NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

LES Review Recommendations May 2022

Primary Care Commissioning Committee

Created by
Vittorio Graziani, Interim Contract Manager Primary Care

LES Review Progress May 2022

- LES Group meeting bi-weekly with interim working groups to progress targeted themes

- Membership includes representation from the following:

  - *Clinical Leadership*
  - *LMC*
  - *Quality*
  - *Primary Care Development*
  - *Contracting*
  - *BI Analysis*
  - *Finance*

- Supplementary Services and South Gloucestershire Basket to be reviewed over a longer time period, anticipated conclusion April 2023

Desktop Reviews 2022

All services currently commissioned under the umbrella of LES have been subject to an annual review process.

Desktop Reviews have been focused on following areas of service delivery:

- Meeting aims & objectives
- Evidence base
- Engagement
- Capacity & Demand
- Specification content
- Financial Appraisal
- Delivery Model
- What would be the impact of decommissioning this service?
- Evaluation
- EMIS extraction
- Recommendations for future of service

LES Proposals Process Overview

- Initial Desktop reviews were developed by the LES contract lead and have been submitted for the further scrutiny from Clinical and Management LES leadership.
- All LES services have been subject to a Quality Impact Assessment refreshment process
- All EMIS Web search criteria for calculating LES payment updated
- Recommendations from the review presented at the PCOG meeting on 19th May 2022 for a full review and an endorsement

PCOG endorsed 2022/23 LES Recommendations

Following LES services to continue during 2022/23 with **no change**:

- **Anticoagulation (advanced / basic)** – emphasis on management of high INR levels. Recommended proposal for in-year audit for anticoagulation activity
- **Deep Vein Thrombosis diagnosis/investigation** – reminder on anticoagulation of patients with suspect DVT
- **Dementia diagnosis and review** – practices encouraged to attend education event. Recommended further system wide alignment with MH team commissioning plans across BNSSG.
- **ADHD review** – Recommended further system wide alignment with ADHD group leadership.
- **Community Phlebotomy** – new agreement. Currently block payment for at least Q1 22/23. Large scale system transformation workstream, needs time to bed in to ensure accurate activity levels recorded, safe patient care, and assessment of general practice and secondary care capacity to undertake this work.

PCOG endorsed 2022/23 LES Recommendations

Insulin Initiation LES

- LES was discussed during the Diabetes Programme Board on 12th May 2022 - roll over for 2022/23 financial year minuted and approved.

- Confirm the non-formulary blood glucose strips prescribing will be highlighted through other Medicines Optimisation workstreams and have included a comment around this in the review.

- Sirona deliver 3 Injectable training courses each year. Dates for this year are currently TBC as planning is currently underway.

PCOG endorsed 2022/23 LES Recommendations

Care Home LES

- It is proposed that the funding aligned to the original GP Support to Care Home LES is maintained through Quarter 1 and Quarter 2 22/23. Linking in with the Ageing Well Programme, practices will be asked to support completion of a baseline exercise during Quarter 1 to understand the extent to which the Enhanced Health in Care Home DES is being delivered.

- It is recognised that there is a lack of data to support this and anecdotal evidence to suggest a varying approach to the delivery of the DES. This baseline work will help us to understand the position, understand issues in relation to data quality, identify best practice and potentially inequalities. It is anticipated that once this baseline work is completed a set of revised measures and outcomes for the LES will be developed.

- This acknowledged that the original GP support to care homes LES has been superseded by the Enhanced Health in Care Homes DES but maintains the commitment to ringfence the associated LES funding within Primary Care.

PCOG endorsed 2022/23 LES Recommendations

Specialist Medicines Monitoring LES

- Removal of Sodium aurothiomalate – At Joint Formulary Group in July 21, it was agreed to withdraw the Shared Care Protocol as no longer required and it has not been prescribed in the last year. Its Traffic Light Status was changed to Red.

- Addition of Testosterone gel

TESTOSTERONE GEL - Tostran® 2% gel and Testogel® 40.5mg/5g gel sachets

Background

Testosterone gel was approved by the BNSSG Joint Formulary Group (JFG) in 2021 and added to the Formulary on completion of a Shared Care Protocol (SCP), Amber 3 months, in January 2022. The criteria for testosterone gel is specific to a cohort of patients who were considered to benefit the most and is restricted to the use in the following:

- for treatment of low libido causing distress in women with optimised HRT **and** with either early menopause (age 45 and under) or
- surgical menopause only

PCOG endorsed 2022/23 LES Recommendations

Use of testosterone gel for women outside of this indication is non-formulary. A detailed BNSSG Menopause Guidelines and HRT Prescribing Pathway, approved in April 2022 by the Area Prescribing and Medicines Optimisation Committee (APMOC) supports the Formulary approved cohort and its place in the HRT treatment pathway.

Monitoring requirements – as per Shared Care Protocol - 6 monthly total testosterone level and sex hormone binding globulin i.e. 2 tests per year. A request for testosterone gel to be included in the Specialist Medicines Monitoring (SMM) LES was made from members of the JFG due to the additional work required to be undertaken by GPs.

Financial risk – under this LES, the blood test monitoring requirements for this medication of 2 tests per year fall in to payment level 1, that is, £50.00 per year. Based on the Formulary approved cohort we expect approximately 102 patients to meet the criteria to be offered testosterone gel. This equates to a total cost of £5,100 per annum in payment to Practices under the SMM LES if all those patients wish to choose treatment with testosterone gel when offered.

PCOG endorsed 2022/23 LES Recommendations

Risks and mitigations – we are confident that we can refine EMIS searches so that only patients meeting the Formulary criteria will be included. This will ensure that patients who may be prescribed testosterone gel for other indications that are non-formulary will be excluded from LES payment. Medicines Optimisation will monitor the patient numbers and spend of testosterone gel and put a plan of action to investigate initiation and prescribing should figures be different to that expected.

Recommendation – to approve addition of testosterone gel as per Joint Formulary indications and Shared Care Protocol to the Specialist Medicines Monitoring LES

Recommendations for PCCC

- Support reissue of the following LESs with no change for the remainder of 22/23:
  - Anticoagulation
  - Deep Vein Thrombosis diagnosis and investigation
  - Insulin initiation
  - Dementia diagnosis and review
  - ADHD review
- Support reissue of the following LESs for Q2 of 22/23
  - Care Home LES
  - Community Phlebotomy
- Support the addition of testosterone gel to the specialist medicines monitoring LES and the removal of sodium aurothiomalate

Desk Top Review template – March 2022

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Local Enhanced Service Name:

Anticoagulation LES: INR monitoring and vitamin K anticoagulant dosing

Contractual notice period of LES:

N/A contract ends 31 March 2023

Date of review:

March 2022

Lead Manager: Debbie Campbell

Lead Clinician: Ali Mundell and Shaba Nabi

EMIS clinical codes:

Anticoagulation
EMIS Web search criteria for calculating LES payment:-
All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
International normalised ratio	257472014
International normalised ratio result obtained using portable international normalised ratio monitoring device	2795101015
International normalised ratio using test strip	679061000000110
INR (International normalised ratio)	3032648015
INR - International normalised ratio	2772581000000114
International normalised ratio	3030961014

Financial Appraisal:

- What is the cost of delivering the service (current forecast outturn)?
- What are we paying for the service (tariff)?
- What would be the costs of not delivering the service?
- Are there any risks of duplicate payments across other contracted services?

