Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Meeting of Primary Care Commissioning Committee

Date: 25th May 2021
Time: 9:30am-12pm
Location: Microsoft Teams

Agenda Number :	7	
Title:	Community Phlebotomy Local Enhanced Service for General Practice	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Decision		
Key Points for Discussion:		

This paper sets out the background to the development of a Local Enhanced Service for secondary care initiated phlebotomy. It describes the current situation of an informal shift of work from acute to general practice and the associated risks. It sets out the work undertaken to date to understand and address this shift and describes a proposal on how to safely transfer bloods out of three acute hospitals to the community, through the use of new digital requisitioning and new uses of existing IT systems. This model of care will allow patients to access phlebotomy at their GP practice as a critical piece of infrastructure to support the digital transformation of acute outpatient departments. The paper also describes the funding mechanism in Q4 20/21 and Q1 21/22 and proposes funding arrangements for Q2 21/22 onwards. The paper recommends acute outpatient growth funding is used within the 2021/22 planning round to fund the service as well as Local Enhanced Service underspend.
The papers also include the Local Enhanced Service specification for the Committee's consideration, and the standard operating procedure.

Recommendations:	To approve • The Local Enhanced Service Specification • The proposed funding mechanism for Q2 21/22 onwards

Previously Considered By and feedback :	Healthier Together Community Phlebotomy Operational Group Healthier Together Outpatients Board Healthier Together Clinical Cabinet LES Steering Group April/May 2021 Primary Care Operational Group May 2021
Management of Declared Interest:	None declared
Risk and Assurance:	Governance for this work will continue through the Community Phlebotomy Operational Group; reporting will also be through this group as well as LES Steering Group and Primary Care Contracting. The main risks are: If funding is not agreed this may delay the go-live date Transformation within the Trusts may be delayed due to resource and therefore impact go-live date Practices may not sign up to the LES which will result in an inconsistent service for patients across BNSSG As we are unsure of demand and primary care capacity there is a risk that practices will not be able to manage the additional activity resulting in using overspill/patients being bled in secondary care.
Financial / Resource Implications:	Funding to date has been a block offer from Covid funds for Q3-Q4 20/21 and rollover to Q1 21/22. There is guaranteed funding until end of Q2 via Covid funds; the proposal utilises Covid funding with a small contribution from LES underspend in Q2. We are proposing an item of service payment from 1st October funded from outpatient growth money and LES underspend. This will then be set as a system priority for 22/23 as budgets are committed against priorities.
Legal, Policy and Regulatory Requirements:	There are no known specific legal requirements.
How does this reduce Health Inequalities:	This service ensures that care is delivered as close to home as possible for patients.
How does this impact on Equality & diversity	Quality assurance in the form of patient and staff surveys, audit and reporting will highlight any areas relating to equality and diversity, or variation to service; these will then be addressed accordingly
Patient and Public Involvement:	To support the development of an out of hospital model for phlebotomy, patient and public views have been sought. Engagement work has been conducted with patients attending the South Bristol hub and North and West Locality practices pilots.
Communications and Engagement:	Clinical Cabinet has been engaged and supports this work as does the Outpatient Board. Clinical Leads in Trusts have been identified and are supporting with internal communications. GPs have been engaged via membership discussions and the GP Bulletin.

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Sponsoring Director / Clinical Lead / Lay Member:	Lisa Manson, Director of Commissioning

Please keep these front pages to a maximum of two

Agenda item: 7

Report title: Community Phlebotomy Local Enhanced Service for General Practice

1. Background

General practice has been responding to secondary care requests for bloods for many years without clinical governance in place, and up until November 2020 this work was unfunded. This has long been raised as an issue by general practice but to date, the system has been unable to agree a formal arrangement to manage and fund this work. Additional challenges have been raised in relation to the handover of requests and results, due to a lack of interface between the different digital systems at acute trusts and practices. Phlebotomy carried out in general practice at the request of secondary care has been communicated by letters from secondary care and has resulted in blood results being returned to the GP rather than the specialist requesting the test. This causes delays in patient care and increased work for general practice. The clinical responsibility has therefore rested with the GP rather than the consultant, with the latter being best placed to interpret the results, hold clinical risk, and adjust the management plan for the patient.

As the potential scale of COVID-19 infections in BNSSG became clear, the transformation of outpatient services was accelerated, which included a review of phlebotomy services. In March 2020 it was estimated that acute hospitals may become up to 70% COVID positive at the peak of the epidemic, and as such action was being taken across multiple services and pathways to keep vulnerable patients away from acute settings as much as possible. Remote consultations were enabled quickly in secondary care and a requirement to carry out blood tests in the community to facilitate remote working is needed to support this transformation.

A system-agreed solution was required with robust governance, where all partners had a clear understanding of the principles and processes to hold patient care between system providers.

The scale of the change proposed should not be underestimated. With 575 WTE GPs and 2780 medical staff across 77 GP practices and 3 acute trusts, there are complex clinical, cultural, technical, and financial considerations to this project.

2. Strategic Case for Change

The changes that happened in response to the pandemic should be seen in the context of the wider strategic ambitions for outpatient transformation. The relevant elements of the Strategic Agreements for Outpatients (signed off by all CEOs, June 2020) and 5 Year Plan (signed off by all CEOs, 2019) are:

- ***Traditional face to face appointments are no longer the default option*** – the switch to virtual review of patients' needs to be underpinned by systems and processes that make this simple for the patient and clinician. One of the central pillars is a phlebotomy provision that allows bloods to be taken close to a patient's home and results available to the requesting clinician
- ***More people are managed locally in integrated care partnerships*** – at present, the vast majority of patients have to travel to busy city centre hospitals unnecessarily for blood appointments. Community phlebotomy will shift this activity closer to where patients live
- ***Every interaction delivers maximum value for user*** – We know from patient reported data that 13% of appointments add little or no value for the patient. We also know that clinicians report a considerable amount of low value outpatient activity. Putting in place infrastructure to take and monitor bloods without the need for an attendance will enable acute clinicians to focus on higher value activity, and patients will only attend when it is value-adding.
- ***Clinic resources are fully utilised*** – The increased use of digitally-enabled remote monitored will enable us to remove a considerable amount of low value outpatient activity, reserving specialist consultant time for patients who really need it. One of the fundamental enablers of this digital and pathway transformation is a well-functioning phlebotomy service.

3. Community Phlebotomy Operational Group

Early on in the Covid response it was recognised that a specific group would need to be convened to address this work. The Community Phlebotomy Operational Group has membership from the acute Trusts, Sirona, One Care and a general practice lead as well as CCG and Healthier Together. A short lived Strategic Group formed to set the direction of the Operational Group; once this was established, the Operational Group met weekly to take this forward.

The set of principles agreed a commonality that would support the service design. These principles supported the decision making of how, when and where phlebotomy could be provided within any constraining factors of the project such as digital interface or workflow complexities.

Principles:

Scope. To contain the complexities of the project, initially only acute generated phlebotomy will be within scope, as well as devising a way to recognise and capture this activity to ensure primary care services are set up to support the acute outpatient digital agenda.

- **All phlebotomy transfers should not in any way fragment pathways.** For instance, some bloods should remain in an Outpatient setting, with a point of care test and then a treatment given, based on results.
- **The clinician who requests a test should receive the results on ICE**. Early in the community phlebotomy project, a proposal was taken to Clinical Cabinet, which mandated that results should be returned to the requesting clinician.
- **Place based decision making.** Patients and local service providers supporting these populations are best positioned to ascertain where phlebotomy services are undertaken. The

Kings Fund recommends 80 per cent of decisions are taken at the level of place and 20 per cent at the wider system level.

