NHS Standard Contract 2021/22

Particulars (Shorter Form)

Contract title / ref:

Name of surgery

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Version number: 1

First published: March 2021

Publication Approval Number: PAR478

Contract Reference	**Name of Surgery_MO_SLA**
DATE OF CONTRACT	**01 March 2022**
SERVICE COMMENCEMENT DATE	**01 March 2022**
CONTRACT TERM	**13 Months commencing 01 March 2022**
COMMISSIONERS	**Name of CCG**
CO-ORDINATING Commissioner	
PROVIDER	**Name of practice** **Principal and/or registered office address:** Practice address

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CONTRACT

Contract title: Abbots Bromley Surgery_MO_SLA_NHS East Staffordshire CCG

Contract ref: 1

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**.

2. the **Service Conditions (Shorter Form)**

3. the **General Conditions (Shorter Form)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

SIGNED by **……..**
Signature

Title

……..
Date

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	*Date of signing contract*
Expected Service Commencement Date	**01 March 2022**
Longstop Date	**31 March 2022**
Service Commencement Date	**01 March 2022**
Contract Term	**13 Months**
Option to extend Contract Term	**No**
Notice Period (for termination under GC17.2)	**1 Month**
SERVICES	
Service Categories	**Indicate <u>all</u> that apply**
Continuing Healthcare Services (including continuing care for children) (CHC)	**NO**
Community Services (CS)	**NO**
Diagnostic, Screening and/or Pathology Services (D)	**NO**
End of Life Care Services (ELC)	**NO**
Mental Health and Learning Disability Services (MH)	**NO**
Patient Transport Services (PT)	**NO**
Co-operation with PCN(s) in service models	
Enhanced Health in Care Homes	**NO**
Service Requirements	
Essential Services (NHS Trusts only)	**NO**
Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of the Contract?	**NO**
PAYMENT	
National Prices apply to some or all Services (including where subject to Local Modification or Local Variation)	**NO**
Local Prices apply to some or all Services	**Yes**
Expected annual Contract Value agreed	**Yes**
GOVERNANCE AND REGULATORY	
Provider's Nominated Individual	**Information provided by practice**
Provider's Information Governance Lead	**Information provided by practice**
Provider's Data Protection Officer (if required by Data Protection Legislation)	**Information provided by practice**
Provider's Caldicott Guardian	**Information provided by practice**

Provider's Senior Information Risk Owner	
Provider's Accountable Emergency Officer	
Provider's Safeguarding Lead (children) / named professional for safeguarding children	
Provider's Safeguarding Lead (adults) / named professional for safeguarding adults	
Provider's Child Sexual Abuse and Exploitation Lead	
Provider's Mental Capacity and Liberty Protection Safeguards Lead	
CONTRACT MANAGEMENT	
Addresses for service of Notices	Lynn Millar Third Floor, Smithfield One Building, Stoke on Trent, ST1 4FA Lynn.Millar@staffsstokeccgs.nhs.uk
Commissioner Representative(s)	**Amin Mitha** **Amin.mitha@staffsstokeccgs.nhs.uk** **Amanda Lovatt** **Amanda.Lovatt@staffsstokeccgs.nhs.uk**
Provider Representative	

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents and complete the following actions:

1.	Evidence of appropriate Indemnity Arrangements
2.	Evidence of CQC registration

C. Extension of Contract Term

Not Applicable

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	1
Service	Primary Care Clinical Pharmacy and Medicines Optimisation
Commissioner Lead	Amin Mitha Acting Deputy Director of Primary Care – Medicines Optimisation
Provider Lead	
Period	1st March 2022-31st March 2023

1. Population Needs

1.1 National/local context and evidence base

Medicines Optimisation Teams (MOT) of Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs) have had a longstanding working relationship with General Practices across Staffordshire and Stoke-on-Trent. The basis of this relationship has been a shared goal of improving the quality, safety and cost-effectiveness of prescribing. The support from the MOT to practices has been targeted based on variation in clinical practice as evidenced by the prescribing data and it has been limited by the fact that it has generally not been patient facing. The CCG staffing cost to provide and manage this service is significant. Additionally, the CCGs offer a local prescribing improvement scheme (PLIS) to incentivise practices to implement changes in prescribing that is critical to the control of prescribing expenditure.

