

April 2014

AVOIDING UNPLANNED ADMISSIONS ENHANCED SERVICE: PROACTIVE CASE FINDING AND CARE REVIEW FOR VULNERABLE PEOPLE

GUIDANCE AND AUDIT REQUIREMENTS

A programme of action for general practice and
clinical commissioning groups

NHS England Gateway reference: 01307



CONTENTS

SECTION 1	BACKGROUND AND PURPOSE	3
SECTION 2	REQUIREMENTS	5
	Practice availability	5
	Proactive case management and personalised care planning	6
	Reviewing and improving the hospital discharge process	10
	Internal practice review	10
SECTION 3	DATA	12
SECTION 4	MONITORING	13
SECTION 5	PAYMENT AND VALIDATION	15
SECTION 6	OTHER PROVISIONS RELATING TO THIS ENHANCED SERVICE	19
ANNEX A	TEMPLATE LETTER TO INFORM PATIENTS OF ENROLMENT INTO ENHANCED SERVICE	20
ANNEX B	PRINCIPLES OF PERSONALISED CARE PLANNING	30
ANNEX C	CARE PLAN TEMPLATE	31
ANNEX D	REPORTING TEMPLATE	34
SECTION 7	QUERIES PROCESS	42

SECTION 1. BACKGROUND AND PURPOSE

Unplanned admissions to hospital are distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital.

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 ES will commence on 1 April 2014 for one year, subject to review.

The funding to support this service has been taken from the retirement of the quality and productivity (QP) domain of the Quality and Outcomes Framework (QOF) and the 2013/14 Risk Profiling and Care Management ES which ceased on 31 March 2014. In addition to these changes, wider amendments to the GMS contract in 2014/15 have also been made to further enable practice staff time to be focused on holistically improving the health and wellbeing of their patients, particularly those who are the most vulnerable or have long term conditions.

The ES requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access. In addition, the practice will also be required to provide timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or accident and emergency (A&E) attendances.

The risk stratification element of the ES will apply to a minimum of two per cent of adult patients (aged 18 and over) of the practice's registered list. In addition to this, any children with complex health and care needs requiring proactive case management and personalised care plans should also be considered for inclusion on the register.

Patients identified as being at high risk of unplanned admission and on the case

management register will be assigned a named accountable GP (and where relevant a care coordinator). This person will have overall responsibility for coordinating the patient's care and sharing information with them, their carer (if applicable) and, if the patient consents, other professionals and organisations involved in their care. These patients will have a personalised care plan which will have been developed collaboratively between the patient, their carer (if applicable) and the named accountable GP and/or care coordinator, detailing how their ongoing health and care needs will be addressed to reduce their risk of avoidable admission to hospital. Patient care will also be reviewed at an interval agreed with the patient and if **applicable, the carer. This may also involve reviewing the patient's personalised care plan.** Practices should also be aware of the needs of carers.

Participating practices will review emergency admissions and A&E attendances of patients on the case management register (i.e. to understand why these admissions or attendances occurred and whether they could have been avoided). They will also review patients newly identified as at risk and other vulnerable patients (such as those living in care or nursing homes) to identify factors which could have avoided the admission or A&E attendance, with a view to taking appropriate action to prevent future episodes. These factors include both changes that the practice can make to their management of these patients, other community support services that need to be put in place for these patients and also changes to admission and discharge processes that will be fed back by the practice to commissioners.

This guidance should be read in conjunction with the 2014/15 NHS England ES specification.¹

¹ <http://www.england.nhs.uk/resources/d-com/gp-contract/>

SECTION 2. REQUIREMENTS

The requirements for taking part in the ES are as follows:

i. Practice availability

- i. The practice will provide timely telephone access via an ex-directory or bypass number to ambulance staff and A&E clinicians to support decisions about hospital transfers and admissions relating to any patient on their registered list². This could, for example, be done by providing different extension options to callers to the practice, as long as this gets the caller straight through to the practice as a priority call. Where an ambulance staff member or A&E clinician specifically ask to speak to a clinician in the practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to whether or not to transfer or admit a patient to hospital i.e. it may be prompt, within an hour or same day. The area team will be required to compile a list of all the by-pass or ex-directory telephone numbers for practices participating in the ES and share it with relevant ambulance staff and A&E clinicians.
- ii. The practice will provide timely telephone access via an ex-directory or bypass number to care and nursing homes, encouraging them to contact the patient's GP practice to discuss options before calling an ambulance (where appropriate – for example, this is not applicable if the patient is at high risk of severe harm or death, if treatment is delayed). This could, for example, be done by providing different extension options to callers to the practice, as long as this gets the caller straight through to the practice as a priority call. Where care or nursing home staff specifically ask to speak to a clinician in the practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to whether or not to call an ambulance i.e. it may be immediate or within a couple of hours. The area team will be required to compile a list of all the by-pass or ex-directory telephone numbers for practices participating in the ES and share it with relevant care and nursing homes.
- iii. The practice will provide timely telephone access to other care providers (e.g. mental health and social care teams) who have any of the practice's registered patients in crisis and who are at risk of admission. Where a specific request is made by one these individuals to speak to a clinician in the practice, then they

² This number is only to be used when ambulance staff and A&E clinicians require support from a patient's practice in making decisions about transferring or admitting patients.

should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to a patient in crisis i.e. it may be immediate, within an hour or same day.

