

NWSI 2026 No. 179

NATIONAL HEALTH SERVICE

The Primary Medical Services (People Living With Frailty in Their Own Homes) (Directed Supplementary Service) (Wales) Directions 2026

Coming into force
Made

1 October 2026
30 September 2026

The Welsh Ministers in exercise of the powers conferred on them by sections 12(3), 45(1), (2), (3)(a) to (d), (4) and (5) 203(9), (10) and 204(1)(b) of the National Health Service (Wales) Act 2006⁽¹⁾, and after consulting in accordance with section 45(4) of that Act with the bodies appearing to them to be representative of persons to whose remuneration these Directions relate, give the following Directions.

Title, application and coming into force

1.—(1) The title of these Directions is the Primary Medical Services (People Living With Frailty in Their Own Homes) (Directed Supplementary Service) (Wales) Directions 2026.

(2) These Directions come into force on 1 October 2026.

(3) These Directions are given to Local Health Boards.

Interpretation

2. In these Directions—

“2006 Act” means the National Health Service (Wales) Act 2006;

“the GMS Contracts Regulations” means the National Health Service (General Medical Services Contracts) (Wales) Regulations 2023⁽²⁾;

“cluster” means a group of local service providers involved in health and care who have agreed to collaboratively work together to deliver primary medical services across a specified geographical area;

“cluster lead practice” means a GMS contractor that has agreed to provide this DSS to its registered patients and to the registered patients of a GMS contractor in its cluster that is not an engaged GMS contractor, and which the Local Health Board agrees will be a cluster lead practice;

(1) 2006 c. 42.

(2) S.I. 2023/953 (W. 155).

“DSS” means the People Living With Frailty in Their Own Homes Directed Supplementary Service established in accordance with paragraph 3;

“engaged GMS contractor” means a GMS contractor that agrees with a Local Health Board to provide this DSS pursuant to an arrangement made in accordance with paragraph 4(1);

“general practitioner” means a medical practitioner whose name is included in a medical performers list prepared by a Local Health Board under regulation 3 of the National Health Service (Performers Lists) (Wales) Regulations 2026(3);

“GMS contract” means a contract for general medical services between a GMS contractor and a Local Health Board made pursuant to section 42 of the 2006 Act;

“GMS contractor” means a person with whom a Local Health Board is entering or has entered into a general medical services contract;

“health care professional” means a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002(4);

“Local Health Board” means a Local Health Board established in accordance with section 11(2) of the 2006 Act;

“nurse” means a nurse registered in the register of nurses established under section 5(1) of the Nursing and Midwifery Order 2001(5);

“polypharmacy” means prescribing of two or more medications inappropriately, or where the intended benefit of the medication is not realised;

“registered patient” has the meaning given to it in regulation 3(1) of the GMS Contracts Regulations;

“Specification” means the Specification for a Directed Supplementary Service for People Living With Frailty in Their Own Homes set out in the Schedule to these Directions;

“Statement of Financial Entitlements” means any directions given by the Welsh Ministers pursuant to section 45 of the 2006 Act in relation to payments to be made by a Local Health Board to a GMS contractor.

Establishment of a People Living With Frailty in Their Own Homes Directed Supplementary Service

3.—(1) Each Local Health Board must, as part of its discharge of its functions under section 41(6) of the 2006 Act (of providing primary medical services within its area, or securing the provision of such services in its area), establish, operate and, as appropriate,

(3) S.I. 2026/63.

(4) 2002 c. 17. Section 25(3) was amended by article 1(5) and Schedule 4 paragraph 10(2) to the Pharmacy Order 2010 (S.I. 2010/231); article 2(1) and Schedule to S.I. 2010/1621; section 170(3)(4) of, and Schedule 10 paragraph 17(2) and 17(3) to the Health and Social Care Act 2008 (c. 14); article 2(i)(xii) of S.I. 2008/3244; section 306(4) of, and Schedule 15 paragraph 56(b) to the Health and Social Care Act 2012 (c. 7); S.I. 2012/1319, article 2(4) of S.I. 2012/1319; section 70(2) of, and Schedule 4 paragraph 2(2) to the Children and Social Work Act 2017 (c. 16); and regulation 2(r) to S.I. 2019/1436.

