

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	
Service	Non recurrent Investment-Enhanced Services, covering; <ul style="list-style-type: none">• Dementia Diagnosis• Learning Disability Health Checks• NHS Health Checks for patients on severe Mental Illness Registers (SMI)
Commissioner Lead	Jo Reynolds
Provider Lead	Wolverhampton GP Practices
Period	November 2018 - 31 March 2019
Date of Review	31 March 2019

1. Population Needs

National/local context and evidence base

There are 3 key areas this specification focuses on, Dementia Diagnosis Rate, Learning Disability Health Checks for adults & children, as well as Health Checks for adults with Serious Mental Illness.

Dementia Diagnosis- A timely diagnosis enables people living with dementia, and their carers/families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease. A timely diagnosis enables primary and secondary health and care services to anticipate needs, and working together with people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes.

LD Health Checks- People with a learning disability can have poorer physical and mental health than other people and studies have shown that they can die on average 20 years younger than the rest of the population The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD 2013) reported that people with a learning disability are three times more likely to die from causes of death that could have been avoided with good quality healthcare. Many of these deaths are avoidable and not inevitable. Annual health checks in people with a learning disability are likely to lead to identification and management of underlying physical health problems at an early stage. Unrecognised physical illness in people with a learning disability may lead to pain and discomfort, which, in turn, may be an important factor in triggering and maintaining behaviour that challenges. Therefore, early identification of physical health problems in people with a learning disability may reduce behaviour that challenges, leading to a reduction in costs associated with assessing and managing such behaviour.

SMI Healthchecks- People living with severe mental illness (SMI) face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15–20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. Smoking is the largest avoidable cause of premature death, with more than 40% of adults with SMI smoking. Individuals with SMI also have 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) than the general population.

Individuals living with SMI are not consistently being offered appropriate or timely physical health assessments despite their higher risk of poor physical health. They are not being supported to use available health information and advice or to take up tests and interventions that reduce the risk of preventable health conditions [1].

Therefore in the Five Year Forward View for Mental Health [1], 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.

The relevant ambitions within the Five Year Forward View for Mental Health are as follows:

NHS England should ensure that by 2020/21, 280,000 people have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

2. Scope

The three areas covered by this specification all feature as part of the National QOF scheme. However, the requirements of QOF will not fully satisfy the outcomes that are sought within this service specification. Therefore, the required performance measures have been defined in order for practices to qualify for additional payment. October 2018 data has been used as the baseline reference point to identify where improvement is required against the CCGs constitutional standards set and overseen by NHS England.

The expectations of QOF for dementia diagnosis, SMI Health Checks and LD health checks are included as appendices to this specification for ease of reference. This enhanced service targets the quantity and quality of those diagnosis rates and health checks, enabling better outcomes for patients.

The practice will be responsible for ensuring that data quality within their respective practice clinical system is improved to demonstrate how, between November 2018 and March 2019 patient records have been duly updated to reflect diagnosis and care planning in all 3 areas based on correspondence provided by acute & mental health trust(s) whilst also improving recording of diagnosis made by the practice. Care planning should be patient centred involving the patient and carer(s) where applicable and based on shared decision making and will be coordinated by an appropriate member of the practice clinical team.

3. Aims

The aim of dementia diagnosis & care planning in this specification is to improve the rate of diagnosis using data available to confirm *estimated diagnosis rate for each practice*. This is based on national data used for planning purposes & seeks to provide an indication of the number of patients who should be on the QOF register (QOF requires a register and corresponding care plan to be in place at practice level to qualify for payment). Early diagnosis enables information and support to be offered to the patient in the form of a care plan and should contribute towards the best quality of life for people living with dementia. Therefore, an increase in dementia diagnosis should be realized by March 2019 the requirement set by NHS England is to maintain the dementia diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care however in order to sustain an outstanding rating the CCG strive to achieve a higher rate of diagnosis.

The aim of the LD health check is to ensure that patients with a learning disability are proactively assessed, that any emerging health problems are identified and treated. Patients shared care plans need to be maintained and acted upon, based on the findings of the health check. Local data confirms that the number & quality of health checks is below the expected standard and this service specification seeks to improve the number of health checks taking place.

