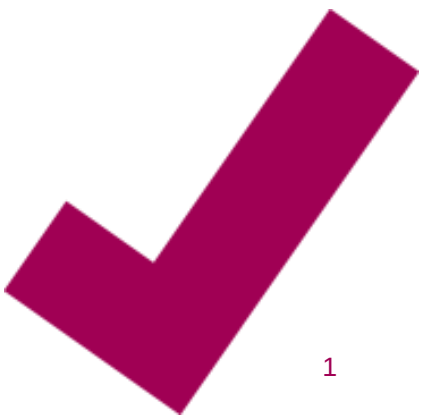
Enhanced service specification

Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people 2015/16



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Enhanced service specification

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

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Equalities and Health Inequalities Statement:

"Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

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1 Introduction

1.1 This enhanced service (ES) is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. The ES should be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions.

1.2 The ES will commence on 1 April 2015 for one year, subject to review.

1.3 This ES is agreed between NHS Employers (on behalf of NHS England[1]) and the British Medical Association (BMA) General Practitioners Committee (GPC). CCGs will be involved in supporting GP practices to deliver this ES[2].

2 Aims

2.1 The aims of this ES in 2015/16 are to provide more personalised support to patients most at risk of unplanned admission, readmission and A&E attendances to help them better manage their health. In order to assist in achieving this overall aim, the service encourages GP practices to:

a. increase practice availability via timely telephone access;

b. identify patients who are at high risk of avoidable unplanned admissions, establish a minimum two per cent case management register and proactively manage these patients;

c. review and improve the hospital discharge process for patients on the register and co-ordinate delivery of care;

d. undertake internal practice reviews of emergency admissions and A&E attendances; and

e. distribute a patient survey (subject to feasibility study).

3 Process

3.1 Commissioners will invite GP practices to participate in this ES before 30 April 2015. GP practices wishing to participate will be required to sign up to it by no

[1] From 1 April 2013 the NHS Commissioning Board (NHS CB) is the body legally responsible for the commissioning of primary care in England. However, the NHS CB operates under the name NHS England, therefore the name NHS England is used throughout this specification.
[2] CCGs will be involved in supporting GP practices to deliver this ES if they are not the commissioner.

later than 30 June 2015. GP practices signing up to this service will be signing up to all components.

1.1 Participating practices are also required to sign up to Calculating Quality Reporting Service (CQRS) and the General Practice Extraction Service (GPES)[3]. Commissioners will record GP practices' participation on CQRS.

3.2 GP practices signing up to this ES by 30 June 2015 will qualify for the component one payment set out in the payment and validation section.

4 Service specification

4.1 The requirements for GP practices participating in this ES cover five areas and are as follows in this section:

a. Practice availability

i. The GP practice will provide timely telephone access via an ex-directory or by-pass number to ambulance staff and A&E clinicians to support decisions about hospital transfers and admissions relating to any patient on their registered list[4]. This could, for example, be done by providing different extension options to callers to the GP practice, as long as this gets the caller straight through to the GP practice as a priority call. Where an ambulance staff member or A&E clinician specifically ask to speak to a clinician in the GP practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe, recognising that the query being raised relates to whether or not to transfer or admit a patient to hospital i.e. it may be immediate within an hour or same day. The commissioner will be required to compile a list of all the by-pass or ex-directory telephone numbers for GP practices participating in the ES and share it with relevant ambulance staff and A&E clinicians.

ii. The GP practice will provide timely telephone access via an ex-directory or by-pass number to care and nursing homes, encouraging them to contact the patient's GP practice to discuss options before calling an ambulance (where appropriate – for example, this is not applicable if the patient is at high risk of severe harm or death, if treatment is delayed). For example, this could be done by providing different extension options to callers to the GP practice, as long as this gets the caller straight through to the GP practice as a priority call. Where care or nursing home staff specifically ask to speak to a clinician in the GP practice,

[3] Further guidance relating to CQRS and GPES will be provided by HSCIC when services are updated.

[4] This number is only to be used when ambulance staff and A&E clinicians require support from a patient's practice in making decisions about transferring or admitting patients.

then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to whether or not to call an ambulance i.e. it may be immediate or within a couple of hours. The commissioner will be required to compile a list of all the by-pass or ex-directory telephone numbers for GP practices participating in the ES and share it with relevant care and nursing homes.

iii. The GP practice will provide timely telephone access to other care providers, (e.g. mental health and social care teams) who have any of the GP practice's registered patients in crisis and who are at risk of admission. Where a specific request is made by one of these individuals to speak to a clinician in the GP practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to a patient in crisis i.e. it may be immediate, within an hour or same day.

iv. The GP practice will provide patients identified on the case management register, who have urgent clinical enquiries, with a same day telephone consultation and where required, follow-up arrangements (e.g. home visit, face-to-face consultation, visit by a community team etc.). This same day telephone consultation will be with the most appropriate healthcare professional in the GP practice.