Above arrangements have been reviewed in light of significant changes in primary care workforce that were brought about by the changes in the GP contract in 2019[1]. Since July 2019, majority of practices have signed up to the Primary Care Network Contract Directed Enhanced Service (PCN DES) which enables practices to benefit from the Additional Roles Reimbursement Scheme (ARRS). As a result of this scheme practices in a PCN now have access to a shared clinical pharmacy workforce (comprising of pharmacists and pharmacy technicians) which is funded nationally. The ARRS is phased over 5 years and every year PCNs will have extra funding to recruit more staff – by 2024 an average PCN could have 6 pharmacists and 1 pharmacy technician. This massive recruitment drive has meant that CCGs are losing their pharmacists and pharmacy technicians to PCNs, but now to recruit to vacancies in CCGs creates a risk for PCNs to develop – this is not desirable as development of PCNs is considered essential for the delivery of the NHS Long Term Plan.

The PCN DES comes with various specifications[2] and the activities defined within these specifications overlap significantly with the usual annual MO plans of CCGs. The ARRS provides information on the remit of clinical pharmacists and pharmacy technicians. The roles described also align with many of the functions of the MOT.

Bearing the above context in mind, this service specification then:

- Presents practices with an opportunity to utilise the shared clinical pharmacy workforce in a gainful way which reduces the need for the CCGs to recruit from the same pool of workforce available locally. Note that the efficiencies made in MO HR budget are being reinvested in MO service provision through General Practice.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2020/03/network-contract-des-specification-pcn-requirements-entitlements-2020-21.pdf

- Brings together PLIS and the MO service element into one contract.

Note that linked to the PCN DES is a national incentive scheme known as the Impact and Investment Fund (IIF)[3]. Fulfilling the requirements of this specification will support PCNs to also meet some of the IIF targets such as:

- EHCH-03: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review
- SMR-01: Percentage of patients eligible to receive a Structured Medication Review who received a Structured Medication Review
- RESP-02: Percentage of patients on the QOF Asthma Register who received six or more SABA inhaler prescriptions* over the previous 12 months

The PCN DES has a specification on Structured Medication Review and Medicines Optimisation. A clause within the DES specification requires:

PCNs to actively work with its CCG in order to optimise the quality of local prescribing of:

1. *antimicrobial medicines;*
2. *medicines which can cause dependency;*
3. *metered dose inhalers, where a lower carbon device may be appropriate; and*
4. *nationally identified medicines of low priority*

If practices agree to deliver this specification, then the requirements as described above will also be met.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

The service will support the delivery of outcomes as part of the STP Enhanced Integrated Primary and Community Care programme

3. Scope

3.1 Aims and objectives of service

- To reduce the risk of medicines related harm to patients
- To optimise treatment of patients with long term conditions
- To improve overall care of patients through clinical audit and provision of medicines and prescribing related information to patients and prescribing clinicians
- To promote prudent and appropriate use of antimicrobial drugs
- To achieve cost-efficiencies in prescribing

[3] https://www.england.nhs.uk/wp-content/uploads/2021/08/B0828-iii-annex-b-investment-and-impact-fund-21-22-22-23.pdf

- To enable development of the clinical pharmacy workforce in practices and Primary Care Networks

3.2 Service description/care pathway

Although this service contract is offered to individual practices, the service specification has been designed on the following basis:

- Practices will utilise the shared PCN Clinical Pharmacy workforce to deliver the service.
- The PCN Clinical Pharmacy Team and the CCGs Medicines Optimisation Team will work collaboratively to deliver the aims of the service as described in section 3.1.
- Pharmacists and/or pharmacy technicians who are employed directly by practices (and not part of shared PCN clinical pharmacy workforce) may also participate in the delivery of this service specification.

There are various service elements as described below:

i. Signing up

Practices will get a signing up fee of £0.26 per patient (weighted practice list size) in recognition of the effort that will be required to put arrangements in place to deliver the service. PCN/practice clinical pharmacy teams will need to attend orientation sessions so that they understand the requirements of this service specification and to attend training for using an online tool to record interventions.

ii. Structured medication reviews (SMRs)

Practices will receive payment for conducting SMRs in any of the following patient cohorts:

- Care home residents
- Patients with asthma/COPD
- Patients with polypharmacy

Maximum activity level (which will attract a payment) has been set at 21 SMRs per 1000 patients for the period March 2022 to March 2023. There is no lower threshold – practices will be due a payment for whatever number of reviews that they have completed up to the maximum activity level.

