

Our Ref: 67316

16 December 2020

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Re: Freedom of Information Request

Please find below the response to your recent Freedom of Information request regarding Optional GP services in 2020/21 within NHS Southport and Formby CCG.

Request/Response:

1. A list of all the optional services and schemes commissioned by the CCG that your member GP practices could choose to participate in, in 2020/21 - such as Local Enhanced Services, Local Improvement Schemes (LISs) and Prescribing Incentive/Improvement schemes^[1]
2. The value of each, ie, the total amount that can be earned for participation in the service/scheme per patient or per procedure
3. The total budget for each for 2020/21
4. The period in which this data for each scheme is valid, ie, the start and end dates of its specification

[For questions 1-4 please see appendix 1.](#)

5. The specification for each of these services/schemes

[Please see appendix 2.](#)

6. Additionally, have any of these schemes been paused, or are any subject to being paused as a result of either Covid-19 or the new Covid vaccine programme?

[All schemes were paused between April 2020 – July 2020 as a result of Covid-19.](#)

Appendix 1

CCG		Service/scheme (e.g. Anticoagulation)	Value (£)	Value description (e.g. per patient, per procedure)	Additional payments if applicable (e.g. annual retainer, one-off payment for signing up, etc.)	Budget (£), 2020/21	Valid from (DD/MM/YYYY)	Valid until (DD/MM/YYYY)
Southport and Formby CCG	Part 1	Clinical	As per weightings	See previous answer	N/A	Up to a maximum of £112.29 per weighted patient. Overall CCG funding for Part 1 Schemes is:	01/04/2020	31/03/2020
Southport and Formby CCG	Part 1	Public Health	As per weightings	See previous answer	N/A	Up to a maximum of £112.29 per weighted patient. Overall CCG funding for Part 1 Schemes is:	01/04/2020	31/03/2020
Southport and Formby CCG	Part 1	Medicines Management	As per weightings	See previous answer	N/A	Up to a maximum of £112.29 per weighted patient. Overall CCG funding for Part 1 Schemes is:	01/04/2020	31/03/2020
Southport and Formby CCG	Part 1	Administration	As per weightings	See previous answer	N/A	Up to a maximum of £112.29 per weighted patient. Overall CCG funding for Part 1 Schemes is:	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Phlebotomy	£2.61 per venipuncture (includes agreed 1% uplift)	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,369	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Primary Care Prescribing	Level 1 £1352.78 fixed annual fee, based on average list size of 5,000 (including agreed 1% uplift) Level 2 £176.89 per patient per annum (including agreed 1% uplift)	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,370	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Drug Administration	£31.22 per injection (including agreed 1% uplift)	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,371	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Frailty/Falls (March 2020 - Sept 2020)	£41.21 per generated/reviewed care plan (including agreed 1% uplift)	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,372	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Covert Drug Administration	£255.03 initial £204.02 review	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,373	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Dementia	£60.60 Per review undertaken in primary care	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,374	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Serious Mental Illness	£80.80 per completed physical health check undertaken in primary care	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,375	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Safeguarding Children and Adults at Risk	TBC following judicial review	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,376	01/04/2020	31/03/2020
Southport and Formby CCG	Part 2	Root Casue Analysis	£240.00 per RCA and subsequent actions	See previous answer	N/A	Overall CCG funding for Part 2 Schemes is: £638,377	01/04/2020	31/03/2020
Southport and Formby CCG	Part 3	Syrian Resettlement Programme	£582.94 retainer per 5000 patients per year paid up front £113.56 per patient on initial registration	See previous answer	N/A	£16,073* *excluding Syrian VPR scheme monies. This scheme is only available, dependent on where families are	01/04/2020	31/03/2020
Southport and Formby CCG	Part 3	Travellers	£582.94 retainer per 5000 patients per year paid up front £113.56 per patient register per year paid quarterly in arrears	See previous answer	N/A	£16,073* *excluding Syrian VPR scheme monies. This scheme is only available, dependent on where families are housed in Sefton.	01/04/2020	31/03/2020



**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

**Local Quality Contract for General Practice
NHS South Sefton CCG and NHS Southport and Formby CCG**

Part 1 - Mandatory

The LQC has seen several years of funding into general practice to align incentives to improve health outcomes, provide value for money, and enhance quality of care. This has provided a wealth of information and experience to enable the development of a revised Part 1 framework.

Part 1 will now encompass a set of ‘Good Practice Standards’ some of which will be familiar to practices from previous LQC schemes that will not be monitored or have funding attached; however practices will be required to be compliant with these standards in order to be eligible to deliver the Part 1 KPI schemes.

LQC Good Practice standards

Cancer Screening

- Eligible patients for each cancer screening programme (Bowel, Breast and Cervical) who have not accessed screening within the recommended time frame, will be identified by a reminder alert on EMIS to enable practices to encourage participation;
- Practices are required to actively promote patient engagement with the national bowel cancer screening programme with the aim that all eligible people aged 60–74 have participated in bowel cancer screening in the last 2.5 years;
- Practices should familiarise themselves with the new faecal-immunochemical test (FIT) bowel screening process, which will be introduced from April 2019. See <https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/faecal-immunochemical-test-fit>

Suspected Cancer

- The practice has a system to ensure that where a decision is made to urgently refer a patient with suspected cancer, the referral is made on eRS with an appointment booked before the patient leaves the practice wherever possible (it is recognised that appointments are not always available to book on eRS, whereupon they should be ‘deferred to provider’)

with the exception of cancer services using a RAS (Referral Assessment Service) model on eRS;

- The practice should refer using the standardised forms based on NICE Guidance for the Recognition and Referral of Suspected Cancer 2015 which are available within EMIS Web;
- All fields within the referral forms should be completed and pre-requisites such as relevant blood tests e.g. GFR, PSA or Ca125 undertaken. It is important to recognise that several cancer services now use the RAS (Referral Assessment Service) function on eRS to triage and direct the patient to the most appropriate diagnostic pre-clinic or to a clinic appointment;
- Ensure up to date contact details, especially mobile telephone numbers for patients undergoing tests, investigations and referrals, because patients are likely to be contacted by telephone to arrange hospital appointments quickly;
- A system to document suspected cancer referrals and primary care-initiated investigations and ensure that patients attend appointments and that results are received;
- A system to ensure that all results are acted on including following up tests/ investigations ordered by locums and doctors absent from the practice.

Learning Disability Health Checks

□ All practices will be offered the opportunity to sign up to deliver the Learning Disability DES at practice level, or via South Sefton Federation who can undertake the DES on behalf of the practice. However, all practices must choose one of the two options to ensure 100% population coverage being offered a health check.

Relationships with Health Care Professionals

- The Practice will have robust communication mechanisms in place, including team meetings, with involvement of attached staff;
- Procedures for sharing and recording information about patients between members of the extended primary healthcare team are agreed, transparent and made known to staff;
- Practices will engage with practice manager, practice nurse, PLT and other CCG wide member events.

Transfer of Care

The following principles will be used to support decision making:

- The clinician who wishes to prescribe medication for the patient should arrange all appropriate tests prior to initiating the treatment. They are also responsible for communicating the rationale for treatment and arranging any follow-up requirements that might be necessary for the patient;
- The clinician who initiates a medication should prescribe sufficient medication to meet the service user's immediate clinical needs until the service user's GP receives the relevant clinic letter and can prescribe accordingly¹. Additionally, with regard to transfer and discharge from acute services the provider shall give to the service user provision of 14 days' supply of the service user's medicines as taken on discharge.² The clinician who arranges a test for a patient is responsible for ensuring that the results are looked at and

¹ Local Transfer and Discharge Policy, Service condition 11.9 and Service condition 11.10

² Generic Policy for 2019/20 contracts- Transfer And Discharge From Care Obligations

any action required is taken. This may be delegated to another provider but only with the consent/ agreement of that provider;

- Clinicians should not recommend treatments for patients that need to be delivered by another service, unless they are sure the other service is prepared to provide the treatment;
- Clinicians who are not trained to prescribe should discuss any requests for medication with a prescriber and document who that prescriber is;
- Secondary care consultants are usually asked to address a specific issue for a patient. The CCG understands that sometimes this issue may require onward referral to another specialist, and in such cases, approve that referral to be made. However, should an unrelated and non-urgent issue arise in the course of the consultation the CCG would prefer it be referred back to the GP for assessment in primary care rather than referred immediately for a secondary care opinion.

Access

- A named GP to be available (on call) for the practice 5 mornings and 5 afternoons per week (core hours) within a reasonable distance of the practice (i.e. 30 minutes travelling time);
- Appropriate digital appointments should be made available for patients;
- The practice must remain open ³ / accessible during COVID-19 to patients throughout the day, except when the practice has a practice training session and this is normally limited to 1 session per month;
- Practices to confirm that a procedure is in place to access and action information received via the practice NHS net account on a daily basis;
- Practices are encouraged to plan holistic reviews; i.e. where a patient has one or more chronic conditions requiring annual review, practices are encouraged to consider undertaking one annual review covering all conditions rather than reviews for each individual condition;
- Practices to advertise the services of the 7 day access hub to patients including notification on practice websites;
- Practices to ensure all contacts with patients are recorded appropriately;
- Practices to ensure that workforce information entered onto the primary care webtool (or equivalent to be confirmed) accurately reflects the practice workforce, and is quality assured by the practice at the end of each quarter. Workforce may be a topic for network consideration - accurate data will be crucial to assist in workforce planning;
- Practices to promote online services;
- Practices to support the development of a GP practice digital improvement programme led by Informatics Merseyside.

Use of Resources

- In order to utilise community services as an alternative to secondary care, practices to ensure that all staff employed including locums are aware of community based services and adhere to referral pathways (as and when agreed with Sefton LMC);
- Feedback on any issues identified with current community services/ waiting times/ referral processes or any other barrier to usage via the locality (or PCN).

Activation of Data Sharing Agreements – Comply or Explain

□ Practices to activate data sharing agreements that have received local relevant approval (e.g. iMerseyside/ LMC) within 4 weeks of issue, or escalate any issues within that 4 week period. Escalate to ccg.sefton@nhs.net

Estates – Comply or Explain

□ Practices to comply with NHSE/CCG requests for completion of CRM1 rent review forms, within 4 weeks of the date of request, or escalate any issues within that 4 week period. Escalate to ccg.sefton@nhs.net

GP Patient Survey Results

□ Practices to discuss 2020 GP Patient Survey results at a locality meeting, in order to share best practice.

Data Provision Notice

3

‘Open’ would mean that the practice doors are open, and practice phone lines are open, (no recorded messages to ring another number). A ‘day’ would be contracted hours 8.00am – 6.30pm, unless anyone has a contract for core hours with NHS England that states a different opening time’

□ All practices are required to participate on CQRS in order to be included in the data collection. Practices will be issued an invitation via CQRS in February 2020 which they must accept.

Update Mobile Contact Details

- Practice to utilise various methods of communication including but not limited to telephone/check in screens/e-consult/online booking screens to collect up to date mobile contact details for patients 18+ (excludes care home patients).

Duty of Co-operation

- Duty of Co-operation (7.13 GMS Contract) will apply to the LQC.

Part 1 KPI Schemes

All Part 1 funding will be associated with KPI schemes and split into 4 areas: Clinical, Public Health, Medicines Management, and Administration.

Part 1 schemes have been designed so that progress and achievement can be extracted via Enterprise searches (where possible), and other data sources which will populate an LQC

dashboard. This will reduce the burden on practices to submit information, whilst allowing practices to monitor their own progress.

Enterprise searches (where possible) will be extracted monthly from the contract start date. Practices will be able to view progress via the LQC dashboard which will be launched in quarter 3 of 2020.

