NHS Rotherham Clinical Commissioning Group

Operational Executive – 9 August 2019

Strategic Clinical Executive – 14 August 2019

Local Medical Committee – 9 September 2019

Primary Care Sub Group – 25 September 2019

Primary Care Commissioning Committee – 9 October 2019

Serious Mental Illness Local Enhanced Service (SMI LES) and Shared Care Protocol Physical Healthcare Assessments and Follow Up Care

Lead Executive:	Ian Atkinson, Deputy Chief Officer, Rotherham Clinical Commissioning Group
Lead Officer:	Kate Tufnell, Joint Head of Adult Mental Health Commissioning, Sara Hartley, Contracting & Service Improvement Manager (Primary Care)
Lead GP:	Dr Russell Brynes, SCE Lead for Mental Health and Learning Disability

Purpose:

The purpose of this paper is to inform the Primary Care Committee of the intention to commission a Serious Mental Health Local Enhanced Service, in line with the requirements of the Mental Health Forward View publication.

Background:

On average men living with severe mental illness die 20 years earlier, whilst Women living with severe mental illness die 15 years earlier

The disparity in these health outcomes is partly due to this cohort of patients not being offered appropriate or timely physical health assessments.

SMI is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, undertaking regular health checks, ensuring people with SMI attend screening programs, referral to appropriate clinical support services, advising on preventive actions, advanced decision making and contingency planning, and signposting people to local information and advice and support services.

2389 people in Rotherham (approximately) are estimated to have a serious mental illness (SMI).

NHS England National Polices

The Mental Health Forward View 2020/2021 ambition is that by 2020/2021 fewer people living with a severe mental illness (SMI) will die prematurely. To achieve this ambition NHS England has committed to provide additional investment.

- To ensure that primary care staff teams feel confident in actively supporting people with severe mental illness to access relevant physical health screenings and interventions.

- To enable CCGs to offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year.

In addition, the 2017/19 CQUIN National Indicators set, included the following target:

- Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI) (goal: Assessment and early interventions offered on lifestyle factors for people admitted with serious mental illness (SMI).

This commitment by NHS England to continue to increase the number of people living with severe mental illness accessing SMI health checks is also reflected in the recently published NHS Mental Health Implementation Plan 2019/20 - 2023/24

Analysis of key issues and of risks

2019/20 SMI National target requires that, 60% of the population with SMI on the GP register receive an annual physical health check and any associated interventions. 50% of these checks should be undertaken in a primary care setting, with 10% taking place in secondary care.

(This Local Enhanced Service, will, however, be offered to all those on the Rotherham SMI GP registers)

Rotherham Performance data

Rotherham's performance against this target continues to remain lower than the national requirement, with the recently submitted record for quarter one (2019/20) showing a decrease against quarter four (2018/19) submission (21.7% vs 32.7%). Although in 2018/19 Rotherham did not achieve the required 60% target, it was, however, ranked above the national average of 30% and at the top of the Yorkshire and Humber benchmarking data, in six of the indicators (refer to appendix 2: NHS England 2018/19 benchmarking and best practice overview).

Current risk: the CCG's SMI annual health check rate remains below the required national target (mitigation: introduction of the SMI LES).

Rotherham Serious Mental Illness Local Enhanced Service (SMI LES)

By commissioning this LES the CCG will ensure that those people living with a severe mental illness in Rotherham can access their physical health checks closer to home. Furthermore, it is anticipated that this early access will improve their physical health and increase life expectancy, with fewer co-morbidities experienced.

In developing the LES specification one of the areas of concern highlighted was that of dental health. The national physical health checks require that a dental check is undertaken, but there is no guidance on what this should comprise of. Feedback from GPs also highlighted this as an area of concern. In view of this Rotherham is proposing to define the requirement for this area, as one in which the GPs will be required to provide a brief intervention to promote dental hygiene. To support the delivery of this element of the LES the CCG is proposing to provide a toothbrush and dental health hygiene awareness leaflet to be given at all SMI physical health checks.

(Details of the LES service specification can be found in appendix 1A)

Primary Care and Severe Mental Illness

Public Health England research and analysis indicates that people with severe mental illness experience the following physical health inequalities. People with SMI in England:

- die on average 15 to 20 years earlier than the general population
- have 3.7 times higher death rate for ages under 75 than the general population
- experience a widening gap in death rates over time

It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented

(Appendix 2 provides further details on the physical health inequalities experienced by people with severe mental illness)

The following tables provides a comparison of the Severe Mental Illness LES and Severe Mental illness QOF requirements:

Requirement	**Severe Mental Illness LES**	**SMI QOF**
A measurement of weight (BMI OR BMI + Waist circumference)	√	√
A blood pressure (diastolic and systolic BP recording OR diastolic and systolic BP recording and recording of pulse rate)	√	√
An assessment of smoking status	√	√
A full blood lipid profile including cholesterol test OR QRISK Assessment	√	×

A fasting blood glucose test **OR** HbA1c test	√	×
An assessment of alcohol consumption	√	×
An assessment of nutritional status or diet and level of physical activity	√	×
An assessment of use of illicit substance / non prescribed drugs	√	×
Support access to relevant national screenings , including: o Cervical Cancer o Breast Cancer o Bowel Cancer	√	×
Medicines reconciliation and review	√	×
Follow-up interventions, including: • Weight management – advice/referral • Blood pressure – lifestyle and dietary interventions • Blood pressure – pharmacological interventions • Blood glucose – high risk/pre-diabetic interventions • Blood glucose – diabetic interventions • Alcohol consumption – advice/referral • Smoking – advice/referral • Substance misuse intervention • Lifestyle interventions in relation to blood lipid measurements and nutritional status, diet and physical activity • Full blood lipid profile including cholesterol	√	×
Sexual health and contraception advice	√	×
Oral health advice	√	×
Prolactin if patient symptomatic as per GASS – refer to shared care protocol for details	√	×

Shared Care Protocol Physical Healthcare Assessments and Follow Up Care

National guidance suggests that 50% of these checks should be undertaken in a primary care setting, with 10% taking place in secondary care. Currently, elements of the SMI physical health check screening is undertaken in primary care through the QOF requirements, as well as in secondary care, as part of the 2017-19 CQUIN requirements. The introduction of the shared care protocol will ensure there is a process in place to systematically share the results of these physical health checks between primary and secondary care. Furthermore, by combining the LES and the Shared care protocol it will ensure improved communication between primary care and secondary care. Consequently, this will reduce duplication in clinical reviews and ensure that one comprehensive physical health check is completed.

(Details of the Shared care protocol can be found in appendix 1B).

Note: the introduction of the SMI LES/Shared care protocol will release capacity within secondary care mental health services. This should allow the RDaSH services to be more responsive to the mental health requirements of this cohort of patients.