- **Safety and risk.** Any new pathways and associated workflows will be assessed on a risk basis. There will be a requirement that they are supported by all clinicians across the partnership.
- **Economic neutrality.** The impact of moving provision of phlebotomy services to community settings must be cost neutral to the system. It must include consideration of transport costs, legacy bloods, new acute digital pathways, and service reconfigurations associated with phlebotomy being delivered in a different location, such as the base of phlebotomy staff.
- **Pace.** Acute trusts have a collective recognition for pace, noting pressure to deploy digital outpatient working to allow social distancing in acute outpatient departments and return activity to pre-COVID levels. Equally GP partners have a shared desire to formally agree the mechanisms, coding and remuneration for the transfer of phlebotomy, recognising GP practices are reporting an increase in acute clinical letters requesting bloods.
- **Communications.** One version of the truth agreed and signed off by the group should be communicated to all stakeholders to support all involved to understand the opportunity, challenges, and associated decisions made.
- **Standard Guidance**. Any phlebotomy request should be in accordance with guidance on Remedy/ICE with the understanding that community phlebotomy may not have the same facilities as a hospital phlebotomy service such as prompt transport and specific equipment for specialist tests.
- **Estates.** General Practice and community estates whilst challenged to provide socially distanced care, are better placed to do so than acute hospitals. i.e. entrance lobbies and lifts in acute trusts make it difficult to increase footfall to pre COVID levels.

4. Work done to date by the Operational Group

The Group proposed two ways of working in the community to pilot and evaluate; a hub in South Bristol run by Sirona, and a general practice pilot in North and West Bristol which was rolled out over several other practices in BNSSG which faced other Trusts, to test new ways of working.

The Group explored the possibilities of setting up hubs in other localities to ensure equity of access for the population but estates constraints meant that this was not possible. The Group also supported the development of one Standard Operating Procedure (SOP) for this work, to include both the general practice and the acute processes. This SOP has been considered and iterated after feedback from GP membership, the operational and clinical leads in all Trusts, and the LMC. It incorporates learning from the pilots in the community, and has now been signed off by all parties involved as comprehensive and clear.


Standard Operating procedure V13(1).doc

In order to ensure a sustainable robust service for the system and patients, an escalation framework for practices was also developed.


Phlebotomy escalation.pptx

Engagement work has been conducted with patients attending the South Bristol hub and North and West Locality practices pilots. The response was overwhelmingly positive and patients valued having these done local to home in their own practices. We also know from this work, and other analogous engagement, that people generally prefer to receive care as close to home as possible.

The Group recognised that whilst a hub solution may be better at scale, estate constraints, patient preference and GPs views meant that a practice based solution was focused on. We are currently exploring the ongoing use of the hub model as overspill; costings have been provided by Sirona and we will be discussing with membership if this is required. Whilst this is discussed, the South Bristol phlebotomy hub will step down from July 2021.

With the support of One Care, an EMIS protocol was developed and rolled out to practices which formed a basis for coding and measuring activity. ICE Licences were procured to face all relevant Trusts by practices, and One Care have been supporting the Trusts to get practices set up with these.

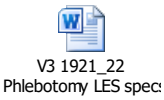
A robust process for pricing up a phlebotomy visit was carried out by One Care and signed off by the Trusts and Healthier Together Outpatient Board. A price point of £5.61 has been agreed, and current activity levels have been analysed to show that we are expecting 80,000 phlebotomy visits in general practice as a result of secondary care requests. There will need to be regular monitoring of this activity in general practice, and the capacity of practices to provide it given the pressures on general practice currently. Activity will be monitored by the CCG Business Intelligence team and fed through to the Outcomes and Activity Group.

A checklist for practices has also been developed by One Care to support practice readiness.


Check list V 2.docx

We would also like the Committee to note that the SOP does also make provision for those patients who are unable to travel to practices for their secondary care blood tests; Sirona will be supporting this process.

As a result of financial discussions which are further detailed in the section below, a Local Enhanced Service specification has been developed which has been agreed with Primary Care Operational Group and the LES Steering Group. It is proposed that if this is agreed by the Committee, this will form part of the suite of enhanced services for practices to sign up to for 2021/2022.



5. Financial resource implications

Financial implications considered by the Operational Group as the project has developed are listed below.

- **ICE and IM&T requirements.** In the BNSSG area there are 3 ICE versions. NBT and UHBW has two separate instances of ICE for Bristol and Weston. To support GP practices to be able to access ICE. UHBW and NBT will need to build EMIS/ICE interop for 36 practices. The costs associated with this change have been identified and are requested to be supported by each trust's IM&T department under their ICE contracts. It has previously been agreed that the trusts are responsible for the first year of the licensing costs and that this will be reviewed and onward managed by the Healthier Together Clinical Interfaces Group.
- **Non-recurrent UHBW laboratory costs.** Once the project goes live, there will be a need to change the labelling and add branding to the laboratory bags to allow them to be separated in practices. There are no costs associated with this change in NBT because we designed the process so NBT did not need to change from their status quo. Currently there is a 6+month supply of bags and labels in the UHBW path labs and distributed across the community, the cost comes from having to remove all of this stock and replace with new bags and labels.
    - £10,220 (not inc VAT) to change labels to reflect Bristol and Weston labs
    - **£5,500 (not inc VAT) to change the sample bags to reflect Bristol and Weston labs.**

System COVID allocations have funded activity during Q3-Q4 of 20/21. This block payment to practices of £177k has recognised both; the legacy phlebotomy activity and the additional capacity as a result of the informal shift from Acute Trusts to General Practice.

The full year cost of the Phlebotomy activity will be c.£405k. It is proposed that for 21/22 and beyond this activity will be funded as follows;

Source of Funds	H1 21/22 (£000's)	H2 21/22 (£000's)	21/22 total (£000's)	22/23 onwards (FYE) (£000's)
Covid	177	0	177	0
Acute Growth	0	95	95	190
Primary Care LES	25.5	107.5	133	215
TOTAL	**202.5**	**202.5**	**405**	**405**

Application of Funds	H1 21/22 (£000's)	H2 21/22 (£000's)	21/22 total (£000's)	22/23 onwards (FYE) (£000's)
Legacy Comm Phlebotomy Service	107.5	107.5	215	215
Growth in Comm Phlebotomy Services	95	95	190	190
TOTAL	**202.5**	**202.5**	**405**	**405**

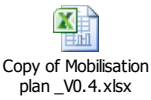
Although this work is about secondary care work moving out into general practice, we are proposing to use the LES underspend to partially fund this. This we recognise will raise concerns with the LMC and general practice colleagues, but will ensure that funding remains within general practice. We recognise this activity as valuable and want to resource it sustainably, and it is also an excellent example of integrated working. Funding on a block basis rather than activity based payments has also been considered.

Block	Activity Based
Consistent with move to acute payment structures	Consistent with other LESs
Provides a consistent revenue to practices, reducing risk if activity were to decrease	Ensures resource follows activity, gives more surety to general practice if activity increases.
Will require regular review so resource still needed to record and monitor activity regularly and top ups may be needed as more phlebotomy activity moves out into community	Relies on high quality data recording and extracting
Reduces financial risk to system in short term	Difficult to plan for - this model is new and high volume - the system is confident that the scale of the service means this financial risk can be mitigated
Does not incentivise efficiency or improved care – may mean practices or PCNs cap activity which will need to be picked up by the system	Encourages the activity so patients get the care they need and practices continue to hold activity in the community

Sirona overspill costs. If practices and PCNs are unable to provide capacity for phlebotomy, the Group has considered the resource needed for Sirona to provide overspill. The information is attached. If Sirona are to be paid on cost and volume then this overspill capacity will not be able to be provided. The Group will present this to GPCB and membership with the options of every practice providing resource to this; or doing without and committing to providing capacity.

