for the Specialist Care Home Nurse role was mainstreamed by the CCG as agreed at the Local Delivery Group meeting on 10 December 2012.

2.6. In 2017/18 both the O/75's schemes and the Specialist Care Homes Service were included, as one service specification, into the Quality Framework (Appendix 1).

2.7. An in-depth service review is currently being undertaken of the different service delivery models across the Localities in East Lancashire for the Over 75's schemes, with a stakeholder workshop to be arranged at the end of October 2018.

2.8. The service review will be completed by 31 March 2018 to enable the service specification to be re-developed by December 2018 for implementation in 2019/20.

3. Hyndburn Care Home Liaison Nurse Service

3.1. The current service for the Hyndburn Care Home Liaison Nurse element is based on a historic grant agreement between the CCG (on behalf of the locality) and Oswald Medical Practice. This is due to come to an end on the 30th September 2018. This service has been running since September 2015. The value of the service is 86K per annum.

3.2. The agreement with the current provider was made as a direct award, following agreement across the locality. The service is currently part of the single practice's CQC registration mentioned as a specific service.

3.3. The 2 Primary Care Networks in Hyndburn have agreed a proposal to include the Care Home Nurse Service in the Quality Framework, in line with other Localities, rather than through the existing grant agreement. It is then a matter for those practices to determine how the service will be best delivered. Any TUPE rights for the existing nurses would be a provider to provider matter.

3.4. This arrangement will enable the service to be maintained after the 30 September 2018.

3.5. Our understanding is that each individual practice in Hyndburn will ask for their allocation of funding to be given to Hyndburn Central PCN to allow Richmond Medical Practice to deliver this service on behalf of the other practices. (Minutes of meetings available where this discussion and agreement took place – Hyndburn Rural PCN, 9th August 2018 and Hyndburn Central 14th August 2018). We believe that these practices will sign up to a Memorandum of Understanding agreeing risk share of employment considerations, but again, this is not a matter for the CCG in contractual terms.

3.6. It is anticipated that this provision will eventually become part of a more integrated service delivery for Primary Care in Hyndburn following the further development of Primary Care Networks.

4. Conclusion

4.1. This report covers two elements Over 75s and the Care Home Liaison Nurses in Hyndburn.

4.2. The significant work on-going to undertake a robust review of the Over 75s/ Care Home Services included in the Quality Framework requires an extension to the current service specification.

4.3. The GP practices in the Hyndburn locality have come together and agreed a way of working that supports the continuing provision of a Care Home Liaison Nurse Service within the borough and enables this to be contracted for a funded through the Quality Framework via an MOU between the practice rather than the historic grant agreement between the CCG and one practice.

5. Recommendations

5.1. The Primary Care Committee are requested to approve:

5.1.1. An extension the current Over 75s/Care Home Service specification for 6 months to bring it in line with the other elements of the quality framework and to allow the completion of an in-depth service review in line with other Community Services reviews.

5.1.2. The inclusion of the Care Home Liaison Nurse Service in Hyndburn into the quality framework and enable practices to agree service provision among themselves via the use of an MOU.

5.1.3. There is a query as to whether or not the Quality Framework is in fact the optimal contracting vehicle for Care Home Liaison Nurse Services, going forwards from 2019/20, but this will require a sensitive negotiation with primary care and legal advice from Hempsons which will be sourced as part of the review.

Rachel Watkin
Locality Manager

Appendix 1

Service Specification No.	**Domain 3F**
Service	**East Lancashire Over 75's / Care Home Services**
Commissioner Lead	**NHS East Lancashire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices in East Lancashire**
Period	**1st April 2018 – 30 September 2018**
Date of Review	**May – August 2018**

1. Population Needs

1.1 National/Local Context and Evidence Base

NHS England's planning guidance, 'Everyone Counts', set out an expectation that CCGs should identify at least £5 per patient from their budgets for 2014/15 and use this to support plans for improving services for older people and those with more complex needs.

CCGs were required to use this funding to commission additional primary care services or community health services (over and above those provided under the new enhanced service) that practices have prioritised.

East Lancashire CCG allocated £5 per patient to each Locality to develop and deliver additional primary care services or commission community health services.

The Framework for Enhancing Health Care in Homes (September 2016) recommended that CCG's:

- Support the provision of high-quality care within care homes
- Ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing; and
- Ensure that we make the best use of resources by reducing unnecessary conveyances to hospitals, hospital admissions and bed days whilst ensuring the best care for residents.

To support the implementation of the NHS Planning Guidance and Enhancing Care in Homes, each Locality has been allocated funding based on the £5 per head of population plus an additional sum of funding for Care Homes. (See Section 5 for a Breakdown of funding). Practices have had the opportunity to influence how this is best spent within their Localities. This specification builds on the good work already being undertaken and aims to set consistent quality standards for each locality to work towards to ensure equity across East Lancashire whilst acknowledging that delivery is best determined locally to best need patient needs.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	**X**
Domain 2	Enhancing quality of life for people with long-term conditions	**X**
Domain 3	Helping people to recover from episodes of ill-health following injury	**X**
Domain 4	Ensuring people have a positive experience of care	**X**
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	**X**

2.2 Local Defined Outcomes

- Localities have an understanding of the number of over 75s with long term care needs to plan local services to support those needs as appropriate
- Localities have an understanding of the numbers of people living with frailty to plan local services to support those needs as appropriate
- Localities have an understanding of the number of people living in Care Homes to plan local services to support those needs as appropriate
- Localities are clear on the needs of those patients and ensure they have the right care at the right time in the right place
- Communication between localities and other services providers is improved as a result of the services
- Patients supported by the services report a positive experience of their care provision
- Avoidable attendances and admissions to hospital are reduced as a result of the support in Localities.