b. Proactive case management and personalised care planning

i. The GP practice will use an appropriate risk stratification5 tool or alternative method6, if a tool is not available, to identify vulnerable older people, high risk patients and patients needing end-of-life care who are at risk of unplanned admission to hospital. If a risk stratification tool is used, commissioners should ensure that a suitable tool has been procured for GP practice use.

ii. The risk stratification tool or other alternative method used should give equal consideration to both physical and mental health conditions. In the event the risk stratification tool does not account for mental health conditions, the GP practice should endeavour to use knowledge of their patients with mental health conditions alongside the risk stratification tool to ensure these patients are considered.

iii. The GP practice will establish a case management register of patients identified as being at risk of an unplanned hospital admission without proactive case management. This register will

[5] NHS England. Handbook on Using Case Finding and Risk Stratification. http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/

[6] This may include using clinical judgement and knowledge of the practice's patient population with regards to those patients who would benefit from this service.

be a minimum of two per cent of the GP practice's registered[7] adult patients (aged 18 and over). The minimum number of patients to be on the register in each six month period will be set on the 1 April 2015 and 1 October 2015 respectively. The minimum register size will be calculated as two per cent of the practice list size (patients aged 18 and over) from CQRS on each of these dates. In addition to this two per cent, any children (aged 17 and under) with complex physical or mental health and care needs, who require proactive case management, should also be considered for the register[8].

iv. In each six month period a tolerance of -0.2 per cent will be allowed (i.e. a register size of 1.8 per cent) to account for situations which temporarily lead to a dip in the number of patients on the register at the end of that six month period. GP practices will also be able to submit manual data (see monitoring section) on any patients who died or moved GP practice during the six month periods[9] and these patients will count towards the minimum two per cent. However, GP practices will need to ensure that over the financial year, the register covers at least an average of two per cent of the GP practice's registered adult patients. Therefore, should the circumstances of any patient change during the first six months of the year (e.g. the patient has died or moved practice), resulting in their removal from the register, GP practices will need to identify additional patients as soon as reasonably possible for the second half of the financial year to ensure the two per cent is maintained. Where a GP practice fails to deliver at least an average of two per cent across the financial year, payments can be reclaimed. See payment and validation section for more details.

v. GP practices will need to ensure that they manage any in-year risk associated with changes in practice list size. In exceptional circumstances which temporarily lead to the register falling below the tolerance, commissioners and practices will need to discuss and review the situation.

vi. The GP practice will undertake monthly reviews of the register to consider any actions which could be taken to prevent unplanned admissions of patients on the register. For example, the reviews may consider whether those patients requiring multi-disciplinary team (MDT) input are receiving it, or whether the GP practice is receiving appropriate feedback from the district nursing team.

vii. GP practices will be required to inform relevant patients that they are eligible to join the programme and what they can expect from

[7] Head count and not weighted list
[8] Children on the case register will not be counted towards the minimum two per cent as detailed in the payment and validation section.
[9] This only applies to one six month period. Any patients claimed for in the first six month period would need to be replaced in the second six month period.

being part of this ES.

viii. Patients on the register from the previous year will already have been notified of their named accountable GP and where applicable, their care co-ordinator and therefore do not need to be informed again unless there have been any changes[10]. Any new patients coming onto the register in-year should be notified[11] within 21 days.

ix. The GP practice will implement proactive case management for all patients on the register. This will include developing collaboratively with a patient and their carer (if applicable) a written/electronic personalised care plan, jointly owned by the patient, carer (if applicable) and named accountable GP and/or care co-ordinator. If the patient consents, the personalised care plan should be shared with the MDT and other relevant providers. Personalised care plans should be developed and agreed for any new patients coming onto the register in year within a reasonable timeframe, but no later than one month after entry onto the register.

x. The aim of proactive personalised care planning is to improve the quality and co-ordination of care given to patients on the register to improve their health and well-being. This should also aid in reducing individual risk of avoidable emergency hospital admissions, readmission(s) or A&E attendances.

xi. Personalised care plans should be developed taking account of the supporting ES guidance, information contained in the NHS England handbook[12] on personalised care and support planning and following good medical practice.

xii. Patients and carers (if applicable) should be invited to contribute to the creation of the personalised care. Members of the MDT[13] (when relevant) and other relevant providers could be invited to contribute to the creation of the personalised care plan. These contributions should inform both the holistic care needs assessment (e.g. to take into account social factors as well as clinical requirements) and the actions that can be taken as a result.

xiii. The personalised care plan should, where possible and through encouragement from the attending practitioner, include a record of the patient's wishes for the future. It should identify the carer(s) and give appropriate permissions to authorise the GP practice to

[10] Practices should notify patients of any changes to their named accountable GP and care co-ordinator.
[11] This can be done via email, letter or verbally.
[12] NHS England Handbooks on personalised care planning. http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/
[13] NHS England. Handbook on MDT. http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/

speak directly to the nominated carer(s) and provide details of support services available to the patient and their family.

