OCCG SERVICE SPECIFICATION (2017/18)

Proactive GP support to patients in Nursing & Residential Homes

Practices that wish to apply to sign up for this service are asked to complete the separate form in Appendix 7

1. Background

This service aims to address the specific additional primary healthcare needs of patients in nursing and residential care homes, recognising the benefits of working in partnership with the home, and the noting the additional input required from GP practices to ensure the highest quality of care and to avoid unnecessary hospital admissions.

All patients in nursing and residential care homes are entitled to register with a GP on arrival at a home and it is the responsibility of the care home to ensure that patients (and their relatives/carers if appropriate) are informed about their options in choosing a GP practice. This model of care recommends that each residential or nursing home should become the responsibility of one specific GP practice, with as many patients as possible registered with that practice, thus enabling the GP to deliver care to the patients in the home in the most coordinated and efficient way. The rationale for this is that the best opportunity for individualised care planning and patient management derives from a level of trust, mutual understanding and familiarity between care home staff, patient and GP. Published evidence is that this leads to reduced inappropriate hospital admissions because a clear plan is in place for each patient and care home staff discuss patients causing concern with a GP (usual GP in hours or OOH GP) rather than call an ambulance.

The project will work alongside the Care Home Support Service (CHSS), who work in partnership with care home staff in all care homes – nursing and residential, with the main focus of supporting care homes to improve the care of their residents.

2. Eligibility

It is a requirement of the scheme that the practice responsible for the home under this scheme will register all patients who wish to do so, potentially up to 100% of residents/patients. A practice will only be eligible to provide this service if more than 70% of residents of the home are registered with the practice taking on responsibility for the home as permanent patients within the time period specified below.

1) Current % of patients registered with practice at start date	**2) Time available from start date to achieve 70% (phase in period)**
3) 0-25%	4) 9 months
5) 26-49%	6) 6 months
7) 50-69%	8) 3 months

Where a practice has signed up under this scheme, it will be eligible to receive payment under this scheme on a per patient basis during the phase-in period even if it is not yet providing care for the majority of patients. However, payment would cease if the practice should fail to reach its 70% target by the end of the phase-in period and the practice would risk losing its eligibility under this scheme. If a patient should choose to register with another practice, this will not affect eligibility as long as a minimum of 70% is maintained.

Once the phase in period is successfully completed, practices will be expected to maintain the percentage of patients registered with them at or above 70%. Should the number of patients in the home who are registered with the responsible practice drop below 70% for two successive quarters, the practice may lose its eligibility to participate in this scheme.

Practices will not be eligible to re-apply to provide care under this scheme if they have previously ended an agreement under this service specification prematurely (i.e. in duration of scheme).

Practices will be able to sign up to this service from February 2015, but practices can also choose to participate at any point in the year if a nursing or care home has not already become the responsibility of another practice. Practices that are already looking after 70% or more of the residents at the start of the scheme will be eligible for the full payment on a quarterly basis from the date of sign up (pro rata for part of a quarter).

Practices who do not meet the eligibility criteria for providing this service, or who choose not to participate, will be expected to continue to provide usual GMS services to their patients in care homes and will not receive any additional funding.

Only care homes that are predominantly for the older adults (over 65 years) will be eligible under this scheme.

Practices will not be eligible for this service if they are already receiving a retainer, other payment or PMS premium that covers any element contained in the service specification unless this payment ceases by the time the practice signs up for the scheme. It is a requirement of this scheme that both the practice and the care home confirm that, as from the start date, there is no private arrangement for any retainer or other payment by the care home to the practice or to any GP partner/employee of the practice for services that duplicate any element of this service.

3. Service outline

The practice taking on responsibility for the home (the providing practice) will be expected to permanently register any resident of the home who is willing to transfer to them. Temporary residents who are willing should also be registered, but will not be included for the purposes of this scheme unless they subsequently become permanently registered. (see section 3.1 below).
The single practice model is the preference, however, there may be circumstances where two practices could share responsibility for a home, e.g. if the home is exceptionally large and if the organisation of the home leads to a natural separation based e.g. on type of service provided or level of dependency of the patients. In determining whether responsibility for the home can be shared, the views of the Care Home Manager will be taken into account.
The key feature of this service is for the practice to provide a usual GP from the practice providing the service to carry out a weekly scheduled visit (please see further clarification in relevant section below) at a dedicated time to review issues, queries, patients causing concern and all proactive care in conjunction with a fully-briefed senior member of staff from the care home. It is not a requirement of this scheme that all patients are reviewed weekly but only if clinically indicated. The details of the expected service under this scheme are detailed below.

