NHS
Somerset
Clinical Commissioning Group

Service Specification No.	11X-38-V5
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 2019 – 31 March 2020 (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	September 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 Findings from Somerset STPs '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:

- 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.
- A wide range of services are delivered at a local practice level and at a 'neighbourhood' level covering 30,000- 50,000 people
- 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
- People with long-term conditions and their carers need a much more joined up service at a local level
- 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

1.3 The primary function of this investment linked with delivery of this specification is to deliver the benefits described above.

1.4 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.

1.5 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.

1.6 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 recommendations from Somerset CCGs 'Fit for my future' primary care strategy.

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.

Year four – Finance

3.7 The full-year financial value of this service will be £10.57 per weighted patient plus 60.9p per registered patient previously commissioned through pre- and post-op care.

3.8 £10.57 per weighted patient of new CCG investment will be off-set in the following way:

1) 01 Apr 2019 – 30 Jun 2019 – off-set by NHS England Extended Hours DES (pro-rata'd) and any payments made in respect of MPIG and PMS protected income.
2) 01 July 2019 – 31 March 2020 – off-set by NHS England Primary Care Network DES and any payments made in respect of MPIG and PMS protected income.

3.9 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

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

Aims and Objectives of Service

3.11 The aims of the specification are as follows:

- To contribute to the delivery of recommendations from the 'Fit for my future' primary care strategy
- Review the number of patients per skill mixed member of staff, thereby improving outcomes for patients
- Reducing avoidable emergency admissions and ED attendances
- 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
- To support the service delivery of the following commissioned pathways within primary care:
  - Electronic ear irrigation
  - Population health management initiatives focused on Cardiovascular Disease (CVD) prevention and early detection
  - Physical health checks for registered patients diagnosed with Serious Mental Illness (SMI)
- Support various Quality Improvement (QI) initiatives and methodologies
- Support development initiatives linked to the promotion of self-care and Clinical Practice Research Datalink (CPRD)
- Improvements in resource utilisation e.g. prescribing
- Supporting the CCG self-care agenda for patients with minor clinical conditions suitable for management by patient purchasing over the counter (OTC) medicine

- Reporting and audit requirements linked to Somerset Treatment Escalation Plans (STEPs)

3.12 Practices are required to undertake the following:

A. Specified Non-Core Contract Work

3.13 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

3.14 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.

3.15 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'

3.16 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-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.

3.17 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. New service delivery

New service delivery

3.18 Three new areas of service delivery will now be included with the core PCIS service offer. Separate guidance notes based on the existing specifications have been developed and included at appendix C. The three new areas are as follows:

1. The provision of electronic ear irrigation as part of the new 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].

2. 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)

3. Physical health checks for patients diagnosed with Serious Mental Illness (SMI)[3]. As expert generalists, practices will support the national commitment to offer timely and appropriate physical health assessments for people living with SMI as part of the five year forward view. This will take the form of a person-centred consultation with an appropriate member or members of the practice team, on an annual basis Practices will, where relevant and clinically justified, ensure the:
   - Completion of recommended physical health assessments
   - Delivery of or referral to appropriate NICE recommended interventions
   - Personalised care planning, engagement and psychological support

D. 7 Day Access to Primary Care

Year one

3.19 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

3.20 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.

3.21 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,

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

[1] As per the Somerset CCG prescribing formulary http://formulary.somersetccg.nhs.uk/ in accordance with the Somerset CCG Evidence Based Intervention Policy https://www.somersetccg.nhs.uk/about-us/how-we-do-things/individual-funding-requests/

[2] in accordance with the Somerset CCG Evidence Based Intervention Policy https://www.somersetccg.nhs.uk/about-us/how-we-do-things/individual-funding-requests/

[3] Practices will adopt an ambition to provide such a person-centred consultation and such interventions as are relevant and clinically justified to 50% of the patients on their SMI register during 2019/20. Where practices have an unusually high prevalence, it is acceptable for practices to aim for 50% of the average Somerset prevalence Current manual data extraction processes shall remain in place until such time as it is replaced by an automated process. In discussion with the CCG.

according to local population needs.