2021/22	Budget	Q1 block	Q2 activity	Q3 actual	Q4 projected	FOT
Anticoag	424,096	106,024	63,907	62,832	63,907	307,169

where the code was added within the search period AND the patient had a VKA medication issue (warfarin, phenindione, acenocoumarol) in the 6 months prior to the end date of the search period		

2020/21 DATA

Anticoagulation 2020-21

Number of patients with current VKA course and INR code in past 100 days

Practice	Q1	Q2	Q3	Q4
Grand Total	**2,760**	**2,826**	**2,863**	**2,908**

2021/22 DATA (Q1-Q3)

Anticoagulation 2021-22

Number of patients with current VKA course and INR code in past 100 days

BNSSG CCG

Practice	Q1	Q2	Q3
Grand Total	**2754**	**2815**	**2754**

1	**Meets aims & objectives** What are the clinical aims and objectives of the service? • How is this / does this continue to align with system/LTP priorities? • Does this service promote the reduction of health	**The aims of this service are:** To ensure patients who need initiation on a Vitamin K antagonist or are receiving maintenance treatment with a vitamin K antagonist get care that is safe, effective, and sustainable. **The objectives of this service are:**

	inequalities? • Was an Equalities Impact Assessment undertaken to support the service? • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? • Does this work impact on existing or proposed pathway work? • Do we commission this service elsewhere? • Is it a duplication of services provided by other organisations? • In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?	• To safely initiate and maintain suitable patients on vitamin K antagonist therapy. • To provide patients receiving a vitamin K antagonist with the information they need to safely manage their treatment. • To improve patient education in relation to their condition, understanding of their treatment, target INR range, the effects of over or under anticoagulation, the effect of diet changes, effects on lifestyle and the importance of interactions with other medications. To ensure patients are given a yellow oral anticoagulant book • To monitor the safety and effectiveness of vitamin K antagonist treatment by ensuring the INR is measured at appropriate regular intervals. • To ensure the GP practice collaborates with specialists when necessary to assist in the management of patients with very high INR results (INR >6) and to ensure a Datix is completed for these patients • To ensure that patients who do not regularly achieve therapeutic INRs are reviewed and appropriate action is taken to improve the patients 'time in therapeutic range' • To provide the service to a high standard in a way that is convenient for patients. • To ensure that providers of care work together and share data relating to anticoagulation to support safe and effective care for the patient. **Alignment with system/LTP priorities:** This service supports the system wide approach to medicines safety, delivering the NHS safety improvement Programme aiming to reduce avoidable medication-related harm by 50% over 5 years. This links to planned care priorities: Providing care closer to home and in the community with key decision making being driven from Primary care to help patients manage their health choices. **Does this service promote the reduction of health inequalities?** No – Continuation of 2 commissioned services across BNSSG

		(advanced and basic service) **Was an Equalities Impact Assessment undertaken to support the service?** Yes  EIA May 22 Anticoag LES.docx **Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)?** Developing a localities or potentially PCN model of service delivery to bring efficiencies and safeguard the quality and service standards. **Does this work impact on existing or proposed pathway work?** If the CCG changes the delivery model then yes this would impact on existing pathways. Option 1 would be de-commissioning hospital services and commissioning localities to undertake this work. It aligns to locality or PCN model for service delivery. Changing the delivery model would mean a change in the pathway for patients and using near patient testing rather than a venous blood test'. As numbers of patients prescribed warfarin are reduced this could present a risk as practice staff may become less familiar with warfarin management. Option 2 would be to stop using near patient testing and to undertake venous samples and to commission the hospitals to undertake this work. However, it is likely that patients would prefer option 1 as it reduces the need for venous blood samples. Option 3 is to continue with the current model. **Do we commission this service elsewhere?** UHBW (BRI site) and NBT for dosing patients from bloods taken by the

		GP (Basic service) **Is it a duplication or in line with other services?** The LES provides two pathways for the service as detailed (basic and advance) which is historic from before BNSSG CCGs merged **In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?** Unknown, (TBC) but this has always been deemed not part of core GMS/PMS contract. Historically vitamin-K antagonist management was undertaken by GP's. As the number of patients on therapy increased hospitals were commissioned to undertake the activity. However, as the prescribing of direct oral anticoagulants (DOACs) increases there is a reduction in the number of patients prescribed warfarin. **Is there any overlap with the DRAFT 2022/23 PCN DES specifications?** No
2	**Evidence base and patient access** What evidence base is there to support that this meets local population health need and/or addresses variation in quality	In 2007 the National Patient Safety Agency (NPSA) issued 'Patient Safety Alert 18' which contained a set of recommendations aimed at increasing the safety of warfarin dosing. • Audit anticoagulant services using BSH/NPSA safety indicators as part of the annual medicines management audit programme. • Ensure that patients prescribed anticoagulants receive appropriate information. • Promote safe practice for prescribers and pharmacists to check that patients' blood clotting (International Normalised Ratio, INR) is

		monitored regularly, and that the INR level is safe before issuing or dispensing repeat prescriptions for oral anticoagulants.
3	**Impact of COVID on LES Delivery** • How has COVID impacted the way this LES can be delivered e.g. switch from face to face to remote delivery? • Does the specification need to be updated to reflect these changes?	Due to Covid a large number of patients have switched from Warfarin to a DOAC. In addition, the frequency of INR testing has been reduced for stable patients to reduce the need for face to face contact. The specification does not need to change but the number of patients will be reduced
4	**Engagement and patient feedback.** What feedback or engagement has there been in the provision/delivery of this service (clinical, patient and/or with other stakeholders)? How could this be incorporated into spec development going forward?	Consideration have been given to burden of audits during the covid 19 pandemic Complaints – *awaiting response*
5	**Specification content** • Do any changes need to be made to the specification based on the evaluation or any other developments? *This should include changes in clinical guidance such as updates to NICE links in the current specification **Please pay particular attention to any links and embedded documents Y/N – if yes, please outline	BNSSG guidance is being written on the prescribing of vitamin K in patients with a high INR. Once this has been approved by APMOC, this can be audited. Consideration have been given to burden of audits during the covid 19 pandemic

6	**Delivery Model** • To ensure best quality and value what footprint is this service best delivered at e.g. Practice / PCN / Locality • For the answer above please state why	Current information technology would accommodate this being delivered at scale within the localities or PCNs to patients. The impact of this change on quality or cost of service is unknown however with less staff needing to maintain highly specialised skills this could improve the quality of the service offered and reduce variation in quality. <u>As the number of patients prescribed warfarin reduces, there is a need to ensure resilience within the PCN.</u> In order to change the service model, this would be relatively easy for those practices currently offering the advanced service, however, would require significantly more resources including digital resources and education for those practices only offering the basic service. .
7	**What would be the impact of decommissioning this service?** • What are the implications for patients? • Is there an impact on other stakeholders, premises, equipment etc.? • Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? • Would decommissioning affect the viability of a provider?	Numbers of patients taking warfarin are reducing, there are situations where DOACs are not licensed or unsuitable and so warfarin will always be required for some patient groups. These patients will always require a service to monitor their INR and advise on dosing. We do not know which service is currently cost and clinically more effective. • **AUDIT for 22/23 as a part of the spec** However, so far it has proven difficult to fully understand the costs of the secondary care service. Decommissioning of the current advanced service is likely to result in patients being registered with an alternative anticoagulation service. This is currently available at NBT or UHBW (BRI site) for vitamin-K anticoagulation management. Negotiations would be needed with NBT and UHBW regarding capacity and cost to take on this additional activity. Decommissioning of the current advanced service would have a significant effect on these services as capacity would need to be

		increased. Also impact on patients would need to be considered. North Somerset Practices and some Bristol practice have already invested in coagu-check INR machines circa. A health inequalities impact assessment was undertaken. If considering decommissioning of the advanced service at the current GP practice providers in North Somerset some practices have employed staff to run this locally enhanced service, so will have impact
8	**Evaluation** • What monitoring takes place and how often is it reported? • Have any audits taken place to assess effectiveness?	
10	**Data Challenges** • Have there been any data extract challenges in relation to this enhanced service?	
11	**EMIS extraction** • Are there any changes recommended to the searches? (please describe changes and why they are needed)	The search has been changed to look for patients with an INR coded within the search timeframe (e.g. Q4 2022-23) and a VKA anticoagulant prescription issue in the 6 months prior to the end date of the search period. INRs should be taken at a maximum of 12 weekly intervals so searching for an INR within the quarter should catch almost all if not all patients. Prescriptions for VKA anticoagulants can be quite infrequent hence why a prescription in the past 6 months is looked for in the search criteria. This change is necessary as the old search looked for patients with a current course of a VKA which can be inaccurate when searching

		historically. Looking for INR testing and recent VKA prescription issues will give more accurate results.
12	**Recommendations for future of service:** • Continue at practice level OR • Continue at PCN or locality level • Minor amendments required • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	It is recommended that we continue with this LES as it is, but continue to monitor the number of patients at practice level. Evidence shows that keeping this work stream in primary care can be done both safely and effectively and does not need to be returned to secondary care, where this work was historically undertaken. If the downward trend in the prescribing of vitamin-K antagonists continues this may need to be reviewed over the next ten years to ensure viability in primary care in relation to the availability of suitably trained healthcare professionals with enough experience to maintain general as well as dosing competency.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	**Risk** - Developing a locality/PCN model of delivery includes risk of de-skilling of prescribers, nurses and GP's who are currently involved in vitamin-K antagonist management in GP practices. **Mitigation** – Ensure service is sufficiently staffed by multiple persons to enable a suitably large cohort of people to retain the necessary skills to ensure resilience and sustainability of a locality model. (e.g. if the locality service was run by two prescribing nurses it would not be resilient against sickness, holidays or resignation from post or retirement) **Risk** - Increased cost to the CCG. Mitigation - renegotiation of contract with UHBW and NBT for the anticoagulant monitoring service they currently provide.