Proposed governance / sign-off process:

- Primary Care Sub-Group - 31 July 2019
- Operational Executive – 9 August 2019
- Strategic Clinical Executive – 14 August 2019
- RCCG/LMC Officers Meeting – 19 August 2019
- Local Medical Committee – 9 September 2019
- Primary Care Sub Group – 25 September 2019
- Primary Care Commissioning Committee – 9 October 2019

Patient, Public and Stakeholder Involvement:

- Joint CCG/RDaSH group developed to support the development of the Shared Care Protocol Physical Healthcare Assessments and Follow Up Care, Chaired by Dr Russell Brynes, SCE Clinical Lead Mental Health.
- Draft Rotherham Severe Mental Illness Health Check LES Service Specification shared with Heidi Robinson, Project officer, NHS England and NHS Improvement – (NE and Yorkshire) feedback received incorporated into service specification.
- Severe Mental Illness Health Check LES Service Specification/Shared Care Protocol Physical Healthcare Assessments and Follow Up Care shared with Dr Julie Eversden, LMC Representative (July 2019).
- Primary Care Sub-Group 31st July 2019: *Severe Mental Illness Physical Health Checks*, Primary Care Enhanced Service Proposal considered.

Equality Impact:

- Severe Mental Illness Health Check LES (including Shared Care Protocol Physical Healthcare Assessments and Follow-up Care) Equality Impact Assessment completed.
- Equality Impact Assessment documentation submitted (01.08.19) to Equality and Diversity Steering Group for approval – refer to appendix 1C.
- Appendix 2 provides details of the physical health inequalities experienced by people with severe mental illness.

Financial Implications:

Practice level:

A total sum of £ 90 per patient per annum is available to practices. Payment will be made to practices for each complete health check undertaken within each quarter.

Rational for Rotherham unit cost:

- Across the Yorkshire & Humber region there is no standard rate for the delivery of this service. Evidence provided by the Yorkshire and Humber Clinical Network indicates that payments received by GP practices for undertaking these physical health checks differs greatly across the region, ranging from £11.50 to £140 per patient. Discussions with NHS England have indicated that the lower payment rates quoted, often only reflect a top-up payment to a price already received by the practices.
- The Proposed Rotherham rate has been set as it aligns with Annual LD Health Check

LES already funded by the CCG. It is, however, slightly lower than the LD LES, as the SMI LES does not have to be completed in one visit and elements of the physical health for this one is already included in the Primary Care QOF.

Benchmarking across South Yorkshire and Bassetlaw CCGs

Barnsley	• No Severe Mental Illness LES in Place • No plans to develop an SMI LES
Bassetlaw	• No SMI LES in place, but are exploring training and developing for primary care clinicians • Considering approaching the GPFV ICS funding to cover training costs
Doncaster	• Do not have an SMI; instead they are going to introduce a primary care lead service. This service will undertake an annual review, with MDT input from prescribing, MH psychiatry & GP (includes diagnostics) and Primary care mental health liaison. This will result in the development of a Health Action Plan
Sheffield	• Awaiting a response

Rotherham Level:

	2019/2020
Estimated total cost of the SMI LES at a borough level (Based on £90 per patient x 2389 people on Rotherham's SMI, the current known population cohort)	£215,010*
Resources to promote dental health awareness (2019/20 only)	£3,000 tbc

*Post meeting note: £215,010 is the estimated cost of completing 100% of physical health checks

Note:

- This figure will be subject to annual fluctuation, as the number of people on the SMI registers changes.
- Funding to support the delivery of this LES has been identified, as part of the Rotherham 2019/2020 Mental Health Investment Plan.
- SMI LES costings calculations - Appendix 3.

Human Resource Implications:

- HR implications will vary across GP practice and each practice will need to ensure it has appropriate staff in place to support the delivery of the LES.
- **Practice workforce development**:
  - To ensure practices have easy access to appropriate training the service

specification provides details of an online training accredited by the Royal College of General Practitioners (appendix 1A).
    - The Yorkshire and Humber Clinical Networks, 'Physical Health in SMI - A Good Practice Sharing Event for South Yorkshire', held in September was promoted to GP practices.

Procurement Advice:

- This LES is an enhancement of the Quality and Outcomes Framework (QOF), currently delivered by Rotherham GP practices.

Data Protection Impact Assessment:

- Data Protection Impact Assessment screening completed and submitted for approval.

Approval history:

- Primary Care Sub-Group – 31 July 2019
- Operational Executive – 9 August 2019
- Strategic Clinical Executive – 14 August 2019
- RCCG/LMC Officers Meeting – 19 August 2019
- Local Medical Committee – 9 September 2019
- Primary Care Sub-Group – 25 September 2019

Recommendations:

The Primary Care Committee is asked to:

- Approve the Serious Mental Illness Local Enhanced Service (SMI LES) and Shared Care Protocol Physical Healthcare Assessments and Follow Up Care.
- Note Rotherham's current performance against the national Physical Health Checks for people with SMI and the action being taken to address this low performance.

Paper is for Approval

NHS Standard Contract - SCHEDULE 2 – THE SERVICES

Severe Mental Illness Health Check LES

Service Specification No.	
Service	Severe Mental Illness Health Check LES
Commissioner Lead/s	Dr Russell Brynes, Strategic Clinical Executive Kate Tufnell, Head of Adult Mental Health Commissioning
Provider Lead	As signed
Period	1 October 2019 to 31st March 2020
Date of Review	End of contract period or as necessary

1. Population Needs

1.1 National context

People living with severe mental illness (SMI) have a life expectancy of 15-20 years lower than the general population. The disparity in these health outcomes is partly due to this cohort of patients not being offered appropriate or timely physical health assessments.

SMI is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, undertaking regular health checks, ensuring people with SMI attend screening programs, referral to appropriate clinical support services, advising on preventive actions, advanced decision making and contingency planning, and signposting people to local information and advice & support services.

1.2 Local context

Around 2389 people in Rotherham are estimated to have a serious mental illness (SMI). The Five Year Forward View for Mental Health has committed that by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

This specification aims to achieve, by the end of 2019/20, 60% of the population with SMI on the GP register receive an annual physical health check and any associated interventions. 50% of these checks should be undertaken in a primary care setting, with 10% taking place in secondary care. Commissioning of improved physical health care for people with an SMI within a primary care setting further builds on work to ensure parity of esteem between mental and physical health by giving equal attention to the physical health of people with mental health problems as is given to the general population.

Regular physical health checks, which include lifestyle and family medical history and routine tests such as weight, blood pressure, glucose and fats or lipids, can identify potential problems before they develop into serious conditions.

