NHS
Somerset
Clinical Commissioning Group

Service Specification No.	11X-25-3
Service	Complex Care
Commissioner Lead	As per the Particulars of the NHS Standard Contract
Provider Lead	As per the Particulars of the NHS Standard Contract
Period	01 April 2019 – 31 March 2021
Date of Review	September 2019

1. Population Needs

National/local context and evidence base

1.1 People in the UK are living longer and one of the challenges this brings is the increasing numbers of older people living with multiple medical conditions which can interact in complex ways.

1.2 Somerset has a higher than average elderly population resulting in a large proportion of patients with complex chronic health care needs many of whom need to live in supported environments like residential and nursing homes.

1.3 Statistics taken from Symphony Joint Venture Data 2013/14 show that by the age of 80 more than a quarter of people in Somerset are living with three or more long-term conditions.

1.4 Somerset Clinical Commissioning Group (CCG) is committed to ensuring that care plans are tailored to each person, giving them choice and control and recognising the inter-related nature of multiple long-term conditions[i].

1.5 Residents should consistently receive high-quality care that is person-centred and dignified, and have the same access to all necessary health care as older people living in other settings.

1.6 The care of these residents is regularly reviewed and coordinated by experienced health professionals working with a multi-disciplinary team including adult social care.

2. Outcomes

2.1 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**	☑

2.2 Local defined outcomes

- Improved advanced care planning and End of Life preferences

3. Scope

Aims and objectives of service

SERVICE AIMS

3.1 The main aims of the service are to provide time-limited enhanced support to selected residential and nursing homes in the locality and help to achieve:

- An improvement in the coordination and planning of patient care
- An improvement in the patient's experience and quality of life
- An improvement in the confidence and capability of nursing and residential home staff
- A reduction in unscheduled avoidable emergency admissions to hospital
- Advanced care planning and choice in end of life care

SERVICE DESCRIPTION/CARE PATHWAY

3.2 This specification defines the Complex Care General Practitioner (CCGP) Service commissioned by Somerset CCG and in accordance with locality proposals as detailed in Appendix 1.

3.3 The service is commissioned from a lead GP practice in each locality to provide enhanced clinical support to residents and staff in specifically targeted nursing and residential care homes across the respective locality.

3.4 For the purposes of this Service, the term 'home' is used to mean either residential home or nursing home. The term 'resident' and 'patient' are used interchangeably and refer to the people whose care is assessed by the CCGP service.

SERVICE TO BE PROVIDED

3.5 The CCGP service will provide the following three main functions which are described in greater detail below:

- Initial engagement with specific homes and where commissioned, 'housebound'[ii] patients in their own homes
- Provision of the service for an agreed period of time. In general, this should be for no longer than one year in any one home
- Monitoring and reporting of outcomes and impact

SELECTION AND ENGAGEMENT OF HOMES

3.6 The CCG will assist the lead GP Provider in identifying the home or homes which are most likely to benefit from the enhanced support. This will include consideration of:

- 999 call out rates
- Local clinical experience
- Requests from homes for enhanced support
- Homes about which safeguarding and other concerns about the quality of the service have been raised

3.7 The CCGP will contact the home or homes to discuss the service available.

3.8 Where the home agrees to receive the support the CCGP will ensure the following

is discussed and agreed:

- The nature and scope of the service to be provided
- Contact details for the service are provided
- Any specific requirements from the home about the approach to providing the service
- The monitoring and reporting arrangements for the service
- Responsibilities of the home staff in support of the CCGP Service (See Annex 1)
- Frequency of visits
- How the staff and residents can make and log comments, suggestions and complaints about the service
- Timeframe for support for the home
- Plans for sustaining improvements following the end of the support period

3.9 Following these initial steps the CCGP service and home manager will identify residents who are most at risk of emergency admissions, i.e. those with complex and higher risk needs, whose care will be reviewed first.

3.10 Before commencing the support to residents of the home:

- the CCGP Service will ensure that the patient's own GP is made aware that the service is being provided to the home
- the home manager will ensure that residents and staff are provided with information about the service and that residents whose care is to be reviewed have given their informed consent for this to take place. Where a consent form is not already available, a template is provided as Annex 2. A copy of this consent form should be stored with the registered practice's clinical record for the patient.

