Unplanned admissions enhanced service: A step by step guide for practices

Introduction

The unplanned admissions enhanced service forms the main new area of work for the 2014/15 contract agreement. In considering this new area of work, practices should note that this enhanced service is funded by and *replaces* the work of the three areas of the QOF-QP domain and the Risk Profiling DES, with these having ceased as of April 1 2014. In addition, wider changes to the contract including QOF clinical point reductions and cessation of the remote monitoring DES and online patient DESs should have reduced bureaucratic workload for practices this year.

This guide is intended to support practices to minimise bureaucracy that could develop in implementation, while maximising care for patients covered in this service. We have produced optional model templates for reporting purposes which we believe satisfy the relevant requirements of the enhanced service while also reducing variable and potentially onerous reporting requirements from individual Area Teams. It is vital that practices act on these changes to manage their workload by not continuing any QP type work, unless they receive specific additional resources from the CCG and agree to carry out this work. Further, for many practices this enhanced service builds upon work that had previously been done under the Risk Profiling DES, rather than starting from scratch.

While the enhanced service is entitled "avoiding unplanned admissions", its focus is really on optimising coordinated care for the most vulnerable patients to best manage them at home. They are likely to be the patients already most frequently seen by a practice. The GPC has been clear to NHS England that avoiding unplanned admissions requires a wider whole system approach that includes NHS 111, community nursing, social care, and rehabilitation services all playing their part within a coordinated approach. As part of this, it is vital that CCGs support practices to deliver this wider agenda by making available the £5 per patient resource specified in NHS England's planning guidance "Everyone Counts" which is intended to support this area of work.

Importantly, this enhanced service empowers practices to make recommendations to the CCG regarding any service gaps or commissioning redesign needed to optimise care for these patients.

For further details of the requirements of this enhanced service, practices should read the official joint enhanced service guidance.

Timescales

Area teams should have sought to invite practices to participate in this enhanced service before 30 April 2014. Practices wishing to participate will be required to sign up by no later than 30 June 2014.

Required steps for practices

The steps that practices need to take to meet the requirements of this enhanced service are:

1. **Establish the case management register**
2. **Inform patients that they are on the register and of their named accountable GP and care co-ordinator**
3. **Put care plans in place for patients on the register**

4. **Offer a bypass number for care providers to discuss patients requiring a potential hospital admission**
5. **Offer same day telephone access to patients on the case register with an urgent medical problem**
6. **Make contact with patients on the case management register following discharge from hospital, to ensure co-ordination and delivery of care**
7. **Regularly review emergency admissions and A&E attendances of their patients from care and nursing homes**
8. **Undertake monthly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the case management register**
9. **Complete a quarterly reporting template for the Area Team**

1. Establish the case management register:

Practices should create a case management register of a minimum of 2% of the adult population (18 years and over) at risk of unplanned admission to hospital. CCGs should provide a risk stratification tool for practices to use to do this but if a tool is not available, practices should use their clinical judgement in creating the list. The joint official guidance on the enhanced service also advises developing care plans for children with complex care needs but these will not count towards payment of the enhanced service.

Patients on the case management register should be coded as:

Admission avoidance care started - Read v2: 8CV4, Read CTV3: XaYD1
Admission avoidance care ended - Read v2: 8CT2, Read CTV3: XaYD2

The "admission avoidance care started" code will be used to identify patients on the case management register. The "Admission avoidance care ended" code will be used to remove patients from the register.

Case Management Register monitoring and payment information:

- The case management register will not be monitored or measured until the second quarter of the financial year, running from 1st July to 30th September. The register must be maintained for quarters 2, 3 and 4 in order to receive the full payment for this element of the enhanced service.

- At the end of quarters 2-4, practices will need a minimum of 1.8% of adult patients on the case management register, **based on the practice list size at the beginning of each quarter** (1st July 2014, 1st October 2014 and 1st January 2015), to receive case management register payments for each quarter.

- The number of patients on the case management register will be measured at the end of each quarter using a proposed extraction via GPES. The 1.8% minimum reflects a 0.2% tolerance negotiated by the GPC but we would advise practices to try and maintain the register at 2% to avoid the potential clawback explained below. Practices should also maintain the 2% register by ensuring that any patients leaving the register (eg those who have died or moved) are replaced by new patients.

