NHS
East Lancashire
Clinical Commissioning Group

Agenda Item No: 6.2

REPORT TO:	**PRIMARY CARE COMMITTEE**	
MEETING DATE:	**18th July 2016**	
REPORT TITLE:	**East Lancashire Over 75's Evaluation 2015/2016**	
SUMMARY OF REPORT:	The report provides an evaluation of the Over 75 Schemes across Localities 2015/16.	
REPORT RECOMMENDATIONS:	The Primary Care Committee are asked to: • To consider the recommendations outlined in each Locality section. • Localities to work together to develop a core offer across East Lancashire based on the good practice highlighted in this report to ensure consistency across all Localities. • To bring in the work of the Care Home Nurses across all Localities under this Scheme. (Some Localities are funded separately). • To consider the Over 75's Schemes as part of a multi-specialty community provider offer and test in the pilot areas of Rossendale and Ribblesdale. • To develop robust data collection and consistency of outcomes monitoring across East Lancashire. • To return to the Primary Care Committee in September with the finalised offer for Localities to include the above recommendations.	
FINANCIAL IMPLICATIONS:	£1,842,000	
REPORT CATEGORY:		**Tick**
	Formally Receipt	X
	Action the recommendations outlined in the report.	X
	Debate the content of the report	
	Receive the report for information	
AUTHOR:	**Kirsty Hamer**	
	Report supported & approved by your Senior Lead	**Y**
PRESENTED BY:	**Kirsty Hamer / Rebecca Demaine**	
OTHER COMMITTEES/ GROUPS CONSULTED:	None	
EQUALITY ANALYSIS (EA) :	Has an EA been completed in respect of this report?	**N**
RISKS:	Have any risks been identified/assessed?	**N**
CONFLICT OF INTEREST:	Is there a conflict of interest with this report?	**N**
PATIENT ENGAGEMENT:	Has there been any patient engagement?	**Y**
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.	**X**
2	Optimise appropriate use of resources and remove inefficiencies.	**X**
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	**X**

East Lancashire Over 75's Evaluation 2015/16

Locality Managers

June 2016

Contents

1. Executive Summary

East Lancashire CCG committed £1.842 million to delivering additional primary care and community health services based on priorities identified by member Practices. Each Locality determined their own schemes which have been in place for 12-18 months. Schemes included Nurse Practitioner Services, Assessments and Extended Access to Primary Care.

Many of the schemes have evaluated well particularly receiving positive feedback from patients, carers and other Health Professionals.

The evaluation has also highlighted that the number of complex patients in each Locality has increased (Aristotle Risk Stratification Tool) and the number of patients aged over 65 in each Locality has increased. However, admissions and readmissions (medical specialties) to hospital for those aged over 65 has reduced and attendances have stayed the same despite the increase in population of this age range. (SUS Data).

There are some areas for improvement acknowledged in the report, this includes schemes that haven't evaluated well, identified gaps in service, inconsistent data collection and outcome measures.

The Localities have recommended the development of an Over 75's Core Offer across East Lancashire based on the evidenced good practice from current schemes and to develop a consistent data collection and appropriate outcome measures to ensure that services are measured equitably across Localities and the CCG are capturing the right information.

2. Introduction

East Lancashire CCG has committed £1.842 million to delivering the Over 75's schemes across East Lancashire. The expectation from NHS England's 'Everyone Counts' planning guidance was that CCG's utilise the funding to support plans for improving services for older people and those with more complex needs. The recommendation was that funding was used to commission additional primary care services or community health services based on priorities identified by Member Practices / CCG. For East Lancashire, a number of schemes were put in place 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.

The funding is split between localities and is based on population as noted below:

Locality	**Funding**
Burnley	£483,000
Hyndburn	£383,000
Pendle	£465,000
Ribblesdale	£185,000
Rossendale	£325,000
Total	**£1,842,000**

Localities were given the opportunity to develop their own service model based on their identified priorities. Each Locality developed a slightly different scheme although many of those provided are of a similar service:

Burnley Over 75's Scheme:

- Specialist Nurse Practitioner Service providing intermediate care to those patients over the age of 75 with complex needs.
- Health and Wellbeing Assessments for patients aged 75 and over.

Hyndburn Over 75's Scheme:

- Specialist Nurse Practitioner Service providing intermediate care to those patients over the age of 75 with complex needs.

- Health and Wellbeing Assessments for patients aged 75 and over.

Pendle Over 75's Scheme:

- Extended primary care access for patients over 75.

Ribblesdale Over 75's Scheme:

- Specialist Nurse Practitioner providing intermediate care to those patients over the age of 75 with complex needs.
- Health and Wellbeing Assessments for patients aged 75 and over.
- Extended primary care access for patients over 75 from 1st January 2016 – 31st March 2016. This was funded utilising unallocated funding from 2014/15.

Rossendale Over 75's Scheme

- Specialist Nurse Practitioner Service providing intermediate care to those patients over the age of 75 with complex needs.
- Extended primary care access for patients over 85's
- Befriender service matching the lonely and vulnerable within appropriate befrienders.
- Part funding on extended care home nursing team who visit on rotation all of the Rossendale Care Homes.

The next section of the report provides further detail of the above schemes within each Locality and this includes evaluation of impact.

3. Evaluation

3.1 East Lancashire Overview

Each Locality determined how they would collate their own data from their Over 75's Scheme. The findings have been split into Locality level data. The evaluation provides both quantitative and qualitative data from the schemes and includes any impact on A&E attendances and non-elective admissions over the time period and in comparison with previous years. The evaluation below also identifies recommendations for each Locality which have been reviewed and support the recommendations section of this evaluation.

The data gathered for the review includes patients aged 65 and over, the reason for this is that for a number of the schemes below, although priority is given to Over 75's with complex needs, patients under this age may have received a service as they could clearly benefit from the support, this is particularly evident with the Care Home Nurses. It was felt that to ensure we covered the entirety of the patients seen with the Over 75's scheme that the data should include patients aged 65 and over.