xiv. The patient's care and personalised care plan should be reviewed at agreed regular intervals with them and if applicable, their carer. Clinician(s) should look at the patient's personalised care plan to ensure that it is accurate and is being implemented, making any changes as appropriate and agreeing these with the patient and where appropriate, the carer. Patients who remain on the case management register from the previous year, will need to have at least one care review, including a review of their personalised care plan, during 2015/16. In some instances, the review may be as a result of a social issue, which could require the assistance of the named accountable GP or care co-ordinator (if applicable) to link with the right people in the MDT or as an area for commissioning or design improvement. GP practices will be required to use the Read2 or CTV3 codes (see section on monitoring) to record when a patient's care plan has been reviewed. This is a specific code introduced solely for use of GP practices participating in this ES.

xv. Where a patient has had a review undertaken by a member of the MDT (i.e. outside of their practice), then the professional having conducted the review must inform the GP practice and the patient's record must be updated by the GP practice. CCGs will need to ensure, through their commissioning relationships with the organisations that work with the GP practice, that they inform the practice that a review has been undertaken.

xvi. The named accountable GP will be responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP). They will also maintain overall accountability for ensuring that the personalised care plan is being delivered and patient care, including the personalised care plan, is being reviewed as necessary.

xvii. The care co-ordinator for the patient (appointed by the named accountable GP, unless they plan to undertake this role themselves) will act as the main point of contact for the patient. They are responsible for overseeing care for the patient, that the care plan is being delivered and that the patient and/or carer (if applicable) is informed of and agrees any changes as required to their personalised care plan. They will also keep in contact with the patient and/or their carer (if applicable) at agreed intervals. In the event the named accountable GP is also the care co-ordinator, then they will be required to undertake all responsibilities for both roles. Where elements of a patient's care or personalised care plan, provided by professionals outside of the practice, are not being delivered then the named accountable GP or care co-ordinator (if applicable) will be required to raise this

accordingly with the relevant organisation(s) and ensure that all those involved are clear in their roles and responsibilities with respect to the patient's care and personalised care plan.

c. Reviewing and improving the hospital discharge process

   i. The GP practice will ensure that when a patient on the register, or newly identified as vulnerable, is discharged from hospital, attempts are made to contact them by an appropriate member of the practice or community staff in a timely manner to ensure co-ordination and delivery of care. This would normally be within three days of the discharge notification being received, excluding weekends and bank holidays, unless there is a reasonable reason for the GP practice not meeting this time target (e.g. the patient has been discharged to an address outside the practice area or is staying temporarily at a different address unknown to the practice).

   ii. The GP practice will share any whole system commissioning action points and recommendations identified as part of this process with their area teams and if appropriate their CCG (if they are not the commissioner of the ES), to help inform commissioning decisions. Information shared with the CCG is in order to help CCGs work with hospitals to improve planning for discharge and to improve arrangements for hospital/practice handover at point of discharge.

d. Internal practice review

   i. The GP practice will be required to regularly review emergency admissions and A&E attendances of their patients from care and nursing homes (i.e. to understand why these admissions or attendances occurred and whether they could have been avoided). The reviews should take place at a regular interval deemed appropriate by the GP practice, in light of the number of emergency admissions or A&E attendances by these patients. During the review, the GP practice should give consideration to whether improvements can be made to processes in care and nursing homes, community services, or GP practice availability or whether any individual care plans need to be reviewed with the patient and carer (if applicable).

   ii. Where a GP practice has a large proportion of their patients in care and nursing homes, it should focus its reviews on any emerging themes from a sample of patients and on any patients who have regular avoidable admissions or A&E attendances. GP practices will be required to agree this with its commissioner at the start of the year. In some circumstances, this may require different arrangements to be made locally to support these practices in undertaking this requirement. Examples of 'local arrangements' may include, but are not limited to, support from the CCG to co-ordinate this or support through a care home community based service.

iii. The GP practice will undertake monthly reviews14 of all unplanned admissions and readmissions and A&E attendances of patients on the register15. During the reviews, the practice will give consideration to:

- the practice's processes
- identifying factors, within the practice's control, that could have avoided the admission(s), readmission(s) and A&E attendances
- rectifying any deficiencies in the patient(s) personalised care plan(s)
- amending or improving the hospital admission and discharge processes; and
- identifying factors outside the practice's control, including any system gaps in community and social care provision and either resolving them (if within the practice's control) or raising them with the commissioner.

e. Patient survey

i. Subject to the outcome of a feasibility study (currently underway), GP practices may be required to survey patients on the case management register using a nationally developed and provided survey questionnaire. The GP practice would be provided with all printed materials and postage (if applicable) and would only be required to identify the correct patients within the identified two per cent cohort and to either send it out or give it to them (exact method to be confirmed). Final survey details would be subject to the outcome of a feasibility study. In the event the survey does go ahead, then funding of £500,000 will be available to support GP practices in implementing the survey.

5 Data

5.1 Commissioners will need to ensure the provision of timely practice level data on admissions and hospital discharges (as well as anonymous benchmarking data for comparison) to their practices. This may require commissioners to review their arrangements for the provision of data, to ensure appropriate support for practices.

