NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group
Governing Body
Paper Summary Sheet
For: PUBLIC session ☒ PRIVATE session ☐

Date of Meeting: 19 May 2015

For: Decision ☐ Discussion ☒ Noting ☐

Agenda Item and title:	**GOV/15/05/14 Update on Transforming Care of Older People programme (TCOP)**
Author:	Jo Cullen, Group Director WWYKD
Lead Director/GP from CCG:	Jo Cullen, Group Director WWYKD TCOP Evaluation and Review Panel
Executive summary:	In 2014, the CCG invited proposals for local schemes to deliver a series of outcomes based on transforming care of patients aged 75 or older and reducing avoidable unplanned admissions by commissioning additional services which practices, individually or collectively (i.e. as a town/cluster/in federation with others) identified will further support the accountable GP in improving the quality of care for older people. This paper updates the Governing Body on the progress in implementation and delivery of these schemes, covering all GP practices in the CCG.
Evidence in support of arguments:	CCG Strategic Plan
Who has been involved/contributed:	TCOP Panel: Dr Mark Smithies (chair), Peter Lucas, Wessex LMC, Healthwatch Wiltshire and NHS England representatives CCG finance, quality and information managers
Cross Reference to Strategic Objectives:	Links to delivery of the Wiltshire CCG Strategic Five Year Plan
Engagement and Involvement:	Not at this stage, although this supports the delivery of the proposed model of care which has been through public, patient and stakeholder engagement.
Communications Issues:	Localities will be expected to develop robust communications plans with all stakeholders and public as

	part of their wider locality implementation.
Financial Implications:	National planning guidance - £5 / head of population. Due diligence checks against project spend against cost breakdown / affordability, potential duplication of funding streams (DES, LES, SLA or core contract); return on investment so the savings derived from avoidable admissions should, at least, cover the investment required and provide assurance that savings can be realised. There is a QIPP target set for TCOP based on the reductions agreed at scheme level. The assumed financial and activity impact across all the schemes for 2015/16 is: • Reduction of 1,046 emergency admissions for over 75s • Reduction of 646 A&E attendances for over 75s • Financial impact (QIPP) of £2.8m
Review arrangements:	In terms of Governance, this programme is monitored monthly with progress reviewed by an Independent Review Panel meeting quarterly and reporting to the Governing Body. Longer term, it is intended that this responsibility will sit with the Primary Care Operational Group reporting to the Joint Commissioning Committee.
Risk Management:	Risk assessments are contained within the individual TCOP business cases. Further assessment was completed during the due diligence check stage.
National Policy/ Legislation:	Five Year Forward View Everyone Counts, DH 2014
Other External Assessment:	Representatives from Healthwatch and Wessex LMC are TCOP panel members.
What specific action do you wish the Governing Body to take at the meeting?	The Governing Body are asked to note: i) the progress made to date in implementing schemes under Transforming Care of Older People across Wiltshire CCG. ii) that the schemes will be further reviewed in three months and are being monitored on implementation, delivery, and return on investment (as part of QIPP plans 15/16). iii) the learning event planned for the Autumn.

TRANSFORMING CARE OF OLDER PEOPLE

CONTEXT

In the Department of Health Planning Guidance "Everyone Counts" in 2014/15[1] there was a specific focus on patients aged 75 years and over and those with complex needs; and Clinical Commissioning Groups (CCGs) were expected to support GP practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. The Guidance set out the expectation that CCGs would provide additional funding to commission additional services which practices, individually or collectively, had identified would further support the *accountable GP*[2] in improving quality of care for older people. The practice plans for these services should be complementary to initiatives through the Better Care Fund.

GP practices could propose under the Guidance that this new funding be used to commission new general practice services that go beyond what is required in the GP contract and the new enhanced service. NHS England would need to be involved under these circumstances in order to help identify the contractual arrangements and help provide appropriate oversight and governance. GP practices could also propose that this money be invested in other community services to secure integration with primary care provision.