Practices providing care under this scheme are required to agree to the Oxfordshire Care Summary system so that OOH GPs and other colleagues can gain access to the key features of a patient's medical record when needed OOH.

3.1 Registration of patients

All patients newly arrived at the home will be invited to register with the GP practice who is responsible for the home as soon as possible. Such patients should be coded as resident in a care home. It is a fundamental principle that registration with the practice caring for the home will be the choice of the patient or, if the patient is not competent to make a choice on their own behalf, of their relatives, carers or advocate, in line with the Mental Capacity Act 2005. The Care Home Manager will be responsible for ensuring that the patient, relative, carer or advocate is able to make an informed decision on the options available by providing a suitable patient information leaflet/letter.

Where possible, residents who are anticipated to be in the home on a temporary basis should remain under the care of their own GP, if local. If this is not an option, the patient should be invited to register as a temporary patient with the providing practice, transferring to permanent registration if they are still in the home after 1 month. The new practice taking responsibility for the patient may register them as permanent if it is expected that their stay will be over 1 month. NHSE Thames Valley recognise that sometimes this is very difficult to predict and would like to reassure practices that no action will be taken against practices who register patients as permanent in the best interest of patient care. Patients who are having short term respite admissions should only be registered as temporary residents.

The practice should ensure they have efficient arrangements to chase up medical records that have not arrived within the expected time frame and to request records urgently when indicated. Practices are also advised to carry out regular checks to ensure patients who have been temporarily registered are flagged after one month and queries raised at regular intervals with the care home to see if it would be more appropriate for them to be registered permanently.

Practices and the usual visiting GP are advised to note the key requirements in situations where patients may lack capacity. This link is a useful summary:
http://www.cqc.org.uk/content/gp-mythbuster-10-gps-and-mental-capacity-act-2005-and-deprivation-liberty-safeguards

3.2 Initial assessment of new nursing home residents

It is the responsibility of the care home to provide a medical summary from the patient's previous GP including prescribed medication and, in the case of hospital discharge (including community hospital), a copy of the medical discharge summary. Other supplementary information should also be provided. It is also the responsibility of nursing home staff to provide baseline data on each patient. See Appendix 1. All newly arrived patients in the home will receive a face-to-face assessment by the GP within 7 working days of arrival with this information to hand. The assessment will include the following:

Initial Care review

- Current concerns of nursing home staff, patient and/or relatives
- Face to face assessment of patient
- Ensuring medication correct (see below)
- Baseline information captured- care home staff should already have documented on admission and recorded on Appendix 1
- Arrangements for chronic disease review, including inclusion on QOF registers, appropriate monitoring and any exception-coding indicated
- Mental health review, including evidence of depression and dementia. A GPCOG is recommended if dementia is suspected which may be carried out by trained care

home staff. A depression questionnaire may also be useful if depression is suspected which can also be carried out by trained care home staff. Dementia should be diagnosed and coded on the patient record where appropriate and this should be communicated to the next of kin if not already aware of the diagnosis.

- Risk of falls and to consider fracture prevention where appropriate
- Nutritional status including any problems with chewing/swallowing – care home should already have documented weight on admission and recorded on Appendix 1 and monthly thereafter
- Continence - care home staff should already have documented on admission and recorded on Appendix 1
- Visual or hearing impairments - care home staff should already have documented on admission and recorded on Appendix 1
- Status of skin and management of any skin problems and wounds – also documented on Appendix 1
- Any additional specific needs including palliative care and end of life care
- Ensuring preparation for Proactive Care Plans are underway (see below).

A summary of the key issues and patient's general status should be made as a consultation note.

Flu immunisations

Practices are expected to ensure that flu immunisation is offered to all patients and provided to those who wish to take it up, either at the initial review or as part of ongoing care

3.3 Medication Reviews

Medication reviews should happen at first encounter with patient after admission, 3 months after admission and then 6-monthly thereafter. Practices need to ensure that a system is in place to ensure that medication reviews take place to the agreed schedule and that review dates are updated once completed. All reviews should be coded in the patient medical record and the review date adjusted accordingly. Any medication changes should be clearly explained to the care home staff, patient/relative as appropriate and the rationale documented in the patient medical record.