Thresholds:

Schemes that have KPI thresholds of 40% - 80% will work on a sliding scale in the following way:

<40% achievement	0 funding
= or > 40%	50% funding
= or > 50%	60% funding
= or > 60%	70% funding
= or > 70%	80% funding
= or > 80%	100% funding

South Sefton Clinical Commissioning Group Southport and Formby Clinical Commissioning Group

Service Specification No.	Part 1
Service	Clinical
Commissioner Lead	
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual


1. Population Needs																
1.1	National/local context and evidence base															
2. Outcomes																
2.1	<u>NHS Outcomes Framework Domains & Indicators</u>															
	<table border="1"> <tr> <td>Domain 1</td> <td>Preventing people from dying prematurely</td> <td>x</td> </tr> <tr> <td>Domain 2</td> <td>Enhancing quality of life for people with long-term x conditions</td> <td>x</td> </tr> <tr> <td>Domain 3</td> <td>Helping people to recover from episodes of ill-health or following injury</td> <td>x</td> </tr> <tr> <td>Domain 4</td> <td>Ensuring people have a positive experience of care</td> <td>x</td> </tr> <tr> <td>Domain 5</td> <td>Treating and caring for people in safe environment and protecting them from avoidable harm</td> <td>x</td> </tr> </table>	Domain 1	Preventing people from dying prematurely	x	Domain 2	Enhancing quality of life for people with long-term x conditions	x	Domain 3	Helping people to recover from episodes of ill-health or following injury	x	Domain 4	Ensuring people have a positive experience of care	x	Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x
Domain 1	Preventing people from dying prematurely	x														
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Domain 3	Helping people to recover from episodes of ill-health or following injury	x														
Domain 4	Ensuring people have a positive experience of care	x														
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x														
2.2	Local defined outcomes															
	<ul style="list-style-type: none"> • Validation of COPD registers • To identify patients at the end of life and develop personalised supportive care plans • To identify patients on CKD registers who are appropriate for statin therapy in accordance with NICE guidelines 															
3. Scope																

3.1 Aims and objectives

- Validation of the COPD diagnosis for all patients coded as having COPD, plus code suitability for Hospital at Home Service
- To proactively identify patients who are within the last 12 months of life, and offer a personalised supportive care plan shared with the patient/ carer, NWAS and OOH
- To ensure those patients with CKD stage 3 who are appropriate for statin therapy are offered it

3.2 Service description/ care pathway

COPD

Indicator	Weighting	Achievement Threshold
01 The % of patients on the COPD register who have been reviewed remotely using the additional questionnaire since 1 st April 2019.  Appendix 1 - Clinical History Questionnaire.d	20%	40% - 80% sliding scale
02 The % of patients on the COPD register coded and highlighted via a patient alert as suitable for Hospital at Home Service provided by CRT (patients where diagnosis has been validated with post bronchodilator spirometry)	10%	40% - 80% sliding scale

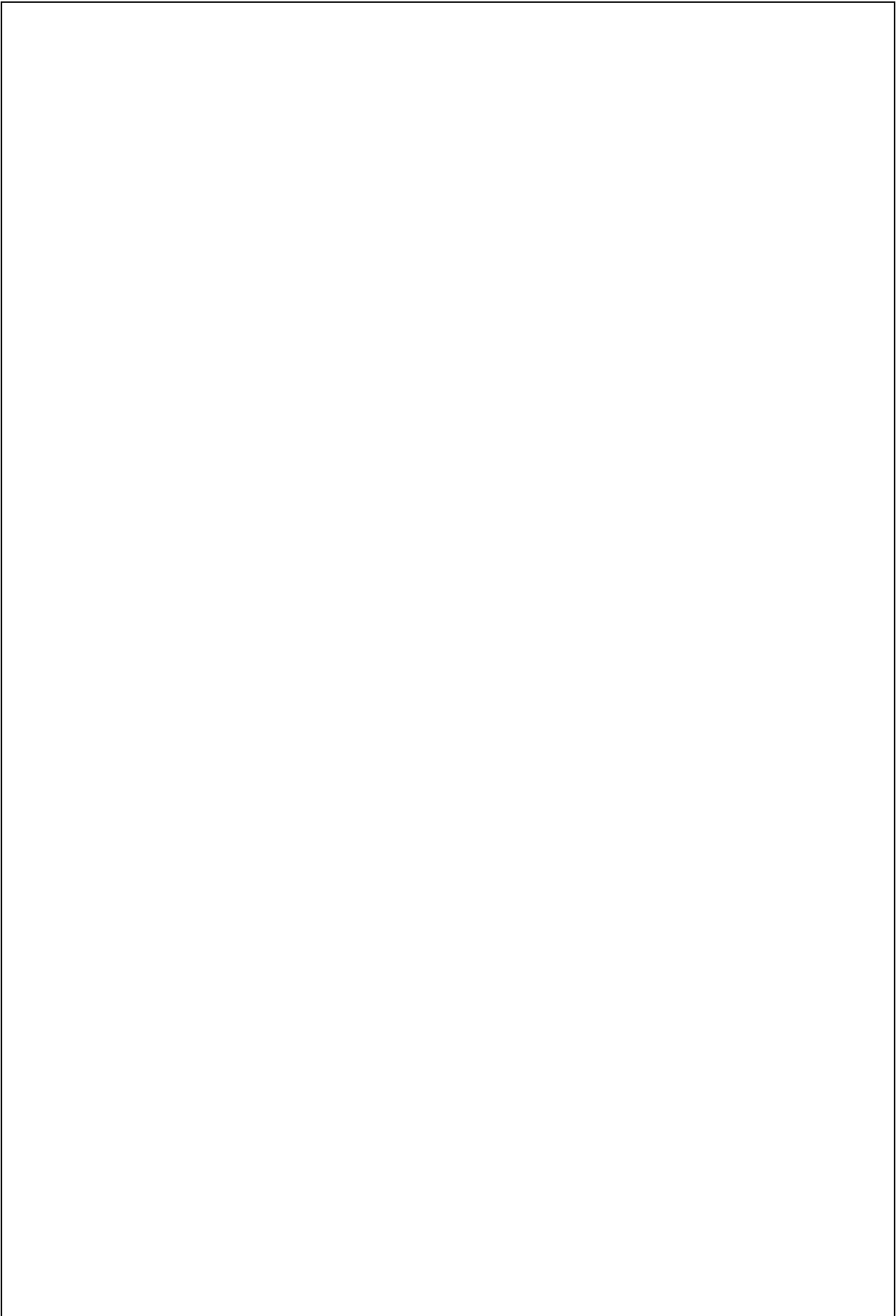
Referral Process for Suspected COPD Exacerbation in to 2 Hour Response Hospital at Home Service



Referral Process for Suspected COPD Exa

End of Life

Indicator	Weighting	Achievement Threshold
03 The practice proactively identifies patients 18+ in the last 12 months of life and codes appropriately. Each identified individual is added to the practice supportive palliative care register.	10%	N/A
04 The % of patients 18+ identified as being within the last 12 months of life with a personalised supportive care plan (PSCP) in place, the existence of which is shared with the patient/ carer, NWAS (through ERISS) and OOHs (Special Patient Note) in the preceding 12 months. [EMBED AGREED PSCP]	0	<30%
	21%	30% - 50%
	30%	>50%



CKD

Indicator	Weighting	Achievement Threshold
05 Number of patients on CKD register (stage 3 and above) aged 18 and over	N/A	N/A
06 The number of patients on the CKD register (stage 3 and above) aged 18 and over who are prescribed a statin, as per NICE guidelines	N/A	N/A
07 The % of patients on the CKD register (stage 3 and above) who are have been assessed for statin therapy, and as a result either prescribed a statin (within the past 3 months) or exception coded (within the past 12 months)	30%	30% - 70% sliding scale
		(See below)

<30% achievement	0 funding
= or > 30%	50% funding
= or > 40%	60% funding
= or > 50%	70% funding
= or > 60%	80% funding
= or > 70%	100% funding

3.3 Population covered

All patients registered with an NHS South Sefton CCG or NHS Southport and Formby CCG GP practice.

3.4 Any acceptance and exclusion criteria and thresholds

As defined in each scheme.

3.5 Interdependence with other services/providers

- Community Trusts
- NWAS
- OOH
- Primary Care Networks / Localities

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

South Sefton Clinical Commissioning Group Southport and Formby Clinical Commissioning Group

Service Specification No.	Part 1
Service	Public Health
Commissioner Lead	
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs

1.1 National/local context and evidence base

Public Health interventions aim to protect and improve the health of the population and at the same time as target those with the poorest health to improve their health outcomes.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term x conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

- Improved health outcomes for the population
- Reduced health inequalities
- Reduced variation

3. Scope

3.1 Aims and objectives of service

- To identify a Cancer Champion in each GP Practice
- To offer an holistic needs assessment to newly diagnosed cancer patients
- To actively promote patient engagement with the national cancer screening programmes
- To introduce a prioritisation programme for influenza and pneumococcal vaccination, improve uptake in identified vaccination and immunisations and reduce practice variation
- Frailty – to inform future commissioning
- Increase the number of SMI physical health checks

3.2 Service description/care pathway

Cancer

Indicator	Weighting	Achievement Threshold
<p>08</p> <p>The Practice identifies a named practice designated Cancer Champion (clinical or non-clinical role) who will manage the practices knowledge and resource repository for cancer and act as a coordinator (for indicators 09-10).</p> <p>Cancer Champion to share the Practice safety netting policy for 2 week referrals by end of the second quarter for review by the CCG Clinical Cancer Lead who will provide feedback if necessary. Collaboration of practices to develop a safety netting policy would be encouraged.</p>	N/A	<p>Named practice Cancer Champion identified on sign up to the LQC</p> <p>Cancer Champion to share policy by 30.09.2020</p>
<p>09</p> <p>The % of patients in the last 6 months for each cancer screening programme (Bowel, Breast and Cervical) who have not accessed screening within the recommended time frame, who are contacted via an appropriate method for the individual patient by the practice within 42 days of the practice receiving the non-responder notification</p>	5%	40% - 80% sliding scale Bowel
	5%	40% - 80% sliding scale Breast
	5%	40% - 80 sliding scale Cervical
<p>10</p> <p>The % of patients referred under 2 week rule in the previous 12 months who have had information provided by the Practice at the time of referral (e.g. a template letter in Emis)</p>	NA	NA

Vaccinations and Immunisations

As a result of COVID-19, and transmission of infectious diseases to susceptible and vulnerable patients, a greater emphasis is being placed on vaccination programmes for influenza and pneumococcus in Sefton.

A programme of prioritisation will apply to ensure that the most vulnerable groups of patients are vaccinated first on receipt of vaccinations from suppliers.

In order to achieve this, there will be a requirement to work in conjunction with local care homes, nursing teams, and local pharmacies to ensure that those prioritised are supported, through minimised contact, thus ensuring that 'every contact counts'.

The LMC are in engagement with the LPC to support delivery.

Practices are also asked to consider working in collaboration to aid resilience to deliver this programme, and development of a plan.

There is an intention to expand the number of vaccinators available across Sefton, and practices are asked to consider staff that could participate in training and contribute towards delivery.

Practices are required to raise an alert to the CCG if there is disruption of supplies which will affect delivery/timescales. This needs to be done when the disruption occurs.

Should there be a second wave of COVID-19, this is seen as an essential programme to continue.

