Service Specification No.	QSL-54
Service	New Funding Framework
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 2024 – 31 March 2025
Date of Review	Before end of contracted period

1 Population Needs

National/local context and evidence base

1.1 The Fuller stock take report "Next Steps for Integrating Primary Care[1]" (2022) outlined a new vision for primary care that reorientates the health and care system to a local population health approach through building neighbourhood teams, streamlining access and helping people to stay healthy.

1.2 Somerset 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 The ICSs recently published primary care strategy identifies ten (10) priority actions which will shape GP services in Somerset over the next five years and support delivery of the seven aims of Somerset ICSs health and care strategy:

Aim 1 Improve the health and wellbeing of the population
Aim 2 Provide the best care and support to children and adults
Aim 3 Strengthen care and support in local communities
Aim 4 Reduce health inequalities
Aim 5 Respond to complex needs
Aim 6 Enable broader social and economic development
Aim 7 Enhance productivity and value for money

1.4 The current challenges within general practices are primarily caused by the capacity/ demand mismatch. This is creating an operating environment of such intensity that there is no time and space to step back. GP services will need to change radically over the next five years to adapt to increasing demand, workforce constraints, a rapidly ageing population and advances in clinical treatments, data and technology and organisation of care.

1.5 The New Funding Framework ("NFF") enhanced service goes a step beyond its predecessor the Primary Care Improvement Scheme ("PCIS") and supports a radical new approach to contracting with general practice. The simplified payment and contracting model will be based on high trust and a move to measuring outcomes rather than activity only. Services will no longer be commissioned piece meal across practices. Instead, the clinical pathways and outcomes of a number of enhanced services will be commissioned through one main enhanced service creating less bureaucracy for provider and commissioner and enabling general practice to prioritise services based on clinical acuity and demand.

1.6 Investment of further monies will enable and empower the GP provider sector to build support for collaborative action, undertake the change management itself and with the support of the wider system, deliver aligned enhanced services that meet the health and care needs of their specific patient population. Better aligning primary care

[1] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

funding with population need will drive up health equity and reduce health inequalities and is an investment in primary care with a “no losers” approach.

2 Outcomes

NHS Outcomes Framework Domains & Indicators

2.1

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	√

3 Scope

Service description/care pathway

3.1 Practices will be expected to provide a professional service, open to peer review and accountability and transparency. Practices will use clinical judgement and best practice guidance to determine the care provided to their patients. This includes:

3.1.1 the care of patients who require anticoagulation and enhanced drug monitoring and the elements previously incentivised by PCIS and,

3.1.2 where the practice has agreed, all other enhanced services now included within this service offer (Appendix 1).

3.2 The ICB would not expect a practice to stop providing any service they have historically delivered simply because it is not specifically incentivised. Where practices collectively wish to make changes, these should be discussed with GP Provider Leadership within the ICS with the support of the Local Medical Committee (“LMC”) as the representative committee of GPs. No changes can be made without ICB approval.

3.3 Should there be any proposed changes to the delivery model e.g., sub-contracting, the GP practice who is commissioned to deliver this patient offer is required to notify and receive agreement from the commissioner before enacting any changes.

3.4 Where a GP practice sub-contracts delivery of the standards to another provider, the GP practice is responsible for ensuring that:

- appropriate sub-contract agreements are in place in accordance with contractual requirements,
- appropriate arrangements are in place which satisfy information governance requirements and ensure that data security will be maintained if patient information is to be transferred between the two parties,
- appropriate arrangements are in place which satisfy clinical governance requirements including:
    - where the sub-contracted service is a clinical service, the GP practice is responsible for ensuring that appropriate arrangements are in place for the patient’s record to be updated with the necessary clinical details as delivered by the sub-contracted provider
    - ensuring that good quality safe services are provided by the sub-contractor in line with the service specification

Aims and objectives of service
Aims

3.5 In delivering the service practices will support the aims of the Somerset ICS Primary Care Strategy. In particular, working with GP Provider Leadership within the ICS, practices will use professional leadership to determine priorities for patient care.

3.6 The objectives of the scheme are to:

- Reduce unwarranted clinical variation
- Improve the management of long term conditions
- Encourage practice engagement in population health management
- Provide stability and increase the equity of funding received by GP practices
- Facilitate access to GP services

3.7 The fundamental principles that support this new funding framework are:

- Professional leadership rather than specification
- Less bureaucracy with move away from reporting
- Reduction of health inequalities
- Focus on population health management

Objectives

3.8 In delivering this enhanced service, practices will also focus on several objectives designed to support the radical change in approach to service delivery.