A prescribing protocol for care homes has been produced by OCCG to facilitate these reviews.

Initial and 3 month medication review

A printed list of medication taken from a GP medical summary +/- hospital discharge summary +/- a photocopy of a hospital drug chart or up to date FP10 should be provided on admission and the GP is advised to not accept medication that is a handwritten list from anyone else due to the risk of error in drug dose or name.

- Any inappropriate medication should be stopped or changed if no clear indication to continue, in particular "specials" and red/blacklisted drugs under the OCCG Traffic Light system. Sip feeds should only be continued in exceptional circumstances as the care home should provide a suitable modified diet as required based on OUHT dietician leaflets and recommendations.
- In most cases, a GP will wish to wait for the patient's full medical record to arrive before deciding about stopping some drugs and a further medication review should take place 3 months after admission in the expectation the medical records will then be available.

- Medications not clearly indicated or considered no longer necessary (esp. anti-psychotic medication, drugs with anticholinergic effects, antidepressants, hypnotics & anxiolytics; diuretics) should be reduced slowly and discontinued if all well.
- Where life expectancy is limited, medications to reduce longer term risk in chronic disease (e.g. statins; anti-hypertensives) should be reviewed and consideration given to stopping especially if side effects may be outweighing benefits (e.g. postural hypotension/falls in those on anti-hypertensives).
- Analgesics – review of efficacy, step-up or down especially where side effects e.g. constipation, may be outweighing benefits. However, all patients should have adequate analgesia where indicated.
- Drug monitoring requirements.
- Use of most cost-effective alternatives and ensuring all medication is consistent with Oxfordshire prescribing guidelines.
- Wound management is consistent with ONPOS formulary unless non-ONPOS items are advised to continue under ongoing monitoring from the local Tissue Viability Service.

6 monthly medication reviews

These should be carried out along the same principles as above thereafter.

3.4 Proactive Care Planning

All patients in the home should have a proactive care plan completed by the GP within 4 weeks of arrival at the home. A care plan must be agreed in collaboration with the patient and/or their relatives/carers (as appropriate). Ideally, care planning should be done via a face to face discussion with the patient, but if the patient does not have capacity to participate, the discussion could be with a relative. If it is not possible for the relative to meet to discuss, they could be invited to complete a Thinking Ahead form. In some circumstances it might also be appropriate for a patient to complete a Thinking Ahead Form, e.g. if they find discussion difficult due to deafness. A sample Thinking Ahead Form is available on the OCCG Intranet, together with an explanatory leaflet for patients and relatives. Should either the relative or the patient choose to complete the form, this will be taken into account in completing the care plan and therefore should ideally be available to the GP in time for the face to face initial assessment or, at the latest, within 2 weeks of admission.

The GP is responsible for completing the care plan and ensuring that copies are held in the medical record and in the care home records, the latter to include an easily accessible orange summary sheet clearly outlining action to be taken in the event of exacerbation of the patient's condition (see example at Appendix 3). Patients and/or relatives should be offered a copy and have the opportunity to discuss any concerns or issues with the usual GP if required. Where patients/relatives or carers decline to contribute to a care plan, this should be documented/coded but the written care plan should still be completed by the usual GP and coded.

Proactive Care Plans should include resuscitation status and, where a patient expresses a preference not to be resuscitated, a DNACPR form should be completed and the lilac copy lodged with the nursing home staff. The DNACPR form should also travel with the patient record if the patient moves to another care setting. The GP will ensure that Proactive care Plans and any Not for Resuscitation forms are coded as active problems on the patient's computerised record so that this information is available via the OCS to the OOH service if needed.

Practices can use any OCCG-approved care plan form as long as the patient/family wishes are included/documented and there is adequate documentation so that it is clear to care home staff when and for whom it would not be appropriate to summon an ambulance for hospitalisation. Instead, the expectation would be to discuss the patient's situation with the GP practice or OOH GP. (Nursing Home staff will have access to the alternative NHS111 number to access an OOH GP if necessary). It is recommended that the GP ensures the care home has a system in place to ensure that even unfamiliar staff can access this information readily at any time.

These care plans could meet the requirements of the Proactive Care Management DES for as long as this continues. All care plans should be reviewed at regular intervals as clinically appropriate and discussed with patients/their relative as required.

