NHS England

NHS Aylesbury Vale Clinical Commissioning Group

Enhanced Service Specification

Avoiding Unplanned Admissions Plus (AUA DES+): Proactive case finding and patient review for vulnerable people, improving the quality of end of life care 15/16

1.0 Introduction

1.1 There is an expectation that under the AUADES practices are already capturing the most vulnerable patients that are most likely to have an A&E attendance or admission on the basis of a predictive algorithm such as the ACG tool. The DES+ will shift the emphasis to those patients identified by asking the question 'would you be surprised if the patient died in the next year' and will include patients not previously identified by the risk assessment tool who develop a life threatening condition. Through this form of early identification and advanced care planning (ACP) in an electronic format accessible to all service providers across care boundaries, it is anticipated that that those at the end of their life (EoL) will experience improved care co-ordination and delivery. As a consequence there will be a reduced likelihood of A&E attendance and unplanned admission in the future, and there will be greater patient and carer satisfaction.

1.2 The AUA DES element commenced on the 1 April 2015. The additional DES+ element of the scheme focusing on EoL will commence on 1 August 2015. The service will come to an end on 31st March 2016, subject to review.

1.3 This DES+ is agreed between NHS England (NHSE) and Aylesbury Vale Clinical Commissioning Group (AVCCG) as part of the primary care co-commissioning opportunity.

1.4 The DES+ will represent an additional payment to general practice expected to cover this additional change to care processes and the skills required to deliver it.

1.5 Co-production of the scheme has involved the local specialist end of life care providers and NHSE. The service will continue to be developed with input from

patients and carers. The final proposed service is evidence based and has been informed by current documents including Dying without Dignity (Parliamentary and Health Ombudsman, 2015), Actions for End of Life Care: 2014-16 (NHS England, Nov 2014) and One Chance to Get it Right (Leadership Alliance for the Care of Dying People, June 2014).

2.0 Aims

2.1 During 2015/16 the aims of the DES+ over and above the AUADES are to

a) Improve the quality of care for those at the EoL.
b) Maximise the opportunity to improve care aligned to the needs of the AVCCG local population afforded to us through jointly commissioning primary care services.
c) Exploit the potential to improve patient outcomes through the AUA DES 14/15 by minimising administration and focusing on the processes necessary to embed appropriate and good quality care.

2.2 As per the nationally mandated scheme the service will provide more personalised support to patients most at risk of unplanned admission, readmission and A&E attendances to help them better manage their health. In addition for those identified as close to the end of life it will provide best practice care at the end of life, with the aim of improving care co-ordination and increasing death in the preferred place. It will also provide an opportunity to audit all deaths to see if the correct patient cohort are being identified, how care could be improved and link this to future commissioning intentions for those at the end of life. In order to assist in achieving this overall aim, the service encourages GP practices to:

a) identify patients who are at high risk of avoidable unplanned admissions establishing a minimum 2% case management register and proactively manage these patients;

b) Identify a minimum of a quarter of the 2% patient cohort described above who are nearing the end of life and establish an ACP register for this subsection (including any patients near EoL not identified by risk stratification tools).

c) Proactively manage these patients using tools and techniques considered to be best practice with the intention of embedding good quality EoL care within primary care.

d) Address requirements common to patients on the case management and ACP registers such as
   - o increased practice availability via timely telephone access;
   - o review and improve the hospital discharge process for patients on the registers and co-ordinate delivery of care;
   - o elicit patient and carer views of services

   Note - The total practice population covered by these two registers will total no less than 2%.

e) Receive training to support EoL care delivery, disseminating learning through the practice

f) Gather detailed patient level data for the AVCCG local population at the EoL or who have died and undertake internal practice audit in order to enable
   - o the practice and CCG to develop a further understanding of early EoL identification
   - o the CCG to state a clear commissioning intention that builds the required level of capacity with the appropriate care provider to support patients to die in their preferred place.

