Specification for a Directed Supplementary Service for people living with severe Frailty in their own homes

Introduction

1. All practices are expected to provide core services to all registered patients under the terms of their GMS Unified contract. The specification of this service therefore outlines the general and more specialised service to be provided that is beyond the scope of the unified contract services and remunerates additional service delivery on top of the practices usual service model. No part of the specification by commission, omission or implication defines or redefines the unified contract. There is a GMS contractual requirement to identify populations at risk of being frail, by degree, using an evidence-based tool (for example electronic frailty index) which is then supplemented by clinical judgement. This Directed Supplementary Service (DSS) builds upon that requirement.

2. The DSS for people living with severe frailty in their own homes recognises the significant pressure that the NHS in Wales is under especially during the winter months and the risk of lengthy stays for those most at risk of decompensation or exacerbation of their condition and an acute hospital admission and increased vulnerability following a prolonged admission. It builds upon the DSS for Complex Multimorbidity and Frailty (December 2024- April 25) The aim of the (DSS) is to increase pre-emptive proactive and anticipatory care, decrease unplanned admissions and decrease unplanned interventions by resourcing additional activity and care coordination in addition to the practice's usual GMS model. The DSS will support practices to review and manage the holistic needs of an identified cohort of high-risk patients in collaboration with other local services. Best Practice Framework for Proactive Care can be found here https://www.gov.wales/older-people-living-frailty-delivering-care-adults-complex-needs.

3. In October 2023, Welsh Government provided Health Boards with 'Further Faster' investment to support the identification of the top 0.5% high risk population and to ensure that processes are in place to review those patients and implement proactive monitoring and timely management of escalating needs in the community. Progress is being made across Wales against this action across Clusters / Health Boards. In December 2024, Welsh government provided investment for a directed supplementary service for complex multi-morbidity and Frailty which was completed in April 2025. Learning from work done over winter 2024-25 has been considered in the preparation of this service specification. In line with GMS contractual requirements, Practices are already identifying people at risk of being frail using an evidence-based tool such as the electronic frailty index (eFI). Once screened, practices will confirm the diagnosis by clinical assessment of the patient and add appropriate coding to the medical record once diagnosis is confirmed, using the Rockwood clinical frailty score to assess the level of frailty. This DSS will concentrate on the needs of those identified as frail or extremely frail focussing on people over the age of 65. For the purpose of this scheme, practices will use an Audit Plus Tool developed by DHCW for the initial screening of the practice list which will then require clinical verification. Patients with an Audit+ risk of frailty score of 13 or greater are most likely to be at risk of frailty and should be considered for inclusion in the cohort once their Rockwood frailty score has been clinically assessed.

4. This DSS remunerates practices to provide additional capacity for completing an holistic, proactive and comprehensive review of this cohort of patients taking consideration of 'what matters' to that individual in line with relevant clinical pathways as well as linking to local intermediate care services, 3rd Sector services and Local Authority partners where relevant in

order to optimise treatment/management; reduce the risk of hospital admission and provide ongoing monitoring and care coordination. The service can be delivered by an individual practice or using a cluster approach. The initial review should be undertaken face to face. All reviews should be completed by the most appropriate practice clinician/MDT member. Where appropriate, it is expected that practices will coordinate with other local services such as the local Community Resource Team, district nursing, local authority services etc especially if the patient is already on their caseload in order to ensure access to relevant interventions for example Enhanced Community Care for escalating needs.

5. A Plan (e.g. Future Care Plan) should be developed and will be used to support families and/or carers to adhere to the patient's wishes through the identification of clearly defined escalation criteria recorded in the Future Care Plan (FCP). The monitoring review will allow the practice to assess the patient's condition, answer any queries they or their family/carer may have, establish if any revisions to the FCP are required.

6. This DSS specifically excludes Care Home residents who should already be receiving an enhanced level of care through the Care Home Directed Supplementary Service (previous DES).

7. This scheme builds upon the learning from the Winter 2024-25 scheme by clarifying the case cohort and making a clearer emphasis on care coordination across the MDT and wider services as well as usual GMS care of long term conditions and frailty.

8. This revised DSS may include those patients and families with whom practices already engaged in the Winter 2024-25 scheme in one of two ways. Those patients who are newly identified this year or who were identified but did not have the proactive comprehensive review may be recruited into the scheme at the point of the proactive comprehensive review. Patients who have already had a proactive comprehensive review in the last series and have already had their holistic care needs optimised, but have been identified as unstable and frail or extremely frail, may go direct into the monthly or bi-monthly review element of the scheme if it is considered that there are further opportunities to optimise their comprehensive care needs beyond what is normally offered by GMS. This decision can be made by the engaged provider at the time of creating or revising the register.