(5) S.I. 2002/253. Section 5(1) was amended by article 1(2)(b)(3) and Schedule 1 paragraph 4(a) to the Nursing and Midwifery (Amendment) Order 2018 (S.I. 2018/838).

(6) There are amendments to section 41 which are not relevant to these Directions.

revise a People Living With Frailty in Their Own Homes Directed Supplementary Service in accordance with these Directions.

(2) The underlying purpose of this DSS is to support the identification of those patients who are aged over 65 and at risk of moderate or severe frailty to—

- (a) optimise treatment and management,
- (b) reduce the risk of hospital admission, and
- (c) provide ongoing monitoring.

(3) Each Local Health Board may establish, operate and, as appropriate, revise a People Living With Frailty in Their Own Homes Directed Supplementary Service for patients who are under 65.

People Living With Frailty in Their Own Homes Directed Supplementary Service

4.—(1) Each Local Health Board must offer to enter into arrangements for the provision of services under this DSS to registered patients—

- (a) in the first instance, with each GMS contractor, in relation to the registered patients of that GMS contractor, and
- (b) thereafter, with—
 - (i) one or more cluster lead practices, in relation to—
 - (aa) the registered patients of each such cluster lead practice, and
 - (bb) the registered patients of any GMS contractors in its cluster that have not agreed, within such time period as the Local Health Board requires, to deliver this DSS under sub-paragraph (a).

(2) Where arrangements are made between a cluster lead practice and a Local Health Board in accordance with sub-paragraph (1)(b)(i), each engaged GMS contractor must co-operate (in accordance with paragraph 13 of Schedule 3 to the GMS Contracts Regulations) both with the other engaged GMS contractors and the cluster lead practice in its cluster in order for the cluster lead practice to complete, by such date as the Local Health Board requires, a plan setting out the arrangement for the delivery of services under this DSS to the registered patients of the GMS contractors across the cluster.

(3) Where there is only one engaged GMS contractor, and it is the cluster lead practice, it shall be responsible for completing the plan referred to in sub-paragraph (2). Where there is no cluster lead practice, and all of the GMS contractors in the cluster are engaged GMS contractors, they shall all be responsible for completing that plan.

(4) Where arrangements are made between the Local Health Board and a GMS contractor under sub-paragraph (1) or (2), those arrangements must, in respect of each financial year (or part of a year) to which they relate, also include a requirement that—

- (a) in addition to these Directions, an engaged GMS contractor adheres to the Specification, which together provide the detailed requirements for this DSS;
- (b) the engaged GMS contractor identifies the cohort of patients for this DSS by—
 - (i) utilising an evidence-based tool, supplemented by clinical judgement,
 - (ii) obtaining clinical verification,
 - (iii) adding appropriate coding to the patient record using the Rockwood Clinical Frailty Scale⁽⁷⁾, and

(7) The Clinical Frailty Scale was developed by Moorhouse P and Rockwood K. Frailty and its quantitative clinical evaluation. Royal College of Physicians Edinburgh. 2012;42:333-340