3.0 Process

3.1 Recognising that the release of the DES+ service specification has not been within the usual annual timescales expected by general practice the adjusted process and dates for sign up are shown below

a) NHSE/AVCCG will invite GP practices to participate in this DES+ before 17 July 2015.
b) GP practices wishing to participate will be required to sign up to it by no later than 31 July 2015.
c) GP practices signing up to this service will be signing up to all components.

d) Participating practices are also required to sign up to Calculating Quality Reporting Service (CQRS) and the General Practice Extraction Service (GPES). Commissioners will record GP practices' participation on CQRS.

e) GP practices signing up to the DES+ are signing up to the use of clinical templates designed to make prompts to care and automatically collect specific data fields which will be reported via EMIS Enterprise

f) GP practices signing up to this DES+ by 31 July 2015 will have already qualified for the component one payment set out in the payment and validation section. In addition practices will receive component four.

4.0 Service specification

4.1 General

4.1.1 The requirements for GP practices participating in this DES+ are split into two sections those that are required for patients identified as vulnerable but not at the end of life who are on the case management register and those that are applicable only to those that have been identified as being at the end of life (a quarter of the 2%) on the ACP register.

4.1.2 The ACP register is distinguishable from the QOF palliative care register and patients on the ACP register will receive care over and above the requirements stipulated by the QOF.

4.1.3 The scheme will not exceed the original 2% of registered list over 18 as is the current commitment under the AUA DES but will enhance the care of at least a quarter of this group who are near the EoL.

4.1.4 By the end of March 2016 the practice is expected to have completed ACP's for the quarter of the 2% at the EoL and continued to meet the AUA DES requirements for the full 2% as per the approximate patient numbers demonstrated in table 1. If at year end a practice does not have sufficient patients to achieve the EoL requirement then the CCG will expect that the total patient list still totals 2% and will review the reasons why this has not been achieved.

4.1.5 For patients identified as suitable for the case management register the practice are expected to deliver the requirements outlined in section 4 of the national AUADES service specification and summarised in table 2.

4.1.6 For the patients at the end of life on the ACP register the expected service requirements are detailed below. Table 2 provides a direct comparison between the two elements of the service dependant on which register the patient sits.

4.1.7 For each individual on the ACP register there will be a corresponding ACP which will take a holistic view of the patients' needs driven by patient choice. The ACP EMIS template will include links to the following informed by national and local process and documentation.

a) Details of patient goals (Priorities of Care (PoC) document or the Future Plan of Care (FPC) in the case of diminished capacity)
b) Treatment escalation / de-escalation plans to include do not attempt resuscitation (DNACPR) and advanced decision to refuse treatment (ADRT)
c) Explicit preferred place of death; even if this means 'patient not sure/undecided'
d) Explicit patient information which can be used to inform and support any member of the multi-disciplinary team in making clinical decisions; this may include
    - a statement of a clinical state in which aligned to the patient's wishes a crisis response (ambulance conveyance or admission) would be acceptable (e.g. trauma/active bleeding) or
    - a note to consider alternatives to admission such as returning to care home, informing the GP or
    - a flag to 111 to trigger an alternative emergency response or
    - direct access to out of hours providers

4.1.8 It is expected that the care plan and associated documents are discussed and shared with patients and carers and will not be static but will be reviewed and amended as required in subsequent appointments with the clinician.

4.1.9 The package of care under this scheme extends to those left after a death and the resources developed by the EoL provider board can be utilised to work up the offer of help and support to this group.

4.1.10 Patients on the ACP register will have a monthly review of their record as a minimum (review coded and recorded); this does not need to be face to face. Triggers for additional reviews may be after an unplanned admission and may warrant a patient/carer contact within 72 hours.

4.1.11 The ACP register will be re-defined on a quarterly basis; auditable through EMIS Enterprise.

4.2 Resources – Templates and Guidance

4.2.1 Practices will be expected to deliver best practice in end of life care using the resources available to them. These resources will be held centrally on the member section of the intranet and linked to the clinical template used on EMIS and will include

a) Evidence base
b) Local EoL data including care profiles and Strategic Clinical Network benchmarking
c) National templates / guidance
d) Locally produced templates designed by our specialist palliative care providers
e) Locally produced templates and resources from general practice peers

4.2.2 Sharing of best practice is encouraged and if practices are using a particular tool, template or technique that has been beneficial in their ability to care for patients at the EoL access to it can be facilitated by the CCG.

