Service	NHS Nottingham & Nottinghamshire CCG Primary Care Severe Multiple Disadvantage Local Enhanced Service
Commissioner Lead	Rachael Harrold, Primary Care Commissioning Manager
Provider Lead	GP Practices of Nottingham & Nottinghamshire CCG
Period	1 April 2021 – 31 March 2023
Date of Review	December 2021

1. Population Needs

1.1 National/local context and evidence base

Severe Multiple Disadvantage (SMD) refers to people with two or more of the following issues: homelessness, mental health issues, offending and substance misuse. It can also include other sources of disadvantage, for instance poor physical health and, particularly for women, being a victim of domestic and sexual abuse.

Homeless people experience some of the poorest health in our communities. Without good health, it can be hard to leave homelessness behind. Improving the health of people who are homeless is central to reducing health inequalities and achieving the goal of ending homelessness. Our National Health Audit found that eight in ten have one or more physical health need, and seven in ten have at least one mental health problem. Research by Crisis in 2011 estimated the average age of death of a homeless person to be 43-47 years of age. People who sleep rough are 35 times more likely to commit suicide than the general population.

The other 'dimensions' of SMD compound the problems of homelessness and make it difficult to engage with single issue treatment and support. For example, substance misuse may lead to exclusion from a mental health service. Nottingham has among the highest rates in the country with an estimated 4650 people in Nottingham City and 5770 people in the County facing SMD.

Given the nature of SMD there is insufficient cross sector collaboration and coordination between mental health, housing, criminal justice and substance misuse services – as well as social care and the DWP. This lack of coordination and collaboration exists at all levels from ground level staff to strategy and commissioning. Part of this lack of collaboration is a lack of data sharing which causes people facing SMD to have to keep repeating their story and this contributes further to their alienation from services.

As SMD is primarily a consequence of trauma, a mental health response is central to meeting needs but often people facing SMD cannot get access to the mental health services they need especially psychological intervention. Nor is there sufficient psychological understanding of people facing SMD from the wider workforce.

The purpose of this Local Enhanced Service is to improve primary care services for people facing SMD. The aim is to increase awareness and understanding among primary care staff and to facilitate the provision of accessible high quality care, in liaison with other agencies and providers across Nottinghamshire.

The key policies related to this service include:

- Everyone Counts: Planning for Patients 2013/14
- Our health, our care, our say: a new direction for community services (2006)
- Our NHS, Our Future (2008)
- Severe Multiple Disadvantage Joint Strategic Needs Assessment: Nottingham City 2019

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

- Improving access and choice for patients
- Providing care closer to home
- Supporting care delivery

3. Scope

3.1 Aims and objectives of service

Aims

- To provide accessible primary care to people who experience SMD
- To improve the physical and mental health of people who experience SMD
- To improve partnership between the practice and specialist SMD services
- Reduce inappropriate ED attendances and secondary care admissions

Objectives

- Enable access to core GP practice services and community and secondary care services
- To provide a service at an appropriate time, location and environment
- To follow local pathways and management based on NICE guidelines
- Support patients to self-manage their long term conditions within the community
- To contribute, through partnership working, to joint case management plans to stabilise health, housing and independence for people experiencing SMD.
- Provide services in line with Care Quality Commission standards
- Facilitate access to secondary care services while working to reduce unnecessary ED attendance and admissions to hospital

3.2 Service description/care pathway

3.2.1 Service Description

The provider shall:

- Provide a GP practice based service for investigations and follow up arising from the management of patients in primary care.
- Identify a 'named lead' for the provision of this service
- Develop a protocol for the provision of this service. This should include a description of the 'culture' of the practice in responding to clients' needs and must be reviewed annually.

Recording

- Produce an up-to-date register of patients who are homeless or face SMD (see section 3.4).
- Ensure an appropriate record of activity is developed and maintained for audit and payment purposes. This will include a computer record of patient encounters and annual reviews.