Practices are encouraged to prioritise care home residents for review, but practices will be provided with the following comparative data to enable practices target SMRs appropriately:

- No. patients prescribed 6 or more SABA inhalers in a 12 month period, who were also prescribed a preventer inhaler but not prescribed an antimuscarinic
- High dose ICS items as a % of all ICS items
- Proportion of patients on triple therapy (LAMA+LABA+ICS) prescribed as separate inhalers
- Percentage of patients (aged 65 or over/75 or over/85 or over) prescribed 10 or more unique medicines

Clinical pharmacy teams must attend orientation sessions on SMRs and follow resources provided to conduct SMRs in line with the CCG MO team's guidance. SMRs must be recorded on an online IT tool called MedOptimise. Training will be provided to use this tool.

iii. Antimicrobial stewardship (AMS)

Practices will receive payment for carrying out an audit identified from the TARGET website, focusing particularly on the following clinical areas:

- Urinary Tract infections
- Upper Respiratory tract infections

Practices will then be required to provide an action plan in order to affect areas identified in the audit.

Practices will also be required to

- identify an antimicrobial champion
- participate in a CCG/ICS led antimicrobial education session
- demonstrate antimicrobial stewardship messages for patient facing activities e.g. practice website or Facebook page

Practices are encouraged to prioritise the clinical area in which has been identified by the specific national metrics. Practices will be provided with the following comparative data to enable practices target their audit appropriately:

- Overall Antimicrobial prescribing – items prescribed per STAR PU*
- Co-amoxiclav, Cephalosporins & Quinolones items prescribed as a percentage of all antibacterial items
- Trimethoprim and nitrofurantoin prescribed to people aged >69yrs - number of items prescribed per 1,000 Patients aged >69yrs

* STAR PU - adjusted patient denominator for the therapeutic area, sex and age band of practice patients Practices will be able to access prescribing data on this group of drugs every month on MedOptimise.

Clinical pharmacy teams must attend orientation sessions on the AMS element of the SLA and follow resources provided to carry out the audit and action plan in line with the CCG MO team's guidance.

The audit and other elements must be recorded on an online IT tool called MedOptimise. Training will be provided to use this tool.

iv. Medicines safety audits

Practices will receive payment for carrying out two medicines safety audits in the following patient cohorts:

- All women and girls (aged 12-55 years) who may be of childbearing potential and are currently prescribed sodium valproate. The aim is to review of sodium Valproate prescribing and adherence to Pregnancy Prevention Programme (PPP) - MHRA
- Patients prescribed high dose opioids (equivalent to >120mg daily dose of morphine). The aim is to review appropriateness of prescribing. Palliative care patients will be excluded.

Practices will then be required to provide an action plan to affect areas identified in the audit.

Clinical pharmacy teams must attend orientation sessions on the audit element of the SLA and follow resources provided to carry out the audit and action plan in line with the CCG MO team's guidance.

The audit and other elements must be recorded on an online IT tool called MedOptimise. Training will be provided to use this tool.

v. Repeat prescribing policy

Practices will receive payment for carrying out an audit of the Repeat prescribing process and will then be required to provide an action plan to affect areas identified in the audit. Based on the results of the audit practices will be required to update the practice's repeat prescribing policy.

Clinical pharmacy teams must attend orientation sessions on the audit element of the SLA and follow resources provided to carry out the audit and action plan in line with the CCG MO team's guidance.

The audit and other elements must be recorded on an online IT tool called MedOptimise. Training will be provided to use this tool.

vi. High Impact Prescribing Interventions (HIPIs)

Practices will receive payment for reviewing prescribing of 5 drugs/products with the highest potential for cost-saving in any of the following drug groups:

- Specials medicines
- High cost drugs
- Potential cost effective switches

Practices will be required to carry out the review 5 times during the period March 2022 to March 2023. The first review needs to be started in March 2022 and thereafter practices should conduct the review once every quarter. Payment will be based this activity being completed for the relevant period.

Practices are encouraged to prioritise those drug groups with the highest potential for reducing prescribing expenditure. They will be provided with the following comparative data to enable practices target the appropriate drugs/products:

- Specials – actual cost of prescribing per 1,000 Patients along with a breakdown of each drug prescribed and compared with the previous year

- High-cost drugs - actual cost of prescribing per 1,000 Patients along with a breakdown of each drug prescribed and compared with the previous year

- Cost effective switches - actual cost of prescribing per 1,000 Patients along with a list of potential like for like switches available.

