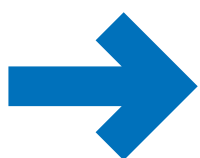


Providing proactive care and avoiding unplanned admissions for vulnerable people:

# A PROGRAMME OF **ACTION** FOR GENERAL PRACTICE ↗



The new enhanced service about to be introduced in general practice – together with new opportunities for clinical commissioning groups (CCGs) to shift funding into primary care services and community health services – are designed to bring about a step change in the quality of care for frail older people and other patients with complex needs.

The cohort of patients that you identify as having the greatest need will be enrolled onto a new, more proactive programme of care, tailored to their individual needs and overseen by a named, accountable GP. This short guide sets out how you and your CCGs can work together to ensure that we achieve the greatest possible benefits for patients – and how NHS England will support you.

## Background

As we all know, unplanned admissions to hospital are often distressing and disruptive for patients, carers and families and they are a significant and unnecessary cost to the NHS. Many unplanned admissions are for those who are frail or have complex physical and/or mental health and care needs; almost 30% of emergency admissions<sup>1</sup> and over 30% of emergency readmissions<sup>2</sup> are for people aged over 75. Multi-morbidity and poly-pharmacy increase clinical workload, so doctors, nurses and pharmacists need to work coherently as a team with a balanced clinical skill-mix. (For example, we know that around five to eight per cent of hospital admissions are due to preventable, adverse effects of medicines).

We are confident that many unplanned admissions can be avoided through freeing up more time for general practice to provide proactive care –

<sup>1</sup> HSCIC (2013) HES Admissions Statistics (<http://www.hscic.gov.uk/catalogue/PUB10584/ccg-ind-toi-mar-13-v4.pdf>).

<sup>2</sup> HES, HSCIC (2012/13). Analysis of finished emergency admissions by age at start of admission episode (acute & geriatric specialties) ([www.hscic.gov.uk/hes](http://www.hscic.gov.uk/hes))



and by ensuring that the right services are in place in the community to support patients.

In the GP contract negotiations between the GPC and NHS England, we agreed that we could do something about this – by radically reducing the size of the Quality and Outcomes Framework to free up your time and provide greater professional freedom, and by agreeing a new focus on proactive care for those at greatest risk.

But this will also require all of us to think differently about the way we plan and provide care for those who are more vulnerable or who have complex physical or mental health needs. And your CCGs also have a vital role to play in giving you – as accountable GPs – the confidence that your patients have access to the services they need.

**“Our ambition is that across the country at least 800,000 people will benefit from this approach to managing care. To achieve this ambition will mean restoring the link between family doctor and patients. General practice is uniquely placed in the health and care system to oversee the care of vulnerable and older people.”**

Jeremy Hunt, *Secretary of State for Health*

This short guide sets out:

1. What this means for general practice
2. What this means for clinical commissioning groups
3. What this will mean for patients and carers

This guide is published alongside more detailed technical guidance on the enhanced service. Standard templates, that you will be able to use for monitoring and for communication with patients, will also follow shortly See: <http://www.england.nhs.uk/resources/d-com/gp-contract/>.

## 1. What this means for general practice

**“GPs want the best care for their most vulnerable and frail patients. This requires a coordinated whole system approach spanning general practice, community services, acute and social care. It is vital that CCGs provide additional resources, as set out in the NHS England planning guidance, to support practices to play their part in this wider programme.”**

Chaand Nagpaul, *Chairman, General Practice Committee (GPC)*

With effect from 1 April 2014, we are retiring around one third of Quality and Outcomes Framework (QOF) points. The freed up funding will be used to fund a significant **new enhanced service** (worth around £20,000 for an average sized practice) that will benefit those patients who are most at risk of unplanned admission to hospital. We wanted to respond to what GPs had been saying for some time about the amount of unnecessary time and bureaucracy that was taken up by some of the QOF indicators.

How we will support you:

- ✓ A template letter that you can send to patients when they are first enrolled onto the programme setting out what they can expect from being part of this programme.
- ✓ Advice and guidance on data sharing and information governance, available at: <http://www.england.nhs.uk/ourwork/tsd/ig/risk-stratification/>
- ✓ Developing a Read code so that you can easily show when a patient care review has taken place.
- ✓ A forum/network that enables you to share ideas and examples of good practice to help spread innovation, including working with CCGs to invest in – and join up – primary care and community health services.



**“This should not be seen as just another ‘DES’. This is an opportunity to fundamentally change the way that we support people with more complex needs. If we can get it right for this group, we will then be in a much stronger position to get it right for everyone living with long term conditions and other vulnerable groups”**

Dr Mike Bewick, former GP and deputy medical director, NHS England



The key components of the **new enhanced service** will be for practices to:

- ✓ improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
- ✓ ensure that other clinicians can easily contact the practice by telephone to support decisions relating to hospital transfers or admissions;
- ✓ carry out regular risk profiling to identify at least two per cent of adult patients – and any children with complex needs – who will benefit from more proactive care management and to enrol them onto the new programme of proactive care;
- ✓ have one-to-one discussions with patients on the programme to agree and regularly review a holistic care plan that reflects their individual needs and wishes;
- ✓ provide proactive care and support for patients on the programme, including ensuring that patients have a named accountable GP and care coordinator;
- ✓ provide timely follow up by an appropriate professional in the practice team when a person is discharged from hospital, to that they receive coordinated care upon discharge;
- ✓ take part in internal reviews of unplanned admissions and/or readmissions and notify any serious incidents to the CCG and/or area team as appropriate.

