

PSNC Briefing 027/14: The Proactive Care Programme

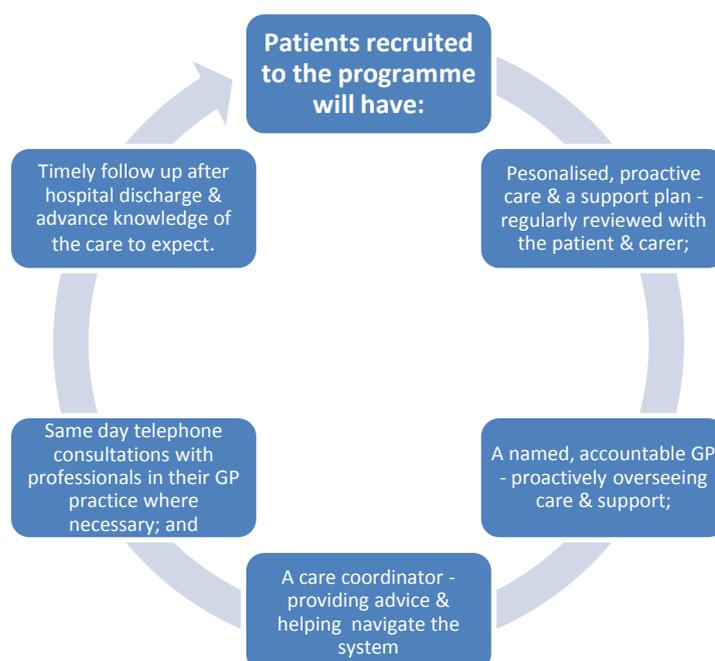
Following on from [PSNC Briefing 026/14: Transforming Primary Care: Safe, proactive, personalised care for those who need it most](#), this briefing provides more detail on the Proactive Care Programme, which was one of the main proposals in the Transforming Primary Care document.

The Proactive Care Programme is new Enhanced service for general practice, which together with new opportunities for clinical commissioning groups (CCGs) to move funding into primary care services and community health services, is designed to bring about a step-change in the quality of care of frail older people and other patients with complex needs. The service has been created to help reduce avoidable unplanned hospital admissions or readmissions for these patients by general practice providing more proactive care. NHS England predicts over 800,000 people should benefit from this approach to managing care.

This PSNC Briefing summarises the elements of the programme that are of most relevance to community pharmacy.

The Programme

The Proactive Care Programme, previously known as the ‘Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people’ Enhanced service went live on 1 April 2014. The programme targets people with the most complex needs and for the patients whose GP practices have signed up to the service, these patients should be starting to experience a step-change in care. Patients enrolled on the programme should see GPs developing a proactive and personalised programme of care and support, tailored to their individual needs and views.



GP practices that wanted to participate in this Enhanced service needed to sign up by 30 June 2014 and patients identified and enrolled on the programme should have been notified who their accountable GP and care coordinator is by the end of July 2014. Personalised care plans for these patients then needed to be in place by the end of September 2014.

For new patients entering the programme at a later date in the year, the patient must be notified of who their accountable GP and care coordinator is within 21 days from enrolment onto the register and their personalised care plan should be created within one month.

Patients and carers (if applicable) should be invited to contribute to the personalised care plan, and members of the multi-disciplinary team and other relevant service providers could also be invited to contribute where appropriate. The care plan should consider holistic care needs, for example, social care needs as well as clinical requirements. Where possible, consideration should also be given to the future and a record of the patient’s wishes should be recorded. For example it could include identification of the patient’s carer(s) and give permission for the GP practice to contact the carer(s) directly and provide details of support services available. The plan should be reviewed regularly to ensure it stays up-to-date and is being implemented.

The accountable GP can take on the role of the care coordinator if they wish; however, they can appoint another person to take on this role. The care coordinator is the main contact for the patient and is responsible for overseeing the care of the patient and for ensuring that their personalised care plan is being followed and updated when required. If the plan is not being followed by professionals outside of the practice, the care coordinator is also responsible for highlighting this with the external organisation and ensuring the patient’s care plan is kept on track. In addition, the care coordinator is responsible for keeping in contact with the patient and/or carer(s) at agreed intervals.

