NHS
Waltham Forest
Clinical Commissioning Group

Waltham Forest CCG APMS Specification

Services Specific to SMA Surgery

Critical Success Factors (CSFs)

The critical success factors set out in the APMS contract have been revised to ensure that potential bidders are aware of the vision for delivery of primary medical services at the SMA practice, which links to the broader primary care strategy for Waltham Forest.

Access

The services procured must be provided at the SMA Medical practice and, where relevant, in other locations and facilities that meet local patient access preferences. Opening hours will be from 8.00am to 6.30pm Monday to Friday and the provider will be expected to open on a Saturday which will be funded via the Extended Hours DES.

The Provider will be required to demonstrate innovative ways of improving patient access e.g. telephone consultations, text reminders, e-consultations etc.

The provider will be expected to deliver Local KPI's developed by the CCG to try to improve access for patients by incentivising increased capacity/ consultations and patient experience.

The provider should develop a model of holistic care, where the patient's broader needs which can impact health are taken into consideration, this can be via the use of the community assets/ partnering with the voluntary sector and utilisation of social prescribing.

Capacity

The Provider will be required to demonstrate that it can provide sufficient clinical and administrative capacity to meet the challenging demands of the area, and develop appropriate skill mix to safely deliver the most appropriate interventions.

The provider will need to embody new models of care which allows for skill mix to be effectively utilised, this could include the use of roles including Clinical pharmacists, Physicians Associates, Assistant Nurses, Mental Health practitioners etc. together with innovative and appropriate joint roles which cover Health and social care. The provider will need to demonstrate how these roles will improve patient care and experience and provide effective care to patients.

The GP would be a key member of the teams and should be freed up to be able to deliver care for patients with long term conditions and those with complex co-morbidities. Demonstrating how the prevention agenda will be taken forward will be key, but this should not deter from having sufficient capacity to effectively manage a growing list.

As training models change with the introduction of apprentices it is expected that the successful provider engages and utilises opportunities to develop existing staff and new staff using this model. In working to provide this, the provider would be expected to work closely with the local community education provider networks.

Skill

The Provider will be required to introduce specialist clinical skills applicable to the local patient needs. The provider should demonstrate how the use of specialists will meet the needs of the population of SMA practice, Segmentation of the practice population could be undertaken to allow for care to be designed around specific needs. The provider should demonstrate they have researched the population and developed plans in relation to how these patients should be managed.

This could include GP's with Special Interest in areas such as mental Health, maternity, young people etc. which would reflect local demographics. Plans for management of each of the cohorts set out by the CQC should be demonstrated, with particular focus on the specific demographics of SMA practice.

Quality

The Provider must provide patient-centred primary medical care services, delivered in a safe and effective manner cognisant to the particular needs of local patient cohorts and in line with the terms and service specifications provided.

The delivery of care will need to be evidence based with systems and processes which support managing clinical governance requirements effectively, for example:

- GDPR (General Data Protection Regulations)
- Provider Partnership agreements
- Data sharing processes

If issues are highlighted in relation to the management of patients or the level of care being delivered at the practice then Commissioners will have access to clinical records and evidence in relation to clinical care via an appropriate clinical lead. The provider should highlight whether they are agreeable to such an open and transparent contractual arrangement in the bid.

Affordability

The primary medical care services procured through the Procurement must be affordable and provide value for money.

The KPI's reflect the specifics of the contractual requirements for SMA practice and aligns with the GMS/ PMS contract equalisation process. Additional KPI's have been incorporated which are specific to the population and allows for equity in payment, as the APMS provider will not be offered the opening hours KPI which is currently a KPI for GMS and PMS providers. The vision is to allow incorporation of a holistic and integrated approach in the delivery of primary medical services.

Integration

The Provider will be expected to integrate with, and positively contribute to, the local healthcare community and in particular with the local CCG.

Integration will be a key element in the delivery of the contract.

The provider will need to demonstrate how they will work alongside the emerging integrated care systems in Waltham Forest, these include:

Urgent Care

Community

End of life

To be able to deliver true integration the provider will need to work collaboratively with other providers in providing delivery of the contract, this collaboration will include but is not limited to community services, the federation, secondary care and the voluntary sector.

The provider will need to demonstrate how they can work in an integrated manner, which could include joint MDTs, care plans, management of patients in the top tier for frailty etc.