Access

- Ensure they operate flexible registration procedures allowing for permanent registration to anyone who requests it, including patients from ‘out-of-area’.
- Operate flexible appointment systems that offer ‘walk in’ appointments and longer appointment times for people with multiple needs. Demonstrate flexibility in managing appointments e.g. for patients arriving late, or requesting immediate attention.
- Facilitate access to the practice for care / support workers and other professionals that may be involved in the patient’s care. This may be through providing details of the practice’s direct access ‘phone line, secure email, or sending a ‘task’ through the clinical IT system.
- Facilitate communication between the practice and other agencies, including secondary care (recognising that this has to be reciprocated by the other party)

Prescribing

- Facilitate dispensing arrangements that allow for the administration of single or daily doses of prescription drugs.
- Adhere to relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity, for example prescribing smaller volumes.

Assessments & Screening

- Provide for appropriate and regular screening assessments based on current research in relation to the health needs and problems of people facing SMD. A template will be developed for recording this information systematically in the clinical computer system.
- Carry out assessments, over the course of 12 months, of the social, physical and mental health needs of patients registered for the service. Key elements should include:
    - A high index of suspicion for conditions of TB, hepatitis B and C and HIV and ensuring that screening is made available where appropriate
    - A high index of suspicion of substance use and, where appropriate, initial assessment and/or referral
    - Assessment of psychological wellbeing and referral if necessary.
    - For patients with severe mental health issues, provide an annual physical health check in line with current recommended practice.
- Provide opportunistic health promotion and a harm minimisation approach

MDTs, Networks & Signposting

- Ensure good communication links with local statutory services and agencies and where appropriate develop joint protocols, e.g. with the Street Outreach Teams, Homeless Health Team, shelters, local addiction services and mental health teams, as well as links with local Emergency Departments (ED) where appropriate.
- Ensure they are aware of local forums and strategies to address SMD.
- Ensure they proactively promote health services to the local community ensuring that they are aware of the range of services available to them.
- Signpost, or refer, as appropriate, to other services or agencies which may include street outreach, homeless health, IAPT and CPN services, community mental health, addiction services.
- Maintain access to an up to date list of available services to facilitate signposting by practice staff.
- Liaise, as requested, with multi-disciplinary teams involved in the care of registered patients.
- Ensure each patient is given, if they wish, information in writing detailing the reason for any tests, how to get the results of the tests, how long they are likely to wait, and who to contact with any queries by the service provider.

Training

- Provide training to all appropriate practice staff that is appropriate to their role ensuring an understanding of and sensitivity towards the particular problems of people facing SMD. Training should provide staff with a general understanding of the range of problems faced, e.g. access to appropriate housing and problems with benefits, in addition to health issues. It

should also include specific training e.g. Psychologically Informed Environment (PIE), Trauma Informed Care (TIC). This may include on-line training and attendance at a regular locum Forum, if available.

General

- Ensure there are adequate back up / contingency plans in place for key staff absence.
- Provide all premises, staffing, equipment and consumables required to carry out the service
- Ensure that all equipment used is maintained and calibrated in accordance with the manufacturer's guidelines.
- Deal with any complaints received from patients about the service, and reporting the complaint and the response to Nottingham & Nottinghamshire CCG. Complaints will be dealt with according to timescales.
- Provide Nottingham & Nottinghamshire CCG with such information as it may reasonably request for the purpose of monitoring performance of the providers obligations under the plan.

3.3 Population covered

The service will be available to adults (aged 16+) who are registered with a Nottingham & Nottinghamshire CCG GP Practice and meet the acceptance criteria.