4.3 Resources – Training

4.3.1 The CCG will offer a package of training to General Practice, to support implementation of the EoL element of the DES+. It will be a standardised development programme in partnership with local EoL care providers. The training is aimed at providing support to general practice in the use of relevant best practice EoL documents but also to address any shortfall in skills required to care for patients at the EoL as identified by the practices.

4.3.2 Healthcare professionals choosing to go on training supported by their practice must demonstrate how their learning has been disseminated within that practice or locality.

4.4 Sharing of Patient Information

4.4.1 Patient data must be recorded in the clinical system (EMIS) and the Bucks Co-ordinated Care Record (BCCR) in a way that a search can be made in the template

e.g. If the BCCR is just scanned into the system its full functionality will not be achieved. It is expected that this will be the case until such a time that the information can be shared directly from the EMIS clinical system i.e. My Care Record

4.4.2 A practice will gain explicit individual consent from the patient (or their representative if more appropriate: e.g. cognitive failure) to share the ACP with other providers of care such as OOH / A&E / hospices / palliative care specialist teams / social care / GP surgery staff.

4.4.3 It is the intention that through making the ACPs visible to other care providers involved in a patients care including the adult community health teams (ACHT) this will improve communication. The CCG will continue to work in developing the shared record to ensure that this is possible and that single data entry is the norm.

4.4.4 It is to be made explicit in the ACP that if a DES+ patient does touch ambulance services/A&E the practice would expect to have contact from those providers (and not just the A&E note) within 48 hours. The AUADES/DES+ access telephone number could be used to facilitate this timely access to primary care. Further work by the CCG to facilitate this with providers may be required.

4.4.5 Practices will be provided with the opportunity to talk directly to commissioners at the CCG about failures in care or quality concerns through a direct link on the ACP templates to the CCG quality feedback tool. Data collected from this source will be collated by the CCG and any emerging themes and patterns highlighted and used to inform subsequent action at CCG or provider level.

5 Data, Outcome Measures and Monitoring

5.1 The thrust of this DES+ is to improve the quality of EoL care by embedding advance care planning as the standard for care delivery at the EoL, the outputs of which are then sharable across the health and social care community involved in that patient's care. For this reason good quality care will be evaluated by the patients and carers, the experiences of healthcare professionals and through quantitative proxy measures and qualitative practice audit. The CCG want to be assured that quality EoL care is being delivered and that patient and carer experience is improving.

5.2 Evaluation of the service will be aligned to current best practice and NICE quality standards for adults at the end of life. Outcome measures will focus on the quality of

patient care and will be sensitive to patients and/or carers changing their mind regarding place of death. Due to the shortened time period on the ES+ the expected positive variation outcomes may not be achieved but all outcomes will still be measured.

5.3 The CCG will continue to work with providers to ensure the provision of timely practice level data on admissions and hospital discharges as well as anonymous benchmarking data for comparison to their practices.

5.4 Patient and carer experience

Practices will be expected to devise and run their own bereaved carers' survey. It might want to seek views on areas of basic care such as dignity, pain control, communication, food, fluids etc.

Practices may also want to consider the use of a carers or patient's diary/notebook which the individual could keep with them to write down comments or questions as they arise.

5.5 Healthcare Professional Experience

As part of the quarterly MDT discussions and review of patients and audit, practices should consider the experiences of their staff and those that they communicate with looking at how they felt about certain actions, situations and/or outcomes and why it happened.

5.6 Quantitative Data Collection

Data collection for audit purposes will be made in as streamlined and time saving way as possible for the practice. This data relating to those on the ACP register will be collated automatically through a predetermined EMIS Enterprise search, however the practice will be expected to run this and robustly review the data to understand any patterns or trends and to link to practice and make recommendations for future care. The CCG will create the EMIS enterprise search which will populate from the patients ACP template in EMIS. Data fields will include whether patient is on ACP, BCCR and preferred place of death.