- (iv) taking account of paragraphs 14(a) to (e) in the Specification.
- (c) the engaged GMS contractor ensures that any health care professional who is involved in administering this DSS has the necessary skills, training, competence and experience to provide the service;
- (d) the engaged GMS contractor develops and maintains a register of the identified cohort in compliance with paragraph 14(f) of the Specification and records initial patient details in Annex D of the Specification;
- (e) the engaged GMS contractor undertakes an initial comprehensive review and as part of that review completes—
 - (i) a face to face patient review for each patient on its register as set out in Annex A of the Specification, taking account of the requirements in paragraphs 10 and 11 of the Specification,
 - (ii) a future care plan as set out in Annex B of the Specification,
 - (iii) an acute care plan as set out in Annex C of the Specification which takes account of the patient's wishes, and
 - (iv) a record of the review, such record along with the future care plan and acute care plan to be shared where appropriate.
- (f) the engaged GMS provider undertakes an annual review within 13 months, beginning with the date the initial comprehensive review under sub-paragraph (e) is completed. The annual review must comprise—
 - (i) a face to face patient review for each patient on its register as set out in Annex A of the Specification, taking account of the requirements in paragraphs 10 and 11 of the Specification,
 - (ii) a future care plan as set out in Annex B of the Specification,
 - (iii) an acute care plan as set out in Annex C of the Specification which takes account of the patient's wishes, and
 - (iv) a record of the review, such record along with the future care plan and acute care plan to be shared where appropriate.
- (g) the engaged GMS contractor undertakes, up to a maximum of, 3 interim reviews as set out in paragraph 14(i) of the Specification. The frequency will be dependent on the needs of the patient which should be proportionate to perceived clinical risk and undertaken either face to face or via phone as appropriate and as determined by the general practitioner;
- (h) the engaged GMS contractor completes Annex D of the Specification on each occasion when an interim review is completed;
- (i) the engaged GMS contractor has in place a robust 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;
- (j) the engaged GMS contractor maintains a record of the attempts made to contact a patient to arrange a review;
- (k) the engaged GMS contractor discusses the risks and benefits of treatment, with the patient and their carers, using accredited decision aids where appropriate;
- (l) where appropriate, the engaged GMS contractor educates patients to ensure that all patients, carers and support staff receive appropriate information in relation to the prevention, management and potential complications associated

- with their condition, including the provision of written materials and audio-visual aids;
- (m) the engaged GMS contractor ensures the patient's carers and family members are supported to keep the patient at home in accordance with the patient's wishes, future care plan and acute care plan;
 - (n) the engaged GMS contractor follows relevant clinical pathways for planned care;
 - (o) the engaged GMS contractor undertakes medication reviews in line with NICE guidance, the British National Formulary, the Local Health Board Formulary and HealthPathways where available;
 - (p) the engaged GMS contractor ensures relevant information is recorded in the patient's lifelong clinical record so that care is properly co-ordinated, and information shared where necessary;
 - (q) the engaged GMS contractor consistently codes each care episode on the clinical IT system using approved codes to enable audit data collection, including a requirement that the engaged GMS contractor uses the SNOMED read code – **"888461000000107 – chronic disease management annual review completed"**;
 - (r) the engaged GMS contractor completes an electronic survey for the purposes of evaluation. In order that learning be shared, it is anticipated that participating practices will discuss this DSS at the next collaborative meeting after 30 April each year;
 - (s) the engaged GMS contractor, submits the completed Annex D and the electronic survey, including feedback and learning by 30 April each year;
 - (t) the engaged GMS contractor allows the Local Health Board to extract data relating to this DSS from the contractor's computerised clinical systems; and
 - (u) the engaged GMS contractor provide the Local Health Board with twelve weeks' written notice if the GMS contractor wishes to cease providing this DSS.

Payment under the People Living With Frailty in Their Own Homes Directed Supplementary Service

5.—(1) Where arrangements are made under paragraph 4(1), those arrangements must also include payment arrangements, which must provide for that engaged GMS contractor to be able to claim (whether acting for itself or as a cluster lead practice)—

- (a) a payment of £125 per engaged GMS contractor for establishing a register using agreed search criteria,
- (b) a payment of £150 per patient for completing, recording and sharing (where appropriate) the initial and annual proactive comprehensive review using Annex A,
- (c) a payment of £50 per patient for undertaking an interim review, up to a maximum of 3 annually, against needs identified in the proactive comprehensive review or newly identified need, using Annex D, and
- (d) a payment of £125 for completion and submission of Annex D and the evaluation survey, to be submitted annually and no later than 30 April each year.