Reducing health inequalities

3.9 "Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies" (NHS England)[2]

There are always going to be differences in health, some are unavoidable e.g. as result of age or genetics but many differences in health are avoidable, unjust, and unfair – it is these that we are concerned about and that this specification seeks to address.

Practices will receive an adjusted payment based on a Public Health assessment of level of deprivation data using the National General Practice Profiles Index of Multiple Deprivation[3].

Wider determinants of health and population health management

3.10 The wider determinants of health are a diverse range of social, economic, and environmental factors which influence people's mental and physical health. Increased focus on reducing inequalities in lifestyle risk factors including but not exclusively smoking, diet, exercise, alcohol consumption and mental wellbeing will support a population health management approach. Population health management helps health and care professionals to identify and quantify the drivers and outcomes for addressing their local population health needs and provide a balanced approach to prevention.

[2] Reducing Health Inequalities - https://www.england.nhs.uk/get-involved/resources/
[3] National General Practice Profiles - Data - OHID (phe.org.uk)

Registered List size of less than 5,000

3.11 The Carr-Hill formula adjusts financial calculations for general practice based on a complex algorithm. Somerset is a sprawling rural county and arguably the adjustment does not compensate enough to avoid some rural and/or small practices facing increased difficulties.

Practice with registered list sizes of ≤5,000 patients will receive an adjusted payment based on their registered population to counteract any variation in funding.

Clinical leadership and Continuity of care

3.12 GPs and other health professionals are at the frontline of healthcare and have a vital role to play in championing the importance of leadership, good governance, and a fair and open culture within general practice. The organic development of clinical leadership will enable more time, space, and opportunity for clinicians to make decisions that are in the best interest of their patients based on clinical need whilst continuing to provide a safe and sustainable service. The Care Quality Commission ("CQC") "Well-led" domain should be considered when developing governance structures.

Creating a resilient infrastructure and resilience around GP creates space to deliver more continuity of care. Valuing, preserving, and developing continuity of care will save lives and save costs across the system. As part of the Primary Care strategy implementation, practices will be required to engage with the continuity of care development plans. The Royal College of General Practitioners ("RCGP") 6-Step Continuity of Care Toolkit is a valuable resource for directing focus towards Quality Improvement ("QI") methods aimed at enhancing continuity of care.

Incentivised Indicator (Year One)

Population Health – Hypertension

3.13 Integrated Care Systems have a statutory duty to improve population health. Most systems have chosen cardiovascular disease ("CVD") as a priority area, with a further focus on hypertension, given the opportunity and evidence base for improvement. Several national resources have been developed, most prominently the University College London ("UCL") Partners Proactive Care Frameworks to support Primary Care Networks ("PCNs") and practices to recover and improve their position on hypertension. There is a significant opportunity for Somerset to reduce mortality and morbidity, and potentially to change life outcomes for a cohort of 30-40,000 at risk people fairly rapidly, i.e., months not years.

3.14 A case finding at-scale mechanism has been established by Public Health to find undiagnosed people in the community. The challenges that General Practice now need to respond to are:

- Initiating and optimising treatment for new patients identified by the cold case-finding above
- Warm case-finding from existing practice lists
- Optimising treatment for existing patients
- Doing all the above in a person-centred way which balances risks and speaks to other agendas including de-prescribing and non-clinical interventions for health and wellbeing.

Area of focus

3.15 Practices shall continue to:

- Follow up Health Checks ("HC") outcomes if of concern when supplied by HC contracted provider
- 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)
- Maintain registration with the Active Practice Charter programme[4]
- Utilise the Somerset Activity and Sports Partnership ("SASP") offer which can be accessed by patients on the GP register aged between 40 – 74 years of age

3.16 With a focus on Hypertension and population health management approach, and with the support of Public Health colleagues' practices will be required to review their practice profile and identify an area of unwarranted variation to reduce inequality at practice or PCN level. Specific focus should be given to understanding and addressing the inequalities in underdiagnosis and poor optimisation within communities and groups of the population.

3.17 Using a QI approach, take action to address the area of unwarranted variation through systematic improvement which would include the Health Innovation Network ("HIN") package (previously Academic Health Science Network) or relevant local tools. This improvement shall have a major focus on digital transformation to help health and care professionals communicate better and enable people to access the care they need quickly and easily. Supporting people, data and technology to evolve as part of the future of the NHS at practice or PCN level.

