SERVICE SPECIFICATION

Service	Proactive Care: Practice Based Service
Commissioner Lead	Leah Herridge
Provider	GP Confederation
Provider Lead	**Amaia Portelli**
Period	April 2018 to end of March 2019
Date of Review	October 2018

1 Context

NHS City and Hackney CCG is committed to achieving high quality care for vulnerable patients who may have problems accessing timely appropriate care. The service builds on the Proactive Care: Home Visiting Service and identifies those patients who would benefit from multi-disciplinary case management and proactive care planning approach but expands the provision to those who do not necessarily require a home visit by the GP.

The practice based service supports proactive care, bringing together GPs, Nurses and Pharmacists and other key clinicians to undertake visits for the frailest patients who are most at risk of emergency admission and inappropriate A&E attendances.

NHS City and Hackney have 42 practices for the registered population of 317,821 (November 2017).
Practice based proactive care is for patients of all ages including children.

2 Outcomes

2.1 **Link to NHS Outcomes Framework domains & Indicators**

1	Preventing people from dying prematurely	x
2	Enhancing quality of life for people with Long term conditions	**x**
3	Helping people recover from episodes of ill health or following injury	x
4	Ensuring people have a positive experience of care	**x**
5	Treating and caring for people in safe environment and protecting them from avoidable harm	**x**

2.2 **GP Confederation Single Contract Unplanned Care Outcomes**

The service gives Primary Care additional resources to manage complex patients, as well as reduce repeat attendances in general practice the service is expected to benefit the system, including:

	Outcome	
1	Reduce the rate of A&E attendances (in core hours 8-8; SUS data)	**x**
2	Reduce the rate of ambulance call outs (in core hours between 8-8; LAS data, some concerns about attribution of data to C&H pts)	**x**
3	Reduce the rate of calls to 111 (in core hours between 8-8, 111 data, some concerns about attribution of data to C&H pts)	**x**
4	Maintain % of patients calling 111 or 999 that are directed to Extended Access primary care services (111 and LAS data)	
5	Reduce rate of emergency admissions (SUS)	**x**
6	Reduce the rate of excess bed days (SUS)	**x**
7	Reduce the rate of readmissions (SUS)	**x**
8	Patients are in control of /feel able to manage their condition **(TBC)**	**x**
9	% patients dying outside of hospital (ONS, NHSE data)	
10	Increase % of people dying in their preferred place of death (GP palliative care registers; CEG)	
11	Maintain carer perceived quality of care in the last 3 months before death (via VOICES survey, TBC)	
12	Mental Health SMI/crisis outcomes (TBC)	

This Proactive Care: Practice Based service is funded on a cost per case basis using primary care PMS premium funding which is ring fenced for primary care is therefore outside of the outcome based incentive payment model used in the single outcomes based contract.

3 Scope of Service

The aim of the Proactive Care: Practice Based service will be to provide more personalised support to patients most at risk of unplanned admission, readmission, and A&E attendances to help them better manage their health.

In order to achieve this, under this service practices will be required to;

Register Creation

- Identify patients who are at high risk of avoidable unplanned admissions (and who do not meet the threshold for Proactive Care: Home Visiting Service) and proactively case manage these patients
- By the end of June 2018 the GP Practice will need to have established a register of patients identified as being at risk of an unplanned hospital admission without proactive management
- Practices will be given a maximum register size. There is no minimum register size set.
- Practices will identify patients for the new register via the following methods:

  Practices will be given a number of tools/resources to support them to create their register

  - ✓ Tool 1: NELIE >1 emergency admission in the last 12 months
  - ✓ Tool 2: NELIE Patients in Risk Band 1 and 2
  - ✓ Tool 3: Frailty Index (severe or moderate frailty)
  - ✓ Tool 4: Decision Tree - Patients with a 50% risk of an emergency admission within the next year
  - ✓ Tool 5: Patients identified in the MDT Frequent Attenders Group
  - ✓ Local clinical knowledge

  Patient data identified from tools above should be triangulated. Where the number of patients identified exceeds the capped register size, patients appearing in more than one source should be prioritised for the register

  The methods used to identify patients for the register should give equal consideration to both physical and mental health conditions, in the event that the risk stratification tool does not account for mental health conditions, the practice should endeavour to use knowledge of their patients with mental health conditions to ensure these patients are considered.

- Patients on the Proactive Care: Practice Based Service should not also be on the Time to Talk register at the same time.
- Patients must not be on both the Proactive Care: Home Visiting and the Proactive care: Practice Based register at the same time.

