SCHEDULE 2 – THE SERVICES

A. Service Specifications (Short Form Contract)

Service Specification No.	11J/0230
Service	Enhanced Frailty Service
Commissioner Lead	Dorset Clinical Commissioning Group
Provider Lead	Primary Care Team
Period	1st April 2018 – 31st March 2020
Date of Review	31st March 2018 (Mid-point review)

1. Population Needs

1.1 National/local context and evidence base

Enhanced services require an enhanced level of provision above what is required under core GMS / PMS and APMS contracts.

The specification of this service is designed to cover the enhanced aspects of clinical care for severe and moderately frail patients all of which are beyond the scope of essential services.

In 2014/15 the NHS paper 'Everyone Counts' stated that CCG's shall be expected to support practices in transforming the care of patients aged 75 and above with a view to reducing avoidable admissions by providing funding to practices to develop schemes to deliver this. The CCG acknowledges that hospital admission is dependent on a number of factors and that the previous over 75 schemes are just one interrelated scheme.

In order to improve prevention and care for frail and older people the NHS Five Year Forward View calls for better integration of GP, community health, mental health and hospital services, as well as more joined up working with domiciliary care and care homes and closer working with the voluntary sector.

General Practice has evolved since the design and implementation of the Over 75 schemes in 2014 and strategically there is a clear direction towards developing integrated community and primary services (ICPS) new models of care, of which this scheme is an integral part. Therefore, this specification should be read in conjunction with Appendix A (Integrated Primary and Community Services, Community Care Model: Key Features, Functions and Outcomes).

This specification moves towards delivering a service based on need and not age alone, recognising that the current service does not support younger and frail people.

It is not expected that individual general practices deliver all of the service model within the specification. The specification asks practices to work with each other and partners within their health community to form the multi-disciplinary, sustainable and resilient health and care teams needed to support their population, making the best of the resources available.

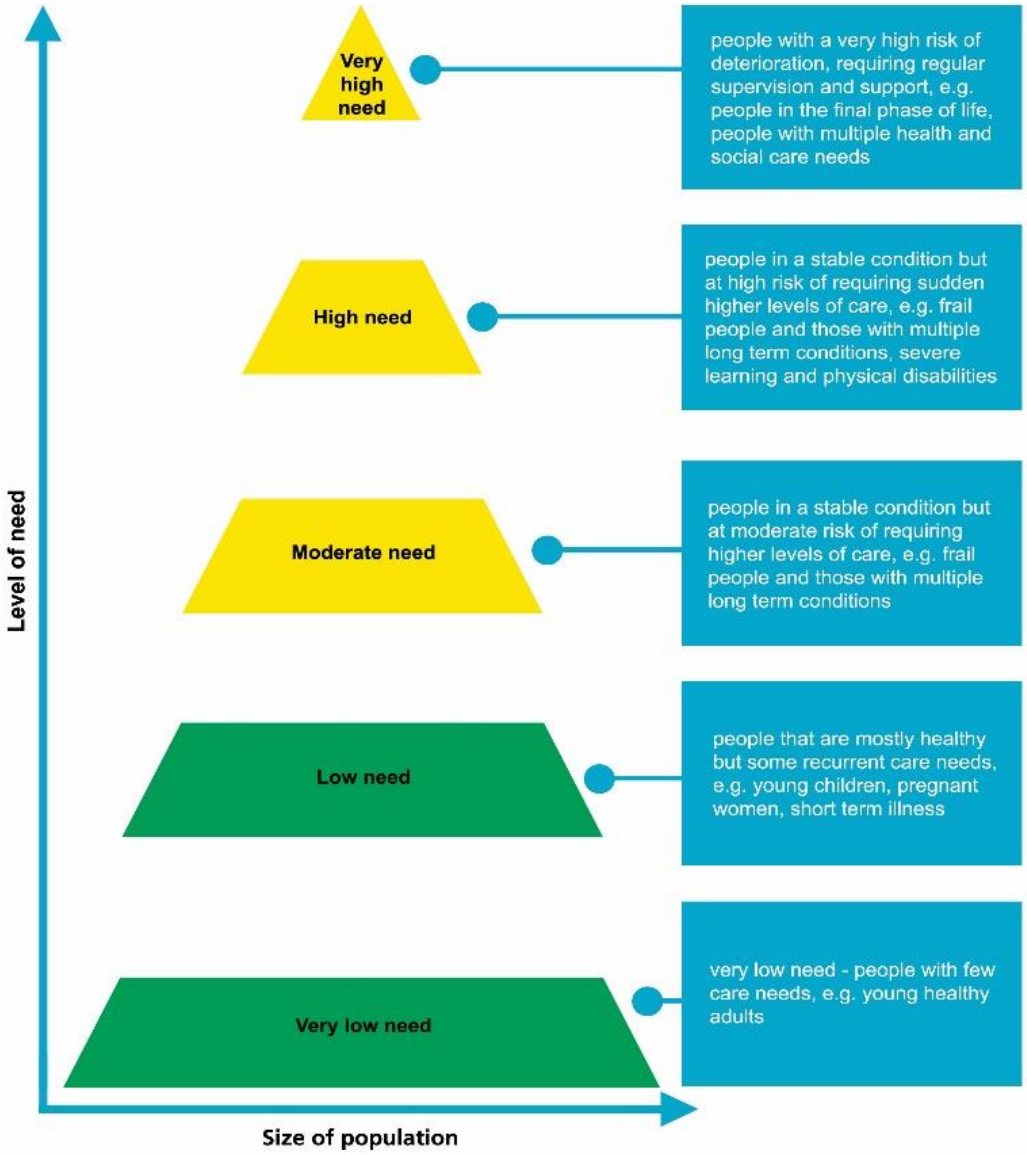
Fundamental to the vision of this specification are the four characteristics of the Primary Care Home model. These being:

1. An integrated workforce, with strong focus on partnerships spanning primary, secondary, community and social care and mental health;
2. A combined focus on personalisation of care with improvements in population health outcomes;
3. Aligned clinical and financial drivers with shared risks and rewards;
4. Provision of care to a defined, registered population of between 30,000 - 50,000.

Further clarification can be found in Appendix B.

The ICPS model developed is based on stratifying the local population needs. This then allows us to configure service delivery around individual levels of need in the most appropriate way. The five broad groupings of population need are outlined overleaf.

Frailty defining terms can be found in Appendix C Frailty Framework.



The CCG recognises that one size does not fit all and frailty schemes will need to be tailored to meet population need, for example support for care homes may be the main requirement for one area but not another. Clear rationale behind choices of service delivery must be demonstrated to be of relevance to the locality population. In order to develop a comprehensive and useful frailty register, patients can be identified through the eFi score, ideally combined with the rockwood score and clinical judgement. Localities are expected to develop Frailty Profiles with support from The CCG Business Intelligence Team, and localities will be required to consistently monitor the effectiveness of the service and adapt it in order to meet the outcomes required.

Practices should work together at scale in a networked way, and with partners to deliver a broad team approach. There is also an expectation that teams will work with the community, voluntary, acute and local authority providers increasingly as an Accountable Care System to ensure a cohesive service for all patients providing full population coverage.

There is also recognition that the focus of this service is on individual patient need as opposed to age. The CCG has developed a Frailty Framework (Appendix C) to support practices in taking a common approach to the early recognition, identification and management of frailty. For many patients, the response needs to be a non-medical model and is more about maintaining social contact with their community. This specification builds on the core requirements as detailed below:

GP CORE CONTRACT REQUIREMENTS:

As of the 1st July 2017 there have been some key changes within the GMS contract which coincides with the Avoiding Unplanned Admissions DES ceasing on 31 March 2017. The funding of £156.7 million was transferred into the global sum, weighted and without the out-of-hours deduction applied, and used to support the new contractual requirement on Identification and Management of Patients with Frailty.

