

Local Improvement Scheme
Elderly Care Facilitator LIS Service Level Agreement
2019-2021

Schedule 1 – Service Specification

Service	Elderly Care Facilitator LIS - Proactive service to reduce admissions
Commissioner Lead	
Provider Lead	Primary Care
Agreement Period	01/07/2019 – 31/03/2021
Date of Review	April 2020

1. Population Needs
<p>Evidence base, national and local context</p> <p>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:-</p> <p>Intrinsic Factors :</p> <ul style="list-style-type: none"> • 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 <p>Extrinsic Factors:</p> <ul style="list-style-type: none"> • 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 <p>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 a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in</p>

the last 12 months and provide any other clinically relevant interventions.

Appendix 1 provides a six stage summary of national contract requirements

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.

The LIS Scheme has been in place for five years and has been reviewed and developed during this time. This 19/20 iteration:-

- removes the reactive element of the service
 - reflects the current proactive services in situ
 - seeks to provide additional clarity requested by practices to support operational deliver,
 - fixes the activity to be delivered at 4% of the list size with effect from 1st September 2019.
- The Full Year Effect target for 2019/20 will be 5 months of the 18/19 target and 7 months of the proposed 19/20 target to reflect the starting point in the year.

The assessment activity may focus on those over 55years and/or practice selected cohorts for those practices with low volumes of patients over 55.

Data requirements align to support internal performance monitoring and evaluation during 19/20 which will look at service impact.

It is anticipated with the development of primary care networks and national Network Service Specifications from 2020 there may be an impact on future service provision, which will be discussed with practices at the relevant time.

Strategic direction.

The proposed approach is reflective of national policies:-

The NHS Five Year Forward View (October 2014) - which aimed to deliver better health, better patient care and **greater efficiency within the NHS.**

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 & 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**

All Practices will agree to record information and share data related to service delivery

The minimum data set is contained in appendix 2

All practices will comply and supply the data requirements of the external evaluation commissioning by the STP.

The evaluation data set is being finalised by Clinical members of the Older peoples Steering Group and will be shared with practices once agreed.

3.Scope

Aim and objectives of service

The aim of the Frail Elderly - Proactive service is to support frail elderly patients by assessing need 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 GMS for the identification and management of severe and moderate frailty.

The objectives of the LIS are to;

- Increase Early Identification of frailty
- Provide fast, timely access to assessment, treatment and care
- Prevent avoidable hospital attendance and admission
- Raise awareness and access to local services most appropriate to their needs
- Develop an individual care plan with emergency care card
- Support the frail elderly to 'Stay Well for longer'

Target Population

Proactive-The volume of activity for this scheme will be set at 4% of list size as of 01/04/2019. Practice case finding will be and practice selection based on risk stratification tools- Aristotle, eFI, combined **with clinical assessment**.

Clinical assessment may include the use of validated tools, which include Rockwood, Tilburg, Edmonton, PRISMA 7 or gait speed.

Practices should **offer all of the required volumes** of assessments and **deliver 90-%** of the required volume.

Proactive Service description

Practices have identified the most appropriate member of the practice team to provide proactive case management, historically funded through the LIS.

Those staff will continue to provide:-

- **For Newly Identified Patients** - A health &/or social needs assessment will be undertaken for all patients newly identified in order to determine further actions required.
- **Existing Patients receiving Proactive Case Management** - Patients already receiving proactive case management from the practice, will undergo a comprehensive annual assessment of health & social needs, utilising a clinical care facilitator role, supported by the wider practice team as appropriate, visits will be home or practice based as appropriate.

NB: The content of assessment delivered by the Elderly Care facilitator (ECF) may vary as different staff groups are carrying out this function, therefore, to complete the full health & social needs assessment some elements may need to be undertaken by an appropriate Health professional.

Best Practice will be for the assessment to take place in the patient's home and where appropriate/available a carer or next of kin should be present.

The assessment will be recorded in the patient's record on the practice clinical system and a summary will be provided to the patient.

