SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Mandatory headings 1-4. Mandatory but detail for local determination and agreement
Optional heading 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	**02_GMS_56**
Service	Tracker Scheme for the Management of Vulnerable Adults at Risk of Admission
Commissioner Lead	*Pan Dorset – re LTC*
Provider Lead	
Period	1ST April 2014 to 30th March 2015
Date of Review	*1st September 2014*

1. Population Needs

1.1 National/local context and evidence base

The locality has 32% of residents over the age of 60 years, compared to the rest of Dorset East Dorset has a higher than average incidence of long term conditions which can be age related including diabetes, coronary heart disease, hypertension and heart failure.

The average spend on people over the age of 65 equates to 40% of the NHS budget. 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 role of case management in managing people with long term conditions. Identifying the most vulnerable patients, targeting resources to meet needs, enables proactive management to reduce the incidence of unplanned admission to secondary care for this group of people.

The Tracker scheme was initially set up by the Cranborne Practice in East Dorset and was subsequently adopted by three other practices locally. The aim is to offer coordinated support of vulnerable adult patients at risk of deterioration/admission. This service includes;

- identification and structured assessment of vulnerable patients;
- recording and tracking the progress/potential deterioration of patients identified; and
- coordination of services to best meet the need of these patients

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

- 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

3. Scope

3.1 Aims and objectives of service

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. 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 and the Quality and Outcomes Framework or funded under other Service specifications. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Objectives:

To deliver supportive services to patients who are identified as being vulnerable to acute admission, where it is appropriate to provide this in primary care.

To improve quality of life and dignity in ageing well.

The services will be timely and closely linked to other services which may offer support for the identified cohort of patients

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.

The service will be delivered by a designated staff who will:

- identify vulnerable patients, including those with complex physical and mental health needs, and work in partnership with the practice and the integrated community teams to address these needs;
- collect and analyse data to predict those people who may become at risk of admission;
- identify and support people at risk of falls;
- work with all local health and social care providers, including care homes, to manage patient health pro-actively and reduce the risk of admission;
- educate and support patients to confidently self manage their conditions
- identify patients requiring supportive care as part of managing the trajectory of long term conditions including end of life care;
- develop a personal plan of care including anticipatory care planning, which is regularly reviewed to meet patient and carer needs;
- maintain an up to date register with details of those being actively case managed;
- regularly review active case load and ensure timely discharge back to self care as appropriate;
- carry out regular prescribing, medicine and medicine use reviews;
- work with patients towards concordance and optimise care outcomes;
- engage with other stakeholders and services to ensure service integration supporting provision of integrated health and social care;
- work directly with integrated community teams to:
    - demonstrate a reduction in secondary care usage, and

length of stay;

- demonstrate a reduction in emergency admissions to secondary care;

- support hospital discharge planning and early facilitated discharge;

- engage with a local clinical forum to undertake peer review and case discussions to improve quality, effectiveness, efficiency and patient outcomes;

- provide regular, demonstrable outcomes of improved patient care and resource use.

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Each episode must be recorded in the lifelong patient record.

3.3 Any acceptance and exclusion criteria and thresholds

The service will be available to patients registered at the practice. Children will not be covered by this service specification.

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 any relevant national standards for service quality and clinical governance including compliance with the NHS Standards for Better Health Framework and relevant NICE guidelines;

- ensure that staff providing the service are competent and that there are in place appropriate arrangements for maintaining and updating relevant skills and knowledge;

- 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 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;

- 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 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 using the provided (see Schedule on Activity). 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:

- 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 goals achieved on care plans by patients on active caseloads
- Percentage of people with a long term condition who have individualised care plans which have been developed with the patient

The provider will conduct an Annual Audit Plan 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);
- patient and carer feedback including complaints. A patient satisfaction survey to be completed at least annually- to be agreed with the commissioner in terms of questions and sample size;
- 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;
- details of adverse incidents (these should be reported in the normal way via the Patient Safety team).

The contractor 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)

See above re patient complaints

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Not relevant

6. Location of Provider Premises

The Provider's Premises are located at:

As defined within the main contract

7. Individual Service User Placement

Not relevant