Indicator	Weighting	Achievement Threshold
11 The Practice identifies a named practice designated vaccination co-ordinator (clinical or non- clinical role) who will manage indicators 12 - 20.	N/A	Named practice vaccination co-ordinator identified on sign up to the LQC
12 The % of all preschool children aged 2 and 3 years old by 31 st March 2021 who receive the flu vaccination by 31 st March 2021. Achievement via ImmForm data (40 - 60% aspiration)	0	<25%
	7%	25% - 50%
	10%	>50%
13 The % of all women coded as pregnant during flu season who received the flu vaccination by 31 st March 2021. Achievement via ImmForm data (55% aspiration)	0	<25%
	7%	25% - 55%
	10%	>55%
14 The % of housebound patients (in any setting, i.e. care home or own home) who received a flu vaccination between 1 st September 2020 and 31 st October 2020 (practices to inform the CCG if delivery of flu vaccinations is not received before the start of October) Patients who are eligible for pneumococcal vaccination should be offered this at the same time as a flu vaccine where practicable. This target/ search excludes patients on the extremely clinically vulnerable list (social shielding) who are not ordinarily housebound	0	<25%
	7%	25% - 55%
	12%	56% – 74%
	19%	>75%
15 Patients on the extremely clinically vulnerable list (social shielding) and patients identified as carers are included in the prioritisation programme for flu vaccination on receipt of the first vaccinations from suppliers; i.e. to be vaccinated by 31 st October 2020. Patients who are eligible for pneumococcal vaccination should be offered this at the same time as flu where practicable.	6%	No threshold will apply but practices will be required to demonstrate that these group have been prioritised by submitting the number of patients in this cohort and the number who have been vaccinated by 31 st October 2020 This submission will be required by November 15 th 2020

<p>16 The practice provides a PSD for each nursing home resident – (where the nursing home have indicated that they can vaccinate their own residents) for the administration of an influenza and pneumococcal vaccination (where indicated). There may be other instances when PSDs are required – the Practice will be given advice where this is the case.</p>	NA	NA
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<p>17 The % of eligible patients aged 2 – 64 in at risk group who have received a pneumococcal vaccine by March 2021. Practices should inform the CCG if they are unable to obtain sufficient supplies of the vaccine.</p>	0	<25%
	7%	25% - 50%
	10%	>50%
<p>18 The % of eligible patients aged 65 and over who have received a pneumococcal vaccine by March 2021. Practices should inform the CCG if they are unable to obtain sufficient supplies of the vaccine.</p>	0	<25%
	7%	25% - 75%
	10%	>75%
<p>19. The practice has a plan to deliver a flu/ pneumococcal vaccination model, taking into account COVID-19, social distancing, workforce and making every contact count.</p>	N/A	Confirmation of a plan will be required on sign up to the LQC
<p>20 The % of registered children aged 2 years by March 2021 who have received one dose of MMR. Achievement via ImmForm data. (95% aspiration)</p>	0	< 75%
	7%	75% - 95% (80% payment)
	10%	>95%

An automated collection via ImmForm of vaccination coverage from GP practices will be used. Numbers of patients who decline are collected but this is not reflected in the target achievement.

Frailty (to inform future commissioning regarding falls etc.)

Indicator	Weighting	Achievement Threshold
21 The % of patients identified with severe frailty (as per the GP contract) in the last 12/12	N/A	N/A
22 The % of patients identified with moderate frailty (as per the GP contract) in the last 12/12	N/A	N/A

Severe Mental Illness (SMI) Physical Health Check

Indicator	Weighting	Achievement Threshold
23 The % of patients on the SMI register who have received a physical health check in the previous 12 months	0	<25%
	7%	25% - 50%
	10%	>50%

3.3 Population covered

Patients registered with an NHS South Sefton CCG or NHS Southport and Formby CCG GP practice.

3.4 Any acceptance and exclusion criteria and thresholds

As defined in each scheme

3.5 Interdependence with other services/providers

- Community services
- Independent services
- Schools
- Care/Nursing homes
- RCGP

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

South Sefton Clinical Commissioning Group Southport and Formby Clinical Commissioning Group

Service Specification No.	Part 1
Service	Medicines Management - Prescribing Quality Scheme
Commissioner Lead	Susanne Lynch
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs			
1.1	National/local context and evidence base		
2. Outcomes			
2.1	<u>NHS Outcomes Framework Domains & Indicators</u>		
	Domain 1	Preventing people from dying prematurely	x
	Domain 2	Enhancing quality of life for people with long-term conditions	x
	Domain 3	Helping people to recover from episodes of ill-health or following injury	x
	Domain 4	Ensuring people have a positive experience of care	x
	Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x
2.2	Local defined outcomes		
3. Scope			

3.1 Aims and objectives of service

3.2 Service description/care pathway

Prescribing Quality Scheme (PQS)



2020 2021 MMT LQC
V3.docx

Indicator	Weighting	Achievement Threshold
Optimised Prescribing – 70%		
24 Evidence of engaging with CCG medicines management team (MMT) and agreement to recommendations/ workstreams supported by MMT and CCG clinical leads (20%)	5%	N/A - COVID-19 pandemic
	5%	PQS KPI detail Quarter 2
	5%	PQS KPI detail Quarter 3
	5%	PQS KPI detail Quarter 4
25 GP practice to engage with and support reviews (in line with local supplied guidance) of all patients prescribed direct oral anticoagulants (DOACs) for non-valvular AF by the MMT (25%)	25%	PQS KPI detail Quarter 4 achievement will be based on GP working with MM as per the PQS
26 All regular prescribers to attend a minimum of two quarterly meetings with medicines management (one for part time prescribers) - (10%)	2.5%	N/A - COVID-19 pandemic
	2.5%	PQS KPI detail Quarter 2
	2.5%	PQS KPI detail Quarter 3
	2.5%	PQS KPI detail Quarter 4
27 Self-Care for minor illnesses and/or self-limiting conditions (15%) Demonstrate utilisation within GP practice as per PQS	3.75%	N/A - COVID-19 pandemic
	3.75%	PQS KPI detail Quarter 2
	3.75%	PQS KPI detail Quarter 3

	3.75%	PQS KPI detail Quarter 4
Controlled drugs – 10%		
28 Quarterly review of Controlled Drug (CD) prescribing data focusing on assurance that risks related to CDs are mitigated and that intelligence and learning are shared	2.5%	N/A - COVID-19 pandemic
	2.5%	PQS KPI detail Quarter 2
	2.5%	PQS KPI detail Quarter 3
	2.5%	PQS KPI detail Quarter 4
Antimicrobial Stewardship – 20%		
29 Practice-based audit of the diagnosis/ treatment of infections. Implementation of locally agreed antimicrobial care pathways e.g. care home UTI assessment pathway Discussion at each practice quarterly meeting	5%	N/A - COVID-19 pandemic
	5%	PQS KPI detail Quarter 2
	5%	PQS KPI detail Quarter 3
	5%	PQS KPI detail Quarter 4

2

about antimicrobial resistance (AMR) including sharing of practice prescribing information for total antimicrobial items per STAR PU, items of trimethoprim prescribed for patients >70 years of age and % co-amoxiclav, cephalosporins and quinolones of total antimicrobial items.		
<p>3.3 Population covered</p> <p>Patients registered with an NHS South Sefton CCG or NHS Southport and Formby CCG GP practice</p> <p>3.4 Any acceptance and exclusion criteria and thresholds</p> <p>As per each scheme</p> <p>3.5 Interdependence with other services/providers</p>		
4. Applicable Service Standards		

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Service Specification No.	Part 1
Service	Administration
Commissioner Lead	
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1.1 National/local context and evidence base

1.1 National/local context and evidence base

With the need to improve patient health outcomes and the increasing pressure on health service resources, it is clear that in order to successfully implement the Shaping Sefton Programme, there needs to be consistent service delivery from primary care.

Patients must have access to consistent GP services which are delivered to an agreed level of quality, and ensure that patients are treated outside of hospital whenever appropriate. This is entirely in line with QIPP principles and will be essential to successful implementation of the Shaping Sefton Programme.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term	x conditions
Domain 3	Helping people to recover from episodes of ill-health or	x
	following injury	
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and	x
	protecting them from avoidable harm	

2.2 Local defined outcomes

- Improved health outcomes for the population
- Reduced health inequalities
- Reduced variation
- Primary care system resilience

3. Scope

3.1 Aims and objectives of service

- Utilisation of Apex/Insight
- Supporting carers who have long term conditions
- Development of care home registers and information sharing □ COVID 19 support/resilience

3.2 Service description/care pathway

Access – Apex/ Insight

Indicator	Weighting	Achievement Threshold
30 Monthly registration data (registrations, deductions and allocations)	10%	100% monthly data submissions (from start of contract to March 2021)
31 Practices work with Apex/Insight to align appointments slots with national data collection categories; moving away from using appointment lists. Practices to have a process in place to close home visit appointment slots on Emis following completion of the consultation or configure the appointment slot to switch off automatic default to DNA	15%	One off payment with assurances that they are using appointments more effectively
32 Apex/Insight tool to be utilised by all practices in 20/21 to understand practice activity, workload and workforce. Information will be aggregated and discussed at locality (or network) level	10%	100%

Carers

Indicator	Weighting	Achievement Threshold
33 The number of patients on the practice carers register	N/A	N/A
34 The practice actively identifies patients who are carers and includes them on the practice carers register (methods to be identified by individual practices) - an increase by March 2021 would be expected following work undertaken in indicator 35	NA	N/A
35 The number of patients on the carers register with a long term condition	N/A	N/A

36

The % of patients on the carers register with a long term condition who receive information from the practice regarding support available to manage their long term condition (method and content to be determined by the practice but as a minimum should include access to services and local support groups)

10%

40% – 80% sliding scale

Care Homes

Indicator	Weighting	Achievement Threshold
<p>37 The practice identifies a non-clinical lead for patients living in a care home/supported living (as specified in indicator 38), who will act as a coordinator for indicators 38-41, and a first point of contact for these indicators</p>	N/A	Named non-clinical lead for care homes identified on sign up to the LQC
<p>38 The practice establishes and maintains a register of all patients living in a care home, and a register of all patients living in LD accommodation identified on the NHSE CQC list below.</p> <p>This may require a data cleanse of current addresses used). The register should identify patients split by residential home/ nursing home/supported living</p>	5%	N/A Monthly extraction through Enterprise (where possible)
<p>39 Practice to engage with information sharing arrangements (developed by PCNs) to enable the delivery of a new care home model</p>	5%	Information sharing in place
<p>40 Number of new care home residents identified on a monthly basis</p>	N/A	N/A
<p>41 % of patients new to all care homes and LD accommodation identified on the NHSE CQC list below, who are referred to the meds management coordinator within 7 days of the address change being recorded on the practice clinical system (this could be patients newly registered with the practice, or patients registered with the practice who move into care)</p>	5%	40% - 80% sliding scale

Practices will be kept informed if there are any alternations made to the NHSE CQC list below.

