Specification for a Directed Supplementary Service for Complex Multi-Morbidity and Frailty

Introduction

1. All practices are expected to provide core services to all registered patients under the terms of their GMS Unified contract. The specification of this service therefore outlines the general and more specialised service to be provided that is beyond the scope of the unified contract services and remunerates additional service delivery on top of the practices usual service model. No part of the specification by commission, omission or implication defines or redefines the unified contract.

2. The Complex Multi-Morbidity and Frailty Supplementary Service (DSS) recognises the significant pressure that the NHS in Wales is under especially during the winter months and the risk of lengthy stays for those most at risk of decompensation or exacerbation of their condition and an acute hospital admission and increased vulnerability following a prolonged admission. The aim of the (DSS) is to increase pre-emptive proactive and anticipatory care, decrease unplanned admissions and decrease unplanned interventions by resourcing additional GMS activity in addition to the practice's usual service model. The DSS will support practices to review and manage an identified cohort of high-risk patients living with multiple co-morbidities such as COPD, Heart Failure, Diabetes and Frailty in their own homes until March 2025.

3. In October 2023, Welsh Government provided Health Boards with 'Further Faster' investment to support the identification of the top 0.5% high risk population and to ensure that processes are in place to review those patients and implement proactive monitoring and timely management of escalating needs in the community. Progress is being made across Wales against this action across Clusters / Health Boards.
This DSS remunerates practices to provide additional capacity for completing a proactive and comprehensive chronic disease review of this cohort of patients taking consideration of 'what matters' to that individual in line with relevant clinical pathways to optimise treatment/management; reduce the risk of hospital admission and provide ongoing monitoring. The service can be delivered by an individual practice or using a cluster approach. The initial review should be undertaken face to face. All reviews should be completed by the most appropriate clinician/MDT member and should ensure alignment with the Enhanced Community Care provision in their local areas.

4. A Plan (e.g. Future Care Plan) should be developed and will be used to support families and/or carers to adhere to the patient's wishes through the identification of clearly defined escalation criteria recorded in the Plan. The monitoring review will allow the practice to assess the patient's condition, answer any queries they or their family/carer may have, establish if any revisions to the Plan are required.

5. This DSS specifically excludes Care Home residents who should already be receiving an enhance level of care through the Care Home Directed Supplementary Service (previous DES).

Delivery

6. Practice to complete a Plan using template provided at Appendix A for identified cohort including:

- Chronic disease review in line with relevant clinical pathways to optimise treatment and/or management (elements of the review completed since September – 2024 may be referenced)
- Liaison with patient/carer/independent advocate in respect of patient specific monitoring thresholds (i.e. BP, pulse, temperature, sats, oral intake, sputum colour/volume and markers for deterioration) as relevant/needed for specific patient.
- Document what is considered "normal" for patient i.e. premorbid state (eg use of Rockwood Clinical Frailty Scale)
- Poly pharmacy review
- Deprescribing, where appropriate
- Agreed management plan for patient/carer – what to do if patient deteriorates i.e.
    - When to contact GP
    - Ensure referral to relevant community professionals such as District Nurse, Specialist Chronic Conditions Nurses, Frailty Nurses and the local Community Resource Teams / Enhanced Community Care providers
    - When to contact 111 or 999
- Confirm influenza and Covid 19 vaccination status (offer vaccination where applicable)
- Future Care Planning to include Advance care planning where relevant and/or DNACPR using preferred local template.
- Recommended 'Read Code' must be used to demonstrate activity from baseline
- Copy of Plan given to patient and/or carer, including "normal" levels
- Liaison with patient/family/carer on purpose of the comprehensive review and mutual decision making to meet the patient's wishes.
- Plan is saved in patients lifelong medical record and shared with relevant stakeholders as appropriate

7. It is the responsibility of the contractor to ensure that all Health Care Professionals participating in this DSS possess the necessary skills, training, competence and experience to deliver the service.