Clinical pharmacy teams must attend orientation sessions on HIPIs and follow resources provided to conduct HIPIs in line with the CCG MO team's guidance. HIPI drug/product reviews must be recorded on an online IT tool called MedOptimise. Training will be provided to use this tool.

vii. Drugs of Limited Clinical Value (DLCV)

Practices will receive payment for reviewing treatment of patients who are on the following products (that should not routinely be prescribed in primary care – also known as "drugs of limited clinical value" or low priority medicines - DLCV) with the aim of de-prescribing or switching to a more cost-effective alternative:

- Aliskiren
- Bath and shower emollients
- Co-proxamol
- Dosulepin
- Doxazosin modified release
- Fentanyl immediate release
- Insulin pen needles costing >£5 for pack of 100
- Lidocaine patches
- Naloxone/oxycodone
- Omega-3 fatty acids
- Rubefacients

- Silk garments
- Tadalafil once daily preparations
- Trimipramine
- Glucosamine/Chondroitin
- Herbal products
- Homeopathy
- Lutein and antioxidants
- Minocycline

Payment will be achieved in two ways based upon baseline performance for the Sep 20 to Aug 21 period:

1. Practices with an Actual cost of > £1,089 per 1,000 Patients then the target is £1,089 and below. Maximum payment will apply if the benchmark is achieved. Practices that do not achieve the benchmark value but have reduced spending from baseline will get a payment that is pro rata to the proportion of reduction achieved.
2. Practices with an Actual cost of < £1,089 per 1,000 Patients are required to maintain the prescribing level below £1089 per 1000 patients to achieve the maximum payment, but if the prescribing expenditure increases then an upper threshold of £1,252 per 1000 patients will apply and no payment will be made if the practice's prescribing expenditure increases to this level. Practices that have an end of the year prescribing expenditure level between £1089 per 1000 patients and £1252 per 1000 patients will receive a pro rata reduction in the maximum payment.

Practices are free to choose which products they wish to target based on data. It would be logical that practices will choose to review prescribing of those products that will return the biggest reductions in drug expenditure for this group of drugs.

They will be provided with the following comparative data to enable practices target reviews appropriately:

- Actual cost of prescribing per 1,000 Patients for DLCV drugs
- A breakdown of each drug prescribed and compared with the previous year

Clinical pharmacy teams must attend orientation sessions on DLCV and follow resources provided to deliver the service in line with the CCG MO team's guidance. DLCV drug reviews must be recorded on an online IT tool called MedOptimise. Training will be provided to use this tool.

viii. Promotion of Self care

Practices will receive payment for reviewing treatment of patients who are on products (medicines) to treat minor, self-limiting conditions as listed in the NHSE OTC guidance, with the aim of de-prescribing.

In some cases there will be a need to conduct specific reviews with the patients. In other cases, it would be a matter of deprescribing a product for a group of patients.

If a product cannot be de-prescribed, there may be the opportunity to switch to a more cost-effective alternative. Systems should also be in place to ensure that OTC products for the listed conditions are not put on repeat prescription

Payment will be achieved in two ways based upon baseline performance for the Sep 20 to Aug 21 period:

1. Practices with an Actual cost of > £8,823 per 1,000 Patients then the target is £8,823 per 1000 patients and below. Maximum payment will apply if the benchmark is achieved. Practices that do not achieve the benchmark value but have reduced spending from baseline will get a payment that is pro rata to the proportion of reduction achieved.

2. Practices with an Actual cost of < £8,823 per 1,000 Patients are required to maintain the prescribing level below £8,823 per 1000 patients to achieve the maximum payment, but if the prescribing expenditure increases then an upper threshold of £9,705 per 1000 patients will apply and no payment will be made if the practice's prescribing expenditure increases to this level. Practices that have an end of the year prescribing expenditure level between £8823 per 1000 patients and £9705 per 1000 patients will receive a pro rata reduction in the maximum payment.

They will also be required to demonstrate engagement with the CCG/ICS Self Care awareness public campaigns e.g. Practice website, Facebook campaigns etc.

Practices are free to choose which products they wish to target based on data. It would be logical that practices will choose to review prescribing of those products that will return the biggest reductions in drug expenditure for this group of drugs.

They will be provided with the following comparative data to enable practices target reviews appropriately:

- Actual cost of prescribing per 1,000 Patients for Self care drugs
- A breakdown of each drug prescribed and compared with the previous year

Clinical pharmacy teams must attend orientation sessions on Self care and follow resources provided to deliver the service in line with the CCG MO team's guidance. Self care drug reviews must be recorded on an online IT tool called MedOptimise. Training will be provided to use this tool.

3.3 Population covered

- As can be seen from the activity descriptions above, the service will be directed at specific cohorts of patients who are registered with the practice.

