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EVALUATION OF THE SEFTON LOCAL QUALITY CONTRACT (LQC) (PHASE 11) April 2025 – March 2026

Version 1.0

May 2026

This is an evaluation of the 2025/26 Phase 11 LQC across South Sefton and Southport & Formby GP practices. The stated aim of the LQC is to invest in the capacity needed to deliver a consistently higher standard of General Practice across South Sefton and Southport & Formby and deliver schemes which result in quality improvements, efficiencies in spend elsewhere in the health economy, and sustainability of general practice. All practices across Sefton took part in the delivery of schemes, which allowed them to achieve in line with the LQC indicators. The requirements and funding of each indicator were clearly laid out in the contract. This report details the findings and attempts to evaluate each indicator/scheme in a fair and balanced manner.

Produced by Jane Elliott – Sefton Primary Care Programme Manager

EXECUTIVE SUMMARY

A Local Quality Contract (LQC) was introduced in Sefton in 2014/15 for participation by GP practices, with reviews and refinements to LQCs annually in subsequent years. This evaluation focuses on LQC Phase 11 covering April 2025 to March 2026.

The purpose of this report is to analyse whether Phase 11 LQC has had a positive impact within Sefton. The criteria used to assess the schemes has been evidence relating to quality improvements, efficiencies in spend elsewhere in the health economy, and sustainability of general practice which reflect the stated LQC aims.

The report begins with the key findings and general themes or improvements found commonly amongst schemes. This is then followed by an introduction to the LQC, aims and purposes, and the aims of the evaluation. The bulk of the report includes the analysis of evidence relating to the specific schemes themselves. The findings have been pulled together into a conclusion to identify the overall impact, success of the Phase 11 LQC, and recommendations.

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SUMMARY OF OUTCOMES 2025/2026

PRACTICE PROFILES MARCH 2025 TO MARCH 2026

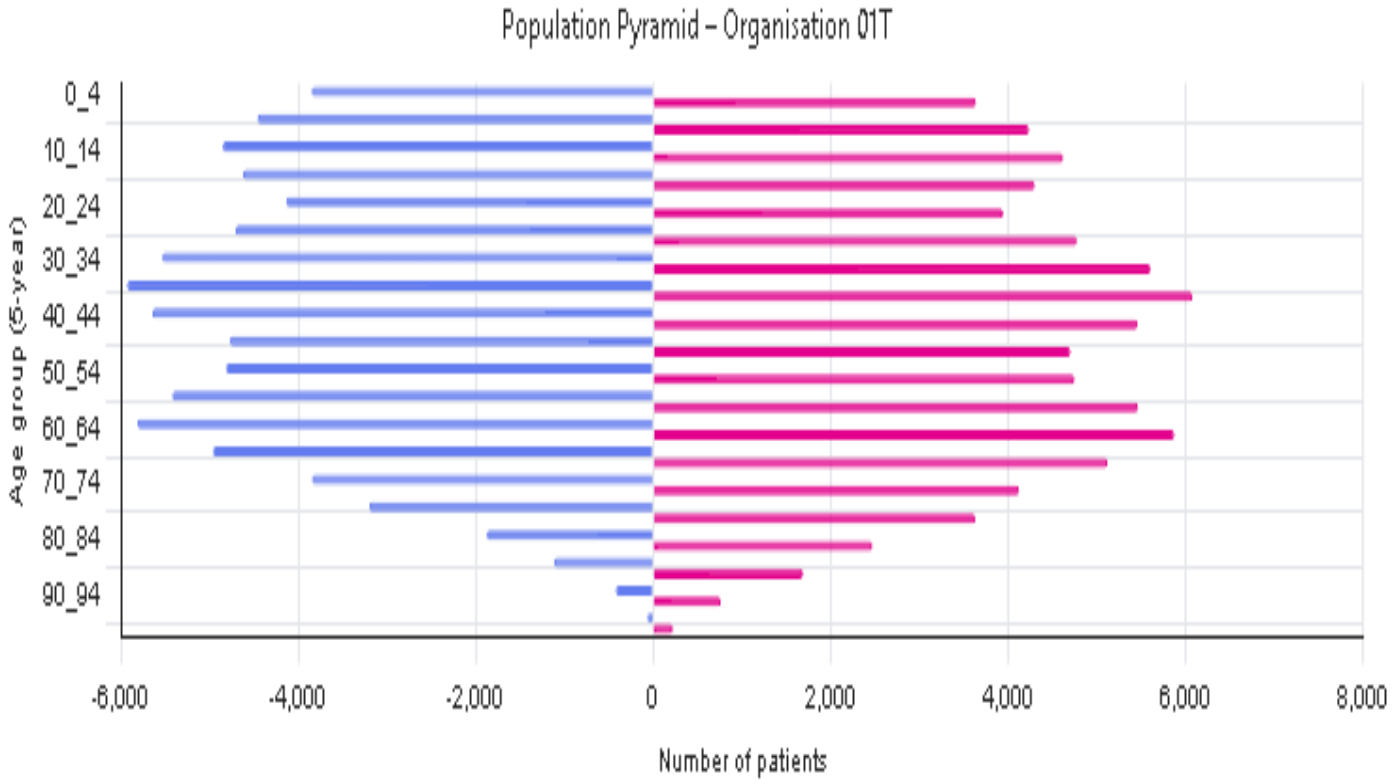
Sefton comprised of 39 Practice, split into 2 Primary Care Networks (PCN); South Sefton PCN and Southport and Formby PCN, which align geographically. Each PCN is split into 4 neighbourhoods (see table below). 6 practices in South Sefton are not included in a PCN and are split across the for localities

PCN	Neighbourhood	Number of practices
South Sefton PCN	Crosby	7
	Maghull	4
	Bootle	7
	Seaforth and Litherland	7
Southport and Formby PCN	North	4
	Central	4
	Formby	2
	Ainsdale and Birkdale	4

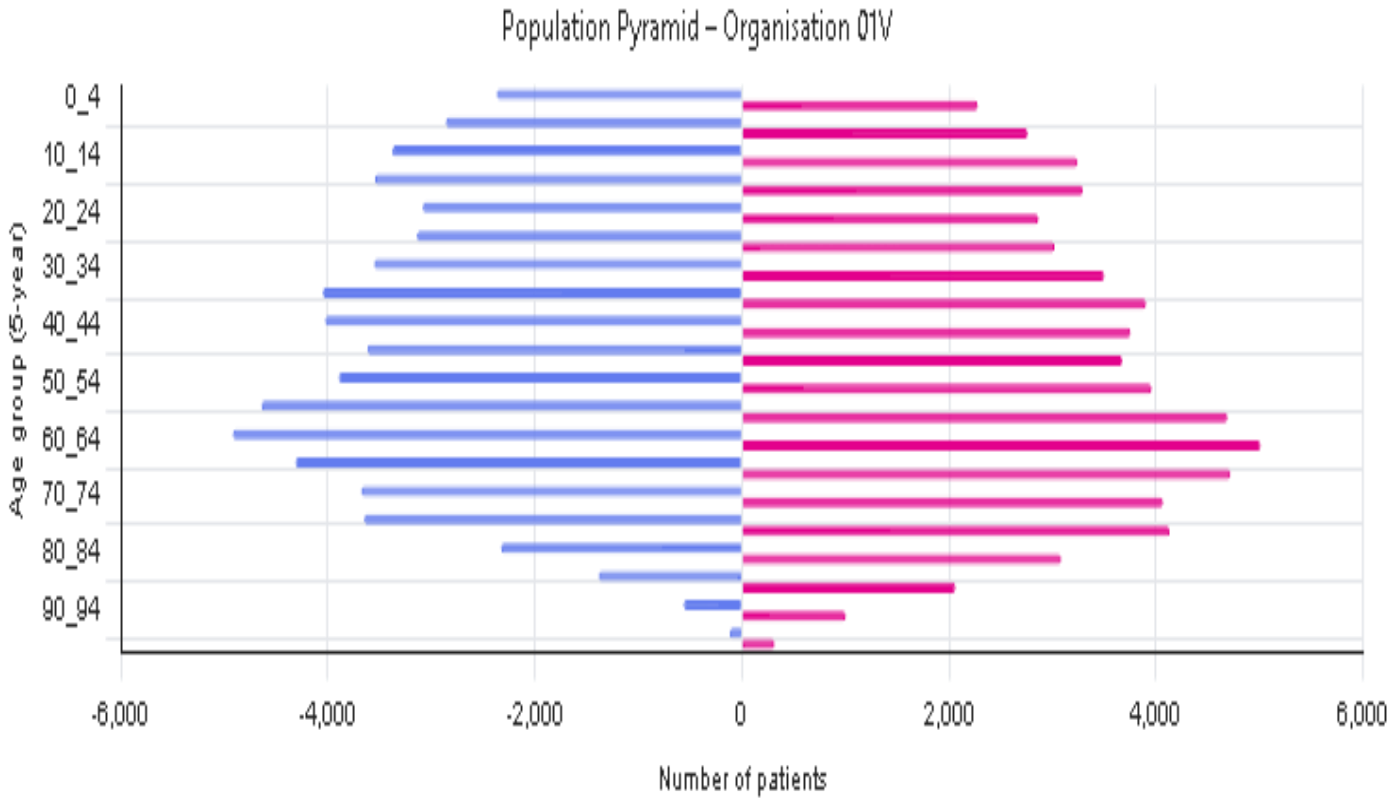
It is important to note that the size and demographics of each PCN differ.

Breakdown of population and Sex

South Sefton as at April 2026
Total population 163,064
Total number of Females 160,232
Total number of Males 323,296

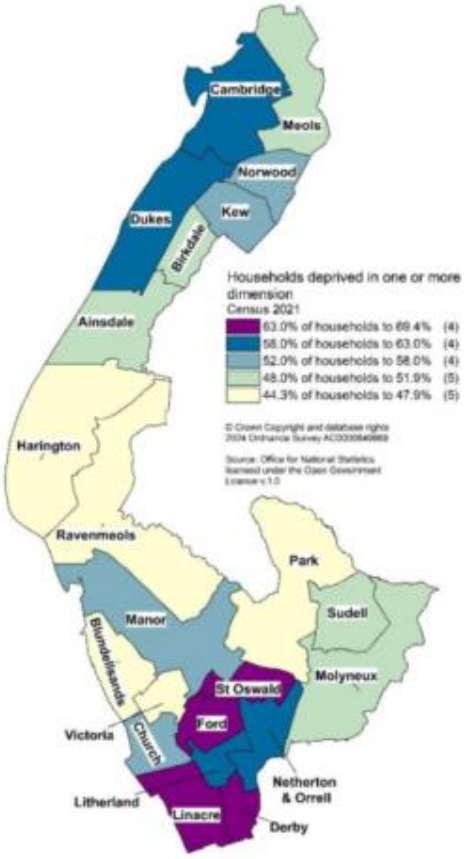


Southport and Formby as at April 2026
Total population 130,822
Total number of Females 126,338
Total number of Males 257,160

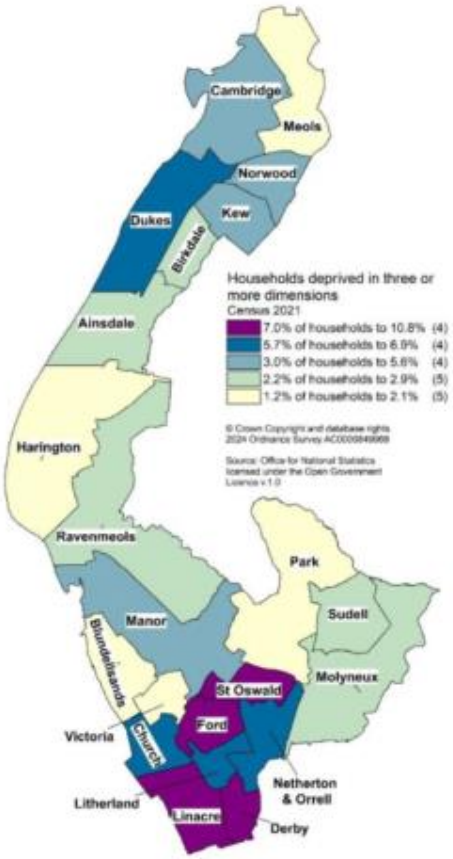


Breakdown of Deprivation Across Sefton

Map 32: Household deprived in one or more dimensions by Sefton wards – Census 2021



Map 33: Household deprived in three or more dimensions by Sefton wards – Census 2021



INTRODUCTION

The aim of the Local Quality Contract (LQC) was to invest in the capacity needed to deliver a consistently higher standard of General Practice across South Sefton and Southport & Formby. This was delivered on the basis of equity across practices through the provision of an agreed level of income per weighted patient, and incentives for delivery of the relevant standards.

Standards within the LQC were above the national GP core contract, Direct Enhanced Services (DES) and QOF. They were developed taking into consideration local clinical feedback and in reference to:

- NHS Long Term Plan
- 2025/26 Priorities and Operational Planning Guidance
- NHS Oversight Framework
- QIPP
- Cheshire and Merseyside Primary Care Strategic Framework

The intention of the LQC was to deliver schemes which would result in quality improvements, efficiencies in spend elsewhere in the health economy, and sustainability of general practice.

This contract was mutually dependent upon the 'core' contract. This meant that only a provider currently offering essential primary medical services to a list of patients under either a General Medical Services Contract (GMS), Personal Medical Services Agreement (PMS) or Alternative Provider Medical Services (APMS) would be capable of providing the services required under the LQC to that same list of patients.

All patients within South Sefton and Southport & Formby were covered by this service.

The funding for the LQC was originally developed to create equity in funding for GP practices. This was achieved through providing funding in Part 1 of the contract which brought practices to a total of £143.50 per weighted patient which includes their core contract. Part 1 schemes are outcome based with most indicators having KPIs with thresholds of achievement identified. For part 2 and 3 the funding was based on activity and the practices were paid on receipt of a quarterly claims form.

Part 1 is mandatory to be able to deliver part 2 or 3 schemes. Vulnerable Resettlement, Gypsies & Travellers and ABPI Part 3 schemes are only relevant to certain practices with the applicable demographics

The creation of the schemes allowed for differences in demography between localities and between practices.

All coding necessary for monitoring the LQC were highlighted to the practice throughout the document. Clinical templates and Letter templates were also shared with practices to enable equitable use to meet the indicators.

AIMS OF THE EVALUATION

Aims

The key aims for this evaluation were to explore and provide a detailed understanding of the following:

1) How the Phase 11 LQC had an impact on primary care in the areas of:
   a) Quality improvements
   b) Efficiencies in spend elsewhere in the health economy
   c) Sustainability of general practice

The report is arranged by scheme rather than by outcome. The justification for this is so that each scheme can be assessed independently for success and the conclusion will be used to identify the outcome areas that saw success or challenges for specific schemes.

Part 1 schemes show an overall achievement for Sefton, and a breakdown of ranges in achievement between the lowest and highest practice. Where it has been possible to show a split in achievement, comparisons between both South Sefton and Southport and Formby have been made.

Part 2 and Part 3 schemes have been evaluated on activity/cost per case.

SCHEMES OVERVIEW/OUTCOME – PART 1

Scheme overview

All practices in Sefton participated in Part 1 schemes.

Practices are paid on weighted list size, with 75% of the contract payment paid in 12ths between April 2025 and March 2026. Funding is readjusted quarterly to reflect quarterly list size movement. A final balancing payment or clawback where appropriate was determined in July 2026.

Most Part 1 schemes have KPI indicators with thresholds of 30%-70%.

Codes for KPI indicators were supplied to GP practices to code the LQC work. Data extracted from GP clinical systems determined the achievement of each indicator.

Some Part 1 indicators had a requirement to undertake pieces of work with timescales and submissions required.

Indicators with either KPI thresholds or timescales for submissions had a financial weighting applied.

There were indicators within Part 1 with no achievement threshold or weighting applied, instead they either provided search criteria/denominators for various sections, or detailed information required on sign up to the contract.

There were indicators in Part 1 that required practices to nominate a clinical or administrative lead. This included Cancer Lead, Mental Health Lead, Digital Champion, Carers Lead and Military Veteran Lead. The Leads would act as a point of contact and co-ordinate activities relating to the designated topic.

Practices are required to deliver all indicators within Part 1 to achieve maximum payment and monitor progress through a monthly suite of EMIS searches forming an LQC support tool.

Part 1 Clinical Scheme Outcomes

Please note that the column numbers in each graph below represents a practice. The correlation between column number and practice differs in each graph.

Palliative Care

This scheme was introduced into the Phase 6 LQC in 2019/20 and has remained in subsequent schemes.

According to the RCGP End of Life and Palliative Care toolkit Approximately 1% of patients on a practice register will die each year. Practices would be expecting around 75% of these deaths therefore a threshold of 0.6% was applied to the denominator of this search.

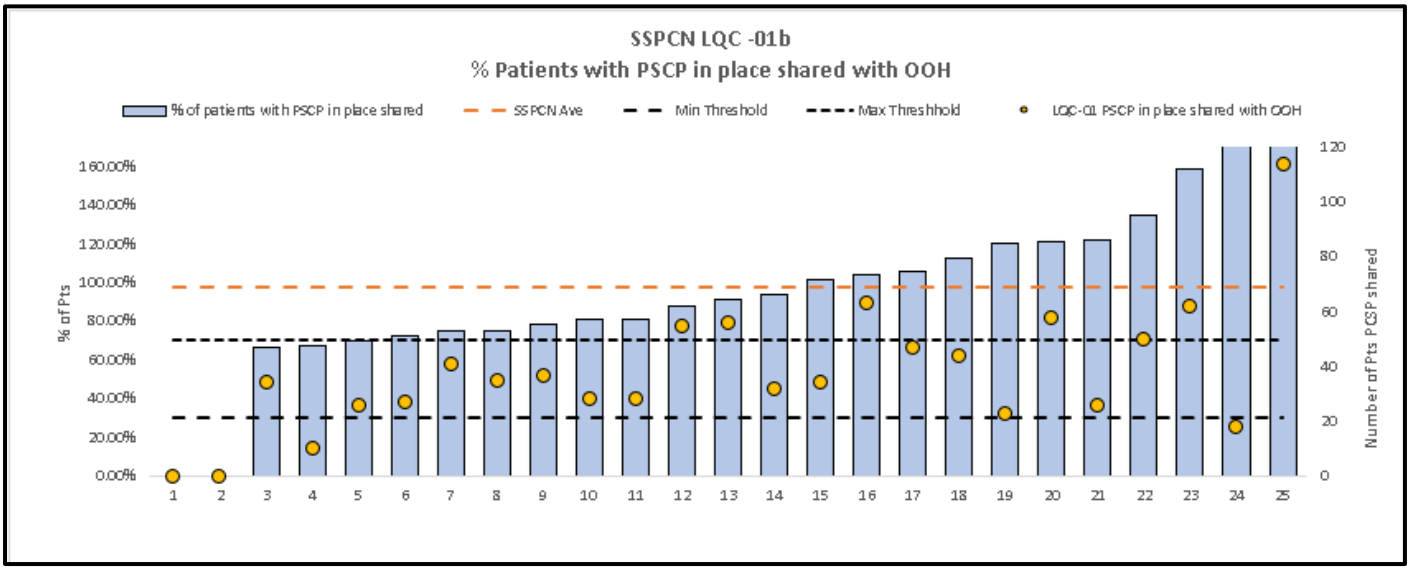
The Quality and Outcomes Framework incentivises practices to identify and maintain a register of all patients in need of palliative care/support irrespective of age.

The aim of the LQC being to proactively identify patients who are within the last 12 months of life (estimated 0.6% of patients aged 18+), and offer a personalised supportive care plan, which is shared with the patient/carer and its existence shared with the Out of Hours service (OOH). Sharing agreements are in place that allow North West Ambulance Service to view care plans via EMIS

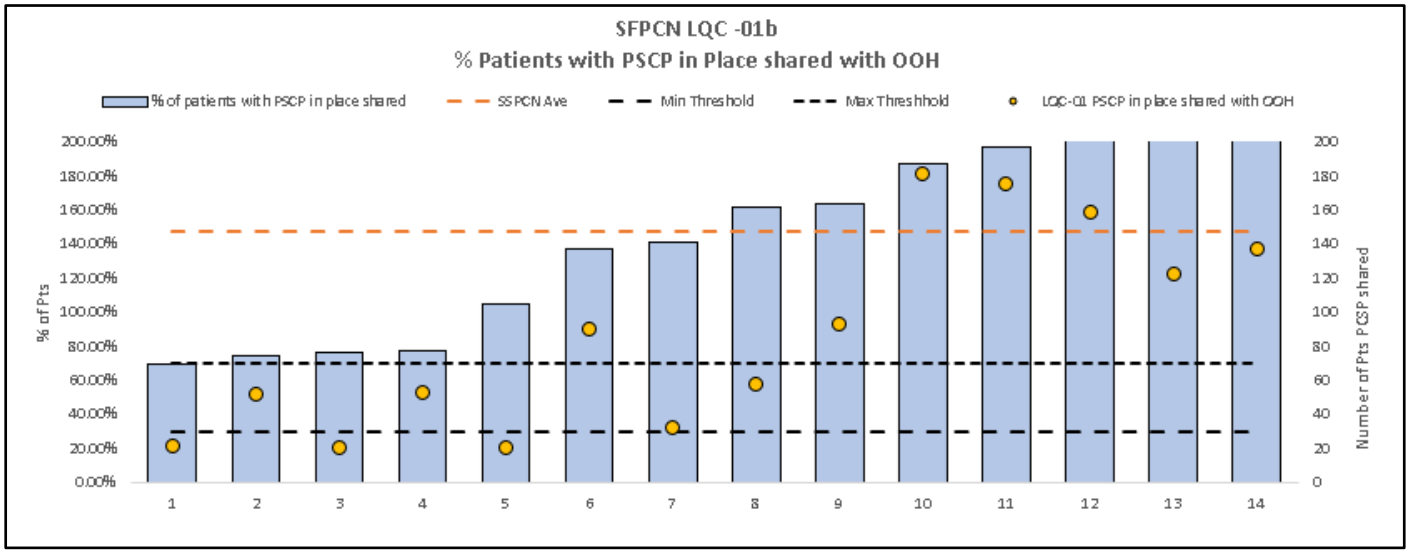
The contract also asked that the preferred place of care is recorded in the patients record; When the patient dies a record of where they died should be recorded. The coding for these indicators mirrors and supports the information and coding collected in Electronics Palliative Care Coordinating System (EPaCCS). The focus on these indicators has resulted in an increase in the Sefton position for EPaCCS extractions, see tables 'Improvement in the recording' below.