The national contract states that practices shall:

- Use an appropriate tool, e.g. Electronic Frailty Index (eFI) to identify patients aged 65 and over who are living with moderate and severe frailty;
- Identify patients living with severe frailty, and deliver a clinical review providing:
    - An annual medication review;
    - Where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions;
- Promote the Summary Care Record (SCR) by seeking informed patient consent to activate the enriched SCR;
- Code clinical interventions for this group appropriately (N.B Read codes detailed in Appendix D)
- Collect data on the number of patients:
    - Recorded with a code of moderate frailty;
    - With severe frailty;

- With severe frailty with an annual medication review;
- With severe frailty who are recorded as having had a fall in the preceding 12 months;
- Severely frail patients who provided explicit consent to activate their enriched SCR. NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This data will not be used for performance management purposes or benchmarking purposes.

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

- Build on the core contract to understand your frail population;
- Improving health of the moderately and severely frail;
- Collaborative working across practices and providers;
- Promote the Enriched Summary Care Record;
- Engagement with the Dorset Care Plan (WORK IN PROGRESS).

3. Scope

3.1 Aims and objectives of service

To improve prevention and care for frail and older people and to reduce avoidable admissions for this cohort of patients, building on the core requirements of the contract.

3.2 Service description/care pathway

This specification focuses on the contribution of General Practice working at scale, to provide frailty schemes, by means of allowing access to patient lists across localities and with partner providers, to cover the enhanced aspects of clinical care for patients living with moderate and severe frailty within the ICPS model. It is imperative that the Practices/Locality work in alliance with other providers to ensure there is a focus on the appropriate skills and expertise to deliver the new models of care and to demonstrate this. For many patients, the response needs to be a non-medical model and is more about maintaining social contact with their community.

A model based on stratifying the local population needs and configuring service delivery with a multi-dimensional, interdisciplinary skill mix which by working with other agencies could include:

- Clinical – GP / Specialist (Geriatrics & other general medical specialities);
- Pharmacy (this could be by linking with an existing community pharmacy or a joint appointment);
- Nursing (practice, community and specialist);
- Therapy;
- Care Co-ordinator;
- Voluntary Sector;
- Care navigator.

Collaborative options practices could work at may include:

- Collaborative model other practices and with community services / other providers (Preferred option);
- Locality or cluster working;
- A network of practices;
- Practices working on behalf of another practice(s);

- Individual practice with an integrated multidisciplinary team (if the practice is large enough to deliver an MDT and is at sufficient scale) – The expectation is that this will be a team approach and not reliant on the GP only.

Please note: With all options there is an expectation that frailty teams work with partners in the health community e.g.:- Community, Acute, Voluntary and Local Authority Partners.

LOCAL ENHANCED REQUIREMENTS

This specification sets out the requirements to be delivered by General Practice preferably at scale for the needs of the patient to enhance the core requirements for the moderately frail. Schemes need to build on the basis of the core contract by developing collaborative working / systems of care, including non-medical / non-physical support.

The practice/collaborative/locality shall:

- Provide on-going case finding and risk stratification methods to identify people requiring proactive care (recommended tools are eFI and the Rockwood scale combined with knowledge of the patient, please see Appendix E – 'Frailty' – Developing a meaningful and accurate register). Dependent on the frailty profile of the local population this may include proactive assessment and management of people in their own home and / or care home settings.

- Provide proactive holistic assessment which will include:
  - Proactive working within the multi-dimensional, interdisciplinary system to plan, assess and provide intervention;
  - Where appropriate, phone and email liaison approach with the wider MDT to gain specialist opinions on complex cases;
  - Where appropriate, promotion of self-management (including apps/improved guidance), telehealth, telecare, education, signposting - including partnership working with the voluntary sector;
  - Access and referral where appropriate to specialist pharmacist or provide in house prescribing reviews to undertake medicines review and reconciliation including on discharge from hospital ;

- A face-to-face medication review appropriate to the needs of the patient are set out by Dorset CCG Medication Review Guidance. Please see Appendix F.
- Develop and support enhanced care into care homes;
- Signposting of carers and families to relevant support recognising need for advocacy where appropriate;
- Cognitive assessment and referral to the Memory Support and Advisory Service (MSAS), where indicated;
- There is recognition that all agencies delivering care will consider the fundamental principles of Wellbeing (Care Act 2014) along with the principles of The Mental Capacity Act (2005) and Adult safeguarding (Empowerment, Prevention, Protection, Proportionality, Partnership, Accountability).