5.7 Additional measures for the full audit of death data will be collected on an agreed template provided by the CCG these include:

a) Number of investigations in the last week of life
b) Time spent in and out of hospital
c) the patients number of contacts with A&E in the last three months and year of life

5.8 Qualitative Audit

Practice audit of all deaths to include

a) Whether the patient has an ACP (where the answer to this is no could the patient have benefited from one, could you have predicted the death and why, where did they die, where the answer to this is yes did the patient die in their preferred place of choice)
b) Details of where a patient went into hospital, why this was the case and whether it was requested e.g. patient changed their mind or there were no appropriate services accessible.

5.9 Desired Outcomes from the service will be

a) Increased numbers of patient identified as close to the EoL and on the EoL register
c) Increased numbers of patients at the EoL with an electronic accessible shared care record
d) Increase in number and quality of EoL conversations with patients / carers
e) Increase in deaths in place of patient choice
f) Reduction in crisis admissions that deviate from patient plans where care could have been delivered in a more appropriate clinical setting aligned to patient preferences.
g) Improved communication between healthcare professionals
h) Increased involvement of palliative care services.

6.0 Payment and validation

6.1 Commissioners will seek to invite GP practices to participate in this DES+ before 17 July 2015. GP practices wishing to participate will be required to sign up to this service by no later than 31 July 2015.

6.2 The funding available to practices choosing to sign up to the DES+ is in addition to the funding already allocated for delivery of the AUADES

6.3 The additional payments will be based on a maximum of £0.75 per registered patient.

6.4 Table 1 provides full details of the income to be expected for fully achieving the requirements of the DES+. For the purposes of payments, the contractor's registered population (CRP) will be as at 1 April 2015 or be the initial CRP if the practice's contract started after 1 April 2015.

6.5 Payment under the DES+ for 2015/16 will be made in five components:

Component One - an upfront payment of 46 per cent of the AUADES allocation

Component Two - mid-year payment of 27 per cent of the AUADES allocation (subject to achieving all of the requirements set out in section 7 of the AUADES)

Component Three - end year payment of 27 per cent of the AUADES allocation (subject to achieving all of the requirements set out in section 7 of the AUADES)

Component Four – an upfront payment of 50 per cent of the DES+ allocation

Component Five – end year payment of 50 per cent of the DES+ allocation subject to achieving all of the requirements set out below:

7.0 Supporting Papers

Department of Health, "End of Life Care and Personalised Care Planning: an 'at a glance' guide for healthcare professionals," 2010. [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215953/dh_124055.pdf. [Accessed 22 04 2015].

Dying Matters Coalition, “Identifying end of life patients,” 2015. [Online]. Available: http://dyingmatters.org/gp_page/identifying-end-life-patients. [Accessed 21 April 2015].

Leadership Alliance for the Care of Dying People, One Chance to Get it Right, June 2014. Available at https://www.gov.uk

HS England, Actions for End of Life Care: 2014-16 Nov 2014. https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf [Accessed 01 03 2015]

NHS England, “Enhanced Service Specification: Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people 2015/16,” 23 March 2015. [Online]. Available: http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/avoid-unplanned-admissions-03-15.pdf. [Accessed 21 April 2015].

NICE Quality Standard for End of Life Care (2011) https://www.nice.org.uk/guidance/qs13 [Accessed 22 04 2015]Nightingale D. P. and Barrett T., “Identifying end of life care patients benefits us all,” April 2014. [Online]. Available: http://www.rcgp.org.uk/~/media/Files/CIRC/End%20of%20Life%20Care/RCGP-Identifying-End-of-Life-Patients-April-2014.ashx. [Accessed 21 April 2015].

Parliamentary and Health Ombudsman, Dying without Dignity 2015 https://www.ombudsman.org.uk/_data/assets/pdf_file/0019/32167/Dying-_without_dignity [Accessed 22 05 2015]

Royal College of General Practitioners and Royal College of Nursing, “Matters of Life and Death: Helping people to live well until they die,” 2012. [Online]. Available: http://www.goldstandardsframework.org.uk/cd-content/uploads/files/Primary%20Care/RCGP%20Matters%20of%20Life%20Death%20-%20Jul12.pdf. [Accessed 21 April 2015].