- NHS England Area Teams should provide practices with the list size denominator at the beginning of each quarter. Practices should run their own search prior to the end of the quarter to ensure that they have sufficient numbers on the register.

  E.g. if 5000 patients above 18 yrs on July 1st – case management register is 2% of 5000= 100 patients

  Number of patients on risk register on 30 September 2014 should be 100 patients

  A new denominator list size will then apply on October 1st,.

- While there is a 0.2% tolerance in place for individual quarters, practices will also need to ensure an average of 2% on the case management register across the three quarters. This will be calculated by taking an average of the percentages taken at the end of each quarter as described above. **If the 2% average is not maintained, Area Teams will be able to claw back payments made for the each of the three quarters.**

2. Inform patients they are on the register and of their named accountable GP and care co-ordinator:

Named accountable GP

Practices should identify a named accountable GP within the practice who has responsibility for the creation of personalised care plans and appointing a care co-ordinator. Named accountable GPs will also maintain overall accountability for ensuring that the personalised care plan is being delivered and that patient care, including the personalised care plan, is being reviewed as necessary. Patients should be made aware that this GP is not the sole provider of their care, and they can continue to see others in the practice as they currently do.

Care co-ordinator

The care co-ordinator will act as the main point of contact for the patient and is responsible for overseeing patient care, checking that the care plan is being delivered and that the patient and / or care agrees and changes to the plan, and keeping in contact with the patient and / or carer at agreed intervals.

The care co-ordinator could be a clinician, practice nurse or healthcare professional from outside the practice team (eg a district nurse or community matron). Where appropriate for the patient, a social worker could also act in this capacity. CCGs as commissioners should ensure that other employing bodies are aware of this and enable it to happen.

Informing Patients

Patients initially added to the register should be informed of their named accountable GP and their care coordinator by the end of July 2014, unless they are aged 75 and over and have already been informed of their named GP as part of the contractual requirements for that age group. Any new patients coming onto the register in-year should be notified within 21 days.

Practices must also inform relevant patients that they are enrolled on the case management register and what it is they can expect from being part of the enhanced service. It is up to the practice to decide how they inform patients about this; it could be verbally or in writing, and NHS England has

produced an optional template letter (Appendix A) which could be modified. To save time, the patient could be informed of the named GP and care coordinator at the same time as agreeing their care plan with them, as long as they meet the deadline requirements for informing patients.

Read code details for informing the patient of the named GP are:

Read v2: 67DJ, Read CTV3: Xab9D

3. Put care plans in place for patients on the register

Personalised care plans should be in place for all patients initially added to the register by the end of September 2014. Thereafter, any new patients coming onto the register in year should have their care plans created and agreed no later than one month after entry onto the register.

Remember patients with dementia, serious mental illness and learning disabilities are also expected to have annual care plans and it is likely that many of these patients will also be on the case management register.

Care plans could be in written form or created electronically. The latter, where possible, would simplify ease of data collection directly from clinical systems.

An optional template care plan is available (Appendix B). Practices are not required to use the template but there are minimum requirements for the content of the care plan:

- patient's name, address, date of birth, contact details and NHS number
- notification if the patient is a nursing or care home resident
- details of the patient's named accountable GP and care coordinator (if this is different to the named accountable GP)
- details of any other clinician(s) who play(s) a significant role in the patient's care relating to their specific condition(s) e.g. diabetic lead clinician, respiratory nurse, Macmillan nurse etc.
- confirmation/details of consent given for information sharing, including if a patient has given permission for a practice to speak directly to their carer(s)
- names and contact details of the patient's next of kin/main carer/responsible adult, if applicable
- details of the patient's condition(s) and significant past medical history
- details of any ongoing medication the patient is prescribed (this may also include over the counter (OTC) medicines, if relevant) and plans for review
- allergies
- details of any individual requirements or preferences which will aid the care and support of the individual
- key action points, for example early detection of impending deterioration with an agreed plan for escalating care, including crisis management

- where possible and as appropriate, signatories of the named GP/care coordinator, patient and/or carer

Read code details associated with recording and reviewing care plans are:

Admission avoidance care plan agreed - Read v2: 8CSB, Read CTV3: XabFm
Admission avoidance care plan declined - Read v2: 8IAe1, Read CTV3: XabFn

4. Offer a bypass number for care providers to discuss patients requiring a potential hospital admission:

This bypass number should be available for ambulance staff, A&E clinicians, care and nursing homes and other care providers to contact the practice for **urgent** matters. This is already established practice in most GP surgeries. Area Teams should collect the practice emergency numbers and liaise with the various bodies that require them

Additional information:

- Different extension options can be given to care providers calling the practice, as long as this gets the caller straight through to the practice as a priority call.

