

SCHEDULE 2 – THE SERVICES

A. 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

Service Specification No.	02_GMS_54
Service	Vulnerable Adults at risk of admission; GP practices in Christchurch locality (replacement of Vulnerable adults LES)
Commissioner Lead	Pan Dorset CCP re LTC GMS
Provider Lead	
Period	April 2014 –March 2017
Date of Review	April 2015

1. Population Needs

1.1 National/local context and evidence base

With an ever increasing elderly population, and 40% of the NHS budget spent on people over the age of 65, proactive management of frail elderly people is key in order to promote self care, increase independence and quality of life with the added benefit of reducing unplanned admission to secondary care.

The NHS Improvement Plan 2004 identified the case management role of community matrons in managing of people with long term conditions. Central to this is the collection and analysis of data to predict those people who are at risk of admission. Identifying the most vulnerable patients and targeting resources to meet needs enables proactive management to reduce the incidence of unplanned admission to secondary care for this group of people.

Teams managing this group of patients will need to work effectively with local social services and voluntary agencies to ensure the necessary care packages are put in place for these patients. These teams will support the development of integrated service planning and delivery including health and social care team work, planned preventive care, admission avoidance, urgent care response, intermediate care and reablement.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing 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 safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

- The vulnerable patient practice register will equate to approximately 5% of the practice population and will represent those who have been risk profiled to be at highest risk of a future unplanned admission
- Emergency admissions will be reduced
- People will feel supported to manage their long term conditions
- 100% of people at risk of falling will be assessed for bone protection medication
- People on an end of life care pathway will be supported to die in their preferred place of death
- 100% of people with a long term condition will have individualised care plans developed with themselves
- increase year on year the percentage of carers of people with a long-term condition who have a carers assessment and support.

3. Scope

3.1 Aims and objectives of service

Aim:

The identification and proactive management of patients deemed to be at risk of admission by reducing unplanned admissions and length of stay through pro-active case management of patients at risk of admission and readmission

Objectives:

The Service will be based on a clear methodology that:

- uses a system to identify and manage risk in the practice population;
- identifies vulnerable patients, including those with complex physical and mental health needs, and works in partnership to address these needs;
- identifies patients requiring supportive care as part of managing the trajectory of long term conditions including end of life care;
- identifies and supports people at risk of falls;
- develops a personal plan of care which is regularly reviewed to meet patient and carer needs;
- carries out regular prescribing, medicine and medicine use reviews;
- works with patients towards concordance and optimises care outcomes;
- works with all local health and social care providers, including care homes, to manage patient health pro-actively and reduce the risk of admission;
- maintains an up to date register with details of those being actively case managed;
- demonstrates a reduction in secondary care usage;
- demonstrates a reduction in emergency admissions to secondary care;
- increases capacity for and ability to self care;

- improves quality of life;
- engages with other stakeholders and services to ensure service integration supporting provision of integrated health and social care;
- engages with a local clinical forum to undertake peer review and case discussions to improve quality, effectiveness, efficiency and patient outcomes;
- provides regular, demonstrable outcomes of improved patient care and resource use;
- supports hospital discharge planning.

3.2 Service description/care pathway

The service should be available during the practices contracted hours (i.e. 8.00am to 6.30pm) for 52 weeks of the year and evidence should be provided that appropriate plans have been devised for cover of leave (both anticipated and unanticipated) and succession planning for staff turnover

- implement an agreed methodology for identifying vulnerable patients and for reviewing the management of their care involving a community multidisciplinary team approach (this may be achieved through the use of a risk stratification tool);
- establish and maintain an up-to-date register of all vulnerable patients registered with the practice and undertake a complete review of the register annually as a minimum
- establish clear processes by which patients and carers can access timely help to meet both physical and mental health needs;
- carry out an agreed risk review on all patients on the vulnerable patient register as a minimum annually;
- allocate a named professional to be responsible for agreeing and implementing a plan of care;
- undertake a full risk assessment for 'at risk ' persons, including identification of all risk factors, avoidable risk and completion of an evidenced risk management plan which is used to provide integrated care and regularly reviewed;
- develop a personal plan of care for each person which includes jointly agreed personal goals and supports their self care;
- identify and support the needs of carers, arranging a full carers assessment where appropriate;
- ensure, where appropriate, that patients have a self management plan including anticipatory care / long-term condition (LTC) (including DNAR where appropriate) plans that are completed and are available for all clinicians including out of hours service Providers;
- demonstrate effective engagement with intermediate care irrespective of Provider, social care, third sector organisations and secondary care admission and discharge teams;
- develop and review the care pathway, including arrangements for rehabilitation and discharge;
- support appropriate service and outcome audits including patient / carer feedback workshops to inform service development.

