NHS
Somerset
Clinical Commissioning Group

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	11X-38-V3
Service	Somerset Primary Care Improvement Scheme
Commissioner Lead	Somerset CCG
Provider Lead	GP practices
Period	1 October 2016 - 31 March 2019 (overall scheme runs from 1 October 2016 – 31 March 2021 to align with specifications developed each year in light of national and local policy developments)
Date of Review	January 2019

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 over the next five years. Sustainability and Transformation Plans (STPs) are 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.

1.2 The Somerset STP describes the need for redesign of primary and community health and care services to reduce reliance on acute services and community beds. Key elements of this approach include:

- New models of primary care service delivery which uses the limited clinical workforce to best effect by deploying highly skill mixed teams delivering person-centred care. The STP 'preferred model' health and wellbeing model.
- Sustainable primary care solution, at scale provision to manage urgent and planned primary care demand
- Risk stratification and proactive care management of complex patients
- Reduce reliance on community hospital beds through redesign and investment into health and care community teams, fully integrated with general practice.

1.3 The STP sets out the need to move financial resources within the Somerset system, recognising that there is only pool of funding and that current spending is in excess of funds available.

1.4 The STP model of primary care service delivery is the 'Health and Wellbeing Model of Primary Care'. Key features are:

- An orientation to support self-care and normalise life difficulties
- Access to social prescribing/ health coaching
- Person-centred consultations
- Effective care co-ordination of patients at high risk of patients and patients moving towards high risk of admission

1.5 It delivers the following benefits:

- Reduced avoidable emergency admissions

- Increased patient activation
- Reduced elective/ prescribing costs

1.6 The primary function of this investment is to deliver the benefits described above.

1.7 The investment also meets the requirements of the national PMS review which are two-fold:

- To move to a position where NHS England contracts with all GP practices (whether GMS or PMS) for essential services, additional services, Directed Enhanced Services and QOF/SPQS on an equal basis.
- To identify the 'premium' paid to PMS practices and remove this from PMS contracts over a five year period. CCGs would then use this money to commission 'supplementary services' from GMS and PMS practices. All released funding must be reinvested in GP practice provided primary care.

1.8 Somerset CCG has worked with NHS England to create a local approach which suits our specific context, whilst meeting the national requirements. The key principles of the agreed approach are:

- As a health and care system, we need stable and effective primary care in order to deliver patient, population and system benefits. In particular we need to prevent avoidable hospital admissions and ED attendances.
- The extent to which a health system has a primary care orientation is closely related to its overall success in reducing population level mortality, as evidenced in international literature
- In order to deliver the requirements of the STP and the General Practice Forward View, there is a need to invest in primary care over a number of years. This would bring GMS practices and lower-funded PMS practices up to a level of funding that can deliver specified system and population benefits.

1.9 This 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.

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 the 'Health and Wellbeing' model of primary care service provision.

2.3 Reduced demand on secondary care services

2.4 Improved resource utilisation and efficiency

3. Scope

Year One - Finance

3.1 The full-year financial value of this service will be £3 (£2.39 new CCG investment plus 60.9p

previously commissioned through pre- and post-op care) per weighted patient.

Year two - Finance

3.2 The full-year financial value of this service will be £8.39 per weighted patient plus 60.9p per registered patient previously commissioned through pre- and post-op care.

3.3 £8.39 per weighted patient of new CCG investment will be off-set by any payments made for the Extended Hours DES, MPIG and PMS protected income.

3.4 Due to the impact of the improved access requirements, practices are receiving an accelerated CCG investment in year two of the scheme.

Year three – Finance

3.5 The full-year financial value of this service will remain at £8.39 per weighted patient plus 60.9p per registered patient previously commissioned through pre- and post-op care.

3.6 £8.39 per weighted patient of new CCG investment will be off-set by any payments made for the Extended Hours DES, MPIG and PMS protected income.

3.7 It is the CCG's intention to move 60.9p per registered patient previously commissioned through pre- and post-op care to weighted population at a later date.

Five year financial plan

3.8 The total financial value of the scheme is planned to increase to £12.54 (£11.94 CCG investment plus 60.9p previously commissioned through pre- and post-op care) in Year 5.

Aims and Objectives of Service

3.9 The aims of the specification are as follows:

- Reducing avoidable emergency admissions and ED attendances
- Starting to implement the 'Health and Wellbeing' model of primary care service provision which will reduce the number of patients per skill mixed member of staff, thereby improving outcomes for patients
- Improvement in access for both urgent and routine patient needs, not necessarily face to face GP appointments
- Some areas of clinical work previously commissioned through individual enhanced services, e.g. neonatal checks, risperidone, pre-and post-operative care and Hepatitis B vaccinations for 'at risk groups'
- Some areas of clinical work that has already transferred from secondary care to primary care over recent years e.g. phlebotomy, follow-up monitoring
- Improvements in resource utilisation e.g. prescribing
- Practice-specific requirements for outlying practices

3.10 Practices are required to undertake the following:

A. Specified Non-Core Contract Work

3.11 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
- Removal of stitches, dressings and wound checks
- Follow-up of patients and ongoing monitoring that has already transferred to primary care
- ECGs

3.12 Practices will now undertake this work as part of the Primary Care Improvement Scheme enhanced service. 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.