CCGs have a delegated responsibility to improve physical healthcare for people with SMI in line with their legislative duties for addressing equalities and health inequalities. In accordance with the Public Sector Equality Duty, section 149 (1) of the Equality Act 2010 and the Health and Social Care 2012, CCGs alongside other bodies have duties regarding:

- eliminating unlawful discrimination under the Equality Act 2010;
- advancing equality of opportunity;
- fostering good relations;
- reducing health inequalities in access to health and health outcomes; and
- improving services and developing more integrated services.

Primary Care currently carry out some of the above through the Quality and Outcomes Framework (QOF). Under the SMI clinical domain, practices undertake the following work:

- Care Plan development
- Blood pressure monitoring
- Smoking Status
- Record of BMI

This LES is an enhancement of the above work and has been designed to further improve the health outcomes of people living with SMI, and includes:

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

This service should be provided in conjunction with the Shared Care Protocol (Appendix One) and the Physical health check and follow-up interventions for people with severe mental illness Technical Guidance (Appendix Two).

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	N/A
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	✓

3. Scope

3.1 Aims

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

- Patients with SMI who are not in contact with secondary mental health services, including both:
  - those whose care has always been solely in primary care, and
  - those who have been discharged from secondary care back to primary care; and

- Patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised.

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

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

This specification looks to provide focus and address the below six areas.

- Ensuring clarity about the required elements of a physical health assessment for someone with an SMI
- Ensuring provision of follow-up interventions to address identified health risks such as a

lack of physical exercise
- Ensuring sufficient capacity in primary care to develop and deliver personalised support plans and provide navigation to ensure that people have access to the right resources and services
- Clarifying roles and responsibilities across primary and secondary care teams in relation to the physical health of people with SMI
- Improving communications and collaboration between primary and secondary care
- Developing confidence and competence within the primary care workforce to deliver good physical healthcare for people with SMI

The provider will ensure that they advertise this service to their patients. Services need to be accessible, appropriate and sensitive to the needs of all service users. No-one should be excluded or experience difficulty in accessing and effectively using the service due to their race, gender, disability, sexual orientation, religion and/or age.

3.2 Objectives

Providers of the service will be required to:

- Ensure people with SMI receive the same level of care among all GP practices in Rotherham
- Ensure each practice has a Lead Clinician for SMI
- Enhance physical health care and health promotion advice for all people with SMI
- Follow-up all people with SMI via delivery of or referral to appropriate interventions, and implement personalised care planning, engagement and psychosocial support.

3.3 Service Description

The requirements for participation in this contract are as follows:

- The Provider shall ensure their SMI register is up to date by sharing and receiving information (in the form of an SMI register) from and to the secondary care mental health provider (Rotherham, Doncaster and South Humber NHS Foundation Trust - RDaSH) on a quarterly basis.
- The Provider will communicate, via the most suitable means, with those patients on their SMI register to inform them of the annual physical health check invite and any follow up invites.
- The Provider shall complete an annual physical health check for those patients on the SMI Register aged 18 years and over (except in first 12 months of treatment under secondary care). The national target for patients receiving a comprehensive physical health check is 60%.
- The physical health check is to include delivery of or referral to appropriate NICE-recommended interventions, follow-up personalised care planning, engagement and psychosocial support.
- The Provider shall use the Bradford Electronic Template to complete and record the annual physical health check.
- The Provider shall report on to the CCG a quarterly basis the total number of people on the GP SMI register
- The Provider shall report on to the CCG a quarterly basis the total number of people on the GP SMI register who have received a full comprehensive physical health check (within the last 12 months) in a primary care setting.

3.4 Target population and eligibility criteria

All patients who are registered with a Rotherham GP and who have a diagnosis of SMI.

3.5 Training

It is recommended that clinicians undertake the online training resource (Physical healthcare for

people with SMI) accredited by the Royal College of General Practitioners which can be accessed through https://portal.e-lfh.org.uk/ . A Mental Health Core Skills Framework has also been developed in collaboration with Skills for Health, which identifies the learning outcomes to be achieved by individuals when addressing the physical health care needs of people with SMI - http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework

All providers are required to carry out the following:

- Have a named Lead Clinician for SMI who will ensure that a SMI update will be included as part of their appraisal process.
- The named Lead Clinician will provide active mentorship and supervision of GPs using the pathway to ensure that diagnosis, treatment and/or referral is appropriate.
- Ensure all staff undertaking the physical health checks:
    - understand what SMI is and how it might be experienced
    - understand the risks of poor physical health and how to support people with SMI to engage and access appropriate physical health care
    - feel confident to talk about health holistically including mental health, healthy lifestyles, risk reduction and physical health
    - have technical skills and expertise in relation to carrying out physical health assessments and obtaining and communicating the results

3.6 Quality requirements

The Provider shall:

- Maintain adequate records of the performance and results of the service provided.
- Maintain full records of all physical health checks and follow up procedures in such a way that aggregated data and details of individual patients are readily accessible.

3.7 Monitoring and evaluation

The Provider must provide NHS Rotherham CCG with such information as may be reasonably required to demonstrate that it has robust systems in place to deliver the Local Enhanced Service.

Providers will be required to provide evidence of the requirements and the specific numbers of people supported under the agreement.

SMI registers will be monitored in order to triangulate the payment process and to ensure appropriate payment.

3.8 Patient satisfaction

In order to ensure patients are satisfied with the SMI Physical Health Check service, the CCG will undertake a rolling survey monkey to monitor patient satisfaction. Providers will provide the patient with the appropriate link for completion.

3.9 Read codes

The SMI primary care disease register is made up of patients who have the following codes:

- Schizophrenia Eu20
- Schizotypal personality Eu21
- Persistent delusional Disorder Eu22
- Acute/Transient psychotic disorders Eu23
- Induced delusional disorder Eu24
- Schizoaffective disorders Eu25
- Manic Episodes Eu30
- Bipolar Disorder Eu31

- Severe Depression with Psychosis Eu323
- Non organic Psychosis E1 (and all subsets)

Other diagnoses, including diagnoses of personality disorder (other than schizotypal personality disorder), substance misuse disorders without co-morbid psychosis, eating disorders or recurrent depression are not included in the definition.

This does not mean that these diagnoses are not 'serious' or do not carry physical health risk but the SMI definition is aligned to current evidence base for physical health checks which is driven by cardio metabolic risks associated with anti-psychotic medications. It also aligns with current QoF register definition.

If national guidance changes regarding these definitions, the service specification will be updated to reflect these changes.

3.10 Payment

A total sum of £ 90 per patient per annum is available to practices. Payment will be made to practices for each complete health check undertaken within each quarter.