3.5 Hospital Admissions

Nursing homes will be provided with the NHS 111 clinician line to facilitate consultation and advice from an OOH GP to ensure patients are managed in their best interests and hospital admissions are avoided unless there is no other reasonable course of action. This applies particularly where there is a proactive care plan indicating intention to avoid hospital admission where possible.

Unplanned hospital admissions and discharges should be coded based on information from the admitting GP, including GPs working in the OOH services. Care home staff must notify the GP practice whenever a patient is admitted by ambulance. As soon as possible on notice of an admission, the practice must ensure that a summary of the patient's medical record, including the last 3 consultations and current medication, should be faxed or emailed to the admissions office of the relevant hospital with a cover note indicating that the patient has been admitted and that the summary is for the information of the attending clinicians. The practice should code date of admission and date of discharge. This will enable the quarterly review of unplanned hospital admissions.

Nursing and Care Home staff should facilitate the timely discharge of their patients from an acute hospital admission by accepting patients back whenever they are ready for discharge from acute care. The usual GP involved with a patient (or GP colleague from the same practice) is expected to be available to support in discharge planning arrangements from a secondary care setting.

3.6 Palliative and End of Life Care

It would be expected that the practice should extend all usual palliative care to ensure comfort and symptoms control with regular reviews of patients in this category. It is recommended that the Gold Standards Palliative Care in Nursing Homes is adopted and promoted. Specialist expertise from local hospices should be sought if further advice on management is required. Patients needing end of life care should be discussed in the regular palliative care practice meetings so that GP colleagues are aware of these patients if the usual GP is not available and also to identify any issues or improvements needed in end of life care.

3.7 Deaths

All deaths should be notified to the practice by the care home and coded on the practice computer system including date and place of death. This will enable the quarterly review of deaths. Relevant codes are listed in Clause 7 below. GPs should be aware that deaths occurring in those subject to Deprivation of Liberty orders have to be notified to the coroner and the GP cannot issue a death certificate.
https://www.easterncheshireccg.nhs.uk/GP%20information.pdf

4. Scheduled weekly visit by usual GP

Practices responsible for supporting a nursing home will be expected to organise a scheduled weekly visit to the home with dedicated time as appropriate to meet the needs of the patients. For smaller homes, there may some weeks where there is no clinical necessity to attend and, in discussion with the care home, it may be appropriate to convert the scheduled visit into a telephone discussion between the GP and the nurse in charge. The care home should still send a list of patients to be discussed or any queries and the call should take place at the agreed time. Practices could also consider the appropriate use of technology such as Skype etc.

The usual GP should be a partner, salaried GP or long-term locum and the weekly visit should not be delegated to a short-term locum or training GP. A GP Registrar should have the opportunity to work with the usual GP in a care home and when deemed sufficiently experienced and trained, may occasionally stand in for the usual GP, but the practice should provide a GP mentor to supervise/debrief after the visit.

During the weekly visit, the GP will be expected to see patients who have become unwell, follow up those who have had a recent illness, review those recently discharged from hospital, discuss patient management issues with staff, complete medication reviews and plan the future care of patients. Visit sessions will also provide an opportunity to carry out initial assessments of new patients and to develop care plans. These routine visits should be recorded as a consultation in a nursing home as opposed to a home visit to distinguish the routine scheduled visit from separate urgent calls to a care home. It is also recommended that the GP adopts a system of recording a 3rd party consultation if the patient is not actually seen so that it is clear, in the event of death, whether one of the requirements for completing a death certificate are met (patient seen by GP in the previous 14 days).

The visiting GP should be aware of and fulfil the obligations of the Mental Capacity Act 2005, Safeguarding and DOLS (Deprivation of Liberty Safeguards) including reporting all concerns to the appropriate authorities.

Practices may like to consider providing a print out of the consultation and any changes in medication for the home so staff are clear about actions and plans and this might avoid subsequent telephone queries.

Care homes should help make best use of time by the following:

a) Complete a patient list of those to be seen/discussed with supporting information (see template in Appendix 4).
b) Ensure good liaison with the practice so that patients who need to be examined are ready in a private room for the GP visit.
c) Ensure all information on new admissions is collected in advance and that follow-up data (e.g. to support advanced care planning) is made available.
d) Ensure that the GP is not expected to write in the nursing record or other paper record but that staff should make their own notes to ensure plans/actions are noted. The GP will make a written entry in the patient's computer record on return to the practice (practices can choose their own preferred way of achieving this).
e) Ensure patients who are declining are reviewed by the GP especially if death is anticipated.