GP practices should have the confidence that, where these initial investment plans successfully reduce emergency admissions, it would be possible to maintain and potentially increase this investment on a recurrent basis. In addition, CCGs will need to demonstrate how individual practices can have as much influence as they need over the commissioning of associated community services, community nursing especially district nursing and end of life care, so that their accountable GPs can discharge their responsibilities and so as to ensure that these services are co-ordinated with the services provided by the practice itself and provide integrated care for patients.

SCOPE

In order to assess the strategic fit against the CCG local priorities, the plans submitted for this funding were reviewed against the following criteria as set out in the CCG 5 Year Plan[3].

The CCG 5 Year Plan places primary care, alongside patients, at the centre of the health and social care economy, with the aim that not only will Primary Care continue to lead the design of the health care system via clinical commissioning, but also provide a greater range and improve the quality and safety of services delivered to patients, and to support our plans for integration (community, social care, mental health) moving care out of hospital and our reconfiguration of community services. A co-ordinated care system with services wrapped around the patient using integrated care services and support accessed and coordinated by Primary Care teams is the foundation stone for our strategic vision. As a system we have used the Better Care Fund as an opportunity to further strengthen this work and deliver at greater pace and scale.

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[1] www.england.nhs.uk/ourwork/sop/

[2] As part of the 14/15 GP Contract negotiations, and as commitment to more personalised care for more patients with long-term conditions, NHS Employers and the General Practitioners Committee of the British Medical Association have agreed that all patients aged 75 and over will have a named accountable GP and receive a health check. The general practice will be required to ensure that there is a named accountable GP assigned to each patient aged 75 and over. The named accountable GP will take lead responsibility for ensuring that all appropriate services required under the core GMS contract are delivered to each of their patients aged 75 and over.

[3] http://www.wiltshireccg.nhs.uk/wp-content/uploads/2014/03/Paper-09-5-Year-Strategic-Plan-v18.pdf

The key design principles of the future CCG care model in the 5 Year Plan are:

- Support and sustain independent, healthy living
- People encouraged and supported to take responsibility for, and to maintain /enhance, their well-being
- Equitable access to a high quality and affordable system, which delivers the best outcomes for the greatest number
- Care should be delivered in the most appropriate setting, wherever possible at, or close to, home
- Where acute care is one-off or infrequent, there should be formal and rapid discharge
- Where care is on-going (e.g. chronic conditions), the default setting of care should be Primary Care

Current Position and Rationale

In 2014, the CCG invited proposals for local schemes to deliver a series of outcomes based on transforming care patients aged 75 or older and reducing avoidable unplanned admissions by commissioning additional services which practices, individually or collectively (i.e. as a town/cluster/in federation with others) have identified will further support the accountable GP in improving the quality of care for older people.

A TCOP Evaluation Panel was established in 2014, chaired by Dr Mark Smithies as the Secondary Care Doctor on the CCG Governing Body (with no conflicts of interest) and Peter Lucas, Lay Member, CCG Vice-Chair and Chair of the Audit and Assurance Committee; with representatives from NHS England, Wessex Local Medical Committee and Health Watch to ensure a robust and non-conflicted process of evaluation, and monitoring, supported through CCG managers from quality, finance, and information.

Proposals were assessed against their ability to meet following criteria:

- The CCG strategic vision
- Improved care for vulnerable older people
- Reduced avoidable admissions
- Continuity of care for older people
- Improved overall quality and productivity of services
- Greater integration of health & care services, in particular out of hospital care

16 schemes were supported and are funded on an on-going basis subject to successful delivery of the outcomes (predominantly admissions avoidance of patients aged over 75 years) covering every GP Practice across the whole of Wiltshire - while there are a number of different solutions, the key theme is wrapping additional services or releasing primary care capacity to proactively identify, manage and support frail and complex patients using the wider primary care and community teams in line with the CCG Delivery Plan.

