

Service	Integrated Pro-active Care Programme Local Enhanced Service (LES)
Commissioner Lead	
Provider Lead	GP Practices of Nottingham & Nottinghamshire ICB
Period	1 st September 2025 to 31 st August 2026
Date of Next Review	Annually

1. Population Needs

1.1 National Context

The 10 Year Health Plan, due to be published in the summer of 2025, will deliver the 3 big shifts the NHS needs to be fit for the future:

- from hospital to community,
- from analogue to digital, and.
- from sickness to prevention.

In advance of the Plan, the Government's Mandate to reform the NHS, [Road to recovery: the government's 2025 mandate to NHS England - GOV.UK](#) lays the foundation for longer-term reform as part of their health mission, focusing on bringing care closer to communities, prioritising prevention over treatment, embracing digital transformation, and embedding financial discipline within the system. Objective 3 of the Mandate: reform to improve urgent and emergency care, includes reducing hospital admissions, especially with respect to emergency bed use.

The establishment of Neighbourhood Multidisciplinary Teams which, as part of the NHS England's Neighbourhood Health Guidelines 2025/26, [NHS England » Neighbourhood health guidelines 2025/26](#) involve multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support from multiple services and organisations, will support this objective. However, supporting GP practices to risk stratify and develop target cohorts for then delivering co-ordinated interventions to address the person's range of needs, will also reduce non-elective admissions.

The Standard General Medical Services (GMS) Contract [Standard General Medical Services Contract](#) clause 7.7AA: Patients living with frailty, includes a requirement for GP practices to identify and annually review frail patients. The specific contractual requirement is to annually identify any registered patient aged 65 years and over who is living with moderate to severe frailty by using the Electronic Frailty Index and subsequently undertake a clinical review in respect of the patient which includes: a) an annual review of the patient's medication; and b) where appropriate, a discussion with the patient about whether the patient has fallen in the last 12 months, providing the patient with any other clinically appropriate interventions.

For the 2025/26 Network Contract Directed Enhanced Service (DES), the Capacity and Access Improvement Payment (CAIP) has been simplified and resource ringfenced to support risk stratification activity with £XX million to support practices to use population health risk stratification tools to assess the need in their communities and identify patients who would benefit most from continuity of care. Delivery of this LES will support compliance with the requirements of CAIP.

1.2 Local Context

Since July 2022, NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) has been the statutory organisation responsible for developing a plan for meeting the health needs of the population, managing NHS budgets, and buying the health services for the area.

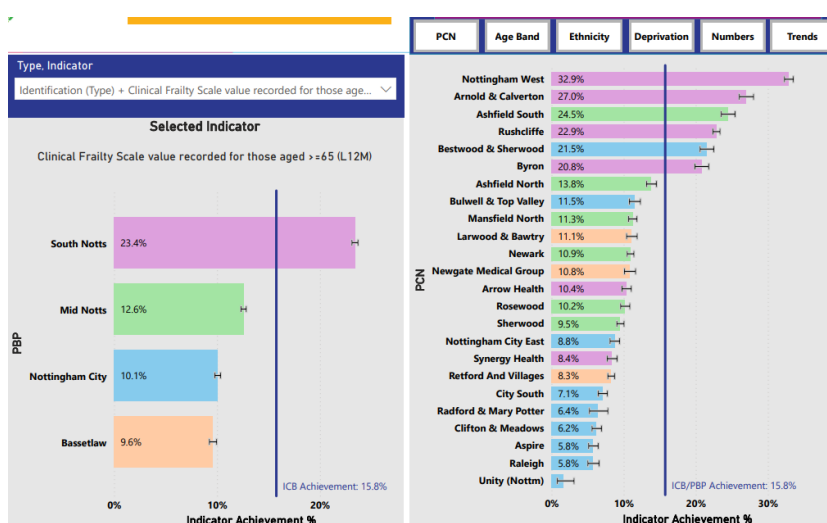
The ICB brings together NHS organisations and partners to improve population health and establish shared priorities within the local NHS. ICBs replaced Clinical Commissioning Groups as the local statutory NHS body.

