BMA

Structured Medication Reviews and Optimisation

Service requirements	PCN workforce involvement	Community workforce involvement	Outcome measures
Identify a clinical lead who will be responsible across the PCN for the delivery of the service requirements Run locally-defined processes at least twice yearly, on a six-monthly basis, to identify the patients within the practice-registered population that require SMRs; the following groups have been identified as being most likely to benefit from an SMR: • All patients in care homes as per the Enhanced Health in Care Home specification • Patients with complex and problematic polypharmacy, specifically those on 10 or more medications • Patients who are being prescribed medicines that are commonly and consistently associated with medication errors • Patients with multiple long-term conditions and/or multiple comorbidities – in particular respiratory disease and cardiovascular disease • Housebound, isolated patients and those with frailty – particularly patients who have had recent admissions to hospital and/or falls • Patients who have received a comprehensive geriatric assessment as per the anticipatory care requirements • Patients with severe frailty and patients prescribed high numbers of addictive pain management medication Develop local processes for reactive SMR referrals, adhering to published guidance; Provide written communication to patients invited for an SMR, detailing the process and intention of the appointment; Offer SMRs to 100% of identified patients, except in exceptional circumstances where the commissioner agrees that proven capacity constraints (where the PCN had demonstrated all reasonable attempts to ensure capacity had been undertaken) would justify a lower proportion of identified patients to be offered a SMR;	Appropriately trained clinicians with a prescribing qualification and advanced assessment and history taking skills: • Clinical Pharmacists If no pharmacists recruited, others that would be appropriate: • General Practitioners • Advanced Nurse Practitioners		The number of individual SMR episodes undertaken, including: • the number of SMR processes undertaken (number of • individual patients given one or more SMR appointment) The number of SMR follow-up appointments Impact of SMR Prescribing rate of nationally identified medicines of low value that should not be routinely prescribed Prescribing rate of low carbon inhalers Prescribing rate of medicines that can cause dependency Prescribing rate of anti-microbial medication

Undertake SMRs and follow-up consultations in line with detailed guidance. CCGs will review variation in the numbers of SMRs undertaken, which will inform the potential development of a standardised requirement in future years; Use appropriate clinical decision-making tools to support the delivery of SMRs, examples of which will be provided through guidance; Clearly record all SMRs within GPIT systems, as well as using appropriate clinical codes to signify the reasons for an SMR; Develop local PCN action plans to reduce inappropriate prescribing of (a) antimicrobial medicines, (b) medicines which can cause dependency, and (c) nationally identified medicines of low priority. This plan will react to guidance specifying how the PCN will deliver against the guidance; Work with community pharmacies locally to ensure alignment with delivery of both the New Medicines Service (to support adherence to newly-prescribed medicines) and developing medicines reconciliation services (to support effective transfers of care between hospital and community); Ensure delivery of SMRs and medication optimisation aligns to the work of medicines optimisation teams within CCGs local to the PCN.			

Enhanced Health in Care Homes

Service requirements	PCN workforce involvement	Community workforce involvement	Outcome measures
Identify a clinical lead, responsible across the PCN for the delivery of the service requirements Ensure every person living permanently in a care home has a named clinical team, including staff from the PCN and relevant providers of community services, who are accountable for the care delivered through the EHCH model	• Clinical Pharmacist to do SMRs (overlap with SMR) • GP or community geriatrician to do ward round fortnightly; other clinician to do alternately • Physiotherapists may attend weekly rounds to undertake appropriate work	Work alongside PCNs and care homes to ensure delivery of the multidisciplinary elements of the service model described below Co- design with the PCN, and thereafter participate in, a multidisciplinary team (MDT) of professionals, to work in close	The rate of emergency admissions for people living in care homes. The rate of urgent care attendances for people living in care homes. The proportion of people living in a care home who have a personalised care and support plan in place.