[14] The reviews are to understand why each individual admission or attendance occurred and whether it could have been avoided.
[15] This applies to all patients on the practice's registered list.

6 Monitoring

6.1 The GP practice will complete a reporting template on a biannual basis, no later than the 31 October 2015 and 30 April 2016 respectively. The reporting template will be for submission to the commissioner and CCG (if CCG not commissioner of the service). The final end of year report (i.e. the second report) should take account of the entire year and is due for submission on or before 30 April 2016. A national reporting template has been developed and sets out the minimum reporting requirements (see Annex A). The reporting template is designed to assess the GP practice's performance against the five key requirements of the scheme:

- GP practice availability
- proactive case management and personalised care planning
- reviewing and improving the hospital discharge process
- internal practice review, taking account of both internal and external practice processes
- patient survey (subject to feasibility study)

6.2 Additionally, the GP practice may also be required, on an exceptional basis, to participate in peer reviews relating to assessment of the GP practice's implementation of this ES. This would only apply where there were concerns regarding a GP practice's performance in adhering to the terms of this ES. It is recommended that in this instance, the Local Medical Committee should be involved.

6.3 Practices will be required to manually input data into CQRS, until GPES[16] is available to conduct electronic data collections. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC website[17]. GP practices will be required to manually submit data to support claims for achievement reporting and associated payment claims. Data will be collected on:

[16] Details as to when GPES becomes available to support this service will be communicated via the HSCIC.
[17] HSCIC. http://systems.hscic.gov.uk/cqrs/participation

i. the number of patients on the case management register

ii. the number of patients on the register who have or have not been informed of their named accountable GP

iii. the number of new patients on the register who have had a personalised care plan agreed with the GP practice

iv. the number of patients who have declined a personalised care plan with informed dissent[18]

v. the number of patients on the register who have no record of a personalised care plan or declining a personalised care plan

vi. the number of patients on the register who have had/have not had care review(s) (including a review of their personalised care plan) that have taken place and the number of patients on the register who have a record of an emergency hospital admission.

6.4 Where necessary, GP practices will be required to submit manual[19] data relating to any patient who may have been on the case management register but who died prior to 30 September 2015 and 31 March 2016 respectively. This would be required where a GP practice has failed the minimum 1.8 per cent in each six month period and because the GP practice has not had reasonable time to replace the patient on the case management register or where the whole year register size falls below the minimum two per cent without taking account of these changes. Those patients claimed for in the first six month period under these circumstances cannot be counted in the second six month period and practices will need to find new patients for the case management register. GP practices will be required to provide the commissioner with the following information, within two weeks of the deadline dates above, relating to each patient being claimed for:

- the patient's NHS number
- the patient's date of registration with the practice (where known)
- the patient's date of death
- evidence that the patient was informed of their named accountable GP; and

[18] These would be patients who agree to be on the case management register to receive benefits from the service but have, post a discussion, declined to have a care plan.
[19] This information cannot be collected via GPES and will need to be manually submitted.

- evidence that a personalised care plan had been developed (see payment and validation section).

6.5 Where necessary, GP practices will be required to submit manual[20] data relating to any patient on the case management register who moved practice prior to 30 September 2015 and 31 March 2016 respectively. This would only be required where a GP practice has failed the minimum 1.8 per cent in each six month period and because the practice has not had reasonable time to replace the patient on the case management register or where the whole year register size falls below the minimum two per cent without taking account of these changes. Those patients claimed for in the first six month period under these circumstances cannot be counted in the second six month period and GP practices will need to find new patients for the case management register. GP practices will be required to provide the commissioner, within two weeks of the deadline dates above, with the following information, relating to each patient being claimed for:

- the patient's NHS number
- the patient's date of registration with the practice (where known)
- the patient's date of deregistration with the practice
- evidence that the patient was informed of their named accountable GP; and
- evidence that a personalised care plan had been developed (see payment and validation section).

6.6 A GP practice that registers a new patient in one of the six month periods who had been on the case management register at their previous practice will only count in the new practice if the personalised care plan is re-discussed with the patient and their carer. The data collection will therefore search for a care plan code post the date of registration for this patient to be counted.

6.7 The manually submitted data from each six month period and automatically collected data from each six month period will be combined to calculate achievement for the component two and three payments respectively (see payment and validation section below). Manual data will only count once for the relevant six month period it was submitted to support. GP practices will

[20] This information cannot be collected via GPES and will need to be manually submitted.

also be required to complete the relevant sections of the reporting template (see Annex A) to confirm that all requirements have been met to date.

6.8 The data collections on number of patients on the register, number of patients informed of their named accountable GP and number of patients with developed, reviewed or declined personalised care plans will be used as key performance indicators. If all three of these are achieved then payments will be triggered. Where required, manually submitted data will also be taken into account in determining if these three key performance indicators have been met. Commissioners will also need to ensure the other requirements of the service have also been met (see payment and validation section).

6.9 For information on how to manually enter data into CQRS, please see the Health and Social Care Information Centre (HSCIC) website[21].