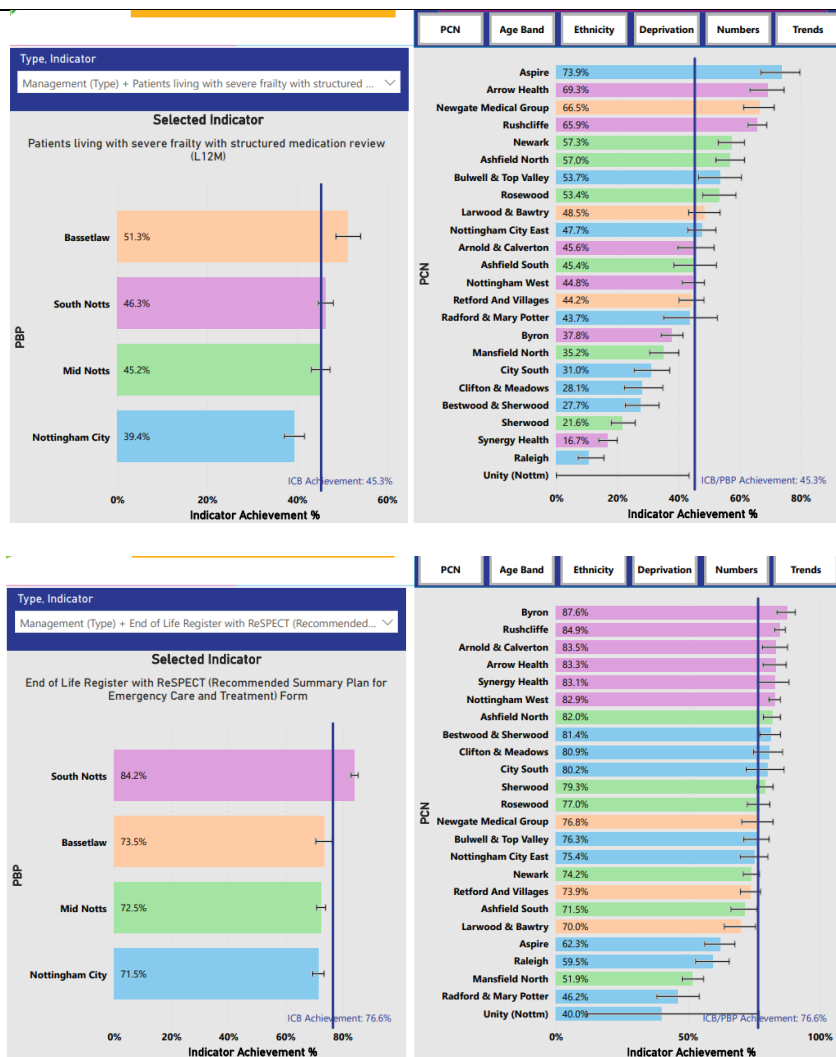
With a population of just over one million people across Nottingham and Nottinghamshire, the ICB aims to ensure citizens have timely access to care to help maximise their health and wellbeing, using its resources to tackle some of the biggest health issues affecting local people. This includes a focus on secondary prevention, providing equity of access by targeting resources to population need for the following priority areas CVD, Diabetes, obesity, smoking, alcohol harm, inactivity, vaccinations and screening.

Locally there is a commitment and focus on frailty, supporting individuals from mild to severe frailty with the relevant interventions to maintain or improve their health status. Through the CFS tool assessing an individual's level of frailty, relevant care plans can be developed to support people to manage risk factors impacting on their health status including behavioural changes and medical needs.

The predictive risk algorithm being introduced alongside this specification will identify more patients in the lower deciles within the indices of multiple deprivation (IMD) and resource will be allocated utilising weighted registered population measures. The delivery of this LES is supported by the Communication Needs Adjustment which the ICB provides to support practices to address the needs of populations who may otherwise find it difficult to access services.

Analysis carried out by the ICB's System Analytics Intelligence Unit (SAIU) shows that there is considerable opportunity to apply the CFS tool, alongside structured medication reviews (SMR) and personalised care plans for those with a long-term condition and therefore increasing risk of frailty. Whilst the data below is presented by PBP and PCN, we know that there is considerable variation in the health status of individuals contributing to health inequalities, including premature morbidity, and therefore, focusing on long term conditions allows us to more effectively identify individuals and support them to improve their health status.