The nature of the challenge in terms of reducing non-elective admissions in the over 75s meant that many of the schemes were unproven, so at the outset of the funding allocation it was made clear that on-going funding would be subject to successful delivery of the outcomes. That said, the CCG was keen to support locality based schemes that improve care for older people and in particular prevent avoidable admission; and so for that reason the process of project evaluation is to review progress in terms of implementation and outcomes and then work with projects to refine proposals where necessary to ensure the greatest chance of success.

Intended Outcomes

A programme of proactive measures targeted at over 75s at locality level, tailored to local needs will result in:

- A reduction in emergency admissions

- A reduction in A&E attendances
- A reduction in re-admissions
- A reduction in admissions from Care Homes
- Improved access to primary care
- Improved access to integrated care
- Enhanced care closer to the patient's home

The baselines for each scheme were calculated using September 2014 data and looked at the past 18 months' worth of data to give an average figure for twelve month period which formed the baseline.

The target is then the reduction that each of the projects submitted as part of their proposal. The activity is reported in two ways - actual figures for each of the measures on a month by month basis and a 12 month rolling average, which removes the monthly variation and gives a more accurate projection of overall trend.

There is a QIPP target set for TCOP based on the reductions agreed at scheme level. The assumed financial and activity impact across all the schemes for 2015/16 is:
- Reduction of 1,046 emergency admissions for over 75s
- Reduction of 646 A&E attendances for over 75s
- Financial impact (QIPP) of £2.8m

Capacity, capability and leadership
- Programme Director Responsibility
- Project management for implementation was included in the project funding and as such is held locally
- Programme manager to oversee process, act as link between information team and locality leads for project based reporting, collate aggregate outcomes, service review panel and provide support, challenge and recommendations re project refinement. Including sharing learning across the system and identifying potential economies of scale
- Incorporated into Locality Plans, with assigned clinical leadership and CCG manager support and facilitation.
- Support for on-going review, refinement, addressing barriers and interdependencies accessed through CCG locality support.
- In terms of Governance, this programme is monitored monthly, and reported monthly to Finance and Performance Committee, with progress reviewed by an Independent Review Panel meeting quarterly and reporting to the Governing Body.
- Longer term, it is intended that this responsibility will sit with the Primary Care Operational Group reporting to the Joint Commissioning Committee.

TCOP Review Panel – 31.03.15
The TCOP review panel meeting on the 31st March 2015 undertook the first formal review of the projects to make on-going funding recommendations to the Clinical Executive. Projects were asked to provide supporting information to ensure the Panel is kept fully informed and can take into account both the quantitative and qualitative information to make the decision.

Following approval from the TCOP panel for funding each project submitted outcome measures and project implementation milestones and these will be the metrics by which the projects will be measured. The review panel considered:
- Implementation Progress
- Delivery of Outcomes
- Subjective Feedback

Outcomes from TCOP Panel Review

The panel was asked to review each project and make one of the following recommendations to the Clinical Executive:

1. On-going project funding recommended – routine review in six months

(Projects who are advanced with regard implementation and delivering against expected outcomes)

2. Extended period of funding recommended – review again in three months

(Projects that are able to demonstrate compliance with implementation milestones and some progress in terms of local KPIs and / or outcomes. 'Watch and Wait')

3. Detailed review recommended – CCG to meet with project leads within one month

Assessment as to whether non-delivery is related to:

- Inability to implement the project i.e. did the project do what it said it was going to do?
- The project is not delivering the outcomes i.e. is the solution the right one?

Actions to be agreed regarding refinement of project to ensure implementation and delivery of outcomes, CCG to support project in refinement options or re-thinking solution including the sharing of learning from other sites

Monthly reviews of project continue until the Panel is confident that the recommendation is to either to move the project to option 2 or 4

4. Withdrawal of funding recommended

Outcomes of Panel 31.3.15

9 schemes were assessed as recommendation 2, with review in 3 months.

