

## A. Service Specifications

<b>Service Specification No.</b>	
<b>Service</b>	Older Adults Service
<b>Commissioner Lead</b>	NHS Lincolnshire Integrated Care Board (ICB)
<b>Period</b>	1 <sup>st</sup> April 2023 to 31 <sup>st</sup> March 2024
<b>Date of Review</b>	March 2023

### 1. Key Service Outcomes

This document defines the standards for the delivery of the Older Adults Service, for the population of Lincolnshire East Locality patients.

The Service Specification supports the provision of best practice and the achievement of the following outcomes:

- Provision of safe alternatives to Secondary Care services.
- Provision of care that proactively identifies vulnerable and at-risk patient groups and defines responsive, appropriate and timely management.
- Improvement in the quality of clinical care and outcomes for our patients.
- Holistic and personalised care planning which supports people and their carers to be involved in the planning of their care, to live well, self-manage independently and have systems in place to support them during crisis/exacerbation of their condition.
- Prevention of avoidable rapid deterioration and adverse effects.
- Integrated neighbourhood working between providers of care and support, to ensure people receive the right care, at the right time by the right people and transitions are seamless with reduced barriers, duplication, inefficiencies and silo working.
- Improvement in patient satisfaction and experience.
- Development of wider system change that supports a drive towards 'out of hospital' provisions of care
- Coordinated care that supports a consistent response and ensures delivery of required care provision.

Five key objectives have been identified as core requirements of the service, (additional supporting information provided in Appendix B):

1. Provision of a service that is embedded within Primary Care, but which is also integral to core integrated neighbourhood team working, ensuring patients have access to a multi-disciplinary approach.
2. Neighbourhood team area population coverage, including details of how/when the team will provide access to the service.
3. Identification of a specific cohort of patients that will be proactively managed under the service (e.g. people deemed to be at a high risk of hospital admission). Evidencing how a reduction in the Secondary Care activity will be achieved and measured.
4. Provision of Case Management to identified cohort of patients ensuring that all patients receive the following:
  - Holistic assessment (including assessment of frailty syndromes, care/carer position)
  - Care planning and support
  - Care co-ordination and advocacy for options and services to meet an individual's holistic needs – the service will be key in overseeing and co-ordinating care and helping the patient to navigate the system.

5. Provision of reactive care for the specific patient cohort as appropriate, including providing a system of patient contact for accessing the service outside of 'planned' activity and active in reach supporting early discharge from hospital.

## 2. Overview and Local Context

Lincolnshire has an increasing over 65 population, 23% of the CCG's total registered population. This age group is projected to more than double in size between 2010 and 2033.

Older people present a significantly higher impact on health and social care resources. Many of the services that respond do not always actively seek out and assess issues, services are fragmented, and they do not always provide a timely or adequate response that supports improved health, continued independence and prevention of re-current problems.

Added to this a presence of a long term condition, or people with multiple conditions, puts people at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, falls, constipation or urine retention).

Around 10% of people aged over 65 years old are reported to have frailty, and this rises to between a quarter and a half of those aged over 85 years old. "Research suggests that only half of older people with frailty syndromes receive effective health care interventions" but it also shows that "focusing community services on those with frailty rather than only on those 'at highest risk of hospital admission' might improve quality of patient care and reduce hospital bed usage." (Fit for Frailty Part 2, British Geriatrics Society, 2014).

Therefore, it is essential we have a coordinated pathway to support patients with greater complexities, such as multi-morbidities.

The development of integrated neighbourhood working is supporting the community providers to work in a joined-up way. Primary Care play a key role in the success of this, supporting patients to self-manage their condition or be assisted to manage their health needs closer to home, in their local communities.

The only foreseeable way to achieve the management required in the absence of effective prevention is to build capacity and capability within Primary Care. The purpose of this design serves as two-fold, firstly to enable more people with complexities to achieve a greater balance in all round health, and secondly to reduce pressures on the acute system, so that it is accessible when it is urgently required.

"GPs are best placed to coordinate the identification of older people with frailty, to perform the initial medical review based on the principles of comprehensive geriatric assessment, and to refer patients" (Fit for Frailty Part 2, British Geriatrics Society, 2014). Primary care and community services are the bedrock of people's daily experience of health care, but improvements are needed.

