

**Proactive care
programme:
CCG support
for
implementation**



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Description	This document is supporting guidance for CCGs for the Avoiding Unplanned Admissions enhanced service (ES) which 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. which 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.
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Cross Reference**Superseded Docs**
(if applicable)

Action Required	Area Teams to update local GMS contracts.
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Timing / Deadlines
(if applicable)

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Document Status

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Proactive care programme: CCG support for implementation

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Proactive Care Programme: CCG support for implementation

The new 2014/15 enhanced service ('Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people') now referred to as the 'proactive care programme', – together with new opportunities for CCGs to shift funding¹ into primary care services and community health services – is designed to bring about a step change in the quality of care for frail older people and other patients with complex needs.

This note sets out the key role that CCGs can play, working with member practices, to help make sure that these services deliver the maximum benefits for patients. This includes making sure that GP practices are able to use risk stratification tools to identify those patients who should be offered the new service.

Background

Under the enhanced service for the proactive care programme, GP practices will identify a cohort of patients with more complex needs (including mental health as well as physical health). This will be a minimum of two per cent of their adult registered list (patients aged 18 and over) who will be enrolled onto a new, more proactive programme of care, tailored to their individual needs and overseen by a named, accountable GP.

Our planning guidance for 2014/15 to 2018/19, 'Everyone Counts', asked CCGs to identify around £5 per patient from their budgets for 2014/15 and use this to support member practices' plans for improving services for patients with more complex needs.

CCGs should use this funding to pay for new primary care or community health services. Where the resource is used for services in general practice, CCGs should ensure these services are clearly over and above those which should be delivered through the basic GMS or PMS contract or within the enhanced service.

Role of CCGs

CCGs should identify a named lead for this new proactive care programme so that we can build up a network to develop more proactive and coordinated care for people with more complex health and care needs. This will also help us work together to review the emerging impact of the new arrangements and identify further improvements.

We anticipate that CCGs will also want to play a key role in helping member practices implement the new enhanced service effectively, both to enhance quality of care for people with more complex needs and to reduce avoidable unplanned hospital admissions.

This could involve supporting member practices in:

- risk stratification to identify which patients would benefit most from this programme (see next section);

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

- working with other provider organisations to develop multi-disciplinary teams to plan and provide care for patients on this new programme of more proactive, tailored care;
- improving care planning;
- developing standard procedures for multi-disciplinary team reviews;
- understanding gaps in service provision and working with providers to commissioner signpost to services;
- working with hospitals to ensure that practices receive timely information on when patients are admitted to hospital and when they are likely to be discharged from hospital and to plan better handover arrangements;
- supporting practices in meeting the needs of carers.

Risk stratification

The enhanced service requires that GP practices use a risk stratification tool approved by their CCG, wherever one is available.

We expect that CCGs will ensure that their commissioning support unit (CSU) provides this risk stratification service to their GP practices, or that an alternative is available. All CSUs are on the section 251 list of approved risk stratification suppliers and their tools/specifications have been verified.

CCGs could alternatively undertake risk stratification in-house, or arrange for a commercial supplier to provide the service, but only if the CCG itself – or the commercial supplier – is on the section 251 list of approved risk stratification providers.

Annex A sets out more detailed advice on risk stratification and how to secure maximum benefits from risk stratification tools .

Assurance

NHS England area teams will be responsible for assuring themselves that the new enhanced service is being implemented effectively. As part of their processes for quality improvement and peer review, CCGs may wish to support member practices in helping provide assurance that the new programme is delivering its intended benefits for patients and in signposting practices to additional support where they need it.

Area teams and CCGs may also agree more specific local arrangements whereby CCGs undertake some aspects of monitoring and assurance on behalf of NHS England.

The specific areas that practices will need to have systems in place to meet the requirements of this service and on which area teams and CCGs need to be able to provide assurance are as follows:

- provide timely telephone access, via an ex-directory or by-pass number, to A&E and ambulance staff to support decisions about hospital transfers and admissions, and to nursing and care homes to discuss the best course of action when someone's condition deteriorates

- provide timely telephone access to other care providers (e.g. mental health and social care teams) to be able to obtain advice when a patient is at risk of an unplanned hospital admission
- ensure that patients on the programme are able to obtain same-day telephone consultations when they have urgent enquiries and, where appropriate, follow-up appointments
- ensure proactive care management for those enrolled on the programme
- follow up rapidly and coordinate patient care after discharge from hospital
- regularly review emergency admissions and A&E attendances for patients in nursing and care homes
- carry out monthly reviews of all unplanned admissions, readmissions and A&E attendances for patients enrolled on the programme and agree follow-up action

Next steps

Area teams will liaise with CCGs to:

- identify the CCG lead for the proactive care programme;
- agree any local arrangements for monitoring and assurance.