Year three – Commissioning of Improved Access year two

3.22 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.

Year four – Commissioning of Improved Access year three

3.23 The national requirements for improved access will continue to be commissioned via the Primary Care Improvement Scheme and delivered by GP practices. The service specification has been updated to reflect the requirements of the new Primary Care Network DES and the inclusion of Extended Hours. The most noticeable change to the Improved Access specification is to the title of the service which will now 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. The purpose of the supplementary specification is to ensure the national Improved Access requirements are reflected in the delivery of the Extended Hours service offered as part of the Network DES.

3.24 Both the Network DES specification for Extended Hours and this supplementary specification should be read in conjunction to ensure Primary Care Networks deliver and meet the full requirements for the Extended Hours service.

E Improvements in Quality and Resource Utilisation - Medicines Management

3.25 Further to the CCGs letter, dated 21 November 2017 and 31 January 2019 respectively, 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:

   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. Commit to work towards achievement of 15/20 green indicators on the prescribing scorecard
7. Support the CCG self-care agenda for patients with minor clinical conditions suitable for management by patient purchasing OTC medicine
8. Support the CCGs low value medicines agenda by de-prescribing medicines which should not be routinely prescribed in primary care https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-guidance-for-ccgs/

3.26 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.

F Collaboration with commissioners

3.27 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.

G Quality Initiatives

3.28 **Access**
The CCG wishes to work collaboratively with providers to improve access to general practice and reduce waiting times.

3.29 **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.

3.30 **Quality Improvement**
As a result of practice feedback and in order to build on the work that has been undertaken through Somerset Practice Quality Scheme (SPQS), as well as to support practices in achieving Quality Outcomes Framework (QOF), practices will:

- Undertake a local (practice or network level) improvement using professionally led QI methodology and led by Practice Nurse (e.g. reducing numbers of urine specimens)
- Ensure a practice nurse attends at least one QI planning meeting during 2019/2020. A total of 3 meetings are planned across the year, (one local, two Somerset-wide), which will be supported by Dr Martyn Hughes.

3.31 **NEWS2**
In order to build on good practice from previous CQUIN schemes, practices will:

- Ensure that the NEWS2 templates on EMIS are used and practices have a trained NEWS2 lead[2]
- Use NEWS2 observation scores, where appropriate, when transferring critically ill patients into emergency care
- Support CCG data requests on proven E coli bloodstream bacterium infections within two weeks. It is anticipated that this would amount to no more than a handful of CCG requests per practice per year
- Undertake Route Cause Analysis (RCA) reports for specific requested Clostridium difficile (C-DIFF) cases at the request of the CCG. It is anticipated that this would amount to no more than 0-2 CCG requests per practice per year

H Development Initiatives

3.32 Practices will engage with two new development initiatives which are:

- Promotion of 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
- Enrolling in the Clinical Practice Research Datalink (CPRD) and participate with national clinical data information extractions to be used to support research

I Reducing Avoidable Emergency Admissions

3.33 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.

[2] Available at https://tfinews.ocbmedia.com/

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.

3.34 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 D. Practices are expected to utilise these initiatives to ensure delivery of these outcomes.

J Somerset Treatment Escalation Plans (STEPs):

3.35 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.

3.36 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.

3.37 There is no minimum/expected number of STEPs and the measurement will not impact on the payment process of PCIS. However, practices will be required to produce an annual report at the request of the commissioner that shows a clear trajectory increase of STEPs produced from 2018/19 to 2019/20. Practice will also be required to an annual quality audit at the request of the Commissioner. Further discussions may also be held with federations where numbers are static/no STEPs are being developed.