3.18 Practices shall also focus on optimising the management of hypertensive patients through:

- Focusing on population health, building further and deeper alliances with all relevant stakeholders within the ICS including SASP and local community partners at PCN level, address movement and exercise, smoking, diet, loneliness and isolation, anxiety, and depression and,
- Personalised care, recognising that this is a major opportunity for personalisation

3.19 Indicator(s) will be reviewed on an annual basis and subject to amendment through agreement between the ICB and the LMC as the representative committee of GPs.

NFF Annual Review

3.20 Should the scheme not continue, then practices will revert to the previous requirements of PCIS, and discussion will be had with the LMC.

Payment

3.21 Payment will be subject to an annual review process and adjusted based on registered list size and other potential factors to ensure equitable allocation of funding.

3.22 Practices will work with the ICB in a high trust environment to ensure that:

3.22.1 Systematic efforts will be made to reduce undiagnosed hypertension and improve treatment optimisation with the aim of moving towards 77% of diagnosed patients being treated to NICE guidance targets. This would

[4] 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.

include use of appropriate resources including those produced by the HIN and other relevant local tools.

3.22.2 Practices will have confidence in investing the additional resource to achieve this aim. Therefore, all practices will qualify for full payment if they undertake 3.22.1 above. There will be no metric for payment in year one however, all practices will need to submit a QI plan (See Annex 1 for timelines).

3.22.3 Metrics and payment thresholds will be reviewed for year two.

Expected annual value

3.23 The annual value for the service will be specific to each individual practice. In year one, practices will be paid the maximum value split evenly across 12 months. There will be no monitoring requirement relating to the Population Health Hypertension Indicator.

3.24 Payment will be based on service availability rather than service volume. Service activity data will be required for a limited number of services to support with transition to this new approach and to enable further joint development and review of the service (Annex 1).

3.25 The commissioner reserves the right to request additional ad-hoc reporting from all practices. Commissioners will allow appropriate notice periods for providers to respond to the request for information.

Monitoring

3.26 Annex 1 provides an overview of evidence that practices may be required to provide for the areas previously incentivised by PCIS or any other enhanced services now included under this offer.

Population covered

3.27 The service will be available to patients registered at a Somerset GP practice.

Any acceptance and exclusion criteria and thresholds

3.28 The registered population of the practice and in line with any specific inclusion/exclusion of care pathways.

Interdependence with other services/providers

3.29 Other providers such as:

- NHS Somerset Foundation Trust
- Primary Care Network Practices
- Neighbourhood Teams
- Voluntary, Community, Faith and Social Enterprises ("VCFSE")/Third Sector
- Public Health
- Local Authority

4 Applicable Service Standards

Applicable national standards (e.g., NICE) and standards set out in guidance and/or issued by a competent body

4.1 Not applicable

Applicable local standards

4.2 Not applicable.

5 Applicable quality requirements

	Applicable Quality Requirements (See Schedule 4C)
5.1	This is a patient focused quality driven offer; there are no additional quality requirements to be achieved in year one.
6	**Location of Provider Premises**
	The Provider's Premises are located at:
6.1	As per the NHS Standard Contract Particulars.

Annex 1:
NFF Population Health Indicator - Hypertension

Area	Practice	ICB/Public Health
Population Health - Hypertension	Practices shall continue to: • Follow up HC outcomes if of concern when supplied by HC contracted provider • Implement an opportunistic reminder system to measure BP if patient has not had BP taken in last five years • Opportunistic pulse checks for over 60s to detect undiagnosed AF • Maintain registration to the Active Practice Charter programme • Utilise the SASP offer which can be accessed by patients on the GP register aged between 40 – 74 years of age. Practices shall also focus on optimising the management of hypertensive patients through: • Focusing on population health, building further and deeper alliances with all relevant stakeholders within the ICS including SASP and local community partners at PCN level, address movement and exercise, smoking, diet, loneliness and isolation, anxiety, and depression and, • Personalised care, recognising that this is a major opportunity for personalisation **QI Focus** With a focus on Hypertension and population health management approach, and with the support of Public Health colleagues' practices will be required to review their practice profile and identify an area of unwarranted variation to reduce inequality at practice or PCN level. Specific focus should be given to understanding and addressing the inequalities in underdiagnosis and poor optimisation within communities and groups of the population. Using a QI approach, take action to address the area of unwarranted variation through systematic improvement which would include the HIN package or other local tools. This	• Public Health to supply practice profiles to all GP practices • Public Health to support to review of profiles • Public Health to review QI plans, where submitted • Public Health to review QI outcomes, where submitted • Monitor 'Size of Prize' over 3 years

	improvement shall have a major focus on digital transformation to help health and care professionals communicate better and enable people to access the care they need quickly and easily. Supporting people, data and technology to evolve as part of the future of the NHS at practice or PCN level. **Suggested timelines:** - Submit QI plans by **15 July 2024**. - Implement QI plans from **01 September 2024** to enable 3 months of implementation. - Evaluate QI project during **January/February 2025**.	