From an East Lancashire perspective, since the commencement of the Over 75's Schemes the following has been noted:

- Emergency Admissions (Medical Specialties) for patients over the age of 65 has reduced by 8%. Average admission rate for Over 65's in 2014/15 was 1125.50, this has reduced to 1039 in 2015/16. (See Appendix A) (SUS Data)
- Readmission rates have also reduced. The average readmission rate in 2014/15 was 17.46%, this has reduced to 16.94% in 2015/16. (See Appendix B) (SUS Data)
- A&E Attendances have stayed the same in 2015/16, however, this is significant due to the increase in numbers of Over 65's across East Lancashire. A&E attendance stayed at similar levels across the year, the CCG didn't see a peak in Winter 201/16 (See Appendix C). (SUS data)
- The above has been achieved despite an increase in complex patients (See Appendix D) (Aristotle Risk Stratification Data)

NB: Caution needs to be taken with the above figures. There may be a number of reasons that the above has been achieved:

- *Additional service developments to support this cohort of patients may have also impacted admissions and attendances i.e., Integrated Neighbourhood Teams, Intensive Home Support Service etc.*

- *Query around winter pressures and whether we had a particularly mild winter which may mean that expected levels weren't realised.*

3.2 Burnley

Burnley were allocated £438,000 for delivery of their Over 75's Schemes. The Locality utilised this funding by commissioning a Specialist Nurse Practitioner (SNP) Service and Health and Wellbeing Assessments for Over 75's. During 2015/16 whilst waiting for the SNP Service to become established, the Locality used this funding to pilot an Integrated Care Access Scheme. Those schemes have been evaluated and impact is highlighted below.

3.2.1 Specialist Nurse Practitioner (SNP) Service

The Specialist Nurse Practitioner Service provides a range of holistic support to elderly patients, particularly those over the age of 75 with additional health and social care needs

The core purpose of the service is to:-

- coordinate the care of those patients identified as requiring enhanced support to ensure that all needs are being met,
- provide regular assessment and review as needs change and
- identification of a case manager to support their on-going needs in line with the development of the Integrated Neighbourhood Teams

The Service has been working exclusively in Burnley Care Homes to support the health issues of residents and to contribute towards improving standards of healthcare within those Homes.

Between April 2015 and March 2016, the service made 5062 visits to patients in Care Homes. This has included assessment and diagnostics for acute conditions, support for ongoing health issues, development of care plan and chairing of MDT's to ensure collaborative working across the INT footprints. 42 patients have been discussed via the MDT's to provide ongoing support for patients with complex health needs.

The SNPs are also providing regular training sessions in the Care Homes to improve staff management of supporting patients with long term conditions in the home and highlighting pathways for accessing services in the right place at the right time.

The service collate stakeholder feedback to monitor impact of the service, all feedback has been positive including:

"Continuity of care – same person dealing with ongoing issues."

"Reassuring to have a service which comes into the home – nice to have a named contact"

"They are doing a really good job"

The Locality have an Over 75's Working Group in place to monitor the effectiveness of the service and to continue to develop the service further including extending support to Over 75's housebound patients.

3.2.2 Burnley Health and Wellbeing Assessments

In 2015/16 the Locality have been providing Health and Wellbeing Assessments to registered patients over the age of 75. The comprehensive assessments give a holistic picture of the patients health and wellbeing needs including physical health, mental health and social care. The health assessments give an opportunity to assess the patient's needs and to refer onto the appropriate services to address any issues that may have arisen from the health and wellbeing assessment. Examples include referring to the wellbeing service for support around benefits, social isolation etc.

In 2015/16, 4,518 health and wellbeing assessments took place. This was out of a total of 7,047, therefore 64% of Over 75's in the Burnley Locality had a wellbeing assessment. For the other 36%, reasons for those varied including some of those patients being in care homes and are picked up via the SNP Service, other Over 75's patients did not want a health and wellbeing assessment.

3.2.3 Burnley Integrated Care Scheme

Due to time taken in recruitment to the SNP Service, the locality were keen to utilise the funding available to address some of the priority areas for Burnley. The scheme consisted of 3 areas; (1) same day access to GP services, (2) adopting the Burnley UTI pathway, (3) adopting the Burnley End of Life Gold Standard. This Scheme was for 15/16 only using non-repetitive funding from the SNP Service.

Results were as followed

Access:

15 practices submitted data, providing evidence of implementation of the access scheme.

- Approximately 6800 over 75s in Burnley

- Average 870 in the top 2% risk stratification
- Average 1950 seen in surgery each month
- Average 290 visited in care homes each month (this does not account for housebound over 75s)

UTI:

15 practices submitted data, providing evidence of implementation of the scheme

- Average 92 suspected UTIs in over 75s per month
- Patchy use/recording of use of fluid intake charts
- Baseline prescribing data of nitrofurantoin and trimethoprim for the period November 14-March 15 not available
- Comparative prescribing data for period November 15-March 16 not yet available

Burnley End of Life Gold Standard (BELGS)

14 practices submitted data, providing evidence of the implementation of the scheme

- Most practice held monthly BELGS meetings
- In most cases, the reason for not being able to hold monthly meetings was one of unplanned staff shortages due to sickness and some planned absences due to holidays (this tends to affect smaller practices more than larger practices)
- The number of Over 75s on the BELGS list tended to vary between practices. Some indicated that they held 2 lists ie those who were given special consideration but were not deemed “end of life” were held on one list with those nearing the end of their life being held on another.
- The use of uDNACPR is still variable in the locality. Care home and community staff tend to want uDNACPRs in place fairly early, but GPs tend to want to wait until a patient is definitely in his/her terminal phase.
- The practices did not formalize the process of gaining feedback from families after the death of a relative. However, discussions at the time of death with all teams involved (community nurses, Macmillan nurses, care home staff, and practice teams) usually include conversations about how the families felt the experience had been for the patient, and the family members supporting them. Monthly audit of patients who had passed away during the preceding month includes this feedback.