3.13 The CCG would not expect a practice to stop providing any service they would define as non-core if commissioned to provide this enhanced service.

B. Previous Commissioned Enhanced Services – Long Acting Antipsychotic Injections in adults, Neonatal Checks, Pre- and Post-Operative Care and Hepatitis B vaccinations for 'at risk groups'

3.14 Four enhanced services previously commissioned individually through the CCG will transferred into this specification and no longer require reporting on individually. Separate guidance notes based on the existing specifications have been developed and included at Appendix B. The four services are Long Acting Antipsychotic Injections in adults, neonatal checks, pre-and post-op care and Hepatitis B vaccinations:

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-centered 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.

3.15 Practices will now undertake this work as part of the Primary Care Improvement Scheme enhanced service. Should there be future changes in commissioning pathways, a primary care impact assessment would need to be undertaken to consider whether further services need to be commissioned from primary care.

C. 7 Day Access to Primary Care

Year one

3.16 An individual requirement for year one was not included but the requirement was expected to be a core part of the additional income and specification in future years.

Year two – Commissioning of Improved Access year one

3.17 Somerset CCG was identified by NHS England as one of the early development sites to receive additional funding for the delivery of improved access to GP services across seven days by 2017/18.

3.18 Somerset CCG commissioned an Improved Access enhanced service from April 2017 giving every patient registered with a Somerset GP practice:

- Access to GP Services for an additional 1.5 hours each weekday, offering a sufficient number of pre-bookable and same day appointments after 6:30pm.
- Access to an additional 30 minutes consultation capacity per 1000 population.
- Access to pre-bookable and same day appointments on Saturdays and Sundays, *according to local population needs*.

Year three – Commissioning of Improved Access year two

3.19 Somerset CCG will continue to commission Improved Access from GP practices in accordance with the updated service specification in Appendix A. The service will continue to deliver the Somerset population with access to the three core requirements as set out above.

D. Improvements in Quality and Resource Utilisation - Medicines Management

3.20 Further to the CCG's letter, dated 21 November 2017 located at Schedule 2 G Other Local Agreements, Policies and Procedures of the NHS Standard Contract the practice should:

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:

   http://nottingham.ac.uk/primis/tools-audits/index.aspx
5. Install and review on a regular basis Eclipse Live and the patient safety alerts generated in order to prevent harm and improve outcomes
6. Commit to work towards achievement of 15/20 green indicators on the prescribing scorecard
7. Support the CCG's self-care agenda for patients with minor clinical conditions

3.21 In future years, the requirements of this element will be reviewed and recommendations for inclusion provided through the Prescribing and Medicines Management Committee. There will also be consideration about further quality improvement initiatives could be included to improve outcomes for patients in primary care.

E. Collaboration with commissioners

3.22 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.

F. Reducing Avoidable Emergency Admissions

3.23 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. The 'Health and Wellbeing' model of primary care is evidence-based and delivers 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 receive a dashboard once a month showing the rate per 1000 weighted patients for four key indicators. This will be shown by practice, provider federation, CCG actual and CCG planned rate:

- Rate of emergency admissions
- Rate of emergency department attendance as a total and in-hours*
- Rate of minor injury unit attendance as a total and in-hours
- Rate of emergency admission for ambulatory care sensitive conditions

* 8am-6:30pm Monday to Friday constitutes in-hours

Practices will examine the data provided on the dashboard monthly and where practices are significant outliers against the planned activity rate practices will investigate and where unwarranted variation exists will put action plans in place to address this and return practices to planned activity rates or an agreed activity rate which recognised particular practice-specific variables. A significant outlier is where the planned level is below the lower confidence limit for the practices actual activity rate.

Treatment Escalation Plans (TEPs):

3.24 Practices will continue to promote a person centred approach, which includes personalised care planning for patients with long term conditions. TEPs help to facilitate discussions between patient and clinician formalising a clear plan which should be actioned should a patient's condition exacerbate.

3.25 TEPs shall be considered for those patients who in their GP's clinical judgement would benefit from such anticipatory care planning. Where practices are already putting in place management plans in the absence of the county wide TEP, an appropriate Read (SNOMED) code should be applied to each patient record to show that care planning is active.

3.26 There is no minimum/expected number of TEPs each quarter and the measurement will not impact on the payment process of PCIS. However further discussions may be held with federations where numbers are static/no TEPs are being developed.

Initiatives:

3.27 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 is at Appendix C. Practices are expected to utilise these initiatives to ensure delivery of these outcomes.

4. Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)
Not applicable

4.2 Applicable Standards set out in Guidance and/or Issued by a Competent Body (e.g. Royal Colleges)
Not applicable

4.3 Applicable Local Standards
Not applicable

5. Applicable quality requirements and CQUIN goals

Not applicable

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

As defined within the Contract Particulars

7. Individual Service User Placement

Not applicable

Appendix A:

Service Specification No.	11X-47
Service	Improved Access to Primary Care Services in Somerset
Commissioner Lead	Somerset Clinical Commissioning Group
Provider Lead	GP Practices
Period	1 April 2018 – 31 March 2019 (overall scheme runs from 1 October 2016 – 31 March 2021 to align with specifications developed each year in light of national and local policy developments)
Date of Review	March 2019

1. Population Needs

1.1 National/local context and evidence base

In 2015 the Conservative Manifesto unveiled the proposals to provide all patients with access to 7 day GP care by 2020. This pledge was reinforced in April 2016 following the publication of the GP Forward View (GPFV).

It was announced in the GPFV that NHS England will provide over £500 million of additional funding, on top of current primary care allocations to enable CCGs to commission and fund extra capacity across England to ensure that by 2020, everyone has access to GP services, including sufficient routine appointments at evenings and weekends to meet locally determined demand.

The NHS Operational Planning and Contracting Guidance 2017 - 2019 was published in September 2016, setting out the requirements to deliver both the Manifesto and the GPFV commitments to improve access to GP services by 2020.

The guidance was influenced through the learning and experience of the GP Access pilot sites who received £150 million investment through the Prime Ministers Challenge Fund from April 2014. These sites will continue into 2017/18, in addition to a number of geographies identified to accelerate the delivery of improving GP services, expanding to all CCGs by 2018/19.

In October 2016, it was announced that Somerset CCG had been identified as one of the early development sites to receive additional funding for the delivery of improved access to GP services across seven days by 2017/18. The decision was made because of the South Somerset PACS Vanguard status.

Since then, NHS England have set out their 7 core requirements.

SEVEN CORE NATIONAL REQUIREMENTS

This section makes practices aware of the seven core requirements of improved access which NHS England has defined nationally and will be used to measure CCG performance.

Timing of appointments

- Commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day
- Commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs,
- Provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week.

Capacity

- Commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

Measurement

- Ensure usage of a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.

Advertising and ease of access

- Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service,
- Ensure ease of access for patients including:
    - all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
    - patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

Digital

- Use of digital approaches to support new models of care in general practice.

Inequalities

- Issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.
- Effective access to wider whole system services
- Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

The national guidance instructs CCGs to commission and fund extra capacity to ensure everyone has access to GP services. To ensure a transparent approach the term GP services has been defined by the project team as;

"A primary medical service delivered by a wide skill mix team with a GP having overall responsibility for patient care. Services are delivered by a range of professional and non-professional staff, not necessarily a GP, through online, telephone and face to face appointments in accordance with patient need."

The service aligns and contributes to all aspects of the Somerset vision for primary care;
A resilient, flourishing primary care system as the foundation of joined up care, with the patient at the heart of all that we do

- A safe, sustainable, integrated primary care system
- Delivery of high quality patient centered care
- Patients seen by the most appropriate person in a timely fashion
- A safe, enjoyable working day for professionals

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	✓

2.2 Local defined outcomes

- Better access to primary care services for the Somerset population.
- Reduction in the number of emergency admissions.
- Manage the demand on primary care services and reduce duplication through the delivery of joined up care.
- Support the future sustainability of primary care in Somerset through collaboration and resilience.

3. Scope

3.1. Aims and objectives of service

3.1.1. The foundation of the Somerset CCG improved access service is based on four primary objectives that are coherent with the Somerset Primary Care Plan and supported by key enablers;

3.1.2. Primary Objectives:

- Commission a sustainable and effective model of care that enhances the availability of primary medical services across the county whilst maintaining high quality services, increasing patient satisfaction, managing demand and reducing duplication.
- To deliver joined up, collaborative and responsive out of hospital care for patients across 7 days, meeting population needs and reducing unnecessary demand through the use of patient education and awareness.
- Increase the capacity of primary medical services through the delivery of at scale services, sharing of resources and utilisation of IT innovations.
- Deliver an integrated and responsive primary medial service that is clinically led and supported by a multi-disciplinary team, providing care to population groups in collaboration with multiple provider organisations.

3.1.3. Enablers:

- Patient education and awareness of alternative health services available, helping patients identify the right care, at the right time, in the right place.
- Develop and pilot IT innovations meeting the needs of patients and delivering high quality outcomes.

- Develop collaborative and trusting relationships with provider organisations across the county, including out of hours and community services.

- Develop robust clinical governance procedures to maintain patient safety and secure information sharing.

- Provide a responsive service to those patients who would benefit most (end of life, complex patients, frail elderly).

3.2. SOMERSET SERVICE REQUIREMENTS

3.2.1. This section sets out the main requirements on practices to ensure Somerset delivers and complies with the national seven core requirements of improved access.

Timing of appointments

- Access to GP Services for an additional 1.5 hours each weekday evening (6:30pm to 8pm.), offering a sufficient number of pre-bookable and same day appointments on each weekday (Monday – Friday).
- Provide access to both pre-bookable and same day appointments on both Saturdays and Sundays, meeting local population needs.
- It is for individual provider groups to determine how routine and same-day appointments will be allocated and apportioned.