The practice has a young population, only 6% of patients are aged over 65 and 28% are under 18 years. The bidder should highlight how they will focus on reducing the estimated to reported prevalence gap for long term conditions, increase immunisations, and improve outcomes for mental health patients, diabetes and asthma. This would support collaborative working with the community provider and incorporate community matrons, school nurses and Health visitors as appropriate.

IAPT-Long Term Condition (LTC) therapist

The provider will be expected to work closely with WF mental health services for the new IAPT-Long Term Condition (LTC) therapist to support people with depression or an anxiety disorder with a co-morbid long-term condition or medically unexplained symptom (MUS). It is expected that the practice will locate these new therapist in the primary care setting and will contribute towards the national plans to increase access to psychological therapies for people with Severe Mental Illnesses or Personality Disorder.

https://www.england.nhs.uk/publication/guidance-on-co-locating-mental-health-therapists-in-primary-care/

Severe Mental Illness Health Checks- the provider will enable their registered patients with schizophrenia, bipolar affective disorder and other psychoses aged 18-64 years old to have an annual physical health check by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year. The provider should focus on achieving the target of 60% of registered SMI register receiving a full and comprehensive physical health check and the required follow up care.

For 18/19 this equates to 72 patients as the QOF register indicates 119 patients on the practice register.

https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf

Patient Involvement

The Provider will be expected to demonstrate a commitment to engage with local patients in a meaningful way so as to deliver services which take account of local patients' needs, preferences and expectations.

The provider should demonstrate innovative ways of engaging with patients which includes a cycle of improvement and relates to primary medical services and the collaborative working approach with other providers.

Innovation

The Provider will be expected to demonstrate its ability and preparedness to innovate in its delivery of primary care services for the registered patient population.

Technological advances being used within General Practice (online, video etc.) should be utilised, and evolving Artificial Intelligence (AI) innovations should be explored within the context of integration and seamlessly managing patients, reducing duplication and providing effective care which is more accessible to patients.

Innovations can also be made in the way that the provider works with stakeholders and the delivery of patient care as a system. The way in which specific cohorts of patients for example 'end of life', frail elderly etc. are managed should also be demonstrated, within the context of integration.

Provider Pool

The Authority wishes to receive applications in response to the ITT from suitably qualified and experienced healthcare providers (including general practitioners, social enterprise / third sector organisations and other providers) with the necessary capacity and capability (or a demonstrable ability to provide the necessary capacity and capability) to provide the range of primary medical care services as set out in the service specification, in a safe and effective manner. Bidders may bid in partnership with other organisations such that the Clinical Services Supplier may be different to the Bidder.

The contract awarded could be to a single Bidder or an accountable Provider leading a partnership or consortium.

The provider should demonstrate whether they will be bidding in partnership- which is the preferred option for the commissioner, as the contract should deliver primary medical services via an integrated manner which incorporates the community and volunteer sector as appropriate

Services Specific to SMA Surgery

1.0 Background

1.1 Multi-morbidity is often associated with the co-existence of physical and mental health problems and can occur in younger ages, particularly in those experiencing high levels of social deprivation. The links between physical and mental health and social factors make it essential that people with multi-morbidity and complex needs are identified, supported and managed in a more effective and efficient way. This requires strong partnership working within the primary care team and across the health and care system, and active patient involvement and empowerment in care and decision making.

1.2 For people with multi-morbidity/complex health and social care needs, coordinated care is essential to support their health and wellbeing. Many of these patients will be receiving care from several different services, which can become confusing and frustrating to patients if the services do not work in close collaboration. This fragmentation can have an impact on the quality of care and outcomes for patients, and can result in duplication and increased workload for those involved in the care team.

1.3 This specification aims to build on promote and integrated and collaborative approach across provides and build on commissioned models within Waltham Forest to deliver an exemplar service which incorporates the values patient cantered care.

1.4 The specification covers enhanced aspects of clinical care which are beyond the scope of core services and the Quality and Outcomes Framework. The proposal is expected to deliver a consistent, equitable and high-quality Primary Care services which will improve patient outcomes and experience, access to a set of services which meet the needs of the population, and reduce pressure in secondary care (via reducing Accident & Emergency (A&E) attendance and admissions).