3.4 Any acceptance and exclusion criteria and thresholds

- The basis of this service specification is that the PCN Clinical Pharmacy Team which is shared by the practices in a PCN will work collaboratively with the CCGs Medicines Optimisation Team to deliver the service specification
- Practice employed pharmacists and technicians would also be eligible to deliver the service.
- Once a month all PCN/practice clinical pharmacists and pharmacy technicians will be required to attend a networking meeting which will be organised by the CCG Medicines Optimisation Team. These sessions will be used to provide orientation and training that will be essential for the delivery of the various elements of the service.
- Clinical pharmacists and pharmacy technicians employed through the additional roles reimbursement scheme must be enrolled on or completed the national Primary Care Pharmacy Education Pathway unless they have been granted an exemption through the College of Pharmacy Practice and Education (CPPE). See appendix 2 for further information on this training requirement.

3.5 Interdependence with other services/providers

The Provider shall ensure that, where appropriate to the service, interdependencies are built with the following service providers:

- Acute Service
- Community Services
- Mental health services

The CCG MO team will provide guidance and relevant resources to the practice teams in order to carry out the activities detailed in section 3.2. The CCG MO team will also monitor the delivery of the service.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following standards are applicable to PCN clinical pharmacists and pharmacy technicians when delivering services within the SLA:

- General Pharmaceutical Council Standards for Pharmacy Professionals[4]
- NICE Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes[5]
- NICE Managing medicines in care homes[6]
- Royal Pharmaceutical Society, Medicines Optimisation: helping patients to make the most of medicines[7]

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

4.3 Applicable local standards

The PCN Clinical Pharmacists and Pharmacy Technicians will adhere to the local formulary, guidelines and prescribing policies available on the following websites:

- http://www.northstaffordshirejointformulary.nhs.uk/
- http://www.southstaffordshirejointformulary.nhs.uk/

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

The service is to be delivered from the GP practice or from another practice or appropriate healthcare setting within the Primary Care Network (PCN) where the shared clinical pharmacy team is hosted

[4] https://www.pharmacyregulation.org/sites/default/files/standards_for_pharmacy_professionals_may_2017_0.pdf

[5] https://www.nice.org.uk/guidance/ng5

[6] https://www.nice.org.uk/guidance/sc1

[7] https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/helping-patients-make-the-most-of-their-medicines.pdf

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

Not Applicable

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

Practice ODS code	Practice code
Practice Name	Practice name
Structured medication reviews (SMRs) 21 SMRs per 1,000 practice patients	411
Review of prescribing: drugs of limited clinical value (DLCV)	SEE SUMARY BELOW
Promotion of self-care	SEE SUMMARY BELOW
Review of prescribing: 5 high impact changes	Dependent on search results
Antimicrobial stewardship	Audit sample population: 20
Review of sodium Valporate prescribing and adherence to Pregnancy Prevention Programme (PPP)	Dependent on search results
Review of prescribing of >120mg morphine equivalent per day in chronic pain	Audit sample population: 20
Repeat prescribing policy	See summary below

Services along with activity levels have been described above under Schedule 2A. A summary is given below

Structure Medication Reviews (SMRs)
The maximum target for SMRs is 21 reviews per 1000 patients (weighted list size) for the period March 2022 to March 2023. Each practice will be provided with target value based on their actual weighted list size.

Ideally SMRs should be conducted throughout the 15 month period based on capacity.

Antimicrobial Stewardship
By June 2022:

- Identify an antimicrobial stewardship champion
- Place antimicrobial stewardship messages on practice website and practice Facebook page
- Complete an antimicrobial prescribing audit as explained above under schedule 2A

By March 2023:

- Send a representative to one of the Staffordshire and Stoke-on-Trent ICS run antimicrobial stewardship education sessions

Medicines Safety Audits
By October 2022:

- Complete the audit on prescribing of sodium valproate as described above under schedule 2A
- Complete an audit on prescribing of opioid drugs (equivalent to >120mg morphine per day) as described above under schedule 2A

Repeat Prescribing Policy
By March 2023:

- Complete the audit on the repeat prescribing process as described above under schedule 2A
- Update the practice's repeat prescribing policy based on the advice from the medicines optimisation team and the learnings from the repeat prescribing audit

Promotion of self-care
There are no mandatory activity targets for this service as the payment is linked to outcome achieved in terms of prescribing expenditure on drugs categorized as self-care. However, practices are advised to:

- On an ongoing basis advise patients to manage minor ailments themselves – in line with the Staffordshire and Stoke-on-Trent Policy for conditions for which over the counter items should not routinely be prescribed in primary care
- Review treatment of patients who are on repeat prescriptions for drugs that are available over the counter. As explained under Schedule 2A, practices will be provided with prescribing data that will enable them to target reviews appropriately. **Any treatment changes must be recorded on Medoptimise**. It would be logical to prioritise these reviews as early as possible during the contracted period as it will maximise the impact on the desired outcomes linked this area of work.
- Engage with CCG run self-care campaign and initiatives.

