NHS
City and Hackney
Clinical Commissioning Group

SCHEDULE 2 – THE SERVICES

Service Specifications

Service Specification No	
Service	ParaDoc
Commissioner	City and Hackney CCG
Commissioner Lead	Leah Herridge
Provider	CHUHSE
Provider Lead	
Date of Review	September 2017

1. Population Needs

The strategic objective of City and Hackney CCG is to provide effective community crisis response to patients in the community, particularly for frail elderly patients.

The service aims to provide an urgent GP response service for addressing urgent primary care needs. It aims to provide a responsive primary care-led service to patients in their own home, reducing unnecessary conveyance to A & E via ambulance.

2. Outcomes

2.1 NHS Outcomes Framework domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with Long term conditions	
Domain 3	Helping people recover from episodes of ill health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

2.2 Outcomes

The CCG is commissioning this Paradoc service to support its overall strategic commissioning intentions of:

- Addressing urgent primary care needs in a patients home
- Reduction in inappropriate conveyances to A&E by ambulance
- Reduction in emergency admissions

The service will need to demonstrate that it can be financially self-sustaining after the contract period from savings in the activity reduction (i.e A&E attendances, admissions and LAS call outs avoided through interventions from the service.

Link with Five Year Forward View

The service directly links with the Five Year Forward View in improving out-of-hospital care, supporting achievement of reduction in emergency admission rates. Additionally the service supports City and Hackney to maintain performance against A&E standards by avoiding inappropriate conveyances to A&E by ambulance.

3. Scope

3.1 Service description/care Pathways

The Provider is expected to provide the service from 12pm to 12am 7 days a week. The City and Hackney ParaDoc Scheme aims to prevent unnecessary hospital admission and ED attendance by providing urgent assessment and provision of intermediate community care by a GP and related community services (nurse practitioners, duty doctors, occupational therapists, physiotherapists, social workers, COPD nurse, heart failure nurse and CHUHSE overnight nurse).

For each shift, the Provider will provide the following:

- General Practitioner x 1
- Healthcare Professional/Driver x 1
- GP OOH drug packs
- Additional OOH consumables packs
- Mobile technology comprising of laptops x 2 for the GP to access Adastra, and GP systems for data collection
- Digital recording for mobile phones
- Transport with driver

The Provider must communicate the outcome of the consultation/attendance to the GP for whom the patient is registered with by 8am the following day.

The Provider will hold regular training sessions in care and nursing homes to ensure appropriate referrals to the service at all times.

The Provider will review a patient's care plan on CMC if there is an auto-flag in ADASTRA.

The Provider must ensure that where clinically appropriate they refer onto alternative urgent care pathways.

3.2 Any acceptance and exclusion criteria

- Patients aged 18 years and over.
- Patients who are a temporary or permanent resident of City and Hackney (including residential and nursing home residents).
- Patients for whom a same-day assessment could prevent admission to A&E
- Patients who are in a safe place or place of residence where they can be assessed

3.3 Categories of Patients Accepted

Patients who would otherwise need conveyance but presenting with:

- Infections, e.g. chest, skin, or urinary tract infection
- Exacerbation of long term condition e.g. COPD, Heart Failure
- Functional deterioration, e.g. acutely chair/bed bound
- Breathing problems (asthma or chest infection)
- Diarrhoea and vomiting
- Generally unwell
- Minor injuries – sprains, strains, cuts & minor burns
- Unstable diabetes
- Acute episode of chronic pain
- Non-injury slips and falls
- Medication issues
- End of life care
- Bed bound patients
- House bound patients
- Elderly patients with co-morbidities
- Catheter problems

3.4 Categories of Patients Not Accepted

- Patients who are medically unstable requiring immediate treatment
- Patients with acute medical conditions or presenting with symptoms such as surgical abdominal pain, cardiac chest pain, DVT, New onset FAST positive stroke or TIA.
- Where Mental Health is the primary diagnosis.
- Patients in public places and business/work place locations. For LAS referrals in the City, referrals will be accepted where private room is available at work places

3.5 Referral Mechanisms

The following is not an exhaustive list of referrals in to the service, and the Provider is expected to accept all referrals that meet the criteria set out in 3.2 and 3.3.

- Via ambulance clinicians following an on scene assessment as described above
- Via referrals from the LAS control room following an enhanced clinical telephone triage
- Referrals from Care Homes, Housing with care, Integrated Independence Team and out of hours
- Other out of hours primary care services in place within City and Hackney (e.g.CHUHSE)

4. Key Performance Indicators

All Key Performance Indicators can be reviewed after 6 months of service delivery.

Performance indicator	**Indicator/Quality Requirement**	**Format & Frequency**	**Consequences of breach**
Key Performance Indicators			

Process: Outcome of the consultation / attendance conveyed to the patient GP by 8am the following day	95%	Monthly data submission	Action Plan
Process: Minimum number of patients seen in 12 hours shift	6	Monthly data submission	Action Plan
Process: Percentage of urgent referrals seen within 2 hours	95%	Monthly data submission	Action Plan
Process: Percentage of non-urgent referrals seen within 4 hours	95%	Monthly data submission	Action Plan
Strategic: Reduction in LAS calls from Nursing and Care homes per month	X% reduction to be confirmed once monthly baseline established. *Average monthly baseline calculated from total calls April 2016 – March 2017.*	Monthly data submission	Action Plan
Patient Experience: Percentage of patients satisfied with the service	90%	Monthly data submission	Action Plan
Clinical: Percentage of Healthcare professionals satisfied with the service	90%	Quarterly data submission	Action Plan
Strategic: Increase in the number of patients referred by the London	X% increase (target to be confirmed once baseline established)	Monthly data submission	Action Plan

Ambulance Service per month	*Average monthly baseline calculated from total calls April 2016 – March 2017.*		
Strategic: Percentage of referrals which resulted in a probable/possible avoided admission	30%	Monthly data submission	Action Plan

5. Reporting Requirements

The Provider must report on the following in a monthly dashboard:

- Total referrals received
- Number of referrals not accepted
- Total number of referrals accepted
- Age of patient
- Sex of patient
- No. of complaints
- Times of referrals
- Referral Source
- Outcome of consultation/attendance
- Onward referrals made
- No. of follow up visits
- Type of follow up by ParaDoc
- No of safeguarding incidents / serious incidents

The provider will undertake regular clinical audits of ParaDoc cases and report to bi-monthly CHUHSE quality and performance review meeting.

6. Financial Summary

The service is funded on a recurrent basis with a contract value of £600k per annum.

Payment terms for the contract is on a block arrangement.

7. Contractual Terms

The contract will run from 1st April 2017 to end of March 2019 and will be based on the NHS Standard contract.

A review will take place in September 2017 to assess the effectiveness in delivering its objectives.

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