3.2.4 Burnley Conclusion / Recommendations

The Locality have reviewed all data and feedback from each of the Over 75's Schemes and the following has been recommended by the Locality:

- Continued work with the SNP Service to develop a robust data collection to ensure we are gathering the right information to inform decision making in the Locality.
- A review of the current SNP workload ensuring that their work continues to compliment the work of primary care and prevent unnecessary admissions to hospital and attendance and Urgent Care / A&E.
- To work with the SNP Service to extend the delivery of the service to housebound patients.
- The Locality felt that the Health and Wellbeing Scheme had some benefits but there was a query as to whether the target audience for the wellbeing assessments was appropriate for the Over 75's scheme i.e., carrying out assessments on Over 75's who were well and didn't require additional support. After discussion at the Over 75's Steering Group it was agreed to cease providing the health and wellbeing assessments in 2016 /17 and to look to utilise this additional funding more effectively in the Locality to address the more complex over 75's.
- The Integrated Care Scheme ceased at the end of March 2016. This funding was non-repetitive. The UTI pathway work will continue to be picked up under the Medicines Management Plan and the End of Life Gold Standards work will be picked up under the Cancer plans.
- The Locality have recommended continuing with the Access element of the Integrated Care Scheme for 2016/17 utilising the funding from the health and wellbeing assessments whilst the Locality work a proposal for commissioning additional support for more complex patients.
- To develop a proposal for the Over 75's Service for 17/18 onwards.

3.3 Hyndburn

Hyndburn were allocated £383,000 for delivery of their Over 75's Schemes. The Locality utilised this funding by commissioning a Specialist Nurse Service (GP Community Matrons) and Health and Wellbeing Assessments for Over 75's.. Those schemes have been evaluated and impact is highlighted below.

3.3.1 GP Community Matrons in Hyndburn

Practices in Hyndburn worked together to employ highly skilled nurses from the Over 75s monies to work particularly with the housebound over 75s and those recently discharged from hospital, who are not on the district nurse caseload. These nurses have undertaken needs assessments and case management for these patients. They are closely linked into the integrated neighbourhood team alongside their own GP Practices. Patients are then referred onto appropriate services if required, including 3rd sector organisations.

Currently each nurse is working slightly differently dependent on the requirements of the practices they are working for.

The evidence from the hospital admissions data suggests that full time nurses are a more effective and efficient way to look after the needs of the Over 75s. This extra capacity enables them the freedom to set their hours around the patients and not around the practices. The model employed by the Blackburn Road Partnership and the Peel House Partnership have proved both the more effective in a hospital admissions sense, alongside more cost effective from the number of Over 75s patients seen.

The host practices collate stakeholder feedback to monitor the impact of the service, all feedback has been positive including the patients feeling that they have a point of contact for advice, confident in the skills and greatly appreciating the visits they receive. GPs have seen a significant reduction in workload and housebound visits due to the commissioning of this service.

Over the busy winter period the GP Community Matron team were hugely involved with Christmas Present collection and delivery to the Hyndburn Over 75 community.

3.3.2 Hyndburn Health and Wellbeing Assessments

In 2015/16 the Locality have been providing Health and Wellbeing Assessments to registered patients over the age of 75. The comprehensive assessments give a holistic picture of the patients health and wellbeing needs including physical health, mental health and social care. The health assessments give an opportunity to assess the patient's needs and to refer onto the appropriate services to address any issues that may have arisen from the health and wellbeing assessment. Examples include referring to the wellbeing service for support around benefits, social isolation etc.

In 2015/16, 1748 health and wellbeing assessments took place. This was out of a total of 5695, therefore 30% of Over 75's in the Hyndburn Locality had a wellbeing assessment.

3.3.3 Hyndburn Conclusion / Recommendations

The Locality have reviewed all data and feedback from each of the Over 75's Schemes and the following has been recommended by the Locality:

- Continued work with the GP Community Matron Service to develop a robust data collection to ensure we are gathering the right information to inform decision making in the Locality.
- A review of the current GP Community Matron workload ensuring that their work continues to compliment the work of primary care and prevent unnecessary admissions to hospital and attendance and Urgent Care / A&E..
- To improve the team working between the nurses and ensure some cross cover can be applied in urgent situations. It would be preferable to review the specifications and ensure working practices are consistent across the locality.
- Towards the latter end of the financial year, the vision would be to have all the GP Community Matrons to be under one employment organisation and line management structure.
- The Locality felt that the Health and Wellbeing Scheme had some benefits but there was a query as to whether the use of funding was appropriate i.e., carrying out assessments on Over 75's who were well and didn't require additional support. After discussion at the Hyndburn Steering Group it was agreed to propose to cease providing the health and wellbeing assessments in late 2016 /17 and to look to utilise this additional funding more effectively in the Locality to address the more complex over 75's.
- To develop a proposal for the Over 75's Service for 17/18 onwards, including HCAs to undertake repeat BPs and Bloods to enable better use of funding and skillsets.

3.4 Pendle

Pendle were allocated £465,000 for delivery of their Over 75's Schemes. The Locality utilised this funding by offering over 75s in the locality to have longer primary care consultations as primary care clinicians felt that time with patients is one of the most valuable resources; which has been recognised nationally. The locality did not wish to be prescriptive in how practices delivered this objective, however it had to be done without impacting on other patient groups and had to incorporate certain criteria of which have been evaluated and impact is highlighted below.

3.4.1 GP Appointment length 15 minutes for all patient's over-75s years

Standard length of a GP appointment is ten minutes, however, with increasing complexity of presenting problems and long-term conditions there was a strong argument to extend the length of appointments. It has also been acknowledged by the British Medical Association who has led a campaign aimed at extending booked GP consultation length, therefore, the overarching vision for the locality scheme was to ensure that Over 75s in Pendle have appropriate access to, and time with healthcare professionals, improving the care of older people, promoting independence and reduce avoidable admissions.