(2) Claims and associated payments will be subject to post payment verification checks as appropriate.

(3) Payments are payable monthly or quarterly in arrears and must be made on the date the engaged GMS contractor's Global Sum monthly payment next falls due in accordance with the Statement of Financial Entitlements.

Contract Variation

6. The Local Health Board must vary the engaged GMS contractor's GMS contract so that the arrangements made under paragraph 4(1) comprise part of that engaged GMS contractor's contract and the requirements of the arrangements are conditions of the contract.

Dispute Resolution

7.—(1) In the case of any dispute arising out of or in connection with this DSS, Local Health Boards and GMS contractors should make every effort to resolve the dispute locally before formally referring the dispute through the NHS dispute resolution procedure.

(2) In this paragraph, "NHS dispute resolution procedure" means the procedure for the resolution of disputes specified in paragraphs 106 and 107 of Schedule 3 to the GMS Contracts Regulations⁽⁸⁾

Revocation

8. The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) Directions 2025⁽⁹⁾ are revoked.

Paul Casey

Deputy Director for Primary and Community Care, under the authority of the Cabinet
Minister for Health and Care, one of the Welsh Ministers
30 September 2026

⁽⁸⁾ Paragraphs 106 and 107 were amended by regulation 18 of S.I. 2023/1421 (W. 250).

⁽⁹⁾ WG 2025 No. 56.

SCHEDULE

Specification for a Directed Supplementary Service for People Living With Frailty in Their Own Homes

Introduction

1. All GP practices are expected to provide unified services to all registered patients under the terms of their GMS contract. The specification of this service therefore outlines the general and more specialised service to be provided that is beyond the scope of unified 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 unified services. There is a GMS contractual requirement to proactively identify people who are frail or at risk of being frail, by degree, using a practice population screening tool (for example electronic frailty index or Digital Health and Care Wales (DHCW) Audit + tool). Individuals identified as being frail or at risk of frailty are then to be clinically assessed and a frailty score applied using the Rockwood frailty score. Appropriate coding of their frailty score should be added to the individual's patient record. This DSS builds upon that requirement.

2. This DSS recognises the fragility of those most at risk of decompensation or exacerbation of their condition, the risk of lengthy stays associated with an acute hospital admission and increased vulnerability following a prolonged admission. The aim of this 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. This 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. This will support the Community by Design programme as outlined in the NHS Wales Planning Framework for 2026 to 2029⁽¹⁰⁾ by supporting people with long-term conditions or frailty to remain well by receiving care in the community. 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 Local 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 continues against this action across Clusters / Local Health Boards. In December 2024, Welsh Government introduced a directed supplementary service for complex multi-morbidity and Frailty. Local Health Boards have been directed to commission this DSS across all GP practices, utilising existing allocations to support delivery. In line with GMS contractual requirements, GP practices are already identifying people at risk of being frail using an evidence-based tool such as the electronic frailty index (eFI) or DHCW audit+ tool. Once screened, GP practices will confirm the diagnosis by clinical assessment of the patient and add appropriate coding to the medical record, using the Rockwood clinical frailty score to assess the level of frailty. This DSS will concentrate on the medical, social and

(10) <https://www.gov.wales/nhs-wales-planning-framework-2026-2029>

holistic needs of those identified as moderately frail or worse based on their Rockwood score focussing on people over the age of 65, with local discretion for younger age groups or individuals based on Local Health Board priorities and resources. For the purpose of this DSS, engaged GMS contractors will have use of the national GP data extraction system (e.g. Audit+) that contains a frailty screening tool developed by DHCW for the initial screening of the GP practice list which will then require clinical verification. As an indication, patients with a screening score of 13 or greater are most likely to be at risk of moderate or severe frailty. Subsequently, any patients with a clinically verified Rockwood score of 6 or greater could be considered for inclusion in the DSS cohort.