	Technical Guidance section
• a measurement of weight (BMI **OR** BMI + Waist circumference)	Part 1
• a blood pressure (diastolic and systolic BP recording **OR** diastolic and systolic BP recording and recording of pulse rate)	Part 1
• a full blood lipid profile including cholesterol test **OR** QRISK Assessment	Part 1
• a fasting blood glucose test **OR** HbA1c test	Part 1
• an assessment of alcohol consumption	Part 1
• an assessment of smoking status	Part 1
• an assessment of nutritional status or diet and level of physical activity	Part 3
• an assessment of use of illicit substance / non prescribed drugs	Part 3
• support access to relevant national screenings , including:	Part 5
○ Cervical Cancer	
○ Breast Cancer	
○ Bowel Cancer	

In line with NHS England guidance document Improving physical healthcare for people living with severe mental illness in primary care, the following additional elements should also be provided for people with SMI as part of a comprehensive health check in line with clinical evidence and consensus:

	Technical Guidance section
• Medicines reconciliation and review	Part 3
• Follow-up interventions, including:	Part 4
○ Weight management – advice/referral	

- Blood pressure – lifestyle and dietary interventions
- Blood pressure – pharmacological interventions
- Blood glucose – high risk/pre-diabetic interventions
- Blood glucose – diabetic interventions
- Alcohol consumption – advice/referral
- Smoking – advice/referral
- Substance misuse intervention
- Lifestyle interventions in relation to blood lipid measurements and nutritional status, diet and physical activity
- Pharmacological interventions relating to blood lipids including cholesterol

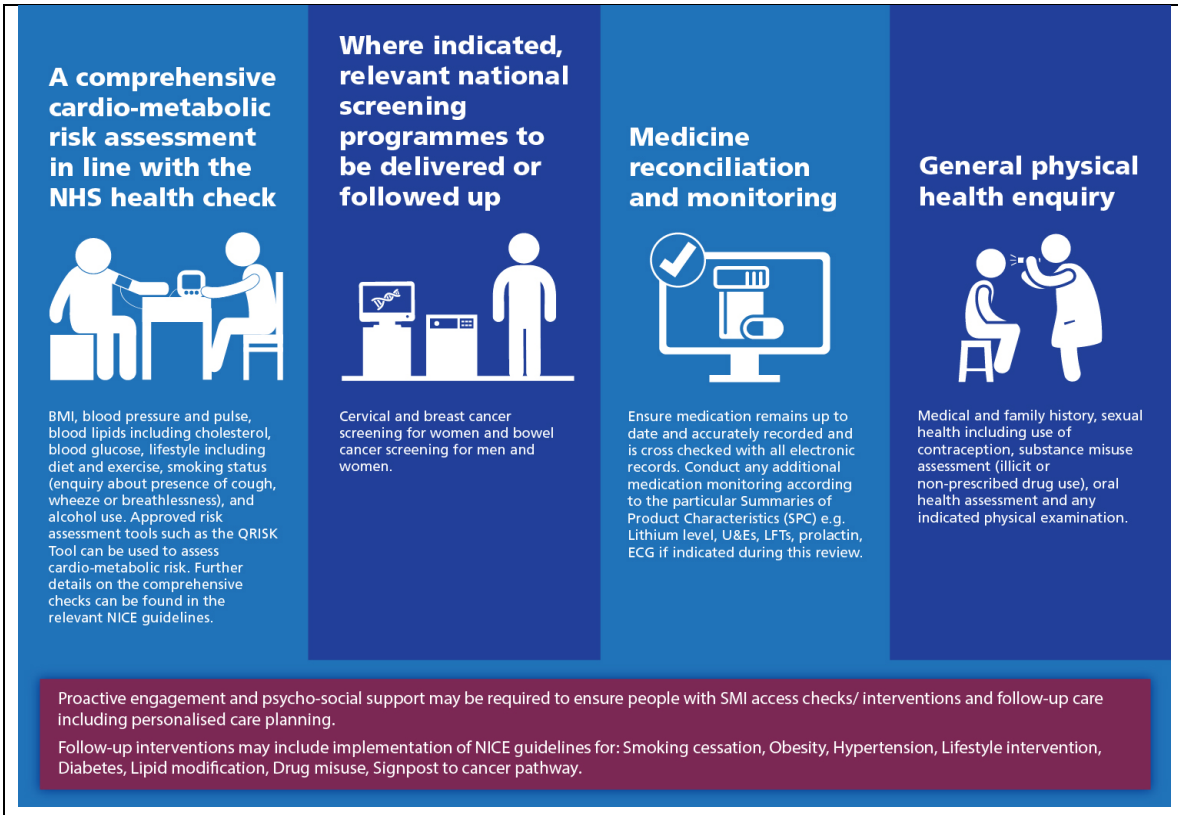
- Sexual health and contraceptive advice – including general contraceptive advice, advice about risks of unprotected sexual intercourse and evaluation of risk of sexual abuse and/or exploitation
- Oral health advice – including general advice regarding oral health, provision of a toothbrush and an information leaflet regarding oral health and how to register with a dentist.
- Prolactin if patient symptomatic as per GASS – refer to shared care protocol for details

For the purpose of claim reimbursement a person is counted as having had a comprehensive physical health assessment if they have received all of the component parts listed above within a twelve month period.

If an element of the health check is offered and a patient refuses e.g. blood tests, the practice should exception code this as appropriate. These health checks will also be eligible for payment under the LES. However, there is an expectation that patients will receive the full health check and use of exception coding should be minimal. Where an exception code is not available, the practice should document refusal in the patient notes.

As per Section 3.7, if there are high numbers of claims for incomplete health checks the CCG reserves the right to request an audit of these claims and supporting information to be submitted.

Practices will not be able to claim for health checks which have not been completed by the practice where this is not due to patients refusing any of the component parts.



<u>Consequences for late submission of activity data:</u>

- 1 – 7 days: 5% of payment
- 8 – 14 days: 10% of payment and payment won't be released until the next payment run
- 15 – 21 days: 50% of payment and payment won't be released until the next payment run
- Submissions received after 21 days (3 weeks) will receive no payment.

A reminder by email will be sent out at least one week prior to submission date. It is the responsibility of the practice to ensure that any changes to contact details for the Practice lead/ practice manager are notified to the GP Commissioning team.

In the event of unforeseen exceptional circumstances e.g. unplanned admission to hospital, there is scope for the CCG to process a payment without precedent. It is however a practice responsibility to put in place sufficient contingency arrangements to ensure activity is submitted by the date specified.

If the CCG makes a payment to a practice under the LES and :

a) The practice was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment **<u>or because the payment was calculated incorrectly</u>** (including where a payment on account overestimates the amount that is to fall due);or

b) the CCG was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money is already been paid,

then the CCG is entitled to repayment of all or part of the money paid.