Capacity

- Provide a defined population with access to an additional 30 minutes of consultation capacity per 1000 population (weighted) on a weekly basis. The April 2018 population figure will be used for the purposes of this calculation.

Measurement

- The identified lead for the provider group should complete and return the data requested that relates to improved access within the CCG enhanced services quarterly monitoring template on behalf of the group.
- Once available, practices will also use the nationally commissioned tool supplied by NHS England that will automatically measure appointment activity.
- Should the CCG be required to report information not being routinely reported e.g. a request from NHS England, the CCG reserves the right to request missing information from practices/provider groups where it is considered appropriate to do so.

Advertising and ease of access

- Practices must ensure the service is clearly advertised to patients, including:
    - Clear notification on practice websites, which includes having a notice/link on the homepage to further information which informs patients on:
- What the service is and how is it being delivered
- Where the service is being delivered
- When the service is available and who it is for (not just when the advertising practice is doing the appointments)
- How patients access the service/book an appointment
    - Display of either the national or local communication tools (at a minimum the display of posters) within the practice and the wider community
- Ensure all practice receptionists are aware and trained on how to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services e.g. training on how to book the appointments.
- Practices should offer all patients a choice of evening or weekend appointments on an equal footing to core hours appointments (subject to local patient safety arrangements).

Digital

- Provider groups will have in place processes to ensure health professionals provide a safe consultation by having appropriate access to the patient's medical records. The service will have in place robust information sharing agreements.
- Practices should consider the use of digital innovations to support the delivery of improved access e.g. online booking/consultations

Inequalities

- Every patient registered with a Somerset GP practice will have access to the improved access service.
- Practices should consider issues of inequalities in patients' experience of accessing general practice identified by local evidence and where appropriate, put actions in place to resolve them.
- Practices should engage in system developments to facilitate the connection to other system services, enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

3.3. SOMERSET DELIVERY MODEL

3.3.1. In addition to the main requirements set out under point 3.3, this section sets out in more detail how improved access will be delivered. Practices are free to innovate and the CCG would be willing to discuss different methods of delivery which deliver the requirements of this specification.

3.3.2. Provider Groups

Practices will provide the improved access service by collaborating in groups ("provider groups") of a size which takes account of the following factors:

- geographical location
- patient demographic
- public transport links
- existing groupings (e.g. federations)

The provider group will identify a 'lead' who will act as the representative and point of contact on behalf of the group.

Each provider group will be asked to complete and return a service delivery plan at the start of the 2018/19 contractual year. The purpose of the simple template is to confirm the delivery model within each provider group and to ensure each core requirement is being met.

3.3.3. Rota

Each provider group will develop and share a rota with the CCG which articulates where and how many improved access hours will be available on each day. This rota should aim to be consistent and it should ideally not repeat any more than 4 weeks. The number of hours delivered each week must equal the minimum number required based on the additional 30 minutes of consultation capacity requirement.

As a minimum, the CCG would expect improved access to be accessible on the same days as year 1 e.g. Monday to Saturday.

Provider groups will agree to host services from one or more locations, ensuring equitable access for the defined population of each provider group. The location can be consistent throughout the week or different on each day. Whilst this is for local determination, provider

groups are encouraged to consider patient transport links and patient demographics.

Provider groups should continue to plan their rota on the understanding that where improved access provision falls on a bank holiday, provider groups either deliver the hours on that day or provide the scheduled hours on an alternative day. The expectation is that where hours are rescheduled, they are delivered within a reasonable timeframe either before or after the bank holiday in question. Should it not be possible to do this, a financial adjustment will be applied.

Provider groups must have an arrangement in place which allows patients to access the improved access service. This includes providing patients across the provider group with equal access to any available appointments after "core hours".

3.3.4. Collaboration and Workforce

Provider groups are encouraged to work in collaboration with other health care providers to share resources and work in partnership to deliver improved access. This could include; Out of Hours, Community Services, Secondary Care and the third sector.

Wide use of healthcare professionals is encouraged and services should not be based purely around GPs and face to face appointments. However, a GP must have clinical oversight of the service being provided in each provider group and patients should have the ability to see a GP if clinically required.

Where different staffing groups are being used for improved access, the provider group should determine locally which patients will be suitable for each appointment to match the individuals skill set. This is to avoid of practices hesitation when booking into cross organisational appointments.

3.3.5. Appointments

The service should provide continuity of care to support those patients who would benefit most from access to GP services (end of life, complex patients, frail elderly), whilst balancing convenience of access. This could include a proportion of pre-bookable appointments being made available to facilitate hospital discharges and complex packages of care at weekends.

In accordance with the both the national and local requirements, provider groups should provide a route for patients to access appointments which can be booked on the same day, which includes at the weekend. Provider groups are also asked to consider putting in place an arrangement that allows patients to access un-booked appointments after 6.30pm during the weekday and at weekend.

Recognising the challenges of practices operating their phone line outside of "core hours", the CCG considers the most pragmatic solution to meet the above requirement is the direct booking by 111 into available improved access appointments, where clinically appropriate.