Criteria	Pt No.	%
Total number of patients on GSF or Palliative Care registers	4,601	
LQC-01a - Denominator (0.6% of practice population over 18 years)	1,743	
LQC-01b Patients who have a care plan in place which has been shared with OOH	2,166	124%
LQC-01c – Denominator (Number of patients with Care Plans who have died between 1.4.24 and 31.3.15)	1,795	
LQC-01c Preferred place of care recorded, resuscitation status and place of death recorded in patient record	1,402	78%
LQC-01c Additional data:		
Number of patients who died in their preferred place of care	*803*	*57%*

South Sefton practices – Patients who are end of life who have a care plan in place that was shared with OOH and NWAS



Southport and Formby practices – Patients who are end of life who have a care plan in place that was shared with OOH and NWAS



Local Variation

Practices were measured against 0.6% of their list size for End of Life (EOL) patients. Some practices identified more than 0.6% at EOL, this resulted in attainment over 100%. Where practices were unable to reach 0.6%, they had to inform commissioners, including what steps had been taken to identify patients; Those practices who assured commissioners proactive work had been undertaken were measured on actual EOL figures. Only 3 practices did not manage to identify 0.6% of their population, and gave assurance around processes to identify patients.

(LQC01b)

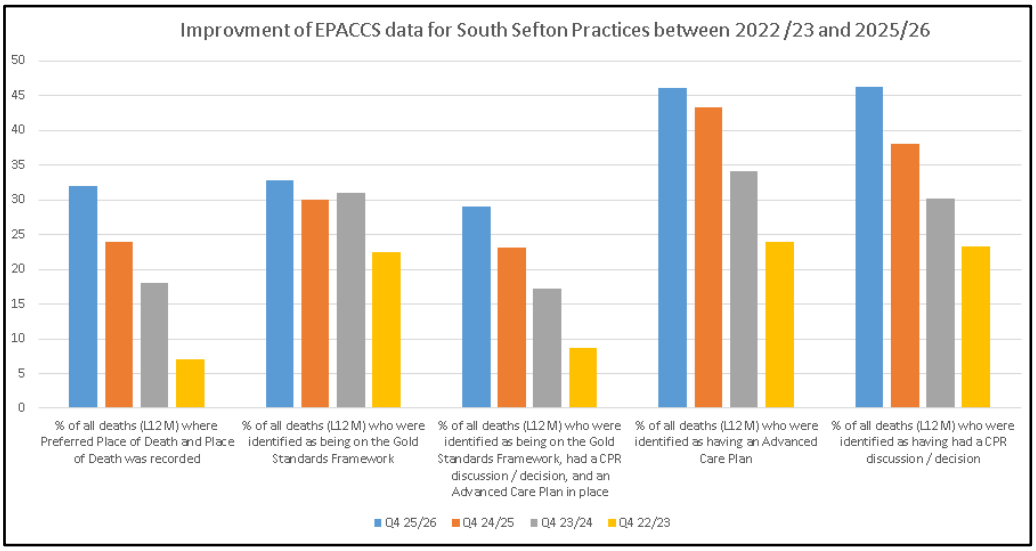
- On average 98% of patients had a care plan in place that was shared with OOH and NWAS in South Sefton compared to 147% of patients in Southport and Formby

- The average number of care plans in place has increased from phase 10 where South Sefton average was 86% and Southport and Formby was 124%
- The individual Sefton practice achievement ranged from 0% to 245%%

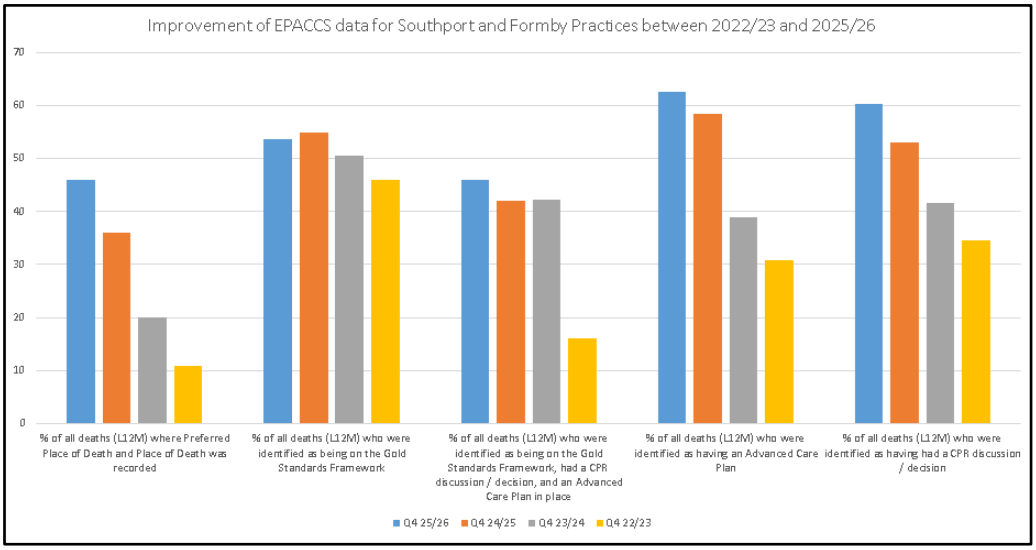
(LQC01c)

- On average 71% of patients had their preferred place of care and place of death recorded in their records in South Sefton compared to 83% in Southport and Formby
- The average number of patients with a preferred place of care has increase from phase 10 where South Sefton average was 56% and Southport and Formby average was also 56%
- The individual Sefton practice achievement ranged from 0% to 100%

South Sefton PCN practices – Improvement in the recording of EPaCCS data



Southport and Formby PCN practices – Improvement in the recording of EPaCCS data



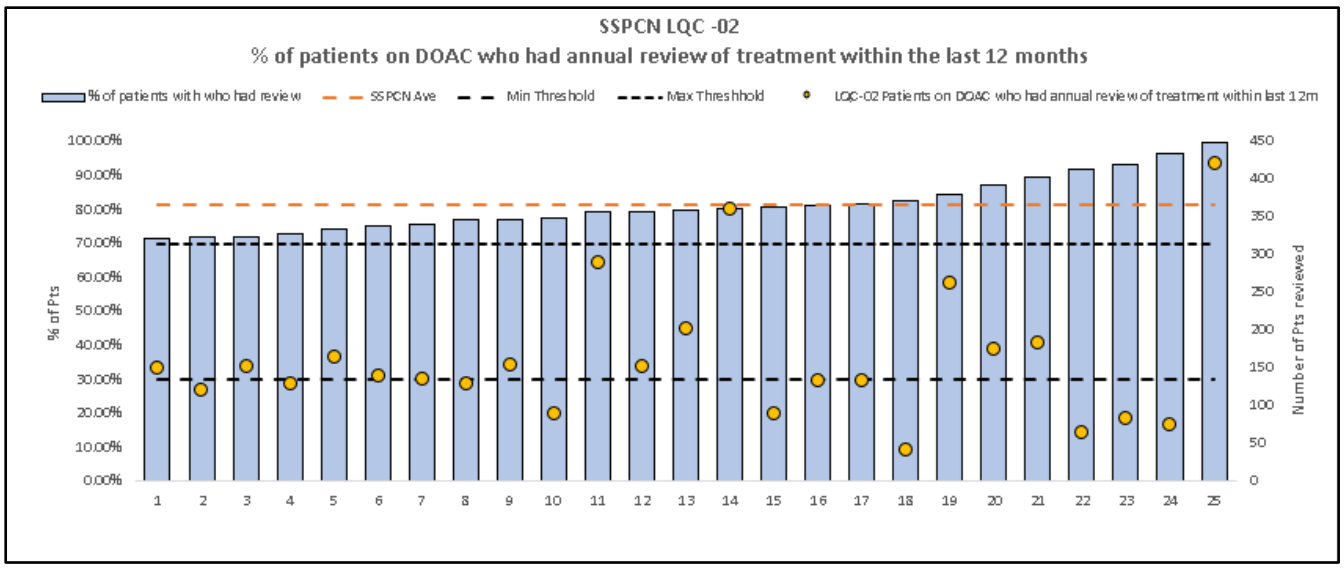
Direct Oral Anticoagulants (DOAC)

The DOAC scheme was introduced to ensuring safe and effective anticoagulation through regular assessment of renal function, dosing appropriateness, and risk factors, enabling early identification of potential complications, reducing medication-related harm and avoidable hospital admissions.

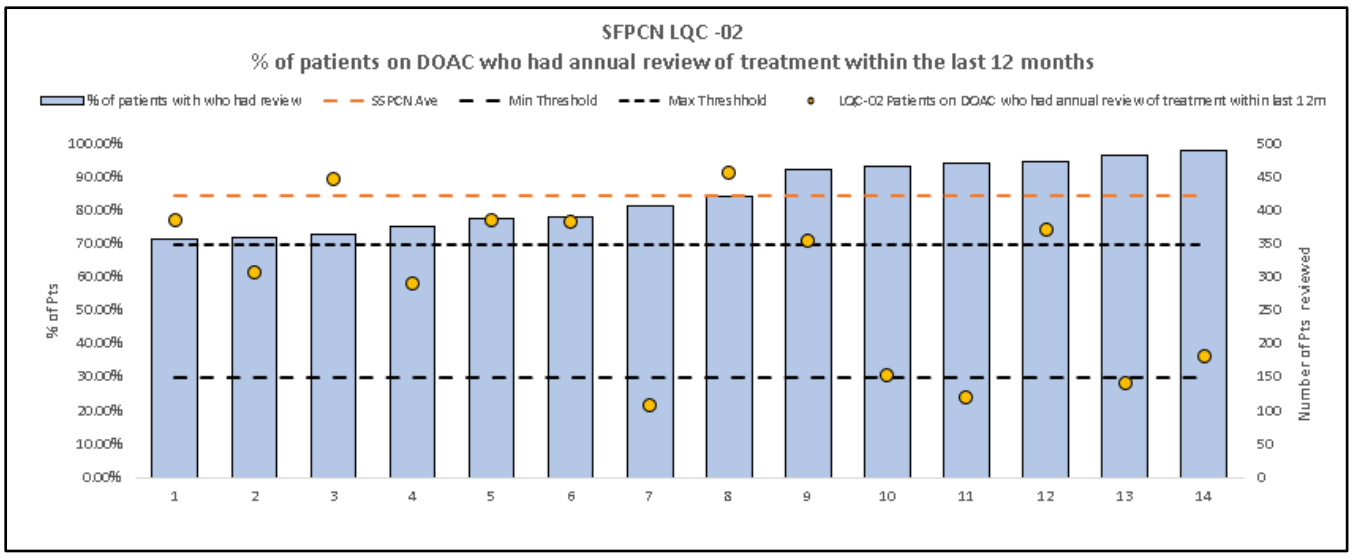
Practices were asked to have a process in place to ensure that patients have the appropriate frequency and monitoring to inform their DOAC dose, based on their individual risk factors. Patients should be seen at least annually.

Criteria	Pt No.	%
LQC-02 Denominator (Number of patients on DOAC)	10,016	
LQC-02 Number of patients that were reviewed at least annually.	8,139	81%

South Sefton PCN practices – Patients who have had a DOAC annual review in the past 12 months



Southport and Formby PCN practices – Patients who have had a DOAC annual review in the past 12 months



Local Variation

(LQC02)

- The South Sefton average for patients on a DOAC that received a clinical review was 81%, and Southport and Formby were 84%.
- The average number of patients on a DOAC who have had a clinical review has increase from phase 10 in South Sefton where the average was 76%. Southport and Formby average has decreased from 86%
- Individual Sefton practice achievement ranged from 71% to 99%

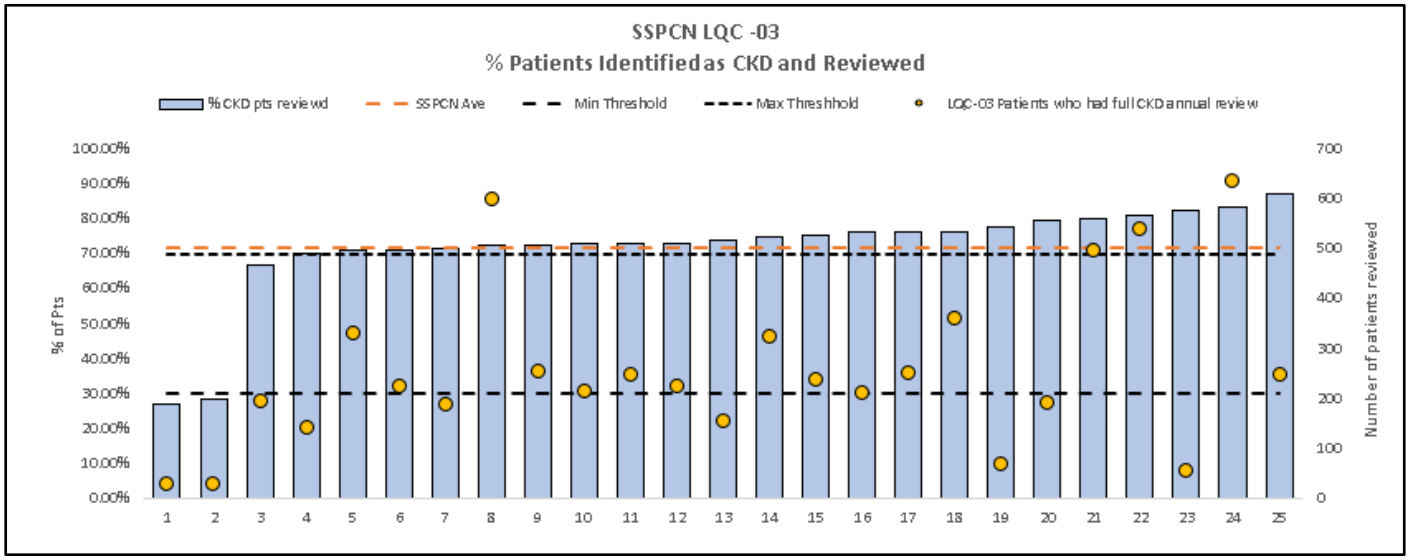
Chronic Kidney Disease (CKD)

Reviewing patients with CKD provides clinical value by supporting accurate diagnosis and ongoing monitoring of renal function, enabling early identification of disease progression and associated cardiovascular risk, facilitating timely intervention and optimisation of treatment, and reducing the risk of complications such as renal failure and cardiovascular events, ultimately preventing avoidable hospital admissions and improving long-term patient outcomes.

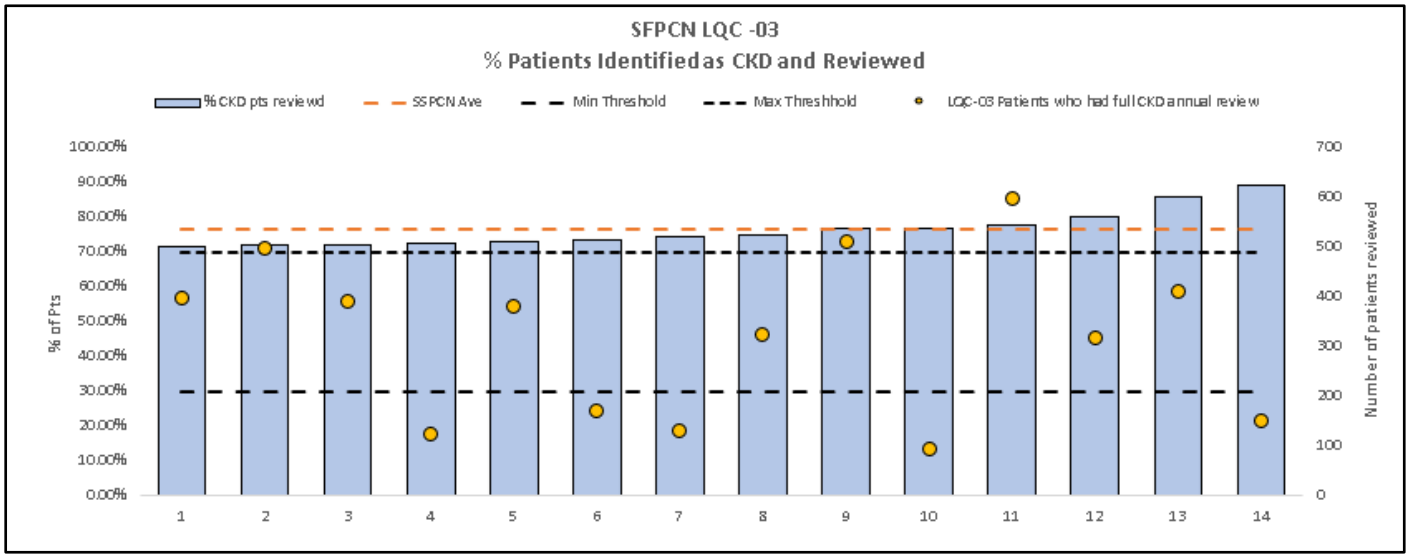
This scheme focused on the validation of patients on the CKD register (stage 3 and above), ensuring they receive an annual review to confirm diagnosis, address cardiovascular risk factors, and identify those at risk of renal deterioration. The review should include a blood pressure check, urine albumin–creatinine ratio, and blood urea and electrolytes (U&Es) to inform ongoing clinical management.

Criteria	Pt No.	%
LQC-03 Denominator (Number of patients on CKD register stage 3 or above)	14,594	
LQC-03 Number of patients who have had annual review in the past 12 months	10,975	75%
LQC-03 additional data		
Number of patients with CKD who have had BP taken in past 12 months	*13,140*	*90%*
Number of patients with CKD who have had Urine Albumin-Creatinine ratio in the past 12 months	*12,083*	*83%*
Number of patients who have eGFR recorded in the past 12 months	*13,330*	*91%*

South Sefton PCN practices – Patients who have had a CKD annual review in the past 12 months



Southport and Formby PCN practices – Patients who have had a CKD annual review in the past 12 months



Local Variation

(LQC03)

- On average 72% of South Sefton patients on the CKD register had an annual review and 76% in Southport and Formby
- The average number of patients who have had a CKD review has increase from phase 10 in South Sefton where the average was 62%. Southport and Formby average has remained the same 76%
- Individual Sefton practice achievement ranged from 27% to 89%

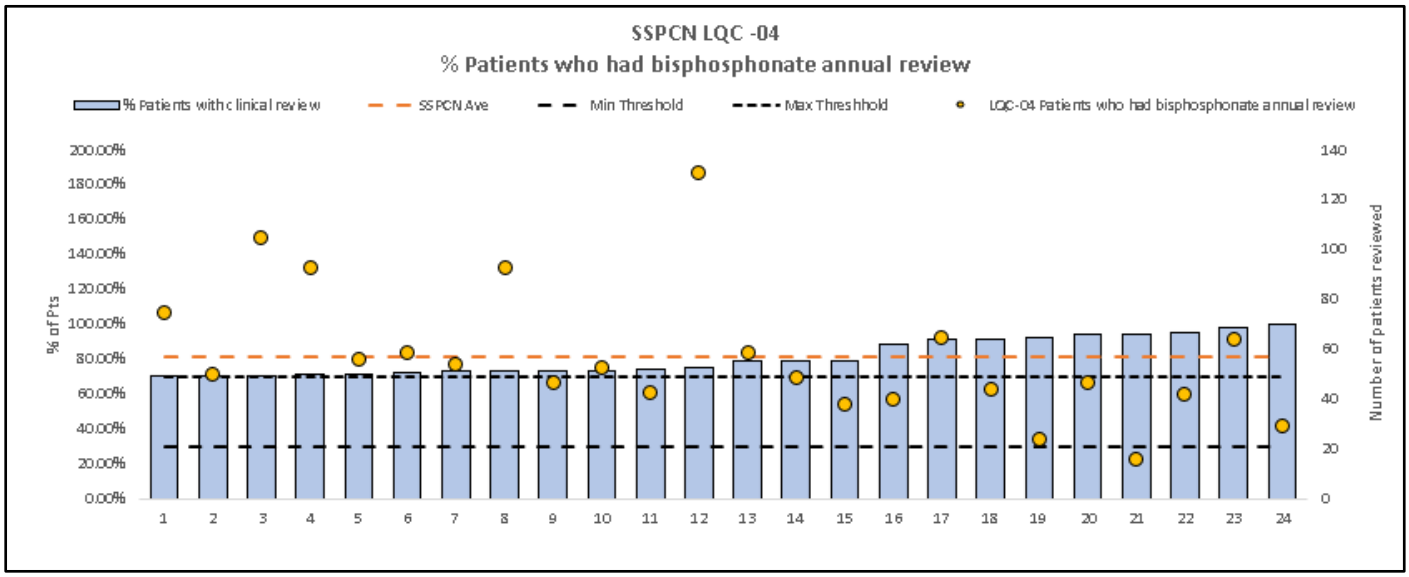
Frailty/Osteoporosis

In line with NHS Long Term Plan commitments on frailty, falls prevention and healthy ageing, this indicator promotes proactive review of osteoporosis treatment to prevent avoidable fractures and optimise long-term medication use.