This LES will support practices in utilising the ICB predictive risk algorithm and in collaborating with the re-commissioned care navigation service to advance population health management and multi-professional working within Integrated Neighbourhood Teams (INTs). It will also promote efforts to reduce unwarranted variation in practice activity by supporting implementation of key ICS Clinical Transformation Recommendations on frailty aimed at improving population outcomes - such as the use of the Clinical Frailty Scale (CFS), provision of structured medication reviews, and development of personalised care plans.

The provision of good, holistic care planning for a population that utilises a lot of primary care resource will, hopefully, reduce demand for primary care in future. Where clinicians have piloted this approach locally, they have valued the opportunity to provide a quality service and be resourced to do so.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X

Domain 3	Helping people to recover from episodes of ill-health or following injury	
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 Local Defined Outcomes

- Increased and improved access to services through the development of INTs.
- Improved detection and management of long-term conditions through care navigation and population health management approaches.
- Improved identification and assessment of frailty and signposting to interventions to maintain and / or improve health status.
- Improved management and outcomes for patients at end of life.
- Increased capacity and capability in primary care.
- Consistent, system wide initiative to improve service quality and resource utilisation.

3. Scope

3.1 Aim & Objectives

The aim of this scheme is to improve outcomes for patients by using the CFS tool to assess a person's level of frailty and support them with proactive and positive health changes. Therefore, the scheme supports varying levels of interventions dependent on the scales of frailty and, for the most severe, the scheme complements the CAIP within the Network Contract DES to risk stratify the population and provide more continuity of care for those who need it.

It will also secure practice participation in the development and implementation of the INTs that are being developed across Nottingham and Nottinghamshire and support the delivery of Clinical Transformation Recommendations to improve patient care and outcomes.

Objectives

The objectives of the scheme are to:

- Embed the identification of frailty within long-term condition review processes, providing the opportunity to work with individuals to target risk factors related to their level of frailty and health status. Secondary prevention is central for those who are mild to moderately frail and will be addressed by onward referral to / delivery of evidence-based interventions to address the person's individual needs (a patient facing guidance document is available here: <https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Older-and-wiser.pdf> a resource to support the identification and management of frailty is available here: [React To Frailty - Clinical Frailty Scale Resource Pack | React To](#)).
- Utilise the predictive risk algorithm to identify patients who will benefit from increased continuity of care, may be approaching EoL and would benefit from a thorough review or their care needs, the development or updating of a personalised care plan and consideration of advance care planning.
- Provide capacity to enable practices to engage in high quality advance care planning (on line tutorials are available here: [Nottinghamshire End of Life Care Toolkit | End of Life Care in Notts...](#) and [Nottinghamshire End of Life Care Toolkit | EPaCCS Tutorial](#)). The quality of advance care planning will be monitored via the following outcomes: % of deaths taking place

in preferred place of death and hospital bed days following non-elective admission in last year of life.

- Provide capacity to enable practices to support the delivery of population health management approaches: supporting the work of and actions identified by the care navigation service (incl. via PCN ARRS staff where appropriate); supporting the delivery of high quality multi-disciplinary team meetings / discussions and the actions that follow.
- Contribute to the development of local Integrated Neighbourhood Teams (INTs) and support the delivery of services through integrated neighbourhood working, including the referral of patients from Primary Care into INTs, and, where appropriate, collaboration with INTs and practice MDTs to review and address care gaps.

3.2 Service Description / Review

Service Description

The LES is offered to practices as a single scheme.

This offer is available to all GP practices in Nottingham and Nottinghamshire ICB to deliver as providers of primary medical care services.

The LES is a single framework above the Standard GMS / PMS / APMS Contract, Directed Enhanced Services, QOF and other locally commissioned primary medical services contracts. Practices who deliver this patient offer will deliver this alongside their Standard GMS / PMS / APMS Contract.

Any practice wishing to deliver the LES must agree to deliver all of the service delivery requirements detailed below.