Sirona Over-Spill Phlebotomy Costing.p

6. Next steps


Copy of Mobilisation plan _V0.4.xlsx

After feedback at PCCC, the Operational Group will consider how this impacts the next steps and will need to:

- Engage with the General Practice Collaborative Board – GPCB has been well engaged in this piece of work to date and has been supportive during its development. The GPCB feel that in order to make the proposal to wider GP there is need of:
    - A formal written intent from the trusts (with the CCG as signatory) detailing the agreement that general practice would need assurance of recurrent funding to continue to deliver secondary care bloods after Q2, with an explanation of the process to date and leading up to Q2 to understand this better.
    - A clear timeline to start the governance aspects (essentially a mandate to all consultants to add any requests to ICE)

- Present the agreed payment structure and specification to membership in June
- Ensure that all communications in the acute Trusts are consistent with those to general practice
- Finalise the work with practices to get ready for go-live
- Launch the service on July 1st 2021
- Prepare for the service evaluation – we are working with the insights and engagement team at the CCG and finalising the feedback survey in the Operational Group
- Prepare for phase 2 of the service which will include STEPS and AWP
- Work with the Outpatient Board on the development of Community Diagnostic Hubs and how this will support and learn from the Community Phlebotomy work

7. Recommendations

The Committee is asked to

- Note the extensive work the Operational Group has undertaken over the last year
- Agree the Local Enhanced Service Specification
- Agree the payment mechanism of cost per volume
- Agree the next steps of the work as detailed above

8. Legal implications

There are no legal implications.

9. Risk implications

Risk	Mitigation
The LES scheme is not supported and incidences of patients being refused bloods in primary care continues.	Clear communicatins of the pathways and expectations of clinicians.
Practices may not sign up to the LES which will result in an inconsistent service for patients across BNSSG.	All practices in BNSSG are already undertaking this work and would welcome better governance around it and funding.
As we are unsure of demand and general practice capacity there is a risk that practices will not be able to manage the additional activity resulting in using overspill/patients not having their blood tests and delays in care.	Robust coding mechanism in place and request underway with CSU regarding data collection. Regular touchpoints will ensure capacity issues are addressed promptly.
Trusts' transformation resource may not be in place to ensure go-live by 1st July.	NBT and UHB transformation resource in place; UHBW do not have enough support in place to mobilise ICE licences for practices; this is being monitored through the Operational Group
Transformation in Trusts may be partially successful/slow process so that requests do not go onto ICE, resulting in delays.	Robust communications designed and held within the Operational Group, consistent across Trusts, led by clinical leads within the Trusts are planned.

10. How does this reduce health inequalities

This work will ensure that patients receive care closer to home with less transport issues which will reduce health inequalities. Patients will also receive care by those who know them best and can tailor communication needs accordingly. Any variation in service delivery will be highlighted through patient feedback and activity monitoring and will be addressed promptly.

11. How does this impact on Equality and Diversity?

Quality assurance in the form of patient and staff surveys, audit and reporting will highlight any areas relating to equality and diversity, or variation to service; these will then be addressed accordingly.

12. Consultation and Communication including Public Involvement

Initial feedback from patients has been sought during the pilot phase, and the Operational Group is finalising feedback surveys with the CCG Insights and Engagement team to go to patients as the service goes live. This will then ensure the service develops in line with patient need and demand.

Appendices

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations. .

AWP	Avon and Wiltshire Partnership Trust, our mental health provider
BNSSG	Bristol, North Somerset, and South Gloucestershire
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CSU	Commissioning Support Unit
GPCB	General Practice Collaborative Board, a group of provider lead GPs

ICE licence	ICE is the software we use in BNSSG clinical systems to request pathology investigations; it requires a license to be held by each practice for each different Trust the practice could take blood for
IM&T	Information management and technology
LES	Local Enhanced Service
NBT	North Bristol Trust
STEPS	Tertiary care provider of eating disorders services in BNSSG
UHBW	University Hospitals Bristol and Weston NHS Foundation Trust

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Standard Operating procedure V.13 – Delegated phlebotomy for secondary care Feb 2021

1. Purpose and Scope

This document details the proposed change in how General Practice manage blood tests taken on behalf of secondary care trusts. It aims to clarify the process and expectations of both primary and secondary care. It has been developed over 12 months with multiple iterations and involved discussions with primary care, local trusts, patients and the CCG and the LMC. It describes the process **from April 2021.**

For many years, General Practice has taken bloods on behalf of secondary care, taking responsibility for both the phlebotomy but also the interpretation, communication and risk holding associated with that blood result. Over the last year we have sought to address both the governance and funding aspects of this currently unfunded work.
There is an SOP in secondary care that mirrors this and describes this new agreed process. It means all clinicians within the system will be working to the same processes.

Continued conversations are needed with AWP, Gender services and STEPS but for now they fall outside the scope of this SOP.

The **overarching principles** of this process are

- Clinical responsibility sits with the clinician who has requested an investigation.
- To support patients to receive safe and good care and where possible, close to home
- All requests made by secondary care for phlebotomy in General Practice must be deferred on ICE
- If a request made by secondary care for phlebotomy in General Practice is not deferred on ICE, the blood test cannot be taken.
- Practices should be able to access all deferred ICE requests by having access to the appropriate ICE systems
- This SOP will be developed iteratively through learning and a changing BNSSG view on phlebotomy
- General practice will be funded to provide phlebotomy for secondary care in the community.
- Any unpredicted increase in activity in primary care will be carefully monitored

2. What is a Secondary care blood delegated to primary care?

Any blood test requested by a hospital speciality team to support ongoing care. More specifically;

- Following an initial assessment where investigations are recommended
- Bloods required by a specialty teams prior to or following review appointments to assess, manage or a condition being managed in secondary care (includes serial tests)
- Monitoring of a red traffic light therapy (where prescribing and monitoring responsibility remains with a specialist team). Includes chemotherapy.

- Monitoring of an amber traffic light therapy within the first one month (for 'amber 1 month' approved therapies) or within the first three months (for 'amber 3 month' approved therapies) i.e before monitoring is agreed to be taken on by General Practice under shared care agreement

Appendix 1 – 'What is a secondary care blood' - resource to support phlebotomy teams

3. When is it appropriate for primary care to take clinical responsibility for blood results requested by secondary care?

- At discharge it is common for a specialty team to recommend bloods be repeated in the community. This is commonly within days or weeks of discharge. Even if there is follow up arranged it is appropriate (at present) for primary care to take responsibility for these.
- If it is clear that a blood test is to influence next stage dosing of a medication prescribed in primary care – e.g' I have increased frusemide today and if kidney function is stable, I would increase this further'.
- Recommended blood monitoring regimen when shared care medications are moved from hospital to community care and the practice have accepted this transfer as per https://remedy.bnssgccg.nhs.uk/formulary-adult/scps/scps/. If in doubt – ask your clinical team.
- If a specialty team discharge a patient but advise monitoring to establish when a referral or rereferral would be appropriate e.g, 'please check PSA 3 monthly and rerefer if >10' (secondary care must communicate frequency of monitoring and threshold for rereferral very clearly or this monitoring cannot happen)
- When requests are made as part of advice and guidance service and if a GP feels confident to interpret the results. Onward referral would be required if requests are outside of clinical skill set to interpret.
- Bloods tests requested by specialist teams outside of the BNSSG area

4. Patients on red drugs/hospital administered medications

- These are medications that require hospital prescribing. As such all related monitoring should be returned to the responsible specialist team.
- It is important that practices consider how they record hospital administered or prescribed (red drugs) in the patient record. This allows your phlebotomists to quickly identify that the medication that needs monitoring is the responsibility of specialist teams (and to look for ICE
- If a patient is on a red drug and needs tests prior to commencing that drug, or regular monitoring, specialist teams will need to add serial postponed deferred ICE requests to reflect the interval between one review and another.
- The prescribing team are responsible for following up results with patients.

5. Patients on both red and amber drugs.

When a patient is on a combination of an amber drug and a red drug, General practice will not be able to interpret red drug monitoring blood tests (what is abnormal and what action is needed?).

Due to the possibility that patients may be on a red drug under one specialty and an amber drug from another speciality and that the monitoring tests may differ and be at different intervals it is felt best that red drug monitoring goes to specialist teams and amber drug monitoring remains with the GP. There is a risk in both primary and secondary care of interpreting results without full knowledge of the other drugs (particularly amber/red ones) that a patient may be on.