Table 1 – AUA DES and AUA DES+ expected patient numbers and income by practice

Practice Name	Registered List April 2015	Registered List Over 18 April 2015	2% AUA DES Patient Numbers	2% AUA DES income (£)	ACP DES+ Patient Numbers	Additional DES+ income (£)
The Swan Practice	19,215	14585	292	55,147	73	14,411
Whitchurch Surgery	4,126	3351	67	11,842	17	3,095
Norden House	9,422	7606	152	27,041	38	7,067
Ashcroft Surgery	4,038	3256	65	11,589	16	3,029
Verney Close	8,767	6947	139	25,161	35	6,575
Wing Surgery	4,919	3913	78	14,118	20	3,689
Edlesborough Surgery	7,497	5834	117	21,516	29	5,623
Oakfield Surgery	4,999	3896	78	14,347	19	3,749
Meadowcroft Surgery	14,041	10232	205	40,298	51	10,531
Mandeville Surgery	16,838	12688	254	48,325	63	12,629
Poplar Grove Practice	18,108	14328	287	51,970	72	13,581
Whitehill Surgery	13,233	10101	202	37,979	51	9,925
Berryfields Medical Centre	4,926	3363	67	14,138	17	3,695
Westongrove Partnership	27,637	21806	436	79,318	109	20,728
The Cross Keys Practice	14,452	11703	234	41,477	59	10,839
Haddenham Medical Centre	7,940	6417	128	22,788	32	5,955
Wellington House	9,068	7284	146	26,025	36	6,801
Trinity Health	11,369	8885	178	32,629	44	8,527
Waddesdon Surgery	5,300	4128	83	15,211	21	3,975
TOTAL	**205,895**	**160,323**	**3,206**	**590,919**	**802**	**154,421**

Table 2 - End of Life (EoL) ES+ Requirement Comparison with the Avoidable Unplanned Admissions DES

Reference	15/16 AUA DES Requirement	15/16 EoL ES+ Requirement
Practice availability		
2.i.i 2.i.ii 2.i.iii	The practice will provide timely telephone access via an ex-directory or bypass number to: • Ambulance staff and A&E clinicians • Care and nursing homes • Other care providers as necessary (e.g. mental health and social care teams)	The practice will provide timely telephone access via an ex-directory or bypass number to: • Ambulance staff and A&E clinicians • Care and nursing homes • Other care providers as necessary (e.g. mental health and social care teams) also in addition • Patients and / or their carers where appropriate • Palliative care providers • ACHT
2.i.iv	Provide patients identified on the case management register with a same day telephone consultation	Provide the patients and/or carers identified as being at the end of life with a same day telephone consultation

Proactive case management and personalised care planning / Advanced Care Planning		
2.ii.i	Use an appropriate **risk stratification tool** or alternative method, if a tool is not available, to identify vulnerable older people, high risk patients, and patients needing end-of-life care who are at risk of unplanned admission to hospital. Risk stratification should give equal weight to physical and mental health.	Practices to use the ACG identified cohort to start with but practices are to use their own knowledge of patient cohorts e.g. elderly person 95years living alone with frailty may not be picked up by ACG but may be appropriate for ACP. Practices may want to choose to use GSF prognostic indicator or others but this is not a contractual requirement of the ES+
2.ii.iii 2.ii.iv 2.ii.v	Establish a **case management register** of patients identified as being at risk of unplanned admission maintained at a **minimum 2% of over 18 population** over the last 3 quarters, with accepted tolerance of -0.2%. Practice must ensure that the maintained register across the three quarters is on average at least 2%. Practices will need to manage any in-year risk associated with changes in practice list size. In addition to this 2% any patients aged 0-17 with complex mental or physical health and care needs who require proactive case management should be considered for the register	Identify a minimum of a quarter of the 2% patient cohort described above who are nearing the end of life and establish an ACP register for this subsection. Establish a register of patients identified as being at the end of life maintained at a minimum of one quarter of the 2% patient cohort of over 18 population, built up over the year. Practices will need to manage any in-year risk associated with changes in practice list size. In addition to this any patients aged 0-17 at the EoL who require proactive case management should be considered for the register. The register known as the ACP register will be separate to the QOF palliative care register.
2.ii.vi	The practice will undertake monthly reviews of the register to consider any actions which could be taken to prevent unplanned	Quarterly review to be carried out at the end of the month following each quarter end of **all** registered patients who have died (whether or not they were on the EoL register).- A basic template will be issued so