- iv. The 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 community team etc.). This same day telephone consultation will be with the most appropriate healthcare professional in the practice.

ii. Proactive case management and personalised care planning

- i. The practice will use an appropriate risk stratification tool or alternative method, if a tool is not available, to identify vulnerable older people, high risk patients and patients needing end-of-life care who are at risk of unplanned admission to hospital. If a risk profiling tool is used, clinical commissioning groups (CCGs) should ensure that a suitable tool has been procured for practice use.
- ii. The risk stratification tool or other alternative method used should give equal consideration to both physical and mental health conditions.
- iii. The practice will establish a case management register of patients identified as being at risk of an unplanned hospital admission without proactive case management. This register will be a minimum of two per cent of the practice's registered³ adult patients (aged 18 and over). The minimum number of patients to be on the register each quarter, will be set on the first day of the respective quarter starting from quarter two (i.e. 1 July 2014 for quarter two, 1 October 2014 for quarter three and 1 January 2015 for quarter four). The minimum register size will be calculated as two per cent of the practice list size (patients aged 18 and over) from Exeter on each of these days. In addition to this two per cent, any children (aged 17 and under) with complex physical or mental health and care needs, who require proactive case management, should also be considered for the register.⁴
- iv. In each quarter a tolerance of -0.2% will be allowed to account for situations which temporarily lead to a dip in the number of patients on the register at the end of that quarter. However, practices will need to ensure that over the last three quarters of the year the register covers at least an average of two per cent of the practice's registered adult patients. Therefore, should the circumstances of any patient change during the year, resulting in their removal from the

³ Head count and not weighted list.

⁴ Children on the case register will not be counted towards the minimum two per cent as detailed in the payment and validation section.

register, practices will need to identify additional patients as soon as reasonably possible to ensure the two per cent is maintained. Where a practice fails to deliver at least an average of two per cent across the last three quarters of the year, payments can be reclaimed. See payment and validation section for more details.

- v. 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, practices and their area teams will need to discuss and review the situation.
- vi. The 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 input are receiving it, or that the practice is receiving appropriate feedback from the district nursing team.
- vii. Practices will be required to inform relevant patients that they are enrolled on the register and what it is they can expect from being part of this ES. An example of a template letter/email or patient leaflet, that could be used by practices (if desired), is available (see Annex A).
- viii. Patients initially added to the register will be informed of their named accountable GP and where applicable their care coordinator by the end of June 2014. Any new patients coming onto the register in-year should be notified within 21 days.
- ix. The 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 coordinator. If the patient consents, the personalised care plan should be shared with the multi-disciplinary team and other relevant providers. Personalised care plans should be in place for all patients initially added to the register by the end of June 2014. Thereafter, any new patients coming onto the register in year should have their personalised care plans created and agreed within a reasonable timeframe, but no later than one month after entry onto the register.
- x. The aim of proactive personalised care planning is to improve the quality and coordination of care given to patients on the register to improve their health and well-being. This should also aid in reducing of individual risk of avoidable emergency hospital admissions or A&E attendances. The principles of care planning can be found in Annex B and practices should take account of these in the care planning discussions.

- xi. Patients and carers (if applicable) should be invited to contribute to the creation of the personalised care plan. Members of the multi-disciplinary team (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.
- xii. The personalised care plan should, where possible and through encouragement from the attending practitioner, include a recording of the patient's wishes for the future. It should identify the carer(s) and give appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family.
- xiii. The personalised care plan will include as a minimum:
- patient's name, address, date of birth, contact details and NHS number
 - notification if the patient is a nursing or care home resident
 - details of the patient's named accountable GP and care coordinator (if this is different to the named accountable GP)
 - details of any other clinician(s) who play(s) a significant role in the patient's care relating to their specific condition(s) e.g. diabetic lead clinician, respiratory nurse, Macmillan nurse etc.
 - confirmation/details of consent given for information sharing, including if a patient has given permission for a practice to speak directly to their carer(s)
 - names and contact details of the patient's next of kin/main carer/responsible adult, if applicable
 - details of the patient's condition(s) and significant past medical history
 - details of any ongoing medication the patient is prescribed (this may also include over the counter (OTC) medicines, if relevant) and plans for review
 - allergies
 - details of any individual requirements or preferences which will aid the care and support of the individual
 - key action points, for example early detection of impending deterioration with an agreed plan for escalating care, including crisis management
 - where possible and as appropriate, signatories of the named GP/care coordinator, patient and/or carer.
- xiv. The patient's care and personalised care plan should be reviewed at agreed regular intervals with them and if applicable, their carer. Where a patient has

had no contact with any member of the multi-disciplinary team within the last three months, it is good practice for the practice to make contact and review **whether that patient's care is in line with their needs**. 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. 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 coordinator (if applicable) to link with the right people in the multi-disciplinary team or as an area for commissioning or design improvement. Practices will be required to use the new Read2 or CTV3 codes **(see section on monitoring) to record when a patient's care plan has been reviewed**. This is a specific code introduced solely for use of practices participating in this ES.

- xv. A national care plan template⁵ is available (see Annex C). While use of the template is not compulsory, it is expected that inclusion of the above information in a care plan would be a minimum requirement. The GP practice will be responsible for ensuring information governance requirements are met.
- xvi. Where a patient has had a review undertaken by a member of the multi-disciplinary team (i.e. outside of their practice), then the professional having **conducted the review must inform the practice and the patient's record updated**. CCGs will need to ensure, through their commissioning relationships with the organisations that work with the practice, that they inform the practice that a review has been undertaken.
- xvii. The named accountable GP will be responsible for ensuring the creation of the personalised care plan and the appointment of a care coordinator (if different to the named accountable GP). They will also maintain overall accountability for ensuring that the personalised care plan is being delivered and patient care, including the personalised care plan, is being reviewed as necessary.
- xviii. The care coordinator for the patient (appointed by the named accountable GP, unless they plan to undertake this role themselves) will act as the main point of contact for the patient. They are responsible for overseeing care for the patient, that the care plan is being delivered and that the patient and/or carer (if applicable) is informed of and agrees (if applicable) any changes made to their personalised care plan. They will also keep in contact with the patient and/or their carer (if applicable) at agreed intervals. In the event the named accountable GP is also the care coordinator, then they will be required to undertake all **responsibilities for both roles. Where elements of a patient's care or**

