

**Facilitation of Admission Avoidance (FAAs)
Service Level Agreement Local Improvement Scheme 2023-2024**

Service	Facilitation of Admission Avoidance Local Improvement Scheme (FAAs LIS)
Commissioner Lead	Jackie Bryan, Primary Care Programme Lead
Provider Lead	Primary Care
Agreement Period	1 June 2023 to 31 March 2024
Date of Review	January 2024

Summary of key changes and requirements for 2023-2024 scheme

Variations of this LIS Scheme have been in place for nine years and the scheme has been reviewed and developed during this time.

This 2023-24 updated version of the scheme has the following additions or emphasis on existing areas:

- NEW: Exclude / remove patients on the learning disability register from this scheme's patient cohort
- NEW: Requirement to check patients are up to date with LTC reviews and book these in if outstanding, where possible, or encourage this to be done
- NEW: 4 new metrics to be reported on for moderately frail patients (with a Rockwood score of 4, 5 and 6)
- NEW: Requirement to follow up the moderately frail patients (with a Rockwood score of 4, 5 and 6) between 3-6 months after initial assessment to collate information on 4 key metrics. For 2023-24 practices will be targeted to follow-up between 15-20% of these patients from the 4% list.
- NEW: Requirement to be part of a Frailty Network / Community of Practice (learning group). Practices should nominate one representative who undertakes the assessments.
- NEW: Predictive Case Finding Tool. Staffordshire & Stoke-on-Trent ICB alongside system partners and a specialist provider (HN) are developing a predictive case finding tool aimed at proactively identifying patient cohorts. The first phase of the pilot for moderate frailty will take place in the South Staffs with the Staying Well Service. This will be a proof of concept to test out the accuracy of the tool in identifying appropriate patients with moderate levels of frailty to be recruited into service. If the pilot phase is successful - the approach will be adopted and rolled out to North providers who will need to commit to adopt this model of pro-active identification through predictive case finding.
- Recommend an annual medication review for all patients where applicable (can be PCN or practice-based clinician)
- Requirement for staff providing the FAA service to demonstrate attendance at training events that are provided
- Requirement to provide patients with advice on minimising risk of falls
- Requirement to provide patient with clear referral options at the end of the review, I.e. IAPT, carers, falls (only for 3+ falls), this should include the Social Prescribing Link Worker (for advice on cold homes, benefits, etc.)

Further information on the above points can be found within the main body of this document.

1. Population Needs

Evidence based, national and local context

Who is at risk of emergency admission?

There are a number of factors that are associated with increased rates of admission, and therefore it is important to consider when targeting interventions to reduce avoidable admissions.

Age

Age is a risk factor for emergency hospital admission, with babies or very young children and older people being at higher risk. However, it is important to recognise that only those aged 5 to 14 years have low risk.

There is evidence to show the elderly population account for 66% of all hospital admissions, and 40% of all emergency admissions. Factors known to contribute to hospital admission in elderly people are numerous and include intrinsic and extrinsic factors:

a) Intrinsic factors:

- Ageing process (risk increases over 65 years)
- Poor mobility
- Cognitive impairment /confusion/agitation (memory loss)
- Continence problems
- History of falls
- Medical conditions
- Sensory deficits (vision, hearing, sensation)
- Poor nutritional status
- Emotional distress/depression
- Social isolation

b) Extrinsic factors:

- Medication known to affect balance/cognition
- Polypharmacy
- Lack of exercise
- Environmental hazards (steps, stairs, worn carpets, rugs etc.)
- Inability to provide appropriate nutrition due to physical factors (lack of transport to shops, inability to use equipment for preparing/cooking etc.)
- Lack of social stimulation and community

Social deprivation

There is evidence that people who live in areas of socio-economic deprivation have higher rates of emergency admissions, after adjusting for other risk factors. In the UK, admission rates are significantly correlated with measures of social deprivation. Socio-demographic variables explain around 45 per cent of the variation in emergency admissions between GP practices, with deprivation more strongly linked to emergency than to elective admission. Practices serving the most deprived populations have emergency admission rates that are around 60–90 per cent higher than those serving the least deprived populations.

Strategic direction

The proposed approach is reflective of national policies:

The NHS 10-year plan (January 2019) - which sets out a vision and plan for significant change in the way that frailty is managed. Currently, most NHS medical contacts occur following a call to NHS 111 or 999, or by a patient visiting a pharmacy, GP practice, urgent care centre or A&E. Moving forwards, this will shift and be supplemented by a move to 'population health management', using predictive prevention to better support people to stay healthy and avoid illness complications. The Frailty pathway is congruent with the major changes to the NHS service model set out in the NHS long term plan, which include:

- Boosting 'out-of-hospital' care
- Giving people more control over their own health, and more personalised care when they need it
- Forging local partnerships and care pathways between primary care and other providers including local authorities working towards Integrated Care Systems (ICSs).

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (January 2019) - which provides additional investment, makes changes to help workforce and workload challenges and delivers expansion in services in primary care.