Other Enhanced Services now included within the NFF

Service	Practice	Monitoring Requirement
Delivered by all		
Anti-Coagulation Initiation, Stabilisation and Monitoring	• Evidence of training compliance • Annual review • Activity monitoring (quarterly)	• Submitting training compliance annually • Quarterly activity monitoring via CQRS Local
Enhanced Drug Monitoring	• Quarterly monitoring for Rheumatology and Dermatology and Gastroenterology patients • Number of patients and tests conducted (annually)	• As per reporting guidance for Immunomodulatory therapies in rheumatology/gastroenterology and dermatology conditions - DMARDS and Dronedarone • Annual activity monitoring via CQRS Local
Continue to deliver if already commissioned to do so as at end 31 March 2024		
Diabetes Insulin Initiation	• Annual audit of: patients continuing on insulin at six months from initiation the % patients at different levels of HbA1C (7 or less, 8 or less and or less)	• Activity monitoring quarterly via CQRS Local • Annual audit to be made available on request
Minor Injuries	• Annual audit of: case mix, outcome and potentially identifying when there were the highest levels of demand	• Annual audit to be made available on request
Fitting of Ambulatory ECG machines	• Activity monitoring as required by Somerset FT • Participation with any evaluation or audit of the service and where necessary will provide any reasonable information required to allow that service evaluation or audit to be carried out • Quarterly activity monitoring	• As per monitoring requirements of Somerset FT • Quarterly activity monitoring via CQRS Local

Unscheduled Care Service	• Annual audit	• Annual audit to be made available on request
Gynaecology Management Service	• Annual audit	• Annual audit to be made available on request
Advanced Learning Disabilities	• Annual audit	• Annual audit to be made available on request

Previously incentivised elements of PCIS as at end 31 March 2024:

Service	Practice	Monitoring requirement
Long-Acting Antipsychotic Injections in adult patients; Neonatal checks; Pre and Post-Operative Care and; Hepatitis B vaccinations for 'at risk groups'	• None	• None
The provision of electronic ear irrigation as part of the ear wax pathway	• None	• None
Enhanced Physical health checks for patients diagnosed with Serious Mental Illness	• Code all elements of the physical health check using appropriate SNOMED codes (Ardens Template)	• None under NFF
Diabetes Service Development	• Participate with one virtual staff clinic with specialist input • Identify team members responsible for diabetes foot check and complete e-learning modules • Actively encourage sign-up to My Diabetes My Way • Ensure the practice has access to a diabetes peer support group	• None
Medicines Management	• Install and use the latest version of the Somerset ICB formulary • Install and use the EMIS web protocols • Review all CAS and patient safety alerts then take appropriate timely action	• None

	• Install and review on a regular basis (ideally weekly) Eclipse Live and the patient safety alerts • Arrange for patients on long term medicines (e.g., DOACs) to have at least an annual blood test where clinically indicated • Practice will work with medicines management and PCN teams to take all reasonable steps to reduce the carbon footprint of medicines optimisation	
Quality Improvement	• Work with the ICB to undertake a local improvement at a PCN level which is focused on improving infection prevention control (IPC) outcomes using Somerset QI methodology • Ensure a Practice Nurse is part of a QI planning meeting during 2024/25 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 • Support the roll out of RESTORE2 • Use NEWS2 observations scores via RESTORE2), where clinically appropriate, when transferring critically ill patients from nursing and residential care homes into emergency care • Use STEPS to facilitate discussions between patient and clinician formalising a clear plan which should be actioned should a patient's condition exacerbate • Review emergency admissions and developing plans to address and reduce, where possible, unwarranted variation	• None
Primary Care Initiatives	• Maintain the Royal College of General Practitioners (RCGP) Green Impact Bronze level • Aspire to achieve Silver, Gold or Carbon Level • Designate a Carers Champion	• Record the name of the Carers Champion on the annual Contract Information Form (CIF) or any other format, as requested by the ICB

N.B. There are specific monitoring processes in place for Infection, Prevention and Control; Safeguarding and Significant/Adverse Events where applicable. Please refer to Appendix 1 and the relevant Schedules of the NHS Standard Contract.