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

5.1 SMI health checks:

The practice will support the CCGs commitment to undertaking health checks for patients with SMI where clinically appropriate

Measure: Undertake health check consultations for at least 50% of patients on their SMI register during 2019/20[3]

5.2 NEWS2
The practice will commit to build on previous CQUIN schemes

Measure: At the request of the commissioner complete data requests on proven E coli bloodstream bacterium infections in < 2 weeks

Measure: At the request of the commissioner undertake Root Cause Analysis (RCA) reports for specific requested Clostridium difficile (C-DIFF) cases

5.3 STEPSs

[3] Where practices have an unusually high prevalence, it is acceptable for practices to aim for 50% of the average Somerset prevalence, in discussion with the CCG

Practices will commit to undertake STEPs for patients whom, in their clinical judgement, would benefit from advanced care planning

Measure: Annual report and audit at the request of the commissioner

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

As per the Particulars of the NHS Standard Contract

Appendix A

Service Specification No.	
Service	Extended Hours – Supplementary Network Service
Commissioner Lead	Somerset Clinical Commissioning Group
Provider Lead	GP Practices
Period	1 July 2019 – 31 March 2020 (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 2020

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 has 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

In March 2019 the national specification for Primary Care Networks was published by NHS England and includes the requirement to deliver Extended Hours. Whilst practices continue to have the option to sign up to the Network Directed Enhanced Service, the CCG has reviewed the commissioning arrangements and the relationship with the 'Improved Access' service commissioned via PCIS.

We also know from the national documentation published at the time of writing this specification that the funding allocation for Improved Access will form part of the Network funding from 2021/2022. NHS England is also undertaking a national access review which is likely to change the current Improved Access requirements set out in 2016.

Using all this information the CCG has taken the decision to treat the two services as one as opposed to two separate and independent services. This position is unique to Somerset as the majority of CCGs have commissioned their Improved Access services from providers other than GP practices.

This review has led to the decision to rebrand the existing 'Improved Access' specification as there was an acknowledgement that by having two separate, but very similar services with a different name was confusing.

From July 2019 onwards the title of this service will be known as "Extended Hours – Supplementary Network Specification". What this means is that practices signed up to the Network DES are required to meet the core Extended Hours requirements set out in the Network DES specification and the requirements set out in this supplementary specification. This is on the basis CCGs are not permitted to add or remove requirements set out in the national Network DES Specification.

CCGs can however commission supplementary services which are in addition to the Network DES and must be delivered by the network. The purpose of this document is to ensure Somerset continues to meet the requirements dictated by the current national improved access service which are over and above the core Network DES specification for Extended Hours.

Both the Network DES specification for Extended Hours and this supplementary specification should be read in conjunction to ensure Networks deliver the full requirements for the Extended Hours service.

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 Extended Hours 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 Primary Care Networks under this Supplementary Network Service. The requirements in this specification are over and above the

requirements specified in the Network DES and add more detail to the core Extended Hours specification to ensure Somerset delivers and complies with both the national seven core requirements of improved access and the core Extended Hours requirements.

Timing of appointments

- Extended Hours appointments must provide 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 Networks to determine how routine and same-day appointments will be allocated and apportioned.

Capacity

- Provide the network population with access to an additional 30 minutes of consultation capacity per 1000 weighted or registered population (whichever is the collective greater population) on a weekly basis. The January 2019 population figure will be used for the purposes of this calculation.

  Networks are not required to deliver 30 minutes under the core requirements and a further 30 minutes under this supplementary network specification. Networks should be delivering an additional 30 minutes in total. The purpose of this requirement is to reflect the Network DES is calculated using registered population and the national Improved Access requirements are calculated using weighted.

Measurement

- A designated practice within the Network should complete and return the data requested within the CCG enhanced services quarterly monitoring template and the data should reflect the work completed by the Network in that quarter.

- Every practice within the Network should 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/Networks where it is considered appropriate to do so.

Advertising and ease of access

As per point 4.6.5 of the main specification, patients must be aware of the service availability. The following requirements add more detail to the core service specification.

- Every practice within the Network 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 within the Network 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

- Networks 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.

- Networks should consider the use of digital innovations to support the delivery of Extended Hours e.g. online booking/consultations

Inequalities

- Every patient registered with a Somerset GP practice will have access to the Extended Hours service.

