Primary Care Services commissioned in support of the Better Care Fund

Stockton Health and Wellbeing Board Meeting 16th October 2014

1.0 Purpose of the Paper

The purpose of this paper is to present the services and schemes that NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) have commissioned. These services are based in the community and primary care and will support delivery of the Better Care Fund (BCF) plans and performance measures whilst also improving patient experience and health outcomes.

2.0 Overview of BCF priorities

The schemes agreed within the BCF plans for the Stockton locality are highlighted below.

2.1 Multi-Disciplinary Team - Community team

- Delivering targeted early intervention and preventative approaches to reduce the individuals need for health and social care services and;
- Effective crisis management to ensure the individual can maintain their levels of independence and maximise their health and well-being.

2.2 Improving Pathways and Care for Dementia

There is a recognised under-diagnosis of dementia in Stockton and it is expected that there will be an increase in the number of people with early on-set dementia and late on-set dementia when diagnosis rates improve. The aim is to enable people to live in their own homes as long as possible. The early introduction of digital health in a familiar environment will support this."

2.3 BCF performance measures

Following the revised guidance a proportion of the national £1 billion will be held back by the CCG and linked to a reduction in total emergency admission. The expected minimum target reduction in emergency admission for Stockton on Tees is 4.3% (1222 admissions prevented). If the locally set target is achieved then all of the funding linked to performance will be released to the Health and Well Being Board to fund the BCF activities. The money will be released from the CCG into the pooled budget dependent on performance achievement.

To manage the process of the funding being held back, the implementation of the BCF plan will have to be phased in to ensure the funds are made available. Stockton Borough Council and NHS Hartlepool and Stockton on Tees CCG have agreed to operate the main schemes on a pilot basis thereby minimising risk of non-delivery and adding flexibility.

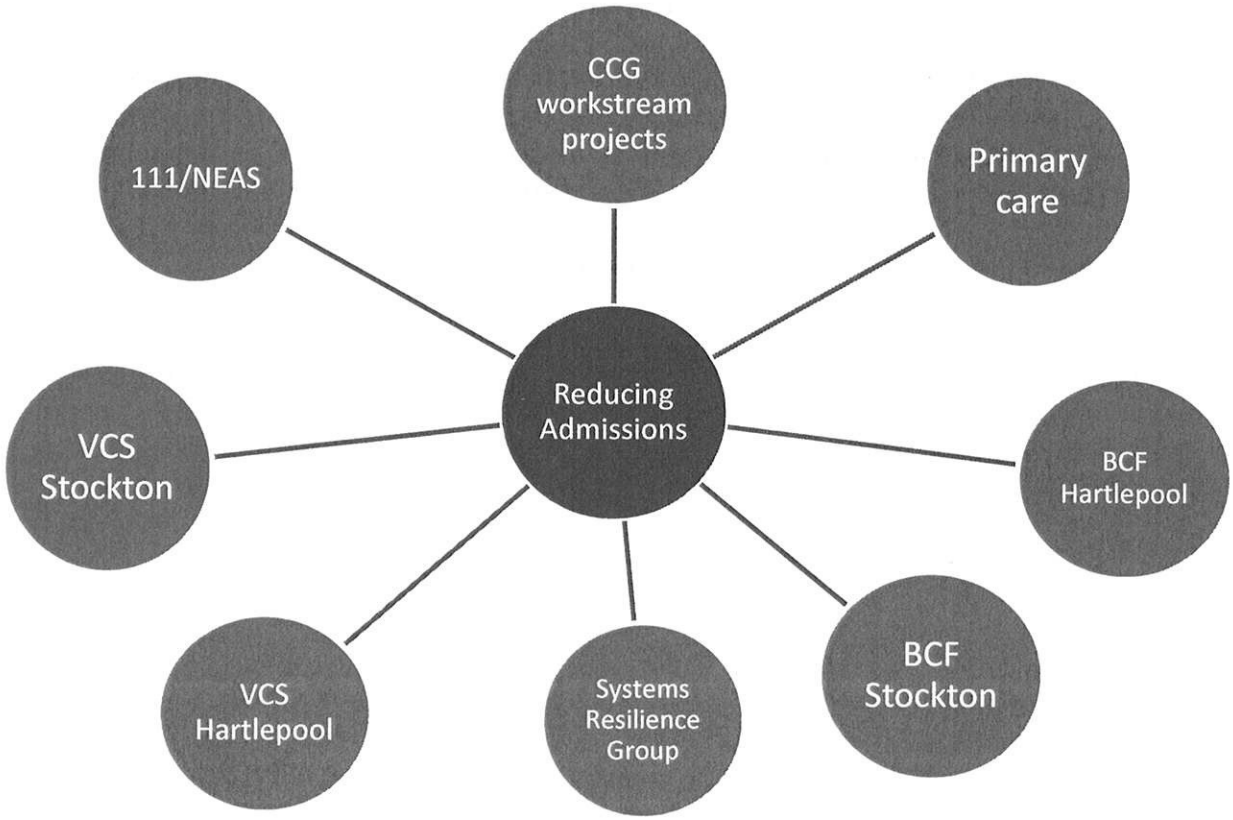
The key performance measures to demonstrate delivery of the BCF plans are:

- Reduction in total emergency admissions
- Reduction in residential admissions
- Proportion of older people 65 and over still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Reduction in delayed transfers of care from hospital
- Patient/service user experience metric
- An increase in the estimated diagnosis rate for people with dementia

The CCG have also commissioned a number of initiatives from other providers including primary care, voluntary and community sector, acute as set out below and as presented in supporting appendices which will further support delivery of the BCF plans specifically in relation to reducing emergency admissions.

3.0 Overview of services and schemes

There are a range of projects that have been commissioned to enable the reduction in reducing emergency admissions and will enhance the BCF plans to ensure delivery.



3.1 Voluntary and Community Sector

The CCG has allocated funding to the Voluntary and Community Sector within the Stockton and Hartlepool localities to support the delivery of CCG priorities including the BCF measures. The CCG has worked with the Stockton Local Authority Public Health Team to jointly commission these and ensure initiatives complement existing commissioned services. The following are the objectives that have been set and a list of the schemes are presented in Appendix 1.

Stockton objectives:

1. Promotion and delivery of healthy weight activities for families to reduce obesity in the population;
2. Decreasing the number of people who smoke including referral to the smoking cessation service;
3. Increasing public mental health awareness of low level anxiety and depression, improving access to psychological therapies (IAPT) services and early identification of dementia;
4. Reducing social isolation in older people and preventing emergency admissions (clearly linking this to Better Care Fund activity);
5. Reducing admissions to hospital through targeted interventions to those at highest risk of admission (clearly linking this to Better Care Fund activity);.

Every project will be required to demonstrate that people are appropriately assessed based on the following and signposted as required to existing services, they should encourage and facilitate engagement with health services by:

- finding people living in the community with memory problems who have not had a formal assessment to ensure timely diagnosis of dementia
- increasing uptake of the NHS Health Check and Lung Health Check in groups least likely to have these
- identify people who smoke and signpost to stop smoking services
- increasing engagement in national cancer screening programmes
- identification of people with alcohol problems through use of the AUDIT C screening tool

The aim is to have all projects evaluated during the year to be able to demonstrate their impact and value for money. Agencies were required to focus on BCF outcomes to ensure they are able to demonstrate they contribute to delivery of the BCF requirements.

3.2 Primary Care

3.2.1 Better Care for at Risk Patients (£5 per head scheme running 2 years)

The following schemes were developed to ensure delivery of the CCG plans including BCF and also fulfil the statutory duty of the CCG to improve the quality of primary care. Whilst developing the plans we have ensured there is no duplication and they support the national Directed Enhanced Service (DES) issued by NHS England to avoid unplanned admissions.

Practices are commissioned to deliver 2 of 3 of the schemes below;

- Improved Access and Capacity for Elderly and Complex Patients – This scheme requires practices to provide longer GP appointments (20mins) to

patients aged over 75 and patients with complex needs that equate to 2% of their practice list. If the practice is not signed up to the reducing avoidable admissions DES then they would also need to produce care plans for a cohort of patients that equate to 2% of their practice list. Patients in the top 2% most at risk as identified by RAIDR should be offered a 20 min appointment every three months. Patients over the age of 75 who aren't identified in the top 2% should be offered an annual 20 minute appointment.

- Proactive Management of Patients in Care Homes – Practices should regularly visit each Care Home where they have a patient(s) registered, and should ensure that all patients in Care Homes have a Personalised Care Plan in place.
- Proactive Care for Patients with Mental Health Conditions – Patients with a Mental Health Condition should have a Personalised Care Plan in place. Practices have agreed their own individual cohort of patients, and should ensure that at least 6% of their population have care plans.

3.2.2 **Quality Improvement Scheme** (running annually)

This scheme is commissioned to enable GP Practices to deliver 3 indicators which were selected from a predefined list identified as priorities within the CCG plans. Practices will work to deliver the targets agreed with the CCG clinical team.