3.4.2 Achieving the aims of individual practice delivery plans

Each practice has produced a quarterly report to evidence the utilisation of the funds in meeting the requirements of the scheme. Key themes on the delivery methods are as follows:

- Additional GP hours/GP Locum to cover additional sessions
- Employment of additional practice nurse/practice nurse hours
- Training of receptionists to become Phlebotomists to free up Healthcare Assistants to visit housebound patients
- Employment of a clinical pharmacist
- Increase Healthcare Assistant hours
- Increase practice Care Navigator Role

3.4.2.1 Areas of best practice

The utilisation of funds within each practice has varied from practice to practice (dependant on funds allocated to each practice). Below are examples of best practice taking place in addition to practices offering extended appointments to over 75s patients:

- Utilisation of extended GP consultations has enabled clinicians to discuss care plans and dementia screening
- Employment of a clinical pharmacist to look at safe prescribing for over 75s , looking at discharge summaries for any medication changes
- Offering Integrated Care Home visits

- Administrative staff have been trained as phlebotomists which has freed up capacity for practice nurses to concentrate on chronic disease management and also put additional capacity in the system for Healthcare Assistants to provide routine home visits for the housebound patients
- Regular audits of Over 75 patients who haven't presented within the last three months. These patients are sent a questionnaire which has enabled the practice to update records with information, for instance, carer information
- Utilisation of Care Navigator role which acts as the first point of contact for patients who have been discharged from hospital. The extension of this role enables the practice to monitor and co-ordinate the care for patients who are elderly and have been in hospital and or require additional care to avoid admission

3.4.3 Supporting the modern model of integrated care

Pendle practices are actively working with the Integrated Neighbourhood Team to develop a service that is aimed at helping patients that are the most vulnerable to hospital admission. It has been acknowledged that this funding has been an enabler to support those patients over 75 and with long term conditions to improve the management and prevent them from requiring secondary care services.

3.5.3.1 Pendle Specialist Nurse Practitioner – Care Homes

In addition to the above, Pendle practices wanted to focus on the needs of older people in nursing and residential care homes. The key aim of the Specialist Nurse Practitioner (SNP) is to manage a clinical caseload, dealing with patients' needs in a care home setting. This in part has been achieved through the introduction of the Telemedicine Service provided by the Digital Care Hub at Airedale NHS Foundation Trust. However, through the successful pilot of an SNP in care homes in Ribblesdale, the role was rolled out across East Lancashire. The role provided an opportunity for new care home residents to have a through medical based assessment in partnership with both Airedale Digital Care Hub and the CCG locality Medicine Management Team. Unfortunately, this service was pulled from the locality in 2015 due to staffing constraints.

3.5.4 Delivering better care through digital revolution

The locality has a long standing history of supporting the digital revolution with regard to implementing Telemedicine within the locality. The locality wanted to improve the lives of over 75s living in residential and nursing home settings, making the home the default setting not a GP surgery, outpatient clinic or emergency department. Working in conjunction with the Airedale Telemedicine Hub, the locality devised a GP Triage service whereby the Hub would clinical assess all calls from homes and onward refer to a healthcare professional within a practice if necessary.

Feedback demonstrates that visit requests have fallen by over 60 per cent. In addition to this, Airedale and Partners Enhanced Health in Care Homes Vanguard are keen to see how this develops and is evaluated by healthcare professionals and care homes for replicability across the Vanguard.

3.4.4.1 GP Feedback:

"Of all the changes in the 15 years I have been working this is the greatest change which has reduced workload I can remember. I don't mind the extra "late" duty doc visit as this is more than made up in the drop in other visits. A big thank you to all involved."

3.4.4.2 Residential Home Manager Feedback

"Since we have been using the new GP Triage service we are able to get medical advice straight away. We no longer have a long list for the GPs on a Monday morning. It's been a major improvement to the well-being of my service users"

3.5.5 Evaluating patient and staff experience

Practices were requested to report on a quarterly basis on the following:

- Survey patients regarding their satisfaction (both over 75s and the wider population)
- Monitor access for the rest of the patient population to ensure that they are not disadvantaged by the process
- Feedback from primary healthcare professionals

On consulting the Patient Participation Groups, members felt that the public may perceive that there would be a reduction in appointments with GPs and would therefore impact on other patients. However, through the Friends and Family Test and in-house patient surveys, there have been no reported complaints about the changes. Feedback received from practices has been positive for both patients and staff. Overall patients have appreciated the extra time the healthcare professionals have provided. The additional clinical sessions have been well received with no impact on service delivery to the rest of the practice population.

3.4.6 Pendle Conclusion / Recommendations

Data and feedback from practices has been reviewed with regard to the Over 75 scheme and linked innovative schemes and the following recommendations can be made:

- The locality have recommended continuing the current scheme utilising the funding to support patients with complex needs and reduce admissions to hospital
- Look at best practice from across the locality and develop a proposal for the Over 75 scheme for 17/18 onwards
- Pursue the re-establishment of the Pendle Specialist Nurse Practitioner in Care Homes

3.5 Ribblesdale

Ribblesdale were allocated £185,000 for delivery of their Over 75's Schemes. The Locality utilised this funding by commissioning a Specialist Nurse Practitioner (SNP) and Health and Social Care Assessments for Over 75s. Additionally, extended appointment times for over 75s were offered for a 3 month period, January to March 2016. All schemes have been evaluated and their impact is highlighted below.

3.5.1 Ribblesdale Specialist Nurse Practitioner for Over 75's

The role of the Over 75s Specialist Practitioner is to support the intensive care management of high risk individuals with multiple long term conditions and complex needs. The Over 75s Specialist Practitioner is a key member of the Ribblesdale Integrated Neighbourhood Team (INT) and works in partnership with District Nurses and the Advanced Practitioner for Care Homes. As part of this collaborative approach to care, the Over 75s Specialist Practitioner manages the care of patients over 75 with complex needs within the community. Importantly patients are supported to avoid a deterioration in health condition wherever possible, therefore avoiding inappropriate hospital attendances and admissions.

Description of Support:

- Provide high-intensity support, to ensure that patients multiple health and social care needs are met and so enable them to remain at home.
- Acting as Case Manager as part of the INT service to ensure that the care of patients over 75 who are in the INT is coordinated and communicated on a regular basis.
- Liaison with other Health and Social Care Services as part of the INT process ensuring that the patient's care is coordinated.
- Referral to Ribblesdale Health and Wellbeing Services for additional support in the home i.e., falls prevention, carers support, befriending services etc.

Referrals are made to the SNP on a weekly basis and in the first 17 months a total of 180 patients were seen. As the geographical area is large, the distance travelled between patient visits can be long.

There are numerous advantages to the Over 75s Specialist Practitioner role including patients being seen in their own home and the identification of problems and/or potential problems. The role provides opportunities regarding health and social care which are equivalent to what those able to access health centres/clinics might experience. A strong rapport is generally built with patients, providing an opportunity for health promotion.

A positive response to the SNP role is evident from health care professional feedback and a review of patient case studies.