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Equality Impact Assessment

Name of Proposal being assessed: Anticoagulation LES: INR monitoring and vitamin K anticoagulant dosing

Does this Proposal relate to a new or existing programme, project, policy or service?

Lead Officer completing EIA	Alison Mundell
Job Title	Principal Medicines Optimisation Pharmacist
Department/Service	Medicines Optimisation
Telephone number	
E-mail address	Alison.mundell@nhs.net
Lead Equality Officer	
Key decision which this EIA will inform and the decision-maker(s)	The production of the anticoagulation local enhanced service.

Step 1: Equality Impact Assessment Screening

1. Does the project affect service users, employees and/or the wider community?

The Anticoagulant local enhanced service (LES) affects the service provided by GP practices for patients who are on vitamin K antagonist anticoagulants (warfarin).

In 2020/21 there were 4,209 patients on this medication across BNSSG. For the same period in 2021/22 this has reduced to 3342 patients.

The Anticoagulant LES enables patients to have their International Normalised Ratio (INR) monitored using near patient testing, or the blood taken for INR monitoring at their GP practice preventing the need for frequent visits to secondary care.

There are two different pathways for this in BNSSG due to the historical processes in the different areas. An options appraisal for the pathways in BNSSG has concluded that currently the different pathways should continue. This is due to the lack of evaluation of clinical superiority or efficacy of either pathway and a lack of clarity of some of the financial impacts. Work will be done in the long term to evaluate the two pathways fully and then a further options appraisal will be undertaken.

In the meantime there will be two pathways and therefore different services offered to different areas of BNSSG.

Basic service – venous blood sample taken at GP surgery, which is then sent to a secondary care laboratory for analysis of INR, a specialist secondary care clinic then doses the warfarin and informs the patient, through letter or phone call.
Advanced service – a coaguchek (near patient testing machine for INR) is used at a GP surgery to check INR. This is then dosed at the GP practice aided by a computer system – INR star.

The advanced service is undertaken in North Somerset and one practice in the rest of BNSSG, the basic service is undertaken in Bristol and South Gloucestershire. This is no change to the services currently offered.

2. Could the proposal impact differently in relation to different characteristics protected by the Equality Act 2010?

Both pathways enable patients to visit their local GP practice for their warfarin monitoring, preventing the need for a visit to secondary care.
Patients on the basic level pathway need to have a morning appointment at the practice for venous bloods to ensure time for it to be sent in and dosed. This may have an impact for people who work.
The advanced level service only requires a finger pick sample compared to a venous blood sample for those on the basic level service. This may have an impact on those with a disability which means they do not 'like' having blood taken.
However these impacts are not new for the proposed service.

Assessment of Impact of Proposal on Protected Characteristics				
Protected Characteristic	**Positive Impact** ✓	**Negative Impact** ✓	**Neutral Impact** ✓	**Please provide reasons for your answer and any mitigation required**
Age* [eg: young adults, working age adults; Older People 60+]			**Yes**	There is no change to the current service
Disability Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty/ Disability; Long-Term Condition	**Yes**			Removing or minimising disadvantages experienced by people with long-term conditions due to their protected characteristics. Taking steps to meet the needs of people with long-term conditions where these are different from the needs of other people
Gender Reassignment [Trans people]			**Yes**	There is no change to the current service

Assessment of Impact of Proposal on Protected Characteristics				
Protected Characteristic	**Positive Impact** ✓	**Negative Impact** ✓	**Neutral Impact** ✓	**Please provide reasons for your answer and any mitigation required**
Race [including nationality and ethnicity]			**Yes**	There is no change to the current service
Religion or Belief			**Yes**	There is no change to the current service
Sex [Male or Female]			**Yes**	There is no change to the current service
Sexual Orientation			**Yes**	There is no change to the current service
Pregnancy and Maternity			**Yes**	There is no change to the current service
Marriage and Civil Partnership			**Yes**	There is no change to the current service

* Under-18s are only protected against age discrimination in relation to work, not in access to services, housing, etc. Children's rights are protected by several other laws and treaties, such as: The Children Act; the Human Rights Act 1998; the UN Convention on the Rights of the Child; the European Convention on Human Rights; the UN Convention on the Rights of Persons with Disabilities; and the UN Convention on the Elimination of Discrimination against Women.

3. Relevance to the Public sector Equality Duty:

All groups are treated equally in the pathway that their area uses.

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.

Not relevant to this project

Advance equality of opportunity between people who share a protected characteristic and those who do not.

Not relevant to this project

Foster good relations between people who share a protected characteristic and those who do not.

Not relevant to this project

4. Health Inequalities:

Does the proposal relate to an area with known Health Inequalities? No

This LES covers the whole of BNSSG and thus would cover geographical areas that have known health inequalities however there is no change to the service so patients should not notice any difference to the way their warfarin is monitored.

5. On the basis of this screening assessment do you consider this proposal to be relevant to the General Duty or to any particular protected characteristic? #yes

6. If no, then set out reasons and evidence here:

7. Conclusion:

Proceed to full EIA? **No**

Signed: A Mundell

Date: 4/5/22

Step 2: Scoping of the Equality Impact Assessment

What are the main aims, purpose and outcomes of the proposal?

[Describe the policy/practice that is being developed or reviewed. Think about:

- What is the purpose of the policy or practice?
- In what context will it operate?
- Who is it intended to benefit?
- What results are intended?
- Why is it needed?]

What aspects of the project are particularly relevant to equality?

[For example: the policy statement, referral or access criteria, communication with patients, equity of access to services, patient experience, stakeholder engagement]

What evidence is already available that will help in the development of both the project and the EIA?

[State the main sources of data and information - for example:

- Equality monitoring data on patients, service users or employees
- Demographic data (including Census)
- Recent engagement work
- Previous engagement work
- Annual reports
- Ad hoc audits
- Joint Strategic Needs Assessment
- Healthwatch reports
- Analysis of PALS, complaints and other feedback
- Equality Delivery System (EDS2) reports
- Comparison with similar work elsewhere]

Do you require further information to gauge the probability and / or extent of any adverse impact on protected groups?

[think about how you might get this information – new consultation activities, benchmarking, etc]

Which communities and groups have been or will need to be consulted or involved in the development /review of the project/service?

[this will help to identify engagement opportunities set out in the Patient and Public Involvement Plan]

Step 3: Equality Analysis

[This section is about bringing together all of your equality information in order to make a judgement about what the likely effect of the policy, practice or service will be on the equality duty and whether you need to make any changes to the policy, practice or service. Be wary of general conclusions – it is not acceptable to simply conclude that a policy will universally benefit all patients, service users or employees regardless of any protected characteristic, without having evidence to support that conclusion.]

[What are the:

- Actual or potential positive outcomes/impacts in relation to the public sector equality duty?
- Actual or potential negative outcomes/impacts?
- Actual or potential neutral outcomes/impacts?]

Statement of actions which have already been taken to remove/minimise the potential for adverse outcomes/impacts and to maximise positive outcomes/ impacts

[Key questions:

- Could the proposal disadvantage people from a particular group?
- Could any part of the proposal discriminate unlawfully?
- How does the proposal advance equality and foster good relations, including participation in public life?
- Are there other projects or policies that need to change to support the effectiveness of this proposal?]