2. Outcomes

• NHS Outcomes Framework Domains and Indicators

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

• Local Defined Outcomes

- The patient and/ or representative shall feel involved in all aspects of their care planning.
- The patient and/ or representative shall feel empowered to make decisions and choices about all aspects of their life, condition, care and services accessed.
- The patient and/ or representative shall feel that they are at all times treated with dignity and respect.
- Enhanced patient and carer experience, independence, satisfaction with the service received and quality of life.
- Assessment per patient and care plan interventions will reduce avoidable hospital attendance and admissions

Data requirements and evaluation frameworks

Practices will agree to record information and share data related to service delivery, patient experience of the service and the sharing of best practice. Practices will be required to complete a service delivery summary template, to be provided by the ICB, at the end of each financial year.

The new outcome measures for moderately frail patients (with a Rockwood score of 4, 5 and 6) are:

1. Lifestyle – Increased physical activity

- Total number and % of patients where low level of physical activity has been identified
- Subset - number and % of patients reporting increased activity/within their capability

2. Quality of life - Reduced Loneliness

- Number and % of people reporting loneliness overall scores reported
- Number and % of people reporting reduced loneliness
- Number and % scores increasing using validated measure following intervention i.e. referral to social prescriber

3. Quality of Life / Wellbeing – health related quality of life measure

- Health Related Quality of Life Measure - EQ5D / EQ5D5L to form part of the assessment process and re-visited at review
- Number and % scores that have improved

4. Health Literacy - Number of medication reviews

- Number and % of patients who have been identified as needing a structured medication review

These measures will be captured by the clinical template on your system provided by the Data Quality Team.

3. Scope

Aim and objectives of service

The aim of the Facilitation of Admission Avoidance Scheme (FAAs) is to support frail patients by assessing their individual needs with delivery and support to access safe and effective services to improve outcomes and reduce avoidable hospital attendance or admission.

This service compliments the requirements within QOF for the identification and management of severe and moderate frailty.

The objectives of this LIS are to:

- Increase early identification of frailty
- Provide fast, timely access to assessment, treatment and care
- Prevent avoidable hospital attendance and admission or re-admission
- Raise awareness and access to local services most appropriate to the patients' needs
- Develop an individual care plan
- Support frail patients to 'stay well for longer'

QOF contract requirements

From 1 July 2017, practices were nationally commissioned to use an appropriate tool to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty, the practice should deliver an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions.

This LIS supports practices to extend the requirements of the national contract and support patients with proactive service(s) aiming to improve patient outcomes and reduce avoidable hospital attendance or admission.

ICB Practice Validation Visits

The ICB is contractually obligated to carry out monitoring and audits of Local Improvement Schemes to meet a variety of key requirements. These audits could take the form of either a clinical and/or quality and/or financial audit. The ICB will continue with a programme of practice validation visits throughout the year to ensure the delivery of the scheme by practices is of a high quality, and that the substantial amount of funding invested in the scheme by the ICB is delivering value of return.

All practices participating in this Facilitation of Admission Avoidance Scheme are required to fully participate in and support a validation visit if requested to do so by the ICB.

Validation checks will involve ICB representative(s) reviewing a random selection of patient's records (who are part of the proactive cohort). The review will ascertain if the appropriate clinical review has been undertaken and information has been captured and care delivered as required by the scheme. *Please refer to appendix 1 of this document which gives further details of the validation visits.*

The validation visits undertaken during the 2022-23 period have allowed the ICB to identify good practice and areas for improvement in delivery with practices being advised and supported accordingly. During the visits it was found that not all staff involved in the delivery of the scheme are always fully aware of all the requirements of the scheme. Therefore, the ICB are recommending that it is best practice for practices to create a scheme delivery protocol. An example of areas for consideration for inclusion in a protocol can be found in Appendix 5.

Target Population

Proactive Cohort

The volume of activity for each year of this scheme will be set at **4% of list size as of 1 January 2023**. Practices are encouraged to work with practices within their PCN to jointly agree the basis for inclusion within a practice's cohort utilising one or more of the available risk stratification tools such as Aristotle and/or eFI. *There are no age restrictions to who can be included within the cohort. Practices should aim to include within the cohort the patients who are most at risk of becoming frail and who will benefit the most from a greater level of practice support this scheme brings.*

Practices should exclude / remove LD patients from the FAA cohort.

Practices within a PCN may also wish to agree to use one or more of the Clinical assessment validated tools such as Rockwood, Tilburg, Edmonton, PRISMA 7 or gait speed.

Please refer to document 'FAA LIS 2023-24 Coding Guide' for further details of clinical codes relevant to this scheme.

A minimum requirement of this 2023-24 scheme is for all patients within the practices cohort to have a Rockwood Clinical Frailty Scale (CFS) completed during the period of this 2023-24 specification. It is expected that this will be completed on an ongoing basis as part of every Health and Social Needs Assessments consultation. Free training on the Clinical Frailty Scale can be accessed via: [Clinical Frailty Scale \(CFS\) Training Module - Overview | Rise 360 \(articulate.com\)](https://www.articulate.com). Appendix 4 gives an example of the CFS template.

Proactive Service description

Practices will have previously identified the most appropriate members of the practice team to provide proactive case management which has been historically funded through variations of this LIS.

The practice are asked to provide the following:

- **Newly identified patients to the proactive cohort:** A health and or social needs assessment will be undertaken for all patients newly identified in order to determine the support and further actions required.
- **Existing proactive cohort patients:** Patients already receiving proactive case management from the practice will undergo a comprehensive annual review of health and social needs utilising a Patient Care Facilitator (PCF) role supported by the wider practice clinical team as appropriate.
- **Proactive cohort patients:** Assessments and reviews can be provided by any of the following:
 - patient's home

- GP practice
- virtually
- telephone

Best practice is for assessments and reviews to be provided face to face to ensure the maximum benefit is received by the patient.