This risk is mitigated by access to connecting care or general practice if needed (secondary care) and good practice documentation of red drugs (https://digital.nhs.uk/services/summary-care-records-scr/recording-medicines-prescribed-elsewhere-into-the-gp-practice-record and access to secondary care advice (primary care)

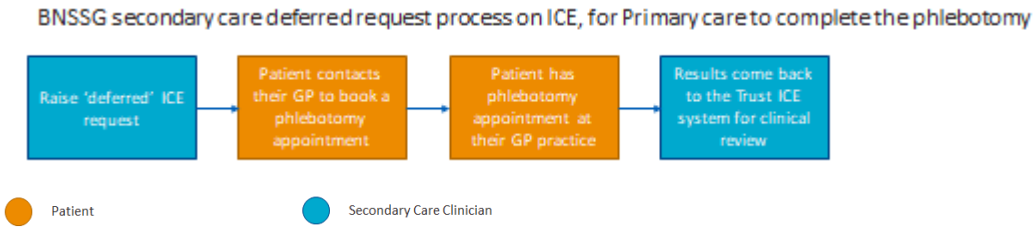
6. Deferred request process

Any request delegated by secondary to be taken in primary care should be on ICE to ensure it returns to the requester – this is called a deferred request.

The agreed process for BNSSG community phlebotomy requires BNSSG Secondary care clinicians 'deferring' the blood request in the ICE system. The requesting clinician is accountable for interpreting and action of the results.

These deferred requests are visible to phlebotomy teams in GP by accessing the ICE system for the trust the consultant works within. Once identified, the phlebotomist can sample off this request in the usual way

Appendix 2 Quick reference guides how to sample requests made by specialist on ICE (phlebotomy teams)



7. Inclusion and exclusion criteria

Further to the above there are some phlebotomy requests that cannot be provided in the community these are summarised in the table below.

Yes, they can be referred	No, they cannot be referred
The Patient: • Older than 12 • Is able to travel to GP practice • Is happy to have phlebotomy at GP practice	The Patient: • If the patient is attending a face to face appointment in the acute trust where the bloods could be taken. • Requires bloods to be taken from in dwelling lines

The bloods: • Are essential • Don't need to be taken within the next 48 hours • Don't require immediate transport to the lab i.e. within the next 30minutes • Don't need results to be reported urgently i.e. within the next week	The bloods need to be: • Taken to the lab for urgent processing i.e. within next 30min • Taken within 48 hours • Reported urgently i.e. within the next 2 weeks

8. Secondary care Housebound bloods

In a situation where secondary care needs a patient to have bloods in a domiciliary setting (housebound) it has been agreed that the specialist team will add the request to ICE and will also need to write to the GP requesting these bloods be arranged at home if appropriate. GP will refer these patients to Sirona by their usual methods of referral. Sirona are aware of this process and have highlighted this element of the SOP to their teams so that these bloods are accepted to be processed.

9. Trust ICE systems

Patients in Bristol predominantly receive their care from specialists at UHBW (including Weston) and NBT. In order for practices to provide phlebotomy for these deferred requests, all practices need access to the ICE systems of the trust providing care for their patients. Weston and UHB currently have separate ICE systems although there are plans to coalesce this in due course.

Practices who do not have access to the ICE systems they need have been identified. Funding and roll out to ensure all practices have access has been agreed. It is expected that this may take 6-12 months to provide full coverage in BNSSG practices.

Whilst awaiting this roll out, any practice awaiting a license has the option to access the deferred request using a web based ICE system (proof of concept demonstrated in primary care). This allows practices to see and sample deferred requests.

Appendix 3: Quick reference guide sampled deferred requests on Web URL
Appendix 5: General practice process – managing phlebotomy requests flowchart

Patients may well attend with a letter detailing a request, a form or a verbal request. If these requests are not on ICE then they should not be sampled unless they are the responsibility of primary care. NBT and UHBW have agreed to the principle of deferring requests and acknowledge that there needs to be an active process to create the change in behaviour throughout the trust specialty teams. There is a plan for rapid roll out specialty by specialty in the next 3 months (Jan – April 2021)
There is a standard letter which can be merged with EMIS and used to send to a specialist team indicating the need for requests to be on ICE or the patients cannot be bled. This would prevent the clinical risks attached with refusing to bleed a patient completely.

Appendix 4: Standard letter to specialist team asking requests be put on ICE

10. IT principles and consumables

- Any delegated secondary phlebotomy request is deferred and added to ICE by the requester
- If a series of tests are needed ALL these tests are postponed and added to ICE
- Each practice will be able to process deferred ICE requests off all trusts they face (ICE licenses for each trust agreed)
- Each practice will have ready access to and understand the differing process and consumables needed when sampling off each ICE system. NBT and UHBW use different label paper.
- Deferred requests sampled off your non-lab facing trust (I.e. if you usually use UHB for labs but need to sample of NBT ICE) can be sent to your usual lab trust and transported between trusts. Please use a see-through bag over the pathology bags (much like smears) to transfer samples to the labs you do not usually face. E.g if you have sampled of NBT but your samples usually go to UHBW
- Labs require practices to use the correct sample labelling paper. NBT and UHBW use different labelling forms and phlebotomy teams will need to use the correct paper in their printers for the trust where the ICE requests sits
- Samples will be moved between trust labs on an hourly basis in weekdays 8-10 p.m

11. To access consumables and request sample forms

Helpful links for UHBW

1. Re-ordering A4 request forms
(Known as GP forms for ICE). State location and contact person to be delivered to.
PathologyPrep-Room@uhbw.nhs.uk

2. ICE Support for all queries with ICE ICE.Support@UHBW.nhs.uk

4. Helpdesk via email ITServiceDesk@UHBW.nhs.uk
or call 0117 34 23939 (IT Service Desk telephone support hours: Mon-Fri, 0700-1900; Sat & Sun, 0830-1630)

Helpful links for NBT

1. Re-ordering A4 request forms
(Known as GP forms for ICE). State location and contact person to be delivered to.
PathologyConsumablesSOuthmead@nbt.nhs.uk

2. ICE Support for all queries with ICE gplinks@nbt.nhs.uk

4. Helpdesk via email ITServiceDesk@UHBW.nhs.uk
or call 0117 4142020 (IT Service Desk telephone support hours: Mon-Fri, 0800-1700)

12. Feedback and learning

As this is a new process we suggest that both secondary care and primary care use the datix system for actively feedback in the early month so that maximal learning can be achieved. We would recommend a review of this at 1, 3 and 6 months to identify early learning. https://bnssg-datix.scwcsu.nhs.uk

It is recommended that we use a measurable KPI to help us review this process; it would be appropriate to run a prospective audit through a number of practices at 1, 3 and 6 months as to the percentage of bloods being added to ICE – the standard being 100% but an increasing percentage is likely to indicate concordance.

Practices are asked to continue to record (code) any secondary care activity using an EMIS F12 which will be expanded to record action if blood requests are not on ICE. Options at this stage could be to refuse to do phlebotomy, ask the patient to communicate with specialty team or practice to write stating not on ICE (preferred option) – not done (template letter available), or take blood as per current system and feedback via DATIX and by letter.

13. Activity assumptions

It has long been difficult to accurately unpick activity relating to secondary care tests taken in primary care. ICE data records the tests requested by individual and the location of that individual, but not who the request was made on behalf of or the number of phlebotomy appointments. Over the last year practices across BNSSG have consistently started to code their secondary care phlebotomy activity.
One Care have supported a wider recording and this will be used to reviewing future funding structures and the sustainability of any service offered. The trusts have given indicative estimates of activity but it is likely that this does not accurately reflect activity at practice level.

14. Appendices

There are resources to support this process for primary care – these will be stored on line to allow edits through early learning

1) *'What is a secondary care blood test?' (for phlebotomy teams)*
2) *Quick reference guides how to sample requests made by specialist on ICE (phlebotomy teams)*
3) *Quick reference guide sampled deferred requests on Web URL*
4) *Standard letter to specialist team asking requests be put on ICE*
5) *General practice process – managing phlebotomy requests flowchart*

Appendix 1. ***What is a secondary care blood? (for phlebotomy teams)***

This guide is to help you decide when to code that you are taking bloods on behalf of secondary care (trusts)

If a patient books for a blood test not requested directly by their GP – i.e they are for hospital care, PLEASE ALWAYS CHECK TO SEE IF A BLOOD TEST IS ON ICE ON THE HOSPITAL SYSTEM.