South Sefton Learning Disability Care Homes on NHSE CQC List

Bedford Road – 153 Bedford Road Bootle L20 2DR
 Cambridge Road – 47 Downing Road Bootle L20 9LU
 Cumberland Gate- 44 Cumberland Gate Netherton L30 7PZ
 Expect Limited - 13 Elm Road Seaforth L21 1BJ
 Expect Limited - 1a Gainsborough Avenue Maghull L31 7AT
 Expect Limited - 39 Beaconsfield Road Bootle L21 1DS
 Expect Limited - 6 Belvidere Park Crosby L23 0SP
 Gladstone Road – 29 Gladstone Road Seaforth L21 1DG
 Manna House – 1 Alexandra Drive Bootle L20 0EE
 Manna Walk - 18 Moss Lane Bootle L20 0ED
 Mount Avenue – 12 Mount Avenue Bootle L20 6DT
 Parkbourn – 1 – 4 Parkbourn Maghull L31 1LH
 Riverside Close – 8 Riverside Close Bootle L20 4QG

Royal Mencap Society - 4 The Stables Millcroft Crosby L23 9YT
 Sefton New Directions Limited – 89 Aintree Lane Aintree L10 2JJ
 Sefton New Directions Limited – 2 Hudson Road Maghull L31 5PA

Southport & Formby Learning Disability Care Homes on NHSE CQC List

Arbour Street – 53 Arbour Street Southport PR8 6SQ
 Ashdown Close – 37 Ashdown Close Southport PR86TL
 Dinorwic Road – 49 Dinorwic Road Southport PR8 4DL
 Griffin House – 28 Lethbridge Road Soutport PR8 6LG
 Lethbridge Road – 2 Lethbridge Road Southport PR8 6JA
 Norwood – 30 Norwood Avenue Southport PR9 7EG
 Revitalise Sandpipers – Fairways Southport PR9 0LA
 Sanderling House – 3 Liverpool Road Formby L37 4BN
 Sefton New Directions Limited - Poplars Resource Centre – 2 Poplar Street Southport PR8 6DX
 Sefton Street – 132 Sefton Street Southport PR8 5DB
 Talbot Street – 72 Talbot Street Southport PR8 1LX
 Windermere – 15c Westcliffe Road Birkdale PR8 2BN
 York Road – 73 York Road Southport PR8 2DU

COVID 19 Support/ Resilience

COVID 19 has been a challenging time with the necessity to adapt at pace, and adopt new ways working.

Shared learning from innovative ways of working, and collaboration across the system should be harnessed to support system transformation, and ensure system resilience in the event of a secon of COVID 19.

Indicator	Weighting	Achievement Threshold
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d wave

<p>42. The practice identifies innovative ways of working resulting from the COVID 19 pandemic, which have had a positive impact on patient care and general practice resilience.</p> <ul style="list-style-type: none"> • Reflect on what has or hasn't worked well • identify practice specific new processes that have been put in place, and share best practice/ ideas at locality/ PCN level • Identify further areas to develop in the event of a second wave • Problem solve challenges to restore general practice to a 'new normal' 	<p>40%</p>	<p>Evidence of shared learning at locality/ PCN level</p>
<p>4. Applicable Service Standards</p>		
<p>4.1 Applicable national standards (eg NICE)</p>		

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

South Sefton Clinical Commissioning Group Southport and Formby Clinical Commissioning Group

Part 2

Service Specification No.	1
Service	Primary Care - Phlebotomy
Commissioner Lead	Jan Leonard
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs															
<p>1.1 National/local context and evidence base</p> <p>Since the introduction of the new GP contract in 2004, the demand for phlebotomy has risen significantly as GP practices have built up disease registers to meet the requirement of the QOF. This demand cannot be met by secondary care provision alone and is neither cost effective nor convenient for patients</p>															
2. Outcomes															
<p>2.1 <u>NHS Outcomes Framework Domains & Indicators</u></p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Domain 1</td> <td style="width: 60%;">Preventing people from dying prematurely</td> <td style="width: 20%; text-align: center;">x</td> </tr> <tr> <td>Domain 2</td> <td>Enhancing quality of life for people with long-term conditions</td> <td style="text-align: center;">x</td> </tr> <tr> <td>Domain 3</td> <td>Helping people to recover from episodes of ill-health or following injury</td> <td style="text-align: center;">x</td> </tr> <tr> <td>Domain 4</td> <td>Ensuring people have a positive experience of care</td> <td style="text-align: center;">x</td> </tr> <tr> <td>Domain 5</td> <td>Treating and caring for people in safe environment and protecting them from avoidable harm</td> <td style="text-align: center;">x</td> </tr> </table>	Domain 1	Preventing people from dying prematurely	x	Domain 2	Enhancing quality of life for people with long-term conditions	x	Domain 3	Helping people to recover from episodes of ill-health or following injury	x	Domain 4	Ensuring people have a positive experience of care	x	Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x
Domain 1	Preventing people from dying prematurely	x													
Domain 2	Enhancing quality of life for people with long-term conditions	x													
Domain 3	Helping people to recover from episodes of ill-health or following injury	x													
Domain 4	Ensuring people have a positive experience of care	x													
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x													
<p>2.2 Local defined outcomes</p> <ul style="list-style-type: none"> • Response to patient representative needs for access to primary care phlebotomy • An increase in primary care capacity to support long term conditions management <input type="checkbox"/> Reduce health inequalities • Support practices to achieve increased capacity and investment 															
3. Scope															

3.1 Aims and objectives of service

To support access to phlebotomy closer to home in GP practices, whilst complimenting current phlebotomy provision by the community services.

3.2 Service description/care pathway

- Practices must state whether an appointment is required
- Practices offering an appointment system should be able to offer an appointment within 48 hours (2 working days)
- Clinicians delivering the service must comply with the practice Health and Safety policy, Sharps

Policy, Infection Control, National Guidance on Clinical Waste and assessed as competent to undertake the task

- Blood samples should be forwarded to Clinical Laboratories at Aintree University Hospital NHS Foundation Trust (for SS practices),
- Practices will indicate if willing to perform phlebotomy for neighbouring practices

Read codes

- Routine blood test – Haematology test performed 4212

3.3 Population covered

Patients registered at the practice aged 16 and over who require routine blood tests.

3.4 Any acceptance and exclusion criteria and thresholds

3.5 Interdependence with other services/providers

- Merseycare NHS Trust
- NHS Local Acute Trusts/ICO
- CCG

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

QOF Long Term Conditions.

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

Practice quarterly report/invoice to include:

- Number of bloods taken per 1000 patients performed at the practice
- Total number of eligible bloods taken

6. Location of Provider Premises

<p>The Provider's Premises are located at:</p> <p>Insert GP practice premises address</p>
<p>7. Individual Service User Placement</p>

Practices will be paid cost per case (i.e. per venepuncture) £2.61 (including agreed 1% uplift) on production of quarterly invoice.



**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 2

Service Specification No.	2
Service	Primary Care Prescribing (previously Shared Care)
Commissioner Lead	Susanne Lynch
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

<p>1. Population Needs</p> <p>1.1 It is important for patient care that there is a clear understanding of where clinical and prescribing responsibility rests between Secondary or Tertiary Care and Primary Care prescribers.</p> <p>1.2 Drugs can only be prescribed to patients on the practice registered list.</p>
<p>2. Outcomes</p>

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

- Response to national drivers for care closer to home
- An increase in primary care capacity to support appropriate prescribing
- Reduce health inequalities
- Support practices to achieve increased capacity and investment

3. Scope

3.1 Aims and objectives of service

The prescribing schedule is intended to enable practices to:

- Be confident in agreeing to accept the legal and clinical responsibility for prescribing for undertaking prescribing recommended by secondary care within the Pan Mersey Area Prescribing Committee (APC) formulary. <http://www.panmerseyapc.nhs.uk/formulary.html>
- It is important to note that practices are only expected to prescribe/monitor those drugs that they feel clinically competent to do so
- Be able to be paid for the prescribing, monitoring and supervision of patients being cared for in accordance with the schedule

- Be able to provide a robust quality service that is convenient to the patient whilst remaining clinically safe

3.2 Service description/care pathway / inclusions

- The Pan Mersey APC formulary details the formulary drugs into different categories. Amber Recommended, Amber Initiated, Amber Patient Retained and Purple Shared Care. The definitions and criteria for inclusion into the categories are detailed at:
<https://www.panmerseyapc.nhs.uk/formulary/rag-criteria/>
- The prescribing schedule enables practices to prescribe safely whilst reinforcing the basic premise that: “When clinical and / or prescribing responsibility for a patient is transferred from Secondary (or Tertiary) to Primary Care, the Primary Care prescriber should have the appropriate confidence to prescribe the necessary medicines. Therefore, it is essential that a transfer of care involving medicines that a Primary Care prescriber would not normally be familiar with, should not take place without the “sharing of information with the Primary Care prescriber and their mutual agreement to the transfer of care.”

Service description/care pathway

- A number of drugs have been identified within the Pan Mersey APC Formulary as suitable for prescribing in primary care.
- Prescribing by a General Practitioner of a drug included in the Pan Mersey APC Formulary should normally be carried out in accordance with the requirements of the drugs classification i.e. Amber Recommended, Amber Initiated, Amber Patient Retained and Purple Shared Care.
- Prescribing support documentation and purple shared care agreements ratified by the CCG can be accessed at <http://nww.southseftonccg.nhs.uk/>
- It is recognised that purple shared care drugs require more intense monitoring and this has been addressed through the different levels of payment (appended to end of specification wording)
- Any drug removed from Amber category (Amber Recommended, Amber Initiated, Amber Patient Retained) during a routine review of the formulary drugs list, will still attract payments for the quarterly period in which removal takes place. Drugs added to the list will only attract payments commencing in that quarter in which they were added.
- The patient must currently be monitored and supervised by the practice for the drugs covered by the schedule during the relevant time period for which payment is claimed for the schedule.
- This service specification will fund the acceptance of clinical responsibility associated with prescribing and monitoring drugs which are Amber Recommended, Amber Initiated, Amber Patient Retained or Purple shared-care within the Pan Mersey APC formulary.
- Prescribing support documents and shared care protocols are developed at a Pan Mersey level and subject to approval by the CCG.
- The practice must have in place an effective and robust system for call and recall of patients it is monitoring. The practice must be confident that if monitoring is taking place in another setting that appropriate arrangements are in place for call and recall. This must include a robust system for the management of non-attendees as per the shared care protocols.
- The practice must ensure that each patient has been provided with relevant patient information. Patients need to be able to access appropriate information in an ongoing manner and must be advised how to do so. The patient must be advised:

- On the risks and benefits of their medication ○
- Patient understanding and consent must be confirmed ○
- The need for monitoring and the schedule explained

- It is primarily the responsibility of the referring specialist to provide this to the patient. Practices should report instances of specialist services' failure to provide this information to the CCG Head of Medicines Management.

3.3 Population covered

The registered practice population.

3.4 Any acceptance and exclusion criteria and thresholds

- There must be appropriate documentation developed at a Pan Mersey level and approved by the CCG available.
- The contractor will currently hold a contract with NHS England to provide essential general/personal medical services.
- The patient must be registered with the practice

3.5 Interdependence with other services/providers

- NHS England
- The Local Medical Committee
- The Area Prescribing Committee
- The CCG
- Acute Trusts/ICO/consultants

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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

4.3 Applicable local standards e.g. Pan Mersey Area Prescribing Committee

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

All healthcare professionals involved in the provision of care to patients in respect of the drugs listed in this agreement should have the relevant skills and be able to satisfy key competencies. Staff should as a minimum:

- Know the clinical indications for treatment and whether the indication is licensed or unlicensed.
- Be aware of the cautions and contraindications of the drug being used.
- Be aware of the dose range and schedule for the drug and the circumstances that might cause dose variation.
- Be aware of any significant drug interactions.
- Be aware of the monitoring schedule needed to ensure safe drug use.
- Be aware of the signs of potential toxicity and the actions to be taken if it is identified.
- Be aware of any issues around the administration of injectable drugs and the subsequent appropriate method of disposal of sharps or medicinal residue.
- Where secondary care does not carry out their responsibilities or monitoring required by the category of the drug, practices should return care and prescribing back to the specialist.
- GP practice to ensure appropriate agreement in place in line with Pan Mersey RAG rating
- GP practice to ensure all monitoring undertaken as stated in the shared care agreement before payment is requested under the schedule

Clinicians must report any adverse events of treatment to the specialist and inform them of any relevant change in the patients' circumstance.