Drugs of limited clinical value (DLCV)
There are no mandatory activity targets for this service as the payment is linked to outcome achieved in terms of prescribing expenditure on drugs categorized as drugs of limited clinical value (see schedule 2A). However, practices are advised to:

- Study their prescribing data to target reviews as appropriate. **Any treatment changes must be recorded on Medoptimise**. It would be logical to prioritise these reviews as early as possible during the contracted period as it will maximise the impact on the desired outcomes linked this area of work.

- Inform the CCG medicines optimisation team of instances of secondary care clinicians initiating or recommending initiation of DLCV inappropriately – see Staffordshire and Stoke-on-Trent Prescribing Commissioning Policy

High Impact Prescribing Interventions
On five occasions between March 2022 – March 2023 practices should review the prescribing data as explained under Schedule 2a above. 5 products/drugs which have the highest impact on prescribing expenditure should be chosen for review. All treatment changes must be recorded on Medoptimise.

D. Essential Services (NHS Trusts only)

Not applicable

G. Other Local Agreements, Policies and Procedures

Practices should adhere to local prescribing formularies wherever possible:

North Staffordshire Joint Formulary Formulary

South Staffordshire Joint Formulary Formulary

Majority of practices across Staffordshire and Stoke-on-Trent have prescribing support tool called Optimise Rx installed on their clinical systems. Wherever possible practices should adhere to recommendations presented by Optimise Rx during the prescribing process.

J. Transfer of and Discharge from Care Protocols

Not applicable

K. Safeguarding Policies and Mental Capacity Act Policies

In addition to the provisions set out in the General Conditions and Service Conditions, the Provider is required to adhere to the policies and procedures for safeguarding adults and children, Mental capacity Act and Deprivation of Liberty Safeguards which are available on the Coordinating Commissioner's website.

There is a single Staffordshire and Stoke on Trent Safeguarding Adults Partnership Board (SSASPB) details regarding this and the 'Inter-agency Adult protection Procedures' can be found at: https://www.ssaspb.org.uk/Home.aspx

The Staffordshire Safeguarding Children Board's Inter-Agency Procedures for Safeguarding Children and Promoting their Welfare is published by Staffordshire Safeguarding Children's Board and the equivalent Stoke-On-Trent procedures manuals are published by Stoke-On-Trent Safeguarding Children's Board. The provider is required to comply with these procedures.
https://www.staffsscb.org.uk/Home.aspx
http://www.safeguardingchildren.stoke.gov.uk/ccm/navigation/professionals/procedure-manuals

SCHEDULE 3 – PAYMENT

A. Local Prices

SECTION A: Signing up fee – Max payment of £0.26 per Patient (weighted list size)
PCN/practice clinical pharmacy teams must attend all orientation and training sessions during January 2022 to qualify for this payment

SECTION B: Cost effective prescribing – Max payment of £1.76 per Patient (weighted list size)				
Service item	Activity/Indicator targets	Deadlines	Payment	Frequency
Structured medication reviews (SMRs)	21 SMRs per 1,000 practice patients recorded on MedOptimise	Mar-23	54p per Practice patient which is equivalent to £25.71 per SMR	Monthly payment
Review of prescribing: drugs of limited clinical value (DLCV)	Target of < £1,089 Actual cost per 1,000 Practice patients	Mar-23	18p per Practice patient *	Jul- 23
Promotion of self-care	Target of < £8,823 Actual cost per 1,000 Practice patients	Mar-23	48p per Practice patient **	Jul-23
Review of prescribing: 5 high impact changes	Enter evidence of quarterly reviews of 5 HIPI medicines on MedOptimise	Mar-23	56p per Practice patient***	Quarterly payment

SECTION C: Medicines safety/quality - Max payment of £0.35 per Patient (weighted list size)				
Service item	Activity targets	Deadlines	Payment	Frequency
Antimicrobial stewardship	One audit and action plan to be completed from the Target website based upon the Practices performance on the MedOptimise AMS indicators. Audit and action plan must be completed on the MedOptimise tool	Jun-22	15p per Practice patient	Jul-22