Assessment of the legality of the proposal

[Key questions:

- Could the proposal disadvantage people with a particular protected characteristic?
- Could any part of the proposal discriminate unlawfully?
- Are there other proposals, projects or policies that need to change to support the effectiveness of this proposal?]

What is the outcome of the Equality Impact Assessment?

Choose ONE option:

No major change – the EIA demonstrates that the project plan is robust. The evidence shows no potential for discrimination and opportunities to promote equality have been identified and implemented.

Adjust the project proposals/plan to remove barriers or to better promote equality. This might mean introducing measures to mitigate the potential effect.

Continue the project despite potential for adverse impact or missed opportunities to promote equality, provided you have satisfied yourself that it does not unlawfully discriminate.

The EIA identified actual or potential unlawful discrimination. Changes have been made to the project to remove any unlawful discrimination.

Action Plan – Details of proposed mitigation/improvement			
Action	**Owner**	**Due Date**	**Outcome**

Step 4: Monitoring, Evaluation and Review

Please provide details of how the actual impact of the project will be monitored?

[Consider:

- How you will measure the effects of the project
- When the policy/ practice will be reviewed and what could trigger an early revision
- Who will be responsible for monitoring and review
- What type of information is needed for monitoring and how often it will be analysed
- How to engage relevant stakeholders in implementation, monitoring and review]

When will this EIA be reviewed?

Date:

Step 5: Approval and publication

Approved by Equality & Diversity Lead	Date: Name:
Approved by Project Lead / RO	Date: Name:

Step 6: Monitoring and Reviewing the Action Plan

Review of EIA - Update / Observations / Changes	
Please provide details:	
Approved by Equality & Diversity Lead	Name: Date:
Approved by Project Lead	Name: Date:
Date of Next Review (If no further review required please provide reasons)	Date:

Desk Top Review template – March 2022

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Local Enhanced Service Name:

DVT LES

Contractual notice period of LES:

N/A contract ends 31 March 2022

Date of review: March 2022

Lead Manager:

Margaret Kemp/ Andy Newton

Lead Clinician

David Peel

EMIS clinical codes:

DVT

EMIS Web search criteria for calculating LES payment:-
All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Point of care D-dimer assay negative	1121441000000116
Point of care D-dimer assay positive	1121381000000119
Test request : D-dimer assay	1822621000006115

where the code was added within the search period AND the patient was 18 years or older at the time of coding.

Financial Appraisal

- What is the cost of delivering the service (current forecast outturn)?
- What are we paying for the service (tariff)?
- What would be the costs of not delivering the service?
- Are there any risks of duplicate payments across other contracted services?

	Budget 21/22	Q1 block	Q2 activity	Q3 actual	Q4 projected	FOT
DVT	63,720	15,930	10,410	9,250	10,410	46,000

2021/22 DATA (Q1-Q3)

DVT 2021/22

(All)

D-Dimer Test/POC Testing Kits			(All)
All practices	**Q1**	**Q2**	**Q3**
Grand Total	**334**	**262**	**233**

1	**Meets aims & objectives** What are the clinical aims and objectives of the service? • How is this / does this continue to align with system/LTP priorities? • Does this service promote the reduction of health inequalities? • Was an Equalities Impact Assessment undertaken to support the service? ***EIA to be REFRESHED and embedded)*** • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? • Does this work impact on existing or proposed pathway work? • Do we commission this service elsewhere? • Is it a duplication of services provided by other organisations?	**Objectives:** Access is available to all registered at the participating practice It is still felt that GP practices are best placed to deliver phase 1 of this pathway with phase 2 clinics being strategically located across the patch. The alternative would be phase 1 being delivered at hub level or in acute trusts. **The DVT pathway (all phases) was due to be evaluated in quarter 1 2021 but this has not happened as yet.** The core contract does not describe the pathway in this level of detail therefore the LES provides this clarity and sets the expectations for practices.

	• In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?	
2	**Evidence base and patient access** What evidence base is there to support that this meets local population health need and/or addresses variation in quality	**Need local evidence to complete**
3	**Impact of COVID on LES Delivery** • How has COVID impacted the way this LES can be delivered e.g. switch from face to face to remote delivery? • Does the specification need to be updated to reflect these changes?	N/A patients require a face to face appointment, referral rates were lower than original estimations and referral rates pre Covid
4	**Engagement and patient feedback.** What feedback or engagement has there been in the provision/delivery of this service (clinical, patient and/or with other stakeholders)?	. No evidence of patient complaints – awaiting verfication
5	**Specification content** • Do any changes need to be made to the specification based on the evaluation or any other developments? *This should include changes in clinical guidance such as updates to NICE links in the current specification **Please pay particular attention to any links and embedded documents Y/N – if yes, please outline	No changes have been requested – continued messaging around anticoagulating patients until the venous d-dimer result is available, and a clinician is able to act on that result

6	**Delivery Model** • To ensure best quality and value what footprint is this service best delivered at e.g. Practice / PCN / Locality • For the answer above please state why	.As noted in previous reviews, the fact that a patient is seen in practice but then asked to attend another location may not be considered good patient experience. However, no feedback has been received in the form of complaints
7	**What would be the impact of decommissioning this service?** • What are the implications for patients? • Is there an impact on other stakeholders, premises, equipment etc.? • Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? • Would decommissioning affect the viability of a provider?	The pathway elements not delivered by Primary Care are contracted to GP care for another 2 years. Removing this stage of the pathway would present a risk to safety / increased cost of an urgent care attendance. To have this located in primary care was identified as beneficial for patients. Need to confirm with outpatients DVT pathways review outcomes
8	**Evaluation** • What monitoring takes place and how often is it reported? • Have any audits taken place to assess effectiveness?	Data extracted via EMIS extract and report Audits have been stood down
10	**Data Challenges**	

	• Have there been any data extract challenges in relation to this enhanced service?	Some practice challenge on the extracted data, these are being worked through
11	**EMIS extraction** • Are there any changes recommended to the searches? (please describe changes and why they are needed)	No changes are planned to the searches for the DVT LES. The Clinical codes used in the search are already aligned with the Ardens template for practices who use this template
12	**Recommendations for future of service:** • Continue at practice level OR • Continue at PCN or locality level • Minor amendments required • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	Continue at practice level with DVT pathways full alignment.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	N/A

Desk Top Review template – April 2022

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Local Enhanced Service Name:

Type 2 Diabetes Insulin Start LES

Contractual notice period of LES: N/A contract ends 31 March 2022

Date of review: April 2022

Lead Manager:

Debbie Campbell

Lead Clinician:

Shaba Nabi / Dr Mike Jenkins

EMIS clinical codes:

EMIS Web search criteria for calculating LES payment:-
All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Conversion to insulin	264706016
Insulin treatment initiated	646031000000112

where the code was added within the search period AND NOT before AND the patient was 16 years or older at the time of coding AND they have type 2 diabetes mellitus coded

Finance 2021/22 :

	Budget	Q1 block	Q2 activity	Q3 actual	Q4 projected	FOT
Insulin	47,132	12,483	8,575	7,350	8,575	36,983

2020/21 DATA (No of pts)

Practice Breakdown - Insulin				
Practice	**Q1**	**Q2**	**Q3**	**Q4**

Grand Total	**42**	**35**	**60**	**60**

2021/22 DATA (Q1-Q3)

Practice Breakdown – Insulin Q1-Q3

BNSSG CCG	**Q1**	**Q2**	**Q3**
Grand Total	**42**	**49**	**42**

1	**Meets aims & objectives** What are the clinical aims and objectives of the service? • How is this / does this continue to align with system/LTP priorities? • Does this service promote the reduction of health inequalities? • Was an Equalities Impact Assessment undertaken to support the service? • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? • Does this work impact on existing or proposed pathway work? • Do we commission this service elsewhere? • Is it a duplication of services provided by other organisations? • In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?	**Objectives:** • To improve the quality of care provided in the community to patients with type 2 diabetes by making the service more accessible and responsive. This is facilitated by the shift from secondary to primary care and removing the need for patients to travel to acute trusts to undergo Insulin Initiation • This enhanced service will fund practices to identify and initiate patients suitable for Insulin initiation, (Hba1c> 57) • Provide patients with education around lifestyle and self-titration of insulin doses, which in turn will promote the self-care agenda as vital in the management of long-term conditions such as diabetes • The frequency of appointments is agreed on an individual basis with the patient. • To reduce HbA1c to agreed individualised targets • To reduce the long-term complications of diabetes