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Practices will be paid on production of a quarterly invoice. Level 1 payment will be £1352.78 fixed annual fee based on list size of 5000. Level 2 payment will be £176.89 per patient per annum.

Level	Drug Category	Payment
1	Amber Recommended, Amber Initiated, Amber Patient Retained	£1352.78 fixed annual fee, based on list size of 5,000 (including agreed 1% uplift)
2	Purple Shared Care	£176.89 per patient per annum (including agreed 1% uplift)

**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 2

Service Specification No.	3	
Service	Drug Administration	
Commissioner Lead	Susanne Lynch	
Provider Lead	Practice Senior Partner	
Period	12 months	
Date of Review	Annual Review	
1. Population Needs		
1.1 National/local context and evidence base		
Safe appropriate and convenient care for the patient resulting in a decrease in secondary care outpatient activity		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x
2.2 Local defined outcomes		
<ul style="list-style-type: none"> • Response to national drivers for care closer to home • An increase in primary care capacity to support provision of shared care in below clinical areas • Reduce health inequalities • Support practices to achieve increased capacity and investment 		
3. Scope		

3.1 Aims and objectives of service

- Suitable patients requiring GnRH analogues, injections, may have their injections delivered in a primary care setting. Patients receiving GnRH analogues will still have a periodic review at the consultant clinic, where all monitoring will take place. Patients who appear unwell or who experience worsening or new symptoms should be referred back to secondary care immediately.
- Suitable patients requiring Denosumab injections for stable osteoporosis may have their injections delivered in a primary care setting. Patients receiving Denosumab will not require a periodic review at the consultant clinic. NICE (2010) expectations state Denosumab will subsequently be delivered almost exclusively in primary care.

A review in primary care is appropriate. It may be appropriate to refer a patient back to secondary care if patient's condition deteriorates after a period of time or stop the medication with patient agreement.

- Suitable patients requiring Degaralix injections for advanced hormone-dependent prostate cancer with spinal metastases may have their injections delivered in a primary care setting. Patients receiving Degaralix will still have a periodic review at the consultant clinic, where all monitoring will take place. Patients who appear unwell or who experience worsening or new symptoms should be referred back to secondary care immediately.
- Suitable patients requiring testosterone injections as per Pan Mersey Area Prescribing Committee (APC) guidance may have their injections delivered in a primary care setting if the GP practices takes over prescribing.
- Suitable patients prescribed Pan Mersey Area Prescribing Committee (APC) red classified drugs by secondary care may have their red drug administered in a primary care setting. GP agreement must be in place and secondary care correspondence from a prescriber requesting administration in a primary care setting must include sufficient detail to authorise a registered nurse in primary care to administer the drug.
- The benefits to the patients are care closer to home where currently frequent attendances at outpatients departments are required

3.2 Service description/care pathway

Any practice wishing to provide drug administration will provide the following information to the Commissioners:

- The name of the clinician carrying out each procedure
- Details of the training undertaken by a suitably qualified clinician – course, provider, dates

This information will be held on a register by the Commissioners.

3.3 Population covered

GnRH Analogues- Triptorelin, Goserelin, Leuprorelin

- Patients registered with a CCG General Practitioner who have been started and stabilised on a GnRH analogue by secondary care.

NB. More than one injection in secondary care may be required until the patient is stable.

Denosumab

- Postmenopausal patients registered with a CCG General Practitioner at increased risk of fractures and started and stabilised on Denosumab by secondary care.

Degaralix

- Patients registered with a CCG General Practitioner being treated for advanced hormonedependent prostate cancer with spinal metastases that have had Degaralix started and stabilised by secondary care.

Testosterone Injections

- Male patients, registered with a CCG General Practitioner being prescribed testosterone injections by primary care.

Red Classified Drugs

- Patients registered with a CCG General Practitioner being prescribed a Pan Mersey APC red classified drug by secondary care.

Pan Mersey APC

Prescribing support documentation is available to support GPs with safe prescribing and administration of these drugs

<p>3.4 Any acceptance and exclusion criteria and thresholds</p> <p>3.5 Interdependence with other services/providers Consultants in local NHS Acute Trusts</p>
<p>4. Applicable Service Standards</p>
<p>4.1 Applicable national standards (e.g. NICE)</p> <p>4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)</p> <p>4.3 Applicable local standards</p> <p><input type="checkbox"/> Local protocol</p>
<p>5. Applicable quality requirements and CQUIN goals</p>
<p>5.1 Applicable Quality Requirements</p> <p>Practice quarterly report/invoice to include:</p> <ul style="list-style-type: none"> • The number of procedures carried out • The number of patients who have full monitoring information recorded, (compliance rate 90%) <input type="checkbox"/> Drug administration coded within patient medical notes using a locally agreed code.
<p>6. Location of Provider Premises</p> <p>The Provider's Premises are located at: Insert GP practice address.</p>
<p>7. Individual Service User Placement</p>

Practices will be paid cost per injection £31.22 on production of quarterly invoice.

South Sefton Clinical Commissioning Group Southport and Formby Clinical Commissioning Group

Part 2

Service Specification No.	4
Service	Covert Drug Administration Plan
Commissioner Lead	Susanne Lynch
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs

1.1 National/local context and evidence base

All patients have the right to refuse to take medicine if they wish to do so, and it is important that this right is recognised. There may be occasions when patients lack the capacity to take medicines or to understand the consequences of refusing to take medicines. In these circumstances, it may be necessary for nurses and carers in care homes to follow a formal process involving the prescriber, other healthcare professionals and the patient's representative to allow them to act in the best interests of the patient.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

To develop a process for managing situations where it is deemed in the best interest of the patient to administer medicines covertly which is safe, legal and ensures patients human rights are upheld.

3. Scope

3.1 Aims and objectives of service

To ensure covert administration:

- Is a last resort – only implemented when there is no viable alternative
- Is medicine specific – the need must be identified for each medicine prescribed.

- Is time limited – it should be used for a short a time as possible and the need should be regularly reviewed

3.2 Service description/care pathway / inclusions

The administration of any drug or medical treatment to a patient without their knowledge, in a disguised or deceptive form, is known as covert administration. Implementation of covert administration requires a complex, multidisciplinary assessment. By its definition, a medicine is given covertly to a patient in a disguised form without their knowledge but in their best interests.

CQC and NICE have both issued guidance for appropriate use of covert administration.

CQC states: “When it is agreed to be in a person’s best interests, the arrangements for giving medicines covertly must be in accordance with the Mental Capacity Act 2005. In line with the Mental Capacity Act 2005, NICE Guideline SC1 (managing medicines in care homes) states: “Health and social care practitioners should not administer medicines to a resident without their knowledge (covert administration) if the resident has capacity to make decisions about their treatment and care”.

NICE Quality Standard 85 (NICE QS85; medicines management in care homes) further supports this by reinforcing that all adults who live in care homes and have been assessed as lacking capacity must only be administered medicines covertly if a management plan is agreed at a meeting held to discuss the patient’s best interests.

Service description/care pathway

- Before consideration is given to covert administration of medicines to a patient, a mental capacity assessment, in line with the Mental Capacity Act 2005 must be undertaken. This is usually completed by an appropriately trained senior carer or nurse involved in the daily administration of medicines to the patient. However, if the outcome of the assessment is not entirely clear, an appropriately trained healthcare professional (e.g. GP or specialist nurse) should be involved.
- When a patient is deemed to lack capacity, all medicines should be reviewed for clinical need. The NICE QS85 guideline suggests that this clinical medication review may be undertaken by the patient’s GP. However, in Southport & Formby the care home pharmacist would complete this review and liaise with the GP. As part of the review, medicines that are not performing a function or contributing to health outcomes should be stopped. Importantly, only medicines essential to a patient’s well-being should be given covertly
- Once this medication review has been undertaken, a meeting about the patient’s best interests should be held. Attendees at this meeting will usually include the prescriber, a nurse or senior carer from the care home, and a patient representative.
- At this meeting, the current and future interests of the patient to decide the best course of action will be discussed. The Mental Capacity Act 2005 provides a checklist that practitioners must follow when making a best interest decision for someone. The checklist ensures that practitioners involved in making best interest decisions:
 - Consider all the relevant circumstances, ensuring that the patient’s age, appearance and behaviour are not influencing the decision;
 - Consider delaying the decision if there is a possibility that the person may regain capacity;
 - Involve the patient in the decision as much as possible; ○ Consider any advance statements made
 - Consider the past and present beliefs and values of the individual, and the patient’s history of decision making;
 - Take into account views of the patient’s representative.
 - Demonstrate that the decision made is the least restrictive alternative or intervention.
- Covert administration plans should be reviewed at least every 6 months.



3.3 Population covered

Patients residing in a nursing home or residential home in Sefton.

3.4 Any acceptance and exclusion criteria and thresholds None

3.5 Interdependence with other services/providers

- NHS England
- The Local Medical Committee
- The Area Prescribing Committee
- The CCG

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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

Mental Health Capacity Act 2005

5. Applicable quality requirements and CQUIN goals

CQUIN does not apply

6. Location of Provider Premises

7. Individual Service User Placement

Patients residing in a nursing home or residential home in Sefton.

Practices will be paid £255.03 initially and £204.02 review per patient

Appendix 2 – Policy for Covert Administration



Appendix 2 - Policy for Covert Administra

Appendix 3 – Flowchart Process Covert Administration



Appendix 3 - Flowchart Process Co

Appendix A – Assessment of Capacity



Appendix A -
Assessment of Capac

Appendix B – Best Interest Decision Aid



Appendix B - Best Interest
Decision Aid.

Appendix C – Covert Administration of Medication Care Plan



Appendix C - Covert
Administration of Med

Appendix D – Covert Administration of Medication Care Plan Review



Appendix D - Covert
Administration of Med

South Sefton Clinical Commissioning Group Southport and Formby Clinical Commissioning Group

Part 2

Service Specification No.	5
Service	Frail Elderly (Southport and Formby Only)
Commissioner Lead	Jan Leonard
Provider Lead	Practice Senior Partner
Period	(discontinued October 2020)
Date of Review	Annual

1. Population Needs

1.1 National/local context and evidence base

The care of the elderly population has changed beyond all recognition in the last 100 years. We have moved from care in extended family settings to care provision as an industry. This has occurred due to a range of societal changes, with social mobility, and the break-up of traditional family units being key influences. However, a very significant change in demographics has played an even greater role. Over the last 50 years (1960-2010) the average life span in the UK has increased by around 10 years for a man and 8 years for a woman.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term	x conditions
Domain 3	Helping people to recover from episodes of ill-health or	x following
	injury	
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and	x protecting
	them from avoidable harm	

2.2 Local defined outcomes

- Maintain frailty register
- Advanced/community care planning
- Proactive reviews of care home patients
- Reduction of avoidable hospital admissions

3. Scope

3.1 Aims and objectives of service

- Identify patients residing in nursing/rest homes and include on a frailty register Offer Care Plan
- Generate integrated community care plans (ICCP) using CCG template for patients on the frailty register

- Increase in prevalence data
- Share existence of care plan with wider healthcare system as appropriate

3.2 Service Description/Pathway

Care Home Patients

- Anyone residing in a care home regardless of age should be placed on the frailty register
- Principles of Best Interest decisions should be adopted
- All care home patients to have a care plan in place signed by a GP
- Where a care plan currently exists, and following patient consent¹ this should be transposed to the CCG ICCP template and shared with relevant organisations. Latest versions of the ICCP template are available via Information Facilitators and on the CCG intranet pages
- Practices to use ERISS to notify NWAS of the existence of a care plan (guide below)



ERISS- Creating Patient Alerts v1.docx

- Special Patient Note to be sent to out of hours provider GTD Healthcare, notifying the organization of the existence of a care plan and/or DNAR form as appropriate (not sharing the care plan itself)
- Practices will generate an invoice for quarterly payment providing the number of care plans generated/reviewed over the course of this LQC period, together with information regarding in which home the patient resides and confirmation that the plan has been shared with other organisations
- Practices to engage with locality meetings in order to discuss scheme outcomes

3.3 Population covered

Patients registered at Southport & Formby GP practices residing in a nursing/rest home.

