Local Enhanced Service for
Closer Working and Anticipatory Care

Service Level Agreement

PRACTICE -

Contents:

1. Financial Details

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

This agreement is to cover the period from 1st July 2009 up to 31st March 2010.

Payment Rate:

Payment

Payment will be made to practices quarterly in arrears on receipt of evidence that a completed Anticipatory Care Patient Alert has been inputted on ADASTRA and received by the Hub (or equivalent):

Plan Completed	£ 60 per initial plan
Plan Reviewed (6 monthly)	£ 40 per plan review

Maximum of £100 per patient ACPA in the first year up to 31st March 2010..

Practices activity will be reviewed and payment will be capped at 1% of their patient list size plus nursing and residential home patients.

Payment Verification

Practices entering in to this contract must participate fully in the verification process determined by the CHP and LMC. Practices should ensure that they keep proper records to ensure a full and proper audit trail, and be able to evidence service delivery if requested by the CHP.

2. Signature Sheet

This document constitutes the agreement between the practice and the PCO in regards to this directed enhanced service.

PRACTICE……

Signature on behalf of the Practice:

Signature	Name	Date

Signature on behalf of the PCO:

Signature	Name	Date

PAYMENT WILL ONLY BE MADE UPON RECEIPT OF THIS SIGNED CONTRACT

3. Introduction

The Cancer/Demand Management LES has already allowed Practices to begin to discuss potential new working approaches to the principles of Closer Working and Collaborative Activity, to help make better use of NHS capacity to deliver a better deal for patients which is quicker, more personal and closer to home.

This has been extended with the development of the Closer Working Enhanced Service which aimed to focus Boards, CHPs and General Practice in developing local solutions to meeting HEAT and the 18wk Referral to treatment targets while driving forward the 'Shifting the Balance of Care' agenda.

It has been recognised that GP practices have a lot to offer in terms of influencing how patients are cared for, and in knowing how to address better ways to deliver services. Currently services lean heavily towards secondary care and it is recognised that Shifting the Balance of Care, and achievement of other linked initiatives and targets will require GP-led solutions.

Anticipatory Care is the next step in moving forward the 'Shifting the Balance of Care Agenda' i.e. that patients are cared for in the right place, at the right time by the right person.

Currently general practice already recognises the importance of anticipatory care planning in collaboration with the person and their family for Palliative Care patients through recent Palliative Care DES's and the Gold Standards Framework. Through discussion with the patient and their family the GP and extended primary care team understand the patients preferred place for end of life care, and every effort is made to plan care for them according to their wishes. Utilisation of the palliative care pathway and Gold Standards Framework prevents unplanned and unnecessary hospital admissions and patients dying in hospital when they had planned to die at home or elsewhere.

This enhanced service looks to extend and develop this work for patients with long term conditions who are identified through SPARRA data as being at risk of hospital admission. In addition practices will be asked to review Care Home patients, both nursing and residential home.

Initially practices will be asked to complete an Anticipatory Care Patient Alert (ACPA) (Appendix 1 in the ACPA Guidance Pack) for patients identified through SPARRA (the ACPA is similar to the Palliative Care Emergency Care Plan). With the full consent of the patient, a copy should be held within the patients medical record i.e. scanned in, and shared with other members of primary care team as required. A copy should also be held (and its location clearly identified) in the patient's home. The practice should also ensure that a copy is entered into the ADASTRA system to ensure that it is available to the Out of Hours Hub, NHS24 and the local A&E or PCEC .

Through the completion of the ACPA there is potential to identify services that could be put in place to prevent the patient's emergency admission, or information that could support the primary care team to potentially facilitate discharge planning if an admission is not avoidable. It is therefore important that this information is available to all members of the Primary Care Team. It is also important that the CHP is made

aware of any gaps in service provision, that if they were in place could prevent a patients admission to hospital.

In summary copies of the Anticipatory Care Patient Alert should be accessible by:

- The patient (paper copy)
- The GP Practice (scanned copy)
- The nearest A&E or PCEC (ADASTRA)
- The Hub & NHS24 (ADASTRA)

Practices should ensure that they are up to date at each location.

The Scottish Ambulance Service Emergency Dispatch Centre will need a copy of any Do Not Attempt Resuscitation documentation. The NHS Highland DNAR form should be used and must be faxed to the HUB and reviewed when applicable. The HUB will ensure that the DNAR is then passed to the SAS.