9. A Health Board who is currently operating its own scheme comparable to that set out in this Specification and associated Directions is not required to commission this service.

Delivery

10. Practice to establish a register of eligible patients based on agreed criteria and record initial patient details on Annex D.

11. Practice to complete a Plan using template provided at Annex A for each patient within the identified cohort including:

- Chronic disease review in line with relevant clinical pathways to optimise treatment and/or management (elements of the review completed since September – 2025 may be referenced)
- Liaison with patient/carer/independent advocate in respect of patient specific monitoring thresholds (i.e. BP, pulse, temperature, sats, oral intake, sputum colour/volume and markers for deterioration) as relevant/needed for specific patient.
- Document what is considered "normal" for patient i.e. premorbid state (the use of Rockwood Clinical Frailty Scale is advocated rockwood_cfs.pdf)

- Poly pharmacy review
- Deprescribing, where appropriate
- Agreed management plan for patient/carer – When and what to do if patient's care needs suddenly deteriorate or they become unwell i.e.
    - Contact GP if they are unwell (this can include early indication of new confusion / disorientation)
    - Contact their community case manager if known to services e.g. social worker, district nurse especially when they are no longer managing with the plan that they have in place
    - Referral to relevant community professionals such as Social Worker, District Nurse, Specialist Chronic Conditions Nurses, Frailty Nurses and / or the local Community Resource Team to ensure holistic assessment and future care planning
    - Refer to your local Enhanced Community Care providers if patient's presenting needs require more intensive and acute intervention as a safe alternative to hospital admission
    - When to contact 111 or 999
- Confirm influenza and Covid 19 vaccination status (offer vaccination where applicable)
- Future Care Planning to include Advance Care Planning where relevant and/or DNACPR using preferred local template.
- Recommended SNOMED /read code must be used to demonstrate activity from baseline
- Copy of FCP given to patient and/or carer, including an outline of their "normal" level of function and condition
- Liaison with patient/family/carer on purpose of the comprehensive review and mutual decision making to meet the patient's wishes.
- FCP is saved in patients lifelong medical record and shared with health and social care professionals involved in their care, support and treatment and wider stakeholders as appropriate

12. It is the responsibility of the contractor to ensure that all Health Care Professionals participating in this DSS possess the necessary skills, training, competence and experience to deliver the service.

Service Outline

13. This DSS will support the management and ongoing monitoring of an identified cohort of patients at high risk of admission or re-admission in the context of the GMS contractual requirement which states that practices will identify populations at risk of being frail, by degree, using an evidence-based tool, supplemented by clinical judgement and that after clinical verification, practices will add appropriate coding to the patient record using Rockwood Clinical Frailty Scale. From this information, the practice will be able to identify the patient cohort suitable for inclusion in the DSS by selecting those who have been identified and coded as moderately or severely frail. For the purpose of this scheme, practices will use an Audit Plus Tool developed by DHCW for the initial screening of the practice list which will then require clinical verification and coding with frailty according to the Rockwood score. Clinical verification would most likely have been done in a face-to-face consultation in the practice or using knowledge acquired via other local clinical services such as local frailty teams, district nursing, community resource teams etc.

a. Prioritisation given to those with the highest clinical frailty score who are not yet benefitting from multi-professional input.