⁵ For standalone template see www.nhsemployers.org/GMS2014-15

personalised care plan, provided by professionals outside of the practice, is not being delivered then the named accountable GP or care coordinator (if applicable) will be required to raise this accordingly with the relevant organisation and ensure that all those involved are clear of their roles and responsibilities with respect to the **patient's care and personalised care plan**.

iii. [Reviewing and improving the hospital discharge process](#)

- i. The 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 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).
- ii. The practice will share any whole system commissioning action points and recommendations identified as part of this process with the CCG and if appropriate the area team, to help inform commissioning decisions. Information shared with the CCG is in order to help CCGs work with hospitals to improve planning for discharge and to improve arrangements for hospital/practice handover at point of discharge.
- iii. We would encourage CCGs to support admission alerts for practices so they can support proactive care planning between the hospital and relevant community based services, particularly for patients flagged as high risk. Proactive sharing of information can help practices coordinate and prepare for discharge and improve communication between named clinicians.

iv. [Internal practice review](#)

- i. The practice will be required to regularly review emergency admissions and A&E attendances of their patients from care and nursing 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 practice, in light of the number of emergency admissions or A&E attendances by these patients. During the review, the practice should give consideration as to whether improvements can be made to processes in care and nursing homes, community services, or practice availability or whether any individual care plans require amendment with agreement from the patient and carer (if applicable).

- ii. Where a practice has a large percentage of their patients in care and nursing homes, they should focus their reviews on any emerging themes from a sample of patients and on any patients who have regular avoidable admissions or A&E attendances. Practices will be required to agree this with their area team at the start of the year. In some circumstances, this may require different arrangements to be made locally to support these practices in undertaking this requirement. **Examples of 'local arrangements' may include, but are not limited to, support from the CCG to coordinate this or support through a care home community based service.**
- iii. The practice will undertake monthly reviews⁶ of all unplanned admissions and readmissions and A&E attendances of patients on the register or those newly identified as vulnerable (i.e. a patient who would now be at high risk of admission such as a patient who has had a stroke). During the reviews, the practice will give consideration to:
 - the practice's processes
 - **identifying factors, within the practice's control, that could have avoided the admission(s) and A&E attendances**
 - rectifying any deficiencies in the patient(s) personalised care plan(s)
 - amending or improving the hospital admission and discharge processes
 - **identifying factors outside the practice's control, including any system gaps in community and social care provision and either resolving them (if within the practice's control) or raising them with the CCG or area team as appropriate.**
- iv. The practice will ensure that any serious incidents are reported to the area team, CCG or both as and when they occur.

⁶ The reviews are to understand why each individual admission or attendance occurred and whether it could have been avoided.

SECTION 3. DATA

Area teams and/or CCGs will need to ensure the provision of timely practice level data on admissions and hospital discharges (as well as anonymous benchmarking data for comparison) to their practices. This may require area teams and/or CCGs to review their arrangements for the provision of data, to ensure appropriate support for practices.

SECTION 4. MONITORING

The practice will complete a reporting template on a quarterly⁷ basis, no later than the last day of the month following the end of the relevant quarter, for submission to the area team and CCG. The final end year report (i.e. that for quarter four) should take account of the entire year and is due for submission to the area team and CCG on or before 30 April 2015. A national reporting template has been developed and sets out the minimum reporting requirements (see Annex D). The reporting template is designed to assess the practice's performance against the four key requirements of the scheme:

- practice availability
- proactive case management and personalised care planning
- reviewing and improving the hospital discharge process
- internal practice review, taking account of both internal and external practice processes.

Additionally the practice may also be required, on an exceptional basis, to participate in peer reviews relating to assessment of the practice's implementation of this ES.

This would only apply where there were concerns regarding a practice's performance in adhering to the terms of this ES. It is recommended that in this instance, Local Medical Committee involvement is encouraged.

When available, GPES extractions will be used to support the achievement of the ES, covering both payment and management information requirements. In the meantime, practices will be required to manually submit data to support claims for achievement reporting and associated payment claims. Data will be extracted on the number of patients who have been included on the register, the number of patients who have had a personalised care plan drawn up by the practice (and the number of patients who have refused a care plan) and the number of patient care reviews (which may include a review of the personalised care plan) that have been reviewed.

In addition, the data manually submitted or extracted will also be used to trigger the three quarterly payments for the registers (see payment and validation section below). Practices will also be required to complete the relevant sections of the

⁷ The quarterly reporting is designed to assist practices and area teams (and CCGs, if relevant) in ensuring that the service is being delivered effectively and to provide any support in year or address any issues/concerns arising.

reporting template – see Annex D.

For information on how to manually enter data into CQRS, please see the Health and Social Care Information Centre (HSCIC) website.⁸

Details as to when and if GPES is available to support this ES will be communicated via the HSCIC.

Practices will be required to use the relevant Read2 and CTV3 codes as published in the supporting business rules on the HSCIC website. NHS Employers and the GPC have also published a document *Technical requirements for 2014/15 GMS contract*⁹ that lists the Read2 and CTV3 codes relevant for this service. The Read2 and CTV3 codes will be used as the basis for the GPES extract, which will allow CQRS to calculate payment based on the aggregated numbers supplied and support the management information extracts, when available. Although practices will be required to manually enter data until such time as GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting business rules will be acceptable to allow CQRS to calculate achievement and payment and for area teams to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and if necessary re-code patients as required.