Service Model and Referral Pathways

- Undertake a minimum of two 30 minute face to face appointments per annum with each patient on the register and review the care plan at each appointment. The appointment can take place wherever is most appropriate.
- Appointments can be undertaken by a GP, Practice Nurse or Practice Pharmacist
- To avoid double payment with work undertaken as part of the GP Contract (Routine Frailty Identification and Frailty Care), the minimum of two reviews required under the Proactive: Practice Based Service will be in addition to the clinical review required for patients identified and coded as living with severe frailty.
- Each practice will be required to designate a lead for the service; this should be the lead for the Proactive Care Home Visiting Service. The Lead GP will work in collaboration with other GP and health care professionals within the practice, to include practice nurses and pharmacists to identify and agree a practice based register of patients eligible for the service.
- The GP lead will develop work in partnership with other health professionals such as social care, London ambulance service, A&E consultants, district nurses, psychologists, to establish the best care and management plan for the patient's needs. Onward referrals will only be undertaken once a full comprehensive assessment has been undertaken.
- To safeguard adults at risk and protect them from avoidable harm by ensuring appropriate safeguarding referrals are made and local resources and support are utilised eg. uptake of local training. This will also include supporting practices to engage in any required actions following submission of safeguarding concerns, which may include a co-ordinated approach to any subsequent enquiry.
- The service will work alongside and link with the Adult Community nursing Team, consultant geriatricians, and psychologists Consultant Psychiatrists and psychiatric nurses are also aligned and offer support and training on mental health problems.

Case Management

- A named accountable GP will have overall accountability, and will be responsible for ensuring that the creation of the care plan and review of the care plan takes place, and the appointment of a care co-ordinator if different to the named accountable GP.
- The care co-ordinator can be the GP, practice nurse or practice pharmacist (whichever is most clinically appropriate) and will create the care plan and undertake the appointments and care plan reviews, and act as the main point of contact for the patient.

- The GP Practice should consider proactive follow up after discharge from hospital if deemed appropriate but will have flexibility to decide when the most clinically appropriate time is to undertake a review.
- Promote self-care and enable patients to optimise their independence and self-management
- Promote health and wellbeing and reduce inequalities by offering relevant advice and information to service users, carers and other professionals.
- Undertake a medication review, reconciliation and assessment of patients adherence to prescribed medication and coordinate prescribing aids and delivery of medication and changes with pharmacists.

Care Planning

- Collaboratively develop personalised CMC care plans with any new patients on the register, and where applicable their carer
- A CMC care plan should be created for any new patient on the register (with patient consent) and reviewed at each appointment within the service.
- Care planning should include holistic care needs, taking into account social factors as well as clinical (eg. the GP Practice should link with Connect Hackney and the work on social isolation where applicable). The care plan forms the basis of the health, social care support and mental health needs and requirements of the patient. The Care Plan will include (where applicable):
    - Medical, psychological, emotional, social, personal, sexual, spiritual and cultural, sight hearing, communication and environmental needs.
    - Palliative and end of life needs
    - Identify health problems (chronic pain, continence and skin)
    - Identify what help they need to look after their own care and support
    - Have a summary of their life story included in the plan if the patient wishes
    - Arrange the support they need and review therapies
    - Include leisure activities outside and inside the home, mobility, transport and adaptations to the home.
    - Include support required for daily activities (employment, hobbies and interests, socialising with friends, financial management, learning, and self-care and taking medication).
    - Key personal and health and social care contracts
    - Treatment Escalation Plan
- Undertake an audit of care plans created to ensure their quality (10% of register) – ensure cross section of care plans across HCPs

Multi-disciplinary Reviews

- The practice will undertake monthly MDT reviews of the register to consider any actions which could be taken to prevent unplanned admission of the register.
    - Other health and social care professionals, including mental health professionals should be invited to the MDTs and each of them encouraged bringing a case for discussion, review and updating the care plan/management.
    - To be most effective a system will need to be put in place where patient's details are shared prior to the MDT taking place, so that a full history review can take place with all professionals involved in the care of the patient.
    - The meetings will be chaired by the nominated GP lead for the practice and coordinated and minuted.
    - These meetings are ideal for discussing safeguarding issues and ensuring appropriate referrals and communication, including referrals to the respective Adult Safeguarding High Risk Panels in Hackney or City, where there is a need to highlight unmanaged risk or address non-engaging agencies eg. housing, social care.
- The GP Practice will be required to undertake quarterly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the register.

To note, the requirements around MDTs may change with the emerging neighbourhood model.

Access

- This is a proactive case management service and will operate within practice core hours of 8am to 6.30 pm, Monday to Friday. Case finding, MDT's and proactive care appointments will be scheduled into the practice's business model.
- Patients will access the service via practice identification of patients at risk of admission.

4 Contract management of the service

Key deliverables include:

- Report and investigate any incidents through their current clinical governance structure, reporting to external bodies when necessary
- Ensure that staff safeguarding training is up to date and policies are in place and imbedded into current daily practice; that safeguarding referrals are made when appropriate, including to the City or the Hackney High Risk Panel where there is a need to highlight unmanaged risk, or address non-engaging agencies, etc. These referrals would normally be made by adult social care with the support of the practice MDT.