The national and local drivers for the provision of services to support care of the older population are set out in documents such as:

- The NHS Five Year Forward View, NHS England, 2014
- NHS England Guidance Everyone Counts – Planning for Patients, 2014/15 – 2018/19
- Fit for Frailty - Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings, British Geriatrics Society in association with the Royal College of General Practitioners and Age UK, 2014
- Fit for Frailty - Part 2: Developing, commissioning and managing services for people living with frailty in community settings, British Geriatrics Society in association with the Royal College of General Practitioners and Age UK, 2015
- NICE Quality Standard QS86, Falls in Older People, 2015
- Safe, Compassionate Care for Frail Older People Using an Integrated Care Pathway, 2014
- Case Management, The Kings Fund, 2011
- LECCG 5 Year Strategic Plan 2014-2019- and 2-Year Operational Plan 2014-16
- Lincolnshire's Joint Health & Wellbeing Strategy, 2013-18

- Lincolnshire Health and Care Programme
- Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professionals, 2014.

<b>NHS Outcomes Framework Domains</b>		
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 that people have a positive experience of care	√
Domain 5	Treating and caring for people in a safe environment & protecting them from avoidable harm	√

NHS planning guidance for 2014-15 (Everyone Counts) required CCGs to create a fund for investment in the care of patients aged 75 years and above, to support practices in transforming the care of these patients, reducing avoidable admissions and Secondary Care activity. The guidance stated that where these initial investment plans successfully reduced emergency admissions, it would be possible to maintain and potentially increase this investment on a recurrent basis. GP Practices were provided with the opportunity to submit plans for consideration that met the requirements of the investment, approved projects were implemented in October 2014.

Since October 2014, LECCG's Primary Care practitioners have undertaken significant work to enhance the care for their elderly population both under the NHSE Admission Avoidance DES and the Older Adult Service identifying and offering preventative care and support to people living in the community who are at risk of losing their independence or of having an unplanned admission to hospital.

The CCG informed practices that their commissioning intentions for future provision of the service (2018/19 onwards) would be to work to align the development of this service with GPFV and the integrated neighbourhood working developments and that:

- services would be universally available to the whole CCG population
- a standardised local price would be determined for service provision

The patient scope was also extended to patients 65 years and over, aligning to the GMS Identification and Management of Frailty.

### **3. Service Scope**

#### **Sources and Process**

##### **3.1 Eligibility**

- All vulnerable patients 65 years and over, registered with a 'participating' GP practice within the East locality of Lincolnshire ICB will be in the scope of the service.
- As part of the prioritisation of 'at risk' and vulnerable people, practices will identify specific cohorts of patients to be managed under the service, this may include some patients younger than 65 years old.

##### **3.2 Exclusions**

None

Access into the service will be accepted from other sources as appropriate, practices will be required to have the mechanism in place which support external identification and referral.

##### **3.3 Location(s) of service delivery**

The service base will be at the GP practice delivering the service; patient response and contact will occur via the following (not exhaustive list):

- Telephone contact
- Home visit

- Practice appointment.

### 3.4 Days/ hours of operation

- The core hours for General Medical Services are 8.00am – 6.30pm, Monday to Friday (excluding Public Holidays). Not all aspects of the Older Adults Service will be covered within these hours.
- It is anticipated that the measures which support the delivery of the service users will be in place during core hours (urgent response, follow up etc).
- Outside of core hours it is anticipated providers will work together to identify appropriate response and educate the patient and carer accordingly, this includes self-management, crisis plans, and responsive care packages in collaboration with other care providers.

### 3.5 Whole System Relationships

Key relationships include, but are not limited to:

- The Patient
- Carers and Family
- Universal Preventative Services
- Primary Care Team
- Community Health Services
- Secondary Care
- Adult Social Care
- Mental Health Services
- Third Sector Organisations
- Specialist Services
- Community Pharmacy

### 3.6 Interdependencies with other services

The service is part of a wider network of care responding to patients and carers needs. This should be a fluid system where the patients can be within several aspects of care pathways at the same time.

The service will work closely with the rest of the primary care team, secondary, intermediate and third sector care providers including diagnostic services, specialist and non-specialist community teams, social care, hospital discharge and hospital at home schemes, palliative care/acute care service providers. All other services that are involved in the care of the person and their carer. Communication, integrated working, appropriate access and response from these services will be crucial in achieving the required patient outcomes.

## 4. Service Delivery

The 4 core elements which are required to be delivered by the service provider are detailed below.

### 4.1 Proactive Care: Identification and prioritisation of patients identified as vulnerable and at risk.

4.1.1. All patients within the scope of the Older Adults Service will receive a communication informing them of the Older Adults Service, this will include as a minimum:

- *Overview of service*
- *Method of contact/access*

4.1.2. The service provider will utilise a method of identifying patients to determine prioritisation of at risk and vulnerable people within the scope of the Older Adults Service population to proactively seek to support and manage.