If a patient on the programme is admitted to hospital, on their discharge the GP practice will attempt to contact them, normally within three days, (excluding weekends and bank holidays) to ensure the required care is being coordinated and delivered to the patient.

What GP practices have to do?

As a result of this programme, GP practices will need to:

<p>Improve practice availability;</p>	<ul style="list-style-type: none"> • All patients who are at risk of unplanned hospital admission should be able to have a same-day telephone consultation • Other clinicians should be able to easily contact the practice to support hospital transfers or admissions
<p>Conduct regular risk profiling;</p>	<ul style="list-style-type: none"> • Identify a minimum of 2% of adult patients (and any children who have complex physical or mental health and care needs) who will benefit from the programme and enrol them on it
<p>Have one-to-one discussions with patients and provide proactive care and support;</p>	<ul style="list-style-type: none"> • Practices need to regularly review a holistic care plan that reflects the patient's individual needs and wishes • Ensure that patients have a named GP and care coordinator
<p>Provide timely follow up when a patient is discharged from hospital; and</p>	<ul style="list-style-type: none"> • An appropriate professional in the practice should follow up to ensure coordinated care is received upon discharge
<p>Participate in monthly internal reviews of unplanned admissions and/or readmissions</p>	<ul style="list-style-type: none"> • Notification of any serious incidents should be made to the CCG and/or Area Team as appropriate

In addition, as good practice, the accountable GP should:

- share information with CCGs, to help promote shared learning, when unexpected events have occurred that involve patients enrolled on the Proactive Care Programme; and
- work with the CCG and local hospital(s) to improve discharge arrangements for patients leaving hospital.

CCGs

As a result of this programme CCGs will be required to work closely with GP practices to ensure the project is a success. CCGs have been instructed by NHS England to identify a named lead for the Proactive Care Programme who should work closely with the GP practices involved to support implementation.

NHS England's planning guidance for 2014/15 to 2018/9 'Everyone Counts' (for more details see [PSNC Briefing 114/13](#)) asked CCGs to identify at least £5 per patient from their budgets for 2014/15 and use this to support their plans for improving services for frail older patients or those with complex needs. This money should be used to fund new primary care or community health services that GP practices involved in the programme have prioritised (these services should be over and above those that are provided through the basic contract or this Enhanced service).

Other ways that CCGs may support participating GP practices could be in:

- risk stratification – helping identify patients who are suitable for the programme;
- improving care planning;
- working with other provider organisations to develop multi-disciplinary teams to plan and provide care for patients on this new programme of more proactive, tailored care;
- working with hospitals to ensure that practices receive timely information on when patients are admitted to hospital and when they are likely to be discharged from hospital and to plan better handover arrangements; and
- supporting practices in meeting the needs of carers.

Funding for the Enhanced service

The Enhanced service had funding allocated for one year and in late September 2014 NHS England agreed to extend the service for a further year. The total 2014/15 funding available for this service is £162m (worth approximately £20,000 for an averaged sized GP practice). Payment is based on five components and if all five components are met, the practice will be paid £2.87 per registered patient). If GP practices only manage to complete certain components, they will receive a reduced fee per patient.

The implications for community pharmacy

GP practices providing this Enhanced service may wish to refer patients covered by the service to their community pharmacy for provision of the NMS or MUR services, as appropriate. The NHS England guidance on the service suggests that CCGs may wish to consider 'additional use of services from pharmacy' in order to support GP practices in the provision of the Enhanced service. This could include specific medicines optimisation services aimed at this group of patients which could be provided by community pharmacies.

Further information on the Enhanced service is available on the [NHS England](#) website. For further background information on the GP contract, visit the [PSNC](#) website.

If you have any queries on this PSNC Briefing or you require more information, please contact [Rosie Taylor, Pharmacy and NHS Policy Officer](#).