

Enhanced service specification

Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people



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1 Introduction

- 1.1 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.
- 1.2 The enhanced service will commence on 1 April 2014 for one year, subject to review.

2 Aims

- 2.1 The aims of this ES in 2014/15 are to encourage GP practices to:
 - a. increase practice availability via timely telephone access;
 - b. identify patients who are at high risk of avoidable unplanned admissions, establish a minimum two per cent case management register and proactively manage these patients;
 - c. review and improve the hospital discharge process for patients on the register and coordinate delivery of care; and
 - d. undertake internal practice reviews of emergency admissions and A&E attendances.

3 Process

- 3.1 Area teams will seek to invite GP practices to participate in this enhanced service by 31 May 2014. GP practices wishing to participate will be required to sign up to it by no later than 30 June 2014. GP practices signing up to this service will be signing up to all components.
- 3.2 NHS England will record GP practices' participation on the Calculating Quality Reporting Service (CQRS). CQRS calculates and reports quality and outcomes, including those enhanced services where achievement data can be obtained from clinical systems, via the GP Extraction Service (GPES).

3.3 GP practices signing up to this enhanced service by 30 June 2014 will qualify for the component one payment set out in the payment and validation section below.

4 Specification

4.1 The requirements for GP practices participating in this enhanced service cover four areas and are as follows:

a. Practice availability

- i. The practice will provide timely telephone access via an ex-directory or by-pass number to ambulance staff and A&E clinicians to support decisions about hospital transfers and admissions relating to any patient on their registered list¹. 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 by-pass 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

¹ 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.

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 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.

b. 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 registered² 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 the Exeter (NHAIS) system 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 register³.
- iv. In each quarter a tolerance of -0.2% will be allowed (i.e. a register size of 1.8%) 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 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

² Head count and not weighted list

³ Children on the case register will not be counted towards the minimum two per cent as detailed in the payment and validation section.

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.
- 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 July 2014⁴. 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 September 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.

⁴ This applies to patients initially added to the register who are under the age of 75. Any patient on the register aged 75 and over would already have been informed as per the requirements for Named GP for patients aged 75 and over. However, patients aged 75 and over will still need to be informed of their inclusion on the register and the name of their care coordinator if applicable.

- xi. Personalised care plans should be developed taking account of the supporting ES guidance.
- xii. 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.
- xiii. The personalised care plan should, where possible and through encouragement from the attending practitioner, include a record 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.
- xiv. The patient's care and personalised care plan should be reviewed at agreed regular intervals with them and if applicable, their carer. 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. 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.

- xvi. 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.
- xvii. 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 any changes made to their personalised care plan (if applicable). 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 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.

c. **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.

d. 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 reviews⁵ of all unplanned admissions and readmissions and A&E attendances of patients on the

⁵ The reviews are to understand why each individual admission or attendance occurred and whether it could have been avoided.

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; and
- 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.

5 Data

5.1 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.

6 Monitoring

6.1 The practice will complete a reporting template on a quarterly⁶ 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 of 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

⁶ 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.

(see Annex A). 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.

6.2 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, the Local Medical Committee should be involved.

6.3 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.

6.4 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 reporting template – see Annex A.

6.5 For information on how to manually enter data into CQRS, please see the Health and Social Care Information Centre (HSCIC) website⁷.

⁷ <http://systems.hscic.gov.uk/cqrs/participation>

- 6.6 Details as to when and if GPES is available to support this ES will be communicated via the HSCIC.
- 6.7 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 “Technical requirements” document for the 2014/15 GMS contract⁸ 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.
- 6.8 CCGs will be involved in supporting practices to deliver this ES.

7 Payment and validation

- 7.1 Area teams will seek to invite practices to participate in this ES before 31 May 2014. Practices wishing to participate will be required to sign up to this service by no later than 30 June 2014.
- 7.2 The total funding available for this ES is £162 million.
- 7.3 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

⁸ <http://www.nhsemployers.org/GMS2014-15>

initial CRP if the practice's contract started after 1 April 2014. A practice with an average list size of 7,087 would receive payments of £20,339.69 for delivering the ES in full.

7.4 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 plans⁹ 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%¹⁰ 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 accountable GP and care coordinator (where applicable) and informing the patients. Achievement of

⁹ Personalised care plans should be agreed for patients on the register initially by end of September 2014 and thereafter for any new patients within one month of entering the register.

¹⁰ This takes into account the -0.2% tolerance.

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.

7.5 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.