For the avoidance of doubt this LES is being commissioned build on the existing contractual requirements to identify and support the management of frailty and long-term conditions by increasing the delivery of evidence-based interventions for particular cohorts of patients. This does not mean that practices should in any way reduce the services they currently provide to other patients or that they can claim funding under this LES for the care provided to those patients.

Review

The content of the LES will be reviewed annually to reflect any changes in the Standard GMS / PMS / APMS Contract.

3.3 Population Covered

The LES will be available to the registered population of all GP practices within Nottingham and Nottinghamshire ICB who agree to deliver the Service.

3.4 Service Delivery Requirements

1. Embed the assessment of frailty (utilising the Clinical Frailty Scale (CFS)) within all long-term condition review appointments for those aged 65 or older with onward referral to / delivery of evidence-based interventions to address risk factors and meet the person's individual needs.
2. Utilise the predictive risk algorithm to meet the requirement of the CAIP within the Network Contract DES and develop processes to provide continuity of care for the identified patients (anticipated to be approximately 24 patients for a 10,000-patient practice list size). A guide on the use of the predictive risk algorithm will be provided.

3. Develop a risk-stratified timetable outlining how and when patients identified by the predictive risk algorithm will be reviewed by a senior clinician in line with paragraph 4 below. Each practice will have an indicative cap on the number of reviews that can be carried out per annum. Practices should endeavour to ensure that all available capacity is utilised and those at highest risk of admission are prioritised for review.

4. The face-to-face review should be recorded on the dedicated frailty service template and must include the following elements:

- Recorded Frailty / Admission Avoidance review.
- Clinical Frailty Score.
- Long-term condition review and plan to manage risk factors (including behavioural changes and clinical interventions for weight management, smoking, alcohol, physical activity and vaccinations); with onward specialist referral if required.
- Anticipatory Care Planning, including EPaCCS completion, ReSPECT (completed or declined) and GSF stage for CFS scale, 7, 8 and 9. Ensuring ReSPECT plans consider preferred place of death, potential hospital admissions, provide information to guide decision making and are set to be fully readable the primary care record.
- For patients identified as CFS 5 or above the following interventions:
 - Structured Medication Review, in accordance with good practice guidelines (<https://www.nottinghamshiremedicinesmanagement.nhs.uk/media/zc3huinj/nottingham-nottinghamshire-icb-smr-standards-v3.pdf>) and including deprescribing where appropriate (which should be in addition to activity currently being delivered to meet the requirements of the Network Contract DES).
 - Falls risk assessment, with onward appropriate referral as indicated e.g. to falls prevention practitioner or programmes to improve strength and balance.
 - Nutritional assessment, provide nutritional support plan and / or refer to specialist agencies where appropriate. Work with Social Prescribing to provide wider support including access to dental care.
 - Comprehensive vaccination either given or declined by patient (COVID, flu, pneumococcal, shingles and RSV, where eligible).
 - Social prescribing Link Worker / other social care / community / voluntary service referral made / considered.
 - A written supportive care plan co-authored by patient & clinician & given to patient.

Experience locally has shown that this review will take between an hour and an hour and a half and is best carried out by a senior clinician with an interest in frailty (whose time could potentially be backfilled utilizing the resources made available within the LES).

5. Support the delivery of population health management approaches, including secondary prevention. Practices will be supported by the Care Navigation Service to identify and arrange interventions and there will be an initial focus on COPD in advance of the winter.

6. Lead the delivery of high-quality, practice level multi-disciplinary team (MDT) meetings / working (including supporting the implementation of resulting actions. Support effective multi-disciplinary team working at INT level.

7. Participate in the development of the local INT and the delivery of services through an integrated



INT Narrative -
19.8.25.pdf

neighbourhood working approach ().

Practice Availability:

- Provide patients identified on the predictive risk algorithm, with continuity of care in accordance with the Network Contract DES CAIP (i.e. a named GP for each patient and where possible ensuring continuity of care with the same GP / ANP / practice nurse having contact with the patient for each episode of care).

Hospital Discharge Improvement:

- Work with partners (including care co-ordinators) in the integrated neighbourhood team to contact discharged patients identified via the predictive risk algorithm within three working days of being notified of a discharge to identify any deterioration in condition and that any necessary amendments to care plans are in place (e.g. ReSPECT documentation may need to be updated if amendments have been made whilst the patient is in hospital and there may be a need to check that ReSPECT plans are set to be fully readable the primary care record).