3.5.2 Ribblesdale Enhanced Primary Care Support - Assessments

Each Practice is responsible for funding Enhanced Primary Care Support. Assessments are generally provided by Practice Nurses and Health Care Assistants and include the following:

- A full Health and Social Care Assessment undertaken by the Nursing support.
- The holistic assessment will identify needs such as:
  - Need for referral onto additional health services such as mental health, therapy services, district nursing.
  - Need for social care support
  - Need to prevent social isolation either via a befriending scheme or social club.
  - Need for physical activity.
- Case management of identified over 75's to ensure that their support is coordinated.
- Referral onto the appropriate local community services to prevent deterioration of health.
- Step up to INT and/or Over 75's Specialist Practitioner if condition deteriorates
- Provide a step-down service for Over 75's from INT and/or Specialist Practitioner if needs improve but still require additional support from the Practice.
- To identify any gaps in services for those low level support services to inform commissioning priorities for both health and social care.

A positive response to assessments has been received to date from patient surveys, including the following feedback:

"Good service, would highly recommend, lovely nurse who took the assessment – easy to talk to"

"Staff are knowledgeable and able to explain things in a way we can understand and put us at ease"

"Very thorough, feel as though I've had a good MOT and listened to"

3.5.3 Ribblesdale Specialist Nurse Practitioner – Care Homes

The key aim of the role is to manage a clinical caseload, dealing with patients' needs in a care home setting. Referrals are sent to the SNP on a daily basis from Practices requesting an acute, on the day visit to a care home. Additionally, the SNP also undertakes the following:

- Undertake advance care planning discussions and produce a care plan for patients in care homes and also for patients on the INT where appropriate
- Complex new assessments and ongoing reviews/acute visits in community settings for patients under 75 and on the INT

The SNP for Care Homes works closely with the SNP for Over 75's to provide advanced nursing care and case management to patients with multiple complex long term conditions.

3.5.4 Enhanced primary care access

Unallocated funding from 2014/15 has been used to extend appointment times for both GPs and Practice Nurses/Health Care Assistants who are managing the care of over 75s. Appointments for over 75s were extended as follows:

- For GPs - from 10 minutes to 15 minutes
- For Practice Nurses/Health Care Assistants - from 20 minutes to 30 minutes

Extended appointment times supported the Over 75s service and has allowed for a more thorough assessment of patients' needs. Importantly, it allowed more time for health professionals to offer health promotion; more time for effective signposting to other agencies and more time to develop effective working relationships with other community services

Overall, feedback from Over 75s patients accessing an extended appointment has been positive. Likewise, appointment access for other patients during the period January – March 2016 has been generally positive.

3.5.5 Ribblesdale Conclusion/Recommendations

The Locality has reviewed all data and feedback from each of the Over 75's Schemes. The following has been recommended by the Locality:

- Continuation of the SNP for Over 75s and the SNP for Care Homes.
- Support for a Health Care Assistant to work alongside the Over 75s SNP to enhance the Over 75s service provision. Lower level input could be undertaken by the HCA including monitoring of patients, checking vital signs and checking any changes to medication. It is envisaged that this will free up time for the highly skilled Over 75s SNP to focus more on health issues and concentrate on reducing avoidable admissions.
- Continuation of the enhanced primary care service for Over 75s.

3.6 Rossendale Over 75s

Rossendale were allocated £325,000 for the delivery of their over 75s schemes. The locality during 2015-16 utilised the majority (£293,374) to commission four main initiatives and a brief description and indication of the impact is highlighted below:-

3.6.1 Rossendale Support Nurse Service

The Support Nurse Service, which is hosted by Rossendale Hospice provides a range of holistic support to elderly patients, particularly those over the age of 75 with additional health and social care needs. In addition the service is supported by Dr Zeenat Sykes who is a local GP and locality Steering Group member.

The core purpose of the service is to:-

- Ensure a coordinated plan for the care of those patients identified as requiring enhanced support to ensure that all needs are being met,
- Apply regular assessment and patient review as needs change and
- Identification of a case manager to support their on-going needs in line with the development of the Integrated Neighbourhood Teams

The Service has been working right across Rossendale and mainly receiving referrals from GP Practices to support the health issues of those referred to them.

The team consists of two full time Support Nurses and an Administrator and between April 2015 and March 2016, the service made just over 2,000 visits to patients in their own homes. The visits include an assessment and diagnostics for acute conditions, support for ongoing health issues.

The service regularly collates stakeholder feedback to monitor impact of the service and an example of the sort of feedback received is as follows:-

> *"We are so lucky to have this support with lovely caring people – Albert 80 years old from Bacup."*
>
> *"The over75s support nurse I have seen has been an amazing support. I couldn't have made it through last year without her support and friendship – Thank you for being there – Ayesha 75 years old from Rawtenstall. "*
>
> *"The help and support of this service is invaluable. Having someone to listen at the right time makes a huge difference – Sarah 82 years old from Edenfield."*

The Locality regularly discuss the service in their Steering Group and Forum meetings.

3.6.2 Rossendale Extended Primary Care Access for patients over 85

Seven of the nine Rossendale GP Practices are providing extended (20 minute appointments) for their patients who are over 85 years of age. This allows participating practices to dedicate more clinical time for their most elderly and vulnerable patients. This initiative was developed by Dr John O'Malley who is a local GP and locality Steering Group member.

The core purpose of the service is to allow for:-

- A more detailed patient consultation, ensuring that all the patient needs are being identified.
- Opportunity for these patients and cares to ask detailed questions with regard to their healthcare.
- The identification of any additional patient needs and the signposting to any appropriate support services including either the Integrated Neighbourhood Teams or Support Nurse Service.

3.6.3 Rossendale Befriender Service

This service is also hosted by Rossendale Hospice through the employment of a Befriending Co-ordinator. This person works on matching each person (befriendee) with a volunteer befriender who will visit regularly to provide some company and in cases, assistance with accessing particular interest groups or sources of support.

All of the prospective befriendees are assessed by the Befriender Co-ordinator who takes care to match them with a volunteer befriender who is able to meet their needs. All volunteer befrienders undergo thorough checks and receive relevant training.

To date the Befriending Co-ordinator is maintaining a group of 30 active befriending matches. Inevitably there are more people in need of a befriendee than volunteer befrienders and therefore a significant focus of the befriending co-ordinator is on recruitment. The Co-ordinator attends a lot of public events and has developed a flyer by way of publicity.