Any suspicions of fraud will be referred to the CCG's Counter Fraud Specialist for further investigation. It is important to recognise that claiming for procedures that do not fall within the service specification may constitute fraud and will be referred to the CCGs Counter Fraud Specialist for further investigation.

3.11 Termination of Agreement

This service is currently being offered as a pilot until 31 March 2020, at which point it will be reviewed. From April 2020, should 75% of practices opt to provide the service, it will form part of the basket of enhanced services of the Rotherham Quality Contract, and will therefore be subject to the terms outlined in the Quality Contract.

Following the recent publication of the 'Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan' the CCG acknowledges that further guidance may influence the future delivery of Local Enhanced Services.

The Local Enhanced Services will be subject to review after Primary Care Networks are formed. Therefore, three months' notice will be given to Providers if services are to cease.

Appendix 1B

Rotherham Doncaster and South Humber NHS Foundation Trust

DRAFT Shared Care Protocol

Physical Healthcare Assessments and Follow Up Care

Contents

Appendices

DOCUMENT CONTROL:	
Version:	1
Ratified by:	
Date ratified:	
Name of originator/author:	Doncaster – David Smith Rotherham – Julie Hunter North Lincolnshire – Claire Coppens GP Primary Care Leads
Name of responsible committee/individual:	Physical Health and Wellbeing
Date issued:	
Review date:	
Target Audience	Primary Care/Secondary Care Teams

1. Introduction

This protocol sets out guidelines for Primary Care and Secondary Care responsibilities for carrying out annual physical health assessments and follow up care. This supports the national guidelines outlined in the Quality Outcome Framework:

PRIMARY CARE

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

1. Patients with SMI who are not in contact with secondary mental health services, including both:

a. those whose care has always been solely in primary care, and
b. those who have been discharged from secondary care back to primary care; and

2. Patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place for Physical Health) for more than 12 months and / or whose condition has stabilised.

SECONDARY CARE

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

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

2. Inpatients

2. Background and Rationale

Rationale for monitoring the cohort of patients with Serious Mental Illness (SMI):

People with severe mental illness (SMI) are at increased risk of poor physical health, and their life-expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital receive the recommended assessment of cardiovascular risk in the previous 12 months. People with SMI are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary physical healthcare they are receiving.

With over 490,000 people with SMI registered with a GP, it is important to ensure a stronger emphasis on collaboration and communication between primary and secondary care. This is necessary given that in the longer term and certainly following discharge from secondary care, people with SMI should be supported to manage their health within primary care.

Appropriate sharing and exchanging of information between practitioners about diagnosed physical and mental health conditions is essential for safe practice.

3. Collaboration with Primary Care Clinicians

This protocol will support the delivery of shared care between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up.

This should include information on:

- Roles and responsibilities, including frequency of follow up annual physical health checks.

- Sharing and exchanging information regarding physical health of people with SMI, via electronic patient records across secondary and primary interfaces.

The rationale for this protocol is to ensure essential information needed for safe and effective care of patients who are also seen by secondary care mental health services is communicated to primary care professionals.

Building on the developments made across England to improve communications between primary and secondary care, responsibilities for conducting physical health checks and the ongoing management of physical healthcare should be clearly identified and formalised locally. Electronic systems and infrastructure should continue to evolve to support the transfer of accurate and up to date patient records, making information accessible.

4. Shared Care Arrangements

4.1 Aspects for which Secondary Care Team is responsible

- Identifying patients who meet the Serious Mental Illness (SMI) criteria and diagnosis. 'SMI' refers to all individuals who have received a diagnosis of schizophrenia or bipolar affective disorder, or who have experienced an episode of non-organic psychosis *(Improving PH for people with SMI [3], NHS England).*
- Maintain and share quarterly with Primary Care an SMI register; to include and identify patients being supported under shared care for physical health.
- Offer an annual physical health check (for those patients who meet the criteria above and are not managed under shared care).
- Providing physical healthcare checks in line with Cardio-Metabolic Assessment and the following cardio metabolic parameters (previously included in the 2017-19 CQUIN):
    - Smoking status;
    - Lifestyle (including exercise, diet alcohol and drugs);
    - Body Mass Index and/or waist circumference;
    - Blood pressure and pulse;
    - Glucose regulation (preferably HbA1c or fasting plasma glucose. Random plasma glucose as appropriate);
    - Full blood lipid profile;
    - Consider use of Glasgow Anti-psychotic Side-effect Scale (GASS) and Prolactin Levels if symptomatic as per GASS.
- Complete and update appropriate Health Action Plan/Care Plan.
- Ensure patient is fully informed of, and engaged with the treatment detailed within the Health Action Plan:
    - That the patient/carer is clear what is being monitored and by whom
    - Following review share with the GP the Health Action Plan/Care Plan
- Provision of an accessible advisory service to the GP in regard to individual patient clinical queries raised:
    - For the Adult Mental Health service the preferred method of communication for routine (Monday to Friday) queries is by telephone to the principal managing team. A record of the advice will be recorded on SystmOne. A copy of the advice given by the RDaSH Clinician will be sent to GPs on the EMIS clinical system. RDaSH will aim to respond to these queries within 24hrs via email or telephone accordingly. If the GP requires a more urgent response they must specify this and their rational at the point of first contact.

Email queries can also be sent to rdash.rotherhampsychiatristadvice@nhs.net . Receipt of emails are acknowledged within 48hours, prioritized and forwarded to the relevant team. RDASH will aim to respond to the query within 5 working days.

- If the patient lacks mental capacity in this area then ensure that information is shared, if this is deemed to be in the best interests of the patient (Mental Capacity Act 2005)
- Ensure that Trust policy regarding informed consent is followed
- RDaSH will be responsible for any referrals to Cardiology/Cardiac Services when an abnormal ECG is taken.

4.2 Aspects for which Primary Care Team is responsible

- Offer an annual physical health check for patients with a shared care agreement
- Providing physical healthcare checks in line with Cardio-Metabolic Assessment and the following cardio metabolic parameters (previously included in the 2017-19 CQUIN):
    - Smoking status;
    - Lifestyle (including exercise, diet alcohol and drugs);
    - Body Mass Index and/or waist circumference;
    - Blood pressure and pulse;
    - Glucose regulation (preferably HbA1c or fasting plasma glucose. Random plasma glucose as appropriate);
    - Full blood lipid profile;
    - Consider use of Glasgow Anti-psychotic Side-effect Scale (GASS) and Prolactin Levels if symptomatic as per GASS.
- Complete and update appropriate Health Action Plan/Care Plan.
- Ensure patient is fully informed of, and engaged with the treatment detailed within the Health Action Plan:
    - That the patient/carer is clear what is being monitored and by whom
    - Following review share with RDaSH. For practices using SystmOne, a task will be sent to the RDaSH advising that a letter has been added to the patient record. For EMIS practices, a letter will be sent to the RDaSH team either via email or hard copy.
- Management of any physical health concerns and ongoing health management as identified by RDaSH (above and beyond low level advice) through the PHC excluding ECGs.