Review of sodium Valporate prescribing and adherence to Pregnancy Prevention Programme(PPP)	Audit and action plan completed on MedOptimise	Oct-22	7.5p per Practice patient	Nov-22
Review of prescribing of >120mg morphine equivalent per day in chronic pain	Audit and action plan completed on MedOptimise	Oct-22	7.5p per Practice patient	Nov-22
Repeat prescribing policy	Audit and action plan completed on MedOptimise	Mar-23	5p per Practice patient	Apr-23

*Practices that are above the benchmark will earn a payment based the movement from baseline value toward the benchmark value. For example, practice with a baseline value of £2,177 per 1000 patients may reduce the spend to £1,633 per 1000 patients during the period of measurement. This equates to 50% reduction compared to the required reduction value and therefore 50% of the payment will apply. Practices that are already below benchmark value will get full payment provided they remain below benchmark value for the period of measurement. However, there is an upper threshold for these practices and therefore any upward movement in expenditure towards the threshold value will mean a pro rata reduction in payment. Upper threshold value: £1,252 per 1000 patients per year

** Practices that are above the benchmark will earn a payment based the movement from baseline value toward the benchmark value. For example, practice with a baseline value of £17,646 per 1000 patients may reduce the spend to £13,235 per 1000 patients during the period of measurement. This equates to 50% reduction compared to the required reduction value and therefore 50% of the payment will apply. Practices that are already below benchmark value will get full payment provided they remain below benchmark value for the period of measurement. However, there is an upper threshold for these practices and therefore any upward movement in expenditure towards the threshold value will mean a pro rata reduction in payment. Upper threshold value: £9,705 per 1000 patients per year

***First review must be started by March 2022 otherwise a lower payment of £0.30 per patient (weighted list size) will apply.

B. Local Variations

Not Applicable

C. Local Modifications

Not Applicable

D. Expected Annual Contract Values

The following table lists potential contract value for each practice based on payment rate of £2.37 per patient on weighted list size. Note that the contract value are based on the assumptions that practices will delivery full level of activity is delivered and also achieve maximum outcome related payments where applicable.

Practice ODS code	PRACTICE CODE
Practice Name	PRACTICE NAME
Sign Up fee	£5091
Structured medication reviews (SMRs) 54p per Practice patient	£10,568
Review of prescribing: drugs of limited clinical value (DLCV) 18p per Practice patient	£3,524
Promotion of self-care 48p Practice patients	£9,398
Review of prescribing: 5 high impact changes 56p per Practice patient	£10,965
Antimicrobial stewardship 15p per Practice patients	£2,937
Review of sodium Valporate prescribing and adherence to Pregnancy Prevention Programme (PPP) 7.5p per Practice patient	£1,469
Review of prescribing of >120mg morphine equivalent per day in chronic pain 7.5p per Practice patient	£1, 469
Repeat prescribing policy 5p per Practice patient	£979
Total income of schemes	£41,309
Total income plus signup fee	£46,400

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards and National Quality Requirements

Ref	Operational Standards/National Quality Requirements	Threshold	Guidance on definition	Period over which the Standard / Requirement is to be achieved	Applicable Service Category
	Duty of candour	Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	See CQC guidance on Regulation 20 at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour	Ongoing	All

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Applicable Service Specification
PCN pharmacist or pharmacy technician must be enrolled on or must have completed the Primary Care Pharmacy Education Pathway administered by the Centre for Pharmacy Postgraduate Education (CPPE) Note some pharmacists and pharmacy technicians may have undertaken equivalent courses in the past and would therefore be exempt from taking this course.	100%	Self-declaration – information will be collected by the CCG medicines optimisation team	As detailed in Schedule 2A above

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report
National Requirements Reported Locally			
1. Incidents, Never Events and the duty of candour	Ongoing	Datix	Reported as soon after the event as practicable
2. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Quarterly	Written (PDF)	Email 5 days following the end of each quarter.
Local Requirements Reported Locally			
Structured medication reviews	Monthly	Medoptimise	CCG MO team will extract report
Antimicrobial Stewardship	By due date (see schedule 2B)	Medoptimise	Ditto
Medicines Safety Audits	By due date (see schedule 2B)	Medoptimise	Ditto
Repeat prescribing audits and policy	By due date (see schedule 2B)	Medoptimise	Ditto
High impact prescribing interventions	March 2022, quarterly thereafter	Medoptimise	Ditto
Promotion of self-care	April 2023	Medoptimise – record of interventions	Ditto
Promotion of self-care	July 2023	EPACT - achievement	Ditto
Drugs of limited clinical value	April 2023	Medoptimise – record of interventions	Ditto
Drugs of limited clinical value	July 2023	EPACT - achievement	Ditto