Risk Stratification

The new enhanced service is designed to ensure that GP practices provide proactive, person-centred care for at least 2 per cent of adult registered patients with the most complex health needs and who are at highest risk of unplanned hospital admission.

The enhanced service requires GP practices to use a risk stratification tool approved by their CCG, wherever one is available.

This note sets out how CCGs can ensure that their GP practices are able to use risk stratification tools in ways that are compliant with current information governance requirements to help them identify patients who should be offered proactive care to help reduce their risk of unplanned hospital admission.

In most cases, we anticipate that CCGs will wish to achieve this by ensuring that their commissioning support unit (CSU) provides a high quality risk stratification service to their GP practices. All CSUs are included on a list of approved risk stratification suppliers; their tools and specifications have been verified by the confidentiality advisory group and have been given legal (Section 251) cover.

To ensure that CSUs can provide this service, CCGs will need to ensure that:

- a) GP practices have privacy notices in place to make patients aware of the uses to which their data will be put, including risk stratification;
- b) GP practices, in their capacity as data controllers, have (i) a data sharing agreement in place with the CCG for risk stratification and (ii) a data sharing contract with the CSU to cover their responsibilities as to how GP data can be used;
- c) they have completed the assurance statement (available at <http://www.england.nhs.uk/wp-content/uploads/2014/02/rsa-state-02-141.pdf>) and have in place assurance processes for the specific requirements (e.g. contractual clauses, data exclusions, retention and process for undertaking risk stratification);
- d) CSUs are able to provide assurance that their risk stratification processes comply with the assurance statement.

Once these steps have been completed, CSUs will be able to: draw data from (i) the Health and Social Care Information Centre's Data Services for Commissioners Regional Offices (DSCROs) and (ii) from GP clinical systems into their risk stratification tool; conduct analyses; and provide reports to GP practices.

CCGs could alternatively undertake risk stratification in-house, or arrange for a commercial supplier to provide the service, but only if the CCG itself – or the commercial supplier – is on the section 251 list of approved risk stratification providers. In these cases, the CCG would need to complete steps (a) to (c) above and have a service level agreement (SLA) arrangement with a CSU for the secondary care data to be released from a DSCRO.

Top tips for risk stratification programmes

1. Consider using a risk stratification tool that uses data from both primary care and secondary care. Such tools can identify patients who are at high risk of unplanned admission who have previously used hospital services but may not have been frequent users of GP services.
2. Make sure you understand the concepts of 'sensitivity' and 'positive predictive value', and how these metrics may be traded off against each other for the tool that you are using (see Nuffield Trust, 2011, p10).
3. Make sure you understand the difference between a patient's risk of future unplanned admission and the likelihood that their risk will be mitigated by the preventive care to be offered, which is sometimes known as their 'impactibility' (see Lewis 2010) .
4. Ensure that you are not inadvertently worsening health care inequalities by excluding certain patient groups, such as patients with alcohol issues or patients with mental health problems such as a personality disorder (see Lewis 2010).
5. Consider the wellbeing of the patient's partner, carers and family members, which can have a significant impact on risk of prolonged hospital admissions.
6. Follow the NHS England Risk Stratification guidance on how to set up the programme and track benefits (see NHS England 2013).
7. Undertake a privacy impact assessment to identify how to make sure that patients know how their data will be used and the benefits for them (see Information Commissioner's Office).
8. The benefits of risk stratification arise ultimately from the quality of the preventive intervention offered to high-risk individuals. Use risk stratification as a service planning tool to help inform the choice of potential interventions needed, including wider community-based services.
9. Be clear how you are going to monitor and evaluate the impact of the programme, including ensuring that you have good baseline data and that you take account of the phenomenon of 'regression to the mean'. Options for evaluation include propensity score matching and regression discontinuity analysis (see Steventon 2013).

Further reading

1. NHS England guidance on risk stratification 2013 (<http://www.england.nhs.uk/wp-content/uploads/2014/02/ig-risk-ccg-gp-2.pdf>)
2. Choosing a predictive risk model: a guide for commissioners in England (http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/choosing_predictive_risk_model_guide_for_commissioners_nov11_0.pdf)
3. Lewis G (2010) "Impactibility models": identifying the subgroup of high-risk patients most amenable to hospital-avoidance programs', *Milbank Q* 88(2), 240–255

4. Information Commissioner's Office. Privacy Impact Assessment Handbook version 2.
http://ico.org.uk/pia_handbook_html_v2/files/PIAhandbookV2.pdf
5. Steventon A (2013). Evaluation methods – where can predictive risk models help?
http://www.nuffieldtrust.org.uk/sites/files/nuffield/adam_steventon_evaluation_methods_080713.ppt