	admissions of patients on the register	that there is standardised data received and collated at CCG level. To include • Patients not on the EoL register and therefore with no ACP including reasons for why not e.g. this may be death in RTA and therefore unpredictable. It is expected that this will assist practices to refine how they choose patients for the register. • patients preferred place of death, actual, reasons if this did not happen, • unscheduled admissions, reasons why and if it could have been avoided. • Numbers of unscheduled admissions / A&E attendances in the year preceding death and in the three months immediately prior to death (this is to allow the CCG to compare with national data) Attention should be made to emerging themes and should be fed into the relevant commissioning process using the links provided on the template. EMIS pop up will be used to prompt and there will be links to resources such as the quality feedback tool and crowd sourcing platform etc.
2.ii.vii 2.ii.viii	Existing patients on the register need no new communication but new patients will need to be informed of named accountable GP and care co-ordinator within 21 days of being identified.	Practices should involve patients and carers in the ACP Process.

2.ii.ix 2.ii.x 2.ii.xi	A written/electronic care plan will be developed and jointly owned by the patient, carer, named GP and/or care coordinator, to be in place by the end of September 2014 for those initially added to the register, and within 1 month of addition to the register for new patients added. Patients and carers (if applicable) should be invited to contribute to the creation of the personalised care plan. Members of the multi-disciplinary team (when relevant) and other relevant providers could be invited to contribute to the creation of the personalised care plan. Holistic care needs must also be considered.	ACP will be used Documents/templates designed by our local palliative care providers will be provided through the member intranet Practice staff will be offered training on ACP by the local palliative care team. If practices have already completed ACP training they will be expected to produce evidence of this. A multidisciplinary meeting will be held quarterly to discuss patients on the ACP and the death audit findings Practices will be expected to sign a data sharing agreement to allow viewing at other sites via the MIG. Practices will be expected to use the BCCR and complete the template to be provided on the primary care system in the short-term to share ACPs with the MDT
2.ii.xii	Where possible the care plan should include a record of the patient's wishes for the future, identifying the carer(s) and giving appropriate permissions and details of support services	The ACP should include a record of the patient's wishes for the future, identifying the carer(s) and giving appropriate permissions and details of support services (as per the Priorities of Care document) Where the patient has been assessed as not having capacity the Future Plan of Care document will be used Additional resources could be considered such as the Gold standards Framework (GSF) - Advance statements of preferences for example.
2.ii.xiii (2.ii.xv)	Minimum requirements of personalised care plan (a national care plan template is available)	Minimum requirements of the chosen ACP – GSF or locally approved All documents supported by the palliative care providers and BCCR template already refers to most of these. The EMIS ACP template

		includes details required for ADRT, FPC, preferred place of dying etc.
2.ii.xiv 2.ii.xvi	Patients on the existing register need to have at least one review within the year. Where the review takes place outside the practice the professional having conducted the review must inform the practice who are then responsible for updating the record	The list of patients and their ACPs are to be reviewed at least quarterly or as clinically necessary. Patients / carers will be involved in any ACP review. In the template the CCG will provide a list of approved national read codes to be used.
2.ii.xvii	The named accountable GP is responsible for creating the care plan, appointing a care coordinator where applicable, and being accountable for ensuring the care plan is being delivered	The GP/health care worker responsible for leading on a patient's care will create the ACP and will be accountable for ensuring the care plan is being delivered
2.ii.xviii	The care coordinator will act as the main point of contact for the patient, responsible for overseeing care and keeping in contact with the patient/carer	Practices will be required to nominate a lead for each person's care on the register
Reviewing and improving the hospital discharge process		
2.iii.i	When a patient on the register is discharged from hospital the practice will attempt to contact them in a timely manner (usually within three working days of discharge notification being received)	When a patient on the register is discharged from hospital the practice will attempt to contact them in a timely manner (usually within three working days of discharge notification being received)
2.iii.ii	The practice will share any recommendations with the CCG and if appropriate the area team to help inform commissioning decisions	As part of the quarterly audit process the practice will share any recommendations with the CCG and if appropriate the area team to help inform commissioning decisions
2.iii.iii	We would encourage CCGs to support admission alerts for practices	The CCG will continue to work with its providers on identifying A&E attendances and emergency admission alerts for those patients on the register