4.3 Patient (or Carers) Responsibilities

- Attend and participate in the monitoring of their physical health
- Share any concerns they have in relation to their physical health
- Report to the specialist or GP if they do not have a clear understanding of their condition and/or treatment
- Report any adverse effects of treatment to their specialist or GP

5. Procedure for Adopting Shared Care

Patients must be considered stable prior to RDaSH making a Shared Care request

A stable patient is considered to be someone who for a minimum of 3 months has not undergone active upward dose titration, changed medication type or actively been involved with acute services for symptom management (e.g. assertive outreach/home treatment teams or inpatient care) where medication changes are likely.

Individuals who have achieved a sufficient reduction in symptoms to not require additional acute services may wish to explore medication dose reduction. An individual's condition would still be considered stable despite down titration of medication. Similar adjustments to refine medication regimes should not exclude these individuals from accessing physical health checks and interventions in primary care.

It is anticipated that once responsibility for monitoring has been transferred to primary care under a shared care arrangement after the first year or first period of stabilisation that primary care would continue to monitor physical health even if there are subsequent relapses or deterioration in symptoms.

RDASH will offer an annual Physical health check prior to requesting shared care.

RDaSH will submit a formal (letter/e-mail) request to the GP requesting shared care of the patient's physical health

It will be assumed that shared care is accepted unless formally declined (in writing) to RDaSH within 6 weeks of receipt of request.

6. References:

1. NHS England, (2018). CQUIN Indicator Specification 2017-2019. [online] Available at: https://www.england.nhs.uk/publication/cquin-indicator-specification/

2. NHS England, (2014). Lester Tool. [online] Available at: https://www.england.nhs.uk/2014/06/lester-tool/

3. NHS England, (2018). Improving physical healthcare for people living with severe mental illness (SMI) in primary care. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf

7. Shared Care Development:

Written by:

Secondary Care:

David Smith, RDASH Doncaster Service Manager
Julie Hunter, RDASH Rotherham Nurse Consultant
Claire Coppens, RDASH North Lincolnshire Clinic Interventions Lead Nurse

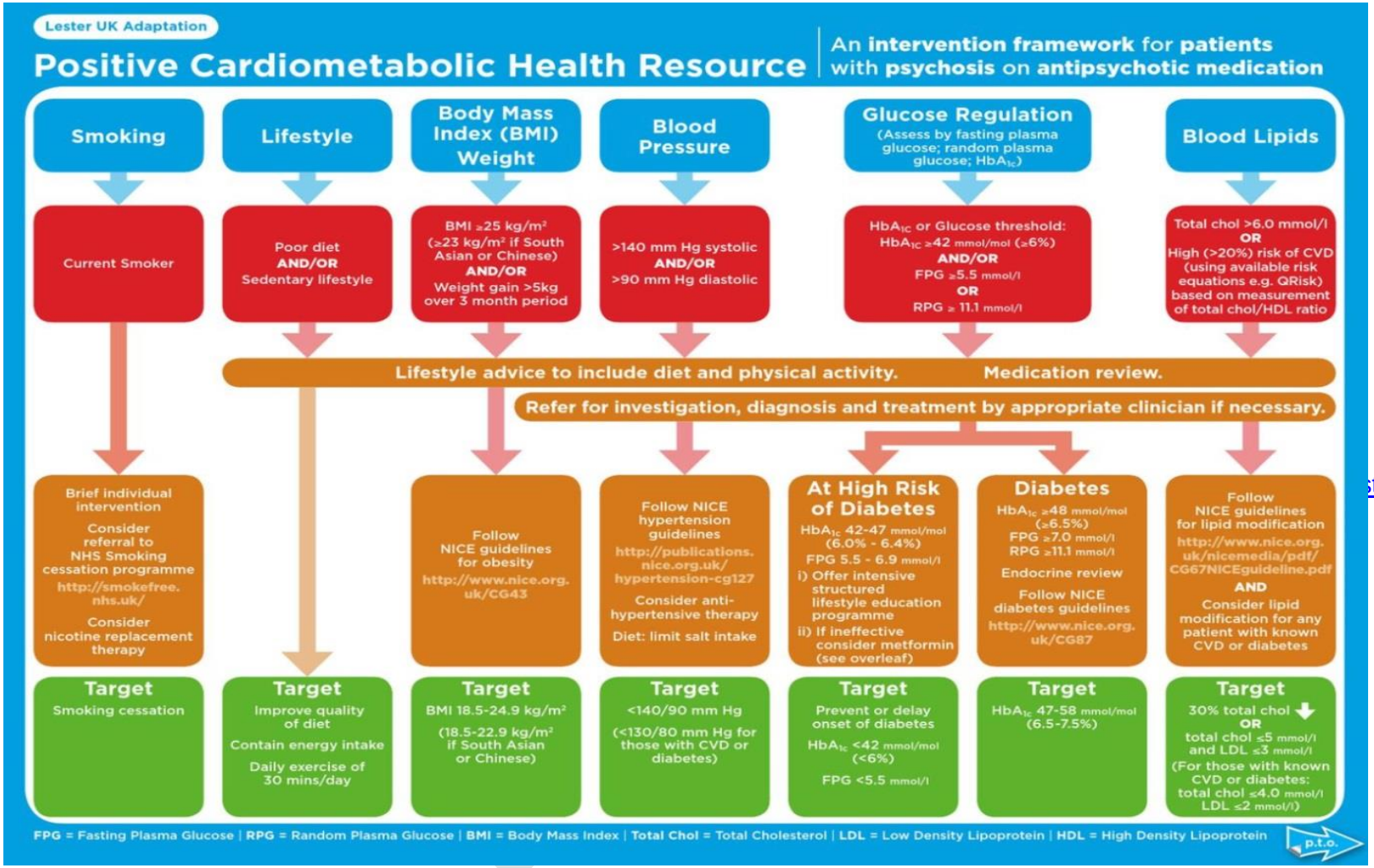
Primary Care:

Doncaster:
Rotherham:
North Lincolnshire:

Reviewed by:

Approved by:

Appendix 1 – Lester Tool



ster-tool/

Appendix 2 – Glasgow Antipsychotic Side-effect Scale (GASS)

Glasgow Antipsychotic Side-effect Scale (GASS)

Name: **Age:** **Sex: M / F**

Please list current medication and total daily doses below:

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects.
Also tick the end or last box if you found that the side effect was distressing for you.