The assessment will include:

- Cognitive Screening / Dementia screening using 6CIT tool or similar
- Mobility & 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.

In addition dedicated weekly GP and nurse time 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.

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

The Service Co-ordinator will:

Review assessments undertaken and data collated to identify patient specific action points and population issues

- Maintain and develop links with community based resources including volunteers and charitable organisations
- Act as the practice contact for patients and their carers
- Maintain information included within the resource pack
- Ensure revision of patient and carer packs on a regular basis

- Ensure patient and carer feedback is provided to GPs to help develop patient led services appropriate to local needs
- Encourage networking with other practices to share best practice & address common issues

Following assessment, implementation of one or more of the components listed below should be considered for each patient :

- A robust care plan collaboratively developed with the patient and or their family / carers where appropriate, visits will be home or practice based as appropriate.

Appendix 3 contains guidance on 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.
- Referral to 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 & education for patients with Long Term Conditions as appropriate
- Patient education regarding the alternatives to A&E (e.g. 111, pharmacy services, self-care, practice opening hours etc.).

For the delivery of the Proactive service , the practice will also

- Provide education packs to be designed and distributed to patients by the practice which may include NHS Choices leaflet, Practice leaflet, Dental Services, NHS 111 Service / OOH service and general pharmacy services. (The CCG may have examples which can be shared)
- 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.
- Monitor patients' feedback on the service.

Interdependencies with other services

The Provider will use their specialist expertise to creatively develop safe and effective ways to deliver positive outcomes in collaboration with partners and by building on existing good practice and positive relationships.

This LIS service links to the developing model of integrated care teams, development of primary care networks and other service developments in primary and community services. E.g. Falls service, High intensity users, Extensivist service.

4. Applicable quality requirements and Accreditation Requirements

4.1 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.

4.2 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. Location of Provider Premises

Practice based or Patients Home /Normal place of residence

Schedule 2 – Activity Plan & Reporting

Proactive assessments

Target assessment Activity based on 1st January 2019 registered population will be provided to each practice for proactive assessments to be offered based on 4 % of the population list size with effect from 1st September 2019 and based on the 18/19 target for the first 5 months of the year. 90% of those offered should receive an assessment.

CCG – The Primary Care Development Support Managers (PCDSM) will monitor data supplied by practices and Business Intelligence (BI) on a regular monthly basis to meet the outcomes set and where performance is declining, will contact and work with those practices in order to review the delivery of the scheme and plan actions to improve. For practices where actions are developed and implemented, the PCDSMs will provide support to submit an update on a basis agreed with the practice e.g. 3-6 months dependent on the change required.

Practices- The GP Practices 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, the patient cohort reviewed. The DSCRO will pseudonymise the NHS number, in the same manner as the DSCRO pseudonymise Secondary Users Services (SUS) activity, to enable a link to SUS activity.

Practices should continue to code all assessments as per previous agreements into the clinical systems. If any codes change please contact your DQF.

The data will be shared from GP Practice to DCSRO via a secure web portal provided by Midlands and Lancashire Commissioning Support Unit
-
<https://datacentral.midlandsandlancashirecsu.nhs.uk> .

GP Practices will be provided with account to enable them to upload the required data to the secure web portal which meets the specifications set by NHS Digital. Please see the DSCRPC Flow (Appendix B). 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 coding entries and any other relevant data must be recorded to ensure compliance with this Service Level agreement can be demonstrated. 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 your data quality facilitator.

Schedule 3 – Pricing & Payment Process

Payment Arrangements:

Funding has been agreed for 2019/20 at £6 per head of population per year based on population size at January 2019.

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 the additional funding.

100% LIS funding is available if both the volumes of assessments are offered and the volumes of assessments are delivered. I.e. 100% of proactive target population must be offered an assessment with delivery of 90% of assessments of those offered.

The 10% difference recognises those who do not consent or who are unable to be assessed for valid health reasons.

