ENCLOSURE: I

Agenda Item: 142/15

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 24 September 2015

Title	**Primary Care Improvement Fund 2016/2017**	
This paper is for **Decision**		
Recommended action for the Governing Body	That the Governing Body: 1. **Approve** that the existing schemes roll forward into 2016/17. 2. **Agree** the delegation of the concept to the PCIF Leadership Group (with GB members involvement).	
Potential areas for Conflicts of interest	Member practices, including some clinical Governing Body members receive funding from the PCIF.	
Executive summary	This paper has been prepared for the Governing Body setting out the process to develop the Primary Care Improvement Fund (PCIF) for Bexley practices for 2016/2017. The PCIF scheme is designed to support the Health Priorities for Bexley residents and the four current elements have been carefully chosen to provide additional support where it is required. Given that the benefits of similar schemes occur across more than one financial year and continue to support CCG and population needs, it is proposed that the four focus areas are retained, with some refining changes, with the detailed rationale set out in the paper.	
How does this paper support the CCGs objectives?	**Patients:**	The PCIF aims to secure better outcomes for Bexley patients.
	People:	The PCIF will allow CCG staff to work more closely with partners and local practices.
	Pounds:	The PCIF scheme is designed to support better use of the total commissioning budget, by putting in place incentives to improve quality within primary care.
	Process:	The governance structure proposed minimises conflicts of interests.
What are the Organisational implications	Key risks	The PCIF scheme does not achieve significant uptake or does not achieve its intended objectives.
	Equality	Expects a consistent level of performance across all

		Bexley practices.
	Financial	None - same as previous year's commitment of £768k to incentivise activity that aligns with the QIPP schemes and commissioning intentions.
	Data	A robust data collection process has been implemented for 2015/2016.
	Legal issues	This is an optional scheme for practices.
	NHS constitution	The principles of the NHS Constitution have been considered when preparing this report.
Engagement	Through the PCIF Design Group that represents localities, LMC and the CCG.	
Audit trail	PCIF Leadership Group.	
Comms plan	Detailed guidance and supporting paperwork to be disseminated to all practices, following GB approval.	
Author:	Clinical lead:	Executive sponsor: Sarah Valentine Director of Commissioning
Date	25 August 2015	

Governing Body
Primary Care Improvement Scheme (2016/2017)

Contents

1.0 Introduction and background

This paper has been prepared for the Governing Body setting out the process to develop the Primary Care Improvement Fund (PCIF) for Bexley practices for 2016/2017.

The Kitemark scheme was developed five years ago and replaced the previous PBC Local Incentive Scheme. In 2015/16 Kitemark was replaced by PCIF.

The principles of the improvement scheme were to incentivise practices to complete work that is above and beyond their core contracted service, which ultimately provides better quality care for patients. The funding was historically £900k, but since April 2014 the commissioning of Health Checks with a value £132k has transferred to the London Borough of Bexley. The value of PCIF is therefore £768k per annum.

There were a number of key deficiencies with the historical Kitemark scheme, summarised as follows;

- The process for agreement of the granular details of the Kitemark schemes were labour intensive and involved the appointment of “locality representatives” who were also supported by the LMC. Despite this, numerous iterations and amendments were needed to get to a final agreement.
- Feedback from the localities signalled that the scheme was “admin” and “meeting attendance” intensive for practices for little monetary award and was also a significant administrative burden for CCG members.
- That how the scheme was divided may not reflect the priorities of the CCG (or the NHS).

As a result of this, the Primary Care Improvement Fund (PCIF) was proposed and agreed by the Governing Body for implementation in 2015/2016. The scheme sought to develop initiatives that are directly linked to our Health Priorities (determined within our Health & Wellbeing Strategy) and to reward practices for delivering better patient services and outcomes.