- **Follow Ups:** Requirement to follow up the moderately frail patients (with a Rockwood score of 4, 5 and 6) between 3-6 months after initial assessment to collate information on 4 key metrics. For 2023-24 practices will be targeted to follow-up between 15-20% of these patients from the 4% list.

The Health and Social Needs Assessment

This will be recorded in the patient's record on the practice clinical system and a summary or care plan will be provided to the patient.

NB: The content of assessment delivered by the Patient Care Facilitator (PCF) may vary as different staff groups are carrying out this function, therefore, to complete a comprehensive health and social needs assessment some elements may need to be undertaken by an appropriate clinician.

The assessment will include:

H&SN Assessment Requirement	Health Assessment	Non-Health Assessment
Cognitive Screening / Dementia screening using 6CIT tool or similar	Yes	
Mobility including activity levels and Falls Risk - using FRAT tool or similar, provide advice on minimising risk of falls	Yes	
Tendency to dizzy spells, falls, faints, drop attacks, fits	Yes	
Mental state	Yes	
Continence	Yes	
Sight	Yes	
Hearing	Yes	
Coping at home		Yes
Social aspects including social isolation / loneliness assessment		Yes
Carer support including a fall-back option is to be highlighted and discussed with the patient in case main carer falls ill or become unavailable.		Yes
Vaccination history e.g., flu, Pneumovax and shingles	Yes	
Moderate Frailty Medication review – identify where a full structured medication review may be needed where appropriate	Yes	
LTC review – check if up to date. If outstanding book in where possible, or encourage this to be done	Yes	
MUST Score – where appropriate	Yes	
Assessment of benefits uptake e.g., attendance allowance (may be in conjunction with external agency i.e., Age UK).		Yes
Identification of alcohol problems by asking about and recording weekly alcohol consumption in writing and using FAST/AUDIT tools where appropriate.	Yes	
Review patients to discuss needs and actions identified and ensure appropriate interventions and referrals, which may be completed within the practice or involve other members of the wider Primary Health Care Team referral or voluntary services.	Yes	Yes
Determine frequency of future reviews to the level of risk identified at	Yes	Yes

the time of assessment.		
Development of a collaborative Care Plan with the patients and their relative / carer where appropriate, with discussion and sign off to be completed by a registered nurse or GP.	Yes	Yes
Use of Rockwood CFS to ensure frailty has been assessed and recorded	Yes	
Use of Health-Related Quality of Life Measure - EQ5D / EQ5D5L	Yes	

The above list is not exhaustive and may be tailored to suit the needs of the practice demographics. However, the clinical system Facilitation of Admission Avoidance template provided by the MLCSU Data Quality team **must** be completed in full to ensure all relevant data is collected.

Proactive Cohort post assessment requirements

Following the patients' assessment, the practice will consider implementation of **two or more** of the components listed below for each patient as necessary:

- For the practice to take a robust approach to ensure that a care plan is collaboratively developed with the patient and or their family / carers where appropriate ensuring that the care plan is fully completed to a high standard.
- Care plans are a useful clinical tool therefore practices are required to ensure that any existing care plans in place are to be reviewed and updated on a regular basis and at least annually.
Appendix 3 contains guidance on care plan content requirements.
- Provision of appointments with an appropriate voluntary service co-ordinator e.g., Age UK, working in conjunction with the practice team. Visits will be home or practice based as appropriate.
- As best practice, where appropriate, the practice will routinely consider referrals to appropriate falls support / service, carer's hub, Social Prescribing Link Worker and NHS Talking Therapies service (previously IAPT).
- Referral to other appropriate community or specialist service.
- Provide same day access to a telephone consultation with an appropriate health professional for urgent queries.
- Provide education packs to be designed and distributed to patients by the practice either paper based or electronically, which may include, but not limited to, NHS Choices leaflet, practice leaflet, dental services, NHS 111 service and general pharmacy services. Please refer to Appendix 6 below which provides examples of the types of information you may wish to include.

Additional requirements for proactive cohort

The practice will also:

- Meet regularly as a team involved in the scheme, to discuss patients identified, any concerns with patients and outcomes of actions implemented.
- Meet on an ad hoc basis to address any urgent concerns.
- Enable all patients to be given the opportunity to provide feedback on the service they have received following an assessment or review. Practices can capture their patients' experience using a simple questionnaire which should include questions such as:
 - was the patient happy with their experience?
 - did the patient feel supported?
 - did the patient feel involved in the completion their care plan?

Practices are expected to consider any concerns raised by patients as part of the feedback. Practices will be required to provide a summary of feedback received, and any actions taken following feedback, to the ICB at the end of each financial year.

Dedicated weekly GP and nurse time for the scheme

This will be put in place to:

- Review patients to discuss needs and actions identified and ensure appropriate interventions and referrals, which may be completed within the practice or involve other members of the wider Primary Health Care Team referral or voluntary services.
- Determine frequency of future reviews to the level of risk identified at the time of assessment.

Patient Care Facilitator (PCF)

Requirements of the PCF role include:

- Review of assessments undertaken, and data collated to identify patient specific action points and population issues
- Develop strong links with PCN Social Prescribing Link Worker to work together to identify suitable support

links for patients including community-based resources including volunteers and charitable organisations and actively sign post patients to these organisations where appropriate.