Service Outline

8. This DSS will support the management and ongoing monitoring of an identified cohort of patients at high risk of admission or re-admission. Pending an agreed All-Wales basis for identifying those most at risk, cohort selection should be done by identifying those patients:

- with multiple coded co-morbidities for Diabetes, COPD, Heart Failure and Frailty
- over the age of 80 and subsequently reducing age boundaries (over 75, over 70 etc) depending on target number of participants
- selection may also take into account local GP practice knowledge (for example if care is already optimised they may be excluded)

- and may also take into account those patients identified in the local pan-cluster planning group who have had multiple or prolonged admissions and undertaken through a systematic, proactive and comprehensive approach.
- Patients not initially identified by the initial practice cohort selection but are identified via the local PCPG or following discharge from hospital may be added to the scheme before the end of March 2025 so long as i) the practice has capacity to do so and ii) after agreement with the local primary care team. The practice may then claim for the completed components once agreed.
- **Development and maintenance of a register** – participating practices to create a register for identified cohort and implement proactive case management for all these patients which may align with the caseloads of 'high risk' patients who would benefit from or are already being managed proactively by community services
- **Call and recall system** - To ensure patients on the register are managed using a systematic call and recall process, including clear arrangements for home-based assessment for house bound patients.
- **Initial Review Bundle –** to include completion and recording of initial comprehensive review, future care plan, sharing of future care plan where appropriate (eg with family or patient representative, out of hours provider)
- **Monthly Review** This recognises that future care planning may be an iterative process that started with the initial review bundle. The review should be proportionate to perceived clinical risk and undertaken either face to face or via phone as appropriate as determined by the GP. The monthly review should include the proactive review of current medical and care needs and identify and implement any changes relevant to the future care plan particularly reflecting on any unscheduled contact with health care services (WAST, GP OOH, Admission etc).
- **Post Unscheduled Care Review** – This should take place within 1 week of discharge and should be reflected in the next scheduled monthly review. The post unscheduled care review will be proportionate to perceived clinical risk and undertaken either face to face or via phone as appropriate as determined by the GP on receipt of the discharge summary, WAST callout or OOH contact information. If the next planned review is more than one week away, it is expected that this will be an additional **'post unscheduled contact review'** in order to ensure a timely response to changes in needs which can then should be reflected in the next monthly submission. Given the focus on any unscheduled contacts, the purpose is to establish if unscheduled care could have been avoided and if so, what actions should be taken to reduce the possibility of further unscheduled care. This review will include discharge medicines and medicines reconciliation, on going medicines optimisation and consideration of de-prescribing where appropriate.
- **Discussion** - with the patient and/or carer about the risks and benefits of treatment, using accredited decision aids.
- **Education for patients** - To ensure that all patients and/or their carers' and support staff when appropriate receive appropriate information in relation to the prevention and management of, the potential complications associated with their condition, including the provision of written materials and /or audio-visual aids.
- **Ensure** - patients and/or their family/carers/independent advocate receive an acute care plan and understand the patient's wishes.
- **Ensure** – carers and/or family members are supported to keep the patient at home in accordance with the patient's wishes and acute care plan.
- **Planned care** – Follow relevant clinical pathways to ensure optimum treatment/management of the condition(s)
- Where clinically indicated, **Medication reviews** will occur in line with NICE guidance, the BNF and/or the local health board formulary and Health Pathways where available.

- **Effective clinical information systems** – ensuring relevant information is recorded in the patient's lifelong clinical record so that care is properly co-ordinated, and information shared where necessary.
- **Consistent Read coding**: The practice must ensure consistent coding of each care episode on the clinical IT system using approved codes.
- **To** enable audit data collection please use the following SNOMED read code;
  888461000000107 – chronic disease management annual review completed
- Where a patient **does not respond** to an invitation for review, the practice will ensure that there is robust evidence of the attempt to contact the patient recorded in the patient's clinical record. e.g. phone call, text, letter etc. Only completed reviews can be reimbursed.
- **Final Report:** The practice will complete a brief electronic survey taking no more than 10 minutes for the purposes of evaluation and is included in the onboarding fee. In order that learning be shared, it is anticipated that participating practices will discuss the project at the next collaborative meeting after the project has finished and collaborative leads will share minutes or themes of that discussion. Alternatively participating practice may submit reflections with the final month submissions or as soon as possible after. Month 3 remuneration is dependent on the completion of the survey and submission of completed monthly review and data sheet (Annex D).