2.0 Implementation of the 2015/2016 PCIF scheme

The 2015/2016 PCIF scheme runs from 1st April 2015 to 31st March 2016 and includes the following four elements

1. Medicines Management
2. Dementia Identification
3. End of Life Care
4. Childhood Obesity

The scheme was implemented early in the current financial year. Practices have been supplied detailed guidance, clinical system searches and sample templates and letters to ensure successful and uniform implementation across Bexley.

In addition, training and ad hoc support has been provided by the Primary Care Development team. Practices appear to understand and be successfully rolling out the schemes, with the majority of the first returns within Element 2 (dementia), being received by the CCG by the due date.

However, we are still early on in the schemes and data is not yet available.

3.0 Proposal for 2016/2017

The PCIF scheme is designed to support our Health Priorities for our population and the four current elements have been carefully chosen to provide additional support, where it is required.

Given that the benefits of similar schemes occur across more than one financial year and are continuing to support CCG and population needs, it is proposed that the four focus areas are retained into the coming financial year, with some refining changes, as follows;

Element A. Medicines Management: Value £230K

Evidence from the first quarterly return has demonstrated that this scheme is highly effective in improving prescribing practice, with a 35% increase in the overall number of KPI's that are rated 'Green', in comparison with performance during 2014/2015.

A prescribing element is necessary to retain in the scheme as it supports the CCG on-going focus needed to ensure the appropriateness of prescribed medications and dressings, used within primary care. Practices are required to organise changes in their prescribing behaviour and will receive appropriate incentive. This will continue to increase the high quality prescribing for CCG patients and will release funds, through move effective medicine choices.

It is proposed that there will be changes to both the target levels and the drug focus areas for 2016/2017, to ensure the scheme remains current and supports the latest changes in practice (this will include methotrexadate).

Element B. Dementia Identification: Value £230K *

The current NHS England DES for dementia ceases on 31st March 2016 and gives incentives for practices to identify assess and provide care plans for patients whose cognitive and mental state is symptomatic of any signs of dementia.

The PCIF scheme provides an additional incentive and support to practices to carry out more detailed searching of the clinical record to case find potential patients.

As a CCG we have a absolute target (part of the quality premium) to identify and diagnosis to a minimum prevalence number of patients.

NHS England has an expectation that the focus on dementia will not stop and CCG's will be incentivised through the Quality Premium to continue to support emphasis on identification of appropriate cases. This is a national operating plan target for each

CCG to achieve and maintain, as a minimum a 67% rate (against a forecast of prevalence in the over 65s).

Despite applying all of the recommended best practice at the end of 2014/2015, Bexley had a current reported rate of 52.3% identification rate of Dementia (in the over 65s), but the expectation is that all practices achieve an identification rate of at least 67%. This minimum percentage must be maintained each month of the year.

It therefore supports the CCG's strategic direction that this element be retained during 2016/2017. However, it is hoped to build in more regular notification to the CCG of patients identified throughout the year, to support CCG close working with NHS England. Monthly returns from practices will be required.

Element C. End of Life Care: Value £152K

This element is designed to improve the usage of CMC (Co-ordinate My Care) and reduce the variation of CMC usage across the Bexley Practices. This will improve care planning for our patients in their last 12 months of life (using Co-ordinate My Care) and enable our patients to plan for their own death as early as possible, with their relatives, next of kin, carers or named individuals involved.

The evidence base is that a high use of CMC increases the % of patients that are enabled to die in their place of choice (which is usually their Normal Place of Residence). This therefore links directly to our End of Life Care strategy of improving the percentage of the population that are enabled to die in their Normal Place of Residence (and also avoid admissions in the last year of life).

Prior to the implementation of the PCIF element, CMC use by practice was extremely variable: 0% in some practices, to 62% in the highest practice. At the end of August, there are now no practices that have zero patients registered, and the numbers of patients added to CMC per month has increased from an average of 29 per month to 71 additions.

Initial unvalidated information from our practices suggests that the % of patients enabled to die in their Normal Place of Residence has increased. National data to substantiate this has a 2 year time lag.