The aim of the SMI health check is to ensure that patients with severe mental illness have a comprehensive physical health check to proactively assess their physical health and identify any risk factors that could impact on their wellbeing, ensuring any relevant interventions to manage these are identified and initiated. There are 3 core requirements that should be achieved for SMI are as follows:-

- a. Completion of recommended physical health assessments
- b. Follow-up: delivery of or referral to appropriate NICE-recommended interventions
- c. Follow-up: personalised care planning, engagement and psychosocial support

Practices will be required to achieve >70% of patients with SMI receiving a physical health check with all 6 indicators completed. October 2018 data demonstrates significant under-performance at only 17% for the CCG:-

Number of indicators achieved	Patient Count
0	10
1	511
2	403
3	445
4	473
5	506
6	483

Total SMI Patients	2831
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To qualify for payment practices will be required to ensure that all SIX indicators have been completed for more than 70% of patients on their register within the preceding months.

4. Service description

Dementia Diagnosis & Care Plan/Review

Practice(s) are required to ensure patient diagnosis has been coded in their clinical system, and for patients already coded should have been invited for a review of their care within the preceding 12 months.

Group Managers have data confirming the estimated diagnosis rate(s) for each practice, they will liaise directly with practices at sign up to provide this information. Further details can be found in Appendix A this is an extract from the technical guidance issued by NHS England.

This specification focuses on increasing diagnosis rates, and the number of patients on the practice register, this can be achieved by targeting the following areas-

- 1) Discharge from hospital- during a hospital stay, a patient may have been diagnosed with dementia. This will be communicated to practices upon discharge, and needs to be coded correctly. Practices will be expected to perform searches to determine if this has happened, and rectify any that may have been missed, including patients identified onto the diagnosis register.
- 2) GP identification of a patient, and refers to the memory clinic. Practices will be expected to identify at risk patients & liaise with colleagues from the Mental Health Trust recording a dementia diagnosis in the practice clinical system.
- 3) Care Home Residents- where a patient resides in a care home, and shows symptoms of dementia, this needs to be documented within their records. In this instance, a care plan is not required, but the patient is still required to be registered on the dementia register.

Quality and Outcomes Framework (QOF) Indicator DEM004: The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months is already captured at practice level as part of QOF. Therefore, newly diagnosed patients will need a care plan prepared within the first 12 months of diagnosis, if not already in place. The requirement to provide this is covered within QOF Indicator DEM004.

For further information on dementia care planning see-

<https://www.england.nhs.uk/wp-content/uploads/2017/11/dementia-good-care-planning-v2.pdf>

for further guidance around dementia pathway see

<https://pathways.nice.org.uk/pathways/dementia#path=view%3A/pathways/dementia/dementia-overview.xml&content=view-index>

LD Physical Health Check

The recommended physical health assessment aligns to the **NHS Health Check** but unlike the NHS Health Check it should be offered annually to all age groups (rather than every 4 years to people aged 40-74). All parts of both health checks are voluntary hence patients may decline and in such circumstances this should be reflected in the patients record.

The Health check should include as a minimum:

- a measurement of weight (BMI or BMI + waist circumference)
- a blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate)
- a blood lipid including cholesterol test (cholesterol measurement or QRISK measurement)
- a blood glucose test (blood glucose or HbA1c measurement)
- an assessment of alcohol consumption
- an assessment of smoking status
- an assessment of nutritional status, diet and level of physical activity
- an assessment of use of illicit substance/non prescribed drugs
- access to relevant national screenings
- medicines reconciliation and review
- general physical health enquiry into sexual health and oral health
- indicated follow-up interventions

In addition to the NHS Health Check assessments the physical health assessment should include; relevant national screening and immunisation programmes, as recommended by Public Health England (PHE), medicines reconciliation, and additional general physical health enquiry into sexual health, oral health and substance misuse.

It is expected then that not only are the checks done but any issues found are treated.