		• To reduce non-elective hospital admissions in patients with diabetes. • To work towards NHS BNSSG CCG's objectives of delivering care closer to home • Improve outcomes for patients by optimising glycaemic control • Facilitate intensification of therapy in primary care when this requires parenteral therapy • Improve adherence to the latest NICE guidance • Deliver safe, effective, and sustainable treatment • Evaluation the quality of care for patients with diabetes through regular audit process **Key Areas of Good Practice** • Providing care for patients out of acute care and closer to home • Cascading of specialist knowledge from DSNs to practice clinicians The aim of this LES is to encourage practices to ensure their staff are well trained and updated. The National Diabetes Audit has shown BNSSG as outliers for diabetes treated to target and a significant aspect of this is clinical inertia – slow movement to the next stage of therapy. Local quality service – not secondary care Practice Clinicians have to have attended insulin training and update **CCG Priorities** This is an example of integrated primary and community care, with simplified access points for patients to specialised services. Along with delivering care closer to home **Reducing Health Inequalities** • There is easier access for patients who are less likely to travel to

		attend secondary care • Patients are more likely to attend GP practice as familiar surroundings. Practices will have more background knowledge of social circumstances to make the care more holistic for the patient **Any other ways of delivering the service** • The service could be delivered by secondary care, community DSNs or localities could provide this service. • This service could be delivered by a practice pharmacist with input from dietitian and practice nurse to ensure patient receives holistic care. • PCNs could collaborate to provide this service – see below **Does this work impact on existing or proposed pathway work?** This pathway exists alongside current pathway work, and links in with healthcare professional education work stream of the STP
2	**Evidence base and patient access** What evidence base is there to support that this meets local population health need and/or addresses variation in quality	Diabetes Insulin initiation occupies an important place in the management of type 2 diabetes. The National Diabetes Audit has shown BNSSG as outliers for 'diabetes treated to target'. Skilled clinicians are required in general practice for recognising insulin as the clear next step and initiating it with confidence as part of normal work. This Local Enhanced Service specification outlines the process for undertaking treatment initiations in primary care, reducing the need for patient referral to secondary care. It will necessitate additional training for some practice clinicians and as such, will help improve the general management of patients with type 2 diabetes. This service is an example of integrated primary and community care, with simplified access points for patients to specialised services **Diabetes Clinical and Social Outcome Measures**

			LTC 3 - Potential Years of Life Lost (PYLL) in people with diabetes LTC14 Smoking in people with diabetes LTC15 Obesity in people with diabetes LTC16 Episodes of ill health requiring emergency admission in people with diabetes LTC17 Days disrupted by care in people with diabetes LTC19 Acute symptoms related to diabetes control LTC23 Acute Kidney Injury (AKI) in people with diabetes LTC53 Lower limb amputation in people with diabetes LTC54 End-Stage Renal Failure (ESRF) in people with diabetes LTC55 Blindness in people with diabetes LTC57 Age at onset of first stroke in people with diabetes LC58 Age at onset of first MI in people with diabetes
3	**Impact of COVID on LES Delivery** • How has COVID impacted the way this LES can be delivered e.g. switch from face to face to remote delivery? • Does the specification need to be updated to reflect these changes?		To support Practice's during the pandemic a guideline was pulled together to support reduced, but safe initiation. This will need to be considered within the audit for 22/23 although it is likely audit requirements will be stood down Changes to staff during the pandemic and the unavailability of Injectables training courses and updates may have resulted in a deskilled practice team and therefore a reduced ability for practices to deliver the LES as they have no trained/competent staff. The Specification currently states GP has to have attended a 2 day insulin initiation and diabetes management course or equivalent training in the past 2 years – this may now be overdue for many.
4	**Engagement and patient feedback.** What feedback or engagement has there been in the provision/delivery of this service (clinical, patient and/or with other stakeholders)? How could this be incorporated into spec development going forward?		. No Patient Complaints Practices have queried funding for GLP1 s (see comment below regarding Specification content which covers possible incorporation of this into the spec ongoing)

5	**Specification content** • Do any changes need to be made to the specification based on the evaluation or any other developments? *This should include changes in clinical guidance such as updates to NICE links in the current specification **Please pay particular attention to any links and embedded documents Y/N – if yes, please outline	Y - Please see tracked changes and comments on Insulin LES Spec review document sent with this document In a previous desktop review, it was noted that *some practices in Bristol and South Glos have expressed concern that GLP1 starts are no longer funded within this LES. Some practices threaten to stop GLP 1 starts and refer these to the DSN team which would undermine the work of the DSN team. The LES needs to state that in order to partake in the LES and receive payment for Insulin starts the practice must also be starting GLP1s where this is routine and straight forward.* I cannot see that this statement is included in the current LES Spec – does this need to be added/considered? The community DSN teams assist with training for both GLP1 and insulin starts and ongoing treatment review – awaiting confirmation from Sirona about the availability of these courses this year.
6	**Delivery Model** • To ensure best quality and value what footprint is this service best delivered at e.g. Practice / PCN / Locality • For the answer above please state why	The service must have a designated lead within the practice/locality. In usual circumstances routine insulin initiation and other non-insulin injectable diabetes treatment initiation must be provided by the practice and its employed clinical staff and not by community or specialist nurses. **Could this service be delivered by another provider?** If the quality of the service can be maintained, then primary care is the ideal place for this service. The service could be delivered by community DSNs but this would put pressure on an already stretched service. The service could be delivered by secondary care DSNs, but this would be at a greater cost, and less accessible for patients. **How would this impact on quality of service delivery and the cost of service delivery?** If fewer staff were involved in the locality model, it would be easier to monitor competency, the quality of the service and reduce variation. It could also reduce the cost of service delivery if it was a specialist service offered within a locality (fewer staff would need training and

		fewer staff would need to remain competent in this specialist area). Specialists would have access to electronic patient records, and would still allow patients to access this service locally. I feel this could probably in the future, once they are more set up, be delivered across a PCN which would support practices who currently do not have competently trained staff. Group starts may be feasible.
7	**What would be the impact of decommissioning this service?** • What are the implications for patients? • Is there an impact on other stakeholders, premises, equipment etc.? • Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? • Would decommissioning affect the viability of a provider?	**Implications for Patients** Patients may not be able to access this service close to home. Practice clinicians would become de-skilled. There would be a negative impact on patient experience. Secondary care and/or community diabetes services would be stretched further. There would be no incentive for practices to remain upskilled and continue this service. **Is there an impact on other stakeholders, premises, equipment etc?** There could be an impact on premises if community providers provide the insulin initiation service at GP practices; there have been reports of GP practices charging community specialists for use of rooms in their practices. Practice room availability is limited across BNSSG. **Would Decommissioning Affect the Viability of the Provider** Decommissioning would not affect the viability of primary care however primary care view pockets of funding such as this as general support to them to maintain a skilled team, able to take on such work. There is a danger that the DSN service would become over stretched if all insulin initiations were transferred to community providers or secondary care – This would also disrupt the model for the community DSN teams which is currently to support primary care development rather than to do the work for primary care. This would also lead to longer waits for patients in order to start insulin if referral to secondary care/community DSN is required.