- Bloods for **investigation** following contact with a consultant team in outpatients (virtual or face to face)

- Bloods for **monitoring of condition** that is managed and followed up in secondary care – best indicator is if there is a follow up appointment or telephone planned.
    - e.g thyroid function when next steps and f/u are with endocrine
    - e.g PSA/tumour markers where follow up is in secondary care
    - e.g ferritin levels for haematology follow up
    - e.g liver function tests for a patient under hepatology
    - e.g lipids requested by lipid clinic
    - e.g weekly CRPs requested by orthopaedics for osteomyelitis
    - e.g oncology requesting tumour markers and monitoring bloods

- Bloods for **monitoring medication** that can only be prescribed by speciality teams/hospital (red drugs). This includes certain mental health drugs for coding purposes.
    - Biologic therapies: (e.g adalimumab, rituximab etc) See PTO
    - Chemotherapy
    - Interferon
    - See reverse for common red drugs where primary care are involved in monitoring

Bloods that are NOT considered secondary care bloods are;

- Bloods requested at discharge after hospital admission to monitor recovery
- Bloods requested will influence dosing decision held by primary care – an increase in diuretics.
- Amber drugs accepted by the practice on share care protocol e.g azathioprine, methotrexate, leflunomide
- Any bloods taken to support private care are NOT delegated secondary care bloods
- ?add- referral to eating disorder service (as opposed to monitoring bloods once under their care)
- For the time being funding is not agreed for STEPs bloods where discussions about funding are ongoing
- For the time being funding is not agreed for AWP bloods for physical or medication monitoring. The current funding is for trust bloods only.

If you are unsure whether a request is secondary care or not – please ask a GP for help.

RED DRUGS – SECONDARY CARE BLOODS

Drug	Monitoring guidance
Abatacept	If on monotherapy – FBC & LFT's at 1, 3 and 6 monthly
Adalimumab	If monotherapy FBC/LFTs at 1,3 and 6 months, then 6 monthly
Anakinra	
Apremilast	
Baricitinib	
Brodalumab	
Certolizumab pegol	FBC/LFT at 1, 3 and 6 months and then 6 monthly
Dupilumab	
Etanercept	FBC/LFT at 1, 3 and 6 months then 6 monthly
Golimumab	FBC/LFT at 1, 3 and 6 months then 6 monthly
Guselkumab	
Infliximab	FBC/LFT/U&E or 2 monthly
Ixekizumab	FBC 6 monthly
Nintedanib	
Risankizumab	
Rituximab	FBC/U&E's For repeat cycles of rituximab:
Sarilumab	FBC and LFT's - at 4 to 8 weeks then suggest 3 monthly Lipids - at 4 to 8 weeks then 6 monthly
Secukinumab	FBC and LFTs 6 monthly
Tildrakizumab	
Tocilizumab	
Tofacitinib	FBC, U&Es, LFTs every 2 weeks until on stable dose for 6 weeks 3 months and then 6 monthly Lipids - at 8-12 weeks
Ustekinumab	
Vedolizumab	

COMMON AMBER DRUGS (NOT SECONDARY CARE AFTER INITIATION AND ACCEPTANCE TO PRESCRIBE)

See practice guidelines for monitoring intervals or https://remedy.bnssgccg.nhs.uk/formulary-adult/scps/scps/

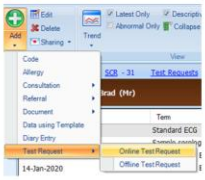
Azathioprine
Mercaptopurine
Methotrexate
Azathioprine
Hydroxychloroquine
Leflunomide
Methotrexate
Mycophenolate (oral)
Penicillamine
Sodium aurothiomalate
Sulfasalazine EC
Azathioprine (oral)
Lithium carbonate
Mercaptopurine (oral)

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

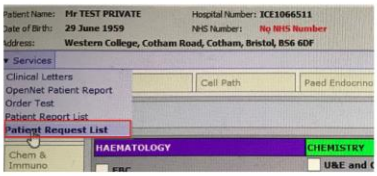
Appendix 2: *Quick reference guides how to sample requests made by specialist on ICE*

How to complete requested tests from hospital clinicians via EMIS

1. Log onto EMIS and Patient required
2. Add/Test request/Online Test Request



3. From the services menu select Patient Request list



4. A list will appear

5. From the list of Requests by patient find the request(s) with status **POS**

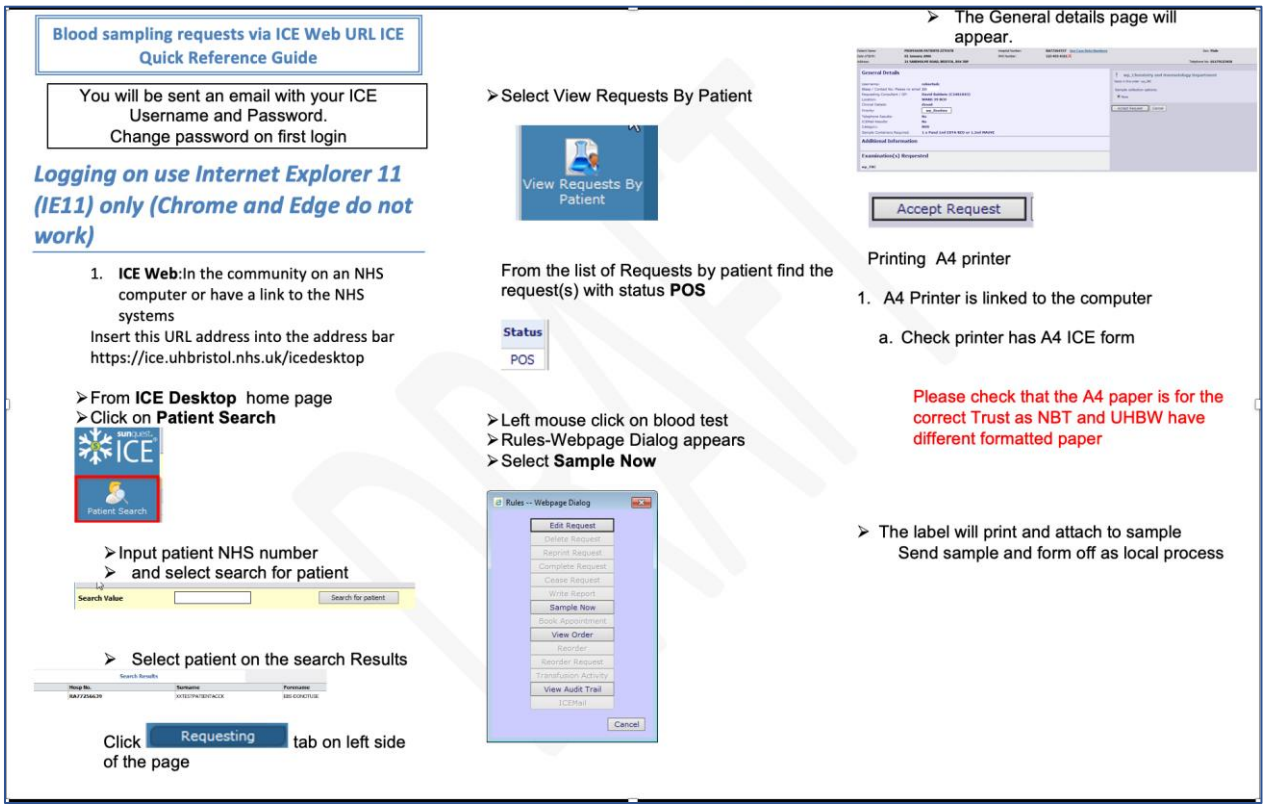
6. Left mouse click on blood test
   Rules-Webpage Dialog appears
   Select **Sample Now**

7. The General details page will appear.

8. Printing A4 printer

- A4 Printer is linked to the computer
- Check printer has A4 ICE form
- The label will print and attach to sample
- Send sample and form off as local process

Appendix 3: Quick reference guide sampled deferred requests on Web URL



Appendix 4: Proposed letter to consultant when request is not on ICE

Dear Consultant,

From April 2021, any requests for blood tests made by secondary care to be actioned in primary care need to be on the ICE system. This is following a decision made between the CCG, primary care and the trust clinical directors to ensure that requesters see their own results

We have received a request from you/your team where these requests are not on ICE. We have not yet taken these blood tests and would **ask that you add the blood tests you require on to the ICE system** to allow us to support this process. This will ensure that the results come back directly to you/your team to review and action as clinically appropriate.