Funding

9. The DSS is funded until 31st March 2025, practices will be reimbursed accordingly using the monthly review and data sheet. **(Annex D).**

- Case finding, cohort selection, establish a register and completing a brief electronic survey for the purposes of evaluation and discussion at the next collaborative meeting after the project has finished and producing a final report: £250 per practice

- Comprehensive review of an identified high-risk patient (completion, recording and sharing (where appropriate) of Annex A, B, C) - £150 per patient. **(Annex D)**

- Monitoring reviews with patient and/or carer - £50 per patient per month **(Annex D)**

Monitoring & Audit

10. The practice will be required to submit the monthly return to the primary care team by 5th of each month in line with WG Reset and Recovery monthly reporting schedule. At the end of the commissioning term practices are required submit completed Annex D and the electronic survey, including feedback and learning. The survey will be shared will be shared via email. Please complete by **15th April 2025.**"

Termination Period

11. Should the practice wish to cease providing the DSS, it will be required to provide 1 months' notice in writing to the Health Board. Should the practice wish to suspend providing the DSS it should contact the Health Board for guidance prior to any action being taken.

12. If, for any reason, a practice terminates/suspends the DSS and, if claims have been made during the current financial year, any reporting/auditing requirements outlined in the specification must be submitted upon request.

General Medical Practice Indemnity

13. This DSS is covered by the scheme for General Medical Practice Indemnity (GMPI) which falls under the GMS Contract Wales.

14. This scheme relates to potential or actual clinical negligence claims arising from incidents on or after 1 April 2019, and captures all General Medical Practice (GP practice) staff undertaking NHS 'primary medical services' as defined in The National Health Service (Clinical Negligence Scheme) (Wales) Regulations 2019

15. The National Health Service (Clinical Negligence Scheme) (Wales) Regulations 2019, sets out the scope of the scheme, namely "primary medical services" which are defined as health services provided under a contract, arrangement or agreement made under or by virtue of the following sections of the National Health Service Wales Act 2006:

(a) section 41(2) (primary medical services);
(b) section 42(1) (general medical services contracts);
(c) section 50 (arrangements by Local Health Boards for the provision of primary medical services).

16. The GMPI will include clinical negligence liabilities for NHS work arising from the activities of all GP practice staff, including GP partners; salaried GPs; locum GPs, if on the All-Wales Locum Register; Practice Pharmacists; Practice Nurses; Practice Healthcare assistants; and any other member of staff providing clinical services. GP trainees and trainee nursing students delivering general medical services will also be covered. The GMPI will also cover any healthcare professionals providing the delivery of NHS Primary Care through Primary Care cluster arrangements and any vicarious liability to practices where a cluster-based health professional is providing direct care to the practice's registered patients.
GP Locums who are registered with and working to the terms of the All-Wales Locum Register (AWLT) for Wales have access to the scheme for GMPI.

Annex A

Initial Patient Review

Patient's Name and address: D.O.B.:

Housebound / not housebound (delete as appropriate)

Registered GP and General Practice address

Practice providing Directed Supplementary Service : yes/no

Date of assessment:

Including (pre morbid) functional (physical and cognitive) baseline (Recommend Rockwood Frailty index)

Mental State Assessment using recognised tool eg Mini-Ace, GPCOG (see local Health Pathway for preferred tool) and record diagnosis where appropriate:

Mini Geriatric Depression Score or 6CIT or similar where relevant would be accepted.

Current Medical Problems:

Systems Review - problems identified

Examination findings

Specific additional areas

Mobility	Unaided / stick or Zimmer / wheelchair / bed bound	Action required

Falls assessment	Risk assessment undertaken / required - Yes / No	Action required
Podiatry	Podiatry assessment undertaken / required - Yes / No	Action required
Oral health	Oral health assessment undertaken / required – Yes / No If Yes, is there evidence of a care plan being delivered	Action required
Pressure area review	Yes / No	Action required
Diet	Normal / soft / supplements / PEG Yes / No	Action required
Hearing	Normal / hearing aid / Other problem (please Specify):	Action required
Eyesight	Normal / glasses / Other problem (Please specify): Is there evidence of a care plan being delivered	Action required
Osteoporosis Risk Assessment (Using local agreed clinical pathway and please note most in this age group will not need a DEXA	Hx of recent falls: Y / N On calcium & Vit D supplements/N On bisphosphonate: Y	Action required