3.11 Where a patient is unable to give consent, the CCGP will assume consent having ascertained that a review of care by the service is in the best interests of the patient and having discussed this with the home manager and patients relatives.

3.12 An information leaflet which localities may use and adopt is included as Annex 3.

SERVICE SPECIFICATION AND CRITERIA

3.13 In support of the three main functions the CCGP service will provide:

- clinical review and review of care plans and treatment for each resident
- initiation or recommendations to change the care provided
- follow up review (within 6 months)

3.14 A template is provided as Annex 4 to record the assessment, changes and recommendations made. (The main review domains should remain but the format can be changed to make recording the information as straightforward as possible).

COMPREHENSIVE REVIEW

3.15 The CCGP Service will provide an initial comprehensive clinical review in accordance with

best practice of the care currently provided to the residents. The scale and depth of the review should be tailored to the needs of the patient, i.e. not all elements will be clinically appropriate to consider with all patients.

3.16 The CCGP is expected to oversee that the following elements of care, which are the duty of the home or another provider, are in place and advise the home or make arrangements for them to be completed:

- Nutritional assessment to include Malnutirion Universal Scoring Tool (MUST) score, Body Mass Index (BMI) and swallowing, and the actions taken following the outcome of this assessment
- Pressure Ulcer Risk Assessment and the actions taken following the outcome of this assessment
- Thromboembolic risk assessment
- Falls assessment –Using falls service model/Occupational Therapy (OT) assessment and the actions taken following the outcome of this assessment
- Osteoporosis screening –Fracture Risk Assessment Tool (FRAX) Scoring and the actions taken following the outcome of this assessment
- Medication review
- Medical record review, including compliance and the provision and administration of medication

- Management of long term conditions for example Chronic Obstructive Pulmonary Disease (COPD), diabetes management
- Screening and immunisation history including flu vaccination status
- Mental health screening to include dementia and depression screening
- End of Life wishes and plan
- Resuscitation status
- Escalation planning
- Staff concerns or suggestions about improving the care for the patient
- Agreed review date

3.17 The initial comprehensive clinical review should also consider the following which should be reviewed annually by the patient's care manager (District Nurse, Community Psychiatric Nurse or Social Worker)

- Patient's current access to other required services including dental, podiatry, eye services, audiology.
- The patient's view and experience
- The view of family and carers where appropriate
- The completeness and relevance of the patient's current care plan including where appropriate signposting to third sector involvement and/or support

3.18 The “Medical Certification of Cause of Death: Form A” can be signed by the CCGP if they have seen the patient within 14 days.

3.19 In the event of a patient who is shortly expected to die, the patient’s own GP would ordinarily sign the Expected Death form (before death) which allows staff not to have to call the Out of Hours Service in the event of the patient having died. Where appropriate, the CCGP can also complete the Expected Death form and notification should be sent to the patient’s own GP.

INITIATING AND RECOMMENDING CHANGES

3.20 Following the comprehensive review the CCGP service will summarise the main needs of the patients, the actions taken and recommendations made to the patient, their relatives, the patient’s usual GP, the staff at the home or recommendations made to other agencies. (See end of Review Template)

3.21 Three paper copies of the Review (including the summary and recommendations) would be kept as follows:

- One copy kept at the home
- One copy kept at the home should accompany the patient to hospital if admitted.
- One copy sent to the patient’s own GP by fax, secure electronic media or post within 24 hrs of the review being conducted

3.22 The CCGP will advise of any identified support for home staff to improve the care or coordination of the care provided to the patient.

3.23 The CCGP in agreement with the home and the patient’s care plan and preferences, will initiate changes to the care provided to the patients.