There is an open referral process as well as through GP Practices, the Support Nurses, INT or Age UK. Most commonly referrals are received from family, friends or providers of healthcare.

3.6.4 Rossendale Extended Care Home Nurse Service

Part of the Rossendale's over 75 funding has been used to offer an extended care home service. This service has been running for over eight years and extremely well respected by both the patients in the homes in addition to the care home management.

This service is hosted by Irwell Medical Practice who employ a team of four Nurse Practitioners visiting on a rotational basis each of the care homes in the locality. The team are supported by a pharmacist who is able to advise on medicines management issues.

The core purpose of the service is to:-

- Support / Advise on the care of patients.
- Develop an expertise in caring for the elderly in a care home environment.
- Ease pressure on primary care who would ordinarily have to make a patient visit to the care home.

From time to time the team have been able to receive support from Dr Amit Paramanik who fulfils a Geriatrician role at ELHT but has supported the Multi-Disciplinary discussions that Rossendale INT have been having. His wealth of experience has been invaluable to the Rossendale Care Home Team.

Finally, the team have full remote access to each patients medical records which makes their patient consultations more comprehensive.

4. Conclusion of East Lancashire Over 75's Schemes

Following on from the evaluation of each Over 75's scheme above the following can be concluded:

- The number of complex patients in each Locality has increased.
- The number of people aged over 65 has increased within each Locality.

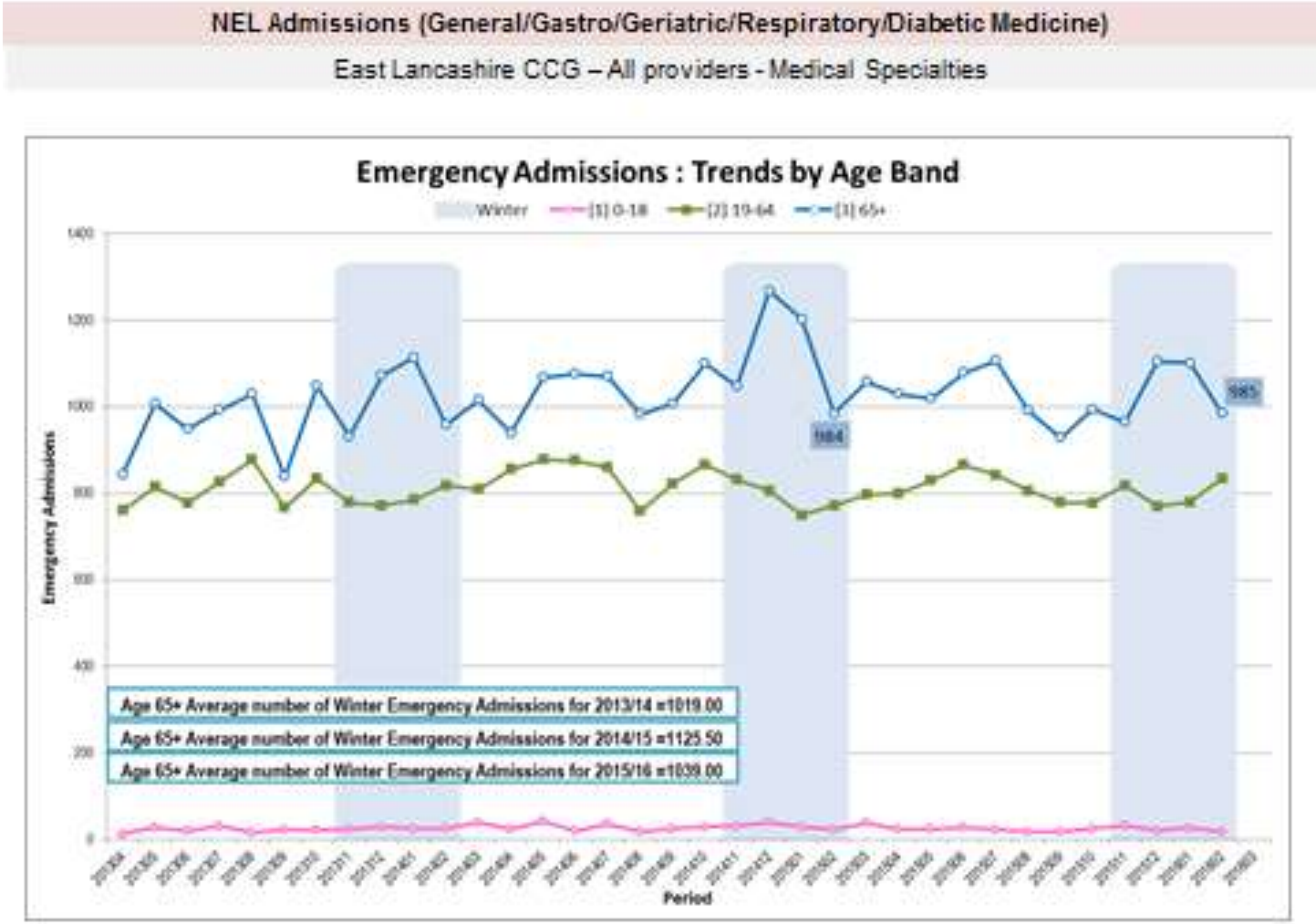
- There has been an overall reduction in emergency admissions and readmissions (medical specialties) in this age range.
- There are examples of excellent practice within the Localities that needs to be built on.
- It is clear that some of the schemes are not having as much of an impact as expected and those schemes need to either be stopped or adapted to ensure maximum impact.
- To be able to fully attribute the reduction in admissions and attendances to the Over 75's Schemes a patient audit would need to take place to gain information on those who have had direct involvement with the Over 75's Schemes.
- It is recognised that there is some inequity between the Localities and it would be useful to develop a core offer for each Locality to ensure some consistency.
- Data collection including outcome measures is inconsistent across the Localities and would benefit from the development of a single approach.