In addition to the standard health check requirements, the following components are required in order for the enhanced physical health checks for patient with a learning disability to be achieved as follows:-

A comprehensive health assessment should include:

- a review of any known or emerging behaviour that challenges and how it may be linked to any physical health problems
- a review of physical health
- a review of all medicines and other types of treatment (for example psychological therapy)
- an agreed and shared care plan for managing any physical health problems (including pain)
- discussion with a family member, carer, healthcare professional or social care practitioner who knows the person.

All physical health assessment results and agreed actions are to be entered into the patient electronic record within the practice clinical system by March 2019 to qualify for payment.

The Technical Guidance for LD health checks can be found in Appendix B & must be fully achieved to qualify for payment. Practices will also be able to claim for completion of the Physical Health Check in line with the Direct Enhanced Service £140 per patient.

Further information relating to LD health checks can be found here- <http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx>

SMI Physical Health Check

Again the physical health assessment aligns to the **NHS Health Check** but unlike the NHS Health Check it should be offered annually to all age groups (rather than every 4 years to people aged 40-74).

In addition to the standard health check requirements, the following components are required in order for the enhanced physical health checks in SMI to be achieved as follows:-

A comprehensive health assessment should include:

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

All six components of the physical health check must be completed as far as reasonably possible unless usual exceptions (QOF apply).

Technical Guidance can be found in Appendix C for further detail.

5. Payment / Monitoring

The CCG is committed to maintaining an outstanding rating and has therefore set aside £285,000 of **non recurring revenue** funding in 2018/19 to incentivize practices to improve performance in all 3 areas detailed below:-

Patient shortfall	Constitutional Standard	Performance Requirements	££Cost Per patient	Total Allocation (assuming 100% achievement)
954	Learning Disability Health Check <i>Reliance on specialist inpatient care for people with a learning disability and/or autism</i> <i>Proportion of people with a learning disability on the GP register receiving an annual health check</i>	greater than 70% of patients on their register with check complete and care plan in place	£38	£36,252.00
2348	Mental Illness <i>Proportion of people on GP severe mental illness register receiving physical health checks in primary care (all 6 care processes)</i>	greater than 70% of patients on their register receive all 6 care processes and care plans in place	£79	£185,492.00
788	Dementia <i>Estimated diagnosis rate for people with dementia</i> <i>Dementia care planning and post-diagnostic support</i>	greater than 70% of their expected prevalence on the register and associated diagnostics and care plans in place	£77	£60,676.00
				£282,420.00

Claims for payment will be required in Quarter 4, the claim form will have been amended to include this enhanced service and can be submitted for payment from mid March through until Friday 19 April 2019.

Payment for each indicator will be based on data available in practice clinical system(s) on 31 March 2019. All claims will be considered by the Primary Care Team and cross referenced with supporting evidence from Graphnet. Practices will be required to demonstrate that the constitutional standard has been met for more than 70% of patients, under performance will result in non payment.

Searches will be run centrally in order for activity to be monitored against achievement of the trajectory. Graphnet data will be reviewed on a monthly basis to monitor improvement in performance for all 3 constitutional standards. Therefore, practices are urged to spread the workload over the period of November 2018 to March 2019 in order to manage competing demands. It is essential that timely coding of activity takes place in the practice clinical system; a full list of appropriate codes is attached to this specification, please refer to Appendix D.

6. Outcomes

6.1 NHS Outcomes Framework Domains & Indicators

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

6.2 Adult Social Care Outcomes Framework

Domain 1	Enhancing quality of life for people with care and support needs	<input type="checkbox"/>
Domain 2	Delaying and reducing the need for care and support	<input type="checkbox"/>
Domain 3	Ensuring that people have a positive experience of care and support	<input type="checkbox"/>
Domain 4	Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	<input type="checkbox"/>

6.3 Clinical Commissioning Group Improvement and Assessment Framework

Domain 1	Better Health (improving the health & wellbeing of the population)	<input type="checkbox"/>
Domain 2	Better care (care re design, performance of constitutional standards and outcomes)	<input type="checkbox"/>
Domain 3	Sustainability (Financial balance and value for money services)	<input type="checkbox"/>
Domain 4	Leadership (Quality planning, working with partners, governance arrangements)	<input type="checkbox"/>

6.4 Public Health Outcomes Framework

Outcome 1	Increased healthy life expectancy	<input type="checkbox"/>
Outcome 2	Reduced differences in life expectancy and healthy life expectancy between communities	<input type="checkbox"/>

6.5 Local defined outcomes

- Improved diagnosis rates for Dementia
- Improved follow up support for diagnosis of dementia
- Improved provision of SMI and LD physical health checks
- Improved completion of SMI and LD physical health checks
- Improved support following a health check & care planning/review

7 Population Covered

All patients at risk or have indicators of dementia

All patients registered with a Wolverhampton GP who is on their practices learning disability register and is over the age of 14.