3.4 Any acceptance and exclusion criteria and thresholds

Care plans generated for patients not residing in nursing/rest home would not generate a payment under this scheme.

3.5 Interdependence with other services/providers

4. Applicable Service Standards

¹ Consent in this instance relates to sharing the existence of a care plan with other organisations, e.g. OOH

4.1	Applicable national standards (e.g. NICE)
N/A	
4.2	Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)
N/A	
4.3	Applicable local standards
N/A	
5. Applicable quality requirements and CQUIN goals	
5.1	Applicable Quality Requirements N/A

2

6. Location of Provider Premises
The Provider's Premises are located at:
7. Individual Service User Placement

Payment to practices will be via quarterly invoice. The value is £41.21 per generated/reviewed care plan. For the purposes of clarification, there will be no more than one payment per patient per year under this scheme.



**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 2

Service Specification No.	6
Service	Dementia
Commissioner Lead	Kevin Thorne
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs
<p>1.1 National/local context and evidence base</p> <p>This local specification builds on the national Enhanced Service for Dementia and complements the Quality Outcomes Framework (QOF) which aim to:</p> <ul style="list-style-type: none"> • Identify patients at clinical risk of dementia • Offer an assessment to detect for possible signs of dementia in those at risk • Offer a referral for diagnosis where dementia is suspected • For people with a diagnosis of dementia, practices to take responsibility for the onward prescribing of dementia medication. Secondary care consultants will initiate, titrate and stabilize patients on the medication and general practice to provide repeat onward prescribing as per PAN Mersey Area Prescribing Committee recommendations.
2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term	x
Domain 3	Helping people to recover from episodes of ill-health or injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

- Identify a practice lead for dementia (not necessarily clinical)
- Provide an annual GP review for patients with a diagnosis of mild cognitive impairment until such time transient state resolves or progresses to dementia.
- Support identification of carers for people with dementia

3. Scope

3.1 Service Description/Pathway

- Establish a dementia lead within the practice (not necessarily clinical). The dementia practice lead will support improvements within the practice environment for dementia care e.g. awareness of the condition and services available, coding, point of contact for support services and to work with the CCG and specialist services in the development of dementia services.
- Establish a register for patients diagnosed with mild cognitive impairment (Read code 28E0).
- The practice needs to have a process in place for monitoring the coding of the register to ensure patients diagnoses are kept up to date. Please refer to the coding systems below
- The practice needs to have a process for patients diagnosed with Mild Cognitive Impairment (Read code 28E0). These patients should be recalled at 12 months post diagnosis, and annually thereafter, to see if this was a transient state which has resolved or is progressing to dementia.

SNOMED-CT Codes - For the current codes to be used, please see the Code guidance document.



North Guidance on
Dementia Coding - FIN

3.2 Population covered

Patients registered at Southport & Formby or South Sefton GP practice

3.3 Any acceptance and exclusion criteria and thresholds

3.4 Interdependence with other services/providers

- Community Services

- Secondary Care
- Out of Hours
- Any other part of the wider healthcare team as appropriate

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

N/A

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

N/A

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

N/A

6. Location of Provider Premises

GP practice premises

2

7. Individual Service User Placement

Payment to practices will be via quarterly invoice. The value is £60.60 per review undertaken in primary care. For the purposes of clarification, there will be no more than one payment per patient per year under this scheme.

Practices can refer to the memory clinic by letter. The Mersey Care mental health referral booklet is available at appendix 4



Appendix 4 -
Merseycare Mental He



**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 2

Service Specification No.	7
Service	Annual Healthcare checks for people with Severe and Enduring Mental Illness (SMI)
Commissioner Lead	Gordon Jones
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs

1.1 National/local context and evidence base

This specification aims to commission an enhanced provision to better address physical health risks and needs within primary care.

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 specification aims to achieve: by the end of 2018/19 60% of the population with SMI on the GP register receive an annual physical health check, and appropriate follow-up care. 50% of these checks are to take place in primary care and 10% are to take place in secondary care.

People with SMI face health inequalities and **are less likely to have their physical health needs met**, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment.

Compared to the general population, individuals with SMI (such as schizophrenia or bipolar disorder):

- Face a **shorter life expectancy** by an average of 15–20 years;
- Are **three times more likely to smoke**;
- Are at double the risk of **obesity and diabetes**, three times the risk of **hypertension and metabolic syndrome**, and five times the risk of **dyslipidaemia** (imbalance of lipids in the bloodstream).

Commissioning of improved physical health care for people with an SMI within a primary care setting further builds on work to ensure parity of esteem between mental and physical health by giving equal attention to the physical health of people with mental health problems as is given to the general population.

Regular physical health checks, which include lifestyle and family medical history and routine tests such as weight, blood pressure, glucose and fats or lipids, can identify potential problems before they develop into serious conditions.

Sefton prevalence and trajectory figures are detailed below:

Sefton CCGs	Estimated number of people with SMI 2018-19	Estimated total number of people on GP SMI register to receive a physical health check and follow up in primary care in 2019-20 (50% target)	Trajectory			
			Q1	Q2	Q3	Q4
Total	3280	1640	410	410	410	410

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

The CCGs' vision is to deliver personalised coordinated care, health and wellbeing services with, and around the person in primary care setting closer to home wherever possible.

3. Scope

3.1 Aims and objectives of service

This specification aims to commission an enhanced provision to better address physical health risks and needs within primary care.

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 for more than 12 months

This specification aims to achieve: by the end of 2020/21 50% of the population with SMI on the GP register receive an annual physical health check, and appropriate follow-up care.

Secondary care (Mersey Care NHS FT) 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

It is estimated that Mersey Care NHS FT will be responsible for the delivery of health checks to 10% of the population with SMI on the GP register.

The SMI health check comprises of 6 elements which are listed in table 2 below. **All 6 must be completed to achieve the standard in accordance with the NHSE/I guidance/standard.**

The provider will ensure that they advertise this service to their patients. Services need to be accessible, appropriate and sensitive to the needs of all service users. No-one should be excluded or experience difficulty in accessing and effectively using the service due to their race, gender, disability, sexual orientation, religion and/or age.

3.2 Service Description/Pathway

The requirements for participation in this contract are as follows:

- The GP practice shall ensure their SMI register is up to date by sharing and receiving information (in the form of an SMI register) from and to the secondary care mental health provider on an annual basis. Information on the SMI register can be found in table 2 below.
- The GP Practice will communicate via the most suitable means to those patients on their SMI register to inform of the physical health check invite and any follow up invites.

The GP practice shall complete an annual physical health check for those patients on the SMI Register aged 18 years and over covering the 6 specified interventions.

To achieve full payment is **ALL 6 elements** of the cardio metabolic risk assessment (also known as the Lester tool). This is a key performance metric by which NHS England judge performance. See table 1 below:

Table 1. SMI Health check - Six Cardio-metabolic Health Check elements

Element	Notes
1. Body Mass Index (BMI)	On weight management as part of physical health check for patents with schizophrenia, bipolar affective disorder and other psychoses (4 QOF points)
2. Blood pressure and pulse check (diastolic and systolic blood pressure recording, or diastolic and systolic blood pressure + pulse rate).	Currently offered MH003
3. Blood lipid including cholesterol test (cholesterol measurement or QRISK measurement).	
4. Blood glucose test (blood glucose or HbA1c measurement).	
5. Assessment of Smoking status	
6. Assessment of Alcohol Consumption	

The NHSE standard is based the **number of people** who have **received each of the six elements above** of the physical health check in the 12 months to the end of the reporting period, delivered in a primary care setting:

The EMIS data capture template to be used for the 6 elements of the SMI Health Check is:

20/21 Annual SMI Physical Health Check

- The GP Practice shall use the iMerseyside/EMIS electronic Template to complete and record the annual physical health check.
- The GP Practice shall report on a quarterly basis (via the quarterly invoicing form) the number of people on the GP SMI register who have received a full set of comprehensive physical health checks in a primary care setting (all elements of the health check needs to be completed to achieve full payment)

- A physical health check can only be attributed to the practice who have completed the work, and not those done by a different practice prior to joining a new list.

- The GP Practice will ensure their workforce is suitably trained to competently undertake and record an annual physical health check.

The changes to the GP contract have confirmed that the ‘personalised care adjustment’ will replace QOF exception coding. Practices should follow the new national guidance when available on when clinicians should consider excluding patients from the SMI register because their illness is in remission.

Where a patient declines an element of the health check:

- As set out the in the [commissioning guidance](#), to help ensure people are fully engaged in physical healthcare, services should:
- Provide reasonable adjustments to support engagement with the physical health assessment, such as longer appointment times
- Undertake proactive follow up on the results of all assessments
- Provide proactive outreach, drawing on resources from peer support and voluntary sector organisations for those struggling to attend appointments or engage with activities to improve overall health and wellbeing
- Individuals should always be supported to take up the physical health assessment but in some circumstances individuals may decline an element of the health check and in these circumstances there should be documented evidence of refusal in clinical systems.
- To reflect this, ‘declined’ codes can be included in searches for the purposes of reporting. Codes attached.

3.3 Population covered

The Clinical Commissioning Group Population.

3.4 Any acceptance and exclusion criteria and thresholds

The SMI primary care disease register is made up of patients who have the following codes:

Condition	EMIS Code	Snomed Code
Schizophrenia	E10 – All	294725013
Schizotypal personality	E2122	155281000006119
Persistent delusional disorder	EU22 – EU2 All	419861000006117
Acute/Transient psychotic disorders	EU23 – EU2 All	362271000006110
Induced delusional disorder	EU24- EU2 All	389641000006110
Schizoaffective disorders	EU25- EU2 All	425541000006110
Manic Episodes	EU30 – All	396741000006113
Bipolar disorder	EU31 – All	367101000006112

Diagnoses, including diagnoses of personality disorder (other than schizotypal personality disorder), substance misuse disorders without co-morbid psychosis, eating disorders or recurrent depression are not included in the definition.

This does not mean that these diagnoses are not ‘serious’ or do not carry physical health risk but the SMI definition is aligned to current evidence base for physical health checks which is driven by cardio metabolic risks associated with anti-psychotic medications. It also aligns with current QoF register definition.

3.5 Interdependence with other services/providers

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Healthcare professionals completing the annual physical health check shall:

- Understand what SMI is and how it might be experienced;
- Understand the excess risks of poor physical health and how best to support people with SMI to engage and access appropriate physical health care;
- Feel confident and empowered to talk about health holistically including mental health, healthy lifestyles, risk reduction and physical health; and
- Have technical skills and expertise in relation to carrying out physical health assessments and obtaining and communicating the results.

NICE Guidance CG185 and CG178 are applicable to this specification.

5. Payment

5.1 Payment Arrangements

Each practice contracted to provide this service will receive a total of £80 per completed physical health check (comprising of the 6 interventions listed above undertaken in primary care) for patients on the SMI Register. Payment will be made on a sliding scale - please see table below:

Number of SMI Health Check interventions	Payment
6 Interventions undertaken	£80.80
5 Interventions undertaken	£70
4 interventions undertaken	£60
3 interventions undertaken	£45
2 interventions undertaken	£30
1 intervention undertaken	£15

It is acknowledged that some SMI patients may be resistant to having some interventions e.g. bloods undertaken, but the practice should code they have made all reasonable efforts to engage the patient. The use of declined codes will be searched upon for the missing elements. See attached list:



SMI 20-21 Decline codes.docx

Payment will be made following the submission of a quarterly report/invoice (but excluding any patient identifiable data) detailing the checks made in a primary care setting. This will be invoiced as per the existing LQC arrangements to the agreed CCG nhs.net account.