	A&E attendance and emergency admission alerts are available through Urgent CareView on SUS+	
2.iv.i	Review at regular intervals emergency admissions and A&E attendances of patients from care and nursing homes	Quarterly review to be carried out at the end of the month following each quarter end of **all** registered patients who have died (whether or not they were on the EoL register).- A basic template will be issued so that there is standardised data received and collated at CCG level. To include • Patients not on the EoL register and therefore with no ACP including reasons for why not e.g. this may be death in RTA and therefore unpredictable. It is expected that this will assist practices to refine how they choose patients for the register. • patients preferred place of death, actual, reasons if this did not happen, • unscheduled admissions, reasons why and if it could have been avoided. • Numbers of unscheduled admissions / A&E attendances in the year preceding death and in the three months immediately prior to death (this is to allow the CCG to compare with national data) Attention should be made to emerging themes and should be fed into the relevant commissioning process using the links provided on the template. EMIS pop up will be used to prompt and there will be links to resources such as the quality feedback tool and crowd sourcing platform etc.

2.iv.ii	Where a practice has a large percentage of their patients in care and nursing homes they should focus on any emerging themes from a sample of patients and patients with regular admissions. These needs to be agreed with the area team at the start of the year.	As above
2.iv.iii	The practice will undertake monthly reviews of all unplanned admissions, readmissions and A&E attendances of patients on the register, or newly identified as vulnerable. These reviews should include: • The practice's processes • Identifying factors within the practice's control that could have avoided admission • Rectifying any deficiencies in the patient's personalised care plans • Amending or improving the hospital admission/discharge process • Identifying any factors outside the practice control, e.g. system gaps Patient survey depending on the outcome of the feasibility study (if this is used then additional monies will be made available	As above EMIS Enterprise will be used by the CCG to streamline reporting where possible

Data		
3	Area teams and/or CCGs will need to ensure the provision of timely practice level data on admissions and hospital discharges, and benchmarking data.	Practices will be auditing their own data Practices will be expected to give the CCG permission to use a specified EMIS Enterprise search with the aim of reducing practice reporting, appropriate read codes will be added to EMIS.
Monitoring		
4	National template for reporting designed to assess • GP practice availability • Proactive case planning and personalised care planning • Reviewing and improving hospital discharge • Internal practice review • Patient survey The reporting template is less than half the size of the 2014-15 version and focuses on self-declaration rather than the time-consuming collation of evidence	Quarterly review to be carried out at the end of the month following each quarter end of **all** registered patients who have died (whether or not they were on the EoL register).- A basic template will be issued so that there is standardised data received and collated at CCG level. To include • Patients not on the EoL register and therefore with no ACP including reasons for why not e.g. this may be death in RTA and therefore unpredictable. It is expected that this will assist practices to refine how they choose patients for the register. • patients preferred place of death, actual, reasons if this did not happen, • unscheduled admissions, reasons why and if it could have been avoided.

	Report on a biannual basis no later than 31st October 15 and 30th April 16. As patients already on the register only require one review there will be less reviews required. Data collected through CQRS & GPES Care plans for patients who have died or moved out of the area can now count towards the practice total for the six month period, practices should keep a record of this as it will need to be manually uploaded in the reporting for September and March.	• Numbers of unscheduled admissions / A&E attendances in the year preceding death and in the three months immediately prior to death (this is to allow the CCG to compare with national data) Attention should be made to emerging themes and should be fed into the relevant commissioning process using the links provided on the template. EMIS pop up will be used to prompt and there will be links to resources such as the quality feedback tool and crowd sourcing platform etc.
5	Practices required to sign up no later than 30th June 2015 Payment to be maintained at £2.87 / registered patient 1. Upfront payment of 46% 2. Mid-year payment of 27% (1st 6 months achievements. 3. End year payment of 27%	The registered population on which payment is based will be updated at two points in the year, April and October. Payment to be £0.75 / registered patient in addition to the AUADES this will be given as an additional two payments 4. Upfront payment of 50% of the EoL element upon signing 5. End year payment of 50%