5. Recommendations of East Lancashire Over 75's Schemes

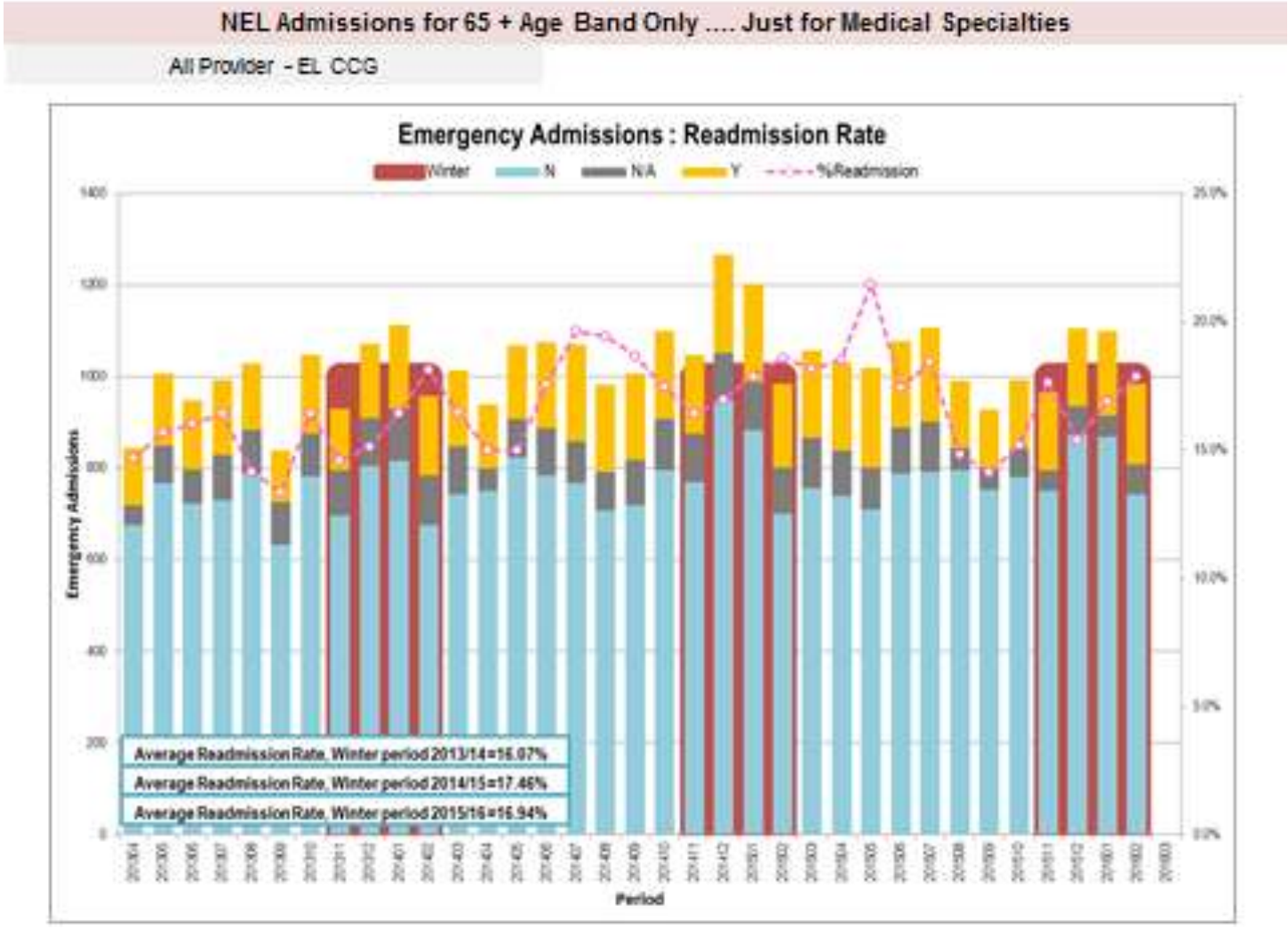
- To consider the recommendations outlined in each Locality section.
- Localities to work together to develop a core offer across East Lancashire based on the good practice highlighted in this report to ensure consistency across all Localities.

- To bring in the work of the Care Home Nurses across all Localities under this Scheme. (Some Localities are funded separately).
- To consider the Over 75's Schemes as part of a multi-specialty community provider offer and test in the pilot areas of Rossendale and Ribblesdale.
- To develop robust data collection and consistency of outcomes monitoring across East Lancashire.
- To return to the Primary Care Committee in September with the finalised offer for Localities to include the above recommendations.