- Networks 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.

- Networks 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 3.2, this section sets out in more detail how Extended Hours will be delivered in Somerset. 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. Networks

As per the Network DES core specification, all Network member practice will be expected to actively engage in planning of the service.

Networks can work across their boundaries to work with neighbouring Networks to deliver the Extended Hours service. However, before putting any arrangements in place Networks must consider the following to ensure patient access is not reduced by the service being extended across a larger geographical area:

- geographical location

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

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

Each Network will be asked to complete and return a service delivery plan. The purpose of the simple template is to confirm the delivery model within each Network and to ensure each core requirement is being met.

3.3.3. Rota

Networks will determine how the Extended Hours appointments will be delivered as part of the Network Agreement. However the CCG has defined some parameters to ensure consistency of the service offered across the county and to maintain ease of patient access and understanding.

Each Network will develop and share a rota with the CCG which articulates where and how many Extended 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 Extended Hours to be accessible on the same days as year 1 e.g. Monday to Saturday.

Networks will agree to host services from one or more locations, ensuring equitable access for the defined population. The location can be consistent throughout the week or different on each day. Whilst this is for local determination, Networks are strongly encouraged to consider patient transport links and patient demographics.

Networks should continue to plan their rota on the understanding that where Extended Hours provision falls on a bank holiday, Networks 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 two weeks (point 4.6.5 of the core specification) either before or after the bank holiday in question. Should it not be possible to do this, a financial adjustment will be applied.

Patients must be notified of any changes as per point 4.6.6 in the core specification.

Networks must have an arrangement in place which allows patients to access the Extended Hours 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

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

As per point 4.6.3 of the core specification not every clinician or practice will be required to deliver a particular share of appointments. 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 Network and patients should have the ability to see a GP if clinically required.

Where different staffing groups are being used for Extended Hours, the Network 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, Networks should provide a route for patients to access appointments which can be booked on the same day, which includes at the weekend. Networks 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 Extended Hours 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 2019/20 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 Network should be given the option to book into Extended Hours 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 Network 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 Networks 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, as at January 2019 to deliver the Extended Hours – Supplementary Network Specification on an individual basis, through the PCIS financial allocations as set out in schedule 3A of this contract.

Practices will have their £6 allocation offset against the £1.099 received as part of the Network DES payment in 2019/20 for delivering the core Extended Hours specification. This means the practice will receive £4.901 under the PCIS and £1.099 under the Network DES, both of which are paid by the CCG.

The Network will be accountable for ensuring the requirements of Extended Hours are continuously delivered. Should an unplanned shortfall in provision occur, the CCG must be notified by the Network. This should take place before the event occurring, where possible.

The CCG will seek assurance that the Network 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 Network that provisions are in place to prevent the possibility of the situation re-occurring.

The CCG would want to support the Network 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.

Networks have the option to sub-contract the delivery of Extended Hours and must follow the core Network DES requirements in respect of sub-contracting.

Where a practice has not signed up to the PCIS or chooses to leave the PCIS within a Network, the practice will not receive the funding for the funding associated with this specification (Extended Hours - Supplementary Network Service). The funding will subsequently be allocated to the provider in that Network 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 full Extended Hours 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 reporting practice in the Network as required under point 3.2.1 in this specification will be required to submit on a quarterly basis the requested data within the CCG quarterly monitoring template on behalf of the Network. This will reflect the work completed by the Network in the quarter.

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/Network 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 Extended Hours 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

As per the NHS Standard Contract Particulars

Population health management initiatives focused on Cardiovascular Disease (CVD) prevention and early detection

This Service confirms the commitment of Somerset Clinical Commissioning Group (the Commissioner) to fund General Practice Providers for the provision of Population health management initiatives focused on Cardiovascular Disease (CVD) prevention and early detection.