It is therefore proposed that this element is retained, since it supports robust patient and commissioning outcomes for this vulnerable group.

We will again be requiring additional quarterly reporting throughout 2016/17.

Element D. Childhood Obesity: Value £152K

This scheme allows us to establish a weight measurement baseline by providing incentives for practices to assess all 7 years olds in the borough for obesity and refer children to receive weight management support, if required. This element requires training for any member of staff providing the service, to enable staff to provide the prescribed intervention and effective guidance to all measured patients.

In Bexley, there are very high rates of childhood obesity (22%) and we have one of the worst obesity rates in children in the country.

The CCG with London Borough of Bexley is establishing a new intensive support service for those children classified as obese or severely obese (identified through the above), for practices to refer children to. It has been hoped to have this service in place for summer 2015, but due to unsuccessful procurement, patients have been referred to interim alternative services across the summer. The CCG is now in urgent discussions with the voluntary sector to provide the Weight Management services (tier 2 & 3) for our 7 year olds to support this initiative. It is envisaged service will be in place by the end of Quarter 3 2015/2016. However, practices are already actively engaging with training and identification of suitable patients for the scheme. The voluntary sector (led by BVSC) are highly excited about this opportunity and demonstrating how they can "step up" and provide the services. Once the BVSC service is organised, we will also consider with the council again what needs to be done in the longer term for all of the Bexley Children and Young People.

In line with the medium term return on investment in public health, it is clear that longer is needed to gauge the impact of the measurement programme. It is proposed that the scheme be extended for a further year. In doing this we would take in the next year of 7 year old children and that some negotiation is carried out to follow up some of the prior year (2015/2016) scheme participants to prove the effectiveness of the service model.

Once we have the 7 year old services in place for tier 2 and 3 we will then be able to gain further information on what these services can achieve (data that is lacking nationally).

4.0 Process for Finalisation of the Scheme

In line with the successful process used previously, a task and finish decision making group (PCIF Leadership Group) will be established to determine the refine and propose any changes for each of the schemes chosen and to ensure that the PCIF fund is focused in line with the strategic direction set by the Governing Body. This group will set the parameters and approve the final scheme changes, but with the detail developed by a detailed working group. The membership for this PCIF Leadership Group will be as follows;

- Sarah Valentine, Director of Commissioning
- Sandra Wakeford, Patient Council and GB member
- Simon Evans-Evans, Director of Governance & Quality

- Dr Peter Fish, GB member and GP in an advisory non-voting capacity (to provide an input on the potential for development of a scheme “do-ability”)

As the above group developed the schemes for 2015/16 then there will not be a large administrative time commitment to agreeing the modifications.

The detailed working group, known as the PCIF design group, will be formed to debate and propose the detailed elements of the prescribing scheme and the refinements to Dementia, EOLC and also Child Weight Management. This group will include representatives from GP’s, practices management and LMC, as well as the CCG Primary Care Development and Commissioning teams.

The final design of the scheme put forward by the PCIF design group will be agreed by the PCIF Leadership Group (on behalf of the GB), in line with the agreed governance process developed in 2015. Details of the final scheme will be presented to the GB in early 2016 to enable ample time for implementation from April 1st 2016.

In line with the spirit of the above proposal, for 2016/2017, it is proposed there is no change to scheme value and for the PCIF, this remains at £768K, in line with current PCIF funding (rolled forward from Kitemark 2014/2015). Therefore, no additional financial control approval is required to proceed.

5.0 Recommendation and conclusion

The Governing Body is asked to

1. Approve that the existing schemes roll forward into 2016/17.
2. Agree the delegation of the concept to the PCIF Leadership Group (with GB members involvement).

A further report on the final agreed scheme will be presented later in the financial year.