The following groups have been highlighted as 'high risk' groups for consideration as part of the identification process:

- Patients identified as 'severely frail' via efrailty index.
- Patients who have not responded to previous contact within a certain timeframe

- Care home/housebound patients
- Patients with multiple LTC (including frailty/dementia)
- Recurrent emergency/urgent Secondary Care users (i.e. more than 2 presentations a year)

4.1.3. Patients identified via the above will be entered onto the service provider’s Older Adult Service register.

**4.2 Reactive Care: Patient review following presentation.**

4.2.1. All patients under the scope of the Older Adults Service and who have presented with an exacerbation of their condition or an urgent care/emergency event within the health or social care system will be provided with a review, including those escalated by EMAS or a member of the integrated neighbourhood team.

4.2.2. Service providers will be required to contact the patient within 72 hours (excluding weekends/Bank Holidays) following receipt of communication of an urgent care/emergency event.

4.2.3. The service provider will have direct links to hospital in-reach teams and where possible support early transfer from hospital.

4.2.4. Contact will be made with people who have suffered bereavement, if appropriate.

4.2.5. Service providers will be required to record and report the patient contact and update the patient record and care plan, accordingly, including details of actions, referrals or care packages put in place to prevent re-occurrence.

**4.3 Case Management: Assessment, Co-ordination and Review.**

Intervention will be undertaken by the Older Adults Service with the aim to identify evidence-based interventions to improve patient outcomes, reduce symptoms and exacerbations of condition(s), support management in the community setting and improve the patient’s quality of life.

**4.3.1. Assessment** - All patients on the Older Adults Register will be provided with an initial holistic assessment to determine their current level of need (recommendation – Older Adult Service Assessment) and required interventions. The following details recommended assessment components. Where appropriate relatives and carers should be present at the assessment:

Domains	
<b>Medical</b>	Current Clinical Assessment (to include communication, speech, hearing, vision, continence, osteoporosis, GSF, sleep patterns)
	Co-morbid conditions and disease severity
	Medication Review
	Nutritional status
	Problem list/Contingency Plans
	Additional/specialist requirements
	<b>Mental Health</b>
	Capacity
	Mood and anxiety
	Fears

<b>Functional capacity</b>	Mobility (including history of falls)
	Basic activities of daily living
	Gait and balance
	Activity/exercise status
	Instrumental activities of daily living
<b>Social circumstances</b>	Living conditions
	Next of Kin
	Informal support available from family or friends (carer information including carer assessment details, family bereavement)
	Social networks such as visitors or daytime activities
	Eligibility for being offered care resources
	Problem list/contingency plan
<b>Environment</b>	Home comfort, facilities and safety
	Use or potential use of telehealth technology etc
	Transport facilities
	Accessibility to local resources
	Housing and finances
	Safety and relationships
	Staying healthy (The 'Easy-care domains')

4.3.2. Details of the assessment will be recorded in the register (recommendation Older Adult SystemOne Template) the level at which the full assessment is completed will be clinically determined, however as a minimum there is the requirement that the following areas are assessed:

- i) **Severity** - the initial assessment must determine the level of severity of the patient's medical/social status (The Edmonton Frail Scale must be used Appendix A). This will provide a common language/approach for all professionals when referring and responding to the patient.
- ii) **Medication review** - taking into account number, type and adherence.
- iii) **Mobility** – taking into account general function and that associated with specific tasks (i.e. stairs, toilets access etc), use of walking aids, and falls history.
- iv) **Carer support** – assessing the carer support that the patient has in place, as well as the support available to the carer.
- v) **End of life status** (discussion as appropriate) – in line with Gold Standards Framework

4.3.3. Details of interventions and onward referrals must be recorded on the service register (recommendation Older Adult SystemOne Template).

4.3.4. **Care Co-Ordination** – Patients under the Older Adult Service will have access to a multi-disciplinary approach to their care. Service providers will triangulate communication between patients, their carers, and the services that are required to be in place to support and care for the patient, and their carers. They will also be responsible for ensuring, and reviewing, interventions. The service provider will be key in overseeing and co-ordinating care and helping the patient to navigate the system.

4.3.5. Where elements of a patient's care or personalised care plan, provided by professionals outside of the practice, are not being delivered then the Older Adults Service will be required to raise this accordingly with the relevant organisation(s).

4.3.6. The service provider will provide a system of patient contact for accessing the service.

4.3.7. Patients will be provided with regular review, the frequency and method will be determined by their level of risk or requirements identified as part of their initial assessment, the interval at which they are reviewed should not exceed the below:

- High risk – 3 monthly
- Moderate risk – 6 monthly
- Low risk – Annually

#### **4.4 Care Planning: Provision of personalised care plans to patients**

The care planning process brings together an individual's personal circumstances (including housing situation, welfare benefits status and access to informal care) with their health and social care needs to create a plan that aims to match needs with service provision.