The enhanced provision should be delivered in line with national guidance and best practice:

https://www.healthcheck.nhs.uk/commissioners-and-providers/governance/national-cvd-prevention-system-leadership-forum/

https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/

https://www.nice.org.uk/guidance/ph25

Background

CVD is the number one cause of death globally, with an estimated 17.7 million people having died from CVD conditions in 2015, representing 31% of all global deaths. CVD deaths still account for 1 in 4 of all deaths in England - the equivalent to 1 death every 4 minutes.

Poor cardiovascular health can cause heart attacks, strokes, heart failure, chronic kidney disease, peripheral arterial disease and the onset of vascular dementia.

The NHS Health Check is a national programme offering a health check-up for adults in England aged 40 to 74 every five years. One of the largest prevention programmes of its type in the world, the programme is designed to help prevent and detect early signs of heart disease, kidney disease, Type 2 diabetes and dementia.

Description

The current national ambition is for 75 percent of 40- to 74-year-olds to have received a CVD risk check and cholesterol measurement.

In order to meet this ambition, GP practice will:

1. Follow up Health Checks outcomes if of concern when supplied by Health Check contracted provider
2. Seek to implement an opportunistic reminder system to measure blood pressure (BP) if patient has not had BP taken in last five years
3. Undertake opportunistic pulse checks for over 60s to detect undiagnosed atrial fibrillation (AF)

Acceptance Criteria

Patients on the GP register aged between 40 – 74 years of age.

Electronic Ear Irrigation

This Service confirms the commitment of Somerset Clinical Commissioning Group (the Commissioner) to fund General Practice Providers for the provision of electronic ear irrigation to adults.

The service should be provided in line with Somerset CCGs current Ear Wax Removal Criteria Based Access (CBA) Policy https://www.somersetccg.nhs.uk/about-us/how-we-do-things/individual-funding-requests/ and NICE Guidance 98 Hearing Loss in adults: assessment and management https://www.nice.org.uk/guidance/NG98

Background

Ear wax may be wet or dry and is a normal physiological substance that protects the ear canal. It has several functions including aiding removal of keratin from the ear canal (earwax naturally migrates out of the ear, aided by the movement of the jaw.) It cleans, lubricates, and protects the lining of the ear canal, trapping dirt and repelling water.

Excessive build-up of ear wax can develop in some people, the wax can become impacted. Although wax frequently obscures the view of the tympanic membrane it does not usually cause hearing impairment.

It is only when the wax is impacted into the deeper canal against the tympanic membrane (often caused by attempts to clean out the ear with a cotton bud, or by the repeated insertion of a hearing aid mould) that it is likely to cause a hearing impairment.

When should ear wax be removed:

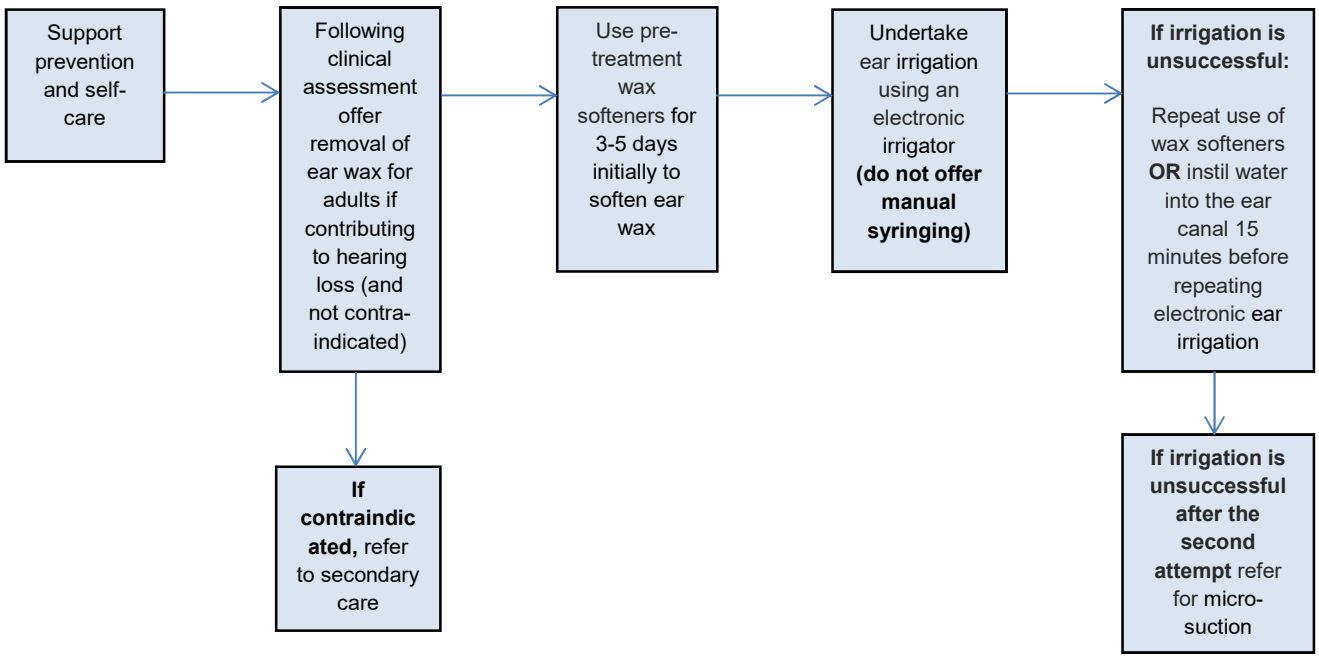
1. If earwax is totally occluding the ear canal and any of the following are present:
   - Hearing loss
   - Earache
   - Tinnitus
   - Vertigo
   - Cough suspected to be due to earwax

2. If the tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis.

3. If the person wears a hearing aid, wax is present and an impression needs to be taken of the ear canal for a mould, or if wax is causing the hearing aid to whistle.

4. **Note:** Do not offer adults manual syringing to remove ear wax as per the above referenced NICE Guidance 98 paragraph 1.2.2.

Pathway



Acceptance Criteria

This service can be accessed by patients registered with a Somerset GP practice aged over 18 years of age.

Contraindications

Do not use manual syringing (it is a requirement of this service specification that ear wax irrigation is undertaken using an electronic irrigator).

Do not use ear irrigation to remove wax for people with:

- A history of any previous problem with irrigation (pain, perforation, severe vertigo).
- Current perforation of the tympanic membrane.
- A history of perforation of the tympanic membrane in the last 12 months. Not all experts would agree with this — some would advise that any history of a perforation at any time, even one that has been surgically repaired, is a contraindication to irrigation because a healed perforation may have a thin area which would be more prone to re-perforation.
- Grommets in place.
- A history of any ear surgery (except extruded grommets within the last 18 months, with subsequent discharge from an Ear Nose and Throat department).
- A mucus discharge from the ear (which may indicate an undiagnosed perforation) within the past 12 months.
- A history of a middle ear infection in the previous 6 weeks.
- Cleft palate, whether repaired or not.
- Acute otitis externa with an oedematous ear canal and painful pinna.
- Presence of a foreign body, including vegetable matter, in the ear. Hygroscopic matter, such as peas or lentils, will expand on contact with water making removal more difficult.
- Hearing in only one ear if it is the ear to be treated, as there is a remote chance that irrigation could cause permanent deafness

When to refer

If two attempts at electronic ear irrigation in primary care have been unsuccessful the patient should be referred for microsuction in line with Somerset CCGs current Ear Wax Removal CBA Policy.

Physical Health Checks for people living with Serious Mental Illness (SMI)

This Service confirms the commitment of Somerset Clinical Commissioning Group (the Commissioner) to fund General Practice Providers for the provision of Physical Health Checks for people living with SMI.

The service should be informed by the following guidance:

https://www.england.nhs.uk/mental-health/resources/smi/, https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/ and https://www.nice.org.uk/guidance/cg178/resources

Background

In the Five Year Forward View for Mental Health, NHS England committed to leading work to ensure that by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

This enhanced provision aims to better address physical health risks and needs within primary care. The national target for CCGs is to ensure that 60% of patients with a SMI diagnosis have had an appropriate physical health check by the end of 2018/19.