Practices will be aware of the national contractual expectations and commitments to introduce direct booking by 111. The CCG will therefore support practices over the 2018/19 contractual year to introduce direct booking, which includes fully evaluating the benefits and address any concerns about its implementation and potential consequences.

The CCG will also support the introduction of local arrangements to meet the above requirement in the absence of direct booking being in place.

Appointments should be configured in accordance with local operating procedures but as a minimum, every practice and their respective patients within the provider group should be given the option to book into improved access appointments on each day the service is available.

Group appointments are permissible, where it is clinically safe to do so. The length of the session will dictate the contribution to the required 30 minutes of additional consultation capacity per 1000 population, not the number of attendees. Group sessions must not replace the ability

for patients to access routine appointments on days when group sessions are taking place.

The provider group should put arrangements in place (at least quarterly) to review utilisation of appointments and where appropriate, undertake agreed actions or make reasonable adjustments to maximise the use of human and financial resources. The CCG may contact provider groups where there are concerns regarding utilisation to understand what actions are being taken to increase utilisation.

3.4. SOMERSET CONTRACTING MODEL

The service and the associated funding will continue to be encompassed into the Somerset Primary Care Improvement Scheme (PCIS). Practices will receive the £6 per head of weighted population to deliver improved access on an individual basis, through the PCIS financial allocations as set out in schedule 3A of this contract.

Practices that wish to continue to be signed up to the DES will have their £6 allocation offset against the £1.90 received from NHS England. This means the practice will receive £4.10 from the CCG and £1.90 from NHS England.

Each provider group will put in place an arrangement with a provider organisation or a lead practice within the provider group who will be responsible for the organisation and delivery of improved access.

The provider group will be jointly accountable for ensuring the requirements of improved access are continuously delivered. Should an unplanned shortfall in provision occur, the CCG must be notified by the lead practice. This should take place before the event occurring, where possible.

The CCG will seek assurance that the group has exhausted all possible options (e.g. another practice or a locum covers a gap) before agreeing to the service not being provided at all.

If the situation of not providing the planned service did occur, there would be an expectation for any hours not delivered to be rescheduled on a different day as a last resort and the CCG would seek assurance from the group that provisions are in place to prevent the possibility of the situation re-occurring.

The CCG would want to support the group to ensure a full service can be delivered before taking any contractual action. In the event that an agreement between the group and the CCG can't be reached and there is an ongoing issue with service delivery or continuous episodes of non-delivery, the CCG would consider the mechanisms within the contract to manage performance.

Provider groups have the option to sub-contract the delivery of Improved Access. It will be for the provider group and the chosen organisation or practice to agree the terms of the sub-contract, including the proportion of funding from the allocation to deliver the service.

Where a practice has not signed up to the PCIS or chooses to leave the PCIS within a federation, the practice will not receive the funding for improved access. The funding will subsequently be allocated to the provider in that federation if they agree to provide the service to the practice's patients. In this circumstance, the patients registered at that practice will be given equitable access to the improved access service. This means the non-participating practice will need to agree and put in place a sharing agreement for the access to patient records.

3.5. Reporting

The practice identified as the lead for the provider group will be required to submit on a quarterly basis the requested data within the CCG quarterly monitoring template on behalf of the

respective provider group.

Once available, practices will also use the nationally commissioned tool supplied by NHS England that will automatically measure appointment activity.

Should the CCG be required to report information not being routinely reported e.g. a request from NHS England, the CCG reserves the right to request missing information from practices/provider groups where it is considered appropriate to do so.

3.6. Population covered
The service will be available and accessible to patients registered at a Somerset GP practice.

3.7. Any acceptance and exclusion criteria and thresholds
Patients whose care is not suitable for primary care management are excluded from this service.

3.8. Interdependence with other services/providers
The improved access service should consider working with other health care providers, enabling patients to receive the right care from the right professional.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

To be considered as appropriate.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Not applicable

4.3 Applicable local standards

The quality standards set out in the contract apply to this service.

5. Applicable quality requirements and CQUIN goals

The quality standards set out in the contract apply to this service.

6. Location of Provider Premises

The Provider's Premises are located at: As defined within the Contract Particulars

7. Individual Service User Placement

Not applicable

Appendix B

Guidance notes for enhanced services commissioned through the Primary Care Improvement Scheme

Hepatitis B vaccinations for 'at risk Groups' (11X-29-5)

This Service confirms the commitment of Somerset Clinical Commissioning Group (the Commissioner) to continue to fund General Practice Providers for the provision of Hepatitis B vaccinations for 'at risk' groups.

Responsibility for the commissioning of hepatitis B vaccination services is as follows:

Service	Commissioner
New-born babies of Hepatitis B mothers	NHS England
Hepatitis B vaccinations for at risk groups (excluding newborn babies of Hepatitis B mothers).	Somerset Clinical Commissioning Group

The service should only be offered to those patients in the 'at risk' groups (see paragraph 3.11), ensuring that:

- service users meet the appropriate criteria
- reasonable adjustments are made to meet the needs of patients who have a disability.