1.5 Previous London wide APMS KPI's for screening and Vaccinations and Immunisations will no longer be incentivised, however the provider will be expected to ensure that these targets are prioritised, as they remain national targets and are key in preventative care.

1.6 The local KPI's have been incorporated to support the vision of equity in contractual provision for primary medical services and to reduce health inequalities, as all contracts will have equal funding by 2020, however additional SMA practice specific KPI's have been developed to incorporate collaborative working across primary and community care, whilst also being reflective of the needs of the practice population.

2.0 Waltham Forest Primary Care in an Integrated System

2.1 The Five Year Forward View sets out the national direction of travel on integrated care systems:

"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."

2.2 National policy centres on integration through integrated care systems. These are systems in which NHS commissioners and providers, often in partnership with local authorities work together to take on clear collective responsibility for resources and population health with the intention of providing joined up, better coordinated care.

Recognition is given to the importance of primary care as the cornerstone of the healthcare system with better joined up services only working with the full engagement and participation of primary care and particularly general practice.

In order to drive forward the role of primary care need to articulate its strategic fit and opportunities that will be created by the national policy focus on integrated care systems. The options and implications of business models will follow as the system emerges.

Primary care needs to respond to the changing environment which involves working more closely with each other and other providers mirroring the integration taking place across local authorities, CCG commissioners and providers.

3. What Integrated Systems Mean for Primary Care

3.1 One of the critical success factors of effective primary care in an integrated system is the quality of relationships and the vision of local leaders who will need to work with and influence for example local providers, social care or the voluntary sector. The CCG sees primary care offering joined up and co-ordinated services across providers for out of hospital care whilst maintaining list based primary care and delivering more holistic patient centred care focused on targeted individual health and care needs rather than one aspect of care. Also providing pro-active supported self-care and personalisation sharing control for their own health with the individual patient

3.2 Partnership working will be required by all health and care service providers at a level that primary care, in particular general practice, has not been required

to demonstrate, increasingly primary care will take on a system leadership role.

Practices working at scale, and increasingly FedNet, the GP provider organisation, are central to the development of the integrated care system. Our ambition is that FedNet will be commissioned to work at scale to expand primary care capacity and resilience to deliver more services where it is appropriate to provide services closer to where people live.

3.3 This means there needs to be a workforce designed to work across organisations and focused on the individual with opportunities to work across care settings. Progressively more services will be designed around and targeted towards segments of the practice(s) patient population. Interoperability and the ability to work across systems is a critical enabler supporting our ambition.

4.0 Integrated Care and the Complex Care LIS

4.1 The provider should is expected to fully incorporate the integrated care pathways and the Complex Care Local Incentive Scheme.

4.2 In 2016, it was agreed that Coordinate My Care (CMC) would be used to share End of Life Care records across WEL. It is currently the only system available that can be accessed by NHS 111, LAS and all emergency services. Additionally from 1 July 2017, GP contracts required the identification of severely frail patients and offering them, where appropriate an End of Life Care Plan, it was felt it appropriate to include this in the creation of plans for all those identified as being in the last year of life. Further details can be found in the attached MOU document. http://gp.walthamforestccg.nhs.uk/gp-services/frailty/38353

MDT and palliative care scheme 18-19 M

5. APMS Pricing

APMS pricing will include:

- GMS Global sum (plus London adjustment)
- £5.00 Risk Premium
- £8.60 local PMS KPI payment which replaces the London KPI payment (£5.35).
- The APMS Mandatory/Premium Services Payment has been removed but the provider is able to participate in the Extended Access DES, which equates to £1.90

The opening hours required under the APMS contract would be 8:00 to 18:30 (Mon to Fri and the Extended hours DES would be expected to be delivered on a Saturday.

5.0 GMS/ PMS contract equalisation KPIs

The following KPIs are currently being offered to all GMS and PMS practices. The APMS contract will be offered the same set of KPI's together with additional SMA specific KPI's set out in section 5.

	Indicator	**Price**
1	Number of consultations	£1.90
2	Patient experience -overall experience of practice	£0.20
3	Patient experience – experience of making an appointment	£0.20
4	At scale plan	£1.80
5	Quality improvement – QI life plan	£1.00
6	Quality improvement- CKD review	£0.80
	Total	**£5.90**

The Schemes incentivise practices to engage in the delivery of the agreed indicators and participants will be remunerated on the basis of the level of performance achieved against the specification for each indicator. It is intended that these schemes will operate until 31 March 2020. Each year, the objectives of the Scheme will be refreshed to ensure consistency with changing directions, guidance and contract regulation and requirements schedules will be re-issued to reflect revised expectations. Such changes will be agreed in collaboration with the local LMC. In addition the indicator schedule will be revised to reflect increasing thresholds agreed during the initial negotiation of the indicators.