7.6 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 A), including having in place personalised care plans for all patients on the register, as per the timeframes outlined in this document, then the area team will be able to claim back the payment made for component one. All claw backs will be made at the end of the year.

- 7.7 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 A).
- 7.8 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 A).
- 7.9 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 A).
- 7.10 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. $Q2 \% + Q3 \% + Q4 \% \text{ divided by } 3$), 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.
- 7.11 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 A), then the area team will not be required to make the component five payment.

7.12 Area teams will be required to calculate the payments relating to components one and five. CQRS will calculate the payments relating to components two, three and four.

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

7.13 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.

7.14 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.

Annex A: 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 by-pass 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>	
<p>2. <u>Supporting timely telephone access to care and nursing home</u></p> <p>a. Please specify the practice's ex-directory or by-pass number telephone number given to care and nursing homes (if different to the above), 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>	
<p>3. <u>Supporting timely telephone access to other care providers (e.g. mental health and social care teams)</u></p> <p>a. Please specify the practice's ex-directory or by-pass number telephone number given to other care providers (if different to the above), as well as the hours it is available?</p> <p>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</p> <p>c. Please provide any information or feedback on the type of reasons for the number being used (if it has been used)?</p>	
<p>4. <u>Same day telephone access for urgent enquires for patients on the register</u></p> <p>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</p> <p>b. Please provide details of the system in place?</p> <p>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</p>	

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.

Annex B: Administrative provisions relating to payments under the enhanced service for avoiding unplanned admissions: proactive case finding and patient care review for vulnerable people

1. Payments under the enhanced service for avoiding unplanned admissions: proactive case finding and patient care review for vulnerable people are to be treated for accounting and superannuation purposes as gross income of the GP practice in the financial year.
2. The amount calculated as payment for the financial year as regards to:
 - a. **Component one** - falls due on the last day of the month following the month during which the GP practice agrees to participate in this enhanced service (i.e. 31 July 2014).
 - b. **Component two** - falls due on the last day of the month following the month during which the GP practice provides the assurance that the case management register remained at a minimum of two per cent per cent, in the eligible patient cohort, in the second quarter of the financial year (i.e. 30 November 2014).
 - c. **Component three** – falls due on the last day of the month following the month during which the GP practice provides assurance that the case management register remained at a minimum of two per cent, in the eligible patient cohort, across the third quarter of the financial year (i.e. 28 February 2015).
 - d. **Component four** – falls due on the last day of the month following the month during which the GP practice provides assurance that the case management register remained at a minimum of two per cent, in the eligible patient cohort, across the fourth quarter of the financial year (i.e. 31 May 2015).
 - e. **Component five** - falls due on the last day of the month following the month during which the GP practice provides assurance that the minimum requirements of the section three and section four of the reporting template were met at the end of the financial year (i.e. 31 May 2015).
3. Payments under this enhanced service, or any part thereof, will be made only if the GP practice satisfies the following conditions:
 - a. the GP practice must make available to the NHS England any information which NHS England needs, and the GP practice either has or could be reasonably expected to obtain, in order to establish whether the GP practice has fulfilled its obligation under the enhanced service arrangements;
 - b. the GP practice must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System or CQRS, and do so promptly and fully; and,

- c. all information supplied pursuant to or in accordance with this paragraph must be accurate.
- 4. If the GP practice does not satisfy any of the above conditions, NHS England may, in appropriate circumstances, withhold payment of any, or any part of, an amount due under this enhanced service that is otherwise payable.
- 5. If NHS England makes a payment to a GP practice under this service and—
 - a. the contractor was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due), or
 - b. NHS England was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid, or
 - c. NHS England is entitled to repayment of all or part of the money paid.

NHS England may recover the money paid by deducting an equivalent amount from any payment payable to the GP practice, and where no such deduction can be made, it is a condition of the payments made under this enhanced service that the contractor must pay to NHS England that equivalent amount.

- 6. Where NHS England is entitled under this enhanced to withhold all or part of a payment because of a breach of a payment condition, and NHS England does so or recovers the money by deducting an equivalent amount from another payment in accordance with paragraph 5 of this annex, it may, where it sees fit to do so, reimburse the contractor the amount withheld or recovered, if the breach is cured.