3.24 The CCGP will recommend appropriate changes to the patient’s own GP, to include:

- Any and all changes to medication, treatment or another element of care
- Suggestions for referral by the patient’s usual GP to other services for example: memory clinics / old age psychiatry, community nursing and matrons, COPD, podiatry, heart failure, diabetes, falls and rehabilitation services

3.25 The CCGP would ensure that any relevant aspect of the patient’s care plans is known by the Ambulance and Out of Hours service, community nursing or other service where appropriate. This would include for example: ‘Special Message Notifications’, Do Not Attend to Resuscitate (DNAR) Forms and End of Life Plans with information included on the CCGs Electronic Palliative and Care Coordination System as appropriate.

PLANNED FOLLOW UP REVIEW

3.26 The CCGP service will provide a subsequent review of the patient’s care at an agreed interval but no less than 6 months after the comprehensive review.

SERVICE MODEL

3.27 The specific approach to delivering the CCGP service in each of the locality areas will be decided and coordinated by the locality in discussion with the local homes; as per Appendix 1.

3.28 The service will however be led, coordinated and delivered by a nominated lead GP who is included on the NHS England National Performer's List.

3.29 The service will have in place CCGP cover and succession planning arrangements to ensure continuity of care.

3.30 The service will have published contact details.

3.31 The contract for the service will be held between Somerset CCG and the nominated lead practice.

3.32 In delivering the service, the lead practice should ensure that key related organisations are informed about the service and know of its existence.

UNMET NEED AND LOCAL SERVICE IMPROVEMENTS

3.33 Where the CCGP identifies unmet needs for patients or improvements required to the provision or structure of local NHS service, these should be raised with Somerset CCG directly.

OTHER SERVICES WITHIN SCOPE

3.34 As part of the service the CCGP can also provide:

- review and support for the home in its attainment of the Gold Standards Framework accreditation.
- support to homes about the improvement of pressure sores, falls and Venous thromboembolism (VTE) assessments.
- initial comprehensive clinical review of care plans and treatment for any patients on respite or step-down programmes including initiation of recommendations to change the care provided
- support to the home with medical queries relating to other residents by exception; on a case by case basis.
- Any other additional services as described in locality bids as detailed in Appendix 1.

SERVICES NOT INCLUDED WITHIN THE SPECIFICATION

3.35 The CCGP service is not commissioned to provide the selected homes with:

- General Primary Medical Services
- An urgent or emergency response service
- Long term, unending, support

RECORD KEEPING

3.36 The CCGP Service will maintain, with the home, the following records for the duration of the support provided as per Appendix 7 :

- The name/s of the homes supported
- A completed review template for each patient with copies stored as Section 11.

- A log of visit dates and times
- A log of any feedback received from patients, carers and staff
- An annual satisfaction survey of patients and staff about the service

OUTCOMES, MEASURES AND REPORTING

Outcomes and Measures

3.37 The success of the CCGP service will be assessed against the following proxy measures relating to harm reduction as per applicable quality requirements (section 5):

- Number of patients supported to die where they wish to
- Reduction in number of falls
- Reduction in the number of pressure ulcers;

which shall lead to an anticipated:

- reduction in emergency admission rates from the home
- increase in patient/carer/family/ home staff satisfaction

Reporting

3.38 The CCGP service will:

- Provide the commissioner with a quarterly report using Annex 4 including the number of comprehensive reviews conducted and information to be provided by the home (as per 3.40)[iii]
- Meet with commissioners to discuss the service as required
- Annual peer review with representatives of other Service Providers which may be undertaken virtually with the assistance of information technology.

3.39 To support the collection of data the CCGP should ensure that the home is aware of their responsibility (using Annex 1) provide the CCGP service with:

- The number of 999 and OOH calls from the home and reasons for the call (log to be retained by the home)
- The number of patients supported to die where they wish to
- The number of pressure sores and grades acquired by patients in the home
- The number of falls sustained by patients in the home

3.40 The CCG will also monitor and provide the CCGP Service with the following information:

- Emergency admission rates from the homes

INFORMATION SHARING

3.41 In providing the service the practices within the locality will ensure that each practice involved has signed up to the Somerset Information Sharing Protocol to underpin the sharing of patient information by relevant practices with the CCGP service. (See Schedule 2 Part G)

MEDICINES MANAGEMENT

3.42 For specialist medicines management advice relating to patients covered by this service the CCGP service should contact the Medicines Management Team at Somerset CCG to consider coordinating medication review. (See Contact Details in Annex 7).