We know that many practices are already working with their CCGs to develop innovative forms of proactive, person-centred care that go far beyond these key elements.

In addition, it would be good practice for the accountable GP to:

- ✓ review any unexpected events that involve patients on the programme and share information with CCGs to help promote shared learning from such events;
- ✓ work with the CCG and your hospital to improve arrangements for patients who are being discharged from hospital.



**“The RCGP strongly supports giving GPs the opportunity to lead a transformation of care for vulnerable older people in the community. We know that these patients, who are more likely to be living with multiple long term conditions, need care which goes beyond the standard ten minute consultation. They need proactive care from an expert generalist able to take the time to properly assess their needs holistically, combined with proactive support from a multi-disciplinary team. This programme is an important first step towards giving GPs the responsibility and the resources to substantially improve care for these patients and has the potential to have a positive impact on the NHS as a whole.”**

Maureen Baker, Chair of Council, Royal College of General Practitioners (RCGP)





## 2. What this means for clinical commissioning groups

**“Empowerment is vital for healthcare reform. Empowerment of primary care by commissioning for outcomes. Empowerment for patients based on local knowledge of their individual circumstances and needs to deliver improved quality of care. CCGs need to commission with NHS England in a co-ordinated manner, and general practice needs to work with patients to achieve these outcomes.”**

Dr Tim Dalton, *Clinical Chair, NHS Wigan Borough CCG*

To realise the full potential of these changes, you will need to work very closely with your CCG. We are asking CCGs to identify an overall lead for this new programme and to work with you – and the practices in your locality – to support implementation. You can play a key role in helping the CCG to commission services that will help you, as accountable GPs, to ensure that patients on the programme get the very best care and support for their physical health, mental health and social care needs.

NHS England’s recent planning guidance, ‘Everyone Counts’, set out an expectation that CCGs should identify at least £5 per patient from their budgets for 2014/15 and use this to support your plans for improving services for older people and those with more complex needs. This broadly equates to £50 per head for patients who are aged 75 and over. See: <http://www.england.nhs.uk/ourwork/sop/>.

CCGs should be using this funding to commission additional primary care services or community health services (over and above those provided under the new enhanced service) that you and other practices in your area have prioritised. It is important that you work closely with your CCG to make the best use of this £5 per patient. Any practice plans should complement the initiatives planned through the Better Care Fund for 2015/16, for which one of the criteria is an accountable professional for integrated packages of care.

Additional services based in general practice might include:

- ✓ funding for additional appointments;

- ✓ 7-day a week pre-planned care for defined patients;
- ✓ additional quality through additional staff.

Additional services based in the community that might support GPs in carrying out this enhanced service might include:

- ✓ rapid response community nursing;
- ✓ additional support from mental health service providers;
- ✓ designated district nursing;
- ✓ additional discharge coordinator services;
- ✓ additional support for carers;
- ✓ targeted social care services;
- ✓ additional services from voluntary and charitable organisations;
- ✓ additional use of services from pharmacy.

But this list is clearly not exhaustive, and we would like to hear from you as to how you and your CCG have used funding to enhance local services.

## 3. What this means for patients and carers

**“To build this new, proactive approach, we need to involve patients, carers and families – and we need to mobilise the full range of services – community mental health, pharmacy, social care, voluntary/charitable providers – who can help people stay independent for longer”**

Dr Martin McShane, *former GP and NHS England lead for Long Term Conditions*

Those patients enrolled onto this new programme of proactive care – and their carers and families – should:

- ✓ be confident that they will be contacted on a regular basis, and at least every three months;
- ✓ have a personalised patient care review to improve the quality and co-ordination of care;



- ✓ be confident that they can always speak to a GP or practice nurse by phone or, when necessary, have a same-day appointment;
- ✓ have a self-management plan, know who to contact if their health suddenly deteriorates (including out-of-hours);
- ✓ know what follow up care to expect upon discharge from hospital;
- ✓ know who their accountable GP is and that he or she has overall responsibility for the care they receive;
- ✓ have the confidence of knowing that their named, accountable GP or their care coordinator is overseeing their care and support on a proactive basis;
- ✓ know that the CQC – in its visits to practices – will assess the quality of care for people enrolled on this programme;

We are also exploring the possibility of developing a bespoke patient experience survey for people on the programme.

## How we will support you

We will provide you and your CCG with benchmarked information on a range of measures of success for this programme to help you identify the impact that you are having on quality of care, including patient experience, and rates of emergency hospital admissions, lengths of stay and available information on costs of care.

National Voices has produced a good practice guide to care and support planning: See [www.nationalvoices.org.uk/care-and-support-planning-information-professionals-and-supporters](http://www.nationalvoices.org.uk/care-and-support-planning-information-professionals-and-supporters)

## Next steps

We have worked with the BMA General Practitioners Committee to develop the guidance and detailed specification for this service, available at <http://www.england.nhs.uk/resources/d-com/gp-contract/>.

To have the greatest possible impact and achieve this step change in care for patients with the greatest needs, it is important that practices start to engage straight away with their CCG and with other service providers and with patient participation groups to prepare for the change.