b. Prioritisation is for 65+years of age with a clinically verified Rockwood score of 6 or more. However, if practices have identified severely frail individuals 55-65 or a Rockwood score of 5 but considered unstable with opportunities to reduce risk beyond normal GMS care, they may wish to include them in the cohort so long as i) the practice has capacity to do so and ii) after agreement with the local primary care team. Patients not initially identified by the initial practice cohort selection but are identified by local multiprofessional services or following discharge from hospital may be added to the scheme before the end of March 2026 so long as i) the practice has capacity to do so and ii) after agreement with the local primary care team. The practice may then claim for the completed components once agreed. Patients should then be added to the Annex D list and component part completed
c. De-selection: the engaged provider should take into account local GP practice knowledge that excludes individuals from this DSS scheme. For example, if the patient's holistic care needs are already addressed and the patient is known to be already benefitting from engagement with integrated care services they may be excluded).
d. Practice capacity may also limit engagement in which case practices should prioritise those identified with greatest need for the identified cohort list.
e. **Development and maintenance of a register** – participating practices to hold a list of patients identified by the Audit+ screening tool and create a register for clinically verified frail cohort and implement proactive case management for all these patients which may align with the caseloads of 'high risk' patients who would benefit from or are already being managed proactively by community services
f. **Call and recall system** - To ensure patients on the register are managed using a systematic call and recall process, including clear arrangements for home-based assessment for house bound patients.
g. **Initial Review Bundle –** to include completion and recording of initial proactive comprehensive review, Future Care Plan (FCP), sharing FCP where appropriate (eg with family or patient representative, out of hours provider)
h. **Monthly or bi-monthly Review** This recognises that future care planning is an iterative process that started with the initial review bundle. The review should be proportionate to perceived clinical risk and undertaken either face to face or via phone as appropriate as determined by the GP. The monthly or bi-monthly review depends on the needs of the patient and should include the proactive review of current medical plus wider-care needs. It should identify and implement any changes relevant to the future care plan particularly reflecting on any unscheduled contact with health care services (WAST, GP OOH, Admission etc).
i. **Post Unscheduled Care Review** – This should take place within 1 week of discharge and should be reflected in the next scheduled monthly review. The post unscheduled care review will be proportionate to perceived clinical risk and undertaken either face to face or via phone as appropriate as determined by the GP on receipt of the discharge summary, WAST callout or OOH contact information. If the next planned review is more than one week away, it is expected that this will be an additional **post unscheduled contact review'** in order to ensure a timely response to changes in needs which then should be reflected in the next monthly submission. Given the focus on any unscheduled contacts, the purpose is to establish if unscheduled care could have been avoided and if so, what actions should be taken to reduce the

possibility of further unscheduled care. This review will include discharge medicines and medicines reconciliation, ongoing medicines optimisation and consideration of de-prescribing where appropriate.

j. **Discussion** - with the patient and/or carer about the risks and benefits of treatment, using accredited decision aids.
k. **Education for patients** - To ensure that all patients and/or their carers' and support staff when appropriate receive appropriate information in relation to the prevention and management of, the potential complications associated with their condition, including the provision of written materials and /or audio-visual aids.
l. **Ensure** - patients and/or their family/carers/independent advocate receive a FCP and Acute Care Plan which outlines the patient's wishes, their self-help plan, a plan for when functional and / or acute needs escalate and advance care planning where appropriate.
m. **Ensure** – carers and/or family members are supported to keep the patient at home in accordance with the patient's wishes and FCP and Acute Care Plan
n. **Planned care** – Follow relevant clinical pathways to ensure optimum treatment/management of the condition(s)
o. Where clinically indicated, **Medication reviews** will occur in line with NICE guidance, the BNF and/or the local health board formulary and Health Pathways where available.
p. **Effective clinical information systems** – ensuring relevant information is recorded in the patient's lifelong clinical record so that care is properly co-ordinated, and information shared where necessary.
q. **Consistent Read coding**: The practice must ensure consistent coding of each care episode on the clinical IT system using approved codes.
r. **To** enable audit data collection please use the following SNOMED / read code;
s. **888461000000107 –** chronic disease management annual review completed
t. Where a patient **does not respond** to an invitation for review, the practice will ensure that there is robust evidence of the attempt to contact the patient recorded in the patient's clinical record. e.g. phone call, text, letter etc. Only completed reviews can be reimbursed.
u. **Final Report:** The practice **must** submit completed annex D by 24th April* and will complete a brief electronic survey taking no more than 10 minutes for the purposes of evaluation. In order that learning be shared locally, it is anticipated that participating practices will discuss the project at the next collaborative meeting after the project has finished and collaborative leads will share minutes or themes of that discussion. Alternatively participating practice may submit reflections with the final month submissions or as soon as possible after.

Funding

14. The DSS is expected to be ongoing (though may be further revised) subject to evaluation at the end of this current scheme which will run from 1st October 2025 until 31st March 2026. Following on from the evaluation of the 2024-25 complex multi-morbidity and frailty (winter) supplementary service, and the current GMS contractual requirement for the identification and management of people with frailty overall remuneration is unchanged but remuneration for initial cohort selection/ register and final submissions (survey and submission Annex D) is split in order to clearly identify the completion of entry and exit components. Practices will be reimbursed accordingly for the following 4 elements:

1) establish a register of eligible participants £125 using agreed search criteria.