8	**Evaluation** • What monitoring takes place and how often is it reported? • Have any audits taken place to assess effectiveness?	Currently no audits take place, suggest auditing of training/competency.
10	**Data Challenges** • Have there been any data extract challenges in relation to this enhanced service?	Not aware of any challenges.
11	**EMIS extraction** • Are there any changes recommended to the searches? (please describe changes and why they are needed)	Yes, EMIS extraction in place on a quarterly basis. The searches should include adherence to formulary choice of testing strips, pen needles and lancets as well as the formulary insulins (although the guidelines and formulary are currently being updated and so may need to be a consideration for next year).
12	**Recommendations for future of service:** • Continue at practice level OR • Continue at PCN or locality level • Minor amendments required • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	No major change is proposed for the year ahead but there is room to open a discussion with PCNs on the future of insulin LES / Diabetes LES and what this could look like in 1, 2 or 5 years time. Room for PCNs to collaborate on insulin starts (?group starts) – PCNs to have local diabetes centres – PCN collaboration to achieve improvement on a diabetes data set (i.e. not simply limited to insulin but looking to general improved outcomes for diabetes across the PCN system.
13	**Risk Assessment**	

	Please provide a summary of any risks arising from recommendations and any proposals for mitigation	The offer to engage with PCNs to discuss the future of LES linked to diabetes – could raise PCN expectations beyond the capacity of the CCG to follow through.

Desk Top Review template – March 2022

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Local Enhanced Service Name: Dementia LES - Recognition and Management of People with Dementia and their Family/Carers in General Practices **Contractual notice period of LES**: N/A contract ends 31 March 2022	**Date of review:** March 2022
Lead Manager: **Ian Popperwell**	**Lead Clinician** Dr Geeta Iyer
EMIS clinical codes: <u>Dementia Diagnosis</u> EMIS Web search criteria for calculating LES payment:- All patients (including deducted and deceased) who have been coded with any of the codes from the QOF (V46 Release 1.1) Dementia Register (DEM001) where the earliest coding is within the search period AND the patient has any of the below codes added in the six months prior to the search period	**Financial Appraisal** • What is the cost of delivering the service (current forecast outturn)? • What are we paying for the service (tariff)? • What would be the costs of not delivering the service? • Are there any risks of duplicate payments across other contracted services?

Clinical Code Description	SNOMED Description ID
Assessment for dementia	2247561000000112
TYM (Test Your Memory) test total score	3637929018
Mini-Cog test score	3289307011
6CIT (Six Item Cognitive Impairment Test) total score	2718871000000119

	Budget	Q1 block	Q2 activity	Q3 actual	Q4 projected
Dementia	497,414	110,319	156,443	142,269	156,443

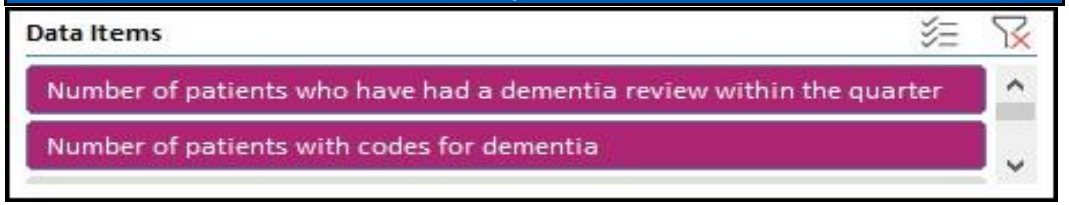
Dementia Review
EMIS Web search criteria for calculating LES payment:-
All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Review of dementia advance care plan	1906941000006119
Review of dementia advance care plan	2742991000000115
Dementia care plan reviewed	2439631000000113

where the code was added within the search period

2021/22 DATA (Q1-Q3)

Practice Breakdown - Dementia
(Multiple Items)



Practice	Q1	Q2	Q3
Grand Total	**1554**	**1795**	**1950**

1	**Meets aims & objectives** What are the clinical aims and objectives of the service? • How is this / does this continue to align with system/LTP priorities?	**Objectives:** The Provider will work with the Commissioner to ensure

	• Does this service promote the reduction of health inequalities? • Was an Equalities Impact Assessment undertaken to support the service? • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? • Does this work impact on existing or proposed pathway work? • Do we commission this service elsewhere? • Is it a duplication of services provided by other organisations? • In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?	that the Service meets the following aims and objectives: • Ensure people with dementia and their family/carers receive the highest possible level of care. • Ensure each practice has a lead GP and lead practice nurse/health practitioner for dementia. • Increase the early recognition and diagnosis of dementia in every GP practice in BNSSG. • Enable secondary care to support primary care to make a diagnosis of dementia. • Provide a recall and comprehensive review system for people who are initiated and stabilised on Cholinesterase Inhibitors and/or Memantine in Primary Care with advice and support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North Somerset and South Gloucestershire. • Provide a comprehensive review process for people with dementia who are on anti-psychotic medication. • Practices should aim for GPs to diagnose dementia in the majority of straightforward cases. Patients with atypical presentations such as young, rapid onset, frontal and Lewy Body patients might expect to be diagnosed by or with the support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North

		Somerset and South Gloucestershire. • Provide a holistic package of care to enable more people with dementia and their carers to live fuller lives and avoid crisis admissions. • Enhance physical care and health promotion advice for all people and carers for people with dementia, especially regarding vascular dementia. **Was an Equalities Impact Assessment undertaken to support the service?**  Dementia_LES_EIA_ 21.11.18_v0.1.docx **How does this align with system/LTP priorities?** Part of the challenge to transform dementia care **Does this service promote the reduction of health inequalities?** By improving early diagnosis , assessment and care for people living with dementia, Ensuring that all people living with dementia have equal access to diagnosis and post diagnostic care ,Providing NHS staff with training on dementia appropriate to their role, Ensuring that every person with dementia receives meaningful care. There are inequalities within the memory services across BNSSG particularly for post diagnostic care of patients in

		North Somerset especially if the GP has made the diagnosis which directly involves this LES. Clear need to triangulate here with commissioning plans for this and any mitigations in place in the meantime? **Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)?** Best practice across area for community care of dementia is the Bristol Wellbeing service. This model provides good back up for GPs to make diagnoses in general practice as there is a simple referral process and good follow up of patients diagnosed by their GPs and support of GPs in their practices by visits from the BWS to discuss patient cases. This model is currently not available in North Somerset or South Gloucestershire as the Bristol service was procured in 2014 through the Bristol Mental Health programme. Memory services are commissioned in BNSSG but there is inequality as outlined above. The GP LES is to reduce the workload of the memory services but GP uptake of LES will remain poor if the local memory service doesn't /can't provide adequate support post diagnosis for patients and for GPs. **In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?** Under core GP contract GP would be expected to assess and investigate a patient who is suspected of having dementia but would not expect to make the diagnosis and

		would not expect to prescribe. Under the LES GPs can only be expected to diagnose those patients who do not have a complicated presentation and only prescribe within their clinical ability. The LES 'empowers' GPs to prescribe 'Amber ' drugs which are usually initiated by consultants and GPs would only provide shared care. To do this GPs have to attend one training day per year and to disseminate the knowledge throughout their practice. This is probably adequate training if the patient and GP can then have good support and back up by the memory services but currently there are no resources to do this adequately in South Gloucestershire and North Somerset as yet. **Is it a duplication of services provided by other organisations?** Dementia is referenced within the Enhanced Support to Care Homes spec however no explicit overlap identified.
2	**Evidence base and patient access** What evidence base is there to support that this meets local population health need and/or addresses variation in quality	Nationally mandated target CCG are required to plan for and achieve.
3	**Impact of COVID on LES Delivery** • How has COVID impacted the way this LES can be delivered e.g. switch from face to face to remote delivery? • Does the specification need to be updated to reflect these changes?	Patient demand was much reduced in General Practice since April 2021, it has gradually increased now back to normal levels and we are seeing and doing dementia assessments face to face as usual. What are the opportunities here for a remote element of assessment and