4.4.1. The Older Adults service must complete a personalised care plan for service users. The minimum requirements should include:

- A health and social care summary** (including symptoms, underlying diagnoses, medications and current social situation).
- The named individual** who is responsible for coordinating care on behalf of the patient and who will be the patient's main point of contact.
- An optimisation and/or maintenance plan** which details patient goals, actions that are going to be taken, who is responsible for doing what (referral/signposting information) and details of review.
- An escalation plan** which describes, what a patient and/or their carer might need to look out for, who to call or what to do if their condition/situation worsens.
- An urgent care plan** which could describe the patient's wishes with respect to the delivery of care in urgent situations, (i.e. hospital admission, preferred place of care), their DNACPR discussion and status, and whether they have 'just-in-case' medications in place. The health professional completing the personalised care plan may not undertake all elements of this planning, however it is important to identify in the plan where arrangements are already in place or where the patient may need to be referred on for relevant discussions. As appropriate this should detail specific plans regarding the patients advance care plan/end of life care plan.

4.4.2. The personalised care plan should, where possible and through encouragement from the attending practitioner, be discussed and agreed with the patients and include a record of the patient's wishes for the future.

4.4.3. A copy of the care plan must be entered on to the clinical systems (recommendation – Older Adults Service Care Plan), a copy must also be left with the patient.

4.4.4. It should be noted that the patients personalised care plan is an adaptive document. The patient's 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.

4.4.5. There must be a system in place for all providers taking part in an individual's care within a neighbourhood support system to be updated, upon changes to the care plan as appropriate.

4.4.6. Enhanced support will be provided to nursing and residential home patients with a focus on strengthening relationships, improving access and more integrated working with care home professionals supporting joint care and support planning and peer support.

4.4.7. Older Adult Service will work to ensure all people in nursing and residential homes have care plans (including dementia where needed) and to provide a holistic review of all people in these homes with updates of their care plans/ advance care planning where necessary.

## 5. Process

Participating practices will be invited to continue to provide the Older Adult Service in line with the agreed Older Adult Service Specification. From 1 July 2018 service providers will be allocated funding based on their January 2018 population figures:

1. Service providers will be required to confirm that they will deliver their service in line with the Older Adult Specification and submit signed Older Adult Service Contract.
2. All service providers will be paid an annual budget based on their January 2018 population figures, this will remain fixed at the levels shown, irrespective of population growth or increased complexity over the next 3 years.
3. Service providers will be paid a quarterly advanced payment commencing in July 2018 following the submission of their baseline information.
4. Payment will be provided subject to the delivery of the Older Adults Service Specification
5. Practices will be required to undertake the reporting requirements detailed in Section 6, it is a key contract requirement that practices submit the monthly minimum data set and payment will be provided subject to this.
6. Whilst it is a requirement of the agreement that the above is undertaken, achievement/non-achievement of Key Performance Indicators will not trigger a financial penalty.
7. To support ongoing review and improvement of the Older Adults Service, best practice delivery and the achievement of CCG objectives, practices will be encouraged to participate in Service Development Forums.

## 6. Reporting Requirements/Key Performance Indicators

The following information will be collected in response to the reporting requirements of the service and to inform the Key Performance Indicators.

A baseline report will be required to be submitted 10<sup>th</sup> July 2018.

	Key Performance Indicators	Requirement of Information	Method of Measurement/Achievement	Frequency/reporting period
1.	Increase the number of eligible patients who have been prioritised according to their level of need and identified for service support.	Development and maintenance of an 'older adult' register  Inform future commissioning	1. Risk stratification/identification of population.  2. The number of the above on register.	Monthly Collection  (SystemOne Report)
2.	90% of patients on the 'Older Adult' register will be provided with an assessment of their needs and as a minimum assessment of the following key areas:  i) Severity ii) Medication Review iii) Mobility(including falls) iv) Carer support v) End of life status (discussion as appropriate)	Standardised quality assessment	1. The number of patients on the 'Older Adult' service register who receive initial assessment.  2. 80% of patients who have had initial assessment have had 6 key areas assessed.	Monthly Collection  (SystemOne Report)
3.	90% of patients on the 'Older Adult' register will be provided with a personalised care plan including as a minimum:	Standardised personal care planning that supports patient/carer to manage condition	1. 90% of patients on the 'Older Adult' register will be provided with a personalised care plan	Monthly Collection  (SystemOne Report)