1.1) For the initial register practices can make a one-off claim directly on FFPS. However, there is no additional payment for amending the register and Annex D for patients identified after the initial search.

2) completion, recording and sharing (where appropriate) of proactive comprehensive review (Annex A) (£150 per capita). GMS contractors cannot claim under this part where patients have not had the proactive comprehensive review under this specification and go direct into the monthly or bi-monthly review element of the scheme.

3) monthly/ bi-monthly monitoring review against needs identified in the proactive comprehensive review or newly identified needs (using Annex D) (£50 per capita, per review)

4) submission completed (annex D) and exit survey April 2026 - £125.

5) Payment is subject to full and complete data returns being made (Annex D) inclusive of service specification requirements captured within Annex D. All columns must be completed each month, even if to record a nil response to enable payment.

6) Practices should only create 1 Annex D updated each month (even if to record a nil response to enable payment) inclusive of all requirements for monthly submission. Multiple ad-hoc versions will not be considered.

Monitoring & Audit

15. The practice will be required to submit the monthly return to the primary care team by 5th of each month in line with WG future
and Recovery monthly reporting schedule. At the end of the commissioning term practices are required to submit completed Annex D and the electronic survey, including feedback and learning. The survey will be shared will be shared via email. Please complete by **24th April 2026**.

Termination Period

16. Should the practice wish to cease providing the DSS, it will be required to provide 4 weeks' notice in writing to the Health Board. Should the practice wish to suspend providing the DSS it should contact the Health Board for guidance prior to any action being taken.

17. If, for any reason, a practice terminates/suspends the DSS and, if claims have been made during the current financial year, any reporting/auditing requirements outlined in the specification must be submitted upon request.

General Medical Practice Indemnity

18. This DSS is covered by the scheme for General Medical Practice Indemnity (GMPI) which falls under the GMS Contract Wales.

19. This scheme relates to potential or actual clinical negligence claims arising from incidents on or after 1 April 2019, and captures all General Medical Practice (GP practice) staff undertaking NHS 'primary medical services' as defined in The National Health Service (Clinical Negligence Scheme) (Wales) Regulations 2019

20. The National Health Service (Clinical Negligence Scheme) (Wales) Regulations 2019, sets out the scope of the scheme, namely “primary medical services” which are defined as health services provided under a contract, arrangement or agreement made under or by virtue of the following sections of the National Health Service Wales Act 2006:

(a) section 41(2) (primary medical services);
(b) section 42(1) (general medical services contracts);
(c) section 50 (arrangements by Local Health Boards for the provision of primary medical services).

21. The GMPI will include clinical negligence liabilities for NHS work arising from the activities of all GP practice staff, including GP partners; salaried GPs; locum GPs, if on the All-Wales Locum Register; Practice Pharmacists; Practice Nurses; Practice Healthcare assistants; and any other member of staff providing clinical services. GP trainees and trainee nursing students delivering general medical services will also be covered. The GMPI will also cover any healthcare professionals providing the delivery of NHS Primary Care through Primary Care cluster arrangements and any vicarious liability to practices where a cluster-based health professional is providing direct care to the practice’s registered patients.

22. GP Locums who are registered with and working to the terms of the All-Wales Locum Register (AWLT) for Wales have access to the scheme for GMPI.

Annex A

Proactive Comprehensive Review

Patient's Name and address: D.O.B.:

Housebound / not housebound (delete as appropriate)

Registered GP and General Practice address

Practice providing Directed Supplementary Service: yes/no

Date of assessment:

Including (pre morbid) functional (physical and cognitive) baseline (Recommend Rockwood Frailty Scale rockwood_cfs.pdf)

Mental State Assessment using recognised tool eg Mini-Ace, GPCOG (see local Health Pathway for preferred tool) and record diagnosis where appropriate:

Mini Geriatric Depression Score or 6CIT or similar where relevant would be accepted.