Provisions relating to GP practices that terminate or withdraw from the enhanced service prior to 31 March 2015 (subject to the provisions below for termination attributable to a GP practice split or merger)

- 7. Where a GP practice has entered into the enhanced service *avoiding unplanned admissions: proactive case finding and care review for vulnerable people* but its primary medical care contract subsequently terminates or the GP practice withdraws from the enhanced service prior to 31 March 2015, the GP practice is entitled to a payment in respect of its participation, calculated in accordance with the provisions set out below. Any payment calculated will fall due on the last day of the month following the month during which NHS England has all the information it needs to calculate such a payment.
- 8. In order to qualify for payment in respect of participation under the enhanced service, the GP practice must provide NHS England with the information under *paragraph 9 and 11 of the enhanced service specification* before payment will be made. This information should be provided in writing, within 28 days following the

termination of the contract or the withdrawal from the enhanced services agreement.

9. The payment due to GP practices who terminate or who withdraw from the enhanced service agreement prior to 31 March 2015 will be calculated¹¹ as:
 - a. **Component one** – calculated as £1.29 divided by 365 days, multiplied by the number of days the GP practice provided the service during the financial year, multiplied by CRP as at 1 April 2014;
 - b. **Component two** – calculated as £0.57 divided by 91 days, multiplied by the number of days the GP practice provided the service during the second quarter of the financial year, multiplied by CRP as at 1 April 2014 and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
 - c. **Component three** – calculated as £0.29 divided by 92 days, multiplied by the number of days the GP practice provided the service during the third quarter of the financial year, multiplied by CRP as at 1 April 2014 and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
 - d. **Component three** – calculated as £0.29 divided by 92 days, multiplied by the number of days the GP practice provided the service during the fourth quarter of the financial year, multiplied by CRP as at 1 April 2014 and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
 - e. **Component five** – calculated as £0.43 divided by 365 days, multiplied by the number of days the GP practice provided the service during the financial year, multiplied by CRP as at 1 April 2014.

Provisions relating to GP practices who merge or split.

10. Where two or more GP practices merge or are formed following a contractual split of single GP practice and as a result the registered population is combined or divided between new GP practice(s), the new GP practice(s) may enter into a new or a varied agreement to provide the enhanced service for avoiding unplanned admissions: proactive case finding and patient care review for vulnerable people.
11. The enhanced service agreements of the GP practices that formed following a contractual merger, or the GP practice prior to contractual split, will be treated as having terminated and the entitlement of the GP practice(s) to any payment(s) will be assessed on the basis of the provisions of paragraph 9 of this annex.

¹¹ Providing the GP practice can demonstrate delivery of the minimum requirements of the service specification for each payment component.

12. The entitlement to any payment(s) of the GP practice(s), formed following a contractual merger or split, entering into the new or varied agreement for the enhanced service, will be assessed and any new arrangements that may be agreed in writing with NHS England will commence at the time the GP practice starts to provide such new arrangements.
13. Where that new or varied agreement is entered into and the new arrangements commence within 28 days of the new GP practice(s) being formed, the new arrangements are deemed to have commenced on the date of the new GP practice(s) being formed. Payment will be assessed in line with the enhanced service specification – subject to provisions of paragraph 14 of this annex.
14. NHS England is entitled to make an adjustment to the payment, or any part thereof, if payment has already been made or is payable to the previous GP practice(s) for participating in the enhanced service. The adjustment may be:
 - a. **Component one** - calculated as £1.29 divided by 365 days, multiplied by the number of days remaining in the financial year from the date of the new arrangements, multiplied by the number of registered patients;
 - b. **Component two** – calculated as £0.57 divided by 91 days, multiplied by the number of days remaining if quarter two from when the new arrangements came into place, multiplied by the number of registered patients and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
 - c. **Component three** – calculated as £0.29 divided by 92 days, multiplied by the number of days remaining if quarter three from when the new arrangements came into place, multiplied by the number of registered patients and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
 - d. **Component four** – calculated as £0.29 divided by 92 days, multiplied by the number of days remaining if quarter four from when the new arrangements came into place, multiplied by the number of registered patients and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
 - e. **Component five** - calculated as £0.43 divided by 365 days, multiplied by the number of days remaining in the financial year from the date of the new arrangements, multiplied by the number of registered patients.

Provisions relating to non-standard splits and mergers

15. Where the GP practice participating in the enhanced service is subject to a split or a merger and—
 - a. the application of the provisions set out above in respect of splits or mergers would, in the reasonable opinion of NHS England, lead to an inequitable result; or,

- b. the circumstances of the split or merger are such that the provisions set out in this section cannot be applied,

NHS England may, in consultation with the GP practice or GP practices concerned, agree to such payments as in NHS England's opinion are reasonable in all circumstances.

[ENDS]