6.10 Details as to when and if GPES is available to support this ES will be communicated via the HSCIC.

6.11 GP practices will be required to use the relevant Read2 and CTV3 codes as published in the supporting business rules on the HSCIC website. The "Technical requirements for the 2014/15 GMS contract"[22] document lists the Read2 and CTV3 codes relevant for this service. The Read2 and CTV3 codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate payment based on the aggregated numbers supplied and support the management information collections, when available. Although practices will be required to manually enter data until GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting Business Rules will be acceptable to allow CQRS to calculate achievement and payment and for area teams to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and if necessary, re-code patients.

[21] HSCIC. CQRS. http://systems.hscic.gov.uk/cqrs/participation
[22] NHS Employers. 2015/16 technical requirements document. http://www.nhsemployers.org/GMS2015/16

7 Payment and validation

7.1 Commissioners will seek to invite GP practices to participate in this ES before 30 April 2015. GP practices wishing to participate will be required to sign up to this service by no later than 30 June 2015.

7.2 The total funding available for this ES is £162 million.

7.3 The payments will be based on a maximum of £2.87 per registered patient. Table 1 provides full details of what payments can be expected for fully achieving the requirements of the ES. For the purposes of payments, the contractor's registered population (CRP) will be as at 1 April 2015 or be the initial CRP if the practice's contract started after 1 April 2015.

7.4 Payment under this ES for 2015/16 will be made in three components:

a. **Component One** - an upfront payment of 46 per cent

b. **Component Two -** mid-year payment of 27 per cent (subject to achieving all of the requirements below):

- For maintaining the register at a minimum of two per cent for the first half of the year (i.e. 1 April 2015 to 30 September 2015). Achievement of this component will be determinant on GP practices having a minimum of 1.8 per cent[23] of patients on the register on 30 September 2015 as a proportion of the list size taken on the 1 April 2015.
- For identifying the named accountable GP and care co-ordinator (if applicable) and informing any new patients added to case management register.
- For developing personalised care plans[24] with any new patients on the case management register or, for all patients already on the register undertaking at least one care review in the last 12 months. The development or review of care plans will be undertaken with the patient and where applicable, their carer.
- For implementing or continuing a system for same day telephone consultations for patients on the case management register with urgent enquires.
- For specifying and using the practice's ex-directory or by-pass telephone number.

[23] This takes into account the 0.2 per cent tolerance.
[24] Including those patients who have declined a care plan with informed dissent but still wish to remain on the case management register to benefit from other aspects of this service.

- For reviewing and improving the hospital discharge process for patients on the case management register, including attempting to contact these patients, by an appropriate member of the practice or community staff, in a timely manner to ensure co-ordination and delivery of care.

- For undertaking regular practices reviews of emergency admissions and A&E attendances of all their registered patients in care and nursing homes, as well as undertaking monthly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the case management register.

- For participating in the survey[25].

c. **Component Three -** end year payment of 27 per cent (subject to achieving all of the requirements below):

- For maintaining the register at a minimum of two per cent for the second half of the year (i.e. 1 October 2015 to 31 March 2016). Achievement of this component will be determinant on practices having a minimum of 1.8 per cent of patients on the register on 31 March 2016 as a proportion of the list size taken on the 1 October 2015.

- For identifying the named accountable GP and care co-ordinator (if applicable) and informing any new patients added to case management register.

- For developing personalised care plans[26] with any new patients on the case management register or, for all patients already on the register undertaking at least one care review in the last 12 months. The development or review of care plans will be undertaken with the patient and where applicable, their carer.

- For implementing or continuing a system for same day telephone consultations for patients on the case management register with urgent enquires.

- For specifying and using the practice's ex-directory or by-pass telephone number.

- For reviewing and improving the hospital discharge process for patients on the case management register, including attempting to contact these patients, by an appropriate member of the practice or community staff, in a timely manner to ensure co-ordination and delivery of care.

- For undertaking regular practices reviews of emergency admissions and A&E attendances of all their registered patients in care and nursing homes, as well as undertaking monthly reviews of all unplanned

[25] Subject to feasibility study and patient survey being implemented.
[26] Including those patients who have declined a care plan with informed dissent but still wish to remain on the case management register to benefit from other aspects of this service.

admissions and readmissions and A&E attendances of patients on the case management register.

- For participating in the survey[27].

7.5 GP practices will need to ensure that they manage any in-year risk associated with changes in practice list size. In exceptional circumstances which temporarily lead to the register falling below the tolerance, commissioners and GP practices will need to discuss and review the situation.

7.6 The component one payment will be payable by commissioners on 31 July 2015.

7.7 The component two payment will be payable by commissioners no later than 30 November 2015, subject to the GP practice delivering the minimum requirements set out above. Payment will be triggered on the basis that the GP practice has a minimum of 1.8 per cent of patients on the register on 30 September 2015 as a proportion of the list size taken on the 1 April 2015 who have been informed of their named accountable GP and who have had in the last 12 months either a care plan developed or a care plan reviewed or a care plan declined[28] . This will be determined from manually submitted data and automated data collections when GPES is available. Commissioners should also check that the other requirements set out above (same day telephone consultations, ex-directory or by-pass numbers, hospital discharge process, practice reviews and if relevant the patient survey) are being delivered.