At the start of each year, the practice will need to confirm that they wish to participate in the scheme for a further year and that they accept any revised performance requirements.

As additional funding is released via the equalisation process, the CCG will incorporate additional Key Performance Indicators.

The MOU for the current schemes can be found here:

PC transformation - Memorandum of Un

Please note that the Opening hours KPI is not being offered to the APMS provider, as opening throughout core hours is a requirement of the APMS contract.

5.0 Proposed Outcome measures/ KPI specific to SMA practice

Long Term Conditions

The need to improve the treatment and management of long-term conditions is the most important challenge facing the NHS. Improving care for people with long-term conditions must involve a shift away from a reactive, disease-focused, fragmented model of care towards one that is more proactive, holistic and preventive, in which people with long-term conditions are encouraged to play a central role in managing their own care. NHS Waltham Forest recognises that this transformational approach can improve patient experience, outcomes and reduce unscheduled use of hospital care. Working in partnership with others: primary care, the ambulance trust, the acute trust, social services and the third sector to join up clinical care pathways and deliver effective care which will prevent unnecessary hospital admission.

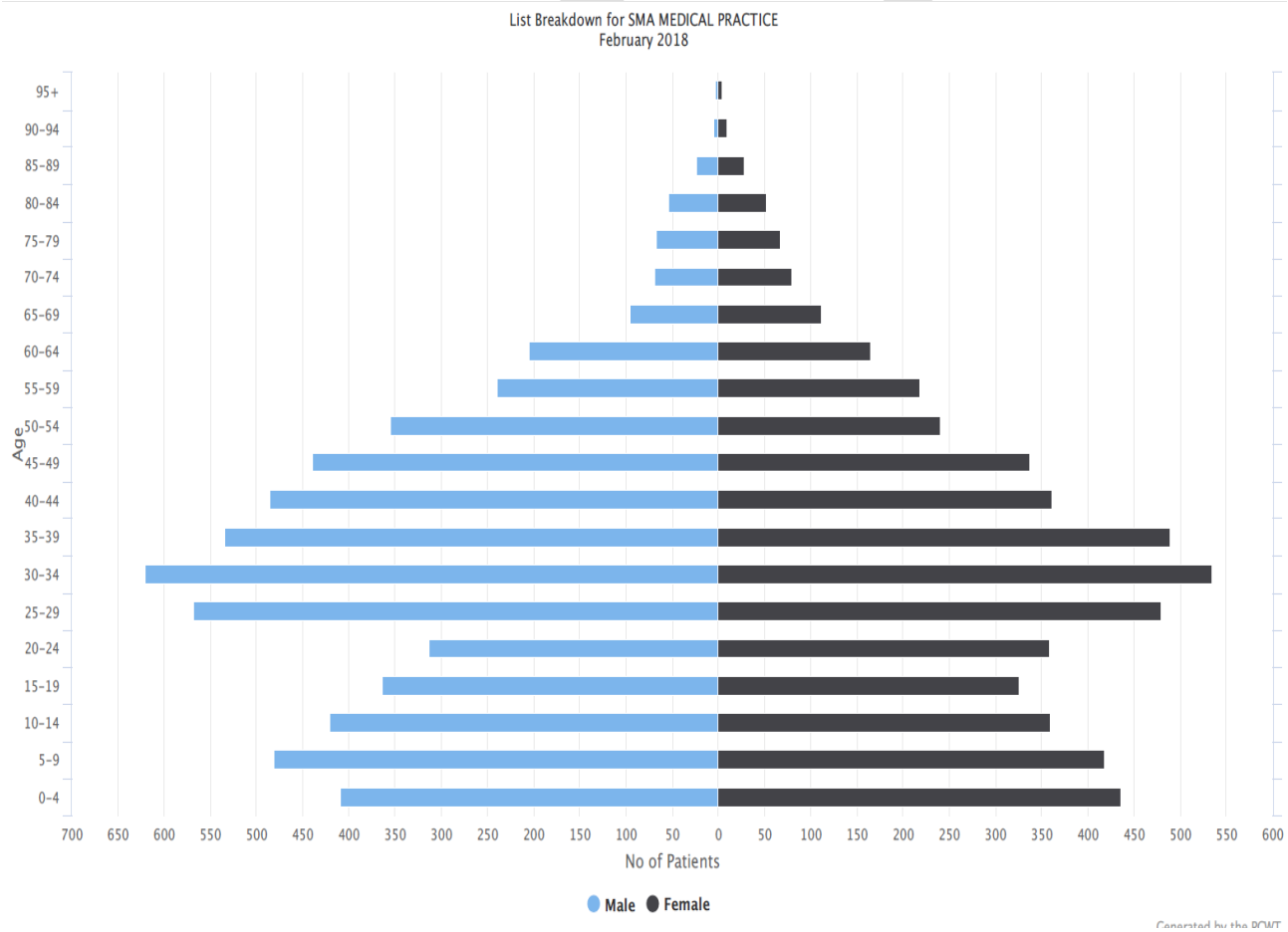

Figure 1: A summary of the patient demographics for the SMA Medical (1)