Internal Reviews:

- Conduct monthly reviews of any emergency admissions of patients identified via the predictive risk algorithm and for whom a care plan has been created to understand why these admissions occurred, including the Respect from box 4 guidance for appropriateness.
- Identify and implement identified areas for improvement following the review.

3.5 Interdependence with Other Services/Providers

The GP practice is expected to work closely, as appropriate, with other service providers in the health community including (but not limited to):

- secondary care providers
- community mental health, nursing and therapy care providers
- other primary care providers
- ambulance services
- local authorities
- nursing and residential homes
- voluntary sector providers

4. Applicable Service Standards**4.1 Applicable National Standards (e.g., NICE)**

The provider must ensure that they are aware of, compliant with, and can provide evidence if required, to demonstrate compliance with all relevant standards including adherence to the relevant NICE guidelines where applicable.

4.2 Applicable Standards Set Out in Guidance and/or Issued by a Competent Body (e.g., Royal Colleges)

Practices must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any relevant standards.

4.3 Applicable Local Standards

CFS: [React To Frailty - Clinical Frailty Scale Resource Pack | React To](#)



MDTs and INTs:

Advance Care Planning: [Nottinghamshire End of Life Care Toolkit | Home](#)
[Nottinghamshire End of Life Care Toolkit | EPaCCS Tutorial](#)
[end_of_life_care_guidance.pdf](#)

SMR: <https://www.nottinghamshiremedicinesmanagement.nhs.uk/media/zc3huinj/nottingham-nottinghamshire-icb-smr-standards-v3.pdf>

4.4 Performance Measures

- CFS Recording for all patients aged 65 and over with a long-term condition.
- Interventions recorded following holistic review.
- % of patients identified via the predictive risk algorithm that have undergone review within the year the practice has signed up to deliver the Scheme as a proportion of the GP practice indicative cap.
- Number of patients recorded on EPaCCS and number with RESPECT in place).
- Percentage of recorded preferred place of death (increase to minimum of 70% for those reviewed).
- Reduced hospital bed days following non-elective admissions in last year of life for those reviewed (measured against baseline).

Other measures that would expect to be improved can be found with the SAIU's Clinical Transformation and Recommendations Dashboard here: <https://nottscollab.sharepoint.com/sites/SAIU-SID20-CTR>

The provider must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with all local policies, procedures and guidance. CQC registration is completed, and the Regulations for Service Providers and Managers met (<https://www.cqc.org.uk/guidance-providers/regulations>). Staff involved in delivering this service should be adequately trained and supervised as determined by the provider and must have suitable indemnity.

The Provider must comply with requests from Nottingham & Nottinghamshire ICB to provide information as it may reasonably request for the purposes of monitoring the providers' performance of its obligations under this service and participate in audits relating to this service as reasonably requested by Nottingham & Nottinghamshire ICB.

Patient Safety Incidents (PSI's)

It is a condition of participation in this service that providers will report all incidents where a patient has experienced harm to the ICB, in line with the Patient Safety Incident Response Framework (PSIRF). Providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response.

Safety Alerts

Providers must ensure that they are aware of and have a process in place for managing any safety alerts from the following sources that apply to any equipment or patient safety concerns associated with this enhanced service and that these are acted upon:

- Medicines and Healthcare products Regulatory Agency (MHRA)
<http://www.mhra.gov.uk/#page=DynamicListMedicines>

- Local or national clinical guidance
- National and local formularies

Where requested details of action taken must be reported back to the ICB within the designated timescale.

Infection Prevention and Control

Good infection prevention and prudent antimicrobial use are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone (The Health Act 2008). Registered providers should meet the requirements of The Health and Social Care Act 2008. The provider should:

- Have systems in place to manage and monitor the prevention of infection, including regular audit and training. Infection prevention and control training for all staff every 2 years and hand hygiene yearly for all clinicians.
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections and meets national estates guidance and local IPC guidance.
- Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely manner.
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
- Systems to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection.
- Provide adequate isolation facilities.
- Secure adequate access to laboratory support.
- Have and adhere to infection prevention and control policies that are based on national and local guidance.
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection and vaccination.
- Have robust systems and processes in place to manage pandemics at a practice level including the management and reporting of staff outbreaks.