The 9 indicators selected are:

- Dementia Prevalence (linked to BCF local quality requirement)
- Diabetes Prevalence
- COPD Prevalence
- QOF Exception Reporting
- QPF/GVIS
- Medicines Waste
- Antibacterial Prescribing
- Repeat Dispensing
- National GP Survey

3.2.3 **Community Based Services**

Services commissioned by the CCG:

- Emergency Eye Care Scheme – Patients can be seen by an Optometrist with acute eye conditions. Referrals are taken for advice, assessment and treatment.
- Low Vision – This service offers assessment of visual function, provision of visual aids and appropriate review.
- Raised Intraocular Pressure – Patients with raised intraocular pressure are reviewed in the Optometrists and retested before a referral to secondary care.
- Anticoagulation – Primary Care monitoring of warfarin therapy, aiming to avoid unnecessary secondary care attendances for monitoring and initiation of oral anticoagulation therapy, and also to provide a single point of contact for patients
- Near Patient Testing – near patient testing service for regular blood monitoring of high risk specialist drugs, aiming to avoid unnecessary secondary care attendances
- Community Based Minor Surgery – 2 GP Practices provide a minor surgery service, performing procedures on behalf of other practices who feel they do

not have the skills within their practice, and as an alternative to a secondary care referral.

- Cataracts – Once a Cataract is identified as causing visual problems, the Optometrist will educate the patient and arrange for the referral for surgery.
- On Demand Availability of Specialist Medicines – Pharmacies stock specialist palliative care drugs to ensure access to medicines outside of normal working hours.

3.2.4 Unplanned Admissions DES (Oversight by Area Team)

Proactively case manage vulnerable patients (both those with physical and mental health conditions) through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator.

Practices must identify at least 2% of adult patients and any children with complex needs and provide with proactive care:

- Named, accountable GP to provide personalised care plans and co-ordinate care for each patient (on the 2% list)
- Same-day telephone consultations for all at-risk patients
- Dedicated practice telephone number for A&E, ambulance service and care home staff, to support decisions relating to admission and transfer to hospital.

3.2.6 Operational Resilience and Capacity Plan initiatives

These initiatives are aimed at increasing capacity within services to support delivery of Urgent Care services - Oversight by System Resilience Group:

- Communications campaign in primary care. Increasing flu immunisation by increasing awareness. The winter 'Keep Calm' campaign will be undertaken and patient leaflets are being developed on how to manage common ailments and signpost to primary and community services.
- A GP paramedic support service during Out of Hours is being commissioned from Northern Doctors Urgent Care. This service has shown to reduce A&E attendances and will reduce non-elective admissions, creating additional capacity within NTHFT (commissioned throughout the year across Tees).
- Seasonal Ailment Scheme - Pharmacies offering advice and pain medication. Patients will be directed to pharmacies locally and via 111. Preventable service that increases capacity in primary care.
- Primary Care scheme (to be confirmed) to be implemented over the winter period to increase capacity within primary care in core hours. Aimed at preventing A&E attendances and emergency admissions.
- The creation of a GP support telephony service within NEAS to support operational Paramedic Staff, working from the ambulance HQ control room. The purpose of this service is to allow Paramedics access to a significant clinical and medical skill-set for the improved triage and care of patients in the home environment, or at the scene of an incident. The service would operate 4pm-2am Monday-Friday (10 hrs. per day), and 8am-2am Saturday and Sunday and Bank Holidays (18 hrs. per day).
- 111 - The directory of service (DOS) captures all service pathways and regular assessment of dispositions to ensure services are meeting the urgent care needs of service users. Any locally identified gaps in provision are discussed by the

SRG and issues escalated to the regional NHS 111 Governance Group to take action.

- In order to increase the usage of the NHS 111 service the System Resilience Group has agreed to fund a communications campaign. A communication plan has been developed 'talk before you walk'. This is a local campaign but further work is to be undertaken to identify the benefits of a North East wide 'talk before you walk' campaign.
- A range of secondary care schemes to prevent admissions and improve pathways to reduce emergency admissions and delayed transfers of care.

4.0 Underpinning approaches

4.1 Improving Quality in Primary Care Strategy

The CCG are in the process of developing a strategy in order to deliver quality improvements in primary care. This strategy recognises that general practice and wider primary care services are face increasing pressures and that general practice needs to transform the way it provides services to reflect these growing challenges.

One of the priority areas for the strategy is improved integration and building upon the CCG vision of establishing a landscape in which different public bodies are able to work together, and with their partners in the third and independent sector including general practice, removing unhelpful boundaries and using their combined resources, to achieve maximum benefit for service users, carers and families.

4.2 GP Practice Variation

Work has continued on Variation within General Practice, working towards consistency of care across the CCG, and ensuring patients are cared for using the most appropriate pathway of care in the most appropriate setting. This includes increasing proactive care to reduce unnecessary admissions to hospital.

4.3 Frail Elderly

The CCG have a recently established Frail Elderly Project Group who will design and implement a new Frail Elderly Pathway over the next 5 years. The first step in this process is to agree the definition of frailty and establish a 'Frailty Register' in General Practice.

Appendix 1: Stockton Voluntary and Community Sector projects commissioned (co-ordinated and supported by Catalyst)

Bid Summary 2014
Monitoring 15 7 14 (6