This service should be provided in line with the Department of Health guidance on Hepatitis B vaccination in Chapter 18 of the Green Book, which can be found at https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18.

The Provider will take all reasonable steps to ensure that the lifelong medical records held by an at-risk patient's GP are kept up-to-date with regard to his or her immunisation status, and in particular include:

- any refusal of an offer of vaccination
- where an offer of vaccination was accepted:
    - details of the consent to the vaccination or immunisation (where a person has consented on an at-risk patient's behalf, that person's relationship to the at risk patient must also be recorded[1])
    - the batch number, expiry date and title of the vaccine
    - the date of administration of the vaccine
    - where two vaccines are administered in close succession, the route of administration and the injection site of each vaccine
    - any contraindications to the vaccination or immunisation
    - any adverse reactions to the vaccination or immunisation

Where patients fail to attend for vaccination it is recommended that they are followed up to ensure that their needs are reviewed to ensure the call/recall system is working effectively.

[1] Refer to the *Mental Capacity Act* if necessary to ensure consent is appropriately obtained

Acceptance and Exclusion Criteria

'AT RISK' GROUPS FOR HEPATITIS B VACCINATION

Family group:

- Foster parents
- Adopting parents of positive child or child from high risk country

High risk sexual behaviour group:

Genito Urinary Medical Services offer a vaccination programme to this group. GP Providers should provide advice and signpost to Genito Urinary Medicine Services, or provide opportunistic vaccination where GP staff are competent.

- Men who have sex with men
- Sex workers
- Frequent sexual partners
- Sexual partners of any of the above

High risk drug use group:

The Drug & Alcohol Action Team have specialist Blood Borne Virus workers who offer a vaccination programme to this group. GP Providers should provide advice and signpost to the Drug & Alcohol Action Team, or to a GP providing the Substance Misuse LES:

- Injecting drug users
- Close household members of infected injecting drug users
- If a Practice is requested to give the vaccination by any of the above services then they may claim under this LES

People living in residential care or nursing home settings:

- People with Learning Difficulties living in a residential care or nursing home setting

People receiving Renal Dialysis or with Liver disease

The following at risk groups are NOT covered:

- People travelling to high risk areas
- People at occupational health risk
- People suffering a needle stick injury
- People living in institutions:
- Patients in a custodial/prison setting
- People with the following medical conditions (secondary care are responsible for vaccination):
    - Frequent blood transfusion

Neo-natal checks (11X-07)

Participating providers will undertake neonatal checks 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.

In accordance with the NHS England Neonatal and Infant Hepatitis B Immunisation Protocol, where a baby is identified as at risk of Hepatitis B Providers shall ensure that mothers are informed of the protocol and immunisation schedule and are signposted to access this service appropriately.
https://www.england.nhs.uk/south/info-professional/public-health/immunisations/hepatitis-b/

* Please note that the administering of the vaccination does not form part of this service specification.

NEONATAL CHECK REQUIREMENTS

The following requirements are sourced from the National Institute for Clinical Excellence (NICE):

- the aims of any physical examination should be fully explained and the results shared with the parents and recorded in the postnatal care plan and the personal child health record
- a complete examination of the baby should take place within 72 hours of birth
- the examination should incorporate a review of parental concerns and the baby's medical history should also be reviewed including: family, maternal, antenatal and perinatal history; fetal, neonatal and infant history including any previously plotted birth-weight and head circumference; whether the baby has passed meconium and urine (and urine stream in a boy). Appropriate recommendations made by the NHS National Screening Committee should also be carried out https://www.gov.uk/topic/population-screening-programmes and https://legacyscreening.phe.org.uk/screening-recommendations.php

Specific details for the physical examination are as below, checking the baby's:

- appearance including colour, breathing, behaviour, activity and posture
- head (including fontanelles), face, nose, mouth including palate, ears, neck and general symmetry of head and facial features. Measure and plot head circumference
- eyes; check opacities and red reflex
- neck and clavicles, limbs, hands, feet and digits; assess proportions and symmetry
- heart; check position, heart rate, rhythm and sounds, murmurs and femoral pulse volume
- lungs; check effort, rate and lung sounds
- abdomen; check shape and palpate to identify any organomegaly; also check condition of umbilical cord
- genitalia and anus; check for completeness and patency and undescended testes in males
- spine; inspect and palpate bony structures and check integrity of the skin
- skin; note colour and texture as well as any birthmarks or rashes
- central nervous system; observe tone, behaviour, movements and posture. Elicit newborn reflexes only if concerned
- hips; check symmetry of the limbs and skin folds (perform Barlow and Ortolani's manoeuvres)
- cry; note sound
- weight; measure and plot

The newborn blood spot test should be offered to parents when their baby is five to eight days old.

Guidance on the outcomes can be sought via the Somerset Pink Book or a paediatrician.

HEALTH RECORD

Information should be recorded in the Personal Child Health Record and in the lifelong medical record.