- The response time for a call should be clinically appropriate, in keeping with established practice. It should only be necessary to interrupt a GP in the middle of a consultation in exceptional circumstances.

5. Offer same day telephone access to patients on the case register with an urgent medical problem:

This telephone consultation will be with the most appropriate healthcare professional in the practice and the commitment is for urgent, not routine situations. Most practices already do this as good medical practice.

6. Make contact with patients on the case management register following discharge from hospital, to ensure co-ordination and delivery of care:

This will normally be within three days of the discharge notification being received, unless there is a reasonable reason for not doing so. This could include, for example, a patient being discharged to a remote address temporarily. This contact does not necessarily have to be made by a GP – it could be any appropriate member of the practice or community staff.

GPC has produced an optional discharge process template (Appendix C) for internal use, to ease the process for reporting information to Area Teams.

The practice should record any service gaps or problems in the discharge arrangements and make commissioning recommendations to the CCG to improve the discharge process.

7. Regularly review emergency admissions and A&E attendances of their patients from care and nursing homes

A GPC optional template for these reviews for internal use is available (Appendix C).

Where a practice has a large percentage of their patients in care and nursing homes, they should focus their reviews on any emerging themes from a sample of patients and on any patients who have regular avoidable admissions or A&E attendances. Such practices will be required to agree this process with their Area Team at the start of the year.

The practice should record any recommendations to the Clinical Commissioning Group (CCG) and the Area Team that could lead to improvements in care for patients in the community, or which identify any service shortcomings.

8. Undertake monthly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the case management register:

A GPC optional template for these reviews for internal use is available (Appendix C).

The practice should record any recommendations to the clinical commissioning group (CCG) and the Area Team that could lead to improvements in care for these patients, or which identify any service shortcomings.

9. Complete a quarterly reporting template for the Area Team (Appendix D):

This should be submitted to the Area Team and CCG no later than the last day of the month following the end of the relevant quarter.

If practices use the templates suggested above then this should satisfy the elements of the reporting template that require evidence from practices.

Payment Information

Payments will be based on a maximum of £2.87 per registered patient, in five components:

1 .Upfront 'establishment' payment of 45%

For setting up the enhanced service including:

- putting a system in place for patients on the register to receive same-day telephone consultations when they have urgent enquiries;
- obtaining, specifying and using the practice's ex-directory or bypass telephone number (if not already available); and
- developing, sharing and reviewing personalised care plans and patient care reviews (as appropriate) for a minimum of two per cent of the practice's adult patients aged 18 or over (i.e. all the patients on the case management register).

2. **Quarter two case management register payment of 20%**

- For maintaining the case management register at a minimum of two per cent for quarter two (i.e. 1 July 2014 to 30 September 2014)
- For identifying the named accountable GP and care coordinator (where applicable) and informing patients

3. **Quarter three case management register payment of 10%**

- For maintaining the register at a minimum of two per cent for quarter three (i.e. 1 October 2014 to 31 December 2014)
- For identifying the named accountable GP and care coordinator (where applicable) and informing patients

4. **Quarter four case management register payment of 10%**

- For maintaining the register at a minimum of two per cent for quarter four (i.e. 1 January 2015 to 31 March 2015)
- For identifying the named accountable GP and care coordinator (where applicable) and informing patients

5. **End-year payment of 15%**

- For reviewing and improving the hospital discharge process
- For undertaking regular internal practice reviews of all unplanned admissions and readmissions for vulnerable patients

APPENDICES:

A. Template letter to notify patients
B. Template care plan
C. Discharge process template, Emergency admission and A&E attendance template
D. Reporting template