		does this impact on quality delivered? We may need to make it clear that this is a f2f assessment although informant history could be via phone/questionnaire.
4	**Engagement and patient feedback.** What feedback or engagement has there been in the provision/delivery of this service (clinical, patient and/or with other stakeholders)? How could this be incorporated into spec development going forward?	. No patient feedback. Could we design a survey for practices to understand what the process is in each practice and for assurance on annual training day attendance and dissemination within practice subsequently? Awaiting verification from complaints. GPs have flagged concern regarding the time required to diagnose dementia within primary care and the lack of post diagnostic support available in particular in North Somerset.
5	**Specification content** • Do any changes need to be made to the specification based on the evaluation or any other developments? *This should include changes in clinical guidance such as updates to NICE links in the current specification **Please pay particular attention to any links and embedded documents Y/N – if yes, please outline	The LES enables practices to diagnose and code dementia providing consistency for simpler cases. It also enables recalling of patients for reviews if the correct emis codes are used to diagnose See above survey suggestion Do we have a standard pack we can give out in BNSSG with support links, DVLA advice, carer advice etc?
6	**Delivery Model** • To ensure best quality and value what footprint is this service best delivered at e.g. Practice / PCN / Locality • For the answer above please state why	Having a PCN delivery model would not necessarily replicate the memory clinic model – I think it would be up to practices to decide if needed on this scale however,

		depending upon skills/training etc
7	**What would be the impact of decommissioning this service?** • What are the implications for patients? • Is there an impact on other stakeholders, premises, equipment etc.? • Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? • Would decommissioning affect the viability of a provider?	Longer waits by patients for potential diagnoses and less accessible care not so near to home. We do not audit accuracy of other general practice activity. There would be more referrals to the Memory service and there would be a lack of parity across BNSSG The future shape of Dementia services are being discussed at senior level therefore until decisions are made the LES must stay in place.
8	**Evaluation** • What monitoring takes place and how often is it reported? • Have any audits taken place to assess effectiveness?	Data extracted on a quarterly basis to inform payment No Audit as part of this enhanced service There is no feedback as to the cases or the quality of the diagnoses or prescribing. GP Education days are held annually to maintain clinical quality as a condition of LES signup.
10	**Data Challenges** • Have there been any data extract challenges in relation to this enhanced service?	There have been practices who have challenged the activity rates that have been extracted by the CCG search

	•	and report mechanism
11	**EMIS extraction** • Are there any changes recommended to the searches? (please describe changes and why they are needed)	<u>Dementia new diagnosis search</u> The old searches just looked for new coding events of dementia and so the search was overestimating the numbers of patients who had had a dementia assessment and diagnosis made by GP surgeries. The search has been updated to look for patients with a new dementia diagnosis coding, but also have had an assessment coded which will make the search results more specifically patients who have at least been assessed in surgery, rather than any new coding of patients where an assessment and diagnosis may have been made elsewhere. <u>Dementia review search</u> The clinical codes that this search looks for have been changed to align with QOF dementia review codes. This should make coding simpler for surgeries as they only need one code to comply with QOF and the LES rather than different codes for each.
12	**Recommendations for future of service:** • Continue at practice level OR • Continue at PCN or locality level • Minor amendments required • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	Continue at practice level. If no suitable training or skill mix for delivery at practice level to consider PCN level service.
13	**Risk Assessment**	• How do we know quality service is delivered?

	Please provide a summary of any risks arising from recommendations and any proposals for mitigation	Ensure up to date template in place, training days established and consider practice survey to ensure LES conditions fulfilled. • Mitigate for disparity in support services across BNSSG – understand commissioning intent and provide standard support pack to practices

NHS
Bristol
North Somerset
South Gloucestershire

Equality Impact Assessment

Name of Proposal being assessed: BNSSG Dementia LES

Does this Proposal relate to a new or existing programme, project, policy or service?

Lead Officer completing EIA	Sally Robinson
Job Title	Performance Improvement Manager
Department/Service	Planned Care – Commissioning
Telephone number	0117 900 2613
E-mail address	sally.robinson9@nhs.net
Lead Equality Officer	Niema Burns
Key decision which this EIA will inform and the decision-maker(s)	

Step 1: Equality Impact Assessment Screening

1. Does the project affect service users, employees and/or the wider community? yes

The Dementia Local Enhanced Service (LES) is currently available in Bristol only, as part of the LES Review, it has been recommended that the Dementia LES is also made available to service users in North Somerset and South Gloucestershire to provide coverage across BNSSG. The aim of the LES is to increase Dementia diagnosis rates across the CCG area.

2. Could the proposal impact differently in relation to different characteristics protected by the Equality Act 2010?

Assessment of Impact of Proposal on Protected Characteristics				
Protected Characteristic	**Positive Impact** ✓	**Negative Impact** ✓	**Neutral Impact** ✓	**Please provide reasons for your answer and any mitigation required**
Age* [eg: young adults, working age adults; Older People 60+]	**Yes**			Dementia is more prevalent in older people.
Disability Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty/ Disability; Long-Term Condition	**Yes**			The Dementia LES is anticipated to increase diagnosis rates of this Long-Term condition and provide support to the person diagnosed and their family/carer(s).
Gender Reassignment [Trans people]			**Yes**	There is unlikely to be a disproportionate impact on these patients.
Race [including nationality and ethnicity]			**Yes**	There is unlikely to be a disproportionate impact on these patients.
Religion or Belief			**Yes**	There is unlikely to be a disproportionate impact on these patients.
Sex [Male or Female]			**Yes**	There is unlikely to be a disproportionate impact on these patients.
Sexual Orientation			**Yes**	There is unlikely to be a disproportionate impact on these patients.
Pregnancy and Maternity			**Yes**	There is unlikely to be a disproportionate impact on these patients.
Marriage and Civil Partnership			**Yes**	There is unlikely to be a disproportionate impact on these patients.

* Under-18s are only protected against age discrimination in relation to work, not in access to services, housing, etc. Children's rights are protected by several other laws and treaties, such as: The Children Act; the Human Rights Act 1998; the UN Convention on the Rights of the Child; the European

Convention on Human Rights; the UN Convention on the Rights of Persons with Disabilities; and the UN Convention on the Elimination of Discrimination against Women.

3. Relevance to the Public sector Equality Duty:

This is not anticipated to be a problem.

4. Health Inequalities:

Does the proposal relate to an area with known Health Inequalities? Yes

The post diagnostic support available differs markedly across the former CCG areas.

5. On the basis of this screening assessment do you consider this proposal to be relevant to the General Duty or to any particular protected characteristic? Yes

The vast majority of patients will be older people.

6. If no, then set out reasons and evidence here:

N/A

7. Conclusion:

Proceed to full EIA? **No**

Signed: Sally Robinson

Date: 22.11.2018

Niema Burns' (Lead Equality Officer) comments: I am happy to approve this EIA screening and its conclusion that a full EIA is not required based on current information. If further information becomes available as a result of the implementation, then I recommend that equality considerations are revisited (07.12.2018).

Step 2: Scoping of the Equality Impact Assessment

What are the main aims, purpose and outcomes of the proposal?

[Describe the policy/practice that is being developed or reviewed. Think about:

- What is the purpose of the policy or practice?
- In what context will it operate?
- Who is it intended to benefit?
- What results are intended?
- Why is it needed?]

What aspects of the project are particularly relevant to equality?

[For example: the policy statement, referral or access criteria, communication with patients, equity of access to services, patient experience, stakeholder engagement]

What evidence is already available that will help in the development of both the project and the EIA?

[State the main sources of data and information - for example:

- Equality monitoring data on patients, service users or employees
- Demographic data (including Census)
- Recent engagement work
- Previous engagement work
- Annual reports
- Ad hoc audits
- Joint Strategic Needs Assessment
- Healthwatch reports
- Analysis of PALS, complaints and other feedback
- Equality Delivery System (EDS2) reports
- Comparison with similar work elsewhere]

Do you require further information to gauge the probability and / or extent of any adverse impact on protected groups?

[think about how you might get this information – new consultation activities, benchmarking, etc]

Which communities and groups have been or will need to be consulted or involved in the development /review of the project/service?

[this will help to identify engagement opportunities set out in the Patient and Public Involvement Plan]

Step 3: Equality Analysis

[This section is about bringing together all of your equality information in order to make a judgement about what the likely effect of the policy, practice or service will be on the equality duty and whether you need to make any changes to the policy, practice or service. Be wary of general conclusions – it is not acceptable to simply conclude that a policy will universally benefit all patients, service users or employees regardless of any protected characteristic, without having evidence to support that conclusion.]

[What are the:

- Actual or potential positive outcomes/impacts in relation to the public sector equality duty?
- Actual or potential negative outcomes/impacts?
- Actual or potential neutral outcomes/impacts?]