Safeguarding

All staff working in this service area will be trained and competent in safeguarding children and adults as outlined in the Intercollegiate Guidance:

Children: <https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies>

Adults: <https://www.rcn.org.uk/Professional-Development/publications/adult-safeguarding-roles-and-competencies-for-health-care-staff-uk-pub-007-069>

Looked After Children: <https://www.rcn.org.uk/Professional-Development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486>

[Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing \(rcn.org.uk\)](https://www.rcn.org.uk/Professional-Development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486)

All staff will comply with Nottingham and Nottinghamshire safeguarding children and adult procedures which can be accessed via these links:

Safeguarding Children Procedures City & County: <https://nottinghamshirescb.proceduresonline.com/>

Safeguarding Adult Procedures Nottinghamshire: <https://nsab.nottinghamshire.gov.uk/procedures/>

Safeguarding Adult Procedures Nottingham City: <https://www.nottinghamcity.gov.uk/information-for-residents/health-and-social-care/adult-social-care/adult-safeguarding>

5. Applicable Quality Requirements

5.1 Applicable Quality Requirements

This is a patient focused, quality driven offer; there are no additional quality requirements to be achieved.

6. Location of Provider Premises

The Provider's Premises:

The Service will be provided within the boundaries of Nottingham & Nottinghamshire ICB. Providers must have adequate mechanisms and facilities including premises and equipment as are necessary to enable the proper provision of this service.

Location(s) of Service Delivery

The Provider is required to carry out the service within a recognised primary care setting registered for the purpose of healthcare.

Days/Hours of Operation

As a minimum the service will operate Monday to Friday 8am to 6.30pm, GP core opening hours. The service will be expected to provide a variety of clinic times providing choice for the patient and will vary from provider to provider.

7. Contract

The contract will run from 1st September 2025 to 31st August 2026 subject to review at which time the ICBs' commissioning intentions for this service will be confirmed.

The notice period is three months for termination under General Condition 17.2 in writing to the Primary Medical Services Commissioning Team nnicb-nn.primarycarenotts@nhs.net

The funding is paid for delivering all the service delivery requirements as per section 3.4 of this specification:

1. A one off initial sum of £XX (adjusted according to distance from the average April 2025 weighted list size within the ICB) for:

- agreeing to utilise the predictive risk algorithm register to meet the requirements of the Network Contract DES Capacity and Access Improvement Payment.
- developing a plan to assess patients identified using the predictive risk algorithm within 2025-26 up to the indicative practice cap on activity.
- embedding CFS within annual LTC reviews.
- supporting population health management approaches and the development and implementation of integrated neighbourhood teams.

2. A quarterly, in arrears payment of £XX for each holistic review undertaken and recorded on the identified template.

The funding includes the cost of consumables, workforce and any other associated costs incurred when delivering the Scheme including any necessary training. A holistic review, including structured medication review to include appropriate de-prescribing by the reviewing clinician is expected to take around an hour.

If a provider fails to meet the standards of this contract the non-compliance will be managed as outlined below and if not resolved this will include the application of a financial penalty with contract payments adjusted accordingly. This is set out in the “Management of non-compliance” section below.

Management of Non-Compliance

Providers are required to deliver all the service delivery requirements set out in section 3.4 of this specification in order to receive the values referenced above.

