

Facilitation of Admission Avoidance (FAAs)
Service Level Agreement Local Improvement Scheme 2021_2022

Service	Facilitation of Admission Avoidance Local Improvement Scheme (FAAs LIS)
Commissioner Lead	Mel Mahon, Head of Primary Care Commissioning
Provider Lead	Primary Care
Agreement Period	1 April 2021 to 31 March 2022
Date of Review	January 2022

Summary of key changes and requirements for 2021_2022 scheme

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

This 2021_2022 updated version of the scheme:

- Provides a change in name from Elderly Care Facilitator Scheme or Facilitation of Admission Avoidance Scheme to reflect that the age restriction for the proactive patient cohort has been removed.
- Requires all practitioners completing the annual health and social care assessments to be trained to level 3 of the Intercollegiate Adult Safeguarding requirement.
- Removes any care home or residential home patients from the cohort (care of these patients is covered under other commissioned schemes).
- Encourages practices within a PCN to agree a cohesive approach to the identification of the proactive cohort and to agree the basis of the delivery of the scheme.
- Requires all practices participating in this scheme to allow the CCG to undertake practice validation visits. Please see page 11 for further details.
- Proactive cohort remains at 4% of practices registered list size with a minimum of 90% of assessments to be completed. Where a patient declines to participate in the scheme or is unsuitable for inclusion then the patient is to be removed from the proactive cohort and a suitable replacement identified.
- Practice ECF role will now be known as a Patient Care Facilitator (PCF).
- Face to face reviews and assessments remain as best practice but only to be carried out when assessed by the practice it is safe to do so during COVID pandemic.
- Proactive cohort post assessment requirements, two or more elements (increase from one or more) are required to be completed. List provided on page 7.
- Practices are required to continue to complete care plans where appropriate and review on a regular basis as required.
- The practice will routinely consider referrals to falls service, carer's hub and IAPT service for older people.
- Patients feedback on the service to be captured using a simple questionnaire. Practices will be required to provide a summary of feedback received to the CCG.
- PCF to develop strong links with PCN Social Prescribing Link Worker.
- Engage with the practices PPG members to raise awareness and understanding of the scheme.
- Monthly activity data will continue to be supplied by the CSU DQ team to practices. This data should be reviewed and any discrepancies raised in a timely manner.

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 CCG, at the end of each financial year.

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.

CCG Practice Validation Visits

The CCG 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 CCG will implement a programme of practice validation visits throughout the year to ensure that delivery of the scheme by practices is of a high quality and that the substantial amount of funding invested in the scheme by the CCG is delivering value of return. The visits will allow the CCG to identify gaps in delivery so practices can be advised and supported accordingly. 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 CCG.

These validation checks will involve CCG representative(s) reviewing a random selection patients 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.*

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 2021**. 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 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.

Practices should **deliver a minimum of 90%** of the required number of assessments each financial year.

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 will provide to:

- **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

Giving choice to the patient whilst ensuring the safety of the patient and practice staff. However, best practice is for assessments and reviews to be provided face to face where possible to ensure the maximum benefit is received by the patient.

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:

- Cognitive Screening / Dementia screening using 6CIT tool or similar
- Mobility and Falls Risk - using FRAT tool or similar
- Tendency to dizzy spells, falls, faints, drop attacks, fits
- Mental state
- Continence
- Sight
- Hearing
- Coping at home
- Social aspects including social isolation
- Vaccination history e.g. flu, Pneumovax and shingles
- Medication review – where appropriate
- MUST Score – where appropriate
- Screening for conditions such as CHD, hypertension, diabetes, CKD, AF
- Assessment of benefits uptake e.g. attendance allowance (may be in conjunction with external agency i.e. Age UK).
- Identification of alcohol problems by asking about and recording weekly alcohol consumption in writing, and using FAST/AUDIT tools where appropriate.
- 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.
- Development of a collaborative Care Plan with the patients and their relative / carer where appropriate.

The above list is not exhaustive and may be tailored to suit the needs of the practice demographics.