7.8 The component three payment will be payable by commissioners no later than 31 May 2016 subject to the GP practice delivering the minimum requirements set out above. Payment will be triggered on the basis that the practice has a minimum of 1.8 per cent of patients on the register on 31 March 2016 as a proportion of the list size taken on the 1 October 2015 who have been informed of their named accountable GP and who have had in the last 12 months either a care plan developed or a care plan reviewed or a care plan declined[29]. This will be determined from manually submitted data and automated data collections when GPES is available. Commissioners should also check that the other requirements set out above (same day telephone

[27] Subject to feasibility study and patient survey being implemented.
[28] Payment will only be triggered if the three key performance indicators are met (determined from both automated and manual data submissions).
[29] Payment will only be triggered if the three key performance indicators are met (determined from both automated and manual data submissions).

consultations, ex-directory or by-pass numbers, hospital discharge process, practice reviews and if relevant the patient survey) are being delivered.

7.9 While there is an accepted tolerance of -0.2 per cent in each six month period, GP practices will need to ensure that across the financial year, their register maintains at least an average of two per cent of the eligible cohort. This will be calculated by taking an average of the percentages in each six month period (i.e. first six months % + second six months % divided by two), calculated as described above in this section i.e. based on the list taken at 1 April 2015 and 1 October 2015 respectively. If there are exceptional circumstances which lead to the average not being maintained, commissioners and GP practices will need to discuss and review the situation.

7.10 GP practices can submit a manual claim, relating to patients who have died or moved practice, if they have not achieved the minimum 1.8 per cent in each six month period. This would only apply if the practice was unable to replace these patients on the case management register within a reasonable timeframe and any patient claimed for in the first six month period cannot be counted again in the second six month period. GP practices will be required to submit the relevant information described in the monitoring section in support of any manual claims, within two weeks of 30 September 2015 and 31 March 2016 respectively.

7.11 A GP practice that registers new patients in-year who have been on a case management register at their previous practice will only count towards the minimum two per cent if their care plan is re-discussed with the patient and carer.

7.12 CQRS will calculate all the payments.

7.13 In the event a GP practice does not achieve components two and three and maintain the case management register at least an average of two per cent of the eligible patient cohort across the financial year, then in accordance with table 1, the commissioner will not be required to make payments or will be able to claw back payments made. Any claw back of payments will be made at the end of the financial year.

Table 1: Summary of payments, amounts and payment due dates

Payment	Percentage of total funding	Per registered patient (total £2.87)	Payable (no later than*)
Component 1	46%	£1.33	31 July 2015
Component 2	27%	£0.77	30 November 2015
Component 3	27%	£0.77	31 May 2016

* Payment by this date is subject to all elements of the payment process being delivered in time, including the practice supplying any manually submitted data to the commissioner.

Table 2: Scenarios for action to be taken in the event a GP practice does not deliver all[30] requirements under this ES

Scenario	Component 2	Component 3	Register	Action
A	Y	Y	Y	Pay components 2 & 3. Practice keeps component 1 payment
B	Y	Y	N	Pay components 2 & 3, commissioner claws back 40% of component 1 (in line with 14/15 claw back on failing register across the year)
C	Y	N	Y	Pay component 2, do not pay component 3. Commissioner claws back 20% of component 1
D	Y	N	N	Pay component 2, do not pay component 3. Commissioner claws back 40% of component 1
E	N	Y	Y	Do not pay component 2, pay component 3. Commissioner claws back 20% of component 1
F	N	Y	N	Do not pay component 2, pay component 3. Commissioner claws back 40% of component 1
G	N	N	N	Do not pay component 2 or 3. Practice is required to demonstrate they have delivered the ES requirements (named GP and personalised care plans) to a minimum 25% of 2% register, as well as undertaking the other requirements in the ES. If the practice can demonstrate this, commissioner claws back

[30] If there are exceptional circumstances which lead to a practice not achieving one element of each component and the reason for doing so can be justified, then the commissioner and practice will need to discuss and review the situation.

Scenario	Component 2	Component 3	Register	Action
				21% of component 1. If the practice cannot demonstrate this, commissioner claws back entire component 1 payment (46%).

7.14 Commissioners will be responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this ES. Commissioners may make use of the information received or extracted.

7.15 Where required, GP practices must make available to commissioners any information they require and that the practice can reasonably be expected to obtain, in order to establish whether or not the practice has fulfilled its obligation under the ES arrangements.