All patients registered with a Wolverhampton GP who have received a diagnosis of schizophrenia or bipolar disorder, or who have experienced an episode of non-organic psychosis.

The SMI element of this service specification does not apply to those patients who are not current inpatients or who have been under care of a mental health team for less than 12 months and/or whose condition has not yet stabilised.

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:
 - a. those whose care has always been solely in primary care, and
 - b. those who have been discharged from secondary care back to primary care; and
2. patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised.

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

1. patients with SMI under care of a mental health team for less than 12 months and/or whose condition has not yet stabilised
2. inpatients

8 Timescales

Activity and claims for the enhanced services detailed will need to take place before 1st April 2019.

Claims for payment must be submitted by no later than Friday 19 April 2019.

9 Applicable Service Standards

Applicable national standards (e.g. NICE)

Appropriate evidence-based physical care interventions should be provided for all physical health risk(s) or conditions identified during the assessment including:

- For alcohol and illicit/non-prescribed drug use: follow guidance on co-occurring substance misuse and SMI (NICE Clinical Guideline **CG120**).
- For **Obesity** prevention [**NICE CG43**]
- For **Physical activity**: brief advice for adults in primary care [**NICE PH44**]
- For **Hypertension** in adults: diagnosis and management [**NICE CG127**,
- For Type 2 diabetes prevention and treatment **NICE PH38**, **NICE NG28**, and [**NICE NG28**]
- For Type 1 diabetes diagnosis and management [**NICE NG17**, **NG18** and **NG19**]
- For **Lipid modification** [**NICE CG181**]
- For current smokers: facilitate smoking cessation through pharmacotherapies, intensive behavioural support, and methods such as carbon monoxide monitoring (NICE Public Health Guideline **PH 48**).

Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset
NICE guideline [**NG16**]

challenging behaviour and learning disabilities (NICE guideline **NG11**)

Learning disabilities: challenging behavior [**QS101**]

NICE Clinical Guidance on Bipolar disorder: assessment and management Clinical guideline

[CG185]

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

Applicable local standards

10. Applicable Quality Requirements & CQUIN Goals

10.1 Applicable Quality Requirements

All practices taking part in the scheme are expected to work within usual contractual terms and conditions.

10.2 Applicable CQUIN goals

11. Location of Provider Premises

The Provider's Premises are located at:

Member practices within Wolverhampton CCG

- Appendix A** Dementia Technical Guidance
- Appendix B** Learning Disability Technical Guidance
- Appendix C** Serious Mental Illness Technical Guidance
- Appendix D** Read Codes

ESS-NRR£/201819/V4.3/SS

Appendix A : Dementia Technical Guidance

35. Dementia care planning and post-diagnostic support (126b)

Domain, Area	Better Care, Dementia
Definition	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months
Purpose (Rationale)	<p>Substantial effort has been made recently to increase the proportion of people living with dementia who have a formal diagnosis in primary care. Clinical evidence shows that formal care planning and other post-diagnostic support is positive for the patient and is expected to lengthen the time which they can live in the community. This indicator tests whether primary care is conducting a timely review of the patient's needs, including that:</p> <ul style="list-style-type: none"><input type="checkbox"/> patients are receiving an appropriate physical, mental health and social review;<input type="checkbox"/> a record is made of the patients' wishes for the future;<input type="checkbox"/> communication and co-ordination arrangements with secondary care (if applicable);<input type="checkbox"/> identification of the patient's carer(s)
Evidence and policy base	<p>Patients diagnosed with dementia are expected to be offered annual face-to-face appointments specifically to review their diagnosis and/or their care plan or advanced care plan. This is in line with the NICE clinical guideline CG42."Dementia. Supporting people with dementia and their carers in health and social care", which is in support of two NICE Quality Standards:</p> <ol style="list-style-type: none">1. NICE Quality Standard 1: Dementia;2. NICE Quality Standard 30: Supporting people to live well with dementia.
Data	
Data source	Quality and Outcomes Framework (QOF) Indicator DEM004: The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months.
Data fields	Numerator and denominator per GP practice as described below.
Data filters	Only currently active GP practices are to be included in the indicator. The annual QOF extract is of high quality and does not include any extraneous practice records; however an assessment of the quality of a quarterly data feed has not yet been