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.
- 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 falls service, carer's hub and IAPT service for older people.
- Referral to other appropriate community or specialist service.
- Provide same day access to a telephone consultation with an appropriate health professional for urgent queries.
- Provision of self-management plans and education for patients with long term conditions as appropriate.
- 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.

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 CCG 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
- Complaints policy

The CCG 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 are 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 at 1st January 2021. The CCG 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) on a monthly basis 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 Practice shall be required to upload an extract on a monthly basis 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 GP Practice to DCSRO via a secure web portal provided by the Midlands and Lancashire Commissioning Support Unit: <https://datacentral.midlandsandlancashirecsu.nhs.uk>

Practices have previously been provided with an account to enable them to upload the required data to the secure web portal, which meets the specifications set by NHS Digital. 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. Practice Staff who upload the patient cohort
2. Data Quality Specialists (employed by the CSU) who can support practice to upload the patient cohorts
3. 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 2021 to 31 March 2022 at £6.00 per head of population per year based on population size as at 1 January 2021. Payment will be made to practices on a monthly basis.

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

A minimum of 90% of the agreed target for proactive assessments must be delivered.

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. **The CCG 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.

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 4 for the sign-up sheet and instructions.

Appendix 1

Practice Validation Visits

1. Introduction

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

- CCG Primary Care team
- CSU Data Quality team
- CCG Medicines Optimisation team
- CCG Finance team
- CCG 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 CCG's discretion. Practices and the CCG should both bear in mind that being selected for a Validation visit does not imply any suspicion of wrong doing.

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 CCG.

2.2. Team

Representatives of the CCG Primary Care team and or CCG 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. CCG Method

The CCG 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 CCG previously for verification may be used at the time of the validation review, such as monthly and quarterly returns submitted to the CCG.
- The practice's 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 CCG 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 CCG 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 CCG such as providing support to a practice and making financial recoveries.

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

2.7. Dispute Process

The practice will have two weeks to notify the CCG Primary Care team if they wish to contest the report in any way and the CCG Primary Care team will ensure such requests are considered by the visiting team. The CCG 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. In the event that 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 CCG panel which will include senior members of the Primary Care team, a CCG Clinical Director and a CCG Lay Member. The decision reached by the panel will be final and adhered to by both the practice and the CCG.

2.8. Follow up Action

The decision on what course of further action, if any, is to be taken rests with the CCG. 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 CCG decides that it is appropriate to reclaim funding as a result of the review, the CCG will communicate this to the practice. The practice will be given a specified period of time 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 CCG may involve the LMC to reach a resolution. If there is, however, a suspicion of fraud, the CCG 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 completely 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
Ethnicity	Proportion		EMIS	Quarterly	Primary care
EFi register Score/Prisma 7/ Rockwood/Tilburg			EMIS /Primary Care	Quarterly	Primary care
System measures – to be monitored by the CCG					
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

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 CCG
Incidents	Number of incidents recorded		Provider data/ DATIX	Quarterly	Practice and CCG
Outcome of incident review	Multi-agency investigation to be completed; outcomes reported		Multi-agency group report/ DATIX	Quarterly	Practice and CCG

Appendix 3

Care Plan Requirements Best Practice Guidance

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

Sample Care Plan



Microsoft Word
Document

Appendix 4

Application form for Local Improvement scheme

Practice Sign-up Sheet for LIS Scheme Facilitation of Admission Avoidance Local Improvement Scheme (FAAs) 2021_22 Confirmation and Acceptance

This document constitutes the agreement between the practice and the CCG in regards to 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:

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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 CCG and a potential reclaim of funding may be made.

Signature	Name	Date

If your practice **does not wish to deliver this LIS** please inform the CCG in writing before 31st March 2021 via CCGpracticeupdate@northstaffs.nhs.uk

Signature on behalf of the CCG

Signature	Name	Date

Please send your signed confirmation (this page only) via email to: CCGpracticeupdate@northstaffs.nhs.uk by midday **31st March 2021** at the latest.