**SCHEDULE 2 – THE SERVICES**

1. **Service Specifications**

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement

Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

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| **Service Specification No.** |  |
| **Service** | Proactive Case Finding and Case Management |
| **Commissioner Lead** | Jill Cunningham, Service Manager – Primary Care |
| **Provider Lead** |  |
| **Period** | 1st April 2016 to 31st March 2017 |
| **Date of Review** | September 2016 |

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| **1. Population Needs** |
|  * 1. **National/local context and evidence base**

This enhanced service (ES) is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. The ES should be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions.The aims of this ES are to provide more personalised support to patients most at risk of unplanned admission, readmission and A&E attendance to help them better manage their health.  |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**

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

**2.2 Local defined outcomes**North East Lincolnshire Clinical Commissioning Group (NELCCG) require excellent patient centred services, which provide high quality standards of care, are easily accessible and have well-designed pathway(s). The aim of this service is to:* To avoid unnecessary Emergency Admissions and Accident & Emergency attendances;
* To improve outcomes for patients with complex conditions/multiple long term conditions and/or life limiting conditions;
* To enhance the quality of life for vulnerable and older people aged 75 or older and their carers by delivering personalised care;
* To provide an integrated approach to ensure a multidisciplinary care package that meets the health and social care needs of patients;
* To ensure early warning signs for patients becoming clinically unstable or deteriorating are identified;
* To educate and promote self-care and health and well-being
* Maintaining or improving independence and opportunity for rehabilitation
* Supporting discharge
* To maximise the use of technology and integrate systems to support the service and generate efficiencies
* To remain within the prescribing budget.

The service must:* Be transparent and accountable;
* Be outcome focused;
* Be responsive and proactive;
* Be safe, and deliver effective high quality care;
* Ensure that the expected clinical outcomes are delivered in line with the defined service specification.
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| **3. Scope** |
| **3.1 Service description/care pathway**The CCG wishes to combine the requirements of the national NHS England Avoiding Unplanned Admissions Enhanced Service with additional local requirements, to ensure that the proactive management approach is applied to a wider cohort of patients.**Part 1: Elements from Avoiding Unplanned Admissions ES:*** Practice Availability

The GP Practice will provide a by-pass number for health and social care providers involved in the care of the cohort of patients covered in this ES to support decisions regarding most appropriate care for the individual. The GP practice will provide patients identified on the case management register, who have urgent clinical enquiries, with a same day telephone consultation and where required, follow-up arrangements (e.g. home visit, face-to-face consultation, visit by a community team etc.). This same day telephone consultation will be with the most appropriate healthcare professional in the GP practice. * Proactive Care Planning and Personalised care