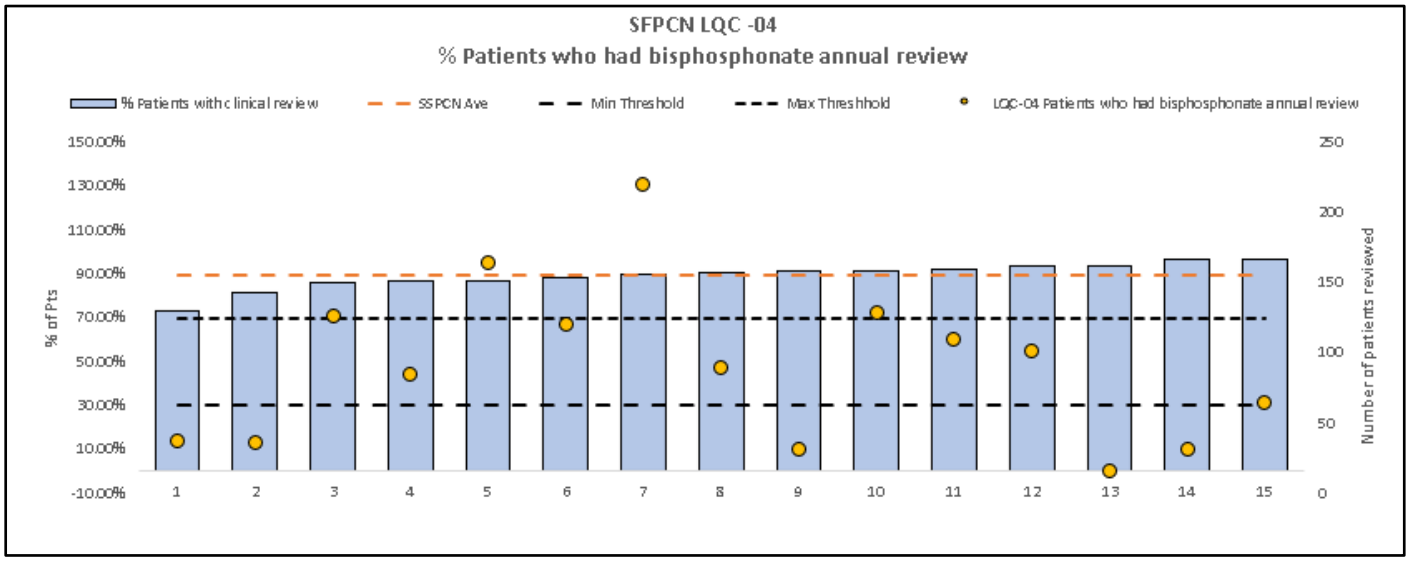
Practices were asked to identify patients who were prescribed an oral bisphosphonate medication for at least 3 years, or previously prescribed one for at least 5 years but have since stopped, who have received a review of their care in the past 12 months to see if they require a repeat BMD/ FRAX score, continued treatment or a referral to secondary care (based on the above guidance), or if they are already under the care of a specialist.

Criteria	Pt No.	%
LQC-04a Denominator: Number of patients currently prescribed an oral bisphosphonate medication for at least 3 years, or previously prescribed one for at least 5 years but have since stopped	3,299	
LQC-04a Number of patients who have received a review of their care in the past 12 months to see if they require a repeat BMD/ FRAX score, continued treatment or a referral to secondary care (based on the above guidance), or if they are already under the care of a specialist.	2,742	83%

South Sefton PCN practices – Patients on case finder search who had a clinical review of their medical records



Southport and Formby PCN practices – Patients on case finder search who had a clinical review of their medical records



Local Variation

(LQC04)

- The South Sefton average for patients who had a review of their care was 81%, and Southport and Formby were 89%.
- Individual Sefton practice data ranges from 70% to 100%

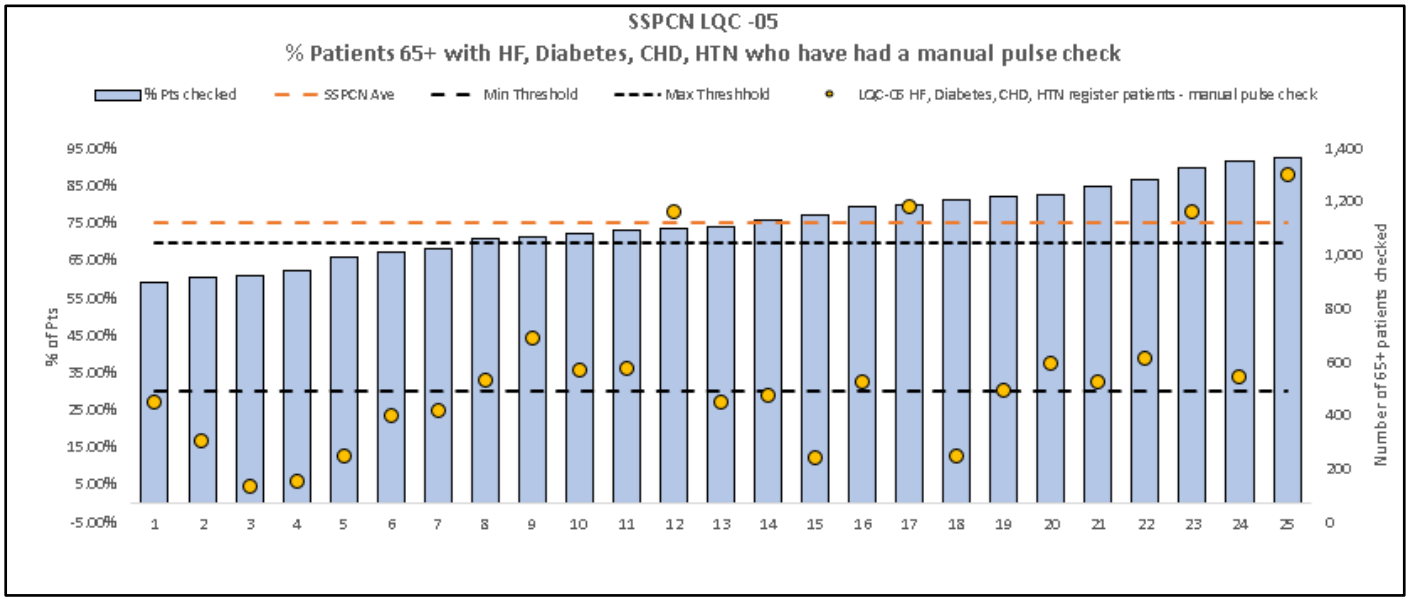
Manual Pulse Checks

The manual pulse check scheme was introduced to support the early identification of atrial fibrillation through routine assessment of pulse rhythm in higher-risk populations, enabling timely diagnosis and intervention to reduce the risk of stroke and other cardiovascular complications, and ultimately prevent avoidable hospital admissions and improve patient outcomes.

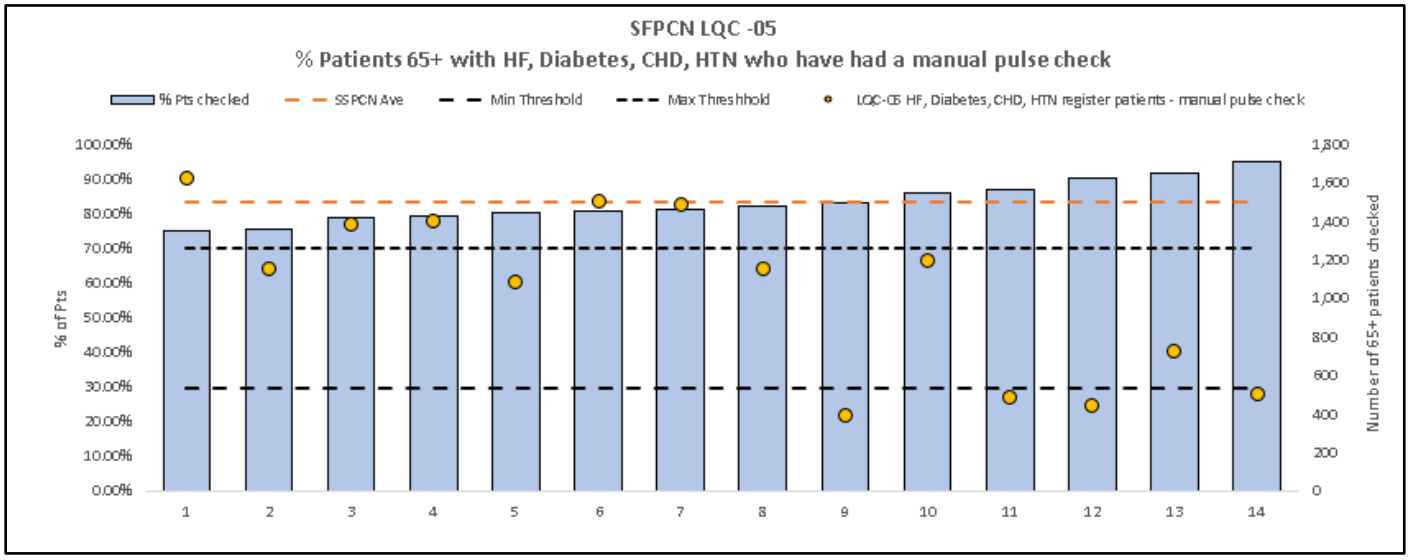
Practices were asked to have a process in place to ensure that patients aged over 65 on the hypertension, coronary heart disease, heart failure, and diabetes registers, who were not already diagnosed with atrial fibrillation/flutter or fitted with a pacemaker, received a pulse check within the previous 12 months. These checks were often undertaken opportunistically during routine consultations to maximise efficiency and patient access.

Criteria	Pt No.	%
LQC-05 Denominator (Patients aged 65 and over excluding AF and pacemaker fitted) who are on other disease registers	36,079	
LQC-05 Patients who had manual pulse check in past 12 months	28,611	79%
LQC-05 additional data		
Number of patients diagnosed with AF following manual pulse check	*640*	

South Sefton practices – Patients over 65 with either Diabetes, CHD, Hypertension who have had a pulse check in the previous 12 months



Southport and Formby practices – Patients over 65 with either Diabetes, CHD, Hypertension who have had a pulse check in the previous 12 months



Local Variation

(LQC-05)

- The South Sefton average for patients aged 65 and over (excluding AF and pacemaker fitted) who had a manual pulse check in the past 12 months was 76%, and Southport and Formby were 83%.
- This has shown averages have remained the same from the previous
- Individual Sefton practice achievement ranged from 60% to 95%

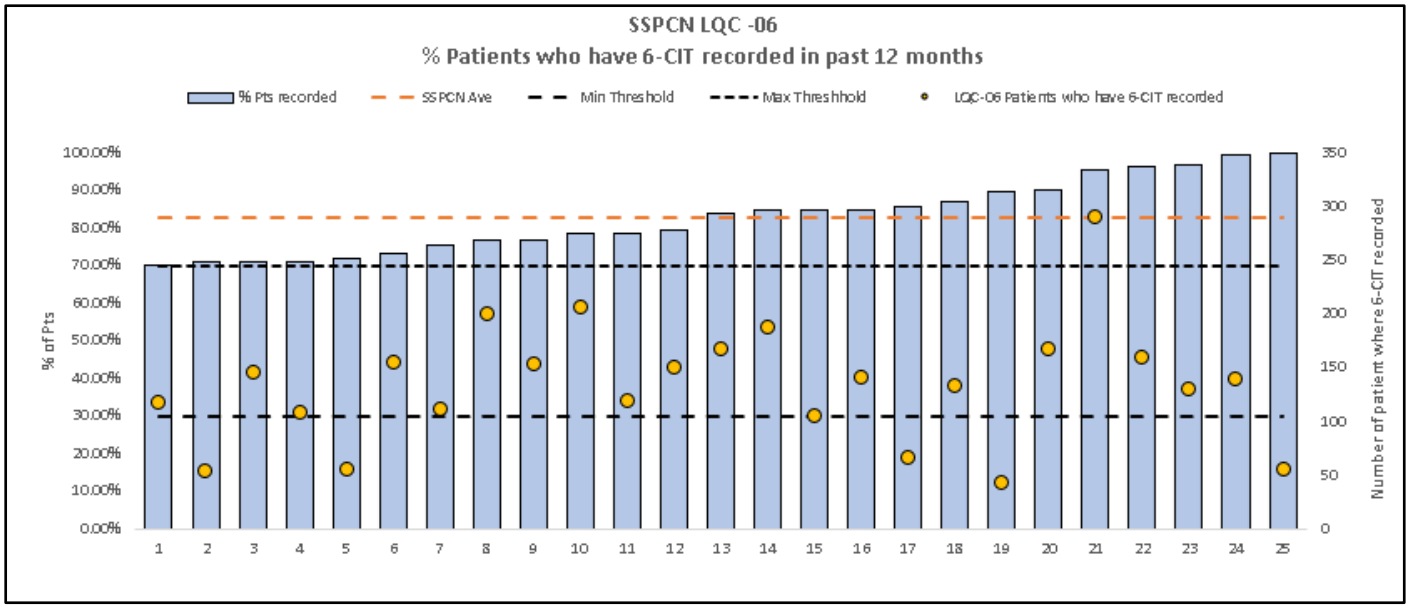
Dementia

The dementia case-finding scheme was introduced to support the early identification of cognitive impairment in at-risk populations through targeted screening, enabling timely diagnosis, appropriate referral, and early intervention to improve patient outcomes, support care planning, and delay disease progression where possible.

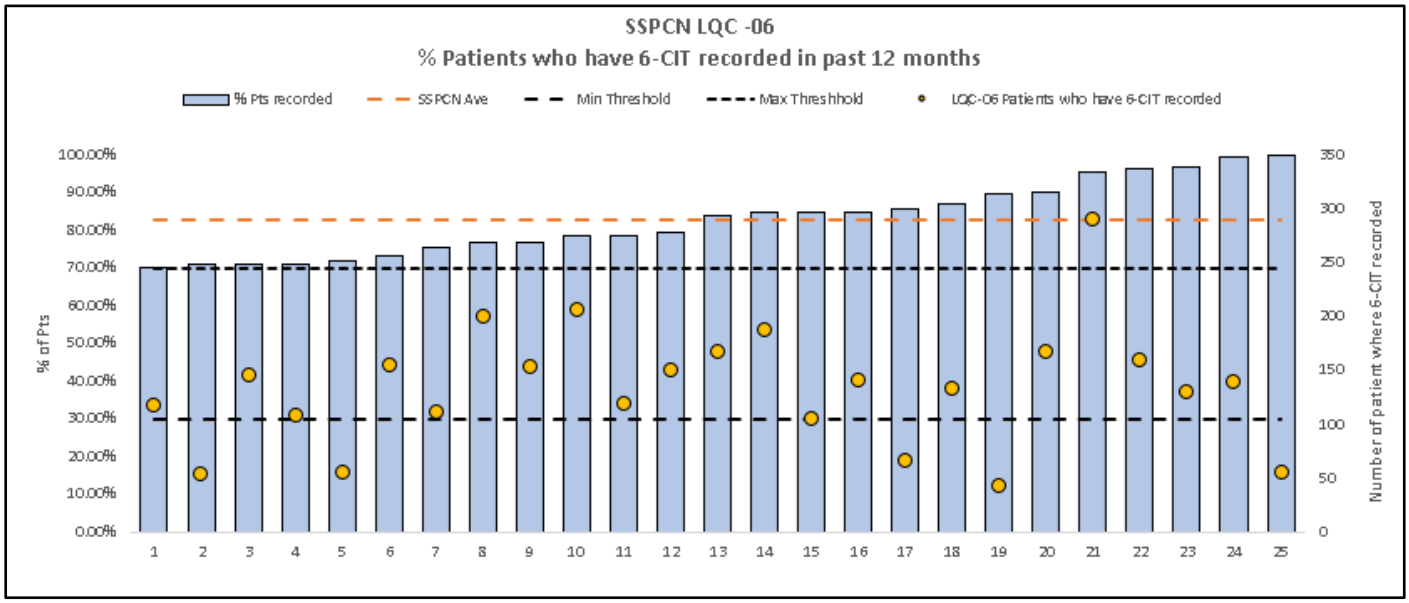
Practices were asked to identify patients aged 65–75 without a pre-existing diagnosis of dementia or mild cognitive impairment, but with defined risk factors such as diabetes, stroke, learning disability, cardiovascular disease, hypertension, previous CABG, or low BMI (<18.5), and to undertake a six-item cognitive impairment test. Practices were expected to act on the results, including making referrals to the memory clinic where clinically appropriate.

Criteria	Pt No.	%
LQC-06 Denominator (Number of patients aged 65-75 without a pre-existing diagnosis of dementia or mild cognitive impairment but have one of the diagnoses mentioned above)	7,229	
LQC-06 Patients who have 6-CIT recorded in the past 12 months	5,854	81%
LQC-06 Additional data		
Patients who had a 6-CIT score of 8 or above	*260*	
Patients who a 6-CIT score of 8 or above who were referred to the memory clinic	*55*	*21%*
Number of patients who had a diagnosis of dementia following a 6CIT	*14*	*5%*
Number of patient who had a diagnosis of Mild Cognitive Impairment following a 6CIT	*8*	*3%*

South Sefton practices – Patients between 65-75 who have been offered 6CIT in the past 12 months



Southport and Formby practices – Patients between 65-75 who have been offered 6CIT in the past 12 months



Local Variation

(LQC06)

- The South Sefton average for patients aged 65-75 on stroke, TIA, diabetes registers with a BMI<18.5, h/o CABG who had a 6-CIT recorded in the past 12 months was 83%, and Southport and Formby were 85%
- Individual Sefton practice achievement ranged from 70% to 100%

Practices need to eliminate reversible causes of cognitive impairment before referring patients to Memory Clinic. This may explain why not all patients who had a 6-CIT score of 8 or more were referred on.

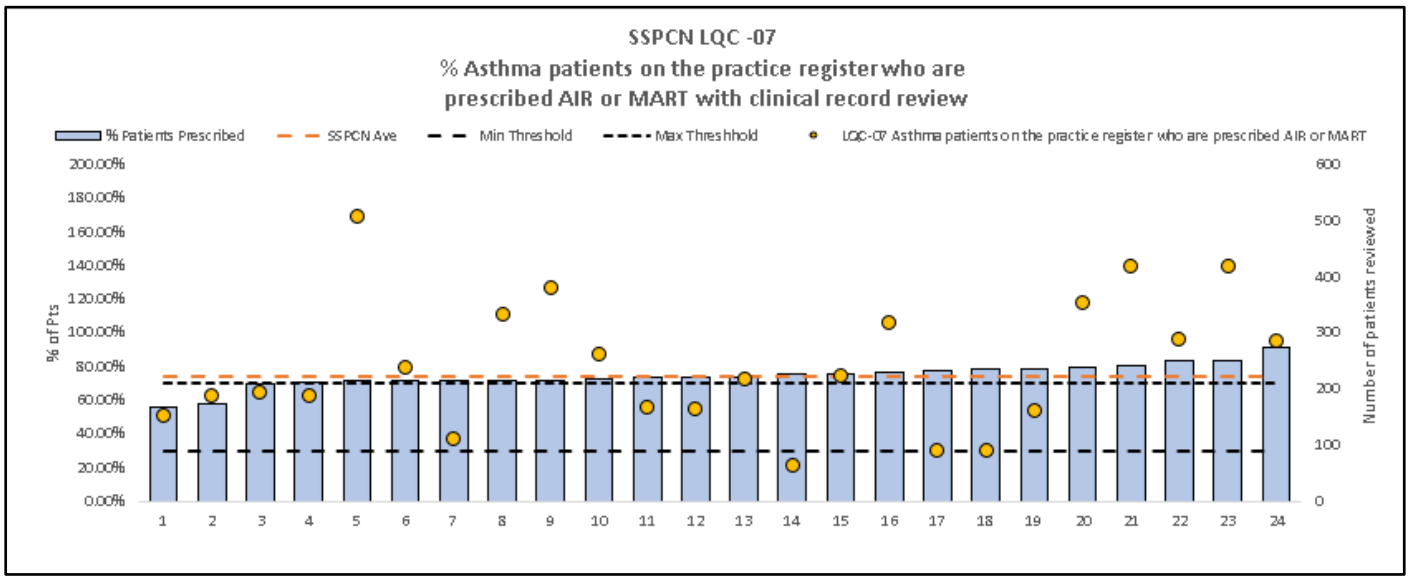
Asthma

The asthma indicator was introduced to support the implementation of updated NICE/BTS/SIGN guidance, which recommends SABA-free treatment pathways to reduce the risks associated with SABA overuse, including increased exacerbations, poor symptom control, and higher risk of hospital admission. Transitioning to anti-inflammatory reliever (AIR) or maintenance and reliever therapy (MART) ensures that patients receive inhaled corticosteroids as part of their reliever treatment, improving overall disease control and reducing airway inflammation.

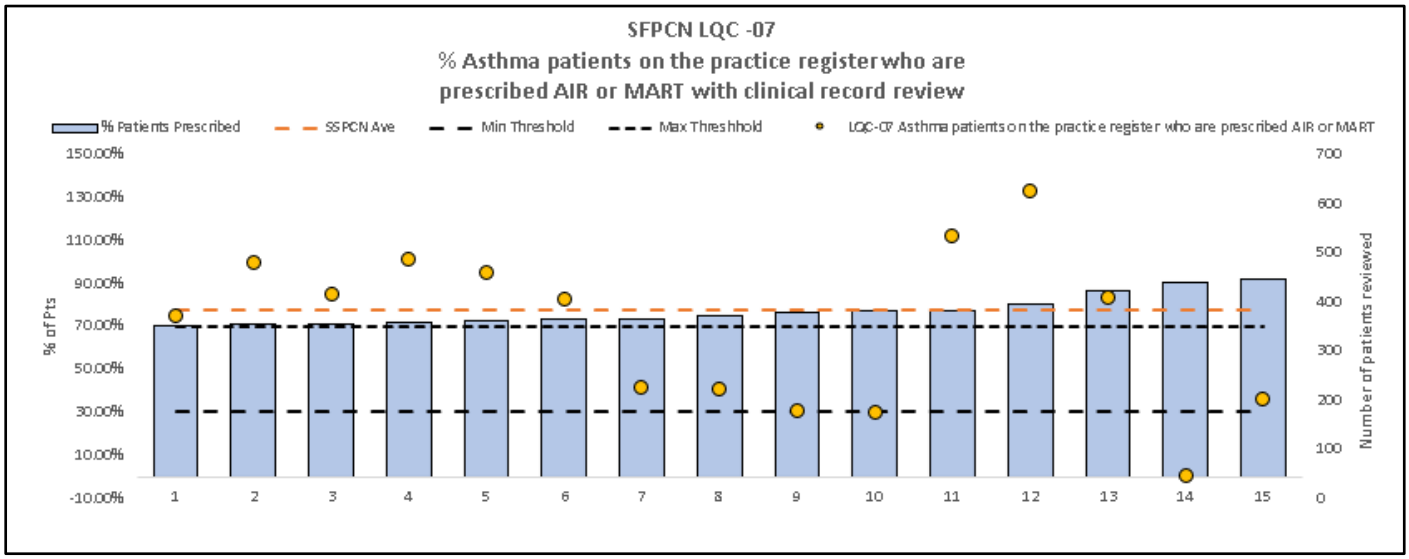
Practices were asked to identify patients with asthma who were prescribed short-acting beta agonists (SABA) and review their treatment, switching them to a SABA-free pathway (AIR or MART therapy) where clinically appropriate, in line with current guidance to support safer and more effective long-term management.