SAFEGUARDING CHILDREN

Anyone undertaking neonatal checks must be aware of their responsibility for safeguarding children and have the knowledge and skills, supported by appropriate training, to identify where there are concerns about the welfare of a child, or indicators of abuse or neglect. If concerns about possible abuse or neglect are identified when the child presents for immunisation the practitioner must follow the relevant provider child protection procedures and ultimately the Somerset Local Safeguarding Children's Board procedures.

Pre and Post-Operative Care (11X-08)

The following list gives guidance on the types of care that would be included within the scope of pre and post-operative care, and is not comprehensive:

- Blood tests
- Electrocardiogram
- Methicillin-resistant Staphylococcus aureus (MRSA) screens, including decolonisation, antibiotic treatment and rescreens in accordance with guidance in respect of positive Methicillin-resistant Staphylococcus aureus (MRSA) results
- suture or clip removal
- wound assessment and wound dressings in accordance with the CCG Wound Care Formulary and Wound Care Policy / Methicillin-resistant Staphylococcus aureus (MRSA) Wound Care Policy
- baseline observation: pulse, blood pressure and temperature, height, weight, nutritional assessment, social assessment

This enhanced service will fund:

- adequate facilities including premises and equipment, as are necessary to enable the proper provision of pre and post-operative care including facilities for cardiopulmonary resuscitation
- appropriately trained health care professionals to undertake the tasks listed above to provide care and support to Service Users undergoing care
- adherence to and maintenance of infection control standards (single use equipment where sterile equipment is needed)
- all drugs, dressings (in accordance with Trust Wound Care Formulary), appliances and necessary equipment to perform the care
- provision of information to Service Users as appropriate to their specific care
- maintenance of records of all care / procedures, consent and transfer of outcomes of pre op care to Service User's Consultant, or as directed

HEALTH RECORD

Providers must ensure that details of the Service User's monitoring is included in his or her lifelong record.

Read Code suggestions:

8920	Consent (given)
8921	Consent (refused)
ZV58312	Suture removal
8PO	Clip removal
81H	Post op dressing
321	Pre Op ECG (identify in free text for pre op)
424	Pre Op blood test (FBC, identify in free text for pre op)

4JRA	Pre Op MRSA swab (identify in free text that for pre op)
4JRA	Post op MRSA swab (identify in free text that for post op)

Long Acting Antipsychotic Injections in adults (11X-09)

The purpose of this service is to continue care, closer to home, in primary care for:

- those patients prescribed a long acting antipsychotic injection with a diagnosis of schizophrenia and other psychoses who have shown either a positive response to oral treatment but for whom concordance with oral therapy is poor or as a switch from one on formulary oral/injectable antipsychotic

- patients who are unable to tolerate conventional depot antipsychotics or who have responded to atypical antipsychotics but who have a history of poor adherence with oral treatment

The scheme will provide a cost-effective means of ensuring that patients suitable for shared care with a long acting antipsychotic injection injection have reduced relapse rates through better adherence to treatment (both as a consequence of less side effects and availability as a long acting injection) to improve clinical outcome and reduce psychiatric re-admission rates.

General Practitioner (GP) providers are required to work with the Psychiatric Service and Community Psychiatric Nurse to ensure the approved shared care agreement is followed (see Appendix 1 and 2). This enhanced service also intends to ensure that patients receiving a long acting antipsychotic injection in primary care receive comprehensive care in line with best practice guidance for patients with a mental health condition.

Specifically the enhanced service requires that:

- each patient receiving a long acting antipsychotic injection must be on the Provider register of people with schizophrenia, bipolar affective disorder and other psychoses

- the GP provider must have a system to identify and follow up patients who do not attend their appointment for administering a long acting antipsychotic injection

- each patient receiving a long acting antipsychotic injection must have a comprehensive care plan documented in their records coving the issues and actions as set out in the current Quality and Outcomes Framework (QOF) guidance for patients on the register of schizophrenia, bipolar affective disorder and other psychoses

- each patient receiving a long acting antipsychotic injection must receive a minimum level two medication review at least annually

- each patient receiving a long acting antipsychotic injection injection must receive, prior to commencing therapy in primary care, a baseline health assessment to include as a minimum:

    - assessment of any issue relating to alcohol or drug use the patient may have

    - a review of the patients smoking status and discussion of support available to the patient should they wish to stop smoking

    - a Cardiovascular Disease risk assessment including blood pressure check and cholesterol check if clinically indicated

    - recording of their Body Mass Index (BMI)

    - a diabetes risk assessment including blood glucose check or HbA1C check if clinically indicated

    - discussion on sexual health issues and cervical screening if clinically appropriate

- each patient receiving a long acting antipsychotic injection must receive a health assessment initially at six months and then annually as a minimum thereafter, covering as a minimum:

    - assessment of any issue relating to alcohol or drug use the patient may have

    - a review of the patients smoking status and discussion of support available to the patient should they wish to stop smoking
    - a Cardiovascular Disease risk assessment including blood pressure check and cholesterol check if clinically indicated
    - recording of their Body Mass Index (BMI)
    - a diabetes risk assessment including Blood glucose check or HbA1C check if clinically indicated
    - discussion on sexual health issues and Cervical screening if clinically appropriate
- the Provider should check that the patient has received the appropriate written information via secondary care which should ensure that all newly diagnosed/treated patients (and/or their carers when appropriate) are supported through receiving appropriate education and advice on management of and prevention of secondary complications of their condition
- the GP provider should provide continuing information for patients. This should ensure that all patients (and/or their carers and support staff when appropriate) are informed of how to access appropriate and relevant information
- If a doctor, nurse, pharmacist or patient suspects that an adverse reaction to a long acting antipsychotic injection has occurred, it should be reported to the Commission on Human Medicines (CHM) using the Yellow Card spontaneous reporting scheme: www.yellowcard.gov.uk.

Exception reporting, including for informed dissent, does not apply.

Shared Care Guidance:

SCG v1-6 Feb-18 Antipsychotic.pdf

Appendix C

Summary of Somerset Reduction in Emergency Admissions Initiatives

Somerset Primary Link (SPL) provides a single point of access across Somerset for the coordination of urgent and unscheduled (non-emergency) care referrals and the transfer of service users from acute to community hospitals. Somerset Primary Link is also a key coordination point for planned ambulatory care referrals e.g. blood transfusions and links with relevant assessment beds sites and ambulatory care.

Urgent Connect is an innovative telecoms system provided by Somerset CCG which enables local GPs to connect directly with consultants in acute specialties to obtain immediate clinical advice and guidance for urgent care rather than going through hospital switchboards. GP practices each have a single telephone number through which they can directly access specialty teams within urgent care in Taunton, Yeovil and Bath. The GP dials the number, selects the specialty and inputs the patient's NHS Number. The call then connects with the relevant team of consultants. Each consultant is given 20 seconds to answer the call; if they are not in a position to take the call then it automatically loops to the next consultant and so on until the call is answered. The service has been running from November 2016 and predominantly operates from 09:00-17:00 Monday-Friday.

SWASFT Right Place, right care initiative has numerous work-streams. Some of these include the development of community pathways with Somerset Partnership to clarify acceptance criteria regarding MIU access. Acute pathway development incorporating SWASFT clinician access to; ambulatory, medical, NOF and paediatrics. Engagement with Care Homes to manage demand – this involve monthly engagement events/meetings. Further demand management regarding non-injured fallers – use of pathways to be utilised.

Assessment beds are sited in Minehead, Frome and West Mendip Community Hospitals, Monday to Friday. The role of the assessment bed is to be able to carry out a planned comprehensive GP led assessment and point of care testing for people with urgent care needs, which avoids an attendance or admission to an acute hospital, and supports the person to return home. Typically this may be someone with an ambulatory care sensitive condition, including frailty, or infection. Referrals may come from SWAST, GPs, or other local healthcare staff.

GP 999 car scheme launched on 12 November 2016 and acts as a mobile treatment service where GPs provide Primary Care support to Paramedics, Specialist Paramedics and other Ambulance Clinicians to manage patients at home and thus avoid admissions to hospital unless clinically appropriate. The service runs for 10 hours per day, one car operating 7 days a week and a second car operating on a Saturday and Sunday. The GP 999 resource is dispatched by the South Western Ambulance Service Foundation Trust Clinical Hub.

ED streaming to OOH GP involves a front of house Primary Care streaming service in EDs. The aim of this model is to ensure that patients are managed by the service most appropriate for their need e.g. primary care, secondary care or referred back to their own GP practice. It is estimated that a quarter of patients presenting at ED could be streamed to a Primary Care clinician.

Urgent Care Service (UCS) – Yeovil is a Nurse led (with GP/Medical oversight) same day service available Saturday and Sunday between the hours of 10.00 – 18.00 offering an alternative to Minor Injury Unit (MIU) or Accident and Emergency department (A&E) attendance. Patients are triaged through the 111 service to the UCS which is co-located with the Out of Hours (OOH) service at Yeovil District Hospital (YDH).

Emergency Admissions Dashboard

The CCG have developed a dashboard which shows an individual practice's rate of emergency admissions, the federation's rate of emergency admissions, the agreed target for the federation and the change from the previous week in an easy to read format. This is emailed to practices on a monthly basis.

What practices could do

- Fully utilise the schemes in place highlighted above.
- Review the monthly dashboard.
- Review data contained within Abacus. Support for interpretation of Abacus data is available from South West Commissioning Support Unit: oliver.taylor@swcsu.nhs.uk
- Discuss emergency admission data by GP at practice meetings.
- Discuss emergency admissions data at federation meetings, sharing good practice.
- Undertake an audit to review emergency admissions. An audit tool is currently being tested and will be shared with practices to support this function.
- Review the patients currently listed under the Avoiding Unplanned Admissions Directed Enhanced Service and discuss as a clinical team any further action that could be taken to prevent any further admissions.
- Care planning:
  Implement 'House of Care' approach and use the clinical communications document to ensure that all relevant clinicians have access to important basic information about the patient.