Annex A: Reporting template

[Name] Commissioner
2015/16 Avoiding Unplanned Admissions Enhanced Service – Reporting Template

Practice Name:

Practice Code:

Signed on behalf of practice: **Date:**

SECTION 1 – practice availability		
1. Please specify how health and social care services can contact the practice in emergency situations regarding patients on the practice's registered list?		
a. A&E and ambulance staff		
b. Care and nursing homes		
c. Other care providers (e.g. mental health and social services)		
2. Does the practice have a system in place to enable patients on the case management register to receive same day telephone consultations for their urgent enquires?		YES / NO

SECTION 2 – proactive case management	
1. Has the practice agreed personalised care plans or undertaken at least one care review during the year, with at least 1.8% per cent of eligible patients (i.e. patients aged 18 and over) by:	
a. 30 September 2015?	YES / NO
b. 31 March 2016?	YES / NO
2. Has the practice agreed personalised care plans with all patients on the case management register or undertaken at least one care review during the year? (i.e. for a minimum of 2% of the practice population aged 18 and over on the register between 1 April 2015 to 31 March 2016)	YES / NO
3. Has the practice submitted manual data relating to any patients who have died or moved in each of the six month periods?	YES / NO
4. Have all patients on the case management register been notified of their named accountable GP?	YES / NO
SECTION 3 – hospital discharge process	
1. Is there a system in place for contacting patients post-discharge from hospital?	YES / NO
2. What recommendations has the practice made to the commissioner and CCG (if not the commissioner of the ES) to support improvements in the commissioning of services for patients in this group? Please provide brief details.	

SECTION 4 – internal practice reviews	
1. Has the practice carried out reviews of emergency admissions and A&E attendances for:	
a. their registered patients living in care and nursing homes?	YES / NO
b. their patients on the case management register?	YES / NO
3. What recommendations has the practice made to the commissioner and CCG (if not the commissioner of the ES) to support improvements in the commissioning of services for patients in this group? Please provide brief details.	
SECTION 5 – patient survey	
1. Has the practice undertaken the survey of patients on the case management register using the materials provided?	YES / NO

Reporting template - notes

Reports are required to be submitted, to the commissioner and CCG (if not the commissioner of the ES), on a twice yearly basis by no later than the last day of the month following the end of the relevant six month period.

This reporting template should be read in conjunction with the specification and guidance.

It is the practice's responsibility to ensure that they are familiar with the guidance set out nationally and that they fully understand the ES requirements for the completion of reporting submissions. Failure to understand the requirements of this ES may result in components not being met and payments being withheld – see section on payment and validation in the service specification. It is essential that GP practices engage with their CCG throughout the process.

The reports should be submitted electronically and any additional documents should be scanned in where possible to minimise paper requirements. The submission email address […to be added by the commissioner/will be confirmed closer to the deadline date]. Please contact your contract manager if you have any queries in the meantime.

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

1. Payments under the ES for avoiding unplanned admissions: proactive case finding and patient care review for vulnerable people are to be treated for accounting and superannuation purposes as gross income of the GP practice in the financial year.
2. The amount calculated as payment for the financial year with respect to:
    - **Component one** falls due on the 31 July 2015, the last day of the month following the month in which GP practices are able to agree to participate in this ES.
    - **Component two** falls due on the last day of the month following the month during which the GP practice provides the assurance that they have delivered the minimum requirements associated with this component.
    - **Component three** falls due on the last day of the month following the month during which the GP practices provides assurance that they have delivered the minimum requirements associated with this component.
3. Payments under this ES, or any part thereof, will be made only if the GP practice satisfies the following conditions:
    a. the GP practice must make available to the commissioner any information which commissioners need and the GP practice either has or could be reasonably expected to obtain, in order to establish whether the GP practice has fulfilled its obligation under the ES arrangements;
    b. the GP practice must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System or CQRS and do so promptly and fully; and
    c. all information supplied pursuant to or in accordance with this paragraph must be accurate.
4. If the GP practice does not satisfy any of the above conditions, commissioners may, in appropriate circumstances, withhold payment of any, or any part of, an amount due under this ES that is otherwise payable.

5. In the event a GP practice does not achieve components two and three and maintain the case management register at least an average of two per cent of the eligible patient cohort across the financial year, then in accordance with table 2 in the payment and validation section (copied here) the commissioner will not be required to make payments or will be able to claw back payments made. Any claw back of payments will be made at the end of the financial year. If there are exceptional circumstances which lead to a GP practice not achieving one element of each component and the reason for doing so can be justified, then the GP practice and their commissioner will need to discuss and review the situation.

Table 2: Scenarios for action to be taken in the event a GP practice does not deliver all[31] requirements under this ES

Scenario	Component 2	Component 3	Register	Action
A	Y	Y	Y	Pay components 2 & 3. Practice keeps component 1 payment
B	Y	Y	N	Pay components 2 & 3, commissioner claws back 40% of component 1 (in line with 14/15 claw back on failing register across the year)
C	Y	N	Y	Pay component 2, do not pay component 3. Commissioner claws back 20% of component 1
D	Y	N	N	Pay component 2, do not pay component 3. Commissioner claws back 40% of component 1
E	N	Y	Y	Do not pay component 2, pay component 3. Commissioner claws back 20% of component 1
F	N	Y	N	Do not pay component 2, pay component 3. Commissioner claws back 40% of component 1
G	N	N	N	Do not pay component 2 or 3. Practice is required to demonstrate they have delivered the ES requirements (named GP and personalised care plans) to a minimum 25% of 2% register, as well as undertaking the other

[31] If there are exceptional circumstances which lead to a practice not achieving one element of each component and the reason for doing so can be justified, then the commissioner and practice will need to discuss and review the situation.