The risk stratification element of the ES requires practices to initially identify a minimum of 2% of adult patients (aged 18 and over) of their registered list who are at risk of unplanned admissions. In the absence of a risk stratification tool[[1]](#footnote-1), practices should concentrate their focus on the following cohorts of patients: **End of Life Care (linked to Gold Standard)Complex CaseloadFrail & ElderlyHigh Volume Users of all Health and Social Care ServicesMental Health (particularly Dementia)**Children with complex health and care needs requiring proactive case management and personalised care plans should also be considered for inclusion on the register, however children will not count towards the 2%. We would expect the list not to dip below 2% throughout the year and acknowledge that for some Practices it would be well over 2%. This will require regular (at least monthly) review of the list.The core contract (page 9, 15/16 GMS Contract guidance) requires that all patients aged over 75, irrespective of whether they appear on the at risk list, have a named GP and are offered Health Checks.GP practices will need to ensure that they manage any in-year risk associated with changes in practice list size. In exceptional circumstances which temporarily lead to the register falling below the tolerance, commissioners and practices will need to discuss and review the situation. The GP practice will undertake monthly reviews of the register to consider any actions which could be taken to prevent unplanned admissions of patients on the register. For example, the reviews may consider whether those patients requiring multi-disciplinary team (MDT) input are receiving it, or whether the GP practice is receiving appropriate feedback from the district nursing team. GP practices will be required to inform relevant patients that they are eligible to join the programme and what they can expect from being part of this ES. Practices will issue a card to patients and ask them to show it whenever they are in contact with other services. This would also include the Practice by-pass number.The Commissioner will work with Practices and Accord to produce a standard information leaflet and card for patients. All patients on the list should have a named GP and Care Co-ordinator (who can be the same). New patients added onto the register will be notified within 21 days. The Care Co-ordinator is the main point of contact and will oversee care, check the care plan is being delivered and ensure the patient is informed of any changes. The Care Co-ordinator will keep in contact with patient at regular agreed intervals.The GP practice will implement proactive case management for all patients on the register. This will include developing collaboratively with a patient and their carer (if applicable) a written/electronic personalised care plan, jointly owned by the patient, carer (if applicable) and named accountable GP and/or care co-ordinator. If the patient consents, the personalised care plan should be shared with the MDT and other relevant providers. Personalised care plans should be developed and agreed for any new patients coming onto the register in year within a reasonable timeframe, but no later than one month after entry onto the register. Patients and carers (if applicable) should be invited to contribute to the creation of the personalised care plan. Members of the MDT (when relevant) and other relevant providers could be invited to contribute to the creation of the personalised care plan. These contributions should inform both the holistic care needs assessment (e.g. to take into account social factors as well as clinical requirements) and the actions that can be taken as a result. The patient’s care and personalised care plan should be reviewed at agreed regular intervals with them and if applicable, their carer. Clinician(s) should look at the patient’s personalised care plan to ensure that it is accurate and is being implemented, making any changes as appropriate and agreeing these with the patient and where appropriate, the carer. Patients who remain on the case management register from the previous year will need to have at least one care review, including a review of their personalised care plan, during 2016/17. In some instances, the review may be as a result of a social issue, which could require the assistance of the named accountable GP or care co-ordinator (if applicable) to link with the right people in the MDT or as an area for commissioning or design improvement. GP practices will be required to use the Read2 or CTV3 codes to record when a patient’s care plan has been reviewed. This is a specific code introduced solely for use of GP practices participating in this ES. Where a patient has had a review undertaken by a member of the MDT (i.e. outside of their practice), then the professional having conducted the review must inform the GP practice and the patient’s record must be updated by the GP practice. CCGs will need to ensure, through their commissioning relationships with the organisations that work with the GP practice, that organisations inform the practice that a review has been undertaken. * Reviewing and improving the hospital discharge process

The GP practice will ensure that when a patient on the register, or newly identified as vulnerable, is discharged from hospital attempts are made to contact them by an appropriate member of the practice or community staff in a timely manner to ensure co-ordination and delivery of care. This would normally be within three days of the discharge notification being received, excluding weekends and bank holidays, unless there is a reasonable reason for the GP practice not meeting this time target (e.g. the patient has been discharged to an address outside the practice area or is staying temporarily at a different address unknown to the practice). The GP practice will share any whole system commissioning action points and recommendations identified as part of this process with their area teams and their CCG, to help inform commissioning decisions. Information shared with the CCG is in order to help the CCG work with the hospital to improve planning for discharge and to improve arrangements for hospital/practice handover at point of discharge. Potential improvements or issues should be flagged via NELCCG.askus@nhs.netThe Urgent Care Dashboard should be used to ensure Practices can identify any patients admitted. WebV can be used to view information of the patient’s admission and current status. The Practice must contact HIT team within 24 hours of admission. * Internal practice review

The GP practice will be required to regularly review emergency admissions and A&E attendances of their patients from care homes (i.e. to understand why these admissions or attendances occurred and whether they could have been avoided). The reviews should take place at a regular interval deemed appropriate by the GP practice, in light of the number of emergency admissions or A&E attendances by these patients. During the review, the GP practice should give consideration to whether improvements can be made to processes in care homes, community services, or GP practice availability or whether any individual care plans need to be reviewed with the patient and carer (if applicable). Where a GP practice has a large proportion of their patients in care homes, it should focus its reviews on any emerging themes from a sample of patients and on any patients who have regular avoidable admissions or A&E attendances. GP practices will be required to agree this with the commissioner at the start of the year. Themes about patients in care homes should be communicated to support to care homes team via NELCCG.askus@nhs.net.* Patient survey

GP practices will be required to survey patients on the case management register using a locally developed and provided survey questionnaire. This should be completed by the end of February 2017. **Part 2: CCG additional local requirements:**The CCG wishes to broaden the approach set out within the AUA to include a wider range of patients (detailed below), and to ensure a complementary service to the ‘Support to Care Homes and those with Multiple Long Term Conditions’ Service. The local requirements will also complement other work on conveyance avoidance. In addition to the identification of the cohort as set out in section 3.1.1, the Practice should apply those requirements to the following individuals (where clinically appropriate)**:** * Housebound with no health needs at present, requiring medicines review only;
* Short-term housebound following short spells of ill health/surgery/injury;
* Care home patients, not already identified within the 2% but who would benefit from regular review in conjunction with the Support to Care Homes Co-ordination Team.