CCGs will be involved in supporting practices to deliver this ES. Details of how CCGs will be involved will be published separately by NHS England.

NHS England is exploring the possibility of developing a patient survey¹⁰ to determine patients' experience of being part of this ES.

⁸ <http://systems.hscic.gov.uk/cqrs/participation>

⁹ <http://www.nhsemployers.org/GMS2014-15>

¹⁰ This survey does not form part of the requirements for this ES.

SECTION 5. PAYMENT AND VALIDATION

Area teams will seek to invite practices to participate in this ES before 30 April 2014. Practices wishing to participate will be required to sign up to this service by no later than 30 June 2014.

The total funding available for this ES is £162 million.

The payments will be based on a maximum of £2.87 per registered patient. Table 1 provides full details of what payments can be expected for fully achieving the requirements of the ES. For the purposes of payments, the contractor's registered population (CRP) will be as at 1 April 2014 or be the initial CRP if the practice's contract started after 1 April 2014. A practice with an average list size of 7087 would receive payments of £20,339.69 for delivering the ES in full.

Payment under this ES for 2014/15 will be made in five components:

- Component One – an upfront 'establishment' payment of 45%
 - For setting up the ES and includes putting a system in place for patients on the register to receive same day telephone consultations when they have urgent enquiries, obtaining (if not already available), specifying and use of the practice's ex-directory or by-pass telephone number and for developing, sharing and reviewing (as appropriate) personalised care plans¹¹ and patient care reviews for a minimum of two per cent of the practice's adult patients aged 18 or over (i.e. all the patients on the register).
- Component Two – quarter two register payment of 20%
 - For maintaining the register at a minimum of two per cent for quarter two (i.e. 1 July 2014 to 30 September 2014), as well as identifying the named accountable GP and care coordinator (where applicable) and informing the patients. Achievement of this component will be determinant on practices having a minimum of 1.8%¹² of patients on the register on 30 September 2014 as a proportion of the list size taken on the 1 July 2014.
- Component Three – quarter three register payment of 10%
 - For maintaining the register at a minimum of two per cent for quarter three (i.e. 1 October 2014 to 31 December 2014), as well as identifying the named

¹¹ Personalised care plans should be agreed for patients on the register initially by end of June 2014 and thereafter for any new patients within one month of entering the register.

¹² This takes into account the -0.2% tolerance.

accountable GP and care coordinator (where applicable) and informing the patients. Achievement of this component will be determinant on practices having a minimum of 1.8% of patients on the register on 31 December 2014 as a proportion of the list size taken on the 1 October 2014.

- Component Four – quarter four register payment of 10%
 - For maintaining the register at a minimum of two per cent for quarter four (i.e. 1 January 2015 to 31 March 2015), as well as identifying the named accountable GP and care coordinator (where applicable) and informing the patients. Achievement of this component will be determinant on practices having a minimum of 1.8% of patients on the register on 31 March 2015 as a proportion of the list size taken on the 1 January 2015.
- Component Five – an end-year payment of 15%
 - For reviewing and improving the hospital discharge process and for undertaking regular internal practice reviews of all unplanned admissions and readmissions for vulnerable patients.

Practices will need to ensure that they manage any in-year risk associated with changes in practice list size. In exceptional circumstances, for components two, three and four, which temporarily lead to the register falling below the tolerance, practices and their area teams will need to discuss and review the situation.

The component one payment will be payable by area teams on the last day of the month following the month in which the practice signed up to this service (i.e. no later than 31 July 2014). In the event a practice has not completed the minimum requirements linked to section one and part two of section two of the reporting template (see Annex D), including having in place personalised care plans for all patients on the register, then the area team will be able to claim back the payment made for component one.

The component two payment will be payable by area teams no later than 30 November 2014 subject to the practice delivering this component (i.e. for meeting the minimum requirements linked to section 2.1 of the reporting template – see Annex D).

The component three payment will be payable by area teams no later than 28 February 2015 subject to the practice delivering this component (i.e. for meeting the minimum requirements linked to section 2.1 of the reporting template – see Annex D).

The component four payment will be payable by area teams no later than 31 May 2015 subject to the practice delivering this component (i.e. for meeting the minimum requirements linked to section 2.1 of the reporting template – see Annex D).

While there is an accepted tolerance of -0.2 per cent in each quarter, practices will need to ensure that across the last three quarters of the financial year, their register maintains at least an average of two per cent of the eligible cohort. This will be calculated by taking an average of the percentages in each quarter (i.e. Q2 % + Q3 % + Q4 % divided by 3), calculated as described above in this section i.e. based on the list taken at the beginning of each quarter. In the event a practice has not maintained this average, then the area team will be able to claim back the payments made for quarters two and three and not make the quarter four payment (i.e. the full 40% or £1.15 per registered patient). If there are exceptional circumstances which lead to the average not being maintained, practices and their area teams will need to discuss and review the situation.

The component five payment will be payable by the area team on the last day of the month following the month during which the practice provides assurance that the minimum requirements of section three and section four of the reporting template were met (i.e. by no later than 31 May 2015). In the event a practice has not completed the minimum requirements of section three and section four of the reporting template (see Annex D), then the area team will not be required to make the component five payment.

CQRS will calculate the payments.