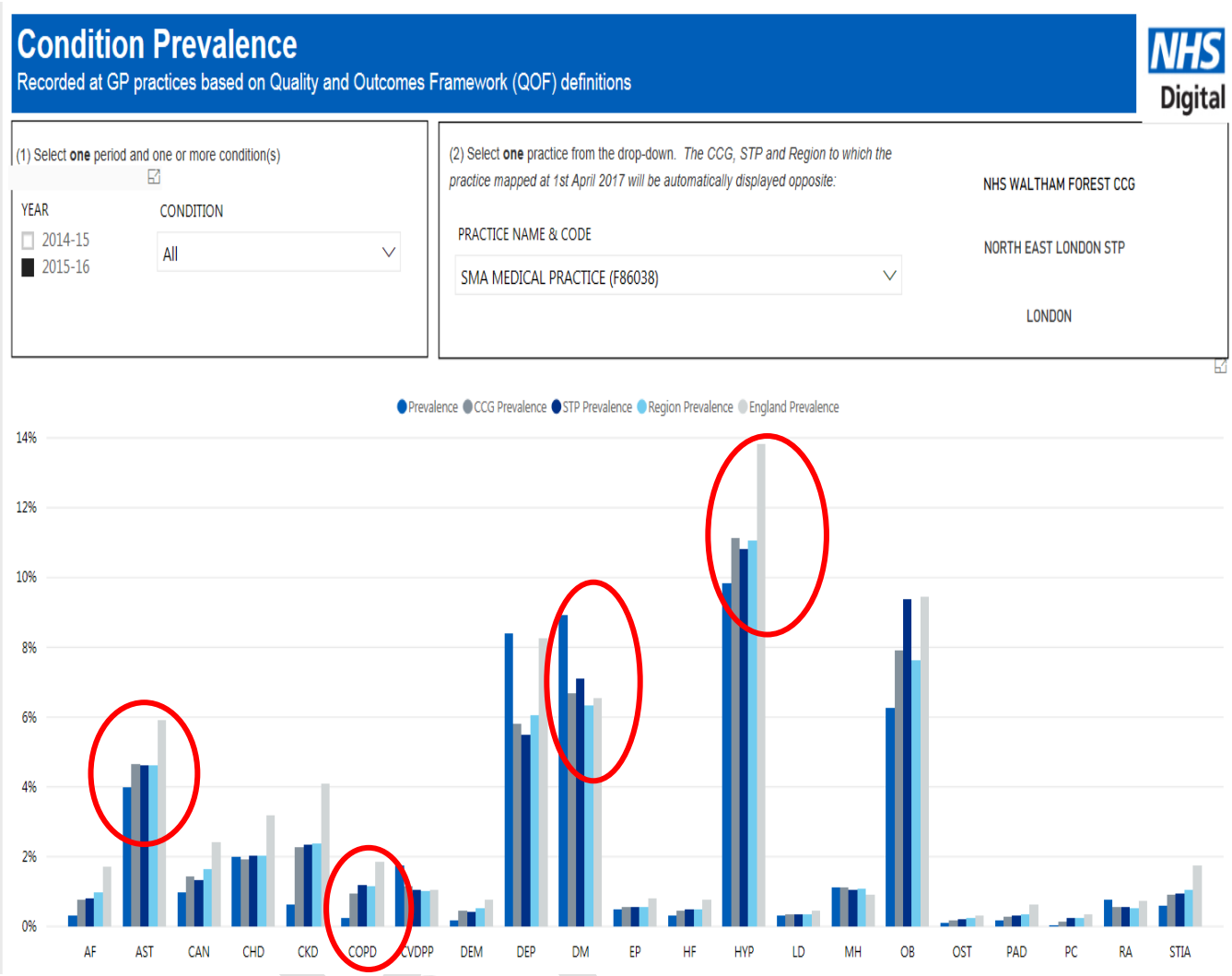

Figure 2: A summary of SMA reported prevalence for a number of clinical conditions compared to CCG, STP, regional and England prevalence

Please not the diabetes prevalence for SMA Medical Practice is greater to than both the CCG and England reported prevalence

6. Key performance Indicators

The following outcome measures have been developed to support the critical success factors outlined in the specification to be realised

	Indicator	Price
1	Long Term Conditions- overarching Key performance Indicator	£1.20
2	Chronic Obstructive Pulmonary Disease (COPD)	£0.50

3	Diabetes: Percentage of high risk diabetic patients reviewed annually	£0.50
4	Asthma: Percentage children and young adults under 18	£0.50
6	**Total**	**£2.70**

Clinical Condition	**Clinical Performance Metrics/Outcomes Key Performance Indicators (KPIs)**	**Monitoring**
Overarching Key performance Indicators • **Reduce the estimated to reported prevalence gap for long term conditions** • **Reduce the rate of emergency hospital admissions for patients with LTC per 1000 population (Diabetes, Respiratory, Cardiovascular disease)** • **Increase the number of patients with LTC who have participated in smoking cessation and quit for 4 weeks or more**		• Health analytics Prevalence data – Can be obtained from NHS Outcome data sets. Baseline for admissions needs to be obtained from health analytics

Clinical Condition	**Evidence Base**	**Clinical Performance Metrics/Outcomes Key Performance Indicators (KPIs)**	**Monitoring**
Chronic Obstructive Pulmonary Disease (COPD)	NICE Quality Standard Starting a pulmonary rehabilitation programme within 4 weeks of hospital discharge after an acute exacerbation reduces the short-term risk of hospital readmission, and improves the quality of life and the short-term exercise capacity of people with COPD. (1)	• Increase the number of patient who complete pulmonary rehabilitation	**Data from provider** (NELFT) • Number of patients referred to Pulmonary Rehab • Number of patients who complete the pulmonary rehabilitation programme.