In addition the ACPA will also give the OOHs GPs or SAS additional information which may influence their decision making when reviewing a patient for the first time and therefore possibly preventing them from admitting the patient or allow them to consider alternative options for that patient.

As patients circumstances continually change and a patients condition may improve or deteriorate this plan needs to reviewed and updated regularly i.e. at a minimum of six monthly intervals, but could be more frequently if the patients circumstances change. The information must be changed on ADASTRA and any paper copies also updated.

SPARRA data will be provided to practices on a quarterly basis via a GP Portal on the NHS Highland Intranet. Practices will be required to complete an AR1 form to gain access. Instructions on how to access the GP Portal are included in the ACPA Guidance Pack.

What is SPARRA?

Scottish
Patients
At
Risk of
Readmission and
Admission

SPARRA estimates a patient's risk of admission or readmission: the algorithm uses the patient's demographics (age, sex, deprivation) and factors from their history of hospital admission over the 3 years prior to the year of interest e.g

- ***Number of previous emergency admissions***
- ***Time since last emergency admission***
- ***Total bed days accumulated in the 3 years***
- ***Principal diagnosis (last emergency admission)***

- ***Co-morbidity – number of diagnostic groups***
- ***Number of Elective admissions***

It then calculates a percentage risk of admission. The limitations of the SPARRA list is that it does not provide up to date information. Up to 20% of the patients identified by SPARRA may no longer be at risk, (improved health, deceased or lower risk). Therefore the data received should be taken in this context.
A Practice of 5,000 patients would need to identify the top 50 still at risk patients from SPARRA and complete ACPAs to meet the maximum 1% of their patient list size, plus any additional patients not identified by SPARRA who are nursing or residential home residents.

Work is going on nationally to evaluate it and other similar tools (e.g Nairn algorithm) with a view to improving risk assessment.

This enhanced service is the **first stage** in the roll out of Anticipatory Care across NHS Highland. In the near future this will lead to the development and completion of full Anticipatory Care Plans for patients with the highest risk of admission or readmission to hospital. Completion of these full anticipatory care plans will rely on a truly multidisciplinary approach to anticipatory care planning with full involvement of all members of the extended community care team. Work is ongoing around the development of full Anticipatory Care Plans. Structured review meetings with the extended team will be required on a regular basis and are good practice.

In addition practices will also continue to have access to their In-patient data (again through the same GP Portal) that they have been sent on a weekly basis as part of the Closer Working Enhanced Service (except A&B). Practices may wish to review this information on a regular basis, and are encouraged to inform their CHP of any issues, themes, trends etc that they may identify. Mechanisms for doing this will be made available through the GP Portal. It is highly likely that some patients who appear on this in-patient list will also appear on the SPARRA list.

It is also hoped that over time other information e.g emergency admission rates, bed day rates etc could be available through the GP Portal.

4. Service Outline

Through this Local Enhanced Service, Practices are expected to:

1. Review the quarterly SPARRA data to identify the top 1% of ‘at risk’ practice patients and the Residential Home and Nursing Home Patients on the practice list.
2. Following discussion with the patients, and where appropriate their family prepare an ACPA for that patient. Ensure that the ACPA has been signed by the patient. (*template included in the guidance pack)* Where the patient is unable to sign the form ensure that an Adults with Incapacity Form has been completed.

3. Input the information from the form into the template on ADASTRA. Fax copy of DNAR form to Hub if applicable.
4. Enter a copy of the ACPA in the patients medical record i.e. scan, and arrange for a copy to be held in the patient's home .
5. Review the ACPA (and DNAR form if applicable) on a six monthly basis, or more frequently if the patients circumstances change substantially.
6. Flag up to the CHP any issues, themes or trends that become evident re service provision. Review the practices in-patient data on a regular basis and inform the CHP of any issues, themes or trends that become evident (with the exception of A&B).
7. Ensure that all GP Registrar referrals have sign off from a GP within the practice.

5. Training and Support

Support will be available as required.

6. Accreditation

Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

7. Dispute Resolution

Every attempt will be made to resolve any dispute informally between the Practice and the PCO. Failing that, the Dispute Procedure contained within the sections 464 to 474 of the Scottish General Medical Services Contract 2004 will apply.

9. Variation and Termination of Contract

Any variation to the terms and conditions contained herein requires to be agreed between the Practice and the PCO. Any termination of services, or any part of the services covered by this contract, requires to be agreed between the Practice and the PCO before any termination takes place.