- Act as the practice point of contact for patients and their carers.
- Maintain information included within the practice resource pack.
- Ensure revision of patient and carer packs on a regular basis.
- Ensure patient and carer feedback (as detailed in section above) is collected and provided to GPs to help develop patient led services in line with local needs.
- Encourage PCFs to network on a regular basis with other PCFs within the practices' PCN to share best practice and address common issues.
- Engage with the practices PPG members to ensure they are aware of this scheme and for support where identified.

4. Applicable quality and accreditation requirements

a) Applicable Quality Requirements

- GDPR
- Consent policy
- Record keeping policy
- Complaint's policy

The ICB reserves the right to suspend the commissioning of this service where there are concerns around compliance and patient safety.

It is important that practices protect adults from avoidable harm (as defined in Safeguarding Adults guidelines) including safeguarding training, training on the Mental Capacity Act and Deprivation of Liberty. A Safeguarding lead should be identified in each practice. In addition, all practitioners completing the annual health and social care assessments will be required to be trained to level 3 of the Intercollegiate Adult Safeguarding requirement to ensure they are competent and confident to address any immediately identified risks of abuse or neglect including self-neglect. The practice is also required to complete the annual safeguarding audit and monitor the number of safeguarding referrals completed.

b) Applicable Accreditation Requirements

Quality Commission (CQC)

The provider must meet CQC standards and where appropriate be registered with the Care Quality Commission (CQC). The standards and the relevant services are contained in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2014.

5. Activity targets and reporting

Targets

a) Proactive assessments target

The practice's proactive assessment target will be 4% of the practice's list size as of 1st January 2023. The ICB will email the practice manager to confirm that number of assessments required at the commencement of the scheme.

Reporting and Data Flow

The Primary Care team will monitor data supplied by practices, by the Data Quality team on behalf of practices and Business Intelligence team (BI), monthly to review against the outcomes set. Where performance is declining, a member of the Primary Care team will work with those practices to review the delivery of the scheme and plan actions required to improve.

The MLCSU Data Quality team on behalf of the practice shall upload an extract monthly detailing the NHS number and date of the annual review relating to this service to the Data Services for Commissioners Regional Office (DSCRO), hosted by Midlands and Lancashire Commissioning Support Services, for the proactive patient cohort. The DSCRO will pseudonymise the NHS number, in the same manner as the DSCRO currently pseudonymise Secondary Users Services (SUS) activity, to enable a link to SUS activity.

The Practice will code all assessments and reviews into the clinical systems observing the coding document provided by the CSU Data Quality team. If the practice wishes to change any codes or use different codes, **you must contact** your Data Quality Specialist as a matter of urgency to advise of the changes.

The assessment and review data will be shared from MLCSU to DCSRO via a secure web portal provided by the Midlands and Lancashire Commissioning Support Unit: <https://datacentral.midlandsandlancashirecsu.nhs.uk> For data flow specifics, please refer to Appendix 2. The web portal is only for uploading data and no data can be extracted from this portal. The portal is only a front-end system and once the data has been received it is only

accessible to the DSCRO staff through an RPC (Regional Processing Centre). Steps are taken by the DSCRO to ensure the data is pseudonymised and checked before it leaves the RPC.

The staff with access to the patient identifiable data are:

1. Data Quality Specialists (employed by the CSU) who can support practice to upload the patient cohorts
2. The DSCRO

Any relevant clinical coded entries and any other pertinent data must be recorded to ensure compliance with this Service Level agreement can be demonstrated by the practice. Practices are encouraged to ensure that a clear audit trail exists to support post payment verification.

If Practices require help or advice on clinical recording, coding and reporting, please contact a member of the CSU Data Quality team.

Funding and Payment Process

Funding has been agreed from 1 April 2023 to 31 March 2024 at £6.00 per head of population per year based on population size as of 1 January 2023. Payment will be made to practices monthly.

Practices should be aware that if the delivery of their plan exceeds the ICB investment value, the practice will be liable for any shortfall.

A minimum of 90% of the agreed target for proactive assessments must be delivered. All patients who receive an assessment must have a Rockwood Clinical Frailty Scale recorded and coded within their patient record between 1st April 2023 and 31st March 2024.

The 10% difference recognises that some patients will not wish to participate in the scheme or who are unable to be assessed for valid health reasons. Where a patient declines to participate in the scheme, or has been found to be unsuitable, the patient should be removed from the proactive cohort and a suitable replacement identified and invited for an initial assessment.

The funding will cover all requirements of this agreement including service delivery, appropriate coding, monitoring, data collection and reporting requirements of the evaluation and performance management of the services. Funding will be withheld or reclaimed from practices who do not achieve the above service levels by the end of each financial year.

Practices will be provided with activity data by a member of the CSU Data Quality team on a monthly basis. **Please ensure that you review this data very carefully** upon receipt and raise with your Data Quality Specialist, within a month of the data being received, any queries or issues. Practices may wish to use this data to ensure that any patients who have completed an assessment have also had a Rockwood CFS added to their clinical record. **The ICB will be unable to rectify any data discrepancies relating to practice activity performance at the end of each financial year.**

For every 1% below the agreed minimum target of 90% of assessments not completed 1% of funding will be reclaimed.
and

For every 1% below the agreed minimum target of 90% of assessments, where a Rockwood Clinical Frailty Scale has not been recorded in the patients record between 1st June 2023 and 31st March 2024, then 1% of funding will be reclaimed.