- The provider will support member practices to engage in CHASB multiagency audits and Adult Safeguarding Reviews and any required actions, that are relevant to this service, where appropriate, whilst recognising that each practice is responsible for safeguarding their patients.
- Ensure all practices are using the correct Read-codes on EMIS to enable the Clinical Effectiveness Group (CEG) to produce monthly dashboards. The provider will monitor and carry out evaluations of the dashboards, highlighting any obvious variations between practices.
- Support and work with practices to investigate any variations in recorded service delivery. Where there is variation – i.e., less than average of 3.5 visits per patient per year per register - the provider will work with the practice to develop an action plan.

5 Applicable Service Standards

✓ End of Life care for adults (QS13)

✓ Dementia, disability and frailty in later life (NG16)

✓ Older People with social care needs and multiple long term conditions (NG22)

✓ Support to older people living in their own homes (NG21)

✓ Depression in adults with chronic physical health problem: recognition and management (CG91)

✓ Mental wellbeing of older people in care homes (QS50)

✓ Mental wellbeing in over 65s: occupational therapy and physical activity interventions (PH16)

✓ Osteoarthritis (QS87)

✓ Community engagement to improve health (LGB16)

✓ Falls in older people (QS86)

✓ Falls in older people: assessing risk and prevention (CG161/4)

✓ Type 2 diabetes in adults: management (NG28)

✓ Chronic obstructive pulmonary disease in adults (QS10)

✓ Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (NG5)

✓ RCGP Adult Safeguarding Toolkit 2017

✓ RCGP Mental Capacity Act Toolkit 2011

✓ City and Hackney Self Neglect (including chronic hoarding) protocol 2016

✓ City and Hackney Safeguarding Adults Board escalation protocol 2016

✓ City High Risk Panel and Hackney High Risk Panel referral forms

✓ (www.hackney.gov.uk/safeguarding-adults-board)

6 Key Performance Indicators and Reporting Requirements

For payment, Practices will need to code each patient on the Proactive Care Practice Based Register as **8CZ0 Provision of Proactive Care**.

The patient remains in the register until they are removed using **Proactive Care Ended (8CT8)**. Each practice is to ensure that a patient is removed from the register when they no longer need the service using the code supplied.
For payment, the practice will ensure each patient has a coordinated support plan on CMC if not already created. This care plan is then reviewed at each visit. Each visit and action should be recorded with the following codes:

- A **Coordinated Support Plan **8CM8**, needs to be coded **once** for each patient. This plan is created on CMC.
- Once a Coordinated Support Plan has been agreed and coded, subsequently, a review of the care plan is required at **every appointment**. **Review of care plan *8CMG3** should be recorded to show this.
- If the patient does not want a care plan, use **Care plan declined *8IAe1** to show this. This code will need to be used on **each appointment** to show that a discussion has taken place and care plan offered.
- Each appointment needs to be recorded with: **9NF9**.

Reporting Requirement	Indicator/Quality Requirement	Format & Frequency	Consequences of breach
Percentage of care plans reviewed on CMC at appointment	100%	Quarterly CEG dashboard	Action Plan
Audit of patients on register (randomized)	10% of register	Audit completed by end of Q3	Action Plan
A minimum of 2 face to face appointments per year with each patient on the register	100%	Quarterly CEG dashboard	Action Plan
Each practice to maintain a register using the code supplied (max register of 1644).	Pass/fail	Quarterly CEG dashboard	Action Plan
Collection of patient feedback at practice level	Survey complete	Part of wider GP Confederation Patient Survey	Action Plan

7 Financial and Procurement Summary

The maximum funding for creation of the register is £89,628 (to be eligible for payment the patient must be enrolled on the register by the end of Q1 2018/19).

The maximum funding for service delivery for 18/19 is £274,581.40.

All funding is on a non-recurrent basis funded from the PMS premium for 2018/19 only.

A maximum register size of 1644 patients across C&H Practices has been set based on the capped funding available. There is no minimum register set across C&H or by Practice.

As there is no minimum register size, payment will be activity based and practices will be paid for the number of patients on their register. The amount paid will be capped to the total maximum register size per practice and the maximum funding allocated to each register.

The capped maximum register/funding for each for each practice has been based on practice register size against number of emergency admissions. All practices will be allocated an equal share of 30% of the funding and the remaining money is split based

on proportion of emergency admissions. This will enable additional investment into those practices where the emergency admissions rate is higher whilst making sure that there is service provision across all practices.

For register creation between April and June 2018, GP Practices will be paid £54 per patient enrolled to the Proactive Care: Practice Based Register. However, the maximum amount of funding each GP Practice can receive cannot exceed the cap specified.