Criteria	Pt No.	%
LQC-07a Denominator Number of patients on the Asthma register aged 12 and over who are prescribed SABA	14,731	
LQC-07a Number of patients who were switched to a SABA free pathway	11,067	75%

South Sefton practices – Patients on the asthma register aged over 12 who have been switched to a SABA free pathway



Southport and Formby practices – Patients on the asthma register aged over 12 who have been switched to a SABA free pathway



Local Variation

(LQC 07)

- The South Sefton average for patients who have been switched to a SABA free pathway was 74.5% and Southport and Formby were 73%
- Individual Sefton practice achievement ranged from 56% to 92%

Serious Mental Health

This indicator was introduced following the publication of health check data for patients with Severe Mental Illness (SMI), which showed that Sefton Place had the lowest achievement rate within Cheshire and Merseyside ICB as at 31 March 2024. In response, Sefton Place sought to maximise the uptake of physical health checks within this cohort, with the aim of improving patient care and reducing health inequalities.

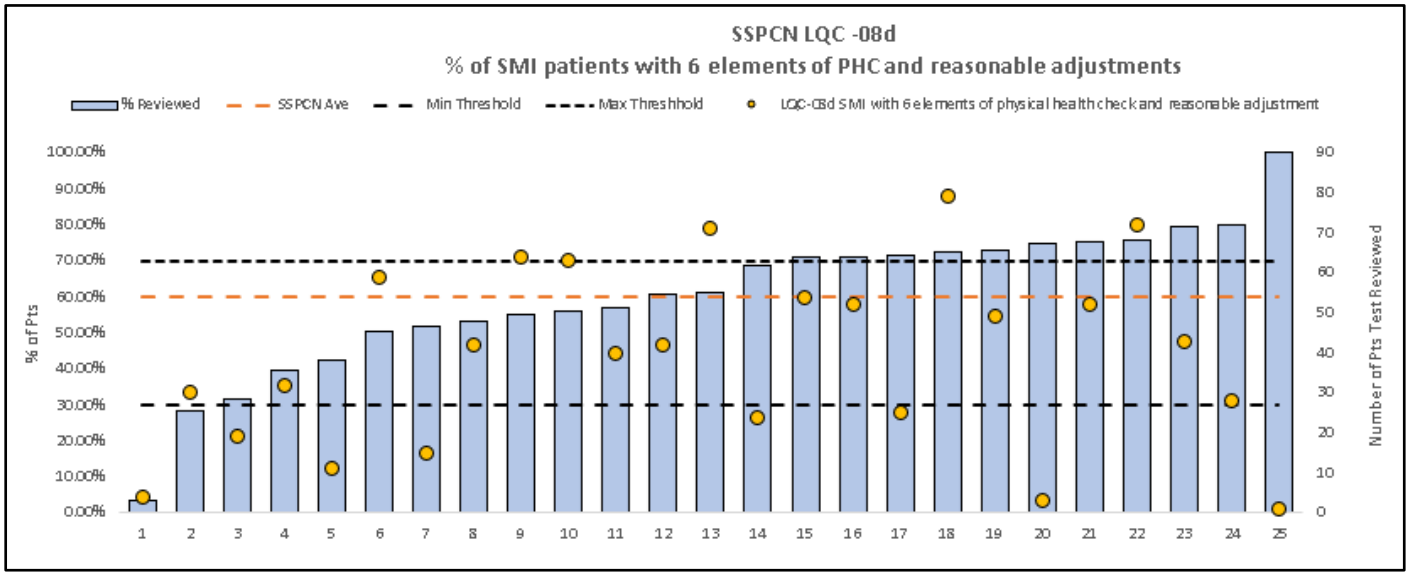
Practices were required to undertake case finding to identify patients with potential SMI using the available Ardens case-finder searches. A clinical review of medical records was then completed to confirm accurate diagnoses and determine appropriate inclusion on the SMI Register. In addition, practices reviewed the records of patients already on the SMI Register to confirm whether they should remain on, or be removed from, the register.

Once registers were validated, practices invited eligible patients to attend a physical health check. This included completion of the six nationally required elements (Alcohol, Blood Glucose, Lipids, BP, BMI and Smoking), alongside consideration of any reasonable adjustments required to ensure equitable access to the Annual Health Check (AHC). Completion of all seven elements was required to meet the indicator criteria.

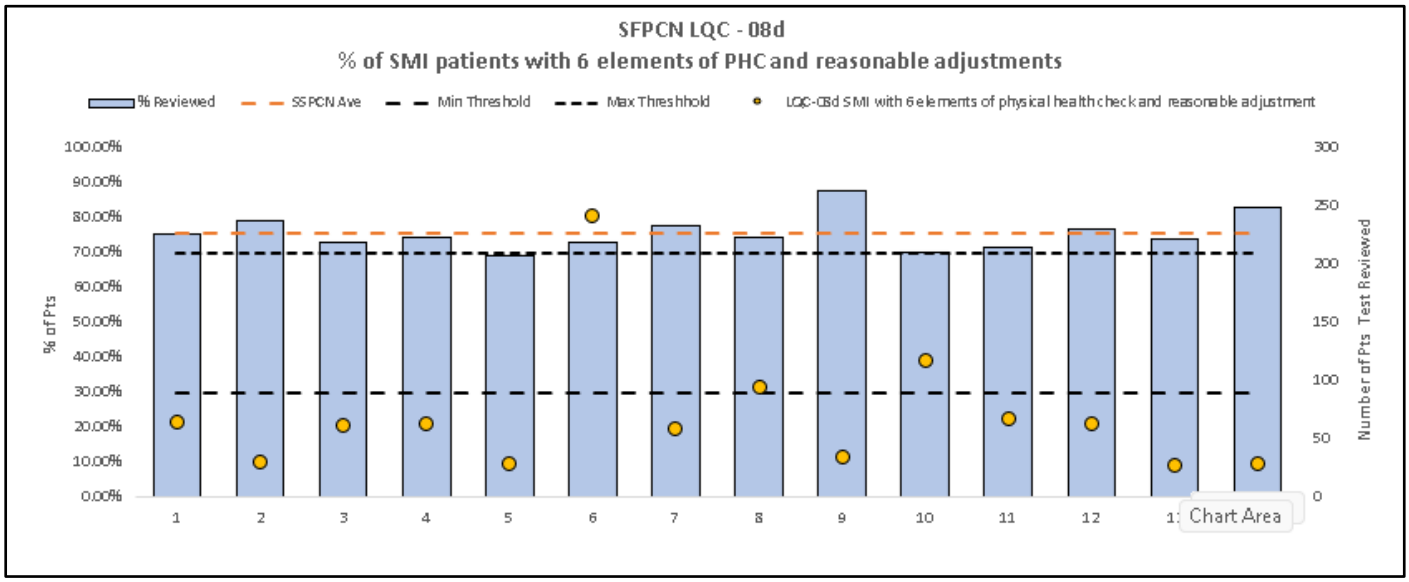
Mersey Care's Community Physical Health Team supported practices to improve AHC uptake. Patients who did not respond to practice invitations were referred to the Community Physical Health Team, who were able to provide more intensive follow-up, including repeated contact attempts and home visits where appropriate. This enhanced approach appears to have contributed to increased patient engagement and higher uptake of AHCs. Sefton Place has met the target of 60% for the first time this year.

Criteria	Pt No.	%
LQC-08a Denominator: Number of patients identified on the Ardens Case Finder searches	1,554	
LQC-08a Number of patients whose medical records were reviewed	1,414	91%
LQC-08a – Additional data		
Number of patients who had a new diagnosis of SMI	*36*	
Number of patients who had no evidence of a mental illness	*1402*	
LQC-08b Denominator: Number of patients on the SMI register at 1.4.25	4,306	
LQC-08b Number of patients whose medical records were reviewed	3,862	
LQC-08c Denominator: Number of patients who have not responded to at least 2 invites in the past 12 months	747	
LQC-08c Number of patients who were referred to Mersey Care Physical Health Team	589	79%
LQC-08d Denominator: Number of patients on the SMI register at 1.4.25	4,306	
LQC-08d Number of patients who have had an SMI physical health check including the 7 criteria (Alcohol, BMI, Lipid, BP, HBA1C, Smoking and Reasonable Adjustments)	1,958	45.5%
LQC-08d Additional data		
Number of patients who have had alcohol consumption recorded	*2,556*	*59%*
Number of patients who have had BMI recorded	*2,547*	*59%*
Number of patients who have had lipid recorded	*2,292*	*53%*
Number of patients who have had blood pressure recorded	*2,558*	*59%*
Number of patients who have had HBA1C	*2,357*	*55%*
Number of patients who have had Smoking	*2,615*	*61%*
Number of patients who have had Reasonable Adjustments	*2,514*	*58%*

South Sefton practices – Number of patients who have had an SMI physical health check in the past 12 months that includes all 7 criteria described above



Southport and Formby practices – Number of patients who have had an SMI physical health check in the past 12 months that includes all 7 criteria described above



Local Variation

(LQC 08a)

- The South Sefton average for patients whose medical records reviewed from the Ardens case finder search was 89% and Southport and Formby were 97%
- Individual Sefton practice achievement ranged from 4% to 100%

(LQC 08b)

- The South Sefton average for patients whose medical records were validated to determine accuracy of diagnosis was 86% and Southport and Formby were 93%
- Individual Sefton practice achievement ranged from 4% to 99%

LQC 08c)

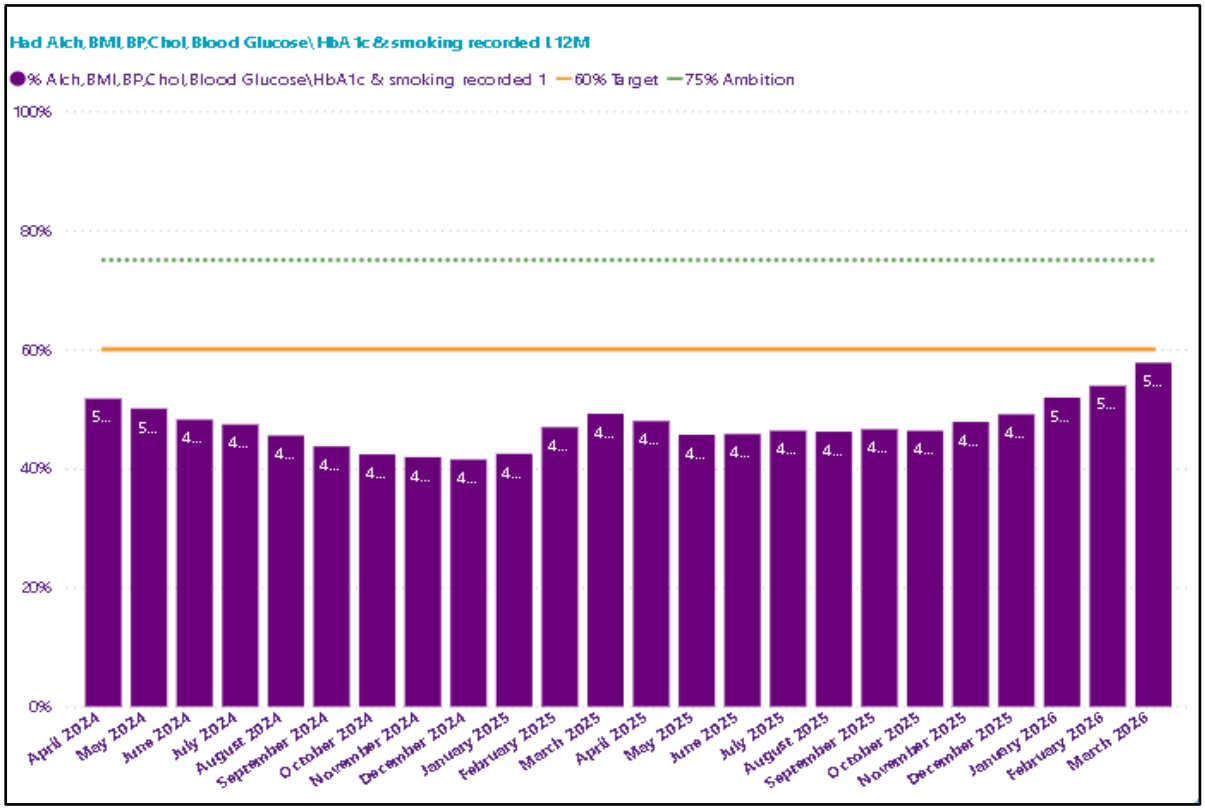
- The South Sefton average for patients who had received 2 invites and we referred to the Mersey Care physical health team was 12% and Southport and Formby were 14%
- Individual Sefton practice achievement ranged from 0% to 67%
- There was not funding attached to this indicator. It was a practice choice if they wanted to engage with the community teams

LQC 08d)

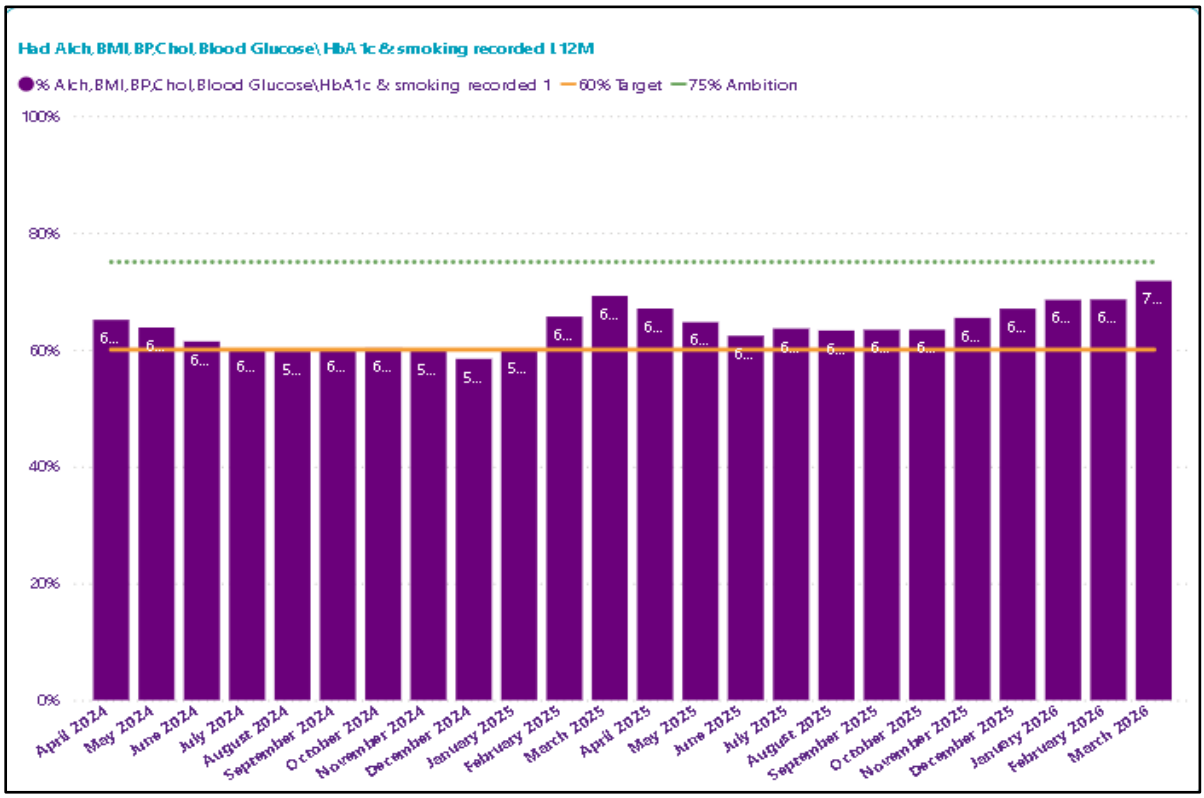
- The South Sefton average for patients who received a physical health check was 60% and Southport and Formby were 76%
- Individual Sefton practice achievement ranged from 4% to 100%

South Sefton practices – Improvement in the recording of SMI Physical Health Checks

There are some discrepancies between National compliance data and data extracted directly from the clinical system. Work is underway to establish how these data issues can be resolved.



Southport and Formby practices – Improvement in the recording of SMI Physical Health Checks



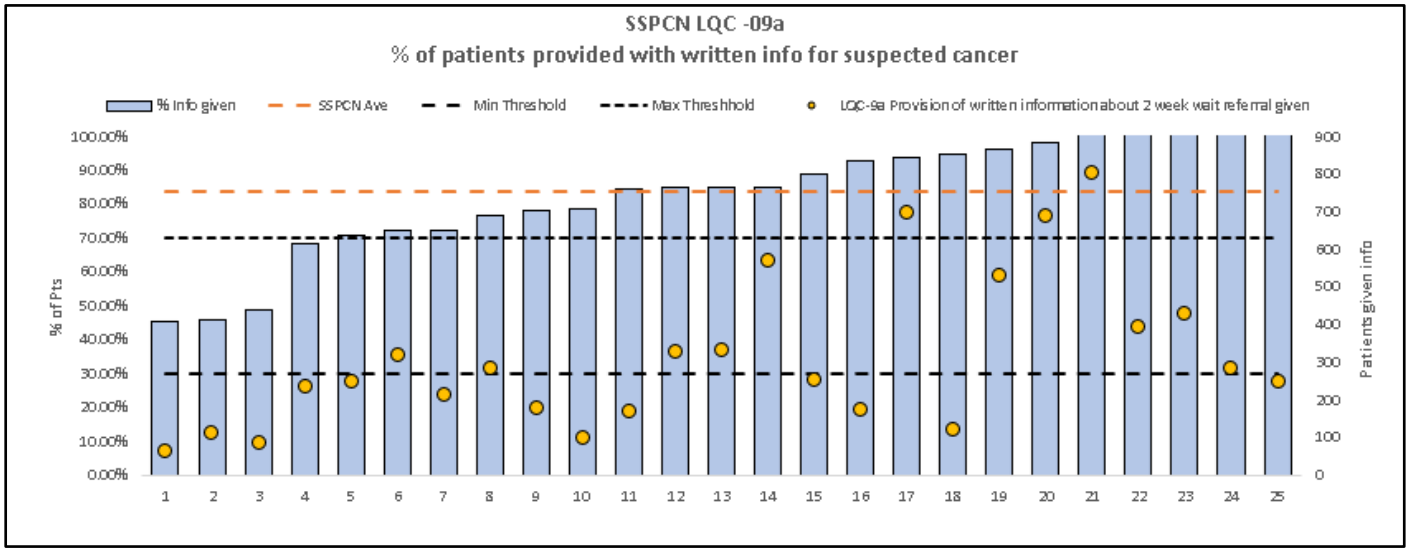
Suspected Cancer

This indicator was reintroduced to underpin the importance of providing patients with written information regarding their referral for suspected cancer. Practices had access to standard templates within their clinical system. Practices were also encouraged to actively record safety netting advice using the Cheshire and Merseyside safety netting template.

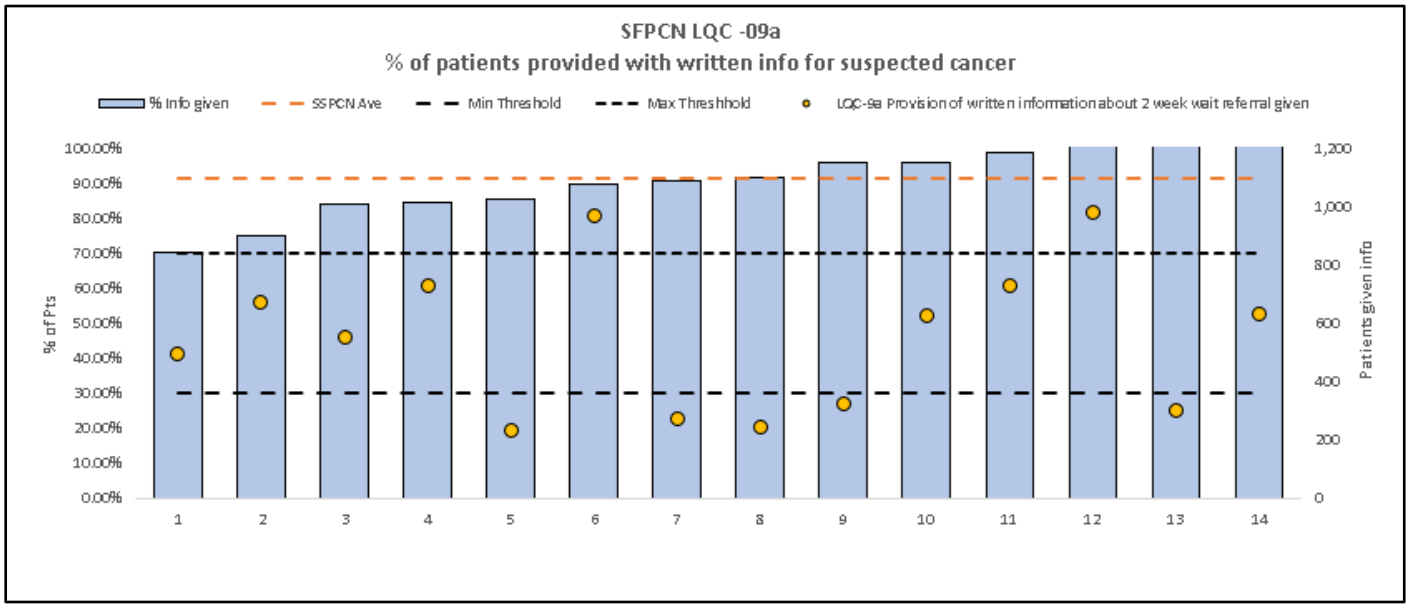
This indicator was also included management of patients with polycystic ovary syndrome (PCOS). This was to address the long-term health risks associated with PCOS. Women with PCOS have a significantly increased risk of endometrial cancer and cardiovascular disease, particularly when prolonged amenorrhoea is present. Risk reduction relies on timely identification and appropriate management, including ensuring regular withdrawal bleeds, offering endometrial protection, or arranging surveillance where indicated. However, some women with PCOS may not have been formally assessed or investigated, highlighting the need to review current practice and identify opportunities for improvement.