Ensure every care home is aligned to a single PCN, and its multidisciplinary team (MDT), that are already registered with a practice in the PCN or choose to register with a practice in the PCN Each PCN will agree the care homes for which it has responsibility with its CCG. People entering the care home should be supported to re-register with the aligned PCN and have the benefits of doing so clearly explained. Where people choose not to register with a practice in the aligned PCN, requirements 4-9 below should be delivered by their registered practice, either directly or through local sub-contracting arrangements Establish and manage a multidisciplinary team (MDT) of professionals, working across organisational boundaries to develop and monitor personalised care and support plans, and the support offers defined in them, for people living in care homes. Establish protocols between the care home and wider system partners for information sharing and shared care planning, use of shared care records and clear clinical governance and accountability Deliver a weekly, in person, 'home round' for their registered patients in the care home(s). The home round must: • be led by a suitable clinician. On at least a fortnightly basis this must be a GP. With local agreement the GP can be substituted by a community geriatrician. • involve a consistent group of staff from the MDT. • focus on people identified for review by the care home, those with the most acute and escalating needs or those who may require palliative or end-of- life care. Own, and coordinate delivery of, a personalised care and support plan with people living in care homes based on relevant		collaboration with care homes to develop and monitor personalised care and support plans. Attend MDT meetings and manage delivery of the MDT if agreed locally Support the establishment of protocols between the care home and wider system partners for information sharing and shared care planning, use of shared care records and clear clinical governance and accountability. Deliver, participate in or prepare for home rounds as agreed with the PCN and provide initial triage of people living in care homes who have been flagged for review. Deliver, as determined by the MDT, elements of holistic assessment for people in care homes across five domains; physical, psychological, functional, social and environmental, drawing on existing assessments that have taken place where possible. Provide input to the person's care and support plan within seven working days of admission to the home, and within seven working days of readmission following a hospital episode.	The number of people living in a care home who receive an appointment as part of the weekly care home round The number and proportion of people living in a care home who receive a structured medication review. The number and proportion of people living in a care home who receive a delirium risk assessment.

assessments of needs and drawing on assessments that have already taken place where possible and: • ensure that this plan is developed and agreed with each new resident within seven days of admission to the home, and within seven days of readmission following a hospital episode. Review the plan when clinically appropriate and refresh it at least annually; • ensure the plan is developed with the person or/or their carer, and reflects their personal goals; • ensure the plan is tailored to the person's particular needs (for example if they are living with dementia) and circumstances (such as those people approaching the end of their life) Coordinate, alongside community providers, one-off or regular support to people within care homes, based on the needs defined in the personalised care and support plan and those identified by care home staff. Directly deliver or support delivery of elements of this support where appropriate, including: • structured medication reviews (SMRs), delivered according to the requirements of the SMR specification. • activities to support the achievement of goals identified as important to the person in their personalised care and support plan, including reasonable efforts to build links with local organisations outside of the home. Provide, through the MDT, identification and assessment of eligibility for urgent community response services Provide support and assistance to the care home by: • supporting the professional development of care home staff by identifying opportunities for training and shared learning; • working with the care home and wider system partners to address challenges the home is facing in coordination with the wider health and care system;		Deliver palliative and end of life care, as required, to care home residents 24 hours a day. Provide one-off or regular support to people within care homes based on the needs defined in the personalised care and support plan and those identified by care home staff. This support must include, but is not limited to: • community nursing • tissue viability • falls prevention, advice and strength and balance training • oral health • speech and language therapy including dysphagia assessment and support • dietetics • hydration and nutrition support • continence assessment and care (urinary and faecal) • psychological therapies e.g. via IAPT services or local older people's mental health services • cognitive stimulation or rehabilitation therapy and reminiscence therapy for people with dementia	

