Service Specification No.	11X-38-V6 (updated)
Service	Somerset Primary Care Improvement Scheme
Commissioner Lead	As per the Particulars of the NHS Standard Contract
Provider Lead	As per the Particulars of the NHS Standard Contract
Period	01 April 2021 – 31 March 2024 (reviewed annually)
Date of Review	October 2021

1. Population Needs

National/Local Context and Evidence Base

1.1 The Five Year Forward View and General Practice Forward View set out the national policy direction for primary care. In January 2019, a five-year GP contract framework 'Investment and Evolution' was also agreed. The framework is intended to stabilise general practice and allow it to be a key vehicle for delivering many of the commitments in the NHS long-term plan and providing a wider range of services to patients.

1.2 The Integrated Care System (ICS) is the local vehicle for putting national policy into practice and ensuring local services are sustainable financially, are of high quality, and improve the health and wellbeing of the population.

1.3 Findings from Somerset ICS 'Fit for my future' health and care strategy clearly outline a case for change in general practice in Somerset. As the foundation of integrated care, there is a need to organise GP services in the most effective way and in line with system-wide redesign to deliver optimal population health management.

Key elements of this approach include:

1. New models of primary care service delivery which use the limited clinical workforce to manage urgent and planned primary care demand to best effect by deploying highly skill mixed teams to delivering person-centred care.

2. A wide range of services are delivered at a local practice level and at a 'neighbourhood' level covering 30,000- 50,000 people

3. A high level of continuity of care for the whole population and access is managed so that all patients receive a timely and responsive service

4. People with long-term conditions and their carers need a much more joined up service at a local level

5. Integration of community services (in their widest sense) with general practice to deliver locally integrated care for example community nursing, community pharmacy, social prescribing, social care

1.4 The investment also meets the requirements of the national PMS review and Somerset CCGs local approach to this. The specification sets out the basis on which practices are provided with income (in addition to the NHS England commissioned core contract) on delivery of specified outcomes and benefits described above.

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 to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

Local Defined Outcomes

2.2 Better health outcomes through implementation of recommendations from Somerset CCGs 'Fit for my future' primary care strategy.

2.3 Support an adequately resourced primary care service to maintain the optimum utilisation of specialist services

2.4 Improved resource utilisation and efficiency including prescribing

2.5 Improved outcomes for patients including reviewing patients per skill mixed member of staff

2.6 Improvement in access for both urgent and routine patient needs, not necessarily face to face GP appointments

3. Scope

Finance

3.1 The full-year financial value of this service will be £12.54 per weighted patient. This investment will be off set against the extended hours element of the Primary Care Network DES.

Aims and Objectives of Service

3.2 The aims of the specification are as follows:

- To contribute to the delivery of recommendations from the 'Fit for my future' primary care strategy
- Financial investment to ensure sustainability of general practice and the delivery of high-quality local services to improve the health and wellbeing of the population
- To deliver the areas of clinical work previously commissioned through individual enhanced services which are now included in this specification e.g. pre and post op care
- To maintain the delivery of clinical work areas that have already transferred from secondary care to primary care over recent years and are referenced in this specification from point 3.4 onwards
- Support the service delivery of a number of clinical pathways across the health system and within primary care as agreed with Somerset LMC
- Support various Quality Improvement (QI) initiatives and methodologies
- Support development initiatives linked to the promotion of self-care and Clinical Practice Research Datalink (CPRD)
- Reporting and audit requirements linked to improving clinical quality

3.3 Practices are required to undertake the following:

A. Specified Non-Core Contract Work

3.4 It is recognised both nationally and locally, that since the introduction of the GMS contract in 2004, there has been an increase in the range of activity that primary care is requested to undertake on behalf of other organisations. This activity includes:

- Blood pressure, pulse and blood test requests (blood test requests should only be performed where the activity was initiated by primary care or as part of an agreed pathway, which includes services commissioned through this specification e.g. pre and post op care)
- Removal of stitches, dressings and wound checks
- Follow-up of patients and ongoing monitoring that has already transferred to primary care
- ECGs

3.5 To facilitate effective triage of 2WW referrals, practices shall have processes in place to ensure all essential blood tests are carried out by the next working day following referral or as is appropriate.

3.6 The CCG would not expect a practice to stop providing any service they have historically delivered and would define as non-core.

3.7 Should there be future changes in commissioning pathways or significant operational changes in secondary care, a primary care impact assessment will need to be undertaken to consider whether further services need to be commissioned from primary care.

B. 7 Day Access to Primary Care

3.8 The national and local requirements remain unchanged for 2021/22. The specification can be found within the supporting documents at Appendix A.

3.9 The specification will continue to be known as 'Extended Hours – Supplementary Network Service'. Practices signed up to the Network DES and the Primary Care Improvement Scheme should consider the two specifications as one service, not separate in respect of service delivery and the associated requirements.