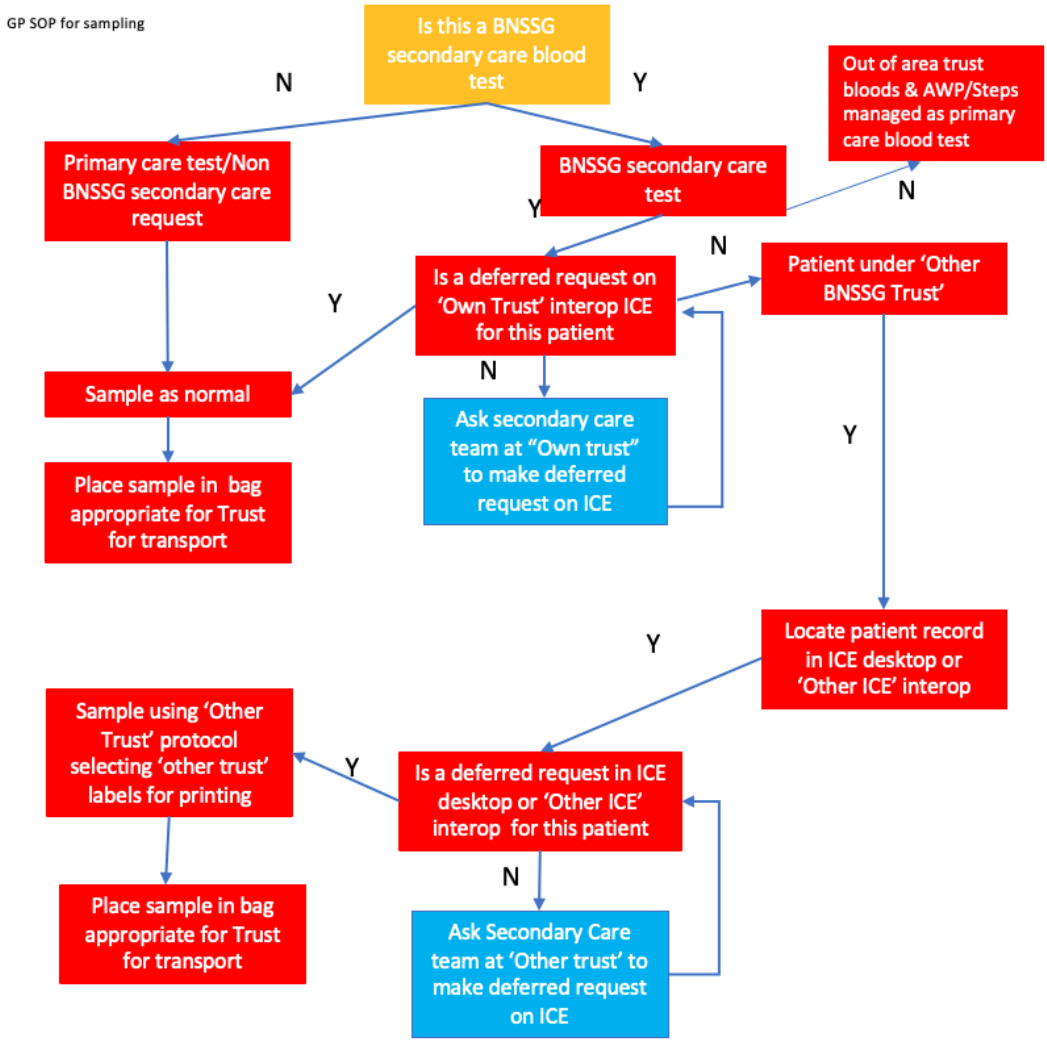
In addition, it is important that appropriate follow-up systems put in place to ensure that the patient has the results communicated to them and appropriate actions taken should there be any abnormalities discovered.

We have attached a copy of the letter where you have outlined the requested tests.

Many thanks for your continued support with this new process.

Kind regards,

Appendix 5 *General practice process – managing phlebotomy requests flowchart*



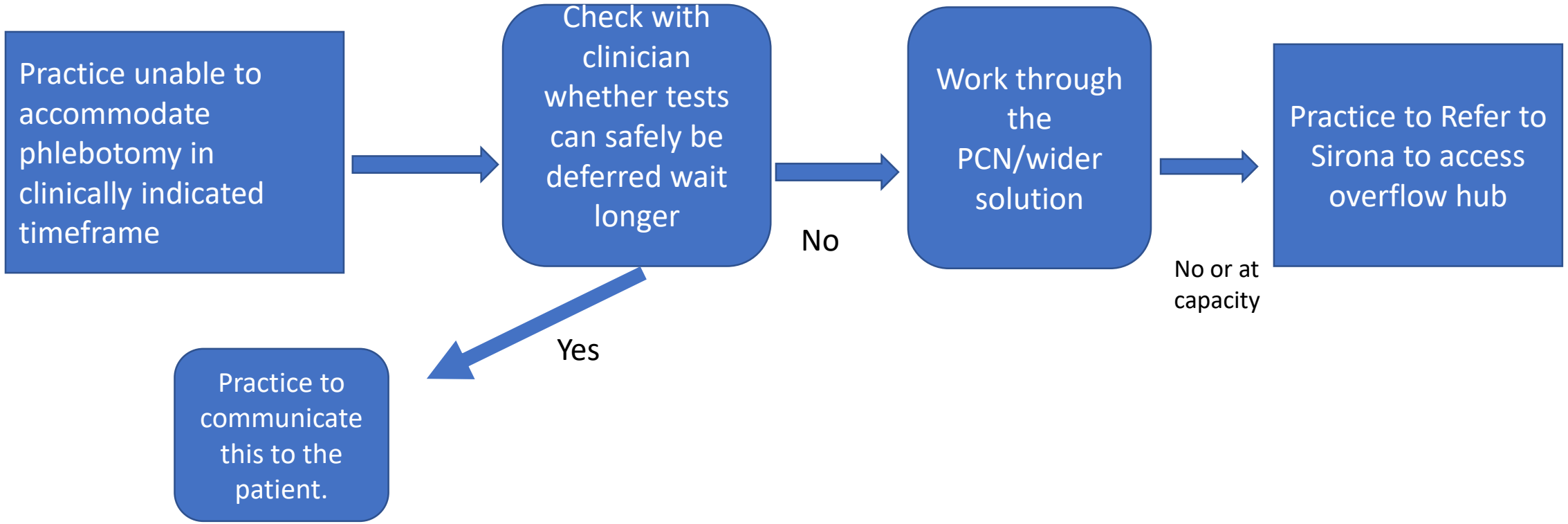
Samples for Bristol printed on red labels to be transported in colour bags with Bristol logo
Samples for NBT printed on white labels to be transporting in clear colour bags
Samples for Weston printed on green labels to be transported in clear bags with Weston Logo

NB If the patient is under the care of an "Other trust" &/or the request to be sampled is on an "Other ICE" then it is essential that the "other trust" protocol is followed when blood is taken. This involves correctly identifying the secondary care clinician; using the correct labels and sample bags specific to that 'Other' Trust. ***All these steps are as important as correctly identifying the patient. Failure to do this will mean the result not being seen by the responsible secondary care team, with consequent harm to the patient***.