Investigations Recommended by assessor

Medication Review with polypharmacy, antipsychotic prescribing considerations and other high risk medicines Y / N

Any Recommended actions:

Future care plan/ and Advance Care Plan / End of life plan discussed. A proforma template is attached Annex B

Summary of further actions and person/s responsible: (e.g. onward referral for hearing test or local MDT)

Name and designation of person completing review: Date:

Annex B

Future Care Plan
(Adapted from the Gold Standards Framework template)

Aims:
1. To provide a written record of 'what matters' to the individual and an outline of a plan that supports achieving that aim including in routine situations and during episodes of sudden escalated need. If appropriate the Plan should also include their preferences at the end of life. The Plan should be considered along with the individual's next of kin and / or independent advocate.
2. Is useful to clinicians in the planning of patient's individual care
3. To reduce crisis decisions or unnecessary admissions to hospital
(to be written following discussion with appropriate input including, but not exclusively, the patient, nursing / care home staff, patient's usual GP and relatives)
4. The Plan is not a one-off statement – it is a 'dynamic' document and should be reviewed regularly and particularly when the person's health condition or social situation changes or as the individual themselves determines the need for a review.
5. Support to develop a Future Care Plan should be considered in the following circumstances:
- The person is approaching the end of life (expected death within 6 months)
- The person is living with one or multiple long term health conditions
- The person is living with disabilities and / or fluctuating and complex health and care needs (including frailty).

THESE PLANS Should be made AVAILABLE TO THE MDT and OOH PROVIDER
1. 'What Matters to you?'
What elements of care are important to you and what would you like to happen in future?

2. Is there anything that you worry about or dread happening? What would you NOT want to happen?

3. Do you have a Living Will or Legal Advance Decision Document?
If yes, please give details (e.g. who has a copy)?

4. Who else would you like to be involved if it ever becomes difficult for you to make decisions or if there was an emergency? Do they have official Lasting Power of Attorney?

Name …….. Contact Details …….

Name …….. Contact Details ……

5. If your condition deteriorates where would you most like to be cared for?

1st Choice ……..

2nd Choice ……

Comments ……

6. Do you have any special requests, preferences or other comments?

Annex C

Patient Acute Care Plan and Flow Chart

Patient Care Plan

Patient Details		General Practice Details	
Name		Practice name	
Date of Birth		Named GP	
NHS Number		Contact number	
Address		Address	

Acute plan completed by:	Date acute plan completed:	Date acute plan due for review:

Patient consent:	YES/NO

Acute Care Plan Key Clinical Information

Key issues:	
Condition specific information and plans:	

Special requirements/disability:	
Problem list and medical history:	
Normal observations and functions (baseline):	
Social situation and preferred contacts:	
Additional information:	

Acute Care Plan

Specific information for ambulance crew:	
Conditions and parameters for escalation level 1a:	
Conditions and parameters for escalation level 1b:	
Conditions and parameters for escalation level 2:	
Conditions and parameters for escalation level 3:	

Escalation levels	Actions
1a – Remain at home – Ongoing remote monitoring Well, very mild symptoms (include examples and diagnostic parameters where applicable)	Self-care (including use of rescue packs) Consider 111
1b – Remain at home – primary care team and specialist advice Symptomatic but otherwise well and physiological state (include examples and diagnostic parameters where applicable)	Contact - District Nurse Specialist Nurse (i.e. Respiratory, Diabetes etc.) or Frailty Nurse
2 – Deteriorating – Home based response or access to intermediate urgent care Deteriorating clinical or social condition that if worsening could lead to hospital admission (include examples and diagnostic parameters where applicable)	Contact - GP or 111
3 – Hospital attendance required Clinical and/or social situation requires care only available in hospital (define specific parameters)	Ambulance required - Access to hospital via required admissions unit/ process without the need for a GP referral

Annex D

Monthly Review (including any unscheduled contacts)

20241216 - Annex D - Monthly Review and