	<ul style="list-style-type: none"> <li>i) A health and social care</li> <li>ii) The named individual</li> <li>iii) An optimisation and/or maintenance plan</li> <li>iv) An escalation plan</li> <li>v) An urgent care plan</li> </ul>			
4.	Increase the number of people aged 65 years and older who are supported to manage their condition out of hospital, working towards supporting the STP target of 27.5% reduction in A&E activity and 10% reduction in avoidable emergency admissions by 31 <sup>st</sup> March 2021.	To support the development of out of hospital provision of care	A baseline of over 65 year olds A&E Attendances and Emergency Admission will be set based on 2017/18 activity. Reduction in activity will be measured against this.	Baseline Monthly Collection (Commissioning Intelligence)
5.	Increase the number of patients on the 'Older Adult' register who receive their care and support within an integrated neighbourhood team.	To measure integrated working	Number of patients jointly review/assessed.  Number of patients reviewed under MDT	Monthly collection (SystemOne Report)
<b>Reporting Requirements</b>				
6.	Record and report the number of patients aged 75 and over who are reviewed post urgent care/A&E attendance/emergency admission within in 72 hours of notification of event	Reactive care provision	The number of patients on Older Adult Service Register who have received review within 72 hours following notification of urgent event increased from baseline June 2016.	Monthly Collection (SystemOne Report)
7.	Record and report referral activity for patients under the Older Adult Service including:	Evidence of care co-ordination as per requirement of specification.	The number of patients on the Older Adults Register and number of referrals to different agencies	Monthly Collection (SystemOne Report)

<ul style="list-style-type: none"> <li>• District nurse team</li> <li>• Complex case manager</li> <li>• Mental health team</li> <li>• Occupational therapy</li> <li>• Social services</li> <li>• Multi-agency support team</li> <li>• Dietician</li> <li>• Podiatrist</li> <li>• Optician Physiotherapist</li> <li>• Voluntary Service</li> </ul>	<p>Inform future commissioning – capacity and demand of support services.</p>		
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## Appendix A

The Edmonton Frail Scale				
Frailty domain	Item	0 points	1 point	2 points
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'.	No errors	Minor spacing errors	Other errors
General health status	In the past year, how many times have you been admitted to a hospital?	0	1-2	≥2
	In general, how would you describe your health?	Excellent/very good/good	Fair	Poor
Functional independence	With how many of the following activities do you require help: meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications?	0-1	2-4	5-8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then when I say 'Go', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3m away), return to the chair and sit down.	0-10 seconds	11-20 seconds	>20 seconds, patient unwilling or requires assistance
Total	Final score is the sum of column totals			/17

**Scoring the Reported Edmonton Frail Scale (/17):**

Not frail 0-5	Moderate frailty 10-11
Apparently vulnerable 6-7	Severe frailty 12-17
Mild frailty 8-9	

(Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professionals, 2014.)

## **Appendix B – summary details on the role to support delivery of the Older Adult specification and the 5 key objectives**

**The role of the Older Adult service is to support both the practice staff and members of the neighbourhood team to identify and support people to reduce the risk of unplanned hospital admissions and to effectively support those individuals in the community.**

1. To liaise with the registered GP and other practice-based staff in addition to all other providers and services utilising, where appropriate, a multi-disciplinary approach.
2. To implement and review individual care plans, a self-management plans and to agree trigger thresholds to contact Case Managers / GP's.
3. Plan visits to housebound people, undertake every 3-6 months, and arrange care plans/ advance care planning where necessary.
4. Enhanced support will be provided to Nursing and Residential home patients with a focus on strengthening relationships, improving access and more integrated working with care home professionals supporting joint care and support planning and peer support.
5. To ensure all people in Nursing and Residential homes have care plans (including dementia where needed) and to provide a holistic review of all people in these homes with updates of their care plans/ advance care planning where necessary.
6. To be a pro-active member of the integrated neighbourhood team
7. Contact or visit where appropriate for people at home following the identification of urgent clinical need including those escalated by EMAS or a member of the integrated neighbourhood team.
8. Practices will be required to contact the patient within 72 hours (excluding weekends/Bank Holidays), following receipt of communication of an urgent care/emergency event.
9. Contact those that have suffered bereavement, if appropriate.
10. Arrange dedicated appointments in practice, for those who wish to visit, with flexibility to expand up to 30 minutes, or as needed.
11. To pro-actively engage with people deemed to be at a high risk of hospital admission
12. As part of Integrated Neighbourhood working, pro-actively engage with professionals that support patients to be managed outside of the hospital setting i.e. The practice will have direct links to Hospital in-reach teams and where possible support early transfer from hospital.