Sarah Valentine
Director of Commissioning

Appendix A: The 2015/2016 PCIF Scheme Elements

The PCIF 2015/2016 scheme, includes the following 4 elements

- Element A: Medicines Management
- Element B: Dementia
- Element C: End of Life Care
- Element D: Childhood Obesity

Detailed notes of each element can be found below:

Element A: Medicines Management:

Value: £230K

Scheme Dates: 1st April 2015 to 31st March 2015

Practices are requested to meet targets in terms of prescribing changes. Practices can achieve either a 'Green' mark worth 2 points or 'Amber' mark worth 1 point, to allow differentiation between performances. The value of each point is calculated according to practice list sizes, to reflect the increased workload in larger units.

The table below summarises the quality and cost effective prescribing targets, agreed with the PCIF design group. Practices will be supported by the medicines management team to undertake the preparation required to effect these changes. Practices will be assessed shortly after 31st March 2016, to calculate the incentive payment earned.

Description of Prescribing Area	Indicator	Current CCG Average	Suggested Target- Green 2 points	Suggested Target- Amber 1 points
All practice to participate (if not completed not				
PRIMIS Pincer Library to for Admissions Avoidance	(1) Deployment (2) Run Audit of one of 8 areas twice (Sept 15 and Feb 16)	Already Deployed in about 25% of practices		
Quality based targets:				
Reduce Prescribing of Antibacterials	Antibacterial items per STAR PU	0.267	0.23	>0.267
Reduce Prescribing of Broad Spectrum (Quinolones, Cephalosphorins and Co-Amoxiclav to reduce risk of C-Diff	Co-amoxiclav, Cephalosporins & Quinolones as % of all antibiotic items	14.80%	< 13.3%	<14.8%
Cost effective targets:				
Reduce prescribing of Pregabalin and optimise dose (If dose is optimised, pregabalin items will fall)	Gabapentin and Amitryptyline as a percentage of all oral neuropathic agents ***(audit if within 2% of target)***	72%	>80%	>72%
Prescribe Sildenafil as 1st line Oral Erectile Dysfunction Drug	Sildenafil as % of all Oral ED Drugs 9Avanafil, Sildenafil, Vardenafil and Tadalafil)	59%	>70%	>59%
Prescribe Zolmitriptan 2.5mg, Zolmitriptan 2.5mg disp, Naratriptan 2.5mg, Sumatriptan 100mg, Sumatriptan 50mg or Rizatriptan 10mg	Category M Triptans as % of all Triptans	76%	>90%	>76%
Review and revise prescribing of ezetimibe in line with NICE guidance. Potential over prescribing of ezetimibe based on observed cost increases	% ezetimibe of all lipid lowering drugs	3.20%	1.71% (top 25th percentile on ONS cluster)	>3.2%
Review omega-3 fatty acid compounds to ensure prescribing as per NICE	omega -3 fatty acid compounds ADQ/STAR PU	0.33	0.233 (ONS cluster average)	>0.33

ELEMENT B: DEMENTIA

Value: £230,000

Scheme dates: 1st April 2015 to 31st March 2016

Scheme Description

This scheme comprises two elements, as follows

Background:

The current NHS England DES for dementia ceases on 31st March 2015. NHS England has an expectation that the focus on dementia will not stop and CCG's will be incentivised through the Quality Premium to continue to support emphasis on identification of appropriate cases. The Quality Premium to a CCG is in addition to our base income, and is only paid if a range of national requirements are met (this is one of them). Dementia is a national operating plan target for each CCG to achieve and maintain, as a minimum a 67% rate (against a forecast of prevalence in the over 65s in 2015/16 this translates to a minimum of 1,802 diagnosed and on the QoF registers every month – so achieving and then maintaining a minimum number).

Bexley has a current reported rate of 52.3%[1] (at end of Jan 2015) identification rate of Dementia (in the over 65s), but the expectation is that all practices achieve an identification rate of at least 67%. This scheme is designed to improve the rates and to help us achieve this national target.

Element 1: Initial Reward Payment for Practices

The CCG recognises that a great deal of work has already been done to increase the rates in 2014/15, but more still needs to be done to achieve the target.