3.10 NHS England are continuing the national review of access to general practice services. Any changes which impact on the local extended hours service specification as a result of the national review will be discussed and agreed locally.

C. Care Pathways

3.11 Separate guidance notes have been developed and can be found within the supporting documents at Appendix B. In brief, these services are:

1. **The provision of Long Acting Antipsychotic Injections in adult patients** with a diagnosis of schizophrenia and other psychoses should only be used in patients who are unable to tolerate conventional depot antipsychotics; or as a switch from oral antipsychotics; or who have responded to atypical antipsychotics but who have a history of poor adherence with oral treatment.
2. **Neonatal checks** should be undertaken in the Service User's home in cases of home confinement or where the check was not completed prior to the discharge of the baby from hospital.
3. **Pre and Post-Operative Care** should be provided in the context of service user-centred care, reducing unnecessary visits to secondary care, and reducing hospital acquired infections.
4. **Hepatitis B vaccinations for 'at risk groups'** should only be offered to patients in the 'at risk' groups defined as the family, high risk sexual behaviour, high risk drug use, people

living in residential or nursing home setting and people receiving renal dialysis or with liver disorder.

5. **The provision of electronic ear irrigation as part of the ear wax pathway[1].** Practices will support prevention and self-care in the first instance. Where appropriate, a trained health care professional (HCP) will offer removal of ear wax for adults if contributing to hearing loss (and not contra-indicated.) The patient will be advised to use pre-treatment wax softeners [1], for a period beforehand before the HCP undertakes up to two attempts at ear irrigation using an electronic irrigator [2].

6. **Population health management initiatives focused on Cardiovascular Disease (CVD) prevention and early detection.** Practices will:

   - Follow up Health Checks (HC) outcomes if of concern when supplied by HC contracted provider
   - Practices will seek to implement an opportunistic reminder system to measure blood pressure (BP) if patient has not had BP taken in last five years
   - Opportunistic pulse checks for over 60s to detect undiagnosed atrial fibrillation (AF)
   - Sign up to the Active Practice Charter programme[2]
   - Utilising the Somerset Activity and Sports Partnership (SASP) offer

7. **Enhanced Physical health checks for patients diagnosed with Serious Mental Illness (SMI)** In line with the CCGs commitment to support practices to undertake a comprehensive health check for 50-90%[3] of their registered population diagnosed with SMI as part of QOF; practices will positively and continuously support patients by undertaking the additional elements not reported through QOF. Where justified and clinically appropriate, practices will enhance the patients personalised care plan by involving the patient, their family, carers and wider agencies to complete the following:

   - Completing an assessment of nutritional status, diet, and level of physical activity (nutrition/diet status + physical activity/exercise) status
   - Completing an assessment of use of illicit substance/non prescribed drugs (substance misuse status)
   - Completing medicines reconciliation or review
   - Initiating follow-up interventions where indicated by the physical health check
   - Initiating access to national screening programmes (breast cancer, bowel cancer, cervical cancer)
   - Completing a general physical health enquiry including sexual health and oral health assessment, in line with commissioning guidance, clinical evidence, and consensus to help address the elevated rates of sexual and oral health complications observed across the SMI cohort.

   Practices will also have access to the NHSE&I Mental Health train the trainer initiative which is focused on improving the quality of SMI health checks providing better outcomes for patients. Practices can individually or collectively as a PCN nominate an individual(s) to attend the dedicated training events and commit to undertake cascade training for health care practitioners who compete health checks. Practices will have access to a peer support network and additional resources via the Charlie Waller Trust: https://charliewaller.org/

8. **Diabetes Service Development** focussed primarily around prevention and condition management. Practices will support system development of prevention through implementing a series of requirements. These requirements include having a non-diabetic hyperglycaemia register in place, participating in EPIC visits and actively encouraging patients to sign up to My Diabetes My Way to support on-going condition management. Additionally, practices will

[1] Do not offer adults manual syringing to remove ear wax as per the above referenced NICE Guidance 98 paragraph 1.2.2

[2] This scheme is mapped across to the RCGP Active Practice Charter, therefore completing the SASP offer will also result in achieving the evidence for the Active Practice Charter.