4. This DSS remunerates GP practices to provide additional capacity for completing an annual holistic, proactive and comprehensive review of this cohort of patients in addition to the GMS contractual obligations, taking consideration of 'what matters' to that individual in line with relevant clinical pathways as well as linking to local intermediate care services, third 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 GP practice or using a collaborative led cluster approach where local commissioning arrangements exist eg through a collaborative, federation or community interest company. The initial and annual review must be undertaken face to face. All reviews should be completed by the most appropriate GP practice clinician/Multi Disciplinary Team (MDT) member. Where appropriate, it is expected that GP 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) provided at Annex B. The FCP must be shared with the patient and their family in advance of the monitoring review. The monitoring review will allow the GP practice to assess the patient's condition, answer any queries they or their family/carer may have and 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 (previously Directed Enhanced Service).

7. This DSS requires the engaged provider to deliver an enhanced level of proactive care to a clearly defined frail cohort with a clear role in care coordination across the MDT and wider services above usual care of long-term conditions and frailty.

8. This DSS includes an initial proactive comprehensive review for new patients including oversight of actions resulting from the assessment. Subsequently, the engaged contractor will undertake a proactive comprehensive annual review of those patients who are still eligible for inclusion in the DSS and ensuring oversight of actions resulting from the review.

9. In addition, reflecting the iterative process of future care planning and the potential fragility of this patient cohort, the engaged contractor may consider it appropriate to offer interim review consultations to further explore the patient's holistic care needs, particularly in the context of unscheduled care contacts where care needs and patient/ family preferences may have changed.

Delivery

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

11. GP practices are to complete a Plan using the template provided at Annex A (year 1 proactive comprehensive review) for each patient and annual review thereafter within 13 months of the previous review . This includes components of the unified contract plus supplementary elements:

- Chronic disease review as per GMS contractual requirement and in line with relevant clinical pathways to optimise treatment and/or management (elements of the review completed);
- Liaison with the 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 using the Rockwood Clinical Frailty Scale(11) ;
- Polypharmacy review;
- Deprescribing, where appropriate;
- Agreed FCP and Acute Care Plan for patient/carer as per Annex B and Annex C – When and what to do if patient's care needs suddenly deteriorate or they become unwell. Interventions include:
 - Contacting their GP if they are unwell (this can include early indication of new confusion / disorientation);
 - Contacting 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;
 - Referral to the 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 all eligible vaccines for the patient are up to date and offer the relevant vaccinations where applicable;
- Future Care Planning to include Advance Care Planning where relevant and/or Do Not Attempt Cardiopulmonary Resuscitation using preferred local template;
- SNOMED 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 the patient/family/carer on purpose of the comprehensive review and mutual decision making to meet the patient's wishes;

(11) https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf

- 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;
- Contractor to ensure actions arising from the review are completed within a reasonable timeframe but within 3 months of the review date.

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.

13. It is the responsibility of the contractor to ensure Annex D is kept up to date and submitted annually to the Local Health Board, including the recording of all initial, annual and interim reviews undertaken under this DSS.

Service Outline

14. This DSS will support the management and ongoing monitoring of an identified cohort of frail patients at higher 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 after that clinical verification, GP practices will add appropriate coding to the patient record using Rockwood Clinical Frailty Scale. From this information and via existing Rockwood score recording, the GP 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 more severely frail (Rockwood 6 or >6). For the purpose of this scheme, GP practices will have use of a evidence-based tool developed by DHCW for the initial screening of the GP 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 is to be given to those with the highest clinical frailty score who are not yet benefitting from multi-professional input. (For example, it is anticipated that most patients with a score of 8 or 9 should already have had holistic care optimised with extensive care packages and a FCP in place. In this instance it is reasonable that the contractor may feel there is nothing further to add and may choose not to include the individual in the service.
- (b) Prioritisation is for 65+years of age with a clinically verified Rockwood score of 6 or more. However, if GP practices have identified younger working age adults considered to be moderately or severely frail based on Rockwood score criteria⁽¹²⁾ with opportunities to reduce risk beyond normal GMS care, they may wish to include them in the cohort so long as i) the GP practice has capacity to do so and ii) after agreement with the local primary care team. Patients not identified by the initial GP practice cohort selection but who are identified by local multiprofessional services or following discharge from hospital may be added to the scheme so long as i) the GP practice has capacity to do so and ii) after agreement with the local primary care team. The GP practice may then claim for the completed components once agreed. Patients should then be added to the Annex D list and component part completed.