Current Medical Problems:

Systems Review - problems identified

Examination findings

Specific additional areas

Known to Community Services	Receiving social care / district nursing / occupational therapy / physiotherapy etc.	Action required
Mobility	Unaided / stick or Zimmer / wheelchair / bed bound	Action required
Falls assessment	Risk assessment undertaken / required - Yes / No	Action required
Podiatry	Podiatry assessment undertaken / required - Yes / No	Action required
Oral health	Oral health assessment undertaken / required – Yes / No If Yes, is there evidence of a care plan being delivered	Action required
Pressure area review	Yes / No	Action required
Diet	Normal / soft / supplements / PEG Yes / No	Action required

Hearing	Normal / hearing aid / Other problem (please Specify):	Action required
Eyesight	Normal / glasses / Other problem (Please specify): Is there evidence of a care plan being delivered	Action required
Osteoporosis Risk Assessment (Using local agreed clinical pathway and please note most in this age group will not need a DEXA	Hx of recent falls: Y / N On calcium & Vit D supplements/N On bisphosphonate: Y	Action required

Investigations Recommended by assessor

Medication Review with polypharmacy, antipsychotic prescribing considerations and other high risk medicines Y / N

Any Recommended actions:

Future Care Planning. A proforma template is attached Annex B

Summary of further actions and person/s responsible: (e.g. onward referral for hearing test or local MDT)

Name and designation of person completing review: Date:

Annex B

Future Care Plan
(Adapted from the Gold Standards Framework template)

Aims:
1. To provide a written record of 'what matters' to the individual and an outline of a plan that supports achieving that aim including in routine situations and during episodes of sudden escalated need. If appropriate the Plan should also include their preferences at the end of life. The Plan should be considered along with the individual's next of kin and / or independent advocate.
2. Is useful to clinicians in the planning of patient's individual care
3. To reduce crisis decisions or unnecessary admissions to hospital
(to be written following discussion with appropriate input including, but not exclusively, the patient, nursing / care home staff, patient's usual GP and relatives)
4. The Plan is not a one-off statement – it is a 'dynamic' document and should be reviewed regularly and particularly when the person's health condition or social situation changes or as the individual themselves determines the need for a review.
5. Support to develop a Future Care Plan should be considered in the following circumstances:
- The person is approaching the end of life (expected death within 6 months)
- The person is living with one or multiple long term health conditions
- The person is living with disabilities and / or fluctuating and complex health and care needs (including frailty).

THESE PLANS Should be made AVAILABLE TO THE MDT and OOH PROVIDER
1. 'What Matters to you?'
What elements of care are important to you and what would you like to happen in future?

2. Is there anything that you worry about or dread happening? What would you NOT want to happen?

3. Do you have a Living Will or Legal Advance Decision Document?
If yes, please give details (e.g. who has a copy)?

4. Who else would you like to be involved if it ever becomes difficult for you to make decisions or if there was an emergency? Do they have official Lasting Power of Attorney?

Name …….. Contact Details …….

Name …….. Contact Details ……

5. If your condition deteriorates where would you most like to be cared for?

1st Choice ……..

2nd Choice ……

Comments ……

6. Do you have any special requests, preferences or other comments?

Annex C

Patient Acute Care Plan and Flow Chart

Patient Care Plan

Patient Details		General Practice Details	
Name		Practice name	
Date of Birth		Named GP	
NHS Number		Contact number	
Address		Address	

Acute plan completed by:	Date acute plan completed:	Date acute plan due for review:

Patient consent:	YES/NO

Acute Care Plan Key Clinical Information

Key issues:	
Condition specific information and plans:	
Special requirements/disability:	
Problem list and medical history:	
Normal observations and functions (baseline):	
Social situation and preferred contacts:	
Additional information:	

Acute Care Plan

Specific information for ambulance crew:	
Conditions and parameters for escalation level 1a:	
Conditions and parameters for escalation level 1b:	
Conditions and parameters for escalation level 2:	
Conditions and parameters for escalation level 3:	

Escalation levels	Actions
1a – Remain at home – Ongoing remote monitoring Well, very mild symptoms (include examples and diagnostic parameters where applicable)	Self-care (including use of rescue packs) Consider 111
1b – Remain at home – primary care team and specialist advice Symptomatic but otherwise well and physiological state (include examples and diagnostic parameters where applicable)	Consider referral to: Community Resource Team and / or their Enhanced Community Care Provider or, District Nurse or Specialist Nurse (i.e. Respiratory, Diabetes, Frailty etc.)
2 – Deteriorating – Home based response or access to intermediate urgent care Deteriorating clinical or social condition that if worsening could lead to hospital admission (include examples and diagnostic parameters where applicable)	Contact - Health Board Single Point of Access or, GP or, 111
3 – Hospital attendance required Clinical and/or social situation requires care only available in hospital (define specific parameters)	Ambulance required - Access to hospital via required admissions unit/ process without the need for a GP referral