• delivering relevant vaccinations for care home staff, in line with the provisions set out in the seasonal influenza DES Working with the CCG to establish processes that improve efficient transfer of clinical care between residential homes, nursing homes and hospices and between care homes and hospitals, as described by NICE guidance Facilitate and support local and national initiatives to support discharge from hospital and psychiatric inpatient units, such as trusted assessor schemes Establish clear referral routes and information sharing arrangements between care homes, PCNs and out of hours providers and providers of a full range of community-based services including specialist mental health, dietetic, speech & language therapy, palliative care and dementia care		Support the identification and assessment of eligibility for urgent community response services and: • deliver urgent community response services (which include provision of crisis response within two hours and reablement within two days of referral); • deliver specialist mental health support in cases of mental health crises and challenging behavioural and psychological symptoms of dementia Where the above would help a person to remain safely and recover in their care home as an alternative to hospital admission or to support timely hospital discharge Make opportunities for training and shared learning available to care home staff, drawing on existing continued professional development programmes for staff working in community services Support the development and delivery of transfer of care schemes Support the development of clear referral routes and information sharing arrangements between the care home and other providers	

BMA

Anticipatory Care

Service requirements	PCN workforce involvement	Community workforce involvement	Outcome measures
Identify a responsible clinical lead for delivery of the model; Assist with the development and improvement of system-level population health management approaches to identify patients with complex needs that would benefit from anticipatory care; Work with others to develop and establish, clinical accountability and governance arrangements to manage the model, through shared design with providers of community services and mental health care, engaging with social care and voluntary services, drawing on existing system-level programmes where possible; Take a leading role in coordinating the care and support of people as patients begin to be treated by Anticipatory Care - building links and working across the system to facilitate development of a wider model of integrated care for individuals living with complex needs. With CCG support, work with others to develop and sign data sharing agreements between practices and with providers delivering community and mental health services, local acute hospitals voluntary sector organisations and social care to support the operation of MDTs and the development of population health analytics data sets. Support the development of system- level linked data sets to build population health analytics capabilities, including the extraction of anonymised, patient level data. Identify a priority list of patients who are at rising risk of unwarranted health outcomes, based on the CCG standard approach where applicable. Prioritisation should focus upon:	This will be a multi disciplinary team meeting regularly to coordinate and manage the care of this cohort. There will be a responsible lead who will retain overall clinical responsibility for delivery	Assist with the development and improvement of system-level population health management approaches to identify patients with complex needs that would benefit from Anticipatory Care. Support the coordination of the care and support of people being treated by the Anticipatory Care model, building links and working across the system to facilitate development of a wider model of integrated care for individuals living with complex needs Work with others to develop and agree delivery, clinical accountability and governance arrangements with practices working as part of a PCN, engaging with other providers of community services, mental health care, social care and voluntary services. Work with the CCG, PCN, providers of social care and voluntary sectors and patient representative groups to co-design and clearly set out how and where the range of support service offers described below (which will be recurrently available through MDTs for those receiving anticipatory care) and other support services will be delivered.	Number of individuals in receipt of the Anticipatory Care model Number of needs assessment carried out for individuals in receipt of the Anticipatory Care model. Number of individuals in the active cohort of the anticipatory care model with a personalised care and support plan. Number of individuals in the active cohort of the anticipatory care model receiving a falls risk assessment. Number of individuals in the active cohort of the anticipatory care model receiving a delirium risk assessment Number of SMRs for the active cohort on the anticipatory care model Number of SMR follow-ups in the active cohort on the anticipatory care model Number of individuals in the active cohort on the anticipatory care model given a referral to social prescribing service or where social prescribing is declined