8 schemes were requested to provide further information to give assurance in one month at the next Review Panel meeting.

Outcomes of Panel 01.05.15

The 8 schemes reviewed were assessed as recommendation 2, with review in 3 months.

Next TCOP Panel planned in 3 months against outcomes measures and KPIs, and will report to the Governing Body.

Learning Event

It was agreed at the TCOP Panel on 31.3.15 to hold an event in October to be hosted by HealthWatch to share the learning from all of the schemes and which could be scaled up further and spread across the localities, and across teams. Learning so far has included:

- Issues and challenges of recruitment of most groups of staff
- Development of new roles such as the ERP, and new ways of employment (secondment, one practice on behalf of others)
- Links and synergy between TCOP and BCP and integrated community teams
- Focus on over 75s, but impact of under 75
- Release of GP capacity and implications of this
- Implications for providing services aligned to primary care at scale, that is a number of practices working together
- Links to other programmes and projects such as work with Care Homes, End of Life, Long term conditions, prevention and MSK
- Impact of the social care model as in the Leg Club schemes
- Impact of medications reviews on health outcomes and costs

Summary of TCOP Schemes:

Locality	Start date	Proposal Summary
WWYKD		
Devizes	**30/11/2014**	Release Primary Care Capacity to deliver proactive care - through the use of Emergency Care Practitioner (seconded from SWAS)
		Enable earlier home / care home visits to reduce need for admission / attendance
Bradford On Avon	**01/10/2014**	Leg Club
		Community Nurse Support and development of Older Peoples Nurse role
Westbury	**Leg Club - 02/03/15 Older Peoples Nurses - 01/04/2015**	Older Peoples nurse to proactively manage the over 75s within the practice
		Day care support service initially focussing on leg club initiative
Avenue, Warminster	**01/11/2014**	Release Primary Care Capacity to deliver proactive care - through the use of Nurse Practitioner and GP support
Trowbridge	**01/12/2014**	Domiciliary medication reviews for over 75s with Pharmacist across all 4 practices
		Increasing capacity through Emergency Response Practitioner role (seconded from GWH) now in place to start 01.06.15 across all 4 practices picking up visits for over 75s.
Melksham	**01/04/2015**	Proactively manage frail elderly in a clinic based setting
		Increased capacity through employment of Nurse Practitioner role for over 75s working closely with Care Co-ordinator and community teams
Smallbrook, Warminster	**01/09/2014**	Increase capacity in primary care to provide proactive care to frail elderly
SARUM		
Sarum North	**01/10/2014**	GP led Weekend Telephone Triage to proactively check on vulnerable patients over the weekend- reviewed and ended after Easter.

		Introducing a domiciliary medication review pharmacist role for over 75s into team based on evidence in other areas
		Just Home from Hospital Checks – supported at Panel 31.3.15 as revised scheme.
		Active review and follow-up on all discharges of patents over 75
Sarum City	**01/10/2014**	Increased GP capacity to proactively care for the over 75s through the use of Elderly Care Clinical Assistants.
		Development of domiciliary medication reviews and integrated teams with care co-ordinator and pharmacist
		GP led Weekend Telephone Triage to proactively check on vulnerable patients over the weekend
Sarum West	**01/10/2014**	Create additional GP capacity to provide proactive review and care and support planning
		Active review and follow-up on all discharges of patents over 75
		Eldercare Facilitator led programme of self-assessment health and care needs with follow-up as required and active discharge follow up
NEW		
NEW East	**01/12/2014**	Create additional GP capacity for GP led multi-morbidity clinics for the more vulnerable patients over 75, supported by practice nurse, care co-ordinator and, where appropriate wider MDT to deliver proactive care and support plans.
NEW North	**01/12/2014**	Create additional GP capacity for GP led multi-morbidity assessment for the more vulnerable patients over 75 to deliver proactive care and support plans.