Therefore, an initial payment under this scheme of £25 will be made, per identified & diagnosed Dementia Patient (aged 65 and over at 31.3.15) on the QoF register at 31.3.15.

Element 2: On-going Identification Support for Practices

The second element of the scheme is designed to increase the rate of diagnosed dementia, in the over 65s. There are two parts (stages) to the scheme – the first is a full scale review of existing patient records, together with assessment of patients and referral to the Memory Service – all to be completed within a given time period (see below). The second element is a further review, later in the year, for any patients that might not have been diagnosed, or spotted in the earlier search period.

Stage 1:

1. Bexley GP practices are to carry out a search to identify patients aged 64 years and above coded with suspected or confirmed memory problems, using clinical system search. The CCG will be providing to all practices the search algorithm, which will also exclude any patients already on the QoF dementia register. This would include searches for read codes containing the words:

    - Dementia
    - Cognitive Decline
    - Confusion
    - Memory

2. The resulting list is to be clinically reviewed by a GP, by checking the medical records to identify those patients who may be clinically at risk of dementia, or have the signs of dementia in their medical records. This will then produce a short list of potential patients, needing further clinical assessment.

3. Based on the results of records based clinical assessment, the patients requiring further clinical assessment are to be invited to attend the practice, or visited by the practice for in depth dementia assessment, arrangement of bloods/diagnostics, or onward referral to the memory clinic.

4. If the patient does not attend the practice, the practice will contact the patient to actively encourage their attendance.

5. If after the clinical assessment, it is clear that the patient is not showing any signs of dementia, then the patient record must clearly show the outcome of this assessment (to avoid duplication at Stage 2)

6. On confirmation of diagnosis from the memory clinic, the practice will update the care record with the correct READ code.

Stage 2:

7. Steps 1 to 6 above will then be completed again by the practice in December of 2015. As records will have been updated, it is expected that this will return a lesser number for review, or that will require face to face clinical assessment.

Administration and Payment Schedule

8. The scheme is subject to the following timetable.

Element 1:

Each practice will produce a report from QoF that shows the number of their diagnosed dementia patients that are aged 65 and over, as at 31.3.15. This will be submitted to the CCG by April 30th 2015 and a payment made at £25.00 per diagnosed dementia patient.

Element 2:

a. The searches and clinical review will be completed within the first two months (i.e. by 31st May) (outlined in points 1 & 2 above)
b. The patient practice visit and any resulting actions will be completed before the 31st July (outlined in points 3 to 5 above)
c. A repeat search comprising a repeat of all tasks 1 to 5 above should be carried out by 31st December 2015. This is to capture any newly registered patients, or changes in clinical condition, in the previous months.

Payment for the second element of scheme will be made in 2 tranches during the year:

Payment 1: Submission of Data to the CCG by 1st week in August for

- Element 1 (at £25.00 per patient aged 65 and over on the QoF register at 31.3.15)
- Element 2 – stage 1 at £0.57 per patient on the practice's list

To achieve payment for Element 2 stage 1 at the end of month 4 (July), practices will need to:

- Identify all patients with a CCG designed clinical system search
- A GP to clinically review the patients' records to identify those patients that are appropriate to invite in to the practice.
- Carry out Dementia assessment and refer on to Memory Clinic, where appropriate
- Enter identified patients onto the practice Dementia register & update records where the review has been undertaken, but there are no clinical signs of dementia.
- The practice will need to provide reports and evidence of the number of patients identified via the search, clinical records reviewed, patients invited for assessment, assessments undertaken, and number referred onto memory clinic.

Payment 2 in January 2016 –

- Element 2 – stage 2 at £0.24 per patient on the practice's list size

- Undertake the repeat search exercise by 31st December 2015.