Scenario	Component 2	Component 3	Register	Action
				requirements in the ES. If the practice can demonstrate this, commissioner claws back 21% of component 1. If the practice cannot demonstrate this, commissioner claws back entire component 1 payment (46%).

6. If the commissioner makes a payment to a GP practice under this ES and:
    a. the GP practice was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due), or
    b. the commissioner was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid, or

    the commissioner is entitled to repayment of all or part of the money paid then.
7. Commissioners may recover the money paid by deducting an equivalent amount from any payment payable to the GP practice and where no such deduction can be made, it is a condition of the payments made under this ES that the contractor must pay to the commissioner that equivalent amount.
8. Where the commissioner is entitled under this ES to withhold all or part of a payment because of a breach of a payment condition and the commissioner does so or recovers the money by deducting an equivalent amount from another payment in accordance with paragraph 5 of this annex, it may, where it sees fit to do so, reimburse the contractor the amount withheld or recovered, if the breach is cured.

Provisions relating to GP practices that terminate or withdraw from the ES prior to 31 March 2016 (subject to the provisions below for termination attributable to a GP practice split or merger)

9. Where a GP practice has entered into the ES avoiding unplanned admissions: proactive case finding and care review for vulnerable people but its primary medical care contract subsequently terminates or the GP practice withdraws from the ES prior to 31 March 2016, the GP practice is entitled to a payment in respect of its participation, calculated in accordance with the provisions set out below. Any payment calculated will fall due on the last day of the month following the month during which the commissioner has all the information its needs to calculate such a payment.
10. In order to qualify for payment in respect of participation under the ES, the GP practice must provide the commissioner with the information under paragraph 6.1, 6.3, 6.4 and 6.5 of the ES specification before payment will be made. This information should be provided in writing, within 28 days following the termination of the contract or the withdrawal from the ES agreement.
11. The payment due to GP practices who terminate or who withdraw from the ES agreement prior to 31 March 2016 will be calculated32 as:
    - **Component one** calculated as £1.33 divided by 365 days, multiplied by the number of days the GP practice provided the service during the financial year, multiplied by CRP as at 1 April 2015.
    - **Component two** calculated as £0.77 divided by 182 days, multiplied by the number of days the GP practice provided the service during the second quarter of the financial year, multiplied by CRP as at 1 April 2015 and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
    - **Component three** calculated as £0.77 divided by 183 days, multiplied by the number of days the GP practice provided the service during the third quarter of the financial year, multiplied by CRP as at 1 April 2015 and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.

Provisions relating to GP practices who merge or split.

12. Where two or more GP practices merge or are formed following a contractual split of single GP practice and as a result the registered population is combined or

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

divided between new GP practice(s), the new GP practice(s) may enter into a new or a varied agreement to provide the ES for avoiding unplanned admissions: proactive case finding and patient care review for vulnerable people.

13. The ES agreements of the GP practices that formed following a contractual merger, or the GP practice prior to contractual split, will be treated as having terminated and the entitlement of the GP practice(s) to any payment(s) will be assessed on the basis of the provisions of paragraph 9 of this annex.
14. The entitlement to any payment(s) of the GP practice(s), formed following a contractual merger or split, entering into the new or varied agreement for the ES, will be assessed and any new arrangements that may be agreed in writing with the commissioner will commence at the time the GP practice starts to provide such new arrangements.
15. Where that new or varied agreement is entered into and the new arrangements commence within 28 days of the new GP practice(s) being formed, the new arrangements are deemed to have commenced on the date of the new GP practice(s) being formed. Payment will be assessed in line with the ES specification – subject to provisions of paragraph 14 of this annex.
16. The commissioner is entitled to make an adjustment to the payment, or any part thereof, if payment has already been made or is payable to the previous GP practice(s) for participating in the ES. The adjustment may be:
    - **Component one** calculated as £1.33 divided by 365 days, multiplied by the number of days remaining in the financial year from the date of the new arrangements, multiplied by the number of registered patients.
    - **Component two** calculated as £0.77 divided by 182 days, multiplied by the number of days remaining if quarter two from when the new arrangements came into place, multiplied by the number of registered patients and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.
    - **Component three** calculated as £0.77 divided by 183 days, multiplied by the number of days remaining if quarter three from when the new arrangements came into place, multiplied by the number of registered patients and if the GP practice maintained a minimum of two per cent for the case management register during the relevant days.

Provisions relating to non-standard splits and mergers

17. Where the GP practice participating in the ES is subject to a split or a merger and:

    a. the application of the provisions set out above in respect of splits or mergers would, in the reasonable opinion of the commissioner, lead to an inequitable result; or,

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

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