- Complete 'The Dorset Care Plan' which includes:
  - A core care plan
  - An admission avoidance care plan
    - which summarises the individuals wishes in the event of a crisis with regards to their own health (i.e. do they want to go to hospital, under what circumstances would they want to stay at home, whether there is a DNACPR order in place) or in the health of the carer should this deteriorate;
  - An advance care plan or end of life care plan
    - which could describe the individual's wishes with respect to their preferred place of dying and whether they have "just in case" medications in place;
  - Upload all the above to the Summary Care Record (SCR)

  Please see Appendix G – The Frailty toolkit

3.3 Population Covered

Those identified with moderate and severe frailty registered with a GP in Dorset.

3.4 Any acceptance and exclusion criteria.

3.5 Interdependences

GP Core Contract – there is a contractual requirement on the identification and management of patients with severe frailty.

System working – in line with the ACS.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

Enhanced Care into Care Homes (NHS England)

https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

- **Applicable local standards**

Monitoring:

Annually via the CCG contract assurance meeting the provider shall:

- Prior to commencing the specification for 18/19 the provider shall inform the CCG whether they are part of a locality/collaborative or individual enhanced frailty service using appendix H.
- Demonstrate that the Enhanced Frailty Specification is included in the locality transformation plan.
- Provide evidence of a locality integrated care board.
- Demonstrate that the scheme is part of a wider multi-dimensional, interdisciplinary skill mix.

Quarterly the provider shall report:

- Number of patients consented to activate the enriched Summary Care Record.
- Percentage of patients identified as severely or moderately frail with a completed Dorset Care Plan.
- Percentage of patients identified with moderate frailty who have received a face-to-face polypharmacy review.
- Number of new dementia diagnosis recorded.
- Providers agree to report activity provided in accordance with this enhanced service on a quarterly basis by completing the monitoring return provided by the Commissioner. The returns should be submitted to the Commissioner within 10 working days of each quarter end.

Quarterly Locality work:

- The locality shall reflect on the data provided by the ICS Dashboard and the impact of the schemes provided at locality/PLT/ transformation meetings.

Dorset CCG shall provide:

- An update to the ICS Dashboard on a quarterly basis.

- The Quarterly Enhanced Services monitoring return template provided by the Commissioner shall allow the Provider to monitor activity provided for each quarter.

Payment Arrangements and Tariff Prices

The Enhanced Frailty budget is based on practices individual over 75 registered populations as at October 2017. The Provider shall be paid for the provision of the Services in twelve equal monthly instalments.

The Commissioner shall not stipulate the level of activity to be provided for each part of the service available to patients as Providers shall have flexibility to make this decision in order to meet the demand profile expected from their patient population.

The Commissioner shall expect Providers to manage delivery of services to their patient population in accordance with the annual budget available to them.

Sub-Contracting Arrangements

In the situation whereby the Provider is unable to maintain one or all of the services commissioned under this enhanced service, they may if they wish enter into a sub-contracting arrangement with another suitably qualified provider able to provide services to patients under the terms of this enhanced service.

The minimum applicable requirements for sub-contracting arrangements shall be:

- The sub-contractor must already be providing the service under this enhanced service as a provider;

- The providers' patients should not be expected to travel more than **7.5 miles** in rural areas or **2.5 miles** in urban areas, depending on the service being sub-contracted

- The provider will be responsible for submitting the returns performed by the sub-contractor to the CCG in accordance with the terms of this agreement.

- Prior to entering into any agreement with a sub-contractor, approval of the proposed arrangements is required from the Commissioner.

- The Provider agrees that the responsibility for any monetary arrangement is between themselves and the sub-contractor and not the Commissioner.

Appendices

Appendix A – Integrated Community and Primary Services, Community Care Model: Key Features, Functions and Outcomes;

Appendix B – Primary Care Home Model Characteristics

Appendix C - Frailty Framework.

Appendix D – Read codes

Appendix E– 'Frailty' – Developing a meaningful and accurate register

Appendix F – Dorset CCG Medication Review Guidance

Appendix G –The Frailty Toolkit including guidance on The Dorset Care Plan

Appendix H – Enhanced Frailty Pro-forma

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

N/A