SIGNIFICANT/ADVERSE EVENTS

3.43 The Department of Health emphasises the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.

3.44 The Provider should be aware of (and use as appropriate) the various reporting systems such as:

- The National Reporting and Learning System (NRLS). Reports to NRLS can be submitted electronically via the General Practice Patient Safely Incident report Form, or the national GP e-form. If using the GP e-form please check the box to share your report with Somerset CCG.
- the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices; and
- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.45 In addition to their statutory obligations, the Provider will notify the Commissioner within 72 hours of being aware of the hospital admission or death of a patient being treated by the Provider under this enhanced service via the email address below..

3.46 In addition to any regulatory requirements the CCG wishes the Provider to use a Significant Event Audit system (agreed with the Clinical Commissioning Group) to facilitate the dissemination of learning, minimising risk and improving patient care and safety. Providers shall:

- Report all significant events to the CCG within 2 working days of being brought to the attention of the Provider somccg.significantevents@nhs.net
- Undertake a significant event audit (SEA) using a tool approved by the CCG and forward the completed SEA report to the CCG within one month of the event via https://www.somersetccg.nhs.uk/about-us/how-we-do-things/general-practice-significant-event-sea-and-serious-incident-support-professional-page/

SERVICE USER AND PUBLIC INVOLVEMENT

3.47 Homes and the CCGP will encourage, consider and report any patient feedback (positive and negative) on the service that they provide and use it to improve the care provided to

patients, particularly if there are plans to alter the way a service is delivered or accessed

PRICING

3.48 Payment for this service is set out in Schedule 3 Part A.

POPULATION COVERED

3.49 Residents in specifically targeted homes across the respective Locality area.

ANY ACCEPTANCE AND EXCLUSION CRITERIA AND THRESHOLDS

3.50 Not applicable.

INTERDEPENDENCE WITH OTHER SERVICES/PROVIDERS

3.51 Not applicable.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The service will be provided to residents in accordance with:

NICE Guidelines NG22 available at
http://www.nice.org.uk/guidance/ng22/chapter/1-Recommendations#care-planning

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

The Nolan Principles (see Annex 6):
https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

The General Medical Council's Good Medical Practice Guidelines available at:
http://www.gmc-uk.org/guidance/good_medical_practice.asp

Nursing and Midwifery Council Code of Professional Conduct, available at:
http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/

Care Home Use of Medicines Study (CHUMS)available at
http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf

The House of Care: https://www.england.nhs.uk/house-of-care/

The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections. The Stationary Office, 2006.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 The Scottish Government Health Delivery Directorate Improvement and Support Team available at: http://www.gov.scot/resource/doc/263175/0078713.pdf

4.4 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 **Applicable quality requirements (See Schedule 4 Parts A-D)**

5.2 Patients feel supported to die where they wish to

- Increased % of deceased patients dying where they wish to

5.3 Patients consider they had been listened to, treated with respect and dignity and have positively contributed to their Care Plan and End of Life Advanced Care Plan

- Improve and maintain the % of patients with a Care Plan
- Improve and maintain the % of patients with an Advanced Care Plan

5.4 The CCGP and home staff will actively work together to reduce avoidable harm to patients

- Annual reduction in the % of unplanned admissions
- Annual reduction in the % of patients with pressure ulcers
- Annual reduction in the % of recorded falls

5.5 Applicable CQUIN goals (See Schedule 4 Part E)

Not applicable

6. Location of Provider Premises

The Provider's Premises are located at:

As per the Particulars of the NHS Standard Contract

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[i] http://www.nice.org.uk/guidance/ng22/chapter/1-Recommendations#care-planning

[ii] Definition of housebound: A patient will be deemed to be housebound when they are unable to leave their home environment through physical and/or psychological illness

[iii] Where suitable anonymised data becomes available to the CCG with improving information technology, it is anticipated that a proportion of the reporting requirements may be accessible to the CCG in an automated format