Performance Monitoring

The Primary Care team will review activity data submitted by the CSU Data Quality team each month and calculate practice performance against agreed targets. Where activity is not in line with anticipated performance trajectory a member of the team will contact the practice to ascertain if there are any issues and to offer support, guidance and to share best practice. Where appropriate the practice will be asked to formulate an action plan and the Primary Care team will continue to work closely with the practice and to monitor activity until delivery performance reaches required levels.

Termination

Should either party wish to terminate this agreement, a minimum period of 3 months' notice must be provided in writing.

Sign-up sheet

Please refer to Appendix 7 for the sign-up sheet and instructions.

Appendix 1

Practice Validation Visits

1. Introduction

Validation checks on behalf of NHS Stoke-on-Trent ICB and NHS North Staffordshire ICB will be completed by the following team members:

- ICB Primary Care team
- CSU Data Quality team
- ICB Medicines Optimisation team
- ICB Finance team
- ICB Lay Person

This list may change dependent upon the elements of the scheme being assessed.

Practices should be aware that all Local Improvement Schemes or Enhanced Services may be subject to Post Payment Validation Checks, as stated in the individual specifications provided to Contractors prior to sign up. Practices are required to retain evidence to substantiate the validity of payments made to them in respect of Local Improvement Schemes. It is particularly important to retain evidence that is generated by the running of computer-generated searches, as this provides the most reliable means of supplying data.

The selection of practices will be at the ICB's discretion. Practices and the ICB should both bear in mind that being selected for a Validation visit does not imply any suspicion of wrongdoing.

2. Protocol – Process

2.1 Selection

Practices can be selected for a Validation visit at any time throughout the year, or at the end of a financial year, as determined by the ICB.

2.2. Team

Representatives of the ICB Primary Care team and or ICB Finance team and or members of the CSU Data Quality team will undertake the Validation visit. The names and roles of the visiting team will be notified to the practice prior to the visit.

2.3. Notice to Practice

Practices will be given two weeks' notice prior to the visit; however, a visit may be made with less notice if this is more convenient for the practice. The requirements of the visit will be discussed with the practice at the time of booking to ensure that the appropriate personnel are available on the day of the visit.

2.4. ICB Method

The ICB will undertake and manage this Validation visit review process:

- Any evidence the practice, or the CSU Data Quality Team on behalf of the practice, has submitted to the ICB previously for verification may be used at the time of the validation review, such as monthly and quarterly returns submitted to the ICB.
- The practices compliance against the Facilitation of Admission Avoidance Scheme specification will be assessed on the day of the visit.

2.5. Visit Content and Format

The content of the validation visit could include the following:

- Review of copies of information shared with patients such as education packs.
- Review of referrals made following a health and social needs assessment.
- Review of patients completed Care Plans and the records or consultations relating to the updating of these plans.
- Review of the consultation(s) where details the patient(s) health and social needs assessment are recorded.
- Review of minutes or records where members of the team involved in the scheme have met to discuss concerns raised about a patient identified as part of the scheme and the outcomes of actions implemented.
- Review of any patient and staff feedback obtained in relation to the service.
- The ICB representatives will require access to the practice's clinical system.
- It is necessary for the Practice Manager, or equivalent, to make themselves available for the entire visit.

2.6. Feedback and Reporting

The ICB representative(s) will provide informal verbal feedback to the Practice Manager, or equivalent, on conclusion of the visit. The practice will be given the opportunity to provide supporting material should this be required in order to verify or inform an outstanding issue. A written report will be produced by the team within two weeks of the visit as an objective documentation of the findings from the visit. The report will provide recommendations on any appropriate

action deemed necessary to be taken by the practice as a result of the findings of the review, and those actions to be undertaken by the ICB such as providing support to a practice and making financial recoveries.

Practice reports may be discussed within the ICBs to highlight and record best practice within the Staffordshire ICBs area. Anonymised reports may also be shared with other practices within Staffordshire ICBs area to share learning and improve quality.

2.7. Dispute Process

The practice will have two weeks to notify the ICB Primary Care team if they wish to contest the report in any way and the ICB Primary Care team will ensure such requests are considered by the visiting team. The ICB Primary Care team will respond formally to the practice in writing within two weeks of any amendments to be made if appropriate.

If, following the response given by the practice, agreement of any amendments is reached, a final version of the report will be sent to the practice. If an agreement has not been reached on the report following the response received, the practice may request a review of the report and its findings by a ICB panel which will include senior members of the Primary Care team, a ICB Clinical Director and a ICB Lay Member. The decision reached by the panel will be final and adhered to by both the practice and the ICB.

2.8. Follow up Action

The decision on what course of further action, if any, is to be taken rests with the ICB. Further action may include undertaking a second visit using a larger sample, providing training and support to a practice or the recovery of funding.

Where the ICB decides that it is appropriate to reclaim funding as a result of the review, the ICB will communicate this to the practice. The practice will be given a specified period in which to appeal against the proposed reclaim of funding.

2.9. Refusal to Participate

If a practice refuses to co-operate with the review visit, the ICB may involve the LMC to reach a resolution. If there is, however, a suspicion of fraud, the ICB must contact their local Counter Fraud Specialist or NHS Counter Fraud Authority immediately.