completed.

Data processing
Construction
Numerator

Not applicable

For each practice in the CCG, the most recently available

Appendix B : Learning Disability Technical Guidance

28. Proportion of people with a learning disability on the GP register receiving an annual health check (124b)

Domain, Area	Better Care, Learning disability
Definition	The proportion of people on the GP Learning Disability Register that have received an annual health check during the year. Measured as a percentage of the CCG's registered learning disability population
Purpose (Rationale)	To encourage CCGs to ensure that people with a learning disability over the age of 14 are offered annual health checks.
Evidence and policy base	NHS England, ADASS and LGA's service model published on 30th October 2015 states that one of the key actions to ensure that people with a learning disability get good care and support from mainstream health services is for health commissioners to ensure that people with a learning disability over the age of 14 are offered annual health checks. This indicator aims to monitor progress and will show which CCGs are not delivering learning disability services in line with this model. The annual health check scheme has been run since 2009. The Confidential Inquiry into premature deaths of people with learning disabilities highlighted the importance of annual health checks.
Data	
Data source	Presently published by NHS Digital (GPES and QOF)
Data fields	From GP Contract Service GPES publication: Annual Summary field LD001 Health Checks From QOF publication: LD field Register
Data filters	None
Data processing	Health Check data from GP practices are aggregated up to CCG level. Practices have been mapped to their respective CCGs using reference data current at 1 April 2017 (Source: Quality Outcomes Framework 2016/17, NHS Digital).
Construction	
Numerator	Number of Annual Health Checks carried out in the last 12 months
Denominator	CCG population on the GP Learning Disability Register
Computation	Numerator / Denominator
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

Appendix C : Serious Mental Illness Technical Guidance

23. Proportion of people on GP severe mental illness register receiving physical health checks (123g)

Domain, Area	Better Care, Mental health
Definition	The proportion of people on General Practice SMI registers who have received a full set of comprehensive physical health checks in a primary care setting in the last 12 months.
Purpose (Rationale)	<p>This indicator tracks progress against the NHS's commitment 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".</p> <p>Due to different methods of data collection for the primary and secondary care elements of this standard the two areas will be monitored separately. This indicator covers the primary care element only</p>
Evidence and policy base	<p>In 2016, the Five Year Forward View Mental Health (MH5YFV) set out NHS England's approach to reducing the stark levels of premature mortality for people living with serious mental illness (SMI) who die 15-20 years earlier than the rest of the population, largely due to preventable or treatable physical health problems. In the MH5YFV 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 equates to a target of 60% of people on the SMI register receiving a full and comprehensive physical health check. This commitment was reiterated in the Five Year Forward View Next Steps</p> <p>Due to different methods of data collection for the primary and secondary care elements of this standard the two areas will be monitored separately.</p> <p>This indicator covers the primary care element only.</p>
Data	
Data source	NHS England SMI Physical Health Checks data collection. Collection to start autumn 2018 – publication details to be confirmed.
Data fields	Numerator: The number of people on the General Practice Serious Mental Illness

registers who have received a full set of comprehensive physical health checks in the last 12 months to the end of the reporting period delivered in a primary care setting.

Appendix D - READ codes

	EMIS	TPP
Dementia		X002w (dementia) Donepezil prescribing
SMI Health checks	MH003 MH006 MH007	
Learning Disability	Eu816 - [X]Mild learning disability Eu814 - [X]Moderate learning disability Eu815 - [X]Severe learning disability Eu817 - [X]Profound learning disability	