Table 1: Summary of payments, amounts and payment due dates

Payment	Percentage of total funding	Per registered patient (total £2.87)	Payable (no later than)
Component 1	45%	£1.29	31 July 2014
Component 2	20%	£0.57	30 November 2014
Component 3	10%	£0.29	28 February 2015
Component 4	10%	£0.29	31 May 2015
Component 5	15%	£0.43	31 May 2015

NHS England will be responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this ES. NHS England may make use of the information received or extracted.

Where required, practices must make available to area teams any information they require and that the practice can reasonably be expected to obtain, in order to establish whether or not the practice has fulfilled its obligation under the ES arrangements.

SECTION 6. OTHER PROVISIONS RELATING TO THIS ENHANCED SERVICE

Full details for the administrative provisions relating to this service are available in the NHS England ES Specification. It contains full details for provisions relating to practices that terminate or withdraw from the ES prior to 31 March 2015, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits.

This specification also sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Annex A. Template letters and leaflets to inform patients of enrolment into enhanced service

Template adult letter / email text

[Practice Address]

[DATE]

[Patient Address]

Dear [Patient Name]

New service for patients

The NHS has introduced a new service for people who are more at risk of an unplanned hospital admission in an emergency situation and who would be likely to benefit from more tailored, active support from their GP surgery. We would like to invite you to be one of the people who receive this service at our surgery. We believe personal care planning could help improve your health and wellbeing, as well as help to reduce the risk of unplanned hospital admissions.

As a member of this programme, you will have Dr XX as your named GP and they will have overall responsibility for the care and support that our surgery will provide you. We will also make sure that you have a named care coordinator, who may be your named GP or another health professional involved in your care and is likely to be the person you see the most. Your named care coordinator will be responsible for sharing information with you, [you carer] and – if you are happy for us to do so – with other health professionals involved in your care. Information would only be shared with other care organisations (e.g. hospitals, emergency services and if you have one, your social care team) to help coordinate your care. These new arrangements do not prevent you making an appointment or seeing any doctor, of your choosing within the surgery, as you would normally do.

Your named GP or named care coordinator will work with you to develop a personal care plan and review / discuss with you any changes needed. We will also invite, with your agreement, other health or care professionals involved in your care to help develop and keep your personal care plan up to date.

Your care planning discussion will help us (you, [your carer], your named GP and named care coordinator) to think about your health and care needs. With your agreement, your personal care plan will include information like:

- your NHS number
- details of the your named GP and care coordinator
- details of any other health or care professionals who are involved in your care
- confirmation that you have agreed to sharing your care plan with relevant health and care professionals
- details of your condition(s) and significant past medical history
- details of any medication(s) you are taking and plans for reviewing them
- any allergies you may have
- the action that you are taking to help manage your health
- how you can detect any early signs that your health may be worsening and what you should do if this happens
- who to contact if you think you need to see a doctor urgently

Your named GP and named care coordinator will work with you to review your health needs as often as necessary and at least every three months. They will ensure that you receive support from us and others to help you manage your health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer not to receive this service, please contact us on [phone number] or at [email address].

Kind Regards

[Name]

Template letter / email text (for a parent of a child on register)

[Practice Address]

[DATE]

[Patient Address]

Dear [Patient Name]

New service for patients

The NHS has introduced a new service for people who are more at risk of an unplanned hospital admission in an emergency situation and who would be likely to benefit from more tailored, active support from their GP surgery. We would like to invite your child, **[insert child's name]**, to be one of the children who receive this service at our surgery. We believe personal care planning could help improve his or her health and wellbeing, as well as help to reduce the risk of unplanned hospital admissions.

Your child will have Dr XX as his or her named GP and they will have overall responsibility for the care and support that our surgery provides to him or her. We will also make sure that he or she has a named care coordinator, who will be the named GP or another health professional involved with his or her care and is likely to be the person that he or she (and you) see the most. The named care coordinator will be responsible for sharing information with you, where appropriate your child and – if you and he or she (where appropriate) are happy for us to do so – with other health and care professionals involved in your child's care. Information would only be shared with other care organisations (e.g. hospitals, emergency services) to help coordinate care. These new arrangements do not prevent you making an appointment or seeing any doctor, of your choosing within the practice, as you would normally do.

Your child's named GP or named care coordinator will work with you and your child, where it is applicable to involve him or her, to develop a personal care plan for your child and review / discuss any changes needed. We will also invite, with your and where appropriate you child's agreement, other health and care professionals involved with your child's care to help develop and keep the personal care plan up to date.

Your child's care planning discussion will help us (you, your child if appropriate, your named GP and named care coordinator) to think about your child's health and care needs. With your agreement, your child's personal care plan will include information

like:

- the NHS number
- details of the named GP and care co-ordinator
- details of any other health and care professionals who are involved in your child's care
- confirmation that you have agreed to sharing your child's care plan with relevant health or care professionals
- **your name and contact details (as the child's parent)**
- details of your child's condition(s) and significant past medical history
- details of any medication(s) your child is taking and plans for reviewing them
- any allergies your child may have
- the action that you and your child can take to help manage his or her health
- how you can detect any early signs that your child's health may be worsening and what you should do if this happens
- who to contact if you think that your child needs to see a doctor or nurse urgently

Your child's named GP and named care coordinator will work with you and your child to review your child's health needs as often as necessary and at least every three months. They will ensure that you and your child receive support from us and others to help manage your child's health. We may also be able to help you find local community resources that you and your child may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse about your child, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer your child does not to receive this service, please contact us on [phone number] or at [email address].