Diabetes	**NHS England Diabetes Care Plan** diabetes-care-plan.doc	• All patients with a confirmed diagnosis of diabetes have an up to date Diabetes care plan in place (2)	**Health Analytics** • 66AR.00 Read Diabetes management plan given

			• 66AS.00 Read Diabetic annual review (4) Data to be obtained from health analytics
Asthma Percentage children and young adults under 18	**NRAD** All people with asthma should be provided with written guidance in the form of a personal asthma action plan (PAAP) that details their own triggers and current treatment, and specifies how to prevent relapse and when and how to seek help in an emergency. (3) All asthma patients who have been prescribed more than 12 short-acting reliever inhalers in	• Increase the number of personalised asthma action plans for children and young adults who have a confirmed diagnosis of asthma • Invite all patients over-ordering more than 6 short-acting	**Health analytics** • 663U.00 Read Asthma management plan given • 663U.00 Read Asthma management plan given • 66Y9.00 Read Step up change in asthma management plan • 66YA.00 Read Step down change in asthma management plan • 8CR0.00 Read Asthma clinical management plan • 66Y9.00 Read Step up change in asthma management plan 66YA.00 Read Step down change in asthma management plan (4)

7. Monitoring

Baseline data will need to be obtained from the relevant data source. Thresholds TBC

8. Contract Length

The service specification will be reviewed by the primary care commissioning team annually. The commissioner will consider whether any specific reviews of individual specifications or KPIs are required. The Contractor will need to confirm that they wish to participate in the scheme for a further year and that they accept any revised performance requirements.

References

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