6. Location of Provider Premises

GP practice premises

7. Individual Service User Placement

Payment to practices will be via quarterly invoice. The value is £80.80 per completed physical health check (6 interventions as listed above) undertaken in primary care. For the purposes of clarification, there will be no more than one payment per patient per year under this scheme.



Appendix 5 -
Merseycare Mental H

**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 2

Service Specification No.	8 Draft - on hold following outcome of judicial review and update from NHSE
Service	Safeguarding Children and Adults at Risk (Reports and Case Conferences)
Commissioner Lead	Wendy Hewitt
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	April 2021

1. Population Needs
<p>1.1 National/local context and evidence base</p> <p>Mature System and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) run services in a more coordinated way, agree system-wide priorities, and plan collectively to improve services for their populations.</p> <p>Safeguarding processes are jointly shared between local authorities, the police; and health, and rely on those systems working together efficiently and sharing information. The importance of safeguarding activity for children and young people in general practice is widely understood and supported; protecting them, preventing serious harm and even death.</p> <p>However, the processes supporting this activity (requesting child protection reports and attendance at case conferences) do not consistently recognise the workload consequences for general practice, with already under pressure resources being diverted away from delivering direct patient care.</p>
2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term x conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

- Enable GP practices to plan for safeguarding workload
- Support timely and effective provision of information
- Recognise resource implications in general practice
- Increase in engagement in case conferences through provision of reports and attendances

3. Scope

3.1 Aims and objectives of service

To ensure that all relevant information in relation to requests for reports/attendance at case conferences from the Local Authority is supported by GPs within the time frame required.

The provision by GPs of the relevant safeguarding services falls outside the scope of the range of essential, additional or enhanced services provided for in parts 8 – 12 of the standard GMS contract. Clause 19.1.2 (a) of the GMS contract specifically permits the contractor to demand or accept a fee or other remuneration ‘from any statutory body for services rendered for the purposes of that body’s statutory functions’. GPC has obtained external legal advice on the issue, and has concluded that GPs **do** have an obligation to comply with their statutory safeguarding duties, but **equally** that they are entitled to a fee.

This enhanced service provides a framework for general practice to provide effective and timely safeguarding information.

3.2 Service description/care pathway

A claim can be made for each safeguarding review that takes place which requires sharing of information.

Child protection case conference report (initial and review)	£ TBC
Safeguarding adult conference report	£ TBC
Attendance in person at a case conference	£ TBC

Practices will be required to populate the spreadsheets below to claim for work undertaken on a quarterly basis:

Reports: work undertaken and submitted by the completion deadline:

LA Reference number	Type of report	Date request received at the practice	Deadline for completion	Date submitted by the practice	Funding

Quality and oversight of reports will be shared with the CCG Safeguarding Lead to identify training needs, and to feedback by exception to individual practices where required.

Attendance at case conferences:

LA Reference number	Date of request received at the practice	Date of case conference	GP in attendance	Funding

3.4 Any acceptance and exclusion criteria and thresholds

Safeguarding children and adults at risk identified by the Local Authority who are registered with a Sefton GP practice.

3.5 Interdependence with other services/providers

Local Authorities

Safeguarding Team

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- Working together to safeguard children 2018 - A guide to inter-agency working to safeguard and promote the welfare of children.
- Safeguarding children and young people: roles and competences for health care staff – Intercollegiate document. 3rd Edition.
- Adult Safeguarding: Roles and Competencies for Health Care Staff – Intercollegiate Document.

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

- Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice <http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgpnsppccsafeguarding-children-toolkit-for-general-Practice.aspx> RCGP

Safeguarding Adults at risk of harm toolkit.

4.3 Applicable local standards

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement



**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 2

Service Specification No.	9
Service	Root Cause Analysis
Commissioner Lead	Brendan Prescott
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	April 2021

1. Population Needs		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x
2.2 Local defined outcomes		
3. Scope		

3.1 Aims and objectives of service

Aim :

The practice will complete analyses and reviews of appropriate cases of declarable infections to learn lessons and reduce the likelihood of further incidences of infections.

Objectives :

1. Led by a health practitioner employee, the necessary review / root cause analysis to determine the cause of the infection if applicable is completed by the practice.
2. Lessons learned if appropriate are identified and an action plan is developed by the practice to influence practice, e.g. influence prescribing decisions, to reduce the risk of further cases of infection.
3. Findings from appropriate reviews / analyses are shared via localities to promote quality improvement across the CCG and local health system to promote the reduction of infections.

3.2 Service description/care pathway

- The practice will actively participate in audits, surveillance and root cause analyses when applicable to practice registered patients with action taken on results and engagement with CCG

and community colleagues when appropriate, e.g. in root cause analyses on Clostridium Difficile cases and Gram-negative bloodstream infections. The practice will be required to complete and submit surveillance templates (appendix 5) to mcn-tr.infection-control@nhs.net



Appendix 5 - CDI
RCA Tool Kit.docx

- For system wide IPC support, and to identify any learning and also contribute to the CCGs wider surveillance system to collate risk factors and key themes across the Sefton healthcare economy.
- Practice obligations in this section of the LQC should not exceed a total of 1 per 1000 patients combined activity in audits, surveillance and root cause analysis.
- The template and guidance sheet for completion has been discussed and agreed by Sefton LMC.
- The practice will not be obliged under the LQC to supply any patient identifiable data following a request if that request and the subsequent data processing cannot be demonstrated to be fully GDPR compliant.
- The practice will demonstrate awareness of NICE guidance.
- The practice will satisfy all Care Quality Commission (CQC) requirements.

3.3 Population covered

Registered practice population

3.4 Any acceptance and exclusion criteria and thresholds

3.5 Interdependence with other services/providers

The practice will liaise with the Sefton Public Health commissioned Sefton Community Infection Prevention and Control Service to submit documentation.

4. Applicable Service Standards

4.1	Applicable national standards (eg NICE)
4.2	Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)
4.3	Applicable local standards
5. Applicable quality requirements and CQUIN goals	
5.1	Applicable Quality Requirements
6. Location of Provider Premises	
The Provider's Premises are located at:	
7. Individual Service User Placement	

Practices will be paid cost per case £240.00 on production of a quarterly invoice (this will be cross referenced with templates submitted to mcn-tr.infection-control@nhs.net in that quarter.



**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 3 – Sefton Wide

Service Specification No.	10
Service	Syrian Vulnerable Persons Resettlement
Commissioner Lead	Jan Leonard
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs

1.1 National/local context and evidence base

The scheme has been designed to facilitate improving the quality of services provided by list based General Practice providers.

The scheme will facilitate improved access to care closer to home for Vulnerable Patients who are part of the Syrian Resettlement Programme (hereafter referred to as Syrian VPR's).

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	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

- Reduce health inequalities

3. Scope

3.1 Aims and objectives of service

Under the Equality Act (2010) – all those who deliver services to the public are required to demonstrate that race equality is considered in all their functions.

The NHS Plans for addressing inequality also requires that all those who are entitled to health care can access it fairly, have good opportunities for receiving health care and treatments and should expect satisfactory health outcomes.(NHS Constitution).

Practices are often presented with additional complex and administrative workloads due to the personal circumstances of Syrian VPR's and their unfamiliarity with the NHS. This scheme allows for the

enhancement of fees to practices where provision of services to a specified standard can be demonstrated.

3.2 Service description/care pathway

Definitions are as follows:

Refugee – status granted to a person who has left their country owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular group or political opinion, and who is unable of owing to such fear, unwilling to avail themselves of the protection of that country, and who has applied for refugee status in another country.

VPR- status granted to refugees who are classed as having VPR status as part of the UNHCR effort. Syrian VPR's are granted 5 years' humanitarian protection, meaning that patients have the same Healthcare entitlement as UK nationals.

For purposes of this scheme, it may be necessary for Syrian VPR's to provide documentation to the GP (Home Office or referral agency) to confirm their status.

The most common difficulties reported to the CCG by patients have been:

- Registration with GPs
- Language barriers
- Cultural barriers
- Limited time for consultation
- Lack of understanding of NHS, resulting inappropriate use e.g. A&E
- Reluctance of health staff to get involved in complex matters, not knowing entitlements and rights.
- Access to services and meaningful opportunities

The scheme aims to provide quality mainstream primary health care to Syrian VPR's thus enabling them to receive optimum advantage from the UK health and social care system which in turn produces benefits in terms of health and independence. It will do this by:

- Incentivising GP's to devote extra time and resource to such patients on their first attendance □ Encouraging GP's and other primary care practitioners to provide the necessary treatment, investigations and explanations to improve health and prevent further deterioration
- Promote continued understanding of the NHS and social care system so as to encourage its subsequent cost effective use and the utilisation of such long term preventative procedures as cervical cytology and immunisation

The scheme will require the following:

- Initial assessment of overall health needs, developing a medical history including information on chronic disease, immunisation and mental health needs; T.B. screening
- Time set aside with a member of the reception team, in the presence of an interpreter, to enable registration to be completed, including a patient profiling questionnaire. This session will also include information on how the practice operates, how referrals to hospitals are made, and how to access walk in centres and emergency services appropriately. It would also involve stressing to patients if they move away they are to inform the Surgery, so records can be amended, and secondary care providers informed as necessary
- Syrian VPR's should also be made aware of other members of the Primary Health care team (and their role), such as Health Visitors, Practice Nurses, Nurse Practitioners
- Promote and make arrangements for the referral of patients with particular needs (e.g. those displaying symptoms of victims of torture, isolation and poor mental health) to specialist agencies
- Referrals to secondary care will inform of language need
- Ensure the service works closely with key stakeholders including the minority ethnic community development service and other key groups
- Ensure staff and leads are culturally competent in understanding and meeting the needs of this cohort

N.B. Foreign students, Asylum Seekers (not those who are part of the Syrian VPR programme), the homeless, migrant workers or those whose first language is not English are not included in the scheme.

The improvement scheme is restricted to the population of persons granted Syrian VPR status and who are readily known to the Home Office.

Monitoring

Read Codes:

Refugee	13ZB
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At the end of each financial year, practices that have claimed under the scheme will be asked to provide the following information as part of their annual report:

- Total number of Syrian VPR's newly registered during the year and total number of patients still registered at year end
- Source of referral to practice
- Languages spoken by Syrian VPR's registered under the scheme
- Use of language Interpreting services as identified through the National Commissioning Board Primary Care Team invoicing systems
- Record of referrals from practices through IT systems

Data Collection/submission:

The providers of the service will be required to provide quarterly activity reports, based on the number of patients treated within the quarter.

3.3 Any acceptance and exclusion criteria and thresholds

1.4 Interdependence with other services/providers

- Other GP practices in Southport & Formby CCG
- NHS England
- North West Commissioning Support Unit (CSU)
- Information Facilitators

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- National GP Contract
- National Patient Survey
- Everyone Counts Planning for Patients

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

- RCGP

4.3 Applicable local standards

- Sefton Big Chat Events
- Healthwatch Priorities
- ECIS report
- Primary Care Foundation Review
- Public Health Report – Key Health Needs 2011

5. Applicable quality requirements and CQUIN goals

6. Location of Provider Premises
The Provider's Premises are located at:
7. Individual Service User Placement
5.1 Applicable Quality Requirements
Practice to provide evidence of compliance to section 3.2 in March 2021.