3. Scope

3.1 Aims and Objectives of Service

The information below details of the aims and objectives the Schemes across East Lancashire are working towards:

- Provide support for elderly patients, particularly those over the age of 75 with long term care needs to prevent them from requiring secondary care services. This includes improved access to Primary Care
- Provide support for those patients over the age of 75 with long term conditions to improve management and prevent them requiring secondary care services
- Provide support for those patients (irrespective of age) residing in a Nursing or Residential Care Home
- Utilisation of telemedicine in Care Homes across East Lancashire
- To be part of the INT wider team and support the INT MDT Process
- Provide case management support as appropriate to ensure patients are seen at the right place at the right time by the right person
- Provide greater use of alternative support to prevent admissions and/or treatment required in secondary care i.e., befriending schemes, third sector referral via Care Navigators etc.

3.2 Service Description/Care Pathway

The delivery of this service description/care pathway for Over 75's and Care Homes will be dependent on the model developed within each Locality, i.e., Responsibility of delivery may be the Over 75's Nurses, Long Term Conditions Nurses, Care Home Nurse and/or GP Practices etc.

The standards set below are not an exhaustive list and Localities have the ability to develop services to meet the needs of their local population but the services must include the quality standards set below.

Quality Standards for Over 75's that these services must provide (taken from Compassionate care for frail older people using an integrated care pathway guidance)

- Identification of over 75's with long term care needs via targeted case finding
- Identification and referral to Age UK Integrated Care programme of patients aged 50+ with high risk of unplanned hospital admissions this could include any number of LTC's, a high frailty score of 5 or above or needing high level intervention. Consent must also be sought by the Practice for those

patients being referred

- Completion of assessment of need for those patients with long term care needs
- Completion of personalised care plans including emergency contingency plans and advanced care plans via targeted case finding
- Sharing of information with other providers as appropriate for example DNACPR and priorities of care
- Close liaison with the Integrated Neighbourhood Teams to facilitate access to community services to manage patient needs, including links to falls services, carer support, and dementia services
- Regular monitoring of hospitalisation and avoidable ED/UCC attendances to determine whether an alternative care pathway might have been more appropriate.

Quality standards for Care Home support that these services must provide (taken from Enhancing Care in Homes (EHCH))

- Each resident has a named GP
- Assessment of need/care plan carried out on a resident's admission
- Ensuring Care provider staff have easy access to reliable and trusted advice and triage including telemedicine
- Self-management and the provision of informal care is encouraged
- Professionals in care homes, health services and the community ensure the care planning process identifies the outcomes that are important to individuals , as well as meeting their health needs in a personalised way
- Individuals are supported to die in their place of choice. This is reinforced through 'advance care planning', personalised care plans and treatment escalation plans

3.3 Population Covered

The service provided shall be for all eligible patients who are registered with a GP practice in the NHS East Lancashire CCG geographical boundaries.

3.4 Interdependencies with Other Services

- NHS East Lancashire CCG
- Primary Care
- Local Acute Trusts (Secondary Care)

4. Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)

The delivery of the commissioned service is underpinned by the appropriate standards, including but not limited to:

- Enhancing Healthcare in Homes
- Compassionate care for frail older people using an integrated care pathway guidance

4.2 Applicable Standards set out in Guidance and/or Issued by a Competent Body

As per the NHS Standard Contract.

4.3 Applicable Local Standards

The provider is required to maintain evidence of continuing professional development in relation to this service. This may be required to be produced as evidence for re-accreditation. Clinical updates/training could include supervised practice, liaison/clinical audit sessions or attendance at appropriate postgraduate meetings/lectures/events etc.

4.4 Monitoring and Reporting

The following data will be gathered by the Data Quality Team:

- How many over 75's registered at Practice?
- How many patients over the age of 75 are in the top 2% risk stratification?
- Number of patients in Practice identified with mild frailty?
- Number of patients in Practice identified with moderate frailty?
- Number of patients in Practice identified with severe frailty?
- Number of patients in Practice identified as living in a care home? (Total Number for both Nursing and Residential)
- Number of patients in Practice identified as living in a Nursing Home?
- Number of patients in Practice identified as living in a Residential Home?
- Number of patients over 75 who have an admissions avoidance care plan?
- Number of patients over 75 who have an advance care plan?
- Number of patients who have had an over 75's assessment in the last 12 months?
- Number of patients within a care home who have an admissions avoidance care plan?
- Number of patients within a care home who have had an assessment within the last 12 months?
- Number of patients within a care home who have an advance care plan?

5. Payment

Resource available per Locality:

Locality	Over 75's Funding	Care home support
Burnley	£483,000	£87,178
Hyndburn	£383,000	£86,073
Rossendale	£325,000	£86,749
Ribblesdale	£185,000	£65,000
Pendle	£465,000	£62,000
Totals	£1,841,000	£387,000

Overall Total: £2,228,000