Appendix A – East Lancashire Emergency Admission (Medical Specialties) 2013-2016



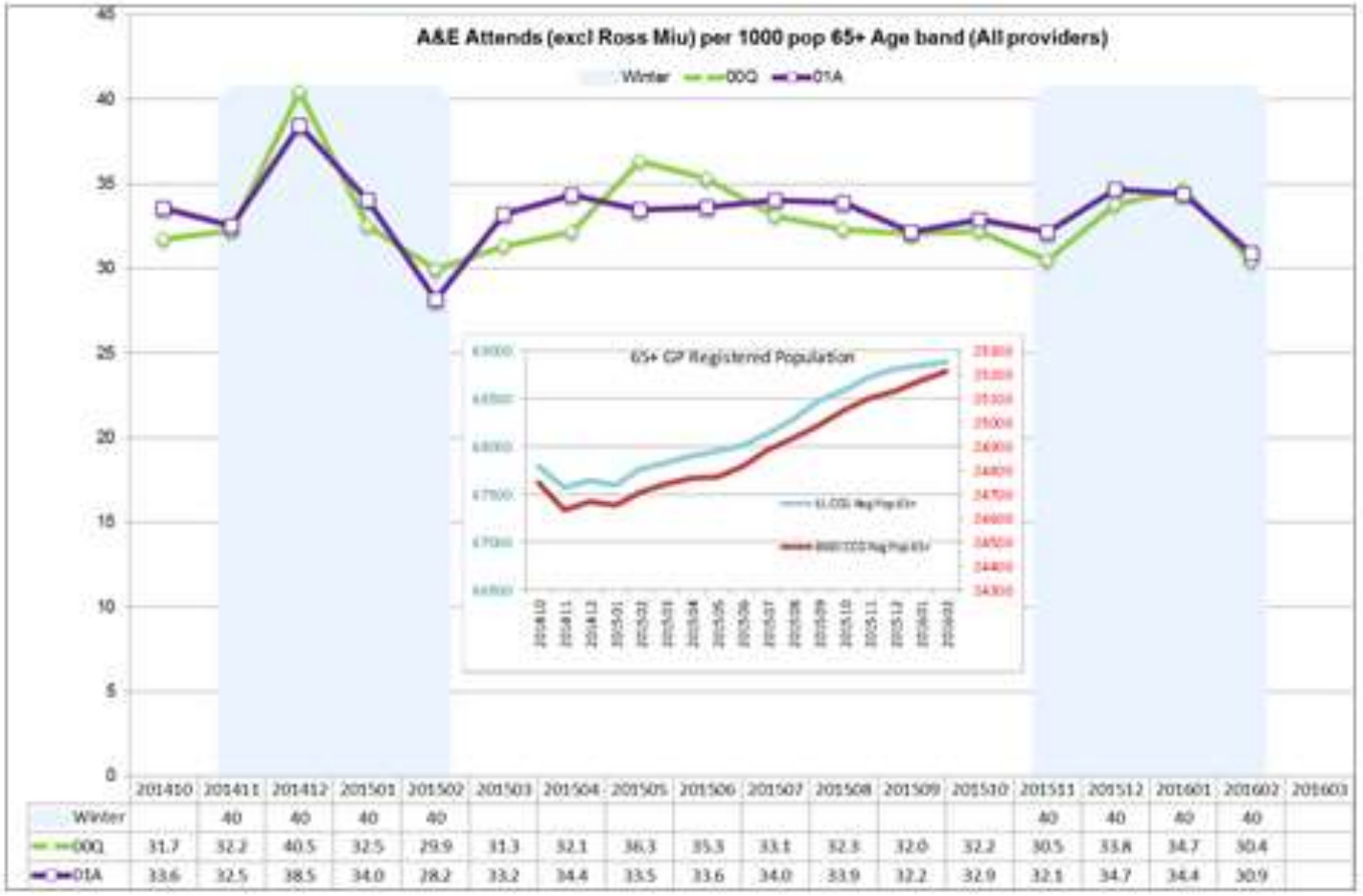
Appendix B – East Lancashire Readmissions (Medical Specialties) 2013-2016



Appendix C – East Lancashire A&E Attendances 2014-2016

A&E Attendances

A&E attends per 1000 population for aged 65+, for all providers for Pennine Lancashire.

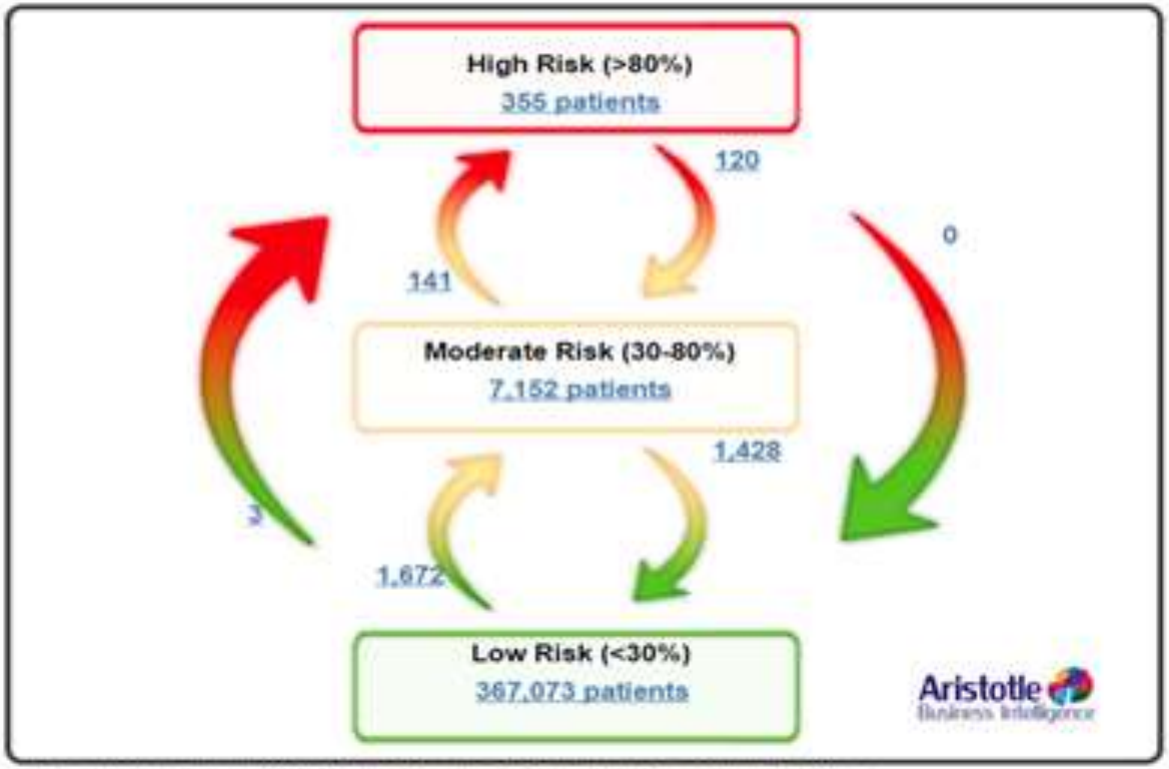


	201410	201411	201412	201501	201502	201503	201504	201505	201506	201507	201508	201509	201510	201511	201512	201601	201602	201603
Winter		40	40	40	40									40	40	40	40	
00Q	31.7	32.2	40.5	32.5	29.9	31.3	32.1	36.3	35.3	33.1	32.3	32.0	32.2	30.5	33.8	34.7	30.4	
01A	33.6	32.5	38.5	34.0	28.2	33.2	34.4	33.5	33.6	34.0	33.9	32.2	32.9	32.1	34.7	34.4	30.9	

Appendix D – East Lancashire Complex Patients (Aristotle Risk Stratification)

Risk Stratification Score Movement – East Lancashire

As patients move through the risk stratification bands, the associated costs for admissions fluctuate accordingly. It is important for services to be available to support patients to ensure that they do not jump through the bandings too quickly and deteriorate.



NB: This shows the number of patients that have moved between Risk Groups in the last month.
All patients for the selected practice(s) are included, i.e. not just patients in the selected cohort.