3.4 Any acceptance and exclusion criteria and thresholds

The service will be available to citizens aged 16 or over registered with a Nottingham & Nottinghamshire CCG GP practice and who are either:

- Homeless: people who are homeless or are 'vulnerably housed' and at significant risk of homelessness – the definition includes rough sleepers, those of 'no fixed abode' or living in short term hostel or refuge accommodation
- Or Facing SMD: defined as 2 out of 4 of the following criteria:
  - Homelessness; as defined above
  - Mental illness; defined as experiencing a mental illness, personality disorder or learning difficulties severe enough to consider referral for specialist intervention or support (at a higher level than IAPT), within the last 6 months
  - Substance misuse (drugs or alcohol); defined as 'problematic', requiring offer of referral to addiction services, or with recent (within the last 6 months) engagement with relevant services
  - Victim of interpersonal violence or abuse; suffering violence or coercive control by a partner or ex-partner, within the past 6 months

Patients may be identified and registered for the service opportunistically, or by conducting a search of practice computer records. Patients may also be identified through discussion with specialist agencies, e.g. Homeless Health Team.

As patients' circumstances change, it is expected that the criteria for acceptance onto this service will be regularly reviewed by the practice against the criteria in this specification, not less than annually, and patients excluded if they no longer meet the threshold. This will be recorded on the clinical computer system and may be audited as detailed under Section 7.

3.5 Interdependence with other services/providers

The service is expected to work closely with other healthcare professionals, including:

- Primary care (GPs and Practice Nurses)
- PCN Pharmacy staff and CCG Prescribing Team
- Community healthcare
- Community mental health team
- Homeless agencies
- Homeless nursing team
- Addiction services
- Secondary care, including ED

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The provider must ensure that they are aware of, compliant with, and can provide evidence if required, to demonstrate compliance with all relevant standards including adherence to the relevant NICE guidelines where applicable.

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

4.3 Applicable local standards

The provider must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with all local policies, procedures and guidance. CQC registration is completed and the essential standards achieved. Staff involved in delivering this service should be adequately trained and supervised as determined by the provider and must have suitable indemnity.

Serious Incidents (SI's) and Patient Safety Incidents (PSI's)

It is a condition of participation in this service that providers will report all Serious Incidents that relate to primary care services to the CCG, in line with NHS England's Serious Incident Framework (March 2015 and anticipated new framework in 2020/21). If it is not clear whether or not an incident fulfils the definition of a serious incident, providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response. If deemed to be a Serious Incident the incident will be logged by the CCG on the current serious incident management system STEIS (the Strategic Executive Information System) or any other data base as directed by national guidance.

Safety Alerts

Providers must ensure that they are aware of, and have a process in place for managing, any safety alerts from the following sources that apply to any equipment or patient safety concerns associated with this enhanced service and that these are acted upon:

- Medicines and Healthcare products Regulatory Agency (MHRA) http://www.mhra.gov.uk/#page=DynamicListMedicines
- Central Alerting System (CAS) https://www.cas.dh.gov.uk/Home.aspx
- Local or national clinical guidance
- National and local formularies

Where requested details of action taken must be reported back to the CCG within the designated timescale.

4.3.1 Infection Prevention and Control

Good infection prevention and prudent antimicrobial use are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone (The Health Act 2008) Registered providers should meet the requirements of The Health and Social Care Act 2008. The provider should:

- Have systems in place to manage and monitor the prevention of infection, including regular audit and training. Infection prevention and control training for all staff every 2 years and hand hygiene yearly for all clinicians
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections and meets national estates guidance and local IPC guidance
- Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely manner
- Ensure prompt identification of people who have or are at risk of developing an infection so that

they receive timely and appropriate treatment to reduce the risk of transmitting infection to others

- Systems to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide adequate isolation facilities
- Secure adequate access to laboratory support
- Have and adhere to infection prevention and control policies that are based on national and local guidance
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
- Have robust systems and processes in place to manage pandemics at a practice level including the management and reporting of staff outbreaks

Safeguarding
All staff working in this service area will be trained and competent in safeguarding children and adults as outlined in the Intercollegiate Guidance: -

Children: https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies

Looked After children
https://www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge_skills_and_competence_of_healthcare_staff.pdf

Adults: https://www.rcn.org.uk/professional-development/publications/pub-007069

All staff will comply with Nottingham and Nottinghamshire safeguarding children and adult procedures which can be accessed via these links: -

Safeguarding Children Procedures City & County: - https://nottinghamshirescb.proceduresonline.com/

Safeguarding Adult Procedures Nottinghamshire : - https://nsab.nottinghamshire.gov.uk/procedures/

Safeguarding Adult Procedures Nottingham City: - https://www.nottinghamcity.gov.uk/information-for-residents/health-and-social-care/adult-social-care/adult-safeguarding

On the request of the commissioner, the provider will provide evidence to give assurance of compliance with safeguarding standards.