Phlebotomy Overflow service

- Consistent Primary care Escalation process
- Central referral process
- ICE functionality
- Cover for each locality
- Governance/monitoring
- Locality resilience

Primary care Phlebotomy escalation process



Community Phlebotomy check list:

Activity	Yes- No
Clinical lead appointed within practice	
Clinical lead to review Standard Operating Procedure version XX (insert Teamnet link)	
Discussed with clinical and administration team to agree on practice procedures:	
1.0 Who will check that the phlebotomy request is on ICE before appointment is made?	
2.0 If not- who will send the letter back to the Trust to add to ICE? (insert link to latest version)	
3.0 What information is given to the patient regarding results particularly if the request is a combination of primary and secondary care requests? • Consider a bulk text to all patients ahead of live date. • Consider an accuRx sent by HCA indicating results will be specialist team's responsibility.	
4.0 Ensure arrangements with PCN are in place to accommodate requests if the practice is unable to undertake. Consider cross organisational access etc.	
5.0 Familiarise with option to refer to Sirona for home visits or where PCN is unable to undertake request in time fame clinically required. ? link to guidance?? For enquiries contact Bristol SPA 0300 125 6789 -option 2	
Emis	
Ensure that you have downloaded the latest protocol for recording data. (insert Teamnet link) for queries contact emis.optimisation@onecare.org.uk	
Add emis protocol to F12 onto desktop for those staff taking blood.	
Add any accuRx template texts	
Upload standard letter to consultants to add request to ICE (consider F12 protocol to facilitate this process.	
ICE	
Do all clinical staff have ICE access to both Trusts? (should already be in place)	
Request admin access to ICE for reception- administration staff if required (see contact details below)	
Are all users set up within EMAS manager? Ice team reply with password for each user. Enter password on EMAS manager screen in Emis under "Test". Requests-user name is user's Emis username	
Check access to Sirona overflow hub via ICE TBC	
For queries contact: UHBW ICE.Support@UHBW.nhs.uk NBT gplinks@nbt.nhs.uk 0117 4142020 (see request form below)	

Copy%20of%20NBT_ICE%20_request_fo	
Lab Stationary	
Confirm that practice has received the appropriate labels from additional Trusts and staff are aware and how to re-order (state location and person to be delivered to) PathologyPrep-room@uhbw.nhs.uk PathologyConsumablesSouthmead@nbt.nhs	
Confirm practice has received appropriate transit bags. Contact details as above.	
Training	
Training session with reception-admin teams to clarify process, access to ICE and who to refer to within practice in the event of a query.	
Training for staff to send letter to Trust where not on ICE.	
Training session with treatment room staff to familiarise with the process and all aspects of the SOP in relation to appropriate and non-appropriate requests, labels, bags and sampling on both ICE systems.	
Discussion with salaried GP's and additional role staff to familiarise themselves with SOP.	
Update locum pack as appropriate	
Payment	
Sign up to the Community Phlebotomy LES 2021. Code: 165791000000107- phlebotomy generated in secondary care done by practice. Payment will be quarterly based on emis search and report by the CCG via Open Exeter.	

Action Log	By Whom	By When

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**Community Phlebotomy Service 2021/22** ***excluding routine sampling for warfarin monitoring ,drugs in shared care agreements or under the specialist meds monitoring LES, and clozapine and STEPS for now***
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG)
Provider Lead	As per provider signatory
Period	01/07/2021 - **(end date to be confirmed),** with a possibility of extension based on service evaluation outcomes
Date of Review	TBC

1. Population Needs

1.1 National/local context and evidence base

Primary care has been responding to secondary care requests for bloods for many years, outside of formal protocols and thus far, this work has been unfunded. To date, the system has been unable to agree a formal arrangement to manage and fund this work. Additional challenges have been raised in relation to the handover of requests and results, due to a lack of interface between the different digital systems at acute trusts, the community provider, and practices. Therefore phlebotomy carried out in general practice at the request of secondary care has resulted in blood results being returned to the GP rather than the specialist requesting the test. The clinical responsibility has therefore rested with the GP rather than the consultant, with the latter being best placed to both interpret the results and hold that risk.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓

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

2.2 Local defined outcomes

- Provide a timely service for phlebotomy related conditions in a primary care setting which are cost effective and equal to or exceed the services provided in secondary care
- To provide a resilient service for patients and the system
- Satisfy local demand from patients
- To offer patients a choice of appointment times and locations as close to their home as possible
- To deliver the shortest pathway possible, compatible with best outcomes for patients
- Help relieve the pressure on secondary care services
- Improve the monitoring and management of Long Term Chronic illness of those under secondary care supervision

3. Scope

3.1 Aims and objectives of service

This service model describes an enhanced service for Primary Care Phlembotomy. This service described is beyond the requirements of the core GMS / PMS / APMS contract.

3.2 Service description / Standard Operating Procedures V13 – Delegated phlebotomy for secondary care (Appendix 1 - below)

It has been developed over 12 months with multiple iterations and involved discussions with primary care, local trusts, patients and the CCG and the LMC

Appendix 1 details how General Practice will manage the blood tests taken on behalf of secondary care Trusts under this enhanced service.

Standard Operating procedure V13(1).doc

Escalation process

The aim of the service is to provide additional system wide phlebotomy resilience.

An escalation process has been developed and will be ~~ie~~mbedded as a part of the Pilot service. Please refer to the attachment below.

It is expected that where a practice is unable to provide a service (for whatever reason) its patients will be seen by other practices within its PCN. Where this is not possible patients should be passed to the escalation provider "who will receive payment"

Phlebotomy escalation.pptx

3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

Please refer to **Standard Operating Procedures V13 – Delegated phlebotomy for secondary care**

3.5 Finance

Agreement has been reached to fund the activity on a price per blood test basis of **£5.60**

Payment by CCG to practice through LES (monthly monitoring, quarterly payment).

To be eligible for payment the practice must use the below SNOMED code:

Cut-off dates for back-dated coding of activity will need to be agreed in line with usual contract terms. This would be monthly extraction aligned to other existing primary care activity recording processes.

165791000000107 - phlebotomy generated in secondary care done by practice

3.6 Activity recording and monitoring

- EMIS protocol capturing monitoring requirements have been developed and all participating providers are expected to utilise it
- Practices will be responsible for recording the volume of secondary care requested bloods, including specialty of requestor
- Acute providers can estimate activity volumes based on deferred requests on ICE, but this will not be a completely accurate picture since it will include other requests. As such, practice recorded data will be recognised as definitive for billing.
- The minimum data required will be:
    - Number of tests undertaken/month (recorded using the specific code)
    - Demographics of the patient – age / gender / ethnicity
    - By practice (as above, or minimum aggregation depending on sensitivity)
    - Clinical specialty to be added
- By signing up to this enhanced service you are giving permission for the CCG to extract the relevant reporting data for activity monitoring and to inform payment.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Please refer to Standard Operating Procedures V13 – Delegated phlebotomy for secondary care

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

6. Location of Provider Premises

Overflow Phlebotomy Clinics Proposal - May 21

	Time period: Monthly costs		Time period: Monthly costs	
	Agency		Employed (Fixed Term)	
	FULL DAYS	*HALF DAYS*	*FULL DAYS*	*HALF DAYS*
	8.5 hours x 3 days pw	*4 hours x 3 days pw*	*8.5 hours x 3 days pw*	*4 hours x 3 days pw*
Pay Costs	**£**	**£**	**£**	**£**
Clinical				
Band 3	2,331	1,097	1,858	874
Non Clinical				
SPA Admin	980	980	980	980
Reception & Project supervision	233	110	233	110
Total pay costs	**3,544**	**2,187**	**3,071**	**1,964**
Non-Pay Costs				
Travel	80	80	80	80
Phlebotomy Equipment & Other non-pay	210	210	210	210
Total non-pay costs	**290**	**290**	**290**	**290**
Total direct costs	**3,834**	**2,477**	**3,361**	**2,254**
Management Overheads (15%)	575	372	504	338
TOTAL COSTS PER MONTH	**4,409**	**2,848**	**3,865**	**2,592**
Annual cost	52,909	34,182	46,375	31,107