Criteria	Pt No.	%
LQC-9a Denominator: (Number of patients who have been referred for suspected cancer in the past 12 months)	17,654	
LQC-9a Number of patients who received written information about their referral	15,666	89%
LQC-9b Number of patients who had safety netting advice recorded	14,859	84%
LQC-9c Denominator: Number of patients age 18 and over who have a diagnosis of polycystic ovaries	3,931	
LQC-9c Number of patients who have had a review in the last 12 months to manage their risk of endometrial hyperplasia and have a cardiovascular risk assessment	3,013	77%

South Sefton practices – Patient who received information about their suspected cancer referral



Southport and Formby practices – Patient who received information about their suspected cancer referral



Local Variation

(LQC9a)

- The South Sefton average for patients referred for suspected in the previous 12 months provided with written information about the referral was 84%, and Southport and Formby were 92%
- The average number of patients receiving written information following a suspected cancer referral has increased from phase 10 where South Sefton average was 69% and Southport and Formby was 87%
- Individual Sefton practice achievement ranged from 46% to 122%
- Some practices show a percentage greater than 100%. This occurs because a patient may receive more than one referral within the year. The denominator counts only one referral per patient, whereas the numerator is based on the number of codes for written information provided. This discrepancy is due to the way the search is structured.

(LQC0b)

- The South Sefton average for patients referred for Suspected Cancer in the previous 12 months who received safety netting advice was 80%, and Southport and Formby were 86%
- The average number of patients referred for Suspected Cancer in the previous 12 months who received safety netting advice has increased from phase 10 where South Sefton average was 64% and Southport and Formby was 81%
- Individual Sefton practice achievement ranged from 39% to 122%
- Some practices show a percentage greater than 100%. This occurs because a patient may receive more than one referral within the year. The denominator counts only one referral per patient, whereas the numerator is based on the number of codes for safety netting provided. This discrepancy is due to the way the search is structured.

(LQC9c)

- The South Sefton average for patients with PCOS receiving a review previous 12 months whose was 80%, and Southport and Formby were 74%
- Individual Sefton practice achievement ranged from 60% to 100%

Depression Screening

This indicator was introduced to Phase 10 to emphasise the importance of supporting Carers and Military Veterans. According to Carers Uk, It is estimated that there are 5 million unpaid carers in the UK. Being a carer can have a significant impact on health and wellbeing.

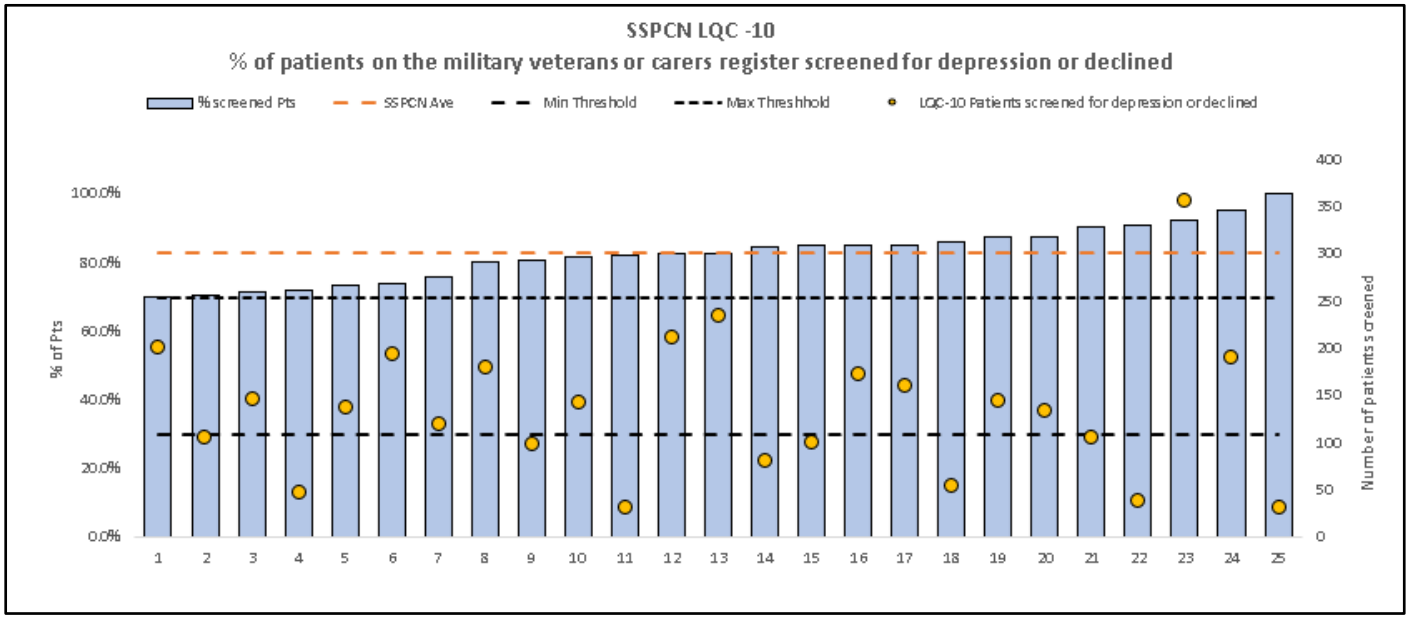
According to a study done by Kings College London, 28% of veterans report symptoms of common mental disorders including depression. This has increased from 22% in 2014. 20-year Study

During Phase 11 of the LQC we have decided to screen patients within LGBTQ+ communities for depression due to the recognised health inequalities and psychosocial stressors that can disproportionately affect these populations. Factors such as stigma, discrimination, social isolation, and barriers to accessing inclusive healthcare can increase vulnerability to poor mental health outcomes. Routine screening supports early identification of depression, enables timely intervention, and helps ensure equitable, person-centred care tailored to individual need.

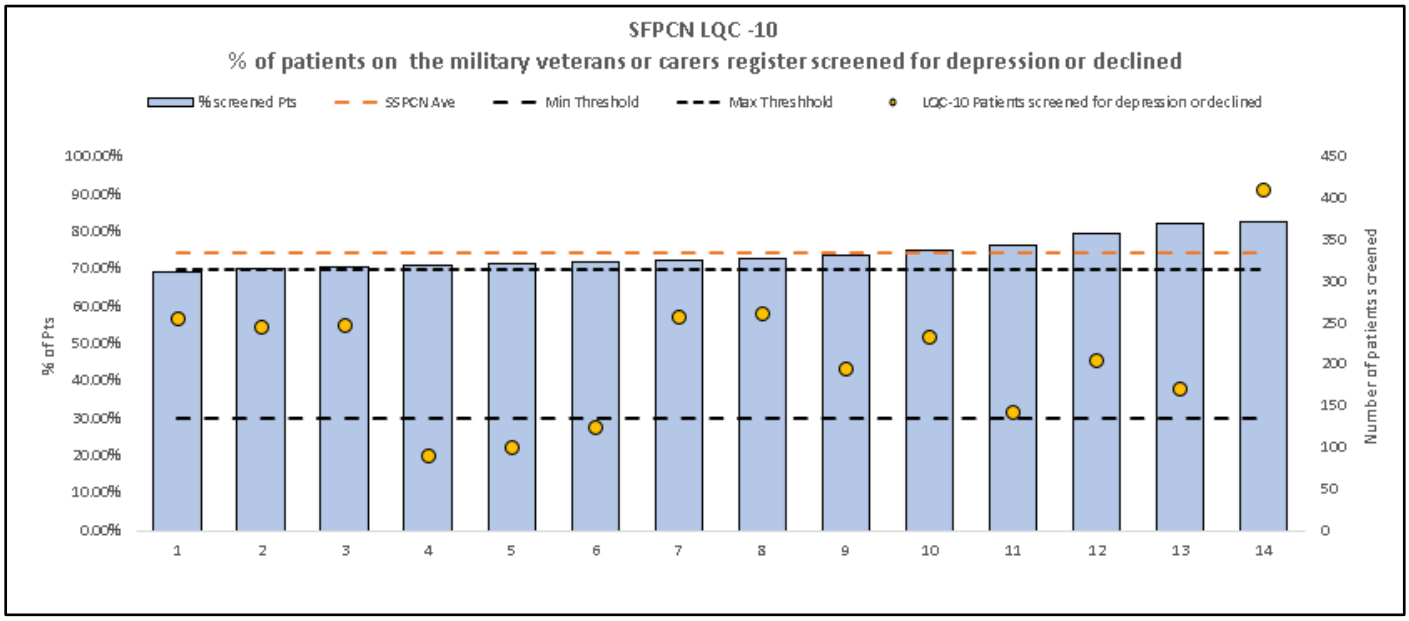
Practices should identify Carers, Military Veterans and patient in the LGBTQ+ communities, and proactively offer PHQ-9 then act appropriately on the score generated.

Criteria	Pt No	%
LQC-10 Denominator (Number of patients who are Carers, Military Veterans or LGBTQ+ patients)	8,131	
LQC-10 Carers, Military Veterans or LGBTQ+ patients who were offered screened for depression using PHQ-9	6,366	78%
LQC-10 Additional data		
Number of patients who took up the offer of depression screening	*3446*	
Number of patients who declined the offer of depression screening	*3017*	
Number of patients diagnosed with Depression following screening	*193*	

South Sefton practices – Patients who have had PHQ-9



Southport and Formby practices – Patients who have had PHQ-9



Local Variation

(LQC10)

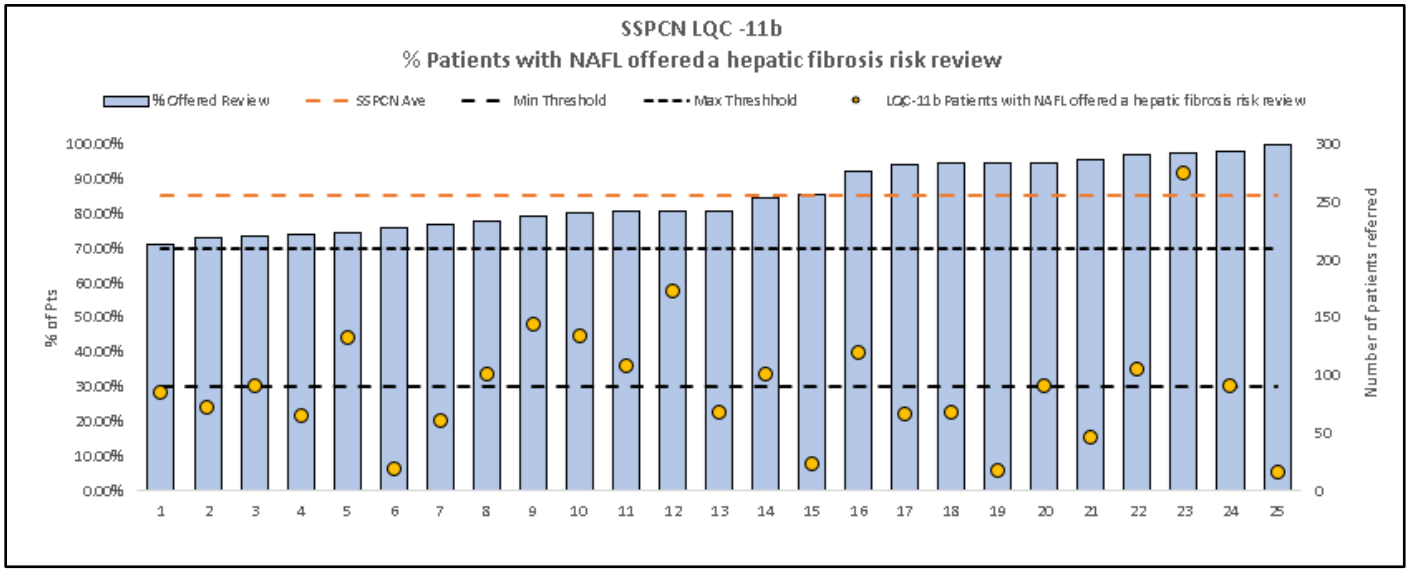
- The South Sefton average of Carers, Military Veterans and LGBTQ+ patients who were offered screening for depression was 82%, and Southport and Formby were 74%
- Individual Sefton practice achievement ranged from 70% to 100%
- Patients may have declined the offer of screening but then decided to take up the offer at a later date. Some patients did not respond to the offer

Non-alcoholic fatty liver disease (NAFLD)

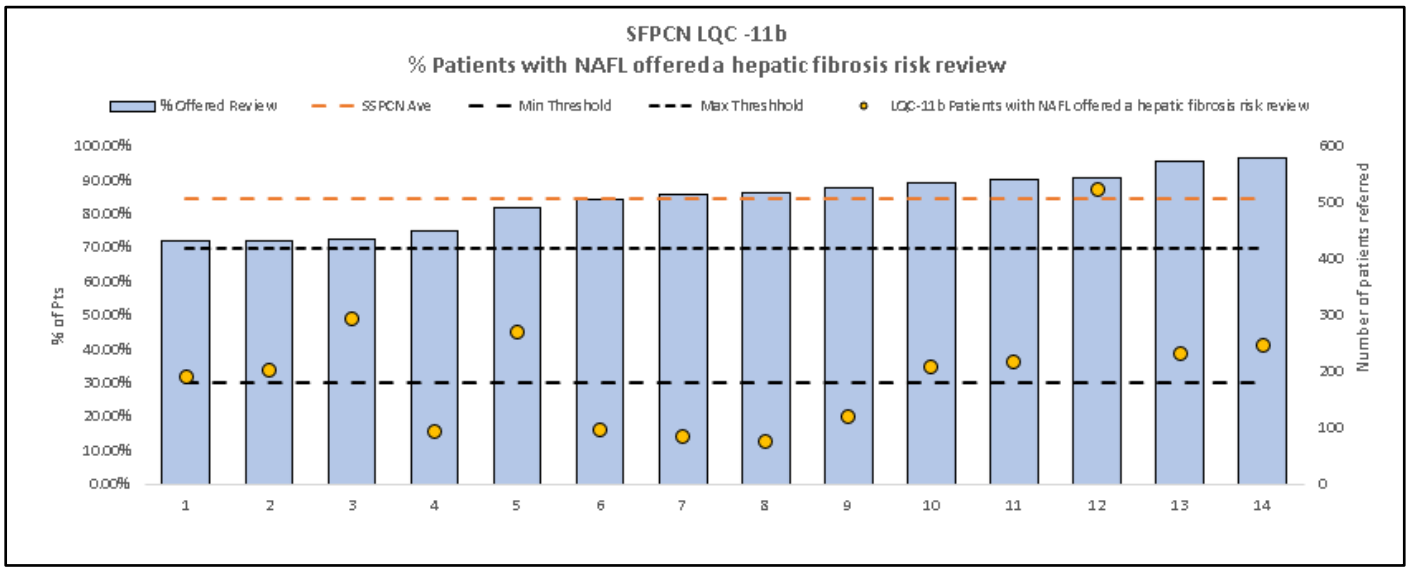
This indicator was introduced in Phase 11 to address gaps in the identification and monitoring of non-alcoholic fatty liver disease (NAFLD). NAFLD is a common condition associated with an increased risk of advanced liver disease, cardiovascular disease, and metabolic disorders such as diabetes and metabolic syndrome. Despite an estimated UK prevalence of 20–25%, many patients remain undiagnosed, and a significant proportion of those diagnosed are not monitored in line with NICE guidance, https://cks.nice.org.uk/topics/non-alcoholic-fatty-liver-disease-nafld/. This evaluation reviews current practice following the introduction of the indicator and assesses its impact on improving the detection and management of NAFLD.

Criteria	Pt No.	%
LQC-11a Denominator: Number of patients with a generic fatty liver code	3,846	
LQC-11a Number of patients who received an review in the previous 12 months to determine Non-Alcohol Fatty Liver Disease	2,964	77%
LQC-11a – Additional data		
How many patients were diagnosed with non-alcohol fatty liver disease	*2778*	
How many patients were diagnosed with alcohol related fatty liver disease	*297*	
LQC-11b Denominator: Number of patients with a diagnosis of Non-Alcohol Fatty Liver Disease	6,113	
LQC-11b Number of patients who received a review in the previous 3 years (1.4.2023) to assess their risk of hepatic fibrosis and cardiovascular risk	5,150	84%
Additional information		
Did we have any patients who were found to have hepatic fibrosis	*68*	
Did we have anyone whose cardiovascular risk was high	*1020*	

South Sefton practices – Patients who have had a hepatic fibrosis risk assessment done



Southport and Formby practices – Patients who have had a hepatic fibrosis risk assessment done



Local Variation

(LQC11a)

- The South Sefton average of patients with Non-Alcoholic Fatty Liver Disease who have had an assessment of the hepatic fibrosis risk was 75%, and Southport and Formby were 79%
- Individual Sefton practice achievement ranged from 12.5% to 91%

(LQC11b)

- The South Sefton average of patients receiving a review to determine Non-Alcoholic Fatty Liver Disease was 85%, and Southport and Formby were 84%
- Individual Sefton practice achievement ranged from 71% to 100%

Digital Champion

A digital champion programme has been established for several years. Sefton Place and iMerseyside Training Service have collaborated to promote digital skills and encourage practices to improve their knowledge and confidence in the use of digital platforms, to support staff and patients.

Each practice nominated a named digital champion from existing staff members who became first point of contact for digital training.

IMerseyside hosted a MS Teams Channel for the Digital Champions. Champions were able to share ideas or gets support from the peers. Feedback given after each event and an end of year report has helped shape the criteria for future inclusion

Criteria	Pt No	%
LQC-12 Denominator: (Number of practices, each should have a digital champion and a Nurse led digital champion)	39	
LQC-12a Number of Digital Champions who completed the annual feedback survey. (no funding was attached to this)	36	92%
LQC-12b Number of Digital Champions who attended at least 3 out of the 4 available training sessions	27	69%
LQC-12b Number of Nurse Digital Champions who attended at least 3 out of the 4 available training sessions	11	28%
LQC-12c Denominator (Number of patients ages 30-70 who do not have access online access)	45,609	
LQC-12c Number of patients who were proactively contacted to encourage them to use online access (NHS APP)	35,880	79%
LQC-12c – Additional data		
Number of patients who were found to be digitally excluded	*573*	
Number of patients who declined to use online services	*12*	
LQC-12d Denominator (Number of patients with online access, who are on repeat prescriptions but are not currently ordering medications online.	22,861	
LQC-12d Number of patients who are proactively contacted to encourage them to order medication online	18,554	81%
LQC-12d – Additional Information		
Number of patients who have subsequently started ordering their medication online	*4918*	
LCQ-12e Denominator (number of patients with a live online account who have 104 codes on their records that prevents them from sharing data)	6,333	
LCQ-12e Number of patients with a live online account with a 104 code who have had a clinical review of their records to establish if it is appropriate to enable their record to be shared	5,043	80%
LCQ-12e – Additional information		

Number of patients where 106 was added	*4356*	
Number of patients where it was deemed appropriate for the record not to be shared.	*592*	

Local Variation

(LQC-12a) Digital Champions were encouraged to take part in a survey around the Digital Champion programme. 39 responses were received as some practices had more than 1 digital champion who attended the sessions. 37 Digital Champions felt that the training sessions were useful and informative whilst 1 Digital Champion felt it was mostly useful and informative. A further 1 Digital Champion felt that not all information applied to North Sefton. The full evaluation can be found in appendix 1

During Phase 11, the Digital Champion Programme was expanded to include the practice nursing team. This development aimed to enhance nurses' awareness and understanding of available digital services and programmes, enabling them to confidently signpost patients to appropriate resources. The need for this extension was identified during a previous nurse-led Protected Learning Time (PLT) session. A Survey was sent out at the beginning of the year to find out which digital programmes the nurses wanted to learn about. These topics were then presented at the sessions. The nursing staff felt that the sessions were not useful for them, it was decided not to include in further LQC. The full evaluation can be found in appendix 2

(LQC-12b) During Phase 11, the delivery format of the Digital Champion sessions was revised. Sessions were reduced to one per quarter, each with a duration of two hours. A total of four sessions were delivered virtually. To meet the programme criteria, Digital Champions were required to attend at least three of these sessions. Where a designated Digital Champion was unable to attend, practices were permitted to nominate an alternative staff member to participate. This ensured continuity of learning, with the expectation that key information and insights would be shared and cascaded to the wider practice team.