• individuals with complex needs: including multiple long-term conditions and/or with frailty. • those that are amenable to improvement through multi-disciplinary intervention and • those that are at high risk of their condition progressing or circumstances or needs substantially changing within the next six months Establish and manage an MDT, to meet regularly to coordinate and manage the care of the cohort of people on the Anticipatory Care list Co- ordinate and deliver comprehensive needs assessments, targeted needs assessments or care co-ordination reviews for the people in this cohort, recording this activity and the person's individual goals in a personalised care and support plan. Coordinate the delivery of support offers as identified by the needs assessment and the patient's personal goals. Via the responsible lead, retain overall clinical responsibility for the delivery of this plan. The available support offers must include (not exhaustive): • medicines optimisation to address problematic polypharmacy, in line with the process established in the SMR specification • social prescription using a broad range of community assets to support well-being and address loneliness and isolation • carer identification and signposting to local support • annual comprehensive or targeted needs assessment for other validated cohorts with complex needs. • annual care coordination review for other validated cohorts with complex needs. • adoption of patient activation measures • non-medical interventions from the personalised care and support plan		Work with others to develop and sign data sharing agreements with practices and with other providers delivering community and mental health services, local acute Trusts, voluntary sector organisations and providers of social care to support the operation of MDTs and the development of population health data sets. Support the development of system-level linked data sets to build population health analytics capabilities, including the extraction of anonymised, patient level data. Support the prioritisation of a target cohort of patients based on professional judgement and/or validated tools. Align relevant community nursing and therapy staff to the local PCN and identify other professions that may need to be involved in the MDT discussion. Attend and participate in the MDT discussion – using available information to plan and co-ordinate the care of patients discussed Co- ordinate and deliver constituent parts of comprehensive and targeted needs assessments with the PCN. Develop or add to care and support plans for the individuals which the MDT identifies should be supported by community health professionals	

Personalised Care

Service objectives 2020/21 to 2023/24	PCN workforce involvement	Community workforce involvement	Outcome measures
Personalised Care and Support Planning Requirement of personalised care and support plans to be in place for at least 5-10:1000 weighted population. This must include: • All people in last 12 months of life • All individuals eligible in the Anticipatory Care and Enhanced Health in Care Homes cohorts **Promotion of Personal Health Budgets** Requirement to promote of Personal Health Budgets for: • People with a legal right to a Personal Health Budget • Any other cohorts identified as eligible for a Personal Health Budget within the CCG local offer • Between 2021/22 and 2023/4 begin to offer Personal Health Budgets directly for specific cohorts **Shared Decision Making** Priority shared decision-making clinical situations, to include at least: • MSK: Back pain, hip pain, knee pain and shoulder pain (led by physiotherapists) • Reducing stroke risk in people with AF (2021/22) • Additional clinical situations to be confirmed (2023/24) **Training and shared learning** Prioritise the following roles for training: • Team members undertaking personal care and support planning conversations • Clinical pharmacists hosting Structured Medicine Reviews • MSK practitioners • Social prescribing link workers **Social prescribing** Required number of social prescribing referrals at least: • 4-8:1000 weighted population • 8-12:1000 weighted population (2021/22) • 12-16:1000 weighted population (2022/23)	• A clinical lead will be responsible across the PCN for the delivery of these service requirements/objectives • Trained physiotherapists to lead conversations with priority cohorts for 2020/21 • For 2020/21 PCNs should prioritise the following roles for training: o Team members undertaking personalised care and support planning conversations o Clinical pharmacists hosting Structured Medicine Reviews o PCN MSK practitioners o Social prescribing link workers	PCNs to refer patients to community nursing and other teams for provision of care (eg for particularly vulnerable patients, for end of life care etc).	The number of personalised care and support plans delivered (including measure of delivery rate for required cohorts) The quality of personalised care and support plans The number of shared decision-making conversations completed (including measure of delivery rate for required cohorts) The quality of shared decision-making conversations The number of social prescribing referrals made The number of patient activation measurement assessments undertaken (including measure of delivery rate for required cohorts) The number of Personal Health Budgets

• 16-22:1000 weighted population (2023/24) **Supported self-management** PCNs to use the Patient Activation Measure (PAM) for the following cohorts: • People living with newly diagnosed Type 2 diabetes • People referred to social prescribing link workers • PCNs to use the Patient Activation Measure for additional cohorts to be confirmed (2021/22 – 2023/24)			