Over the past <u>week</u>:	*Never*	*Once*	*A few times*	*Every day*	*Tick this box if distressing*
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. My muscles have been tense or jerky					
6. My hands or arms have been shaky					
7. My legs have felt restless and/or I couldn't sit still					
8. I have been drooling					
9. My movements or walking have been slower than usual					
10. I have had uncontrollable movements of my face or body					
11. My vision has been blurry					
12. My mouth has been dry					
13. I have had difficulty passing urine					
14. I have felt like I am going to be sick or have vomited					
15. I have wet the bed					
16. I have been very thirsty and/or passing urine frequently					
17. The areas around my nipples have been sore and swollen					
18. I have noticed fluid coming from my nipples					
19. I have had problems enjoying sex					
20. **<u>Men only</u>:** I have had problems getting an erection					

Tick yes or no *for the* ***last <u>three months</u>***	*No*	*Yes*	*Tick this box if distressing*
21. **<u>Women only</u>**: I have noticed a change in my periods			
22. **<u>Men and women</u>**: I have been gaining weight			

Staff Information (for interpreting GASS questionnaire)

1. Allow the patient to fill in the questionnaire themselves. All questions relate to the previous week.

2. Scoring for questions 1-20

Patient answer	Points
Never	0
Once	1
A few times	2
Every day	3

Scoring for questions 21-22

Patient answer	Points
No	0
Yes	3

Total for all questions=

3. For male and female patients a score of:
0-21 absent/mild side effects
22-42 moderate side effects
43-63 severe side effects

4. Side effects covered include:

Question	Parameter
1-2	sedation and CNS side effects
3-4	cardiovascular side effects
5-10	extra pyramidal side effects
11-13	anticholinergic side effects
14	gastro-intestinal side effects
15	genitourinary side effects
16	screening question for diabetes mellitus
17-21	prolactinaemic side effects
22	weight gain

5. The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

Equality Impact and Engagement Assessment Form		
Complete this section **Please retain one copy, and pass one copy to both the Equalities and Engagement leads**		
Section one – Project or plan details		
1.1	**Project Title:**	
	Local Enhanced Services - Physical Health Checks for patients with Severe Mental Illness, including Shared Care Protocol Physical Healthcare Assessments and Follow Up Care.	
1.2	**Project Lead:**	**Contact Details:**
	Kate Tufnell	01709 302743
1.3	**This activity /project is:**	
	Other	
1.4	**Describe the activity/project**	
	Around 2389 people in Rotherham are estimated to have a serious mental illness (SMI). The Five Year Forward View for Mental Health has committed that by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year. The introduction of the Local Enhanced Service (LES) – Physical Health Checks for patients with Severe Mental Illness aims to achieve, by the end of 2019/20, 60% of the population with SMI on the GP register receiving an annual physical health check and any associated interventions. Commissioning of improved physical health care for people with an SMI within a primary care setting further builds on work to ensure parity of esteem between mental and physical health by giving equal attention to the physical health of people with mental health problems as is given to the general population. Regular physical health checks, which include lifestyle and family medical history and routine tests such as weight, blood pressure, glucose and fats or lipids, can identify potential problems before they develop into serious conditions.	
1.5	**Timescales**	
	To be introduced by October 2019	
2	**Equality Impact Assessment**	
2.1	**Gathering of Information:** This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty. Please add any general information here.	
	As this is a national requirement, the CCG has not undertaken a patient consultation around the introduction of the service. In February 2016, NHS England (NHSE) published guidance which detailed the work needed to be undertaken improve mental health services, the introduction of a physical health check is one of these workstreams Additional National / local evidence to support the implementation of the SMI LES /Shared Care Protocol: • On average men living with severe mental illness die 20 years earlier, whilst women living with severe mental illness die 15 years earlier This LES would support the Rotherham principle of commissioning high quality service closer to home	

- A survey quoted in the Mental Health Five Year Forward stated, that "42% of practice nurses reported that they had received no mental health training at all". The Rotherham LES includes resource to support workforce development.

2.2 **Screening**

Please complete each area)	What key impact have you identified?			Information Source
	Positive Impact - will actively promote or improve equality of opportunity.	**Neutral Impact -** where there are no notable consequences for any group.	**Negative Impact** negative or adverse impact causes disadvantage or exclusion. **If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures.**	What action, if any, is needed to address these issues and what difference will this make? For example: *At this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess.*
Human Rights	**N**	**Y**	**N**	**Disability**: This LES with positively target individuals with a severe mental illness listed on Rotherham GPs SMI registered. It will provide a comprehensive physical health check and in doing so improve their access to early interventions **Religious beliefs** - The CCG will ensure that the promotional toothbrush (to promote dental health awareness) is not made with pig hair bristles
Age	**N**	**Y**	**N**	
Carers	**N**	**Y**	**N**	
Disability	**Y**	**N**	**N**	
Sex	**N**	**Y**	**N**	
Race	**N**	**Y**	**N**	
Religion or belief	**Y**	**N**	**N**	
Sexual Orientation	**N**	**Y**	**N**	
Gender reassignment	**N**	**Y**	**N**	
Pregnancy and maternity	**N**	**Y**	**N**	
Marriage/civil partnership (only eliminating discrimination)	**N**	**Y**	**N**	
Other relevant groups	**N**	**Y**	**N**	

3 Engagement Assessment

3.1 **What is the level of service change**? – see diagram 3 above

If your project is classed as a 'significant variation' (level 3) or 'major change' (level 4) please contact england.yhclinicalstrategy@nhs.net for a preliminary discussion to support planning and agree whether the service change needs to follow the NHS England Service Change Assurance process.

The assurance process generally looks at the 'case for change' The key players in the process include overview and scrutiny teams, and the clinical senates. You can also refer to the DH guidance: (please note that level 4 changes will require considerable long term planning and this DH guidance is mandatory for all level 4 changes)
http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-hempsons_stp.pdf DH 2013

Circle or highlight the appropriate level of service change

Level 1 Level 2 Level 3 Level 4

	Add additional information and rationale for this scoring below
	This is an introduction of a service designed to benefit patients and improve health outcomes. Quarterly reports are submitted to NHS England which means the CCG will be able to monitor the delivery of the service and practices providing the LES will receive payment for each completed check.
3.2	**Who are your stakeholders?** Consider using a mapping tool to identify stakeholders - who is the change going to affect and how? Complete below or attach or link to a mapping document