The sessions included:

- Introduction to the LQC phase 11
- Windows 11 roll out
- GP2GP
- NHS APP
- Liverpool Place Digital Health Activation Team Presentation
- Digital Inclusion
- Website Support
- EMIS X
- Microsoft 365 bitesize sessions
- Cheshire and Merseyside Connected Care Record
- Accessible Information Standards
- Copilot
- IM training system and Portal

(LQC12c)

- The South Sefton average of patients aged 30 - 70 contacted to offer online access was 83%, and Southport and Formby were 75%
- Individual Sefton practice achievement ranged from 70% to 99%

(LQC-12d)

- The South Sefton average of patients who had online access but didn't currently order prescriptions and were proactively contacted to proactive contacted to promote ordering online was 81%, and Southport and Formby were 79%
- Individual Sefton practice achievement ranged from 6% to 96%

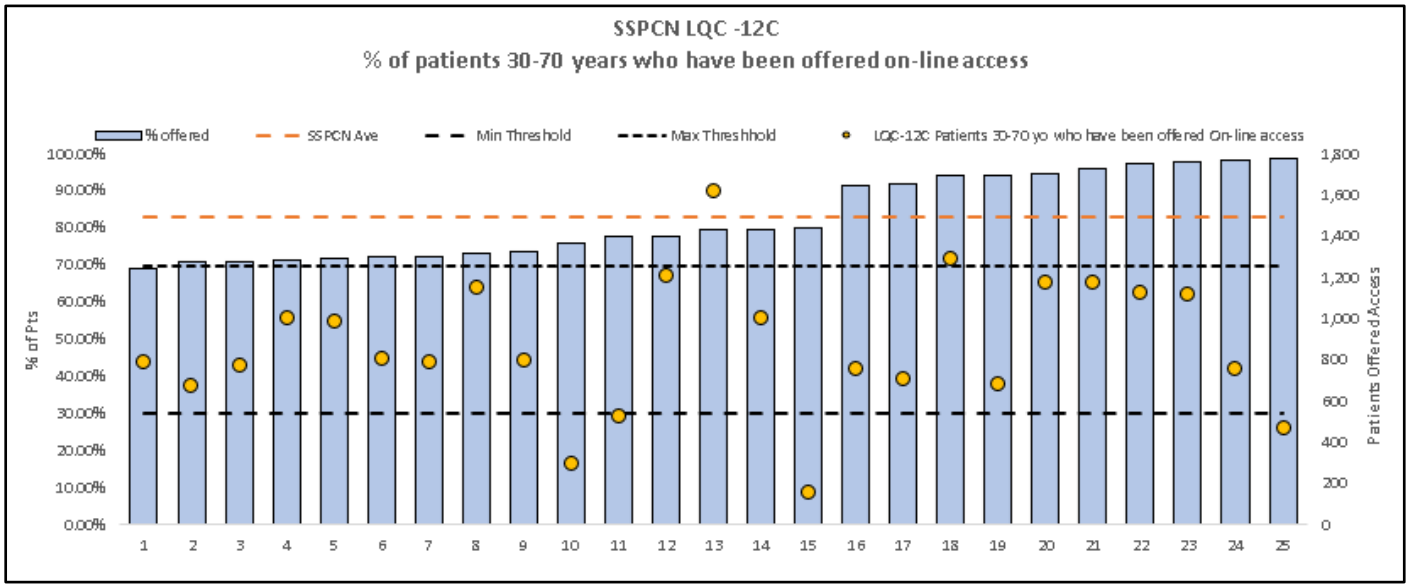
LQC-12e

- The South Sefton average of patients who had online access but had 104 code on record and had a clinical review to see if the 104 code was appropriate or not was 83%, and Southport and Formby were 82%
- Individual Sefton practice achievement ranged from 0% to 100%

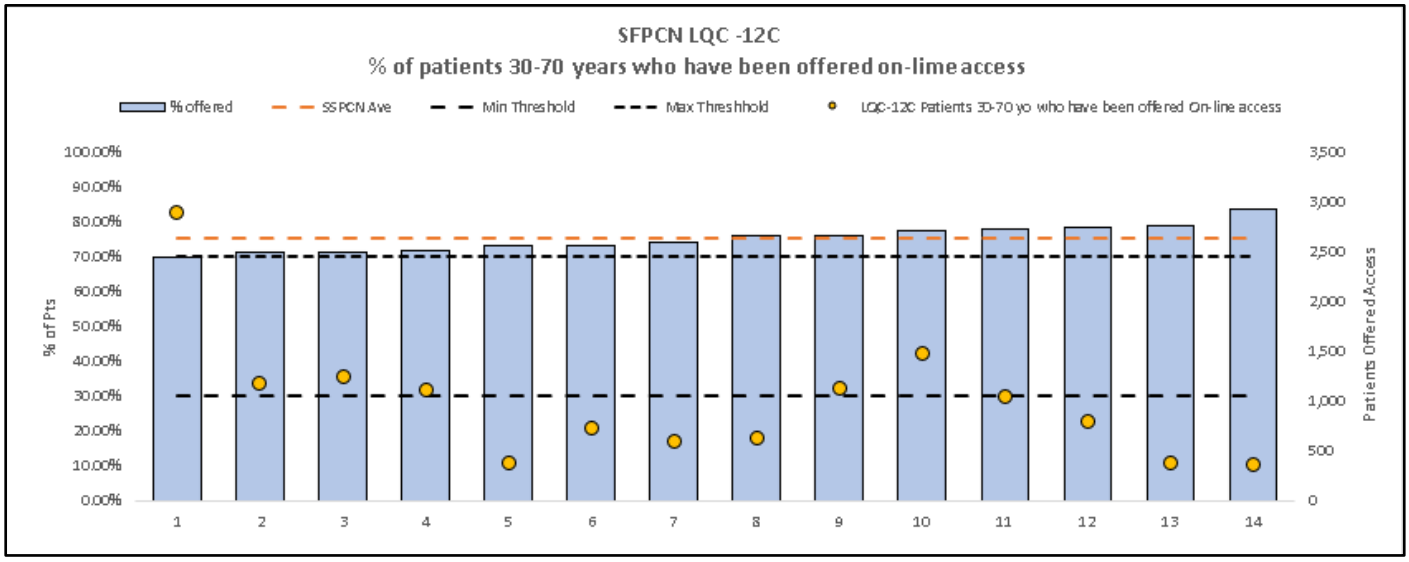
A *104* code recorded in their clinical records indicates that the patient's detailed coded health information is not currently enabled for online sharing. These records were to be clinically reviewed to assess whether it would be appropriate to provide the patient with access to their detailed health information.

A 106 code recorded in the patients record indicates that the detailed health record can be enabled for online sharing.

South Sefton practices – Number of patients aged 30 -70 who have been contacted to promote online access



Southport and Formby Practices - Number of patients aged 30 -70 who have been contacted to promote online access



Health Promotion Indicator

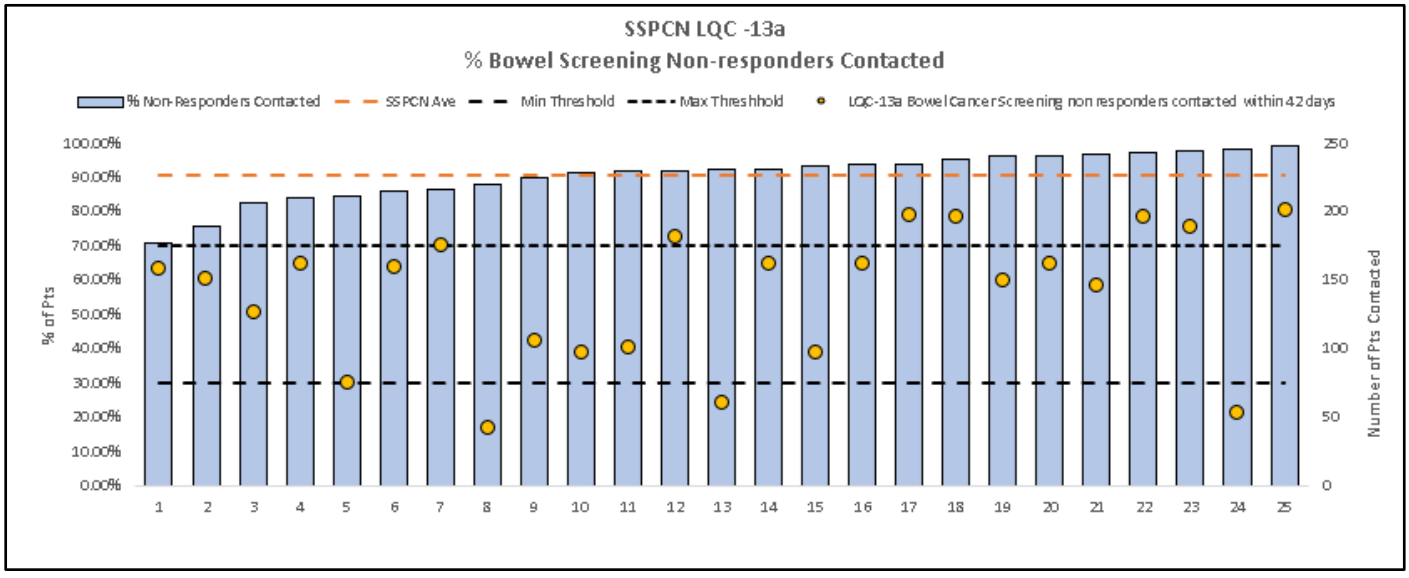
In phase 11 of the LQC it was decided to create a Health Promotion indictor which encompassed a variety of criteria that had previously been included in other areas of the LQC

Bowel Cancer Screening

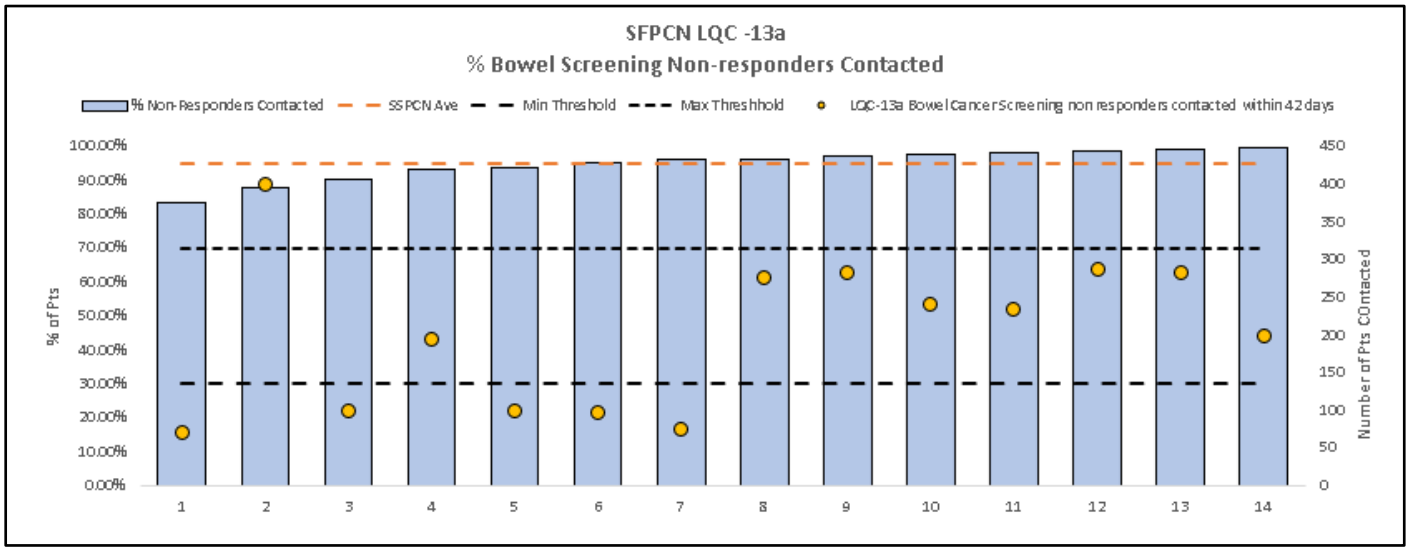
The purpose of this scheme was to ensure that patients who have not accessed either bowel, screening within the recommended time frame, are contacted by the practice within 42 days of the practice receiving the non-responder notification to encourage participation in the national screening programmes.

Criteria	Pt No.	%
LQC-13a Denominator (Bowel Cancer screening Non responders – last 12 months)	6,891	
LQC-13a Bowel Cancer Screening non responders contacted within 42 days	6,366	92%
LQC-13a – Additional data		
Number of patients who went on to have bowel screening following a reminder from the practice	*6335*	

South Sefton practices – Patients who were contacted following a non-response to Bowel Screening



Southport and Formby practices – Patients who were contacted following a non-response to Bowel Screening



Local Variation

(LQC 13a)

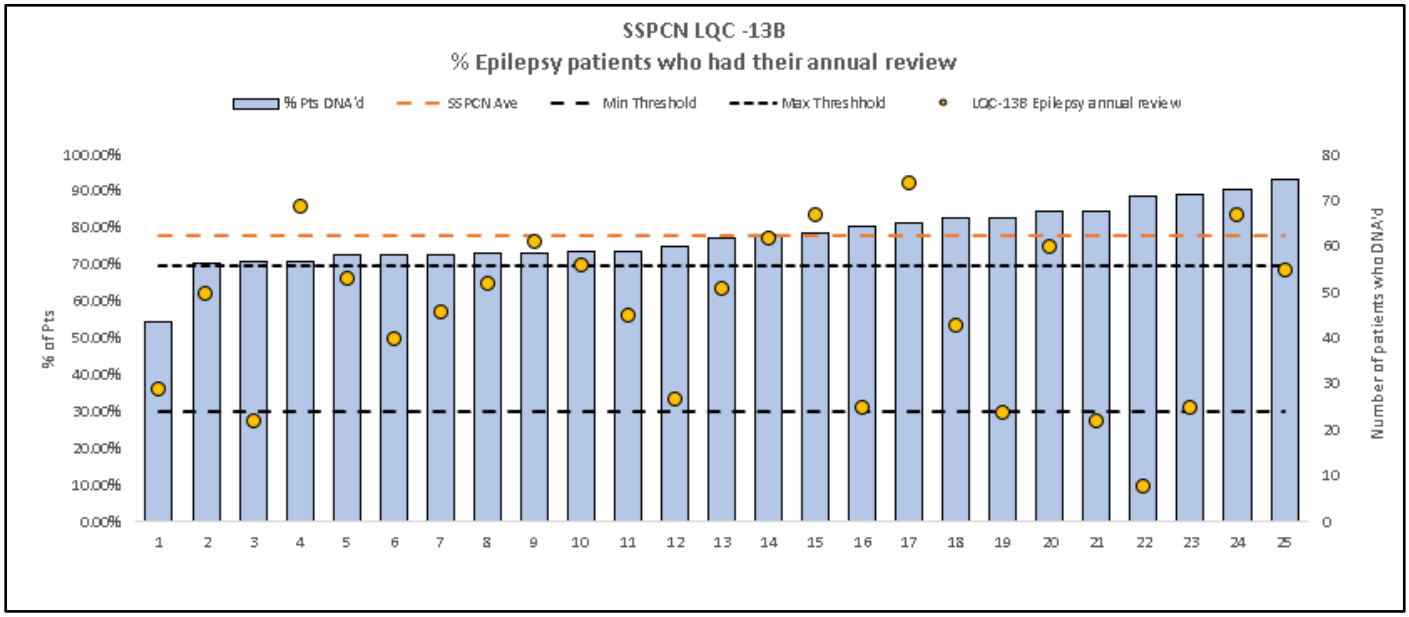
- The South Sefton average for Bowel Cancer screening non-responders in the last 12 months who were contacted within 42 days was 91%, and Southport and Formby were 95%.
- The average number of patients who have received a bowel screening reminder from the practice within 42 days of notification as non-responder has increased from phase 10 where South Sefton average was 80% and Southport and Formby was 93%
- Individual Sefton practice achievement ranged from 70% to 99.5%

Epilepsy

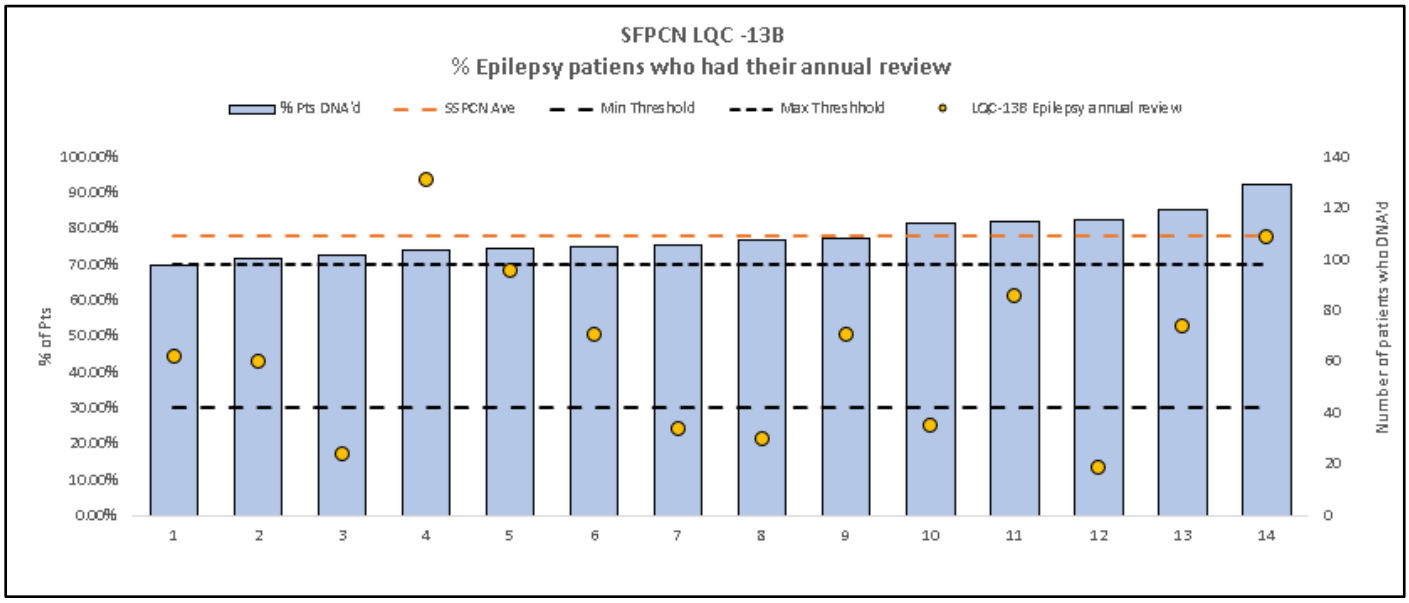
Epilepsy was removed from QOF from April 2014; to ensure that the patients aged 18 or over in Sefton had access to an annual review regardless of which practice they were registered it was decided to introduce this indicator. An assumption was made that children will under the age of 18 would be under the care of secondary care services. It is expected that anyone with a diagnosis of Epilepsy should have an annual review as per NICE Guidelines. https://cks.nice.org.uk/topics/epilepsy/management/routine-epilepsy-review/

Criteria	Pt No.	%
LQC-13b Denominator (Number of patients with Epilepsy aged 18 or over)	2,629	
LQC-13b Number of patients who received an annual health check in the previous 12 months	2,035	77%

South Sefton practices – Patients who received an Epilepsy annual health check



Southport and Formby practices – Patients who received an Epilepsy annual health check



Local Variation

(LQC 13b)

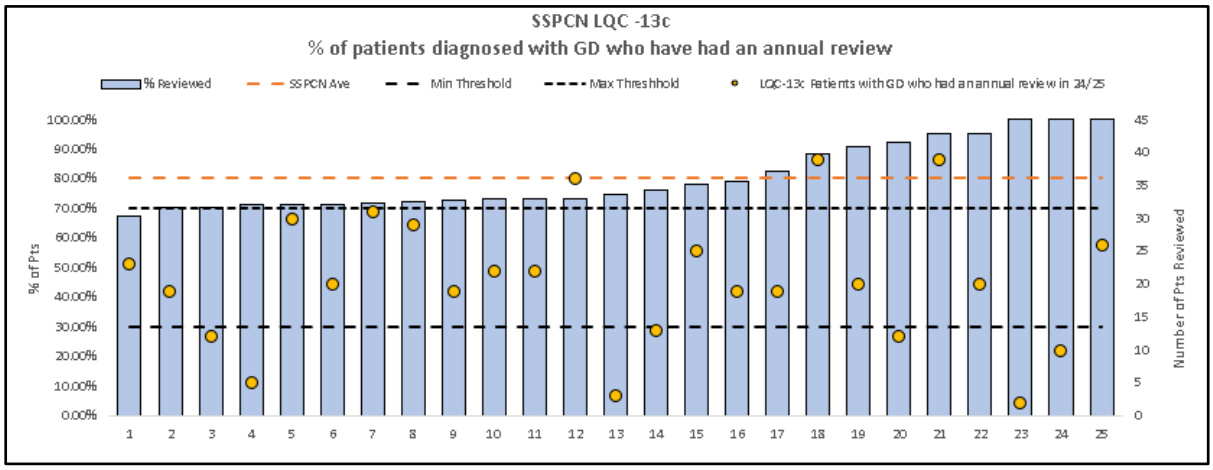
- The South Sefton average for carrying out an Epilepsy Annual review 78%, and Southport and Formby were 78%.
- The average number of patients who have received an epilepsy review has increased from phase 10 where South Sefton average was 73% However Southport and Formby seems to have decrease from phase 10 where it was 81%
- Individual Sefton practice achievement ranged from 56% to 93%

Gestational Diabetes

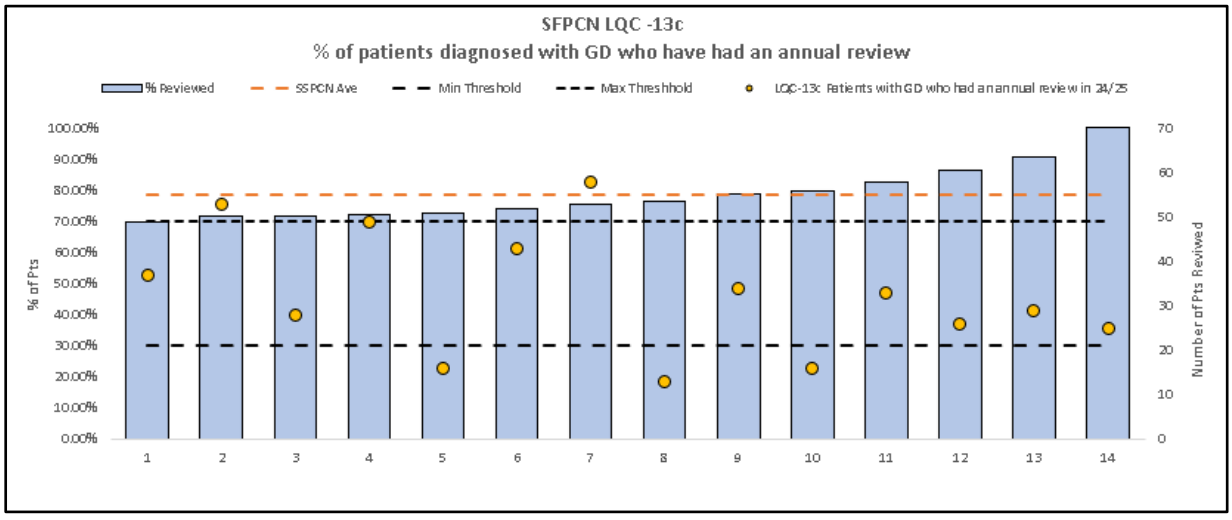
Practices were asked to identify patients with a history of Gestational Diabetes and offer them a review in accordance with NICE guidelines Recommendations | Diabetes in pregnancy: management from preconception to the postnatal period | Guidance | NICE. Practices were asked to refer patients to NDPP were appropriate.