Payment is as per schedule, and will be as follows (includes an agreed 1% uplift):

- £582.94** retainer per 5000 patient practice per year paid up front
- Formula - retainer fee divided by 5000 x practice list size
- £113.56** per patient on initial registration

Future years/phases will be determined based on the outcome of this scheme.

**South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group**

Part 3 – South Sefton

Service Specification No.	11
Service	Primary Care - ABPI
Commissioner Lead	Jan Leonard
Provider Lead	Practice Senior Partner
Period	12 months
Date of Review	Annual

1. Population Needs

1.1 National/local context and evidence base

It has been estimated by Local Vascular Consultants that approximately 25% of referrals are for Peripheral Vascular Disease (PVD) which could be managed in primary care.

There are guidelines produced by national bodies (SIGN, MOM, and Target PAD) that have been adapted and agreed by local experts. Please see Peripheral Arterial Disease (PAD) Primary Care Algorithm appended within specification.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

- Commissioning strategy to reduce secondary care referrals

3. Scope

3.1 Aims and objectives of service

To provide ABPI tests in a community setting for patients who are experiencing symptoms of claudication without leg ulceration. The service will be provided from more than one location in order to improve access and patient choice.

3.2 Service description/care pathway

To provide ABPI tests in a community setting for patients who are experiencing symptoms of claudication without leg ulceration. The service will be provided from more than one GP practice in order to improve access and patient choice.

1. This service can be performed by Health Care Assistants or Practice Nurses who have received specific training and have successfully been deemed competent (proof required)
2. It is the responsibility of the practice to ensure that new staff attend training (proof required)
3. Consent for the procedure must be recorded within the patient's medical record. Where practices offer this service to patients outside their practice records of summaries of attendance / consent must be kept.
4. A summary of the test recorded within the patient's medical record, where practices offer this service to patients outside their practice a summary is sent back to the referring GP. (Referral/summary of test is available on CCG website)
5. Participating practices will provide appointments for ABPI tests
6. The practice will be responsible for supplying relevant consumables
7. Practices must provide a comfortable and safe environment for patients attending community based ABPI
8. Clinicians delivering the service must comply with practice Health and Safety Policy, Infection Control Policy, National Guidance on Clinical Waste and assessed as competent to undertake the task.
9. Quarterly activity / breakdown of referrals to be forwarded to the CCG
10. Annual patient satisfaction surveys must be undertaken by the participating practice
11. A list of participating practices with contact details will be displayed on the CCG website

3.3 Population covered

Patients registered at a South Sefton GP Practice.

3.4 Any acceptance and exclusion criteria and thresholds

N/A

3.5 Interdependence with other services/providers

- Vascular Consultants working in local NHS Trusts.
- CCG

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

N/A

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

Quarterly report / invoice detailing:

- Number of procedures carried out
- Whether the test was within or outside normal range
- Neighbouring practices who have referred to the service
- Patient satisfaction survey (20 random samples) annually

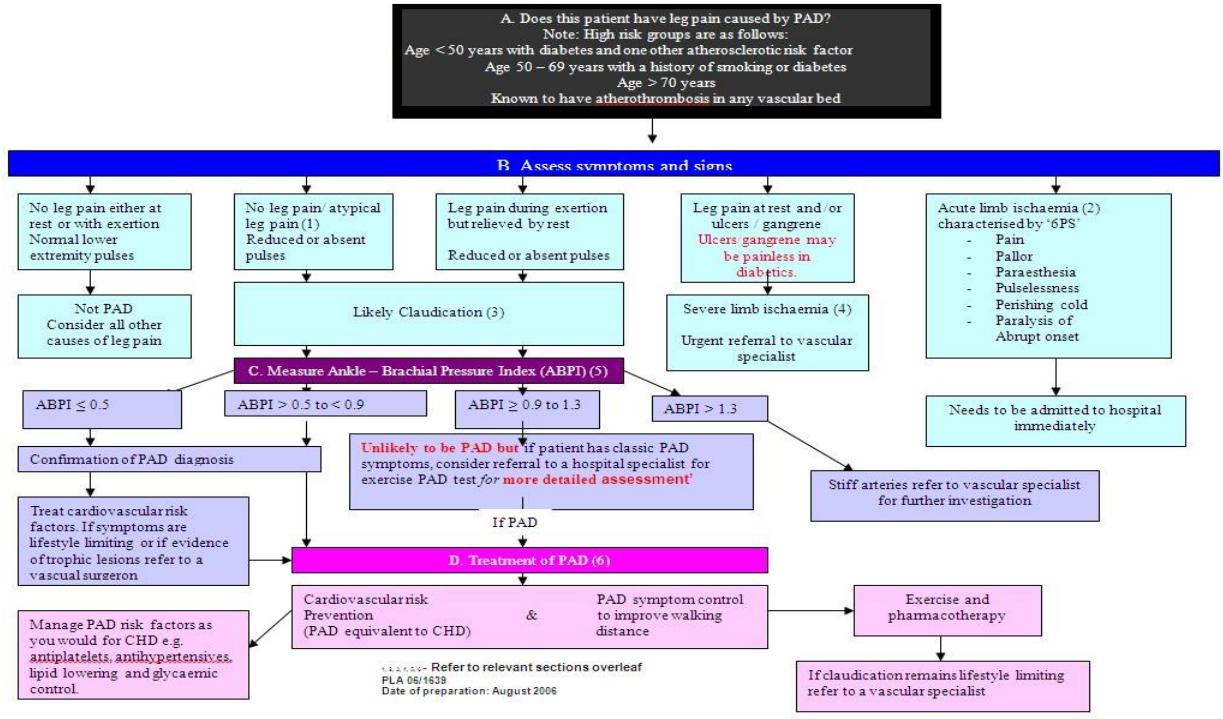
6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Practices will be paid cost per case £31.22 on production of quarterly invoice (including agreed 1% uplift)

Peripheral Arterial Disease (PAD) Primary Care Algorithm





South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Part 3 Southport & Formby

Service Specification No.	12
Service	Primary Care – Gypsies and Travellers
Commissioner Lead	Jan Leonard
Provider Lead	Practice Senior Partner
Period	18 months
Date of Review	Annual Review

1. Population Needs
<p>1.1 National/local context and evidence base</p> <p>Under the Race relations Amendments Act (2000) all those who deliver services to the public are required to demonstrate that race equality is considered in all their functions. The CCG already commissions a Local Enhanced Service (LES) for the Travelling Community and, with the abolition of LES as a contractual route for the provision of services delivered over and above essential and additional to core contract, there is a need to recommission this to ensure that this group can access health care fairly, have good opportunities for receiving health care and treatments and should have satisfactory health outcomes.</p> <p>Results of the “004 University of Sheffield report “The health status of Gypsies and Travellers in England” found that Gypsies and Travellers have significantly poorer health status and significantly more self-reported symptoms of ill-health than other UK resident, English speaking ethnic minorities and economically disadvantaged white UK residents. The report concluded that the scale of health inequality between Gypsies and Travellers and the UK population is large, with reported health problems between twice and five times more prevalent.</p> <p>There is a well-established Travellers community in the CCG.</p>
2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

- Reduce Health inequalities

3. Scope

3.1 Aims and objectives of service

The common difficulties of this group are:

- Registration with GPs.
- Limited time for consultation.
- Reluctance of health staff to get involved in complex matters.
- Racism and discrimination of transient population.
- Poor literacy levels.

The service would aim to provide quality mainstream primary health care to Gypsies and Travellers thus enabling them to receive optimum advantage from the UK health and social care system which, in turn, produces benefits in terms of health and independence. It will do this by:

- Incentivising GPs to devote time and resources to such patients.
- Encouraging GPs and other primary care practitioners to provide the necessary treatment, investigations and explanations to improve health and prevent further deterioration.
- Promote continued understanding of the NHS and social care system so as to encourage its subsequent cost effective use and the utilisation of such long term preventative procedures as cervical cytology and immunisation.

3.2 Service description/care pathway

Any Traveller residing in the Sefton area would be able to register with the practice under this scheme.

Registration: Practices should have a policy of registering Gypsies and Travellers as Fully Registered patients wherever possible, rather than as Temporary Residents. People who travel away within the UK (for up to 3 months) should not automatically be de-registered.

Walk-in appointments: Practices should adopt a policy of not turning away any Gypsy/Traveller who attends without an agreed appointment.

Longer consultations: Practices should allow up to 20 minutes for consultations. Any requests to see other family members in the consulting room should be agreed (within reason), as this provides an opportunity to improve the screening status of potentially vulnerable patients.

Screening, child health surveillance & immunisations: given the fact that mobile Gypsies and Travellers may be forced to move on from unauthorised sites, as well as travel of their choice, it is likely that Gypsies and Travellers will not be as reliable as the settled population in keeping or making appointments. Using SMS text messaging software to send reminders may be useful here. The CCG will make allowance for the consequent impact on a practice's QoF points; for instance a practice may find it hard to achieve maximum QoF points if some patients do not attend at the specified intervals for immunisations

Records: practices should use a special flag to identify Gypsy and Traveller records, and apply Read Codes to all identified Gypsies and Travellers (it is important to record ethnic status as Gypsies and Travellers are not currently included in the official list of ethnicity codes).

Traveller Gypsy	9T2
Traveller – ethnic category 2001 census	9i2D
Irish Traveller – ethnic category 2001 census	9i2C

Consideration should be given to:

- Developing a template for collecting health information on Gypsies and Travellers
- Making summary printouts available for people to take with them when they go travelling. (NB Particular care is needed here to avoid confidentiality errors).
- **Patient information:** Provision of Gypsy and Traveller-friendly leaflets and health promotion material.
- **Cultural awareness training:** this should be mandatory for all doctors and practice-based staff providing the scheme. This training should be planned and delivered by community members working in partnership with, and supported by, staff from the CCG or another service.
- **Outreach:** this could take the form of a nominated practice-based outreach worker/advocate, (or a nurse) with responsibility for
 - visiting sites regularly to provide health information and promote proactive health care and facilitate access to mainstream service
 - encouraging screening and full GP registration
 - liaison with other community staff serving the Gypsy and Traveller communities
 - promoting cultural awareness within the GP practice
 - monitoring Gypsy and Traveller views of services being provided.

3.3 Population covered

The Gypsies and Travellers based within Sefton.

3.4 Any acceptance and exclusion criteria and thresholds

The patient should be recognized as a member of the Gypsy or Travelling community.

3.5 Interdependence with other services/providers

- Close connections to be developed between the GP practice and the School Nursing Service which liaises with the Travelling community in Sefton.
- Social Services.
- District Nursing services □ Local NHS Acute Trusts.
- Optometrists
- Dentists
- Pharmacists
- Schools
- Public Health

4. Applicable Service Standards

<p>4.1 Applicable national standards (e.g. NICE)</p> <p>RCGP document – Improving Access to health care for Gypsies and Travellers, homeless people and sex workers.</p> <p>4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)</p> <p>4.3 Applicable local standards</p> <p>Equality and Diversity Policy</p>
5. Applicable quality requirements and CQUIN goals
<p>5.1 Applicable Quality Requirements</p> <p>Annual report to evidence compliance with section 3.2</p>
6. Location of Provider Premises
<p>The Provider's Premises are located at:</p> <p>Insert address of GP premises.</p>
7. Individual Service User Placement

The service will be funded as follows (including agreed 1% uplift):

- **£582.94** retainer per 5000 patient practice per year paid up front Formula - retainer fee divided by 5000 x practice list size
- **£113.46** per patient register per year paid quarterly in arrears

Future years/phases will be determined based on the outcome of this scheme.