GPs will also be expected to respond to requests to visit a patient who needs medical attention outside the scheduled visit times, but it is expected that the number of unplanned visits will reduce as proactive management of patients in partnership with the home becomes routine. It is also expected that a GP who knows the Care/Nursing Home

residents and staff well will be able to manage a broader range of problems with telephone advice and practices are encouraged to ensure that their reception staff are correctly briefed about how to pass on urgent queries from Care/Nursing Homes staff in a timely fashion.

5. Clinical Governance Meetings

Participating practices will be required to meet on a 6-monthly schedule with the Care Home Manager and relevant staff to discuss a range of clinical governance issues as below and to document key points of note. Where appropriate, the GP or care home staff may invite a member of the Care Home Support Service to participate in meetings. A suggested template for these meetings is attached as Appendix 5.

- Review unplanned admissions to hospital and agree actions in response including system changes
- Review patient deaths
- Review any safeguarding issues
- Review any serious incidents in the home affecting individual
- Update any relevant local policies or protocols
- Plan for any seasonal initiatives such as flu/pneumococcal vaccinations
- Review the quality of communication between the Practice and the Home, and with other health or social care providers.
- Discuss OCCG-provided comparative data for other care homes on prescribing, unplanned admissions, place of death and other comparators and provide any comments or action plans to address any issues of concern

6. Responsibilities of Care Home Manager

The care/nursing home manager will be expected to support proactive GP involvement for their homes and provide feedback to relevant bodies of any concerns as follows:

- Arrange for a patient to be registered with the nominated GP practice under this scheme as soon as possible upon arrival in the home unless the patient is choosing to stay with another GP practice.
- Ensure that summary patient information from the patient's previous practice, including list of medications, is available to the GP within 3 days of the patient's arrival in the home as well as the completed Nursing Home Admission form (Appendix 1)
- Seek information from the patient or their relatives on their current situation, preferences and concerns (e.g. using the Thinking Ahead form) and provide to the GP.
- Make sure that the patient's medication record and any new any hospital-provided or community service information is made available to the GP when visiting the patient.
- Provide the GP with a list of patients with queries/issues prior to every weekly visit using a secure method of communication (see Appendix 4).
- Arrange for the nurse in charge/on duty to be available to discuss patients on the list with the visiting GP and accompany the GP to see any patients. Drug charts should be to hand.
- Ensure that key points arising from these visits are communicated to colleagues or written in nursing notes.
- Work with the GP to address medication issues in order to reduce prescribing errors and promote high quality and cost effective prescribing.
- Make all reasonable efforts (including stating clearly to reception/other telephone staff when an urgent response is required) to contact the responsible GP practice

during core hours, or an Out of Hours GP outside core hours, before arranging for a patient to be admitted urgently to hospital.

- Ensure that any healthcare practitioner attending in the event of an emergency is aware of the existence of a patient's Proactive Care Plan including summary and DNACPR form and can access them.
- Enable patients' relatives to be present during GP visits (if appropriate and with the consent of the patient) and facilitate communication of concerns or queries from relatives to the GP.
- Make all staff familiar with the materials produced by OCCG and the Care Home Support Service for advice to care home staff about management of common conditions and how to relay appropriate information when consulting with a GP.
- Provide and train staff in nursing homes to be able to carry out male and female catheterisations, use of an auriscope to check for ear wax and urine testing strips for possible infection. Also ensure suitable staff have the ability to carry out a GPCOG assessment, a depression screen using a standard form and assist patients/their relative to complete the Thinking Ahead form where appropriate.
- Nursing homes with over 60 residents would be expected to have a syringe driver available to support end of life care and to ensure key nursing staff are trained in its use.
- Arrange for the Home Manager or deputy to attend the twice year Clinical Governance meetings at the practice providing this service.
- Key Nursing Home staff should be trained to confirm expected death.

7. Audit & Monitoring

Participating practices will be asked to carry out a manual data return based on the coding below, at the request of the CSU on a quarterly basis. This return will be used for the purposes of quality and activity monitoring and to validate payments. Copies of the minutes of clinical governance meetings should be provided every 6 months.

The codes below should be used to record activity carried out under this specification. This is available on a template for Emis web practices which can be downloaded from the OCCG intranet and imported directly. The template also includes the Care Home admission information form so that data can be inputted directly by admin staff. Codes highlighted in yellow are expected for all patients registered to the aligned practice in the nursing/care home and are required for payment purposes. Codes highlighted in green are for information. There is no set target for payment but it is expected that data will be coded and submitted where relevant.