⁽¹²⁾ While Rockwood and other frailty risk scores were designed for older people, they can be used cautiously in primary care to support risk stratification in under 65s, provided results are interpreted alongside clinical judgement. <https://bmjopen.bmj.com/content/11/3/e047051>

- (c) Individuals may be assessed as suitable and recruited into the service at any time of the year, within the agreed DSS cohort and GP practice capacity, including where they replace patients removed from the Annex D register.
- (d) Annex D should be maintained as a rolling register. GP practices should use the annual Annex D submission to confirm that the register has been reviewed and updated, including recording any patients added during the year, any patients removed because they are deceased, have moved into a care home, are no longer eligible or no longer require the DSS, and any annual or interim reviews completed. New patients may be added during the year where they fall within the agreed DSS cohort and GP practice capacity, including where they replace patients removed from the register.
- (e) GP practice capacity may also limit engagement in which case GP practices should prioritise those identified with greatest need for the identified cohort list.
- (f) **Development and maintenance of a register** (Annex D)– A frailty register is already a GMS contractual requirement. Therefore, participating GP practices will use Annex D for the purposes of a DSS register where they will hold a list of patients identified by the screening tool, and create a register for clinically verified frail cohort (Rockwood 6 or >6) 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.
- (g) **Call and recall system** - To ensure patients on the Annex D register are managed using a systematic call and recall process, including clear arrangements for home-based assessment for house bound patients.
- (h) **Initial Assessment / annual review Bundle** – to include completion and recording of an initial proactive comprehensive review, FCP, sharing FCP where appropriate (e.g. with family or patient representative, out of hours provider).
- (i) **Patient Review Cycle:** There is no formal recommended review cycle, but this recognises that future care planning is an iterative process that started with the initial assessment bundle and the actions arising from the initial or annual assessment. Therefore, the specification will provide resource towards a maximum of 3 interim reviews to take place based on the needs of the patient and the judgement of the provider. Resulting actions should be proportionate to perceived clinical risk and overseen by the engaged contractor, taking into account the holistic needs of the patient and including the proactive review of current medical plus wider-care needs. The engaged contractor should specifically identify and implement any changes relevant to the future care plan following any unscheduled contact with health care services (Welsh Ambulance Services Trust, GP Out of Hours, Admission etc). The review should be proportionate to perceived clinical risk and undertaken either face to face or via phone as appropriate and as determined by the GP. For the purpose of data collection and service evaluation, this activity must be captured on Annex D.
- (j) **Annual' Review:** All patients must have an 'annual' proactive comprehensive review within 13 months, or as soon as possible if there are extenuating circumstances e.g. hospital admission of their initial annual review under the DSS to ensure that they remain eligible and to ensure that their holistic care needs are being met, following engagement with the individual, their family and carers (where applicable) and the multi-agency teams and expertise around the individual and to reassess their level of fragility, admission prevention strategies etc. Annex D should be used for this purpose. Following this review, the engaged

contractor may choose to de-select the patient from future reviews at this stage (see 13 (d)) and this should be recorded on Annex D.