5. Applicable quality requirements

5.1 Applicable quality requirements
The provider will offer an annual review of the patients' social, mental and physical wellbeing and record this on their clinical computer system. This can take place opportunistically and over the course of several encounters.

The quality requirement is that the full review is completed for every patient over the course of 12 months from the point of initial registration for the service, and annually thereafter. The provider will provide evidence, in the form of an audit, or computer search, to demonstrate that this requirement has been met. The audit requirement will be adjusted to reflect that this is a hard to reach group.

6. Location of Provider Premises

The Provider's Premises:
The Service will be provided within the boundaries of Nottingham & Nottinghamshire CCG. Providers must have adequate mechanisms and facilities including premises and equipment as are necessary to enable the proper provision of this service.

Location(s) of Service Delivery
The Provider is required to carry out the service within a recognised primary care setting registered for the purpose of healthcare.

Days/Hours of operation
As a minimum the service will operate Monday to Friday 8am to 6.30pm, GP core opening hours. The service will be expected to provide a variety of clinic times providing choice for the patient and will vary from provider to provider. The provider will be expected to demonstrate flexibility

7. Contract

The contract will run from 1st April 2021 to 31st March 2023 subject to review at nine months (December 2021) at which time the CCG's commissioning intentions for this service for the remainder of the contract will be confirmed, based on the outcome of the Nottingham & Nottinghamshire CCG's review of Local Enhanced Services.

The notice period is three months for termination under General Condition 17.2.

Remuneration and Outcome Measures
Payment
The payment is £120 per patient registered for the SMD service per annum.

Payments are made quarterly, in arrears, based on receipt of an activity report (number of patients registered for the service). The price includes all consumables.

Quality requirements for quarterly reporting

- Number of SMD patients registered for the service who have been offered a review assessment (social, physical and mental health) within 12 months of registration for the service – this will be captured on a computer template

Information Requirements

- Number of SMD patients registered with GP practice (see above)
- Number of annual review assessments completed (see above)
- Annual template detailing: practice 'lead', confirmation of required training, practice arrangements for patient registration, flexible access and MDT working

SMD1: Severe Multiple Disadvantages (SMD)

SystmOne
For SystmOne practices, as part of F12 there is a report for SMD in the F12 Local Enhanced Services Claims folder which make it simple to find the numbers for claiming. These reports show patients coded as below (consider using the F12 LES templates for the service where green stars indicate the codes to add for claiming purposes). The F12 reports *will* account for any current active patients AND any deducted *within* that quarter where you have been caring for them.

EMIS
Unfortunately, EMIS reports cannot be shared centrally in the way we as SystmOne, therefore practices will need to write these searches for themselves currently– the same codes and criteria should be used for reporting purposes, however.

Report Name	Criteria and requirements	F12 Template
HOM1: Patients Assessed -	Any patient with a code of (166461000000103*) **added this quarter** ***note this continues to use the homeless enhanced service code for consistent collection about those homeless and /or with other disadvantages**	SMD Data Entry Template

Providers will be required to:

- Undertake patient satisfaction survey annually (this should include at least a small number of patients registered for this service).
- Comply with requests from Nottingham & Nottinghamshire CCG to provide information as it may reasonably request for the purposes of monitoring the providers' performance of its obligations under this service.
- Participate in an audit relating to this service as requested by Nottingham & Nottinghamshire CCG, if required.