Please note all the required payment codes in yellow, except for medication review, are embedded in the digital Proactive Care Plan (dPCP) and this is in the supporting EMIS template for Care Homes which can be downloaded from the OCCG intranet section on Care Homes

Admission to nursing home	8Ht	In last quarter	To identify proactive care planning within one month
Lives in nursing home	13f61	Each quarter	This, along with post code, is to identify patient eligible for payment under this service
Or lives in a residential home	13FK		This, along with post code, is to identify

			patient eligible for payment under this service
Deaths		In last quarter	
Preferred place of care documented	8Ce4 (nursing home) Or 8Ce5 (residential home) Or 8Ce3 (hospital) Or 8Ce2 (community hospital)	Number new in past quarter and total number with one of these codes	Number new should roughly equate to new admissions past quarter
Admission avoidance care started	8CV4	Number new in past quarter and total number with this coded	For patients at risk of hospitalisation
Admission Avoidance Care Plan agreed	8CSB	Number new in past quarter and total number with this code	For patients at risk of hospitalisation
Has anticipatory care plan	8CMM	Number new in past quarter and total number with this coded	An alternative if not appropriate for admission avoidance care plan
Review of care plan	8CMG3	Number in past 6 months	As required by Unplanned admissions DES
Not for resuscitation	1R1 Or EMISNQAl9 Or EMISNQDO14	Number new in past quarter and total number coded	
Place of death	9493 (in nursing home) 9494 (in residential home) 949D (in care home) 9495 (in hospital)	Total number should equal total number with place of death recorded	
Medication review	8B3V Or 8B3S Or 8b314 Or 8B3x Or 8B3h	Number new in past quarter and total in past 6 months	
Emergency admission to hospital	8H2	In past quarter	
Discharged from inpatient care	8He2	In past quarter	

8. Payment

Practices participating in this service will be paid £250 per patient in a nursing home bed per year. This payment is intended to reimburse practices for the additional medical and administrative resource involved in taking responsibility for all (or a majority) of a nursing home's patients, carrying out the initial assessments of patients on first coming into the home, taking a proactive approach to the ongoing care of patients, including 6-monthly medication reviews, and participating in Clinical Governance meetings with the Care Home

Payment will be made quarterly in arrears on submission of an invoice, completion of the data requirements set out in Clause 8 above and receipt of the 6 monthly clinical governance meeting minutes.

The following elements of the service are funded from other sources

- All medical care provided to the patient falling within the categories of Essential & Additional Services, Directed Enhanced Services and QOF is funded through the GP Contract. This includes care planning for patients at risk of hospitalisation under the Proactive Care Management DES.
- OCCG-commissioned services such as Warfarin Monitoring, Near Patient Testing & Leg Ulcer Care are funded through the Oxfordshire CCG Contract for Primary Care Services.

9. Termination

This service will terminate on 31st March 2018 or such earlier date as mutually agreed. If either party wishes to terminate the service early, 6 month's notice must be given.

Appendix 1: Care Home Admission Data Collection form

NURSING/CARE HOME ADMISSIONS FORM

Please note this is not mandatory but just for convenience, as care home staff can complete and pass to practice for coding for information and QOF requirements. The Emis web template that can be downloaded from the CCG intranet can be imported and used to record this data.

Name of resident	
Date of birth	
Date of admission	
Next of kin (Name): Relationship: Contact telephone numbers: Can records be discussed YES / NO	
Conversation and mental alertness	Able to converse normally Able to converse but some confusion evident Able to converse but very confused Unable to converse
If any apparent confusion and not known to have dementia already, please complete GP COG if trained to do so	GPCOG (patient) score: (out of 9) GPCOG (informant) score (if possible): (out of 6)
Smoking status	Not known Never smoked tobacco □ Current smoker □Ex smoker □ Date ceased smoking □
Weight:	
Systolic blood pressure: Diastolic blood pressure:	
Mobility assessment:	Independent walking □ Stick for walking □ Uses zimmer frame Wheelchair-dependent indoors Immobile □
Hearing:	O/E – hearing normal □ O/E – slightly deaf □ O/E – significantly deaf □ O/E – completely deaf □ Hearing aid worn □
Vision:	Blind (subjectively) □ Partially sighted (subjectively) □ Vision normal (subjectively) □
Bowels:	Incontinent □ Occasional accident □ Fully continent □ Normal □
Bladder:	Incontinent □ Occasional accident □ Fully continent