	• General Practice staff
	  ○ (improve understanding of mental health (training),
	  ○ Staff will be involved in the delivery of the LES,
	  ○ reduce duplication of records / screening completed
	  ○ better communication /sharing of information between primary and secondary care
	• Patients with a severe mental illness on Rotherham GPs SMI registers
	  ○ improved access to a comprehensive physical health check, closer to home,
	  ○ improve access to early detection and preventative services,
	  ○ improved life expectancy, reduced duplication of screening
	  ○ Increase in the number of people with SMI receiving a comprehensive physical health check
	• Rotherham, Doncaster and South Humber NHS Trust
	  ○ reduced duplication of screening, better communication /sharing of information between primary and secondary care

3.3	**What do we already know?** What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.
	Page 14 of the Mental Health Five Year Forward View states ' People with existing mental health problems told us that services should be integrated - for example, physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness.' Recent monitoring has identified that whilst a significant number of patients on Severe Mental Illness registers are receiving elements of the health checks already, few are receiving all of them within a 12 month period. The LES aims to increase this figure. A survey quoted in the Mental Health Five Year Forward stated, that "42% of practice nurses reported that they had received no mental health training at all". On average men living with severe mental illness die 20 years earlier, whilst women living with severe mental illness die 15 years earlier

	Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight? How will the insight available to you help to inform your decision?
	Given the neutral impact identified above and recognising that the introduction of advice and guidance is a national directive, there are no existing arrangements in place to involve patients around the introduction of the LES.
	Briefly describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?
	There is no proposal at this time to engage with patients around the introduction of the LES.
3.4	**Reaching out to overlooked communities** Are additional arrangements for patient and public involvement required for this activity and in particular will you ensure that 'seldom-heard' groups, those with 'protected characteristics' under the Equality Act, those experiencing health inequalities are involved • Seldom-heard groups Yes • Nine Protected Characteristics Yes • Health inequalities Yes If yes, please provide a brief outline of your approach and objectives for any additional patient participation targeted at these groups
	This is a nationally driven requirement and will target individuals with severe mental illness, one of the seldom heard groups
	Do you need to make any of your resources accessible (i.e. for people with learning disabilities, sight impairments, or alternative languages?)
	• Resources, such as translation services are already available in general practice • Dental awareness leaflet – To be sourced from NHS England
3.5	**What resources do you need for this?** Consider the sections above • The timescales • The need to reach overlooked communities • Accessible materials • Gaps in knowledge
	Easy read format dental awareness leaflet
4	**Feedback and Evaluation**
4.1	How will you use the feedback – who does it need to be shared with?
	Quarterly reports are submitted to NHS England which means the CCG will be able to monitor the delivery of the service and practices providing the LES will receive payment for each completed check. A patient survey will also be made available for users of the service to complete. Practices will be

	requested to provide a weblink to patients receiving a health check.
4.2	Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity.
	The patient survey information will be reviewed on a quarterly basis. Any service issues which are identified through the survey will be reviewed and changes made as appropriate.
4.3	How will the outcomes of participation be reported back to those involved?
	The CCG will provide reports to the Primary Care Commissioning Committee on a six-monthly basis on the survey outcomes. These reports are made public on the CCG internet page.
4.4	How will you assess the ongoing impact of the change on patients and the public after it has been completed?
	The submission of quarterly reports by the providers, along with feedback from general practice will enable the CCG to determine whether the LES is being delivered in accordance with the national requirements. The CCG will also be able to review the impact of the LES the uptake of the health checks and meeting the 60% national requirement. The patient feedback from the survey will also assist the CCG in determining whether patients are receiving the intended benefits of the service.

5	**Engagement and Equality Impact Plan**				
	Action	**Approx. Timescale**	**Lead**	**Deadline**	**Comments/ progress**
	Not applicable				

6	Form details	
	Completed by:	Sara Hartley
	Job title:	Contract and Service Improvement Manager (Primary Care)
	Date	22 July 2019
	Reported to	

Appendix 2: Extract from 'Research and analysis 'Severe mental illness (SMI) and physical health inequalities: briefing'

"People with SMI are at a greater risk of poor physical health and have a higher premature mortality than the general population . People with SMI in England:

- die on average 15 to 20 years earlier than the general population
- have 3.7 times higher death rate for ages under 75 than the general population
- experience a widening gap in death rates over time

It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented. Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension.

Compared to the general population, people aged under-75 in contact with mental health services in England have death rates that are:

- 5 times higher for liver disease
- 4.7 times higher for respiratory disease
- 3.3 times higher for cardiovascular disease
- 2 times higher for cancer

At the same time, the difference between the death rate in people under 75 years of age in contact with mental health services and the general population is:

- 84 more deaths per 100,000 population in adults with SMI for liver disease
- 147 more deaths per 100,000 population in adults with SMI for respiratory disease
- 198 more deaths per 100,000 population in adults with SMI for cardiovascular disease
- 142 more deaths per 100,000 population in adults with SMI for cancer

Reducing the difference in the premature death rate from each of the conditions will address health inequality experienced by the population with SMI. However, action to address cardiovascular disease mortality has the potential to impact on most people.

In addition to chronic physical health conditions, suicide is also an important cause of death in the SMI population. Suicide risk in people with SMI is high following acute psychotic episodes and psychiatric hospitalisation. It peaks during psychiatric hospital admission and shortly after discharge. Other causes of death include substance abuse, Parkinson's disease, accidents, dementia (including Alzheimer's disease), and infections and respiratory acute conditions (particularly pneumonia) ".

Appendix 3: Severe Mental Illness Costing Breakdown

Procedure	Clinician	Hourly rate	Estimate of time	Total cost
Measurement of weight	Health Care Assistant	14.87	45 mins	11.15
Blood Pressure – Routine work not included in costing				
Blood glucose or HbA1c				
Assessment of alcohol consumption				
Assessment of smoking status				
Weight management advice/referral				
Blood lipid or QRISK assessment	Practice nurse	26.22	1 hour 30 mins	39.33
Assessment of nutritional status				
Support access to screening programmes				
BP - lifestyle interventions Blood pressure - pharmacological interventions				
Blood glucose - high risk/pre-diabetic interventions				
Blood glucose - diabetic interventions				
Alcohol consumption - advice/referral				
Smoking - advice/referral				
Lifestyle interventions in relation to blood lipid levels and diet				
Blood lipids including cholesterol				
Oral health advice				
Assessment of use of illicit substance / non-prescribed drugs				
Substance misuse interventions				
Sexual health advice				
Medicines reconciliation and review – Routine work not included in costing	Clinical Pharmacist	31.4	10 mins	5.25
Providing prescribing advice /support to GP/Nurse				
Providing support for assessment of use of illicit substance / non-prescribed drugs	GP	77.27	10 mins	12.88
Providing support for substance misuse interventions				
Providing support for sexual health advice				

	68.61
Plus 30% (Indirect & overhead costs 20% plus 10% contribution to bottom line)	20.58
TOTAL COST	**89.19**