Recognising that this is a new requirement, during 2019/20 practices will adopt an ambition to provide such a person-centred consultation and such interventions as are relevant and clinically justified to 50% of the patients on their SMI register during 2019/20. Where practices have an unusually high prevalence, it is acceptable for practices to aim for 50% of the average Somerset prevalence, in discussion with the CCG. Current manual data extraction processes shall remain in place until such time as it is replaced by an automated process.

The following data will be collected as part of the manual extraction process. Results for requests starting with 'S' will show the relevant counts. Results for requests starting 'B' should be retained by the practice due to General Data Protection Regulations:

SINIT/BINIT:	Patients who have experienced SMI-type events during the above period.
SLITH/BLITH:	Patients on lithium (lithium prescribed in last 6 months of period and no lithium-stopped code present)
SREMF/BREMF:	Patients with a full remission mental health code events in the above period, if any (excluded from totals)
SREMP/BREMP:	Patients with partial remission MH code events, if any (for info only)
SINITL:	(Intermediate working subset)
SBASE/BBASE:	Baseline set of MH patients for subsequent steps (MHINIT OR MHLITH but excluding MHREMF)
SBMI/BBMI:	Patients in base list who have had a BMI check in the above period.
SBP1/SBP2:	(Intermediate working subsets).
SBP:	Patients in base list who have had a blood pressure check in the above period.
SPUL:	Patients in base list with pulse rate taken
SBPP/BBPP:	Patients with both blood pressure and pulse rate taken
SLIPC/BLIPC:	Base list SMI pts who have had a cholesterol reading or QRISK measurement in the above period.
SGLUC/BGLUC:	Base list SMI pts with blood glucose recordings or HBA1c measurements in the above period
SALCO/BALCO:	Base list SMI pts with alcohol status recorded in the above period
SSMOK/BSMOK:	Base list SMI pts with a smoking status recorded in the above period.
SNUT/BNUT:	Base list SMI pts with healthy eating
SPHYS/BPHYS:	Base list SMI pts with physical activity level assessment
SNUTP/BNUTP:	Base list SMI pts with both healthy eating and physical activity level assessment
SILL/BILL:	Base list SMI pts with illicit substances assessment
SMEDR/BMEDR:	Base list SMI pts with medicine reconciliation/review
SFAT:	Base list SMI pts with BMI>=25
SFATF/BFATF:	Base list SMI pts with BMI>=25 who have had weight mgmt. interventions

SSYS/SDIA/SBPHI:	Base list SMI pts with high BP - subset
SBPHIF/BBPHIF:	Base list SMI pts with high BP who have had follow-up interventions
SGLUC:	Base list SMI pts who are prediabetic - subset
SGLUCF/BGLUCF:	Base list SMI pts who are prediabetic who have had follow-up interventions
SALCO:	Base list SMI pts who are alcohol misusers – subset
SALCOF/BALCOF:	Base list SMI pts who are alcohol misusers who have had follow-up interventions
SSMOK:	Base list SMI pts who smoke - subset
SSMOKF/BSMOKF:	Base list SMI pts who smoke who have been referred to stop smoking services
SSABU:	Base list SMI pts who are substance misusers – subset
SSABUF/BSABUF:	Base list SMI pts who are substance misusers who were referred to substance misuse svcs
SMASS/BMASS:	Base list SMI pts who have had weight mgmt interventions
SFCYT/BFCYT:	SMI female pts 25-64 for whom cervical screening would be relevant
SFCYT2/BFCYT2:	SMI cervical-relevant pts who have been screened in last 5 years
SFBOO/BFBOO:	SMI female pts 50-70 for whom breast cancer screening would be relevant
SFBOO2/BFBOO2:	SMI breast cancer screening-relevant pts who have been screened in last 3 years
SBOWL/BBOWL:	SMI pts 50-70 for whom bowel cancer screening would be relevant
SBOWL2/BBOWL2:	SMI bowel-cancer-relevant pts who have been screened in last 2 years