Community Phlebotomy go live plan

Last Modified: 20 April 2021

Complete | Underway and on-track | Planned / scheduled but not yet started | At risk/overdue

Activity	Lead	Overall status	Start date	End date	Mar-21		Apr-21				May-21					Jun-21				Jul-21				
					22-26 Mar	29 Mar-2 Apr	5-9 Apr	12-16 Apr	19-23 Apr	26-30 Apr	3-7 May	10-14 May	17-21 May	24-28 May	31 May - 4 Jun	7-11 Jun	14-18 Jun	21-25 Jun	28 Jun - 2 Jul	5-9 Jul	12-16 Jul	19-23 Jul	26-30 Jul	2-6 Aug
General practice readiness																								
prepare LES offer for Q1, Q2 and Q3 onwards for Primary Care to consider	DM, JD, GI																							
Communications to GP practices re update status of project via membership	GI, NM, KM																							
Formal written intent to continue post Sept requested	David Moss																							
ICE licences ready for go live	BW, BS																							
confirm laboratories ready to start receiving samples and communicate how obtain consumables to practices - how to push this out to practices?	GI, NM, KM																							
practices to have obtained consumables	JW																							
LES offer prepared for PCCC sign off	VG, SK																							
LES offer made and practices signed up to LES	VG, SK																							
Communication of go live and what is required from practices, inc data recording including PM check list / comms package ready to go to practices	GI, NM, KM																							
Date when GPs start asking acute clinicians to ensure request is on ICE via letter	All to agree in line with acute role out plans																							
NBT acute readiness																								
prepare transformation resource for roll out	LL																							
prepare communications to clinical body	LL																							
share roll out plan to share with community phlebotomy operational group	LL																							
Confirm to Phlebotomy operational group all ICE licences are set up and ready to use	BW																							
Confirm laboratories ready to start receiving samples and share with GPs how obtain hardware to sample	LL																							
start mass communication and dispatching of training material/guidance to acute clinicians	LL																							
Go live	LL																		Go Live					
UHBW acute readiness																								
order stationery for labs	JW																							
prepare transformation resource for roll out	JW																							
prepare communications to clinical body CCIO, clinical chairs	JW																							
share roll out plan to share with community phlebotomy ops group	JW										27-Apr													
Setting up short life working group	JW																							
Confirm to Phlebotomy operational group all ICE licences are set up and ready to use	BS																							
Confirm laboratories ready to start receiving samples and share with GPs how obtain consumables to sample	JW																							
start mass communication and dispatching of training material/guidance to acute clinicians	JW																							
Go live	JW																		Go live					
Sirona - over spill																								
escalation protocol agreed	NM, GI, KL																							
finalise escalation sites available to general practice	KL																							
EMIS search criteria to be shared with Sirona	Colette (OC)																							
Set up GP referral to Sirona via ICE	BW / BS																							
Set up permissions in practices to send referral to Sirona	BW/BS																							
Set up Weston ICE to be available to Sirona Bristol SPA	BS																							
Confirm coding of activity and payment mechanism	Jamie Denton																							
transport for sites to labs	TBC																							
share comms to operational group of how the referral process technically works	BW																							
Monitoring																								
what's on ICE as a deferred request by speciality - process to consider																								
Find a way to report what gets bounced back to acutes and which specialties to enable 360 feedback. Validate on draft template	Emma Gara / Lauren																							
shadow EMIS reported activity	Emma Gara / Lauren																							
Use of refreshed EMIS template to ensure activity recorded	Colette																							
EMIS monthly reporting live	QY and Emma Gara																							Run report 5th July for month on June 2021
Evaluation																								
Patient satisfaction survey	Lauren Oakes																							
Process for survey to be designed	LL/JW																							
Interim report of activity moved and impact to Outpatient Board																								
Survey Live																								

Aug-21				Sep-21			
9-13 Aug	16-20 Aug	23-27 Aug	30 Aug-3 Sept	6-10 Sept	13-17 Sept	20-24 Sept	27 Sept - 1 Oct

Action	Lead	Action Described	Progress
1	Marisa	BHOC keen to use - NM discuss offline with Jagi, Marissa and clinician to review criteria on SOP and recast activity	20.04.21 In Progress - chasing clinicians availability
2	Kyle Lansdown	Sirona referral process for all primary care localities to be standardised ahead of 1st May	27.04.21 - Complete
3	David Moss	Prepare offer for general practice - confirmation of intent letter from Q3 onwards	20.04.21 Complete
4	Geeta Iyer	Follow up with James Dunn the formal written intent to continue post Sept	27.04.21 - GI chasing
5	Vittorio Graziani	Prepare LES offer; take to PCCC on 27.04.21 for governance. Liaise with Keith Minty re coding and counting	20.04.21 In progress - VG drafting LES, meeting KM 21.04.21
6	Nicola McGuinness	Share agreed escalation protocol for Sirona overspill with Kyle. Nicola and Geeta to consult with membership on how overflow is funded	20.04.21 In progress
7	Bob Seymour	Liaise with Weston Hospital to obtain ICE licences for use at South Bristol SPA	20.04.21 In progress
8	Nicola McGuinness	Review EMIS questions shared by Bev Willis to support digital referral to Sirona	20.04.21 In progress
9	Geeta Iyer	EMIS template review for 360 feedback - find a way to code what gets bounced back to acutes and which specialties to enable 360 feedback of who not using new process	27.04.21 - Complete
10	Bev Willis	Report back to next meeting on progress of licences for the 26 practices	20.04.21 Complete
11	Bob Seymour	All licences required by end April - need to chase Clinisys	20.04.21 In progress - risk of resource noted
12	One Care/Geeta Iyer	Comms to practices - practice manager checklist of what is required of them for go live. Include route for obtaining consumables	
13	Kyle Lansdown	Finalise escalation site for north of region. Once known, co-ordinate dates with South Bristol and Clevedon Hospital	20.04.21 In progress - East Trees??
14	Emma Gara	EMIS search criteria to be shared with Sirona, need to quantify numbers going to Sirona (payment criteria)	20.04.21 In progress - Clarify payment criteria?? 27.04.21 - LO to ask EG and QY to attend next meeting
15	David Moss	Patient satisfaction survey - send example to Lauren to standardise with qualitative questions. Lauren to link with evaluation team at CCG	20.04.21 - In progress
16	Geeta Iyer	Contact Sarah Robinson at NBT to stress importance of allocating resource to project	
17	JW	JW to send evaluation forms for Attend Anywhere and A&G to LO	
18	Bob Seymour	Bob send practice list to LL and JW and check list to new ICE users to KM and BW - send to BW and BW to amalgamate	
19	Geeta Iyer	GI to think about comms from HT outpatient board and what this needs to pull in	

Programme	Date Logged	Decision	Updates	Status
Community Phlebotomy	20.04.21	Group agreement to do a hard launch at the start of Q2 (1st July) to allow for messaging to go out through June		

Programme	Risk Title	Date logged	Description of Risk As a result of… There is a risk that…. Which may result in…	Mitigating Actions	Progress on actions and target date for completion	Risk Owner (for updates)	Initial risk score (probability x severity)	Mitigated risk score (probability x severity)	Current risk score (probability x severity)	Last reviewed	Risk open or closed	Notes
Community Phlebotomy	UHB Administration and project support resource to get ICE licence	20/04/2021	As a result of UHB having limited administration and project support resource there is a risk that ICE licences will not be obtained on time which may result in a delayed go live date									
Community Phlebotomy	LES sign up	20/04/2021	Practices may not sign up to the LES which will result in an inconsistent service for patients across BNSSG									
Community Phlebotomy	Managing additional activity	20/04/2021	As we are unsure of demand and primary care capacity there is a risk that practices will not be able to manage the additional activity resulting in using overspill / patients being bled in secondary care	Monitoring demand and capacity at regular intervals								
Community Phlebotomy	NBT transformation resource	20/04/2021	NBT have been unable to source transformation resource to support the project, so there is a risk to the go-live date	Is there HT transformation resource we can access? Internal NBT discussions ongoing								