Service Specification 2015/16

Frail Home Visiting (FHV) service

1. Background

The CCG is committed to achieving higher quality care for frail vulnerable patients who may have problems accessing timely and appropriate care.

This CCG Contract will ensure that frail patients receive an intensive GP-led home visiting service. The GP will have an extensive role in care plan implementation and care coordination. The GP should make all necessary referrals, and be prepared to discuss the care of the patient with relatives, the quadrant and RICS MDTs, and other relevant One Hackney integrated care services when requested. Visiting when requested or in response to urgent need is part of the core GP contract.

This CCG Contract will also ensure that GPs are able to participate in a collaborative case management approach delivered through a multi-disciplinary meeting (MDT) structure. This structure consists of monthly practice-level MDT meetings and quarterly quadrant-level MDT meetings. The practice-level meetings will focus on MDT case discussions of patients on the frail home visiting register – responsibility for running each of these meetings will lie with individual practices. Quadrant meetings will address the development and education needs of practices and other members of the multi-disciplinary team in relation to delivering this service. The CCG is also commissioning a number of other services, under the ‘One Hackney’ integrated care initiative, that will support practices in delivering the Frail Home Visiting service, including providing support for quadrant level meetings and additional services to keep frail patients out of hospital.

2. Aims

The scheme has the following three specific aims:

1. To provide a high quality and intensive GP-led home visiting service for the frailest patients
2. To facilitate multidisciplinary working at practice level
3. To develop proactive care planning for frail patients and support training in active case management.

3. Identifying patients for the frail home visiting service

There is a maximum number of overall visits that the CCG will fund as part of this contract. The estimated maximum number of patients applicable for this service is 1788, based on 20% of over 75s. The average number of visits for this service per patient is 3.5. There the maximum cap of funded visits across City and Hackney is

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6,258 (1788 multiplied by 3.5). Each patient should have a care plan and should receive between 2 and 8 visits per annum according to need. The care plan should be reviewed at each visit.

The patients should be housebound or unable to get to the surgery for reasons of frailty and require home visits to access GP care. New patients can join the list at any time of the year as long as the practice’s maximum number of visits is not exceeded.

The risk stratification tool NELIE will help identify patients with increased risks of emergency admission or alerts. In addition GPs can identify patients for this home visiting service through the following criteria:

- Well known to GPs as vulnerable;
- A recent fall or 2 or more falls in 2 months;
- Medically unstable;
- Socially isolated;
- Receive a high intensity social services package;
- Under the reablement and intermediate care services;
- Death of spouse or close family member within the last 6 months;
- On four of more medicines prescribed for 6 months or more;
- Repeatedly fail to attend medication reviews when invited;
- Over 75 and have not visited the surgery in 3 years;
- On other disease registers (e.g. Severe Mental Illness or Learning Disabilities);
- Significant impairment in one or more major activity involved in daily living;
- Over 65 years with prescribing costs more than £100 per month;
- Over 65 years and have had 2 or more outpatient visits in last 12 months;
- Patients where hospital has telephoned practice to discuss (e.g. re: faxback);
- Patients identified to practices by discharge communications.

4. The service we are expecting practices to provide

**GP home visiting service**

1. There may be a minimum of 2 visits and a maximum of 8 visits for each individual patient
2. Home visits by GPs and care planning should be undertaken in collaboration with adult community nurses and community matrons
3. Reviewing patients' conditions and recent history and ensure diagnoses and management reflects current best clinical practice.
4. Reviewing patients’ care plans and ensuring they reflect their wishes.
5. Review lifestyle issues (diet, exercise, smoking, alcohol) and psychological status.
6. Arranging annual immunizations.
7. Managing medicines and medication reviews with Community Pharmacists.
8. Reviewing exercise rehabilitation needs and referring for physiotherapy and OT.
9. Considering patient and carer education about condition and support services.
10. Assessing carers and their needs.
11. Arranging and attending appropriate network meetings with families if needed.
12. Ensuring patients and carers are clear about alarm signs and know when and how to contact community team, GP and OOH early when crises occur.
13. Assess need for Social Services support/benefits advice and liaise with paid carers.
14. The CEG template will be used to record every home visit – using the codes outlined in section 5.