Description

Physical Health checks should comply with the twelve national requirements, where clinically relevant, appropriate, and suitable to the preferences and priorities of the patient themselves. These are detailed within the following NHS England technical guidance https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/05/FINAL-Technical-definition-2019-20-physical-health-SMI-data-collection-16.04.2019-correction.pdf and summarised below;

The core physical health check for 2019/20 (6 elements)

A person is counted as having had the core physical health check if they have received all of the 6 component parts listed at any point in the 12 months to the end of the reporting period:

1. A measurement of weight (BMI or BMI + Waist circumference)
2. A blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate)
3. A blood lipid including cholesterol test (cholesterol measurement or QRISK® measurement)*
4. A blood glucose test (blood glucose or HbA1c measurement)*
5. An assessment of alcohol consumption
6. An assessment of smoking status

*where relevant and clinically justified

The indicator also specifies national reporting in 2019/20 on the following supporting measures:

Nationally monitored 2019/20 additional elements of a comprehensive health assessment (6 elements)

7. An assessment of nutritional status, diet and level of physical activity (nutrition/diet status + physical activity/exercise) status
8. An assessment of use of illicit substance/non prescribed drugs (substance misuse status)
9. Medicines reconciliation or review
10. Follow-up interventions where indicated by the physical health check
11. Access to national screening programmes (breast cancer, bowel cancer, cervical cancer)
12. To address the elevated rates of sexual and oral health complications observed across the SMI cohort, a general physical health enquiry, including sexual health and oral health assessment, should be provided as part of comprehensive physical healthcare in line with commissioning guidance, clinical evidence and consensus

Current use of data collection:

Data against nationally monitored additional elements will not form part of the core standard.

NHS England commissioning guidance emphasises that all elements should be provided for people with SMI as part of a comprehensive assessment, in line with clinical evidence and consensus. Points 3 and 4 of the core physical health check shall be provided where relevant and clinically justified. CCGs are required to submit data on all elements to aid understanding of service delivery and facilitate local benchmarking.

In addition to the elements outlined above, to address the elevated rates of sexual and oral health complications observed in people with SMI, a general physical health enquiry, including sexual health and oral health assessment should be provided as part of comprehensive physical health assessment in line with commissioning guidance, clinical evidence and consensus. However, national reporting on the delivery of sexual health and oral health checks is not required for the purposes of this collection.

Acceptance and Exclusion Criteria:

Acceptance

Primary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. Patients with SMI who are not in contact with secondary mental health services, including both:
    - those whose care has always been solely in primary care, and
    - those who have been discharged from secondary care back to primary care; and

2. Patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised.

All adults on the SMI register should receive the full list of recommended physical health assessments as part of a routine check at least annually (NICE clinical guidelines CG185 and CG178).

Assessments should be undertaken more frequently as required:

a. For the purposes of monitoring specific antipsychotics or other medications (local policies and procedures may apply according to Somerset CCG Prescribing and Medicines Management Group); **OR**
b. Where a significant physical illness or risk of a physical illness has already been identified (NICE clinical guideline CG120)

Exclusion

Secondary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. Patients with SMI under care of mental health team for less than 12 months and / or whose condition has not yet stabilised; **OR**
2. Inpatients

Appendix D

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 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 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 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.

Emergency Admissions 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.

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.
- 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.

Single Point of Access (SPOA) is an Integrated Urgent Care service a single point of access for health and social care professionals to access advice and guidance in relation to alternative services/pathways. Ambulance Crews and Care Home Staff have immediate access to this service.

Rapid Response service aims to reduce A&E admissions and LOS related to frailty (falls and confusion) through Rapid Response which is a multi-agency service supporting GPs and ambulance crews with a credible alternative to A&E.

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 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[4])
    - 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.

Acceptance and Exclusion Criteria

'AT RISK' GROUPS FOR HEPATITIS B VACCINATION

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

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.