Kind Regards

[Name]

Template letter / email text (for a guardian of a child on register)

[Practice Address]

[DATE]

[Patient Address]

Dear [Patient Name]

New service for patients

The NHS has introduced a new service for people who are more at risk of an unplanned hospital admission in an emergency situation and who would be likely to benefit from more tailored, active support from their GP surgery. We would like to invite **[insert child's name], to be one of the children who receive this service at our surgery.** We believe personal care planning could help improve his or her health and wellbeing, as well as help to reduce the risk of unplanned hospital admissions.

As a member of this programme, [patient name] will have Dr XX as his or her named GP and they will have overall responsibility for the care and support that our surgery provides to him or her. We also make sure that he or she has a named care coordinator, who may be the named GP or another health professional involved with his or her care and is likely to be the person he or she (and you) see the most. The named care coordinator will be responsible for sharing information with you, where appropriate the child and – if you and he or she (where appropriate) are happy for us to do so – with other health and care professionals involved in his or her care. Information would only be shared with other care organisations (e.g. hospitals, emergency) to help coordinate care. These new arrangements do not prevent you making an appointment or seeing any doctor of your choosing within the practice as you would normally do.

The child's named GP or named care coordinator will work with you and with the child, where it is applicable to involve him or her, to develop a personal care plan and review / discuss any changes needed. We will also invite, with your and where **appropriate the child's agreement, any other health or care professionals involved** with his or her care to help develop and keep this personal care plan up to date. **Your child's care planning discussion will help us** (you, the child if appropriate, the named GP and named care coordinator) to think about his or her health and care needs. With your agreement, the personal care plan will include information like:

- the child's NHS number
- details of the named GP and care co-ordinator

- details of any health or care professionals who are involved in **the child's** care
- confirmation that you have agreed to sharing the care plan with relevant health or care professionals
- **name and contact details for you as the child's guardian (and any other relevant next of kin)**
- details of the child's condition(s) and significant past medical history
- details of any medication(s) the child is taking and plans for reviewing them
- any allergies the child may have
- the action that you and the child will be taking to help manage his or her health
- how you can detect any early signs that the child's health may be worsening and what you should do if this happens
- who to contact if you think the child needs to see a doctor or nurse urgently

The named GP and named care coordinator will work with you and the child to review his or her health needs as often as necessary and at least every three months. They will ensure that you and the child receive support from us and others to help manage his or her health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer your child not to receive this service, please contact us on [phone number] or at [email address].

Kind Regards

[Name]

Template leaflet for adult patients

The NHS England has introduced a new service for people who are more at risk of an unplanned hospital admissions and who would be likely to benefit from more tailored, active support from their GP surgery. We believe personal care planning could help improve the health and wellbeing of patients receiving this service, as well as to help reduce the risk of unplanned hospital admissions.

[What does this mean for you, as a patient?](#)

As a member of this programme, you will have a named GP from our surgery and they will have overall responsibility for the care and support that our surgery provides for you. We will also make sure that you have a named care coordinator, who may be your named GP or another health professional involved in your care and who will likely be the person from our surgery who you see the most. Your named care coordinator will be responsible for sharing information with you, [your carer] and – if you are happy for us to do so – with other health or care professionals involved in your care. Information will only be shared with other care organisations (e.g. hospitals, emergency services and, if you have one, your social care team) to help coordinate your care. These new arrangements do not prevent you making an appointment or seeing any doctor of your choosing within the surgery, as you would normally do.

Your named GP and named care coordinator will work with you to develop a personal care plan and review / discuss any changes needed. We will also invite, with your agreement, other health and care professionals involved in your care to help develop and keep your personal care plan up to date.

Your care planning discussion will help us (you, [your carer], your named GP and named care coordinator) to think about your health and care needs. With your agreement, your personal care plan will include information like:

- your NHS number
- details of your named GP and care co-ordinator
- details of any other health and care professional who are involved in your care
- confirmation that you have agreed to sharing your care plan with relevant health or care professionals
- details of the your condition(s) and significant past medical history
- details of any medication(s) that you are taking and plans for reviewing them

- any allergies
- the action that you are taking to manage your health
- how you can detect any early signs that your health may be worsening and what you should do if this happens
- who to contact if you think that you need to see a doctor or nurse urgently.

Your named GP and named care coordinator will work with you to review your health needs as often as necessary and at least every three months. They will ensure that you receive support from us and others to help you manage your health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer not to receive this service, please contact us on [phone number] or at [email address].

Template leaflet for parents or guardians of child patients

The NHS has introduced a new service for people who are more at risk of an unplanned hospital admission in an emergency situation and who would be likely to benefit from more tailored, active support from their GP surgery. We believe personal care planning could help improve the health and wellbeing of patients receiving this service, as well as help reduce the risk of unplanned hospital admissions.

[What does this mean for your child or a child in your care?](#)

As a member of this programme your child will have a named GP from our surgery and they will have overall responsibility for the care and support that our surgery provides to him or her. We will also make sure that your child has a named care coordinator, who may be the named GP or another health professional involved in his or her care and who will likely be the person from our surgery who you and him or her see the most. **Your child's** named care coordinator will be responsible for sharing information with you, as their parent or guardian and – if you and your child (where appropriate) are happy for us to do so – with other health and care professionals involved in his or her care. Information will only be shared with other care organisations (e.g. hospitals, emergency services and if the child has one, the social care team) to help coordinate care. These new arrangements do not prevent you making an appointment or seeing any doctor, of your choosing within the surgery, as you would normally do.

Your child's named GP and named care coordinator will work with you and your child, where it is applicable to involve him or her, to develop a personal care plan and review / discuss with you any changes needed. We will also invite, with your and where appropriate your child's agreement, any other health and care professionals involved in your child's care to help develop and keep the personal care plan up to date.