The funding will cover all requirements of this agreement including service delivery, appropriate coding, and monitoring and 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 the financial year. Reconciliations will take place quarterly via the DQF

For every 1 % of assessments not offered 1 % of funding will be reclaimed

And / Or

For every 1% of assessments not delivered 1 % of funding will be reclaimed

Schedule 4 – Performance Monitoring

Performance regarding the delivery of the services will be discussed at the pre-arranged practice quality visits and monitored quarterly.

Schedule 5 – Termination

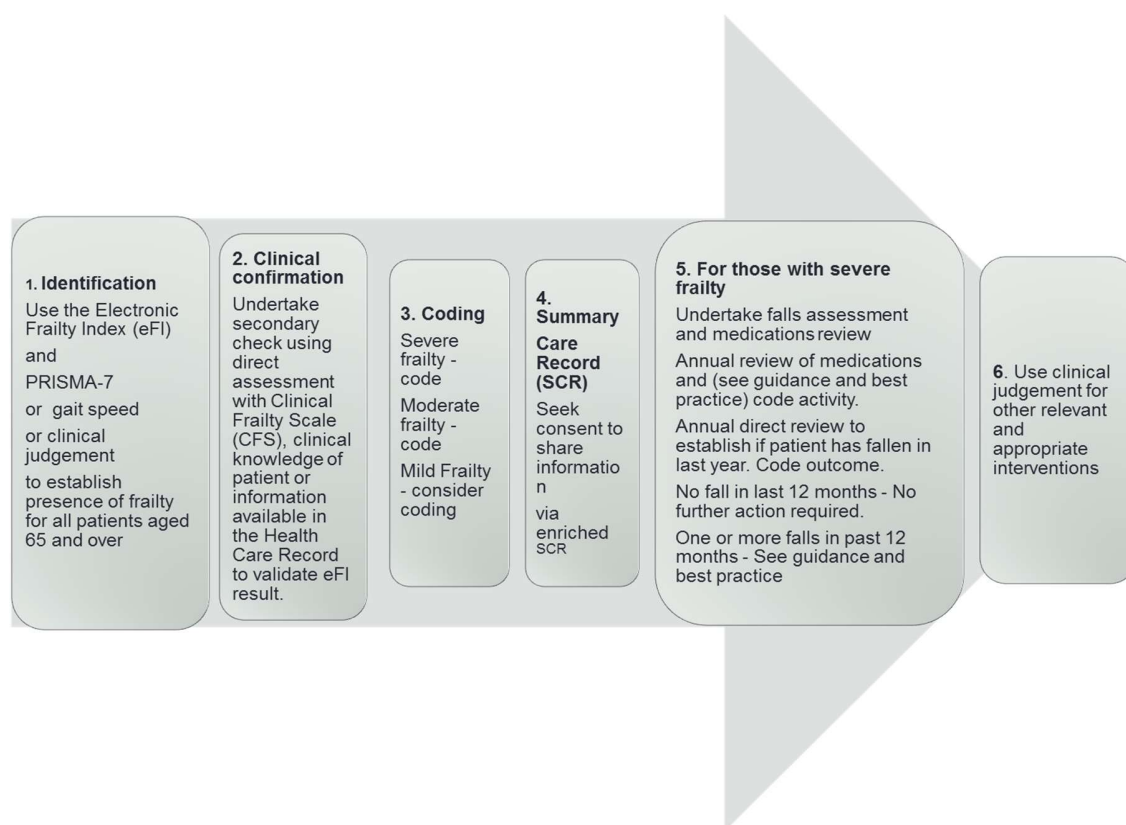
Should either party wish to terminate this agreement, a minimum period of 3 months' notice must be provided in writing.

Schedule 6 –Signatures

As per appendix 4 – Approved application form for Local Improvement scheme with details of your likely selected cohort and staffing.