**Other core components of the service**

1. Practices will identify a lead GP to take responsibility for the frail home visiting service at practice level – this individual will also be expected to be the lead for the One Hackney Initiative. Please identify your lead GP to the confederation.
2. Develop a jointly agreed practice based register of patients eligible for this service.
3. Institute a call/recall system to deliver planned GP home visiting service to each identified patient on basis according to risk and need. The home visit will involve reviewing and if necessary updating the care plan.
4. Allocate each patient to a named GP and create a way of identifying the named GP to ensure all staff know who has responsibility for that patient.
5. Practices will undertake practice-based monthly multi-disciplinary meetings, which are minuted, chaired by the lead GP for this service (or a nominated Deputy in exceptional circumstances, e.g. leave), and for which attendance lists are produced – each practice has responsibility for running these meetings. All practice GPs should attend where possible and there will be a range of multi-disciplinary health and social care staff present as required. At this meeting the practice based register will be reviewed, actions arising from home visits and care plans will be discussed and particular health and social care problems will be discussed and addressed. At this meeting care plans will be shared for the patients discussed.
6. Attend quadrant-based integrated care meetings quarterly with the wider multi-disciplinary care team – it is expected that these meetings will be attended by at least the lead practice GP for home visiting and integrated care. These quadrant meetings should support the development and educational needs of practices and improve links and communication with other MDT members. The quadrant meetings will be administered and organized by One Hackney.
7. Practices will use the care planning and the multi-disciplinary meeting process to identify service gaps for improving care for frail patients. Practices will identify service gaps to the CCG to inform future commissioning.

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5. How this service will be paid for

**Overall remuneration**

1. The CCG will provide the GP Confederation with funding of up to: £1,341,775. This equates to £750.43 per patient on the FHV Practice Register. This funding covers the whole financial year of 1st April 2015 – 31 March 2016. The confederation will determine practice payments. The CCG will need to be assured of the quality of the care plan and engagement of all practices in integrated care, evidenced via the CCG commissioning LES audit, and minutes of MDT meetings. Feedback from other services will be sought to ensure practices are engaged in the MDT, are proactive in care co-ordination, making good appropriate referrals and are available to discuss care when clinically appropriate either with colleagues or MDT meetings.

2. Practices must undertake a minimum of 2 visits and a maximum of 8 visits for each individual patient. Payments will be made at year-end for each patient on the FHV register, where between 2 and 8 visits have been undertaken.

3. Each practice will have a maximum cap of the total number of visits across all patients that can be undertaken over the course of the year as set out in appendix 1. This funding budget is set up to cover the needs of the most frail housebound patients in the CCG (Currently 1788)

**How practices record activity for this CCG Contract**

1. Every patient on the frail home visiting register will need to have an initial visit and receive a care plan. All patients will need to have this recorded for the 14/15 To record this activity for 14/15, the practice will need to enter the following below codes on the Clinical Effectiveness Group (CEG) template for every patient who receives a care plan and is on the frail home visiting register. CEG will confirm the exact details of the codes for practices, but indicative codes are set out below:
   - Care Plan Code
   - Housebound Code

2. The practice needs to record the number of visits undertaken for every patient. Each visit should be recorded with the following codes:
   - Visited by GP
   - Care Plan Review done or Admission Avoidance Care Plan Reviewed

3. The CEG Template will be updated and issued to practices monthly.

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1 This includes £987,575 from the original specification and additional funding of £354,200 – this additional funding has been agreed at the CCG prioritisation committee and awaits final sign-off by the CCG Contract Sub-Committee by 15th September 2014

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How the Confederation will co-ordinate payments for the contract

1. Due to payments being linked to a minimum number of visits per annum all earnings will be calculated after year-end (i.e. after 31.3.16) resulting in a single payment for the whole year.

2. At year end, the CEG will gather FHV activity results via EMIS WEB – this data will be pulled from the codes practices enter for each care plan and each visit.

3. The CEG will provide practices’ data to the confederation and the CCG - in Apr/May 2015.

4. The confederation will be responsible for setting up a process for payments with practices.

5. The CCG may wish to consider undertaking post payment verification visits – in order to audit practice records based on the published FHV specification and templates provided.

City and Hackney CCG, February 2015