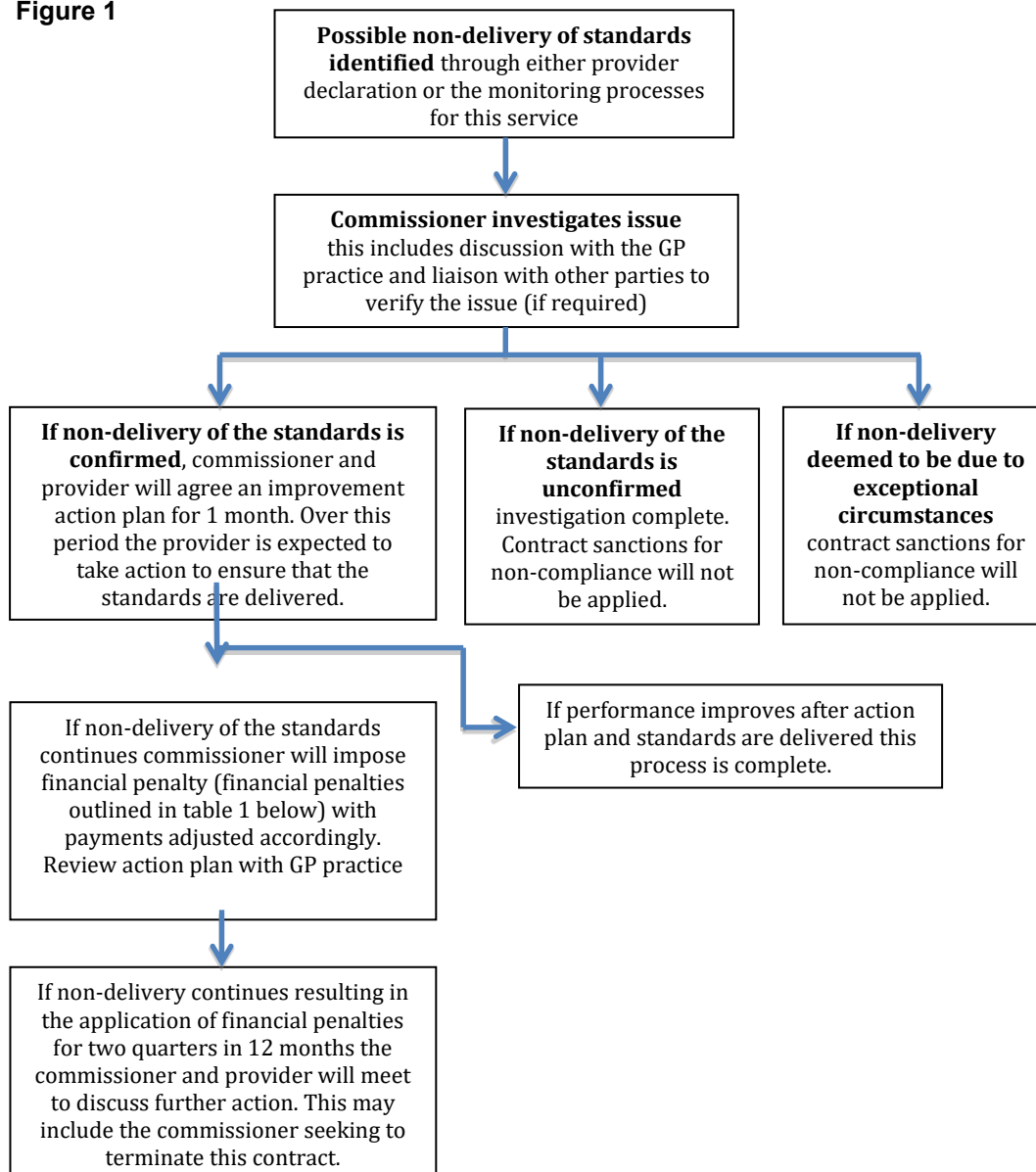
Failure to deliver the elements linked to payment 1 in the list above will result in that payment being clawed back.

Where it is identified that a provider is not delivering the standards / services as per this specification the contract management process outlined in figure 1 will be followed.

It is acknowledged that there may at times be exceptional circumstances where a provider is unable to deliver the standards and / or reporting requirements as detailed within this specification. The GP practice is responsible for notifying the commissioner immediately as soon as they become aware, and these will be reviewed on an individual basis. This is referenced in figure 1 below.

Management of Non-Compliance:

Figure 1



Timelines

Evidence of the practice's use of the predictive risk algorithm and the development of a risk stratified plan for reviews should be submitted for review within 1 month of the contract start date. This can be submitted to the Primary Medical Service Commissioning Team nnicb-nn.primarycarenotts@nhs.net.

If, due to failure of the practice to meet the deadline set, payment will not be made and (except in exceptional circumstances) practice income will be lost.