3.3 Population covered

The registered patients at the GP practice

3.4 Any acceptance and exclusion criteria and thresholds

This specification is for the Management of Vulnerable Adults at risk of Admission and outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services

3.5 Interdependence with other services/providers

The service will work closely with:

- community nursing services
- intermediate care services
- social services
- palliative care teams
- secondary care

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The service Provider will:

- demonstrate compliance with all relevant national standards for service quality and clinical governance including compliance with the NHS Standards for Better Health Framework and relevant NICE guidelines;
- demonstrate that a system of clinical governance and quality assurance is in place, including systems for managing population risk and ensuring registration with appropriate quality bodies i.e. Care Quality Commission;
- ensure that staff providing the service are suitably qualified and competent and that there are in place appropriate arrangements for maintaining and updating relevant skills and knowledge and for supervision
- ensure that lines of professional and clinical responsibility and accountability are clearly identified;
- ensure that all premises and equipment used for the provision of the enhanced service are at all times suitable for the delivery of those services and sufficient to meet the reasonable needs of patients or clients. This includes provision of a suitable room, with couch and sufficient space and equipment for resuscitation if required. Suitable equipment for the insertion and removal (single use) needs to be provided as well as facility for local anaesthesia to be administered;
- practices must follow infection control policies that are compliant with national and local guidelines. All infection control, decontamination measures and sterilisation of equipment must meet the standards within the Health and Social Care Act (2008) and its associated "Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance";
- comply with Section 11 Children Act 2004 and associated Guidance issued by the Secretary of State, in part summarised in the document "Duty of Contractors and Commissioned Service Providers to Safeguard and Promote the Welfare of Children";

- comply with monitoring arrangements designed to ensure compliance with the Children Act 2004, as required on the part of the commissioner;
- ensure that there is a robust system of reporting adverse incidents or serious untoward incidents, that all incidents are documented, investigated and followed up with appropriate action and that any lessons learnt from incidents are shared across the organisation and with the commissioners;
- ensure that relevant safety alerts and Medical & Healthcare Products Regulatory Agency (MHRA) notices are circulated to staff and acted upon where necessary;
- ensure that an effective complaints procedure for patients is in place, in line with the current NHS Complaints Procedure guidance, to deal with any complaints in relation to the provision of the enhanced service;
- ensure that a process is in place for any member of the professional team to raise concerns in a confidential and structured way;
- demonstrate a robust information service/source for patients and review regularly based on patient feedback;
- ensure that patients are able to contribute to the planning of their own care and that opportunities for feedback are easily available;
- ensure that treatment, care and information provided is culturally appropriate and is available in a form that is accessible to people who have additional needs, such as people with physical, cognitive or sensory disabilities, and people who do not speak or read English.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

The Provider must ensure an appropriate record of activity is developed and maintained for audit and payment purposes and which meets the requirements of this specification.

The provider shall provide quarterly activity data to the CCG for this service within 1 calendar month following the end of each quarter during the year.

Activity data will include:

- number of patients on practice / locality vulnerable patient register during the quarter;
- number of patients on active patient caseload during quarter;
- number of new patients added to caseload/register;
- number of patients discharged from caseload/register;
- number of emergency admissions of patients on caseload/register;
- number of patients whose personalised care plan has been reviewed.
- Number commenced on bone protection medications
- Number of unplanned admissions due to exacerbation of COPD

Performance information will include:

- Proportion of people feeling supported to manage their condition – LTC6
- 100% of people assessed for risk of falling
- 85% of patients on an end of life care pathway dying in their preferred place of death
- Average percentage of personal goals achieved on care plans by patients on active caseload

Annual Audit Plan

The provider will conduct an annual audit/review of the service. The results will be submitted to the CCG. The review/audit will cover the following:

- description of the methodology used to identify vulnerable patients including a register; this may include the utilisation of a vulnerable adult management tool;
- the process for patients and carers to access timely help (response times in days);
- Results of an annual patient satisfaction survey
- Summary of complaints;
- concordance with medications;
- practice engagement with partner agencies related to this service;
- details of workforce profile identifying staff by grade and numbers of hours worked;
- details of staff supervision, professional development, appraisal and clinical audit;
- evidence of how the service has reduced hospital admissions and length of stay for patients on register/active caseload;

The provider must inform the CCG, at the earliest opportunity, if there is a significant disruption to the service in order that continuity can be maintained through an alternative provider

5. Applicable quality requirements and CQUIN goals

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

details of adverse incidents and patient complaints
 details of annual patient satisfaction survey

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

none

6. Location of Provider Premises

**The Provider's Premises are located at:
 as defined in the NHS contract**