Individuals eligible for this service are identified via the practice housebound registers, District Nurses (DN), practice multi-disciplinary meetings, the Support to Care Homes Co-ordination Team and secondary care discharge letters (short-term housebound). Where requested, and following conversation with the Support to Care Homes Co-ordination Team regarding the need, the practice will provide GP input to the Multi-Disciplinary Team as required to support the patient’s needs (ensuring delivery of the Support to Care Homes & those with Multiple Long Term Conditions Specification). Practices will also provide in-reach into the Acute Trust or intermediate care to support timely discharge and a review following discharge as follows: * Ensure coordination of good quality care with in-reach into hospital/ the Beacon Intermediate Care to reduce Delayed Transfers of Care (DToC).
* Establish and maintain a programme of multi-disciplinary integrated reviews for each Resident (at least quarterly or immediately following discharge from hospital/ intermediate care).
* **Top 2% Cohort Investigation**

A small additional premium will be paid to Practices who work with the CCG in year on a Cohort Investigation. This aim of this investigation is to understand the circumstances of patients that led to them being considered for inclusion onto the top 2% list in order to identify any preventative or early intervention action that could have been taken by health and social care services in advance of the deterioration or episode. This will help the design of services and shape the commissioning arrangements.* **Summary Care Records**

In order to contribute to local priorities around conveyance avoidance, an additional premium will be paid to Practices for completion of Summary Care Records for the following cohort:* Complex care (multiple long term disorders and/or chronic diseases);
* End of life/palliative care;
* Housebound with no health needs at present, requiring medicines review only;
* Short-term housebound following short spells of ill health/surgery;
* Care Home patients.

A Task and Finish Group will be established by the CCG in order to develop a template for Summary Care Records to be completed for patients meeting the above criteria.**3.2 Population covered**The service is accessible to all patients registered with a General Practitioner within the North East Lincolnshire CCG locality, encompassing a population in excess of 168,000. **3.3 Any acceptance and exclusion criteria and thresholds**This service is accessible to patients who are risk stratified as top 2% users as well as any patients aged over 75 not included in the top 2%. **3.4 Interdependence with other services/providers**Seamless service delivery is dependent on building and maintaining effective working relationships including the development of robust communication and liaison mechanisms. All staff are therefore required to establish and maintain effective key stakeholder relationships by working closely with the following key services/staff groups:* Practice Multi-disciplinary Teams;
* Other relevant Multi-disciplinary Teams;
* Single Point of Access (SPA);
* Care management staff;
* Home care staff;
* Intermediate Tier Services (Rapid Response, The Beacon);
* Mental health service staff;
* A&E Northern Lincolnshire & Goole Hospitals NHS Foundation Trust;
* Community Nursing;
* HIT Team
* Care Homes Staff;
* Ambulance Providers;
* Other community providers, as appropriate.

The commissioner will be required to compile a list of all the by-pass or ex-directory telephone numbers for GP practices participating in the ES and share it with relevant ambulance staff and A&E clinicians and other providers as appropriate. |
| **4. Applicable Service Standards** |
| **4.1 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)** * NHS England - Everyone Counts: Planning for Patients 2014/15 – 2018/19.
* All relevant standards applicable to Primary Care, eg; Care Act, NICE

**4.2 Applicable local standards*** Significant Event Reporting.
* The practice is required to complete an audit of the service to identify improvements in several specified areas which are set out in detail in Section 5.1. Performance audits should be undertaken from the service commencement date to the xx and be submitted to NELCCG no later than the xx to NELCCG.SIP@nhs.net.
* Submission of caseload figures to NELCCG.SIP@nhs.net illustrating, as at xx:

- Overall caseload;- The number of patients within in categorised level of need (where appropriate).* All equipment used to deliver the service will be serviced in line with the manufacturer’s recommendations.