2.10. Suspicions of Fraud

The local Counter Fraud Specialist will be informed of the schedule of review visits prior to any visits being undertaken where fraud is suspected. Checks and visits to investigate a suspicion of fraud can take place throughout the year and are separate to this review process.

Appendix 2					
Minimum data set Data Type	Description	Metrics	Source of Data	Frequency	Who
Demographics					
Age	Mean/ range		EMIS	Quarterly	Primary care
EFi register Score/Prisma 7/ Rockwood/Tilburg	Score		EMIS /Primary Care	Quarterly	Primary care
System measures – to be monitored by the ICB					
Occupied bed days	Per head of population		SUS/ SLAM	Monthly	External evaluation
A&E attendances	Per head of population		SUS/ SLAM	Monthly	External evaluation
Non-Elective admissions	Per head of population		SUS/ SLAM	Monthly	External evaluation
Number of re-admissions within 30 days	Per head of population		SUS/ SLAM	Monthly	External evaluation
Practice activity					
Number of patients assessed or reviewed within the proactive cohort		Actual vs target	practice clinical systems	Monthly	Practice
Referrals to other services e.g. voluntary sector, community services, acute or specialist.			practice clinical systems	Monthly	Practice
Percentage of patients within the proactive cohort with a care plan created or reviewed within financial year			practice clinical systems	Monthly	Practice
Review of patient cohort for suitability for inclusion on the scheme.		Actual vs target	practice clinical systems	Monthly	Practice
Number of patients who have been assessed or reviewed within the proactive cohort who have also had a Rockwood Clinical Scale recorded		Actual vs target	practice clinical systems	Monthly	Practice
Lifestyle – Increased physical activity <ul style="list-style-type: none"> Total number and % of patients where low level of physical activity has been identified Subset - number and % of patients reporting increased activity/within capability 			practice clinical systems	Monthly	Practice
Quality of life - Reduced Loneliness <ul style="list-style-type: none"> Number and % of people reporting loneliness overall scores reported Number and % of people reporting reduced loneliness Number and % scores increasing using validated measure following intervention i.e. referral to social prescriber 			practice clinical systems	Monthly	Practice

Health Literacy - Number of medication reviews			practice clinical systems	Monthly	Practice
<ul style="list-style-type: none"> Number and % of patients who have been identified as needing a structured medication review 					
Quality of Life / Wellbeing – health related quality of life measure			practice clinical systems	Monthly	Practice
<ul style="list-style-type: none"> Health Related Quality of Life Measure - EQ5D / EQ5D5L to form part of the assessment process and re-visited at review Health related quality of life score Number and % scores that have improved 					

Patient experience and reported outcomes					
Patient experience post-assessment or contact	Patient feedback questionnaire		Practice data	At end of each financial year	Practice
Risks and Complaints					
Complaints	Number of complaints received		Provider data/ DATIX	Quarterly	Practice and ICB
Incidents	Number of incidents recorded		Provider data/ DATIX	Quarterly	Practice and ICB
Outcome of incident review	Multi-agency investigation to be completed; outcomes reported		Multi-agency group report/ DATIX	Quarterly	Practice and ICB

Appendix 3

Care Plan Requirements Best Practice Guidance

Care plans are a useful clinical tool therefore personalised care plans should be developed taking into account information contained in the NHS England handbook on personalised care and support planning and following good medical practice.

The personalised care plan should include:

- Patient Name, Address, NHS Number and date of birth
- Contact details including any specific arrangements i.e., "phone daughter"
- Key safe / door access code
- Practice name, address and contact number including bypass number where applicable
- Named GP and / or care coordinator / facilitator
- 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)
- Patient (or other allowed individual) consent to share information
- Next of Kin details including name, address, relationship and contact details
- Relevant conditions, diagnosis and latest test results
- Significant past medical history
- Current Medication
- Allergies
- Baseline Observations appropriate to the patient completed on the WMAS template attached.
- Key Action points: i.e., guidance on intervention / deterioration, unmet need to support patient (specify), agreed plan in emergency (ICE) / useful situation etc.
- Other relevant information i.e., preferred place of care, identification of whether the person is themselves a carer (formal or informal) for another person
- Other support services e.g., local authority support, housing
- Agreement of Anticipatory care plan / drugs
- Record of any discussions regarding emergency care and treatment: 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.
- 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.).
- Where possible and appropriate through encouragement from the attending practitioner, include a record of the patient's wishes for the future.
- Date of Care Plan and review date

Example Care Plan



Microsoft Word
Document

Appendix 4

The Clinical Frailty Scale (CFS)

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Appendix 5

Facilitation of Admission Avoidance (FAAs) **Example Practice Protocol Requirements**

It is best practice for practices to produce an operating protocol in relation to the FAAs scheme delivery. Below are suggested items you may wish to consider for inclusion within your practice protocol, this list is not exhaustive.