Criteria	Pt No	%
LQC-13c Denominator (Number of patients who have a history of Gestational Diabetes)	1,250	
LQC-13c Number of patients who received a review	975	78%

South Sefton Practice – Number of patients with a history of gestational diabetes who have had an annual review



Southport and Formby Practices - Number of patients with a history of gestational diabetes who have had an annual review



Local Variation

(LQC 15c)

- The South Sefton average of patient with a history of gestational diabetes who received an annual review was 81%, and Southport and Formby were 79%
- The average number of patients with a history of gestational diabetes who have received an annual review has increased from phase 10 where South Sefton average was 77% However Southport and Formby seems to have maintained their average from phase 10 where it was 79%
- Individual Sefton practice achievement ranged from 68% to 100%

LGBTQ+ Accreditation

The evidence shows that the LGBTQ+ community have disproportionately worse health outcomes and experiences of health care. A National survey undertaken in 2017 describes a situation where this community faces discrimination, felt their needs were not being met and had major concerns about accessing health care.

Following this, the Government Equalities Office brought together a national LGBT+ action plan to tackle the issues that had been identified in the survey. To support this and reduce inequalities in Sefton we asked each of the practices to work toward the Navajo accreditation or equivalent.

Criteria	Pt No	%
LQC-13d Denominator (Number of Practices in Sefton)	39	
LQC-13d Number of practices who have gained accreditation or are working towards accreditation, awaiting a decision	13	33%

Local Variation

(LQC 13d) Some practices felt that the workload associated with these criteria exceeded the value of the indicator and as such decided not to undertake the accreditation.

Part 1 Medicines Management Prescribing Quality Schemes (PQS)

A Prescribing Quality Scheme has been delivered in Sefton for several years. The scheme consists of three main areas; optimised prescribing, controlled drugs, and antimicrobial stewardship. Each area has KPI indicators with outcomes defined in each quarter.

South Sefton - Compliance of practices in the PSQ key areas

Practice	Optimised Prescribing (70%)								Controlled Drugs (15%)	Antimicrobial Stewardship (15%)			Validation Outcome	
	Evidence of engaging with QIPP		Parenteral medication	Safety Searches		Monitoring	Increase prescribing of dry powder inhalers in asthmatic patients 10%							
	Evidence of engaging with individual workstreams 30%	Engagement with targeted QIPP areas 10%	GP practice has a robust recall system in place to ensure that patients receive medication administered parenterally at the appropriate intervals 10%	GP practice to review all patients identified on the Safety searches which include medications identified from MHRA alerts and CQC searches 5%	Data	Monitoring 5%	Review asthmatic patients prescribed MDI inhalers and where appropriate switch from MDI to Dry powder devices 10%	Data	6 monthly review of Controlled Drug (CD) prescribing data focusing on assurance that risks related to CDs are mitigated and that intelligence and learning is shared	Practice-based audit of the diagnosis/ treatment of infections 5%	Discussion at each practice quarterly meeting about antimicrobial resistance (AMR) including sharing of practice prescribing information for total antimicrobial items per STAR PU, items of trimethoprim prescribed for patients >70 years of age and % co-amoxiclav, cephalsporins and quinolones of total antimicrobial items 5%	Attending TARGET training at a PLT 5%	Medicine Management analysis/ recommendations	
MOORE STREET MEDICAL CENTRE	y	y	y	n	65% achieved	y	y		y	y	y	y	n	95%
BOOTLE VILLAGE SURGERY	y	y	y	y		y	y		y	y	y	y	y	100%
PARK STREET SURGERY	y	y	y	y		y	y		y	y	y	y	y	100%
EASTVIEW SURGERY	y	y	y	y		y	n	72.84% to 75.66%	y	y	y	y	n	90%
KINGSWAY SURGERY	y	y	y	y		y	n	68.35% to 70.70%	y	y	y	y	n	90%
BRIDGE ROAD MEDICAL CENTRE	y	y	y	y		y	y		y	y	y	y	y	100%
CONCEPT HOUSE SURGERY	y	y	y	y		y	y		y	y	y	y	y	100%
GLOVERS LANE SURGERY	y	y	y	y		y	n	75.64% to 76.39%	y	y	y	y	n	90%
PC 24 Great Crosby and Thornton F	y	y	y	y		y	n	72.50% to 73.47%	y	y	y	y	n	90%
PC24 Seaforth, Litherland and Neth	y	y	y	y		y	y		y	y	y	y	y	100%
PC24 Maghull Practice	y	y	y	y		y	y		y	y	y	y	y	100%
THE STRAND MEDICAL CENTRE	y	y	y	y		y	y		y	y	y	y	y	100%
MAGHULL HEALTH CENTRE DR SAI	y	y	y	y		y	n	72.43% to 73.93%	y	y	y	y	n	90%
ORRELL PARK MEDICAL CENTRE	y	y	y	y		y	n	71.71% to 73.11%	y	y	y	y	n	90%
NORTH PARK HEALTH CENTRE - PC	y	y	y	y		y	y		y	y	y	y	y	100%
15 SEFTON ROAD- pc24	y	y	y	y		y	y		y	y	y	y	y	100%
AINTREE ROAD MEDICAL CENTRE	y	y	y	y		y	y		y	y	y	y	y	100%
FORD MEDICAL PRACTICE	y	y	y	y		y	y		y	y	y	y	y	100%
Rawson Road Surgery	y	y	y	y		y	n	59.52% to 62.33%	y	y	y	y	n	90%
42 KINGSWAY	y	y	y	y		y	y		y	y	y	y	y	100%
Hightown Village Surgery - pc24	y	y	y	y		y	y		y	y	y	y	y	100%
Westway Medical Centre	y	y	y	y		y	y		y	y	y	y	y	100%
Blundellsands Surgery	y	y	y	y		y	y		y	y	y	y	y	100%
Liverpool Rd Medical Practice	y	y	y	y		y	n	69.08% to 74.03%	y	y	y	y	n	90%
High Pastures Surgery	y	y	y	y		y	n	65.43% to 66.35%	y	y	y	y	n	90%

Southport and Formby - Compliance of practices in the PSQ key areas

Practice	Optimised Prescribing (70%)								Controlled Drugs (15%)	Antimicrobial Stewardship (15%)			Validation Outcome	
	Evidence of engaging with QIPP		Parenteral medication	Safety Searches		Monitoring	Increase prescribing of dry powder inhalers in asthmatic patients 10%							
	Evidence of engaging with individual workstreams 30%	Engagement with targeted QIPP areas 10%	GP practice has a robust recall system in place to ensure that patients receive medication administered parenterally at the appropriate intervals 10%	GP practice to review all patients identified on the Safety searches which include medications identified from MHRA alerts and CQC searches 5%	Data	Monitoring 5%	Review asthmatic patients prescribed MDI inhalers and where appropriate switch from MDI to Dry powder devices 10%	Data	6 monthly review of Controlled Drug (CD) prescribing data focusing on assurance that risks related to CDs are mitigated and that intelligence and learning is shared	Practice-based audit of the diagnosis/ treatment of infections 5%	Discussion at each practice quarterly meeting about antimicrobial resistance (AMR) including sharing of practice prescribing information for total antimicrobial items per STAR PU, items of trimethoprim prescribed for patients >70 years of age and % co-amoxiclav, cephalsporins and quinolones of total antimicrobial items 5%	Attending TARGET training at a PLT 5%	Medicine Management analysis/ recommendations	
AINSDALE MEDICAL CENTRE	y	y	y	y		y	n	68.83% to 74.28%	y	y	y	y	n	90%
AINSDALE VILLAGE SURGERY	y	y	y	y		y	y		y	y	y	y	y	100%
CHAPEL LANE SURGERY/ the hollie	y	y	y	y		y	y		y	y	y	y	y	100%
CHURCHTOWN MEDICAL CENTRE	y	y	y	y		y	y		y	y	y	y	y	100%
CUMBERLAND HOUSE SURGERY	y	y	y	y		y	y		y	y	y	y	y	100%
CHRISTIANNA HARTLEY	y	y	y	y		y	y		y	y	y	y	y	100%
GRANGE SURGERY	y	y	y	y		y	n	60.05% to 62.50%	y	y	y	y	n	90%
KEW SURGERY	y	y	y	y		y	y		y	y	y	y	y	100%
NORWOOD SURGERY	y	y	y	y		y	n	62.52% to 64.49%	y	y	y	y	n	90%
ST MARKS MEDICAL CENTRE	y	y	y	y		y	y		y	y	y	y	y	100%
THE CORNER SURGERY (DR MULLA)	y	y	y	y		y	y		y	y	y	y	y	100%
THE FAMILY SURGERY	y	y	y	y		y	n	65.50% to 66.77%	y	y	y	y	n	90%
THE MARSHSIDE SURGERY	y	y	y	y		y	n	61.59% to 61.62%	y	y	y	y	n	90%
THE VILLAGE SURGERY FORMBY	y	y	y	y		y	n	74.41% to 78.32%	y	y	y	y	n	90%

Medicines management PQS evaluation

During 2025-2026 all practices continued to engage and support the Medicines Management ICB priorities with all practices achieving 100%

- 100% of practices supported the CRES priorities. The CRES target was £943,877 and we achieved £1,495,267.
- The prescribing support software saved £271,837.78 with all practices prescribing (for new initiations) in line with the ICB preferred choice 70% of the time
- 100% of practices provided us with a written policy around how they manage 'medicines prescribed elsewhere' ensuring the summary of care records are correct
- 100% achieved a target of reviewing 70% of patients identified on safety searches which include medications identified from MHRA alerts and CQC searches
- All practices engaged with 6 monthly reviews of Controlled Drug (CD) prescribing data working with the team to provide assurance that risks related to CDs are mitigated and that intelligence and learning is shared.
- All practices engaged with antimicrobial stewardship, completing an audit of the prescribing of 'Prescribing of High-Risk antimicrobials', to ensure prescribing is in line with the Cheshire and Merseyside formulary. All practices sent a GP to a Target training event and all practices engaged with a 6 monthly review of antimicrobial prescribing data.
- 100% achieved a target of reviewing 70% of patients identified as being prescribed 4 or more medicines with an unintended hypotensive effect

Part 1 Achievement/Validation

Achievement

Final year achievement is based on the information available through the LQC dashboard with a small number of indicators in Part 1 collected through practice assurance.

Validation

- A validation panel with representation from Primary Care Clinical Lead, Practice Manager Representative, LMC, Sefton Place Primary Care, and Medicines Management Teams took place in June 2026
- Anonymised practice LQC dashboard and assurance data was reviewed.

Communication to practices took place following the validation process, which included a summary of practice achievement and funding implications.

Practices where a final payment was due, received full payment in August 2026.

Appeals

Practices were advised of the appeals process.

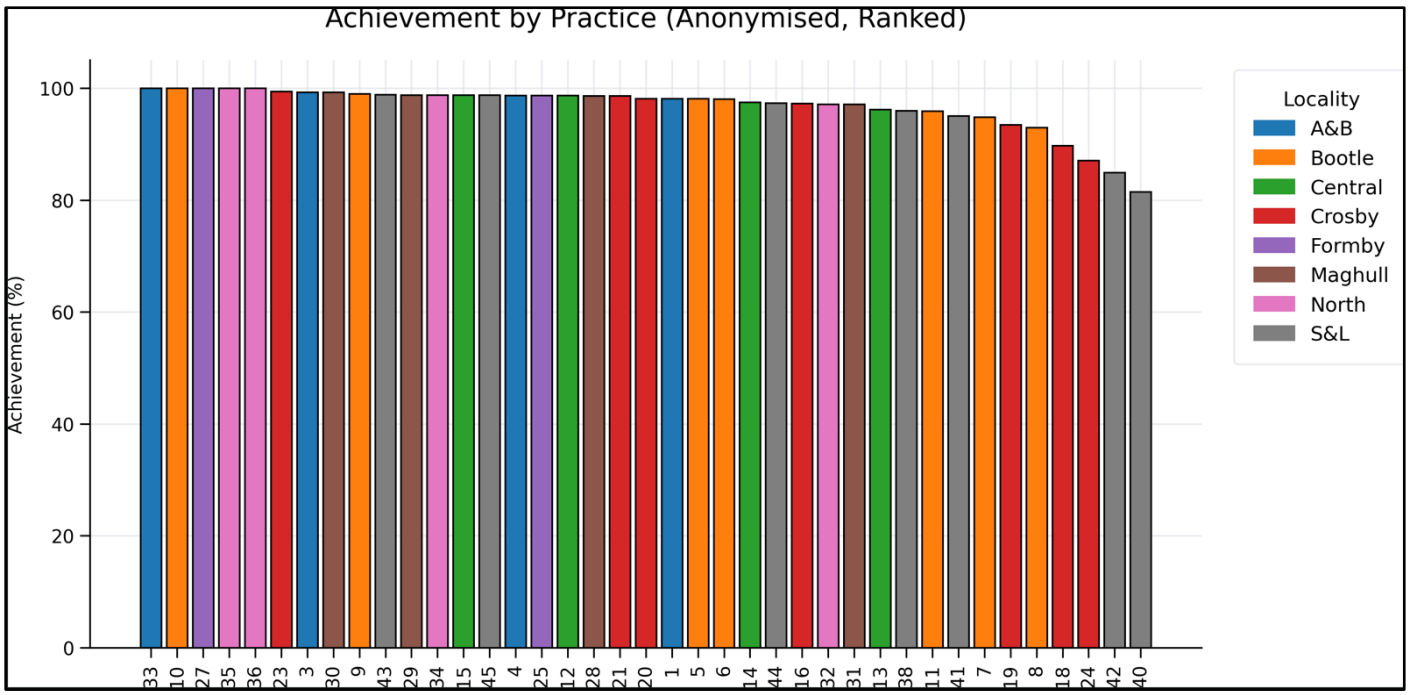
- Appeals from 3 practices were received, spanning several indicators and reasons
- All 3 practices appeals were upheld
- An appeals panel which had LMC, clinical and Sefton Place managerial representation was held virtually via email to review anonymised data

The outcome of the appeal was shared with each practice, including their final financial achievement.

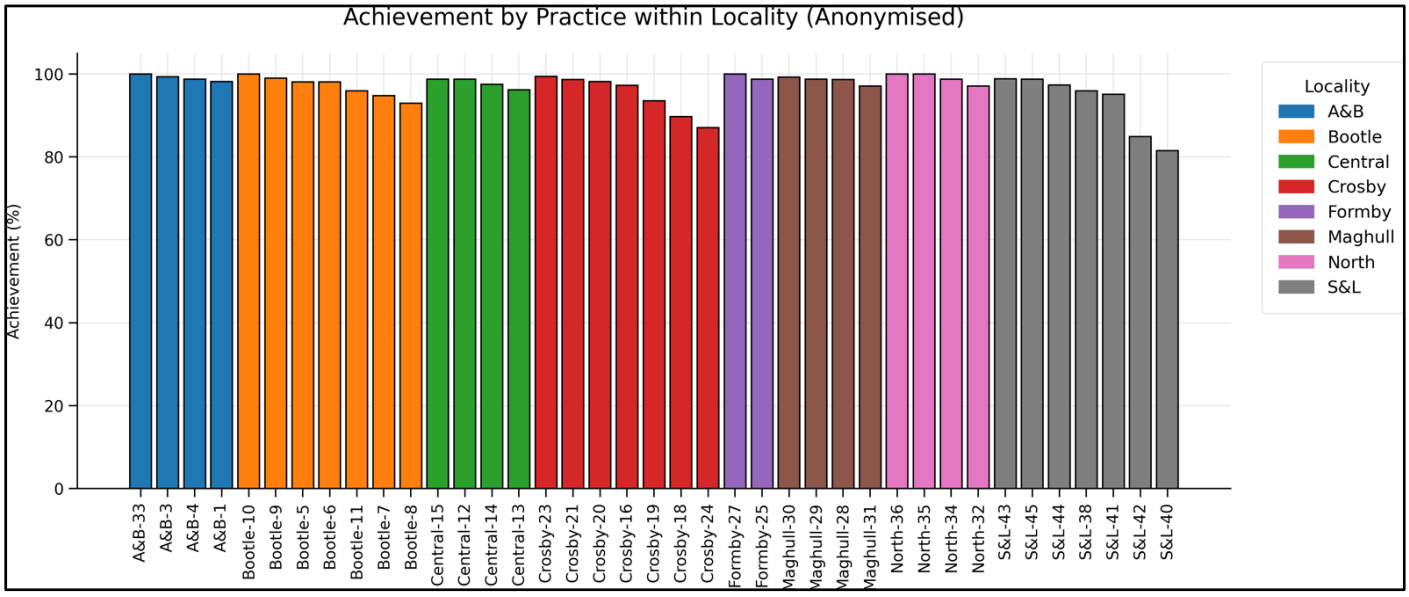
Achievement data shows:

- Practices in order of achievement identified by locality.
- Achievement placed in order of locality
- Achievement comparison between Phase 9, Phase 10 and Phase 11
- Achievement across Sefton which ranges between 81% - 100%.
- Overall achievement is higher than previous year
- 90% (35 practices) achieved between 90 – 100%
- 10% (4 practices) achieved between 75 – 89%

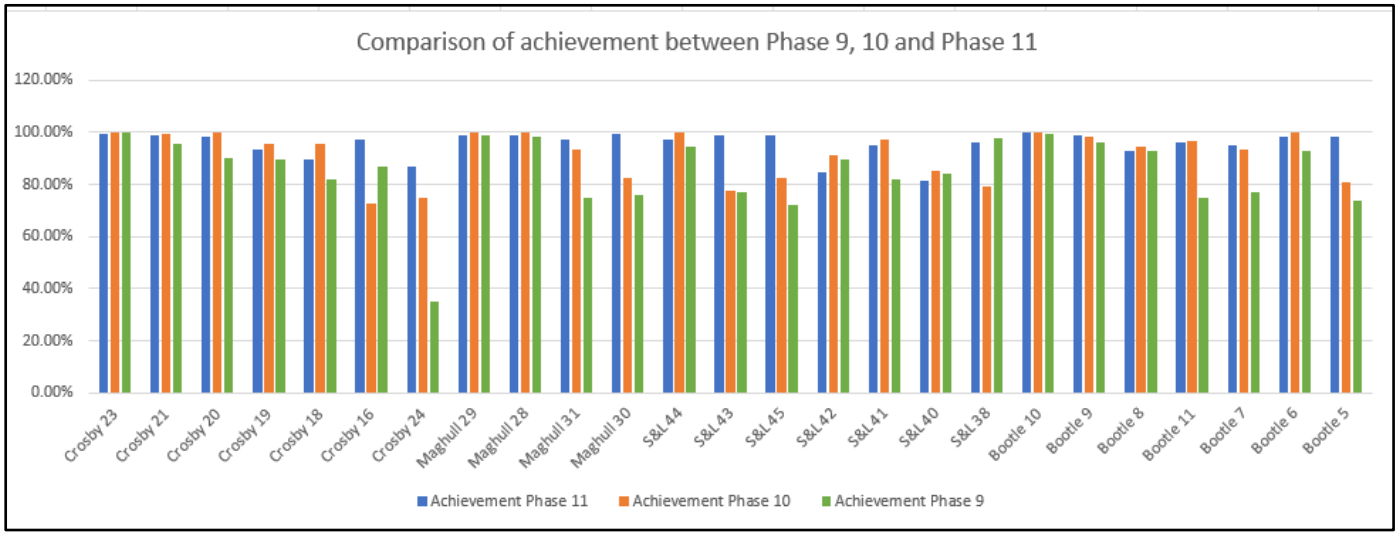
Anonymised Achievment placed in order of achievement



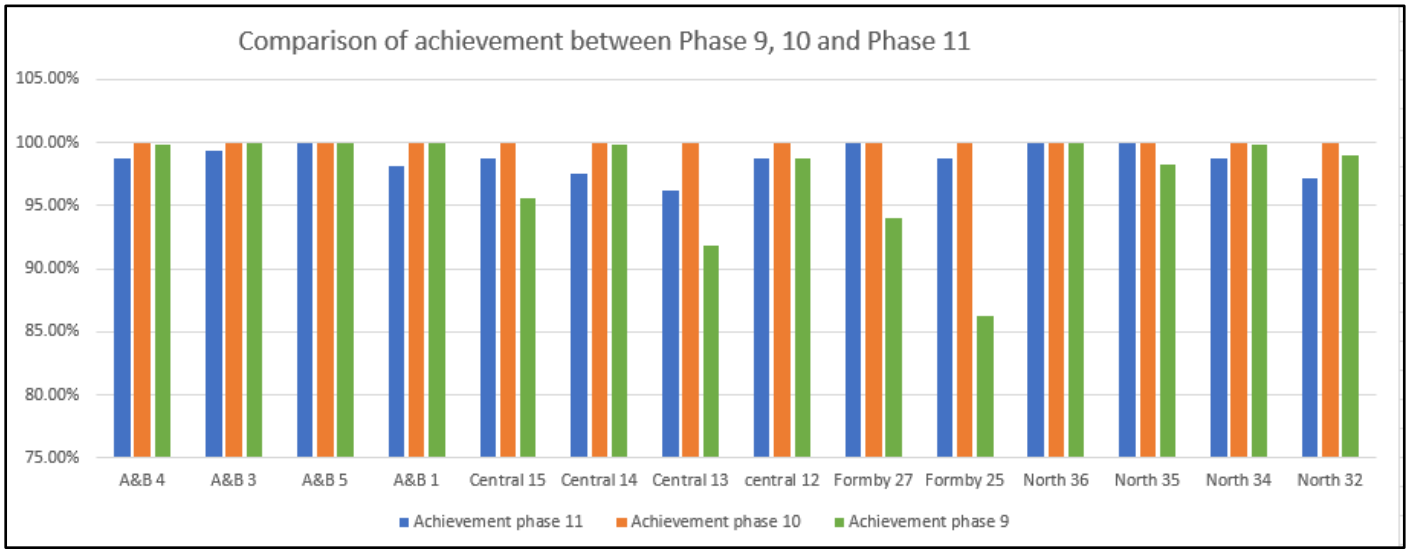
Anonymised Acheivment placed in order of Locality



Comparing Phase 9 Achievement to Phase 11 Achievement by South Sefton Practice



Comparing Phase 9 Achievement to Phase 11 Achievement by Southport and Formby Practice



SCHEMES OVERVIEW/OUTCOME – PART 2 AND 3

Scheme Overview

Part 2 and 3 schemes are optional. Part 2 schemes are available to any practice to take part in whilst Part 3 schemes are only available to those practices who can deliver on behalf of other practices, dependant on available populations.