[3] QOF achievement thresholds: MH002 40 – 90% and MH003, MH006, MH007, MH011, MH012 and SMOK002 50 – 90% https://www.england.nhs.uk/wp-content/uploads/2021/03/B0456-update-on-quality-outcomes-framework-changes-for-21-22-.pdf

host and participate in at least one virtual staff clinic with specialist input. These should focus on managing high risk patients. In addition to QOF achievement thresholds, practices will ensure all patients have been offered interventions to achieve all the NICE recommended treatment targets as per the following guidance:
https://www.england.nhs.uk/diabetes/treatment-care/
Practice will also identify team members in the practice responsible for diabetes foot checks (including a pulse check to check blood is still flowing to the diabetic foot) and complete the E-learning modules

D. Improvements in Quality and Resource Utilisation - Medicines Management

3.12 Practices will:

1. Install and use the latest version of the Somerset CCG formulary onto your GP system

2. Install and use the EMIS web protocols designed by the medicines management team to support correct formulary choices

3. Install and use the EMIS web protocols designed by the medicines management team linked to safer prescribing

4. Install and use the free PRIMIS audit tools to support improved identification and subsequent improved prescribing and clinical management of long-term conditions:

   https://www.nottingham.ac.uk/primis/tools/tools.aspx

5. Install and review on a weekly basis Eclipse Live and the patient safety alerts generated in order to prevent harm and improve outcomes

6. Arrange for patients on long term medicines to have at least an annual blood test where clinically indicated to ensure the dose of their medicine is still safe and causing no harm, where clinically indicated. Additional guidance can be found here:
   https://www.sps.nhs.uk/articles/suggestions-for-therapeutic-drug-monitoring-in-adults-in-primary-care-2/

7. Practice will work with medicines management to take all reasonable steps to reduce the carbon footprint of medicines optimisation including inhalers and de-prescribing contributing towards a 'Green NHS' and delivering a 'Net Zero' National Health Service

E. Collaboration with commissioners

System representation

3.13 The practice should enable discussions to take place with other key stakeholders to ensure primary care has a strong voice in redesigning the health and care system.

3.14 **Access**
The CCG wishes to work collaboratively with providers to improve access to general practice and reduce waiting times. Practices may wish to utilise resources available through the Access Improvement Programme.

Self-care

3.15 Practices will promote self-care linked with development of websites. Each practice will be required to include a link on its website to reliable self-care information such as www.nhs.uk and to discuss with its Patient Participation Group (PPG) how the PPG can support the promotion of self-care and implement any recommendations

Supporting Clinical Research

3.16 Continue with participation in the Clinical Practice Research Datalink (CPRD) and participate with national clinical data information extractions to be used to support research

3.17 **Continuity of care**
Practices will be required to reflect on continuity of care and consider how it can organise itself to promote continuity of care.

F. Quality Initiatives

3.18 Practices will be required to undertake work in priority areas below providing self-assessment assurance to the CCG on an annual basis on work undertaken and highlighting key learning.

Quality Improvement

3.19 As well as supporting practices in achieving QOF requirements, practices will:

- Work with the CCG to undertake a local improvement at a PCN level which is focused on improving infection prevention control (IPC) outcomes using Somerset QI methodology. The CCG will provide training and coaching as required by Primary Care Providers, as part of its membership of the Somerset Quality Improvement Faculty

- Projects will be agreed between Somerset CCG and PCNs, the agreement will include elements such as CCG IPC team support and Quality lead support, training and coaching offers to the PCN

- Ensure a Practice Nurse is part of a QI planning meeting during 2021/22 and is an active part of the practice Improvement team

- A member of the practice QI team (or agreed representatives from the PCN) will attend one county wide QI meeting each year which will be supplementary to the PCN level QI meetings undertaken as part of QOF

NEWS2 / RESTORE2

3.20 In order to build on the implementation of NEWS2, practices will support the roll out of RESTORE2 (a document including NEWS2 and SBARD) as part of an urgent care pathway for patients in nursing and residential homes.

3.21 Practices (individually or as part of a PCN) will support the roll out of RESTORE2 in nursing and residential care homes as part of the clinical pathway for nursing home patients in need of acute/critical care.

3.22 Use NEWS2 observations scores (via RESTORE2), where clinically appropriate, when transferring critically ill patients from nursing and residential care homes into emergency care.

Somerset Treatment Escalation Plans (STEPs):

3.23 Practices will continue to promote a person-centred approach, which includes personalised care planning for patients with long term conditions. STEPs help to facilitate discussions between patient and clinician formalising a clear plan which should be actioned should a patient's condition exacerbate. This may be undertaken as an individual practice or as part of a PCN.

3.24 STEPs shall be considered for those patients who in their GPs clinical judgement would benefit from such anticipatory care planning. Practices will utilise the STEP template available through EMIS.

3.25 There is no minimum/expected number of STEPs and the measurement will not impact on the payment process of PCIS. However, practices (Or PCNs) may be required to produce an end of year self-assessment of STEP usage/activities, including learning to be shared with the system and highlighting improvements made in the quality of STEPs or their use)

3.26 PCNs (or individual Practices) will also be required to undertake an annual quality audit at the request of the Commissioner if there are significant system concerns raised in regard to the PCN or practices STEP processes. Further discussions may also be held with the PCN or practice where numbers are static/no STEPs are being developed or there are significant quality concerns raised. As part of this annual quality audit, practices shall review all deaths of registered population to determine if, where a clinically appropriate, a STEP was in place.