For service delivery from April 2018, £167 will be paid per patient on the Proactive Care: Practice Based Register per year up to maximum cap specified. In order for the patient to be eligible for payment, the GP practice must have undertaken and recorded:

- A minimum of two face to face appointments per annum
- A care plan created on CMC which must be reviewed at each appointment

8 Proposed Contractual Terms

Type of contract proposed (NHS Standard contract, Grant agreement, Alliance contract): NHS Standard Contract with GP Confederation

Service Commencement date: 1st April 2018

Contract duration: 12 months

Interdependencies with other City and Hackney CCG and National GP contracts:

- Patients on the Proactive Care: Practice Based Service should not also be on the Time to Talk register at the same time.
- Patients must not be on both the Proactive Care: Home Visiting and the Proactive care: Practice Based register at the same time.

Appendix A: Register Size by Practice

	16/17 Emergency Admissions	16/17 Emergency Admissions % Split	Maximum Allocation for Creation of Register	Maximum Allocation for service delivery	Maximum Register Size
North East 1					
The Springfield Health Centre	456	2.14%	£1,982.41	£6,073.25	36
Stamford Hill Group Practice	843	3.95%	£3,121.53	£9,563.01	57
The Surgery (Cranwich Road)	347	1.63%	£1,661.58	£5,090.35	30
Tollgate Lodge Practice	528	2.48%	£2,194.34	£6,722.51	40
North East 2					
Fountayne Road Health Centre	335	1.57%	£1,626.26	£4,982.14	30
The Elm Practice	188	0.88%	£1,193.57	£3,656.58	22
Healy Medical Centre	460	2.16%	£1,994.19	£6,109.32	37
The Nightingale Practice	901	4.23%	£3,292.25	£10,086.02	60
The Riverside Practice	296	1.39%	£1,511.46	£4,630.46	28
Rosewood Practice	136	0.64%	£1,040.51	£3,187.67	19
The Clapton Surgery	387	1.82%	£1,779.31	£5,451.05	33
South East 1					

Athena Medical Centre	331	1.55%	£1,614.48	£4,946.07	30
Lower Clapton Group Practice	1045	4.90%	£3,716.10	£11,384.53	68
The Sorsby Health Centre	524	2.46%	£2,182.57	£6,686.44	40
Latimer Health Centre	291	1.37%	£1,496.74	£4,585.37	27
The Lea Surgery	734	3.44%	£2,800.69	£8,580.11	51
South East 2					
Elsdale Street Surgery	471	2.21%	£2,026.56	£6,208.52	37
Kingsmead Healthcare	409	1.92%	£1,844.07	£5,649.43	34
The Wick Health Centre	545	2.56%	£2,244.38	£6,875.81	41
Trowbridge Practice	376	1.76%	£1,746.94	£5,351.86	32
Well Street Surgery	1145	5.37%	£4,010.45	£12,286.28	74
The Greenhouse Walk-in	273	1.28%	£1,443.76	£4,423.06	26
South West and the City1					
The Dalston Practice	360	1.69%	£1,699.84	£5,207.58	31
Beechwood Medical Centre	283	1.33%	£1,473.20	£4,513.23	27
Richmond Road Medical Centre	289	1.36%	£1,490.86	£4,567.34	27
London Fields Medical Centre	622	2.92%	£2,471.02	£7,570.15	45
Queensbridge Group Practice	660	3.10%	£2,582.88	£7,912.81	47
Sandringham Practice	355	1.67%	£1,685.12	£5,162.49	31
South West and the City2					

Shoreditch Park Surgery	455	2.13%	£1,979.47	£6,064.24	36
Southgate Road Medical Centre	542	2.54%	£2,235.55	£6,848.75	41
De Beauvoir Surgery	451	2.12%	£1,967.70	£6,028.17	36
The Hoxton Surgery	312	1.46%	£1,558.56	£4,774.74	29
The Lawson Practice	983	4.61%	£3,533.61	£10,825.45	65
The Neaman Practice	559	2.62%	£2,285.59	£7,002.05	42
North West 1					
The Cedar Practice	428	2.01%	£1,900.00	£5,820.76	35
The Heron Practice	763	3.58%	£2,886.05	£8,841.61	53
The Allerton Road Surgery	358	1.68%	£1,693.95	£5,189.54	31
The Statham Grove Surgery	507	2.38%	£2,132.53	£6,533.14	39
North West 2					
Barton House Group Practice	989	4.64%	£3,551.27	£10,879.56	65
Somerford Grove Practice	766	3.59%	£2,894.88	£8,868.66	53
Abney House Medical Centre	194	0.91%	£1,211.23	£3,710.68	22
The Surgery (Barretts Grove)	259	1.22%	£1,402.55	£4,296.82	26
The Surgery (Brooke Road)	159	0.75%	£1,108.21	£3,395.07	20