The care planning discussion will help us (you, your child if appropriate, the named GP and named care coordinator) to think about your child's health and care needs. With your agreement, your child will have a personal care plan that includes information like:

- the child's NHS number
- details of the named GP and care co-ordinator

- details of any other health and care professionals who are involved in **your child's** care
- confirmation that you have agreed to sharing the care plan with relevant health and care professionals
- **name and contact details for you as the child's parent or guardian**
- details of your child's condition(s) and significant past medical history
- details of any medication(s) your child is taking and plans for reviewing them
- any allergies your child may have
- the action that you and your child are taking to help manage his or her health
- how you can detect any early signs that your child's health may be worsening and what you should do if this happens
- who to contact if you think that you need to see a doctor or nurse urgently

Your **child's named GP and named care coordinator will work with to review your child's** health needs as often as necessary and at least every three months. They will ensure that your child receives support from us and others to manage his or her health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer your child not to receive this service, please contact us on [phone number] or at [email address].

Annex B. Principles of personalised care planning

The ES requires practices to follow a collaborative process of personalised care planning with patients. It is important that the personalised care plan is developed collaboratively between the clinician, patient and if applicable the patient's carer(s). The patient and carer (if applicable) should feel informed and supported in managing their health and care needs. The personalised care plan should outline a coordinated package of care and the patient and their carer (if applicable) should have a copy of the written or electronic care plan. The personalised care plan should be reviewed at agreed regular intervals with the patient and the carer (if applicable) or as necessary.

Annex C. Care plan template

[NAME OF PRACTICE]
 [PRACTICE ADDRESS]
 [PRACTICE TELEPHONE NUMBER]

PERSONALISED CARE PLAN		
PATIENT INFORMATION		
Patient name:	Title:	NHS Number:
		Date of birth: / /
Address:		
Post code:		
Is the patient a nursing or care home resident: YES / NO		
Contact details:	Key safe door access code:	
Named accountable GP:	Care coordinator (if appropriate):	
Other named professionals (e.g. care coordinator, other healthcare professionals or social worker) involved in patient's care, if appropriate (include contact details where possible):		
<p>Has information been shared on the patient's behalf?: YES / NO If YES, by whom: (only applicable where the patient does not have the capacity to make this decision)</p> <p>Patient (or other allowed individual) consent to share information:</p> <ul style="list-style-type: none"> with other healthcare professionals involved in the patient's care, e.g. carer, OOH etc: YES / NO with the multi-disciplinary team: YES / NO 		
NEXT OF KIN / CARER / RESPONSIBLE ADULTS INFORMATION		
Name:	Title:	
Address (if different from above):		
Post code:		
Contact details:	Relationship:	
Additional emergency contact (if appropriate):		
Name:		
Contact details:	Relationship:	
PATIENTS MEDICAL INFORMATION		
Relevant conditions, diagnosis and latest test results:		

Significant past medical history:	
Current medication:	
Date of planned review of medications:	
Allergies:	
KEY ACTION POINTS	
For example: guidance on intervention / deterioration, unmet need to support patient (specify), agreed plan in emergency (ICE)/ useful situation etc.	
OTHER RELEVANT INFORMATION (if appropriate)	
Preferred place of care :	
Other support services e.g. local authority support, housing	
Identification of whether the person is themselves a carer (formal or informal) for another person	
Anticipatory care plan agreed: YES / NO/ N/A	Anticipatory drugs supplied: YES / NO/ N/A
Emergency care and treatment discussed: YES / NO	If yes, please specify outcome: e.g.: cardiopulmonary resuscitation – has the patient agreed a DNR or what treatment should be given if seizures last longer than x do y etc.
Date of assessment: / /	Date of review(s):
Any special communication considerations (e.g. patient is deaf or language communication differences):	
Any special physical or medical considerations (e.g. specific postural or support needs or information about medical condition - patient needs at least x mgs of drug before it works etc):	

SIGNATORIES (if appropriate and / or possible)	
Patient signature:	
	Date:
Carer (if applicable) signature:	
	Date:
Named accountable GP signature:	
	Date:
Care Coordinator signature (if applicable):	
	Date:

Annex D: Reporting template

[Name] Area Team / CCG

2014/15 Avoiding Unplanned Admissions Enhanced Service – Reporting Template

Practice Name:

Practice Code:

Signed on behalf of practice:

Date:

SECTION ONE - practice availability	Achieved (Y/N)
<p>1. <u>Supporting timely telephone access to A&E and ambulance staff decisions relating to hospital transfers and admissions relating to any patient on the practice's registered list.</u></p> <p>a. Please specify the practice's ex-directory or bypass telephone number given to A&E clinicians and ambulance staff, as well as the hours it is available.</p> <p>b. Please provide any information or feedback on the type of reasons for the number being used (if it has been used)?</p>	

2. Supporting timely telephone access to care and nursing home

- a. Please specify the practice's ex-directory or bypass number telephone number given to care and nursing homes (if different to the above), as well as the hours it is available.
- b. Please provide any information or feedback on the type of reasons for the number being used (if it has been used)?

3. Supporting timely telephone access to other care providers (e.g. mental health and social care teams)

- a. Please specify the practice's ex-directory or bypass number telephone number given to other care providers (if different to the above), as well as the hours it is available?
- b. Has the practice provided timely telephone access to other care providers who have any patient in crisis (who is registered with the practice) and at risk of admission, e.g. mental health providers, crisis teams, social care etc.?
YES / NO
- c. Please provide any information or feedback on the type of reasons for the number being used (if it has been used)?

4. Same day telephone access for urgent enquires for patients on the register

a. Has the practice a system in place to enable vulnerable patients, identified through risk profiling (i.e. on the register), who have urgent enquiries, to receive same day telephone consultation?