Infection Prevention & Control

3.27 In accordance with the Health & Social Care Act 2008 code of practice on the prevention and control of infections (Update 2015) practices will have the appropriate systems in place to manage and monitor the prevention and control of infection. Through local reporting processes practices will;

- undertake mandatory surveillance of Healthcare Associated Infection (HCAI) organisms monitoring including Post Infection Review (PIR) within two weeks as per Public Health England guidelines where required for Clostridioides difficile, multi resistant gram-negative bloodstream infections, Meticillin-resistant Staphylococcus aureus and Meticillin- sensitive Staphylococcus aureus. PIRs shall be submitted to somccg.infectionpreventioncontrolteam@nhs.net

- demonstrate the competency of the designated practice IP&C Lead in accordance with RCN, NHS E&I IP&C Link/Champion guidelines and Infection Prevention Society Competency Framework. Guidelines can be found in the following links: Coronavirus » Every action counts (england.nhs.uk) and IPS Competencies Framework - https://www.ips.uk.net/ctool/background.php?t=SVE2TTlpcVJYclBpMU1POTBPeTljdz09 The Role of the Link Nurse in Infection Prevention and Control | Royal College of Nursing (rcn.org.uk) and

- attendance at least quarterly at CCG IP&C meetings by the practices designated IP&C lead or representative.

3.28 Practices will also be required to implement the recommendations from the new National Standards of Healthcare Cleanliness published in April 2021 over the course of 2021/22 contracting year.

G. Reducing Avoidable Emergency Admissions

3.29 Primary care providers make an important contribution to the sustainability of the health system by delivering proactive co-ordinated care that avoids admission to hospital wherever possible. Recommendations from the 'Fit for my future' primary care strategy support reduced utilisation of hospital care through better integrated out of hospital care. The main purpose of this investment is to deliver the new model, but in the short term there is a need to sustain the health system. Practices will have responsibility for reviewing emergency admissions and developing plans to address and reduce, where possible, unwarranted variation. The CCG can provide additional data upon request to support development of action plans.

3.30 The CCG has a number of initiatives in place to support the achievement of a reduction in emergency admissions. A summary of these initiatives has been developed and can be found in within the supporting documents at Appendix C. Practices are expected to utilise these initiatives to ensure delivery of these outcomes.

H. Primary Care Initiatives

3.31 A number of helpful initiatives have been identified that will lead to improvements in the quality of patient care as well as the sustainability of primary care. Practices will be required to undertake work in a number of key areas as detailed below:

Green Impact For Health (GIH)

3.32 The NHS has pledged as part of "for a greener NHS" to reduce its carbon footprint and become more environmentally friendly. To help support this ambition practices are asked to improve the sustainability of Primary Care in Somerset by;

- Registering for the Royal College of General Practitioners (RCGP) Green Impact Bronze level at https://www.greenimpact.org.uk/giforhealth/register (registration code 134)
- Selecting and completing actions worth at least 75 points from any of the criteria in any of the categories Bronze, Silver, Gold or Carbon) to gain a Bronze award

3.33 Practices to provide evidence on request of successful registration and accreditation.

3.34 Practices are also encouraged to share and promote any additional local changes to support climate change and sustainability as part of the greener NHS campaign - https://www.england.nhs.uk/greenernhs/national-ambition/

3.35 Following the significant increase in use of Personal Protective Equipment (PPE) and associated cleaning products resultant of COVID19, the RCGP will be incorporating 'PPE best practice' into the updated guidance. This will be added into the toolkit by late Sept 2021 and practices are encouraged to review this once available. In the intervening period, practices may choose to focus efforts in undertaking actions within WR004, HP004 and WR015 of the toolkit.

Carers Champion

3.36 The practice is required to have a designated Carers Champion. The role should be a formal part of a person's job, with time allowed to carry out the role effectively.

3.37 The Carers Champion will:

- Link with the Carers Support Service
- Encourage accurate processes for identification of carers
- Ensure information for carers is available (leaflets/ website)

3.38 As part of the Contract Information Form issued to practices prior to the beginning of each contractual year; practices will be required to confirm the nominated individual for their Carers Champion

Reporting Criteria

3.39 Practices will be required to complete an annual self-assessment provided by the commissioner to provide assurance that work has been undertaken in line with the requirements of this specification.

4. Applicable Service Standards

Not applicable

5. Applicable quality requirements

Not applicable

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

As per the Particulars of the NHS Standard Contract

Glossary of supporting documentation:

Appendix A Extended Hours – Supplementary Network Service
Appendix B Care Pathways
Appendix C Summary of Somerset Reduction in Emergency Admissions Initiatives