Failure to comply with the audit and patient satisfaction survey will result in funding being temporarily withheld. On-going failure will lead to termination of funding for this service. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable quality requirements (See Schedule 4 Parts A-D)**

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| **Quality Requirement** | **Threshold** | **Method of Measurement** | **Consequence of breach** |
| Maintain or reduce attendances to Accident & Emergency department for patients accessing this service.  | Previous year as baseline. | Performance Audit. | Remedial Action Plan. |
| Maintain or reduce emergency admissions for patients accessing this service.  | Previous year as baseline. | Performance Audit. | Remedial Action Plan. |
| Increased patient contact with the practice by way of the most appropriate medium.  | Previous year as baseline. | Performance Audit. | Remedial Action Plan. |
| Where applicable, patients feel they are able to manage their diagnosed condition more effectively due to self-management, education and signposting.  | 70% of returns. | Patient Satisfaction Survey. | Remedial Action Plan. |
| Patients accessing this service will be satisfied with the care received and will provide feedback in order for the provider to assess effectiveness.  | 50% response rate.80% minimum satisfaction rate. | Patient Satisfaction Survey.  | Remedial Action Plan. |

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| **6. Corporate & Clinical Governance** |
| **6.1 Responsibilities of the provider**The Provider will:* Apply the principles of sound clinical and corporate governance;
* Actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;
* Undertake systematic risk assessment and risk management to meet requirements monitored by Care Quality Commission;
* Ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;
* Challenge discrimination, promote equality and respect human rights;
* Develop, implement and adhere to quality standards and protocols;
* Ensure all interventions carried out will be shared with the patients’ registered GP as well as with the patient and/or carer.

The Provider will ensure that:* Clinical care and treatment are carried out under supervision and leadership, at appropriately regular intervals, expected to be at least quarterly;
* Clinicians continuously update skills and techniques relevant to their clinical work and maintain relevant professional registration;
* Clinicians participate in regular clinical audit and reviews of clinical services, with relevant partners (this could be GP Practice, Intermediate Tier, Secondary Care).

 **6.2 Safeguarding Adults**The provider has a duty to work within the Adult Safeguarding Policy and Procedure Framework, until statutory legislation is in place.**6.3 Complaints policy**The service is expected to operate and promote an effective complaints policy in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 for users of its services or their representatives.   Any person wishing to make a complaint has the right to complain either to the provider or the commissioner (in this case NELCCG).  All complaints correspondence should be acknowledged within three working days and responded to in writing within a timescale agreed with the complainant.  If the complainant is not satisfied after receiving the written response they have the right to refer their complaint to either the Local Government Ombudsman (for Complaints about Adult Social Care) or the Parliamentary Health Service Ombudsman (for complaints about health services).   Providers are required to provide a quarterly report to the Commissioner detailing all complaints received, The procedure should aim to meet the following objectives:1. Be well publicised;
2. Be consistent;
3. Be easy to access, simple to understand and use;
4. Be fair and impartial to staff and complainants alike;
5. Ensure that the care of patients will not be adversely affected if they or their advocate make a complaint;
6. Ensure that rights to confidentiality and privacy are respected;
7. Provide a thorough and effective mechanism for resolving complaints and satisfying the concerns of the complainant;
8. Provide answers or explanations promptly and within agreed time limits;
9. Keep the complainant or their representative informed of progress;
10. Enable lessons learnt to be used, and evidenced, to improve the quality of services to patients;
11. Regularly review the complaints procedure and amend if found to be lacking in any respect.

**6.4 Providers Premises**The Provider’s Premises are located at:Please see Practice specific Business Plan Proposal attached.  |
| **7. Payment** |
| ***Part 1: £2.87 per patient population, as per NHS England AUA Specification******Part 2: £3.87 per patient population, part linked to process and part to outcomes at 5.1******Specific breakdown of CCG payment to be determined.*** |

1. **Indicative Activity Plan**

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| **Insert text locally or state Not Applicable** |

1. **Activity Planning Assumptions**

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1. *Although no overarching risk stratification tool is available System1 and EMIS templates are available to support risk stratification. Please contact Martin Rabbetts should you wish to discuss further.*  [↑](#footnote-ref-1)