- (k) **Discussion** - with the patient and/or carer about the risks and benefits of treatment, using accredited decision aids.
- (l) **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, and the potential complications associated with their condition, including the provision of written materials and /or audio-visual aids.
- (m) **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.
- (n) **Ensure** – carers and/or family members are supported to keep the patient at home in accordance with the patient's wishes, FCP and Acute Care Plan.
- (o) **Planned care** – Follow relevant clinical pathways to ensure optimum treatment/management of the condition(s).
- (p) 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.
- (q) **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 is shared where necessary.
- (r) **Consistent Read coding**: The GP practice must ensure consistent coding of each care episode on the clinical IT system using approved codes.
- (s) To enable data collection the following SNOMED code must be used; **888461000000107** - chronic disease management and annual review completed.
- (t) Where a patient **does not respond** to an invitation for review, the GP 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) **Annual Report**: The GP practice **must** submit completed Annex D annually and will complete a brief electronic survey taking no more than 20 minutes for the purposes of ongoing evaluation. This survey may include an element for the participating practice to share with the patient, relative or carer and MDT. In order that learning be shared locally, it is anticipated that participating GP practices will discuss this DSS each quarter at the collaborative meeting. It is recommended that collaborative leads or participating GP practices will share minutes or themes of that discussion with their Local Health Board where it may influence or impact service delivery.

Funding

15. This DSS is expected to be a rolling and evolving scheme that may be subject to revisions based upon ongoing evaluation.

- (1) GP practices new to the DSS (or who have not continuously participated in the DSS for over one year) are to establish and maintain a register of DSS eligible patients using Annex D as a record of participants for a one-off fee of £125 claimed directly on the Family Practitioner Payment System (FPPS) using the

agreed search criteria and for the purposes of monitoring and reporting. However, there is no subsequent additional payment for amending the register and Annex D for patients identified after the initial search.

- (2) Completion, recording and sharing (where appropriate) of initial/annual proactive comprehensive review (Annex A) (£150 per capita for each element). GMS contractors cannot claim under this part where patients have not had the initial / annual proactive comprehensive review under this specification.
- (3) Interim reviews (up to 3 funded reviews) £50. Details must be documented in the patient record, FCP updated appropriately and recorded on Annex D. GMS contractors cannot claim under this part where patients have not had the initial / annual proactive comprehensive review in that same year under this specification.
- (4) 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, even if to record a nil response to enable payment for any completed elements.
- (5) GP practices should only create 1 Annex D which is to be kept up to date and submitted annually (even if to record a nil response to enable payment) inclusive of any interim reviews. Multiple ad-hoc versions will not be considered.

Payment Arrangements

16. Payments are payable either monthly or quarterly in arrears and payable on the first date after the payment is authorised on which one of the engaged GMS contractor's Global Sum monthly payment falls due in accordance with the Statement of Financial Entitlements.

Post Payment Verification

17. Claims and associated payments will be subject to post payment verification checks as appropriate.

Monitoring and Audit

18. The GP practice will be required to submit completed Annex D annually and the electronic survey, including feedback and learning. The survey will be shared via email / QR code. Please complete annually and by 30th April each year.

19. A contractor must allow the extraction from the contractor's computerised clinical systems by the Local Health Board of the data on the practice frailty registers.

Termination Period

20. Should the GP practice wish to cease providing the DSS, it will be required to provide 12 weeks' notice in writing to the Local Health Board. Should the GP practice wish to suspend providing the DSS it should contact the Local Health Board for guidance prior to any action being taken.

21. If, for any reason, a GP 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

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

23. 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⁽¹³⁾.

24. 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 2006 Act:

- (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).

25. 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.

26. 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.

⁽¹³⁾ S.I. 2019/422 (W. 97)

Annex A

Initial / Annual 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 initial / annual assessment (Including (pre morbid) functional (physical and cognitive) baseline):

Screening score:

Rockwood Frailty Scale score: [rockwood_cfs.pdf](#)

If annual review, is there any change from previous year?

Mental State Assessment using recognised tool e.g. 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
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Investigations Recommended by assessor

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

Any Recommended actions:

Future Care Planning to complete/review/update as appropriate. 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
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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

Monthly Review (including any unscheduled contacts)

Annex D