For all elements, the terms of payment is that it is all inclusive and includes for example:

- Receptionist and Admin support
- Premises Costs
- Clinician time
- IT templates
- Advertising and Contacting patients
- Payment administration to practices

1. NHS England Primary Care Web Tool
   https://www.primarycare.nhs.uk/private/dpc/dpc_main.aspx

Element C: Improving End of Life Care

Value: £152,000

Scheme dates: 1st April 2015 to 31st March 2016

Scheme Description

1. Bexley GPs are asked to complete Co-ordinate My Care [CMC] entries for the expected number of patients likely to be in the last year of life, to enable the patient to plan for their death and achieve their last wishes. CMC is recognised as a good solution for visibility. CMC alerts LAS, Hurley group, Acute Trusts and District Nurses.

2. There expected number of suitable patients for practices to upload to the CMC register is between a maximum and minimum target, but between these limits ,is determined by the practice, according to clinical opinion. The maximum of records the practice can receive reimbursement for is calculated as being the historic numbers of deaths during the previous 12 months (approx. 1%), while the minimum is calculated at 0.25% total list size.

3. There will be an agreed minimum data entry level per record upload to CMC to achieve payment. This will ensure that sufficient information is stored, which reflects the patients' wishes. This requires a meeting with the patient and NoK, or significant other.

4. The Practice CMC register should aim to correlate those cases uploaded to CMC with the Palliative Care Register, to ensure that correct patients are selected.

5. Data can be collected onto EMIS/Vision templates, which will auto-fill with patient demographics and uploaded separately to CMC. The upload onto the CMC register can be carried out by individual Practices, as a locality or Bexley wide. Alternatively, practices may wish to upload direct to CMC, during the consultation.

6. Payments will be made at 2 intervals during the year (end Quarter 2 and 4).

To achieve the payment at the end of Quarter 2, practices will need to:

- Identify and select suitable patients, subject to above maximum and minimum claimable records.
- Discuss the CMC entry with the patient, and give the patient a record of their CMC record and/or Advanced Care Plan.
- Load the required number of records onto CMC database, in line with minimum data set.
- The practice will receive £50 per uploaded patient.

- Worked example: the practice had 100 deaths during 2014/2015 and is aiming to upload the maximum number of CMC records (100). If the practice uploads 100 records, by the end of Q2, they qualify for a payment of £5,000 –i.e. £50 by 100)

To achieve the payment at the end of Quarter 4, practices will need to:

- Review their current patients on the CMC register and remove any patient that has died or been deregistered. For patients that remain on the register, the CMC register should be updated to show any key changes in condition or needs, related to end of life care, after a further face to face review.
- Confirm attendance at, at least three out of four, quarterly Palliative care Round table meetings held during the year.
- Identify and select further suitable patients, subject to above maximum and minimum claimable records.
- For newly added patients:
    - Discuss the CMC entry with the patient, and give the patient a record of their CMC record and/or Advanced Care Plan.
    - Load the minimum number of records onto CMC database, in line with minimum data set.
- The practice will receive £35 for all previously listed patients that are reviewed again between Q2 and Q4 and £50 for all newly added patients.

- Worked example: the practice had 100 deaths during 2014/2015 and is aiming to upload the maximum number of CMC records (100). By the end of Q2, 25 patients have died. The practice therefore removes the 25 CMC records and identifies a further suitable 25 patients which would benefit from CMC. The practice reviews the remaining 75 patients on the list to ensure the CMC record is accurate and there are no significant changes. The practice qualifies for a payment of £3,875-i.e. 75 review of old records at £35 per record and 25 new records at £50 per record.

The payment schedule is all inclusive and includes for example:

- Receptionist and administration support
- Premises Costs
- Clinician time
- IT templates
- Advertising and Contacting patients
- Payment administration, if the practice sub contracts this scheme
- Practice staff access to CMC and attending relevant training
- Message in a bottle (CCG to support practices to purchase relevant ‘bottles’ to hold details of patient wishes)

Notes:

This scheme is designed to improve the usage of CMC and reduce the variation of CMC usage across the Bexley Practices. Currently the use of CMC (which is an excellent planning tool for patients to express their wishes) by practice is extremely variable: 0% in some practices, to 62% in the highest practice.

