

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	<b>11J/203</b>
<b>Service</b>	Over 75 Locality Development Scheme
<b>Commissioner Lead</b>	Poole North Locality
<b>Provider Lead</b>	Birchwood Medical Centre
<b>Period</b>	1 October 2015 to 31 March 2018
<b>Date of Review</b>	

#### 1. Population Needs

##### 1.1 National/local context and evidence base

The proposal enhances/supports the following objectives:

- ‘A Call for Action’ – Improving General Practice (March 2014) by providing proactive co-ordinated care.
- Transforming Our Health Care System – Kings fund 2014 by supporting good discharge planning and post discharge support, supporting people to live well with simple or complex co-morbidities and enabling choice control towards the end of life.
- NHS England’s Mission by helping people recover from episodes of ill health and reducing premature mortality;
- Link with Local Authority to focus on developing arrangements of the Better Care Fund enabling more care to be delivered locally to support the person and family/carers

#### 2. Outcomes

##### 2.1 NHS Outcomes Framework Domains & Indicators

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

## **2.2 Local defined outcomes**

The proposed targets are as per the recommended KPIs:

- 1) Minimum of 3.5% reduction in non-elective admissions.
- 2) Anticipatory care plans for an additional 2% of most vulnerable patients.
- 3) Increase of special messages to Out of Hours for at least 2% of patients.

## **3. Scope**

### **3.1 Aims and objectives of service**

Two 'Over 75's' sessions by GP's to run each week

One 'Over 75's' phlebotomy session each month. These will be over and above the GMS/PMS contract as they will be linked to the clinics as part of the screening process. The will also hopefully enable us to identify potential problems which may occur.

These sessions will consist of either 4 x consultations with some being home visits depending on demand

### **3.2 Service description/care pathway**

Prior to the introduction of Phase 1, our 'over 75' patient population had to access the surgery in the same way as any other patient. In practice, this meant that they could book a 10 minute consultation with a doctor when they felt they needed one. Many on the over 75 population have chronic diseases (such as diabetes and COPD), these patients would also have routine nurse led reviews on a yearly basis for the specific chronic disease they were suffering from.

By offering an elderly patient a 30 minute 'over 75 health check' either at the surgery or at their home we can focus on more than just their 'presenting complaint'.

- 1) provide time to look at all their co-morbidities, rather than just focusing on one. We could review and rationalise their medications. We would hope that by decreasing medications (and therefore potential adverse reactions and interactions) we could reduce unnecessary complications and potential admissions.
- 2) A reduction in medications would also be an additional cost saving.
- 3) We could arrange for anticipatory medications to be in place. For example if a patient suffers with COPD, we could ensure she had a prescription of steroids and antibiotics in the house should she have an exacerbation (particularly over a weekend); if a patient suffered recurrent UTIs, we could ensure she had a supply of Trimethoprim in the cupboard.
- 4) A 30 minute consultation allows us to explore a patient's social situation. It gives us time to explore why their diet and exercise habits are as they are and potentially work on ways to improve these.
- 5) We can use the time to discuss advanced care plans if appropriate. Potentially make decisions on resuscitation. We can advise patients on arranging 'power of attorney' or even advance directives. This would certainly decrease admissions further. It would also increase our 'special messages to Out of Hours' that is required on the KPI.
- 6) We could also utilise the appointment for opportunistic measures, ie flu, shingles, pneumonia vacs and pulses etc.

### **3.3 Population Covered**

The Practice has an over 75 population of 566.

### **3.4 Any acceptance and exclusion criteria.**

All our patients over the age of 75 are invited to attend an 'over 75 health check'. Two GP sessions per week. Each session would consist of 4 x 30 minute patient consultations with additional time for associated administration and to also cater for home visits.

Checks in care homes for those not ambulatory could be included- pro-active input into care homes is seeming to have good rewards for patients, the system and in reducing GP urgent care workload

### **3.5 Interdependence with other services/providers**

See 2.2 above.

## **4.**

### **4.1 Applicable national standards (e.g. NICE)**

### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

### **4.3 Applicable local standards**

## **5. Applicable quality requirements and CQUIN goals**

### **5.1 Applicable quality requirements (See Schedule 4 Parts A-D)**

### **5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

## **6. Location of Provider Premises**

### **The Provider's Premises are located at:**

The service will be provided from Birchwood Medical Centre

The service will also provide visits in patient's place of residence.

## **7. Individual Service User Placement**

Not Applicable

## FINANCIAL STATEMENT

Please refer to the Financial Summary for Phase 1.

We do not envisage any new impact on the existing workforce within the surgery as we are already running this programme as Phase 1. Phase 1 has proved to be very successful and has provided a high degree of patient satisfaction. We have the available rooms in the surgery and the reception and secretarial support is already in place.

The only additional training required would be to train 2 x receptionists in venepuncture, as our HCA has recently left the practice. We are, however, in the process of recruiting a replacement. Venepuncture training will be an additional £354.00 to the Phase 1 Financial Analysis.

### PHASE 2 BUDGET = £24,340.90

2 x GP sessions/week @ £205.76/session = £411.52 x 52 weeks = £21,399.04

1 x Phlebotomy session/month @ £48.85/session x 52 weeks = £586.20

1 x Prescribing Administrator session/month @ £242.50/session x 12 months = £00.00 (*role currently fulfilled by GP*)

Mileage for home visits @45p/mile = £468.00 per annum.

One off Venepuncture training for receptionists (see 6 above) £295.00 + VAT @ £59.00 = £354.00

Uniform for receptionist to practice venepuncture = £40.00 x 2 = £80.00 per annum.

Uniform for new HCA = £40.00 x 2 = £80.00 per annum.

### Total Estimated Income to Provide Phase 2 = £22,967.24

It is our intention to withhold the remaining £1,373.66 with a view to contribute towards any shared services which may be commissioned between the other 3 practices within the Poole North Locality.