Supporting Early Cancer Diagnosis

Service objectives	PCN workforce involvement	Community workforce involvement	Outcome measures
2020/21 Improving referral practice • Enable and support practices to improve the quality of their referrals for suspected cancer (including recurrent cancers), in line with NICE guidance and making use of new RDC pathway for people with serious but non-specific symptoms where available. • Introduce safety netting approach for monitoring patients referred for suspected cancer and those who have been referred for investigations to inform decision to refer. • Ensure patients receive high-quality information on their referral. • Increasing uptake of National Cancer Screening Programmes • Building on existing practice-level actions, lead and coordinate practices' contribution to improving screening uptake. • Develop a PCN screening improvement action plan for 2021/22 that contributes to delivery of the local system plan (shared with Public Health Commissioning team and Cancer Alliance)	Practices to identify a clinical lead who will be responsible across the PCN for the delivery of the service requirements in this section		The proportion of cancers diagnosed at early stage (stage 1 and 2) – progress towards local Cancer Alliance target PCN-level participation in breast, bowel and cervical screening programmes Proportion of urgent cancer referrals that were safety netted The number of new cancer cases treated that have resulted from a two week wait referral (the 'detection' rate) The number of two-week referrals resulting in a diagnosis of cancer (the 'conversion' rate) Number of cancers diagnosed via emergency presentation

• Improving outcomes through reflective learning and local system partnerships • Develop a community of practice across the PCN and encourage practices' engagement with local system partners, in particular the Cancer Alliance, to enable delivery of the service requirements. 2021/22 Improving referral practice • Increase the proportion of people diagnosed at stages 1 and 2 by identifying and referring suspected cancer early, contributing to delivery of local CA target for improvement • Continue to review and improve referral practices, building on 2020/21 learning and activities, including through Significant Event Analysis and peer to peer learning and further analysis of local population data • Expand safety netting to include monitoring of patients with non-specific symptoms where the GP has a significant clinical concern but are not immediately referred for suspected cancer. • Continue to ensure patients receive high-quality information on their referral (for all future years) • Increasing uptake of National Cancer Screening Programmes • Deliver agreed actions from their 2021/22 PCN screening improvement action plan, in line with Public Health Commissioning and Cancer Alliance plan. Update plan for 2022/23 Improving outcomes through reflective learning and local system partnerships. Working with local system partners (including patient groups), PCNs to proactively engage the local community to promote healthier lifestyles, awareness of signs and symptoms and availability of support. 2022/23 Improving referral practice			

• Increase the proportion of people diagnosed at stages 1 and 2 by identifying and referring suspected cancer early, contributing to delivery of local CA target for improvement. • PCNs continue to review and improve referral practices, building on 20/21 learning and activities, including through Significant Event Analysis and peer to peer learning • Increasing uptake of National Cancer Screening Programmes • Update and implement local screening improvement action plan • Improving outcomes through reflective learning and local system partnerships • Working with local system partners, PCNs proactively engage the local community to promote healthier lifestyles, awareness of signs and symptoms and available support. This includes identifying people at higher risk of developing cancer. 2023/24 Improving referral practice • Increase the proportion of people diagnosed at stages 1 and 2 by identifying and referring suspected cancer early, contributing to delivery of local CA target for improvement • All patients are receiving high-quality information about their referral. Those that are deemed to require additional support for their referral are signposted to the PCN social prescribing link workers. • Continued implementation of a consistent approach to safety netting across the PCN, and all people with serious but non-specific symptoms into Rapid Diagnostic Centres • Increasing uptake of National Cancer Screening Programmes • Subject to success of pilots, Targeted Lung Health Checks are scheduled for national roll out. PCNs should help practices to			

encourage participation in the programme for those who could benefit • Improving outcomes through reflective learning and local system partnerships • Working with local system partners, proactively engage the local community to promote healthier lifestyles, awareness of signs and symptoms and availability of support. This includes identifying people at higher risk of developing cancer			