- Ensure all members of staff involved in the delivery of the scheme are familiar with its aims and delivery requirements.
- Process for identification of your practice's proactive cohort and which risk stratification tools are to be utilised.
- Process for removal of patients from the scheme.
- Ensure all members of staff who deliver Health and Social Needs Assessment understand the requirements of the assessment. For example, best practice is for this to be completed face to face in the patients home where possible.
- The identification of staff training requirements necessary to deliver a Health and Social Needs Assessment. For example, is the staff member completing the assessment:
 - Competent to use all assessment tools required within the clinical system FAA template?
 - Trained to safeguarding level 3?
 - Has a good understanding of pathways and criteria for referrals to other services or professionals?
 - Understands the process for who is clinically responsible for the different elements of the review? For example, a medication review needs to be undertaken by a Registered Healthcare professional and if a non-prescriber this should be signed off by a prescriber in accordance with the Repeat Prescribing Policy.
- Staff providing the assessments need to demonstrate attendance at any training events that they are available to attend
- Specify clinical supervision requirements. Staff undertaking the assessments should have defined access to a GP to review any patient needs and actions identified. This should occur on at least a weekly basis. A HCSW should always work under supervision of a Nurse or other appropriate member of the clinical team.
- Specify the process for capturing patient feedback.
- Detail a robust patient recall process tailored to individual patients need.
- Contain details of the provision of same day access to a telephone consultation with an appropriate health professional for urgent queries including training and staff awareness of the provision.
- Detail the process for monitoring practice KPI delivery performance.
- Details the requirements of the patient education pack and how this is distributed to patients.
- Process for reviewing and validating data provided by the MLCSU Data Quality Team.
- Details when a care plan should be completed or updated for a cohort patient.
- Details of the process for dealing with any complaints in relation to the scheme delivery.
- Ensure appropriate staff are familiar with the schemes clinical system coding guide.
- Process for ensuring all patients are made aware of their practice Patient Care Facilitator (PCF) and how they may contact them.

The protocol should be reviewed every 12 months in line with the publication of future schemes.

Appendix 6

Checklist for inclusion in FAA Patient Education pack (this list is not exhaustive)

<i>Suggested information for inclusion in practice FAA Education pack (include contact details and detailed information about what the service offers etc.)</i>	<i>Contact numbers</i>	<i>Website</i>
Age UK	01782 200739	www.ageuk.org.uk/staffordshire
Ageing Well Project (Gentle Exercise)	01782 200739	Ageing Well in Stoke on Trent Age UK Staffordshire
All Age Carers Service	01782 793100	S-O-T All Age Carers Service North Staffs Carers (carersfirst.com)
Attendance Allowance	0800 731 0122	Attendance Allowance: How to claim - GOV.UK (www.gov.uk)
Beat the Cold	01782 914915 or freephone 0800 389 2258	Beat the Cold – Stoke-on-Trent and Staffordshire's Fuel Advice Charity (beatcold.org.uk)
Benefits Calculator	0808 802 2000	Contact us - Turn2us
Blue Badge		Apply for or renew a Blue Badge - GOV.UK (www.gov.uk)
Brighter Futures	0808 800 2234	www.brighter-futures.org.uk
British Heart Foundation	0300 330 3311	www.bhf.org.uk
British Lung Foundation	0300 222 5800	www.blf.org.uk
Care Alarms & Key safes		
Care Facilitator		
Changes	01782 413101	www.changes.org.uk/
Chiropody Clinics		
Citizens Advice Bureau	Advice line - 0808 278 7876 or Reception - 01782 801234	www.citizensadvice.org.uk
Coeliac UK (live well Gluten Free)	0333 332 2033	www.coeliac.org.uk
Community Drug and Alcohol Service (CDAS) Stoke-on-Trent only	01782 283113	www.scdas.org.uk/
Council tax exemption		
Dental care (incl emergency contact)		
Department of works and Pensions		https://www.gov.uk/guidance/contact-the-department-for-work-and-pensions-about-its-policies
Diabetes UK	0345 123 2399	www.diabetes.org.uk

Diabetes UK North Staffordshire Voluntary groups	01782 861690	www.diabetesuknorthstaffs.org
Disabled driver Badge		https://www.gov.uk/apply-blue-badge
District Nursing team		
Dove Service	01782 683155	www.thedoveservice.org.uk
DVLA		
Fire Brigade (incl additional services)	0300 330 1000	www.staffordshirefire.gov.uk
Foodbanks (Staffordshire)		Food banks - Search Results Staffordshire Connects
Foodbanks (Stoke on Trent)		Get Help Stoke-on-Trent Foodbank
Gamcare UK	0808 8020 133	www.gamcare.org.uk
Healthy Eating Advice		Healthy Eating - HelpGuide.org
Hearing and Eye tests		
Lasting Power of Attorney	0300 456 0300	Make, register or end a lasting power of attorney: Overview - GOV.UK (www.gov.uk)
Legal advice		
Local friends support group		
Meals on Wheels (Stoke on Trent)	08005610015	Meals On Wheels (stoke.gov.uk)
MIND	01782 262100	www.nsmind.org.uk/
My live well with pain		www.my.livewellwithpain.co.uk
North Staffordshire carers association	01782 793100	www.carers.uk.org
North Staffordshire and Stoke on Trent Citizens Advice Bureau	0808 2787876	www.snscab.org.uk
North Staffordshire Combined Healthcare	0300 123 0907 (option 1). Text service for hearing impaired 07739 775202	www.combined.nhs.uk/how-to-access-us-in-a-crisis/
Occupational Therapy		
Patient Advice Liaison Service (PALS)		-
Patient Participation Group (PPG)		
Pharmacy (incl emergency contact)		
Physiotherapy clinics		
Police Non-Urgent Helpline	101	
Royal Voluntary Services (RVS)	01782 917938	www.royalvoluntaryservice.org.uk
Saltbox	01782 810320	www.saltbox.org.uk
Silverline	0800 470 8090	www.thesilverline.org.uk
Smokefree National Helpline	0300 123 1044	www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/
Quit Smoking (Stoke-on-Trent only)	0800 085 0928	www.stoke.gov.uk/site/xfp/scripts/xforms_form.php?formID=78&language=en
Staffordshire and Stoke-on-Trent wellbeing service	0800 032 8728	www.staffsandstokewellbeing.nhs.uk
Staffordshire connects		www.staffordshireconnects.info