ELEMENT D: CHILDHOOD OBESITY

Value: £152,000K

Scheme dates: 1st April 2015 to 31st March 2016

Scheme Description

1. Bexley GP practices to provide a 'Child Screening Review', for all child patients aged 7 in 2015/16.
2. The child will be invited at age 7 and before 8th birthday, to attend the surgery for a 30 minute appointment with a doctor, nurse or HCA who has undertaken the relevant training, to carry out weight and measurement check, and to provide a prescribed "brief intervention" for any child who is overweight to severely obese (see below), to prevent childhood obesity. The child will have measurements for height and weight recorded by the clinician and carry out a prescribed formatted consultation.
3. Based on the results of the consultation, the child will be recorded as either:

    - 1) Normal weight
    - 2) Overweight *
    - 3) Obese *
    - 4) Severely obese *

For *, a detailed classification will be provided by the end of Quarter 1.

4. The GP practice will then carry out the following tasks (hereafter, the tasks are known as numbered interventions A, B, C), depending on the outcome of the weight record;

- For 1) Normal Weight–Intervention Type A- the practice should record the weight measurements and no further action is needed (unless clinically appropriate)

- For 2) Overweight – Intervention Type B- the practice should undertake a formal "Brief Intervention" giving advice on better weight management and should arrange a follow up consultation within 3 months to review progress. Height and weight should be recorded at the follow up consultation and a further "Brief Intervention" given, if the child remains overweight.

- For 3) Obese and 4) Severely obese –Intervention Type C- the practice should undertake a formal "Brief Intervention" and make a referral to the London Borough of Bexley Childhood obesity programme (details are to follow). The practice should arrange a follow up consultation within 6 months to review progress. Height and weight should be recorded at the follow up consultation and a further "Brief Intervention" given, if the child remains obese or severely obese or overweight .

5. A payment of £35 will be made for each first appointment with Intervention Type A, B & C undertaken and £25 for each follow up appointment with Intervention Type B & C undertaken.

6. Any clinician providing this service, must have undertaken “Brief Intervention” training in childhood weight management and obesity, before seeing any child. This training will be organised by the CCG for the practices.

The payment is all inclusive and includes for example:

- Receptionist and Admin support
- Premises Costs
- Clinician time
- IT templates
- Advertising and Contacting patients
- Payment administration to practices
- Attending Staff Training (to be procured via London Borough of Bexley public health department, with the support of the CCG)
- Providing reports to the CCG on the number of children reviewed by practice, and also the outcomes of those reviews using the classifications shown at point 3 above (likely reported outcomes and format for reporting will be agreed with practices, but are likely to include child original weight, child’s excess weight levels, measurement of weight loss or gain at second intervention). Payments will be made at the end of Quarters 2, 3 and 4, based on the submission of an agreed reports. The CCG will commit that sufficient training is in place by the end of Quarter 1 to support practices. (note: children who turn 8 before the end of Quarter 1, can be seen and claimed in Quarter 2)

Notes:

In Bexley, there are very high rates of childhood obesity (22%) and we have one of the worst obesity rates in children in the country. The CCG with London Borough of Bexley, is establishing a new service for those children classified as obese or severely obese, for practices to refer children to.

This scheme requires training for any member of staff providing the service, and a standardised training course will be given, that will enable staff to provide the “Brief Intervention” described above.

This scheme could be operated at a practice or locality level, but services must be available throughout the geographical area, as the further the child and their family (or carer) needs to travel, the less likely they are to attend the appointment. At present this is a one year only scheme, so that evidence can be gathered on the efficacy of this interventional service.

The CCG will only pay for the appointments attended; therefore it will be part of the role within the scheme for practice's to encourage the children and their parent/ carer to attend.