SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	11J/0232
Service	Enhanced Frailty Service (Christchurch MP and Farmhouse Surgery)
Commissioner Lead	Primary Care Team
Provider Lead	Claire Richards
Period	01/10/2017-31/03/2018
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

- 'A Call for Action' Improving General Practice (March 2014) by providing pro-active co-ordinated care.
- Transforming Our Health Care System -Kings fund 2014 by supporting good discharge planning and post discharge support, supporting people to live well with simple or complex co-morbidities and enabling choice control towards the end of life.
- NHS England's Mission by helping people recover from episodes of ill health and reducing premature mortality;
- Link with Local Authority to focus on developing arrangements of the Better Care Fund enabling more care to be delivered locally to support the person and family/carers

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

- Reduction in unplanned admissions and better outcomes following hospital admissions. Contributes to the Dorset target to reduce unplanned admissions overall by 3.5%
- Better coordination of care packages between services (through increased use of and review of anticipatory care plans and regular multi-disciplinary case reviews)
- Timely provision of appropriate anticipatory care through use of remote technology and priority note summarising
- Increased uptake of advanced planning and end of life care plans
- Improved diagnostic rates for dementia

- Improved Referral activity to rehabilitation services, memory gateway, and social services
- Improved management of chronic disease not optimally monitored/managed - for housebound patients
- Improved communication and support for carers and residential and care home colleagues
- Reduction in non-urgent call out requests for GPs, allowing more primary care capacity

3. Scope

3.1 Aims and objectives of service

The demographics of CMC practices means that there is considerable additional workload generated by co-morbidity, polypharmacy, complex issues that are common to the 65+ patients, and ergo which affect their frailty. The aim and objects of this service are to address these issues.

The team will be made up of practitioners that will be able to focus specifically on the needs of 65+ group, work together, with community colleagues, to improve provision for this group.

3.2 Service description/care pathway

Priority/area	**Anticipated Outcome**
Review of polypharmacy for 65+ patients This also aligns considerably to the Frailty specification: Building on core contract to understand frail population; Improving health of moderate/severe frail;	Meds reviews are critical for our demographic of 65+. While it is acknowledged that this is already part of the Core Contract, and for those who live with severe frailty, the frailty spec extends the review to include ***moderate*** frailty. Assessment of frailty for the patient group would be undertaken by use of appropriate means, e.g. eFI/Rockwood/Clinical judgement. *Further,* in expansion of the meds review provided within the Core Contract, the frailty team provides the opportunity to take the reviews to a more thorough, detailed level – something that cannot always be achieved within the pressured usual clinic times. The frailty spec specifically talks about need for meds reviews and tools to improve health of the moderately and severely frail. The anticipated outcomes are: reduction in medications; clearer guidelines for patients; removal of any unnecessary medications; increased confidence of patients in relation to meds management; closer addressing of meds management objectives against e.g. audits; reduction in meds budget/spend;

		reduction in frailty. It is very well recorded that a significant number of hospital admissions are meds related amongst the elderly population. We consider that improved meds management will ergo have impact in a reduction in the number of unplanned admissions. This priority also allows for a very proactive approach to our patient care, which is also in line with Frailty spec.	
	Dementia reviews and memory assessments undertaken/updated. Aligns with Frailty spec: Building on core contract to understand frail population; Improving health of moderate/severe frail;	GPs have identified an additional burden from the relative increase (due to percentage of patients 65+ and therefore higher incidence of dementia) in number of dementia cases and particularly referrals back to surgery from EMHT for assessment reviews. The inclusion of more e.g. HCA staff who can undertake the annual dementia reviews, particularly for EMHT patients means that we can develop stronger sustainable strategies with all agencies, for the safest dementia management for the patient and their family/carers. While this work is recognised within the GP Contract Plus, our Frailty Team means that we can extend this provision to proactive review of those who are not yet on medication, but nonetheless are at risk or identifying signs or early-onset dementia. This would once again also alleviate a considerable burden from not just the GPs but also ensure that patients receive the best service as soon as possible. With high correlation between dementia and frailty this also means that we can collaborate with all relevant agencies/bodies to improve the care of dementia patients in a far more proactive manner.	
	Use of high level clinician - NP/Paramedic to undertake earlier intervention on need for home visits for frail group. Aligns with Frailty spec:	Although this application is currently from CMC practices, with Barn and Orchard merging with Burton & Bransgore we will collaborate on the work that they have already undertaken in greater utilisation of their NP team and a Paramedic. Our proposal should therefore be seen as part of a wider multi-dimensional, interdisciplinary skill mix. Working with other providers and the locality/Federation: 1. DHUFT: We are working with the other practices in the locality/federation to	

Collaborative working across practices and providers	integrate the community nurse teams in our practice teams to provide seamless care for our patients whatever their needs as part of a pilot project. From the point of view of the frail elderly this means we can call on the expertise of the most appropriate person to deliver the correct care in a timely manner in the setting that is right for the patient depending on their needs at the time. As a larger merged organisation we are reviewing our current MDT arrangements with DHUFT with a view to creating an enhanced MDT bringing in the wider rehab team as well as mental health and RBCH teams. 2. RBCH. We are engaged with locality/federation discussions with RBCH with regard to enhanced access for acute primary care problems at the RBCH hub. We welcome their input at MDTs and seek to enhance this. Information sharing via SystmOne is crucial to extended hours services proving appropriate care for our frail elderly patients. 3. Care homes. Already as a merged organisation we have streamlined the access of care homes to our service. We can visit more efficiently and in a more timely way using our resources more effectively. We have also committed to locality/federation initiatives around care home access and visiting.	

3.3 Population Covered

65+ Patients from Christchurch MP and Farmhouse Surgery (Approx. 20k)

3.4 Any acceptance and exclusion criteria and thresholds

The service is to provide care above and beyond the usual GP care and to compliment and not replace existing community and secondary care services. On this basis, we are taking a positive approach to working with other services/organisations, and not dismissing any options at this time.

3.5 Interdependence with other services/providers

Internally – clinicians; AMBER team (Vulnerable Adults)

Externally – DN, HV, MDT, voluntary groups e.g. Angels, RBH for pharmacy links, CCG colleagues, ECP

4. Applicable Service Standards

4.1 Applicable National standards (e.g. NICE)

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

4.3 Applicable local standards

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

8.