YES / NO

b. Please provide details of the system in place?

c. Please provide any information on the type of reasons for patients requesting a consultation and whether or not it helped to avoid an A&E attendance or admission

SECTION TWO - proactive case management

1. The case management register

Quarter two register

a. What was the percentage of eligible patients (aged 18 and over) on the register on 30 September 2014 as a proportion of list size taken on 1 July 2014?

b. If this percentage was below 1.8%, please provide reasons as to why.

c. Have all the patients on the register been informed of their named accountable GP and where applicable, their care co-ordinator?

YES / NO

Quarter three register

d. What was the percentage of eligible patients (aged 18 and over) on the register on 31 December 2014 as a proportion of list size taken on 1 October 2014?

e. If this percentage was below 1.8%, please provide reasons as to why.

f. Have all the patients on the register been informed of their named accountable GP and where applicable, their care co-ordinator?

YES / NO

Quarter four register

g. What was the percentage of eligible patients (aged 18 and over) on the register on 31 March 2015 as a proportion of list size taken on 1 January 2015?

h. If this percentage was below 1.8%, please provide reasons as to why.

i. Have all the patients on the register been informed of their named accountable GP and where applicable, their care co-ordinator?

YES / NO

Minimum register size across quarters two, three and four

j. What is the average percentage across the last three quarters of the financial year (Q2 % + Q3 % + Q4 % divided by 3)?

2. Proactive case management of patients on the register

- a. Have personalised care plans* been produced by the practice for all patients on the register (this must be for a minimum of 2% of the practice's adult population)?

- b. How many patients have refused to have a personalised care plan?

- c. Using relevant codes for patient care reviews, how many patients have had a proactive planned review?

- d. In addition to the minimum 2% of the adult population, how many children are being proactively case managed**?

*Area teams may request to audit some of the care plans to determine if they meet the minimum requirements as set out in the supporting guidance.

**For management information purposes only and not linked to any payment.

SECTION THREE - hospital discharge process

1. Timely patient contact post hospital discharge for patients on the register or newly identified as vulnerable
 - a. Have patients on the register been contacted post hospital discharge? Please provide evidence, including how long after the notification was received.
 - b. What recommendations has the practice made to the clinical commissioning group (CCG) and the area team to support whole system commissioning? Please provide brief details.

SECTION FOUR - internal practice reviews

1. Practice reviews of emergency admissions and A&E attendances for their registered patients living in care and nursing homes
 - a. How frequently has the practice undertaken the reviews? Please provide evidence (e.g. minutes / notes of meetings etc.).
 - b. What actions have been taken and lessons learnt to ensure co-ordination and delivery of care post hospital discharge for these patients?
 - c. Where relevant, what lessons have been learnt or changes made as a result of the practice reviewing emergency admissions and A&E attendances? Please provide details of any improvements been identified to processes and/or practice availability?

d. Have any patient care plans been amended as a result of these reviews?

YES / NO

e. What recommendations has the practice made to the clinical commissioning group (CCG) and the area team to support whole system commissioning? Please provide brief details.

2. Practice monthly reviews of all unplanned admissions, readmissions and A&E attendances for patients on the register

a. Has the practice undertaken monthly reviews of the register to consider what action can be taken to prevent unplanned admissions or A&E attendances of patients on the register?

YES / NO

b. What actions have been taken?

Please provide details and evidence, having regard to the list of considerations in the supporting guidance. (i.e. practice processes, factors that could have avoided the admission(s) and A&E attendance, rectifying any deficiencies in patient care plans, amending or improving the hospital discharge process and identifying any gaps in community or social care provision)

c. What recommendations has the practice made to the clinical commissioning group (CCG) and the area team to support whole system commissioning? Please provide brief details.

Notes

Reports are required to be submitted, to the area team and CCG, on a quarterly basis by no later than the last day of the month following the end of the relevant quarter. The final end year report (i.e. that for quarter four) should take account of the entire year and are due for submission to the CCG and the area team on or before 30 April 2015.

This reporting template should be read in conjunction with the specification and guidance.

It is the practice's responsibility to ensure that they are familiar with the guidance set out nationally and that they fully understand the ES requirements for the completion of reporting submissions. Failure to understand the requirements of this ES may result in components not being met and payments being withheld – see section on payment and validation in the guidance.

It is essential that practices engage with their CCG throughout the process. We will be working closely with the CCG leads throughout the year and it is anticipated the CCGs will be engaged in the initial assessment of the quality of submissions.

The reports should be submitted electronically and any additional documents should be scanned in where possible to minimise paper requirements. The submission email address [is...to be added by area team / will be confirmed closer to the deadline date]. Please contact your contract manager if you have any queries in the meantime.

SECTION 7. QUERIES PROCESS

Queries can be divided into three main categories:

1. those which can be resolved by referring to the specification or guidance
2. those which require interpretation of the guidance or Business Rules
3. those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

Where queries cannot be answered by reading this guidance document or any of the supporting Business Rules and FAQ documents, queries should be directed as follows:

1. Queries relating to Business Rules/coding queries should be sent to the HSCIC via enquiries@hscic.gov.uk. Where required, the HSCIC will work with other key stakeholders to respond.
2. Policy, clinical and miscellaneous queries should be sent to:
 - NHS Employers for NHS England area teams via GMScontract@nhsemployers.org
 - GPC for general practice via info.gpc@bma.org.uk

NHS Employers
www.nhsemployers.org

General Practitioners
Committee
www.bma.org.uk/gpc

NHS England
www.england.nhs.uk

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