Practice summary of schemes signed up to

Criteria	No of SS Practice	No of SF Practices
Part 2 Schemes		
Number of practices	25	14
Phlebotomy	24	14
Primary Care Prescribing (Shared Care)	25	14
Drug Administration	25	14
Convert Drug Administration	24	14
Dementia	25	14
Frailty, Fails and Fracture Review	25	14
Winter Pressures	25	14
Compression Hosiery Leg Measurements	9	6
Part 3 Schemes		
Vulnerable Patients Resettlement Scheme	0	0
Travellers	1	1
ABPI	4	5
Designated Medical Prescribers	2	1

OUTCOME OF PART 2 AND 3 SCHEMES

Phlebotomy

A phlebotomy scheme in general practice has been available for several years, as the demand for phlebotomy since the introduction of QOF has risen significantly, and demand cannot be met by community/secondary provision alone, neither is it cost effective or convenient for patients without a general practice offer. For these patients, a reduction in time spent in hospital and a reduced number of trips is an important outcome. Furthermore, as a great deal of phlebotomy activity takes place in community care it is important to recognise the reduced pressure on community treatment room services and impact on waiting times.

1 practice in Sefton did not participate in the phlebotomy scheme.

Phlebotomy	Activity	Cost per Venepuncture
	113,098 venepunctures have taken place in primary care	£2.78

Primary Care Prescribing

This scheme has been in the LQC for several years and focuses on prescribing, monitoring and supervision of patients in a primary care setting, who would otherwise be treated in secondary or tertiary care.

It enables practices to be confident in agreeing to accept the legal and clinical responsibility for undertaking prescribing recommended by secondary care within the Cheshire and Merseyside Area Prescribing Group (CMAPG)

Primary Care Prescribing	Activity	Cost
Amber Fixed Annual Fee	£2,875.67 fixed annual fee, based on list size of 5,000	There is no unit price defined
Purple Shared Care	3,067 patients receiving monitoring for purple drugs	£188

Drug Administration

The Drug Administration scheme's primary outcome is that savings are made by moving drug administration away from secondary care and into primary care. In addition to this, the number of instances where drug administration is carried out in primary care - rather than secondary care – can be used as a qualitative outcome i.e. in each instance, a patient has been able to access care closer to home, rather than in an acute trust.

Drug Administration	Activity	Cost per Injection
	2,066 injections have been administered in primary care	£34.10

Covert Drug Administration

This scheme was introduced several years ago to ensure there was a process for managing situations where it is deemed in the best interest of the patient to administer medicines covertly which is safe, legal and ensures patients human rights are upheld.

Covert administration is a complex issue involving formal decision-making between a multidisciplinary team. It is essential that there is a formal process in place to facilitate the least restrictive option to a patients' rights and freedom. Following a full medication review by a pharmacist in discussion with a patients GPs a management plan is formulated. This plan is medication specific and ensures only medication that is considered essential is continued. It outlines how the medication can be covertly given safely, taking into consideration pharmaceutical issues around individual medication. It is important that the plan is regularly reviewed as capacity can fluctuate and the patient's situation and needs can change.

Covert Drug Administration	Activity	Cost per Review
	30 patients underwent an initial review	£271.08 per initial review
	79 had a follow up review	£216.84 per follow up review

Dementia

This scheme's objective was to identify patients at risk of dementia. Patients who have a diagnosis of mild cognitive impairment should have an annual review until such time transient state resolves or progresses to dementia.

Dementia	Activity	Cost per Review
	242 annual reviews of patients with mild cognitive impairment	£64.41

Frailty Falls and Fracture Reviews

This scheme was introduced in Phase 10 and continues in phase 11, to link in with the Part 1 Frailty scheme criteria. The scheme focused on patients who were not known to have osteoporosis but had had an accidental fall and may be at risk of osteoporosis. Patients were then offered a clinical review to determine management plan.

Frailty, Falls and Fracture Reviews	Activity	Cost per Review
	1,248 patients underwent a review	£83.35
	125 patients diagnosed with osteoporosis following review	

Winter Pressure Scheme

This scheme was introduced in Phase 10 and continues in phase 11, to help practices respond to increased activity in general practice, prevent patients inappropriately accessing secondary care, or attending emergency services, during the winter months (October 2025 to March 2026). Individual practices were able to decide on areas of prioritisation, from dealing with backlog of chronic disease reviews, extra clinical appointments or increase administrative support. Practices were allocated £1.02 per weighted patients and asked to make the most efficient use of resources whilst taking into consideration available skill mix/workforce.

Below is the total activity put into place.

Winter Pressures	Activity
Extra Appointment Total	21,288
F2F	12310
Telephone	4094
Online	4887
Extra Administrative Hours	140

Compression Hosiery Leg Measurement

This scheme was introduced in Phase 9 of the LQC and has continued in Phase 11 as demand for leg measurements for compression Hosiery had significantly increased with no commissioned services locally. practices were paid per patient; this could include measuring both legs.

Leg Measurement	Activity	Cost per Analysis
	273 people had legs measured	£3.61 per person

Vulnerable Patient Resettlement Scheme

The scheme aimed to ensure that the complex issues faced by vulnerable persons arriving from overseas could be managed within the Locality/ICB area. However, there was no families on the resettlement scheme this year.

Vulnerable patient Resettlement Scheme	Activity	Cost per Analysis
1 practice	Retainer fee per 5000 patients	£619.59
	0 patients	£120.70 per person per annum £30.18 per person per quarter

Gypsies & Travellers

There is a well-established Gypsy & Traveller population within the locality/ICB area. There is 1 practice in Southport and 1 practice in South Sefton offering this scheme; these align geographically to where the settlements are. This scheme looked at the obstacles facing Gypsies & Travellers and then attempted to alleviate these as far as possible through requesting that GPs take into account the unique nature of this community and applied guidelines for the practices to employ. The health outcomes that have been identified by this report may well be difficult to measure; however this proactive approach will foster better long term health and take pressure off other areas of the health and social care economy. Furthermore, for the patients themselves it will improve long term health as well as dealing more effectively with chronic conditions.

Travellers	Activity	Cost per Patient
	Retainer fee per 5000 patients	£619.59
	74 Patients are part of this scheme	£118.16 per patient per annum £30.18 per patient per quarter

ABPI

ABPI (Ankle-Brachial Pressure Index) for peripheral arterial disease (PAD) was introduced in order to provide care and diagnostics which traditionally would have been done in secondary care. The ABPI scheme can be looked at both as an efficiency saving (by reducing outpatient attendances) and as a quality improvement in terms of care as it allows people to be diagnosed and treated closer to their home and without the need to go to hospital.

ABPI	Activity	Cost per Test
	676 ABPI taken place	£33.19

Designated Medical Practitioner (DMP)

This scheme was introduced in Phase 10 and continues in phase 11 to support training of pharmacists to enable them to become prescribers. Two Clinical pharmacists were mentored during 2025-2026. The development of non-medical prescribers (NMPs) enables appropriately trained healthcare professionals to expand their roles and fully utilise their skills and competencies to enhance patient care across diverse settings. The designated medical practitioner (DMP) plays a vital role in supporting trainee NMPs by

providing access to a patient-centred environment where they can safely develop and practice prescribing skills under supervision. The practical training period is essential to the development of safe and effective prescribers. NMPs facilitate timely access to medicines, enhancing patient choice while reducing the demand on primary care services and easing the workload of GPs

DMP	Activity	Cost per Placement
	2 Pharmacists underwent training	£4,036

KEY FINDINGS

Supporting Neighbourhood Health

The Phase 11 LQC demonstrates strong alignment with and delivery of neighbourhood working priorities across Sefton, underpinned by clear and measurable outcomes across priority areas. In frailty, 83% of patients on osteoporosis pathways received a clinical review, alongside 1,248 frailty, falls and fracture reviews, evidencing a proactive, preventative approach to managing an ageing population and reducing avoidable harm. In mental health, there has been a marked improvement in both identification and engagement, with 91% of case-finding cohorts reviewed, 45.5% of patients on the SMI register receiving a full physical health check, and 79% of non-responders successfully engaged through referral to Mersey Care community teams, demonstrating effective partnership working and outreach to underserved groups. This is further strengthened by 78% of carers, veterans and LGBTQ+ patients being offered depression screening, supporting earlier intervention and addressing health inequalities at neighbourhood level.

Children and young people's outcomes are supported through improvements in long-term condition management, including 75% of asthma patients (aged 12+) being transitioned to safer SABA-free pathways, reducing exacerbation risk and future demand on urgent care. More broadly, neighbourhood-based, coordinated care is evidenced through palliative care improvements, where over 2,100 patients had a care plan in place shared with out-of-hours and ambulance services, contributing to 57% of patients dying in their preferred place of care, a key indicator of personalised, integrated care delivery. Preventative population health approaches are also evident, with 92% of bowel screening non-responders contacted within 42 days, resulting in a substantial proportion subsequently engaging with screening programmes.

The LQC has also demonstrably increased system capacity and supported care closer to home, with over 21,000 additional winter appointments delivered, alongside high volumes of activity such as 113,098 phlebotomy procedures and over 2,000 drug administrations undertaken in primary care, reducing reliance on secondary care services. These improvements are supported by strong infrastructure for neighbourhood working, including 100% practice engagement in medicines optimisation and delivery as well as high uptake of digital and access initiatives, with 77% of eligible patients proactively supported to use online services. Collectively, these outcomes provide clear evidence of a mature neighbourhood model in Sefton, delivering coordinated, preventative, and person-centred care, improving population health outcomes while reducing inequalities and system pressure.

Quality Improvements - *Patient Care*

- End of Life patient care plans have been shared with NWAS and OOH supporting enabling professionals outside of general practice, to support patients according to their wishes.
- Improvement on Sefton position on EPACCS data
- Reviewing patients on DOACs ensures medication is prescribed safely and reduces the risk of patient having a stroke or adverse bleeding incidents, therefore reducing the need for urgent care interventions.
- Manual pulse checks have identified patients who were previously undetected with Atrial Fibrillation, with the correct treatment we can avoid more serious health conditions such as strokes and other long- term conditions
- A focus on case finding has identified patients with undiagnosed dementia, osteoporosis, and depression in carers, Military Veterans and patient in the LGBTQ+ community, enabling them to access treatment and reduce the risk for urgent care interventions
- There has been a focus on conducting reviews for renal function, CKD, diabetes, gestational diabetes, cognitive impairment, epilepsy, serious mental health, hypertension, patients on DOAC medications, frailty and Covert Drug Administration. This has enabled current treatment plans to be adjusted where necessary and bring in additional support.
- Enhanced patient safety through adherence to Local and National guidelines such as NICE
- Patients who were non-responders for the national bowel screening programmes, went on to have screening following encouragement from their practice
- Giving patients written information and recording safety netting advice about their cancer referral may reduce patient anxiety and make them more likely to attend appointments and compliance with interventions.
- Patients generally wish to access primary care as close to home as possible and many of the schemes (phlebotomy, primary care prescribing, drug administration, compression hosiery and ABPI) increased the ability for patients to do this
- Recording reasonable adjustments for patient whose first language is not English or who have a visual or hearing impairment means patients can access health care easier reducing health inequalities and supports Accessible Information Standards and the Equality Act 2010
- Reduction in health inequalities through targeted support for vulnerable populations (e.g. SMI, carers, LGBTQ+, Gypsy & Traveller, Vulnerable Patient Resettlement Scheme)
- Increase capacity in general practice to support to support the wider health economy during the winter period
- Standardisation of health care across Sefton reducing inequalities
- Improved patient experience due to better delivery of care
- Underpins priorities in Core20PLUS5
- Enhanced data-driven decision-making and continuous quality improvement through robust KPI monitoring and validation processes

Efficiencies in Spend Elsewhere in the **Health Economy**

Financial Implications – there are several caveats in relation to this section as Secondary Care and Community Trust contracts do not have the breakdown of individually priced costs that can be used as a comparison; therefore, this section is difficult to quantify, however, should all this activity have taken place in Secondary Care this would have resulted in an increase in the block contract for the following year. Several common-sense assumptions have been made regarding reduced hospital outpatient attendances and admissions.

- Practices have worked with the Medicines Management Team to deliver the Prescribing Quality Scheme with a good degree of compliance
- Sharing the knowledge of an end-of-life care plan with NWAS and OOH has reduced inappropriate hospital admissions

- Identifying and treating patients with undiagnosed AF, CKD, Diabetes, Frailty, Dementia, Osteoporosis and Depression has reduced the risk of unplanned admissions to hospital and of patients requiring packages of social care
- Phlebotomy takes place in at least three separate providers (community services, primary care, and secondary care), therefore, due to the caveats above cost saving are not immediately clear. It is likely that without the primary care scheme most appointments would have taken place in the community, placing pressure upon treatment room capacity, and waiting times
- Drug administration and Primary Care Prescribing has reduced the need and cost for outpatient secondary care appointments
- ABPI (Ankle-Brachial Pressure Index) which took place in primary care has reduced the need and cost for outpatient secondary care appointments
- Hosiery is recommended to provide graduated pressure for the distal to proximal portion of the leg and increase venous blood flow my improving the action of the calf muscle pump. Hosiery can only be provided following appropriate assessment and measurement. Leg measurement for compression hosiery was done in primary care as there were no alternative commissioned services.
- Additional 21,288 appointments in general practice over the winter months will have prevented increased pressure in urgent care settings such as A&E or urgent care centres
- Reduced costs for patients in terms of travel expenses
- By keeping services in the local community would reduce the need for use of transport thus reducing carbon emissions. This Supports 'Delivering a Net Zero National Health Service'
- LQC practice payments reflect practice actual achievement.
- Improved utilisation of workforce through skill mix (e.g. nurses, HCAs, pharmacists) and additional capacity planning.
- Increased digital utilisation (e.g. NHS App, online prescribing), reducing administrative burden and transactional costs
- PQS Schemes made savings of £1,495,266

Sustainability of General Practice

Skills & Capacity

- Investment in General Practice overall to invest in workforce and services to improve capacity and access in general practice
- The Digital Champion programme has supported training across GP practices in digital developments reducing the use of paper significantly
- Encouraging preventative care via screening programmes and annual health check reducing the need for urgent or complicated interventions
- Reducing travel emissions by offering remote or digital appointments where appropriate
- The digital Champion programme has supported patients accessing digital technology for health care as an alternative to telephoning practices or using unnecessary appointments.
- Investment in winter access funding to increase appointments and administration time to deal with increasing demand.
- Practices were able to increase income and capacity by delivering part 2 and 3 schemes
- Training was provided during 2025/26 to upskill staff to expand their competencies
- By investing in staff via training, staff are more likely to remain at practice supporting recruitment and retention.
- Increased digital inclusion and patient empowerment through promotion of online access and NHS App usage reducing the administrative burden on practices.
- Practices worked collaboratively with Mersey Care Physical Health team to offer SMI annual health checks to those harder to reach patients.

CONCLUSION

- All practices had the same opportunity to access equitable funding to deliver the LQC supported by the Primary Care Team, Medicines Management Team and the Information Facilitator Team
- There will be a cost of ongoing monitoring and prescribing for patients identified with new long-term conditions, however this will reduce late diagnosis and possibly prevent disease progression through earlier treatment
- There is less variation in Part 1 achievement across practices compared to Phase 10
- For the small variation that does exist, there does not appear to be a link between demographics and lower achievement (Locality Rank by Achievement Table Page 45).
- Comparison between South Sefton PCN and Southport and Formby PCN shows a greater Part 1 achievement overall in Southport and Formby PCN, however South Sefton have made a significant increase in achievement from Phase 10
- There is clear evidence of improved integration and partnership working across the system, particularly with community and specialist services (e.g. Mersey Care, NWAS, Medicines Management), enabling coordinated care delivery and improved patient engagement, especially for harder-to-reach populations.
- The LQC has demonstrably supported a shift toward preventative and proactive care, with high levels of screening, case finding and early intervention (e.g. frailty, cancer screening, mental health), which is expected to reduce future demand on urgent and secondary care services.
- The programme has increased primary care capacity and contributed to system resilience, evidenced by additional winter appointments, expanded service delivery (e.g. phlebotomy, drug administration), and the ability to manage more care within community settings.
- There is strong evidence of tackling health inequalities through targeted interventions, including focused work with SMI patients, carers, veterans, LGBTQ+ populations and Gypsy & Traveller communities, improving access and outcomes for underserved groups.
- Standardised approaches, shared templates and consistent coding have supported more equitable and consistent delivery across practices, reducing unwarranted variation and supporting scalable neighbourhood working.
- Digital transformation has supported both patient access and workforce development, with widespread uptake of digital champions and proactive engagement with patients to improve use of online services, although some variation in engagement remains.
- The LQC framework supports neighbourhood-level delivery by enabling flexibility in responding to local population needs, while maintaining a consistent core standard across Sefton.

RECOMMENDATIONS

- Achievements via the LQC to be recognised with further areas of focus for future LQC schemes to be developed.
- Continue to offer Clinicians and Practice Managers participation in sessions to introduce and discuss new LQC schemes to ensure full understanding and expectation.
- Encourage practices to plan LQC work across all 4 quarters and to engage with their Information Facilitators to understand practice progress throughout the year.
- Offer all practices the opportunity to discuss LQC achievement during Locality Meetings
- Undertake targeted analysis to understand and address the differences in achievement between South Sefton and Southport & Formby PCNs, including sharing best practice and identifying system or workforce factors contributing to variation

- Practices who consistently underachieve in the schemes should be supported to improve achievement to reduce variation between practices.
- Further strengthen partnership working with community and secondary care teams (e.g. Mersey Care, NWAS) to build on successful engagement models and improve outcomes for complex and hard-to-reach patients.
- Use evaluation findings to refine future LQC indicators, focusing on areas with the greatest population health impact and opportunities for system-wide benefit.

Abbreviations

104	This is a snomed code that indicates that the patient record cannot be shared online
106	This is a snomed code that indication that the patient record can be shared online
6 CIT	Six Item Cognitive Impairment Test
ABPI	Ankle Brachial Pressure Index
ACR	Albumin to Creatine ratio
A&E	Accident and Emergency Department
AF	Atrial Fibrillation
APC	Area Prescribing Committee
APG	Area Prescribing Group
APMS	Alternative Provider Medical Services
ARI	Acute Respiratory Infection
BMD	Bone Mineral Density
BMI	Body Mass Index
CABG	Coronary Artery Bypass Graft
CCG	Clinical Commissioning Group
CD	Controlled Drugs
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
CPHT	Community Physical Health Team
CQRS	Calculating Quality Reporting Service
CVD	Cardiovascular Disease
DES	Direct Enhanced Service
DMP	Designation Medical Practitioner
DOAC	Direct Oral Anticoagulants
DPP	Designated prescribing Practitioner
DSA	Digital Skills Assessment
eGFR	Estimated glomerular filtration rate
EMIS	Practice Clinical System
EOL	End of Life
EPaCCS	Electronic Palliative Care Coordinating System
EPPS	Electronic Prescribing Service
ERRIS	Clinical Recording System use by Ambulance Service
FIB-4	A scoring system used to assess liver fibrosis risk
FIT	Faecal Immunochemical test

FRAX	Fracture Risk Assessment Tool
GMS	General Medical Services
GP2GP	Process for moving patient records electronically
GSF	Gold Standard Framework
HBA1C	Blood test showing glucose levels
HPV	Human Papilloma Virus
HTN	Hypertension
ICB	Integrated Commissioning Board
KPI	Key Performance Indicators
LD	Learning Disability
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and others
LMC	Local Medical Council
LQC	Local Quality Contract
MART	Maintenance and Reliever Therapy; asthma treatment
MMT	Medicines Management Team
MS Teams	Microsoft Teams
NAFLD	Non-Alcoholic Fatty Liver Disease
NCVIN	National Cardiovascular Intelligence Network
NWAS	North West Ambulance Service
OOH	Out of Hours
PCN	Primary Care Network
PAD	Peripheral Arterial Disease
PCARP	Primary Care Access Recovery Plan
PLT	Protected Learning Time
PHQ9	Patient Health Questionnaire
PMS	Personal Medical Services
PQS	Prescribing Quality Scheme
QIPP	Quality Innovation Productivity Prevention
QOF	Quality Outcome Framework
RCGP	Royal College of General Practitioners
S&F PCN	Southport and Formby Primary Care Network
SS PCN	South Sefton Primary Care Network
SDS	Spine Directory Service
SMI	Serious Mental Illness
SPICT	Supportive and Palliative Care Indicators Tool
SS PCN	South Sefton Primary Care Network
U&E	Urea and Electrolytes (blood test)
VPR	Vulnerable Patients Resettlement Programme

Appendix 1 – Digital Champion Programme Evaluation

DCN Year 1 Feedback Survey Report - Sefto

Appendix 2 – Digital Champion Nursing Programme Evaluation

Sefton Nurses end of year report 2025-26.p