Staffordshire Treatment and Recovery Service (STARS) North staffs only.	01783 639856	www.humankindcharity.org.uk/service/staffordshire-treatment-and-recovery-service/
Stoke on Trent City Council Community Directory		Directory - Stoke Community Directory
Vaccinations		
Walk in Centre – Haywood	0300 303 1268	
Walk in Centre – Leek Moorlands Hospital	0300 123 1894	
Wheelie Bin Assisted Collection (Newcastle Under Lyme)		Need a little extra help? – Newcastle-under-Lyme Borough Council (newcastle-staffs.gov.uk)
Wheelie Bin Assisted Collection (Staffs County Council)		Assisted collection - Staffordshire Moorlands District Council (staffsmoorlands.gov.uk)
Wheeling Bin Assisted Collection (Stoke on Trent)		Get help putting your bin out (stoke.gov.uk)
Young Carers Support (Stoke on Trent)	01782 232200	https://www.stoke.gov.uk/info/20009/children_and_families/128/help_for_young_carers

Checklist for inclusion in Practice Leaflet (this list is not exhaustive)

Suggested items for inclusion in Practice Leaflet	Added to Practice Leaflet
About the practice:	
Name/Address and Contact details of practice	
List of Staff members	
Opening Hours (including extended supervision)	
Home visits	
Catchment area	
Results availability	
Access including disability adjustments (i.e. hearing loop, ramp etc)	
Services available	
Telephone advice	
Confidentiality	
Freedom of Information	
Complaint's process	
Zero Tolerance	
Rights and responsibilities	
Alternatives to A&E	
Extended access	
Haywood Hospital	
Out of Hours	
Leek Minor injuries	

<i>Useful contact details</i>	
<i>Local Pharmacies</i>	
<i>Local Dentists</i>	

Appendix 7

Application form for Local Improvement scheme

Practice Sign-up Sheet for LIS Scheme

Facilitation of Admission Avoidance Local Improvement Scheme (FAAs) 2023-24

Confirmation and Acceptance

This document constitutes the agreement between the practice and the ICB regarding participation with the Facilitation of Admission Avoidance Local Improvement Scheme (FAAs)

Practice Name	
Practice Code (M##### / Y#####)	

Agreement to a PCN cohesive approach

The practice **have / have not*** agreed a cohesive approach to the identification of the proactive cohort with their PCN practice members, using agreed risk stratification tools, and **have / have not*** agreed a basis for the delivery of the scheme. (**delete as appropriate*).

Please provide below *brief details* of the approach to be taken to identify the proactive cohort, risk stratification tools to be used and where appropriate, basis of the agreement for delivery of the scheme:

--

Signature on behalf of the practice

I have discussed the scheme with relevant colleagues within the practice and agree to participation in the Local Improvement Scheme as outlined above. The practice understands that if the plan is not fully implemented including planned spend, agreed delivery activity or the outcomes are not delivered, a review will be carried out by the ICB and a potential reclaim of funding may be made.

Signature	Name	Date

Please send your signed confirmation (this page only) via email to: Primarycareteam@staffsstoke.icb.nhs.uk by midday **29th September 2023** at the latest.

If your practice **does not wish to participate in this scheme**, please inform the ICB in writing before **29th September 2023** via Primarycareteam@staffsstoke.icb.nhs.uk

Signature on behalf of the ICB

Signature	Name	Date

Appendix 8
Moderate Frailty – Proposed Outcome Measures & Method

Outcome	Suggested Tool
Lifestyle – Increased physical activity total number and % of patients where low level of physical activity has been identified subset -- number and % of patients reporting increased activity	<ul style="list-style-type: none"> • Yes – physically active as per NHS guidelines for over 65s (light activity daily, 150 mins moderate or 75 mins vigorous activity a week, 2 days a week strength/balance/flexibility) • Yes – physically active but less than NHS guidelines (NHS guidelines are not within physical capability) • Yes – physically inactive but this is appropriate to individual's capability • No – physically active but not meeting NHS guidelines (NHS guidelines are within physical capability) • No – largely inactive (light activity is within individual's capability)
Quality of life - Reduced Loneliness Number and % of people reporting loneliness overall scores reported number and % scores increasing using validated measure following intervention i.e. referral to social prescriber	Measuring Loneliness: National Indicators Table 1 page 4 https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/measuringlonelinessguidanceforuseofthenationalindicatorsonsurveys
Health literacy Number of medication reviews	Activity measure – Number and % of patients who have been identified as needing a structured medication review
Quality of Life / Wellbeing	<ul style="list-style-type: none"> • Health Related Quality of Life Measure - EQ5D / EQ5D5L to form part of the assessment process and re-visited at review 5L UserGuide.indd (unmc.edu) • Number and % scores that have improved