Appendix 1

Six stage contract process for frailty



Metrics measured in the contract.
<ul style="list-style-type: none"> the number of patients recorded with a diagnosis of moderate frailty the number of patients with severe frailty the number of patients with severe frailty with an annual medication review the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months the number of severely frail patients who provided explicit consent to activate their enriched SCR

Appendix 2 – Draft Minimum data set- *maybe subject to additions post clinical review in July 2019 to support evaluation

	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 over 55*		SUS/ SLAM	Monthly	External evaluation
Delayed Transfer of Care	Per head of population over 55*		SUS/ SLAM		External evaluation
A&E attendances	Per head of population over 55*		SUS/ SLAM	Monthly	External evaluation
Non-Elective admissions	Per head of population over 55*		SUS/ SLAM	Monthly	External evaluation
Number of re-admissions within 30 days	Patients over 55 who have been re-admitted within 30 days		SUS/ SLAM	Monthly	External evaluation
Rate of Admissions to long term care					External evaluation metrics TBC
Proactive activity- Assessments					
Number of patients offered assessment	Target number by practice	Actual vs trajectory	DQS Reports from practice clinical systems	Quarterly	GP

number of patients assessed	Total number identified within primary care	Actual vs trajectory	DQS Reports from practice clinical systems	Quarterly	GP
Referrals to other services e.g. Practice, community services, acute or specialist.	Number referred by practice		DQS Reports from practice clinical systems	Quarterly	GP
% of patients with a care plan	100% of identified patients in receipt of care plan	Service data Statistically significant sample audit of care plans to be completed	DQS Reports from practice clinical systems	Monthly	GP
Patient experience and reported outcomes* To be shared once agreed					
Patient Reported Outcomes Measures Questionnaire pre and post-assessment	EQ-5D/ Warwick & Edinburgh Mental Wellbeing Scale* TBC	Quantify change in status	Provider data	Quarterly	Increase number of patients who feel involved in their care plan
Patient Reported Experience Questionnaire pre and post-assessment experience Measures	IntegRATE/ CollaboRATE* TBC	Quantify change in status	Provider data	Quarterly	Increase number of patients who feel involved in their care plan
Risks and Complaints					
Complaints	Number of complaints received		Provider data/ DATIX	Quarterly	All Org systems via leads
Incidents	Number of incidents recorded		Provider data/ DATIX	Quarterly	All Org systems via leads

Outcome of incident review	Multi-agency investigation to be completed; outcomes reported		Multi-agency group report/ DATIX	Quarterly	All Org systems via leads
Compliments			Multi-agency group report/ DATIX	Quarterly	All Org systems via leads

Appendix 3: Care Plan Requirements Best Practice Guidance

Personalised care plans should be developed taking 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 & 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 & 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 re 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 (as per Avoiding Unplanned Admissions LES)



Microsoft Word
Document

Appendix 4 - Application form for Local Improvement scheme

Practice Sign-up Sheet for LIS Scheme Elderly Care Facilitator LIS Service Level Agreement Confirmation and Acceptance

This document constitutes the agreement between the practice and the CCG in regards to participation with the Reducing Admissions ECF LIS Scheme

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

Signature on behalf of the practice

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

Signature	Name	Date

If the practice does not wish to continue delivering this LIS but is happy for the service to be delivered by another practice within the Primary Care Network (PCN) please confirm by email to: CCGpracticeupdate@northstaffs.nhs.uk.

Signature on behalf of the CCG

Signature	Name	Date

Please complete

Practice selected Indicative cohorts to meet target volume of assessments offered and delivered	Please tick 1 or more
>55 s	
65-75s	
75-85s	
>85s	
Other * only applicable for practices with low volumes of > 55s	Provide details of proposed cohort and intervention

Staff group delivering patient assessments	Please circle as appropriate Clinical / Non-clinical Role
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Please return your completed signed agreement by **1st September 2019** by email to CCGpracticeupdate@northstaffs.nhs.uk (NB: a scanned signature is acceptable)

or by post to Jess Taylor, Primary Care Team

**North Staffordshire CCG and Stoke-on-Trent CCG
Floor 3, 1 Smithfield
Leonard Coates Way
Hanley
Stoke -on-Trent
ST1 4FA**