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) Other Patient Safety Incidents
NHS Improvement Policy: 'Serious Incident Framework: Supporting learning to prevent recurrence' (Revised March 2015) https://improvement.nhs.uk/resources/serious-incident-framework/ The above policy to be used in conjunction with the Co-ordinating Commissioner's Serious Incident Policy– link below: https://www.stokeccg.nhs.uk/stoke-governance/policies/health-safety-incident-reporting/484-stoke- ccg-serious-incident-policy-march-2013-final1/file

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

Not Applicable

SCHEDULE 7 – PENSIONS

Not Applicable

SCHEDULE 8 – TUPE*

1. The Provider must comply and must ensure that any Sub-Contractor will comply with their respective obligations under TUPE and COSOP in relation to any persons who transfer to the employment of the Provider or that Sub-Contractor by operation of TUPE and/or COSOP as a result of this Contract or any Sub-Contract, and that the Provider or the relevant Sub-Contractor (as appropriate) will ensure a smooth transfer of those persons to its employment. The Provider must indemnify and keep indemnified the Commissioners and any previous provider of services equivalent to the Services or any of them before the Service Commencement Date against any Losses in respect of:

    1.1 any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any relevant transfer under TUPE and/or COSOP;

    1.2 any claim by any person that any proposed or actual substantial change by the Provider and/or any Sub-Contractor to that person's working conditions or any proposed measures on the part of the Provider and/or any Sub-Contractor are to that person's detriment, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor; and/or

    1.3 any claim by any person in relation to any breach of contract arising from any proposed measures on the part of the Provider and/or any Sub-Contractor, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor.

2. If the Co-ordinating Commissioner notifies the Provider that any Commissioner intends to tender or retender any Services, the Provider must within 20 Operational Days following written request (unless otherwise agreed in writing) provide the Co-ordinating Commissioner with anonymised details (as set out in Regulation 11(2) of TUPE) of Staff engaged in the provision of the relevant Services who may be subject to TUPE. The Provider must indemnify and keep indemnified the relevant Commissioner and, at the Co-ordinating Commissioner's request, any new provider who provides any services equivalent to the Services or any of them after expiry or termination of this Contract or termination of a Service, against any Losses in respect any inaccuracy in or omission from the information provided under this Schedule.

3. During the 3 months immediately preceding the expiry of this Contract or at any time following a notice of termination of this Contract or of any Service being given, the Provider must not and must procure that its Sub-Contractors do not, without the prior written consent of the Co-ordinating Commissioner (that consent not to be unreasonably withheld or delayed), in relation to any persons engaged in the provision of the Services or the relevant Service:

    3.1 terminate or give notice to terminate the employment of any person engaged in the provision of the Services or the relevant Service (other than for gross misconduct);

    3.2 increase or reduce the total number of people employed or engaged in the provision of the Services or the relevant Service by the Provider and any Sub-Contractor by more than 5% (except in the ordinary course of business);

    3.3 propose, make or promise to make any material change to the remuneration or other terms and conditions of employment of the individuals engaged in the provision of the Services or the relevant Service;

    3.4 replace or relocate any persons engaged in the provision of the Services or the relevant Service or reassign any of them to duties unconnected with the Services or the relevant Service; and/or

3.5 assign or redeploy to the Services or the relevant Service any person who was not previously a member of Staff engaged in the provision of the Services or the relevant Service.

4. On termination or expiry of this Contract or of any Service for any reason, the Provider must indemnify and keep indemnified the relevant Commissioners and any new provider who provides any services equivalent to the Services or any of them after that expiry or termination against any Losses in respect of:

4.1 the employment or termination of employment of any person employed or engaged in the delivery of the relevant Services by the Provider and/or any Sub-Contractor before the expiry or termination of this Contract or of any Service which arise from the acts or omissions of the Provider and/or any Sub-Contractor;

4.2 claims brought by any other person employed or engaged by the Provider and/or any Sub-Contractor who is found to or is alleged to transfer to any Commissioner or new provider under TUPE and/or COSOP; and/or

4.3 any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any transfer to any Commissioner or new provider.

5. In this Schedule:

COSOP means the Cabinet Office Statement of Practice *Staff Transfers in the Public Sector* January 2000

TUPE means the Transfer of Undertakings (Protection of Employment) Regulations 2006

***Note: it may in certain circumstances be appropriate to omit the text set out in paragraphs 1-5 above or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.*

First published March 2021
Published in electronic format only