	□
Bladder care:	Indwelling suprapubic catheter □ Indwelling urethral catheter □ Penile sheath provision □
Skin status (please state site of any problems)	Superficial pressure sore □ Deep pressure sore Leg ulcer(s) Other problem (please specify) □

Appendix 2: Deleted

Appendix 3: Anticipatory Care for Hospitalisation Summary sheet *(to be printed on orange paper for easy identification)*

Anticipatory Care Plan for Hospitalisation

This should be printed on orange paper and, when completed, kept easily visible in Nursing or Care Home Patient record

On the basis of the patient's wishes (where patient has capacity to make decisions of this nature), or a best interests decision (where patient does not have capacity) and taking into account the clinical situation as interpreted by the attending/usual GP the following decision has been made to guide other health workers and carers in event that urgent hospitalisation is considered:

☐ **Patient can be admitted if clinically appropriate to do so.**

☐ **Patient should not be admitted without discussion with GP. If necessary "999"/ambulance can be called for paramedic support until discussion with a GP can occur.**

☐ **Patient is terminally ill / on end of life care pathway and should not be admitted to hospital.**

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Signed: (Doctor) Print name: Date:

If review occurs, please note date of review and sign below. If status is changed please sign and date any changes against sections above.

Date of review	Signature	Print name

Appendix 4: List of patients to discuss at weekly GP visit template form

GP Visit Patient List			Date	
Rm no.	**Resident's name**	**Problems**	**Duration**	**(Temp, BP, Pulse, Urine as indicated)**

AGENDA TEMPLATE

CLINICAL GOVERNANCE MEETING

[Name of Home] [Date]

Present: Name and job titles

1. Review of Emergency Hospital Admissions

Patient ID	*Date of admission*	*Admitted by (eg OOH, 999, GP)*	*Reason for admission*	*Date of discharge*	*Could admission have been avoided*	*Actions/notes*
1						
2						
3						
4 etc						

2. Review of Patient Deaths

Patient ID	*Date of death*	*Place of death*	*Cause of death*	*Date of discharge*	*Issues/learning points*	*Actions*
1						
2						
3						
4 etc						

3. Safeguarding Issues / Serious Incidents

4. Local Policies and Protocol Updates

5. Seasonal Initiatives

6. AOB

Appendix 6: Invoice Template

Name of GP Practice

INVOICE

[Address]

[Town, County & Postcode]

K code:

Phone: [ ] **Fax: [ ]**

VAT Registration No. xxxxxx

INVOICE No

DATE:[ ]

Billing Address:
Oxfordshire CCG – Sara Wallcraft
10Q Payables K445
Phoenix House
Topcliffe Lane
Tingley, Wakefield
West Yorkshire WF3 1WE

Invoice		
Quantity	**Item**	**Cost**
[No.]	**Patients cared for under the Proactive GP Support to Nursing and Residential Care Homes Scheme in *[name of home]* during *Quarter [x]* @ £62.50 per patient per quarter.**	**£**
	Total	**£**

Payment details			
Name of Bank Account		**Bank Name**	
Sort Code		**Branch**	
Account Number			

Appendix 7: Sign up form

Proactive GP Support to patients in Nursing and Residential Care Homes

Agreement to provide

Practice Name: ……..…… Code: K……

The Practice confirms that, as from *[date]* it wishes to provide proactive care to patients in the following home(s) in line with the provisions set out in the ***Service Specification for Proactive GP Support to Patients in Nursing & Residential Care Homes***.

Name of home:
Address:

Type of home: Residential/Nursing/Both

Number of patients/residents:

Number of patients/residents registered with this practice:

Designated Usual GP to visit weekly *(if known)*:

The practice also confirms that, as from the start date of this service, it will not be receiving any other retainer or payment from this care home, or any PMS premium, to provide any element of care included in the service specification.

Signed on behalf of the practice: ……..

Name: …….. *(Partner)* **Date: …….**

Approved on behalf of OCCG

Signed ……..

Name: ……

Job Title: …… **Date: ……**

Please return a signed copy of this form to:
Sara Wallcraft Oxfordshire CCG, Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Cowley, Oxford OX4 2LH
or by email with electronic signature to sara.wallcraft@oxfordshireccg.nhs.uk