Statement of actions which have already been taken to remove/minimise the potential for adverse outcomes/impacts and to maximise positive outcomes/ impacts

[Key questions:

- Could the proposal disadvantage people from a particular group?
- Could any part of the proposal discriminate unlawfully?
- How does the proposal advance equality and foster good relations, including participation in public life?
- Are there other projects or policies that need to change to support the effectiveness of this proposal?]

Assessment of the legality of the proposal

[Key questions:

- Could the proposal disadvantage people with a particular protected characteristic?
- Could any part of the proposal discriminate unlawfully?
- Are there other proposals, projects or policies that need to change to support the effectiveness of this proposal?]

What is the outcome of the Equality Impact Assessment?

Choose ONE option:

No major change – the EIA demonstrates that the project plan is robust. The evidence shows no potential for discrimination and opportunities to promote equality have been identified and implemented.

Adjust the project proposals/plan to remove barriers or to better promote equality. This might mean introducing measures to mitigate the potential effect.

Continue the project despite potential for adverse impact or missed opportunities to promote equality, provided you have satisfied yourself that it does not unlawfully discriminate.

The EIA identified actual or potential unlawful discrimination. Changes have been made to the project to remove any unlawful discrimination.

Action Plan – Details of proposed mitigation/improvement			
Action	**Owner**	**Due Date**	**Outcome**

Step 4: Monitoring, Evaluation and Review

Please provide details of how the actual impact of the project will be monitored?

[Consider:

- How you will measure the effects of the project
- When the policy/ practice will be reviewed and what could trigger an early revision
- Who will be responsible for monitoring and review
- What type of information is needed for monitoring and how often it will be analysed
- How to engage relevant stakeholders in implementation, monitoring and review]

When will this EIA be reviewed?

Date:

Step 5: Approval and publication

Approved by Equality & Diversity Lead	Date: Screening approved 07.12.18 Name: Niema Burns
Approved by Project Lead / RO	Date: Name:

Step 6: Monitoring and Reviewing the Action Plan

Review of EIA - Update / Observations / Changes	
Please provide details:	
Approved by Equality & Diversity Lead	Name: Date:
Approved by Project Lead	Name: Date:
Date of Next Review (If no further review required please provide reasons)	Date:

Desk Top Review template – March 2022

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Local Enhanced Service Name: **Contractual notice period of LES**: N/A contract ends 31 March 2022	**Date of review:** February 2022
Lead Manager: Emma Gennard Interim Mental Health Programme Manager	**Lead Clinician:** Dr Alison Bolam *(Dr Bolam has now left her post)* Mental Health Clinical Lead
EMIS clinical codes: EMIS Web search criteria for calculating LES payment:- All patients (including deducted and deceased) who have been coded with any of: **Clinical Code Description** / **SNOMED Description ID** ADHD (attention deficit hyperactivity disorder) annual review – 1551761000000116 Attention deficit hyperactivity disorder annual review – 1551611000000112 where the code was added within the search period AND the patient was 18 years or older at the time of coding.	**Financial Appraisal** *£41 per annual review completed*

2021/22 DATA (Q1-Q3)

BNSSG CCG

Practice	Q1	Q2	Q3	Q4
Grand Total	**14**	**26**	**31**	**64**

Identified Issues:

Unclear referral process from AWP resulting in a very low number of referrals. Attempts to engage with MH trust to clarify pathways

1	**Meets aims & objectives** What are the clinical aims and objectives of the service? • How is this / does this continue to align with system/LTP priorities? • Does this service promote the reduction of health inequalities? • Was an Equalities Impact Assessment undertaken to support the service? • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? • Does this work impact on existing or proposed pathway work? • Do we commission this service elsewhere? • Is it a duplication of services provided by other organisations? • In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?	**Objectives:** • To reduce the waiting list for assessment at AWP by offering annual reviews in primary care. • Benefit to patients of receiving care closer to home at their surgery. • Equitable service, all patients entitled to the review but location on dependant on practice sign up. • LES should improve access to assessment and reduced waiting times. (could impact on other primary care capacity) Potential benefits of having a more holistic annual review process, as a result of the wider understanding of the patient held within Primary Care. There should no duplication of activity. The individual patients will either have their review with AWP or at the practice (if discharged under the LES) This is not recognised as core work and therefore the LES is above and beyond

2	**Evidence base and patient access** What evidence base is there to support that this meets local population health need and/or addresses variation in quality	AWP discharging stable patients to primary care services
3	**Impact of COVID on LES Delivery** • How has COVID impacted the way this LES can be delivered e.g. switch from face to face to remote delivery? • Does the specification need to be updated to reflect these changes?	Specification reviewed and updated in November 2021.
4	**Engagement and patient feedback.** • What feedback or engagement has there been in the provision/delivery of this service (clinical, patient and/or with other stakeholders)? • How could this be incorporated into spec development going forward?	. A service user reference group was heavily involved in shaping the approach with a sample of GPs with experience of working with patients with ADHD. From this engagement, a full report was produced capturing overall insights around the experience of accessing support for ADHD in Primary Care and within the service, as well as co-designing a range of materials to support service users, including materials to be used as part of the LES process.
5	**Specification content** • Do any changes need to be made to the specification based on the evaluation or any other developments? *This should include changes in clinical guidance such as updates to NICE links in the current specification **Please pay particular attention to any links and embedded documents Y/N – if yes, please outline	No – specification has been updated prior to launch at end of November 2021. Currently with Dr Bolam to gather feedback for 2022/23.

6	**Delivery Model** • To ensure best quality and value what footprint is this service best delivered at e.g. Practice / PCN / Locality • For the answer above please state why	.The service is suitable for individual practice delivery. The role of the mental health practitioner through ARRS may support a move to a PCN offer at a later date, however role is not yet defined. **Locality level offer could also be considered**. Benefits of going to individual practice remain personalised care closer to home, continuity of care for patients with co morbidities
7	**What would be the impact of decommissioning this service?** • What are the implications for patients? • Is there an impact on other stakeholders, premises, equipment etc.? • Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? • Would decommissioning affect the viability of a provider?	The implication for patients of decommissioning this service would be primarily the inability to access their annual review at their local GP surgery, which would potentially be more convenient in terms of location and provide a more holistic assessment of their needs based on a better understanding of their full range of requirements outside of their ADHD diagnosis. More broadly, the allocation of resources within the AWP service into annual reviews for patients with a stable diagnosis and treatment protocol may restrict the ability of other patients to access initial assessments and ongoing support. As above, any redeployment of resource from Primary Care back into the AWP service would have an impact on the available resources (staff, premises and so on) within the AWP adult ADHD service

8	**Evaluation** • What monitoring takes place and how often is it reported? • Have any audits taken place to assess effectiveness?	Number of annual reviews completed. Monitoring will be coded in EMIS and recorded through the template. No audits took place during 21/22 due to COVID 19
10	**Data Challenges** • Have there been any data extract challenges in relation to this enhanced service?	
11	**EMIS extraction** • Are there any changes recommended to the searches? (please describe changes and why they are needed)	Additional annual review code 'Attention deficit hyperactivity disorder annual review' added to EMIS Web search as this is the code used in Ardens template. Adding this code helps to ensure surgeries who choose to use the Ardens template will get paid for the reviews.
12	**Recommendations for future of service:** • Continue at practice level OR • Continue at PCN or locality level • Minor amendments required • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	**Continue at practice level, however more suitable for PCN delivery therefore maturity of the PCNs needed.** **If a PCN wish to deliver the service at that level this can be facilitated with support from contracts team**.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any	The main risk identified about this process is that,

	proposals for mitigation	during the process of a routine annual review, a Primary Care clinician will identify that a patient has a need which can only be met by the ADHD specialist service. As a mitigation, the service has an escalation process (for both urgent and routine requirements), so that the service can be made of, and respond to, additional support needs from Primary Care clinicians. This process needs to be refreshed with Primary Care, and these materials have been also distributed via the GP bulletin.

Desk Top Review template – FEBRUARY 2022

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Local Enhanced Service Name: Care Home Support LES **Contractual notice period of LES:** N/A contract ends 31 March 2022	**Date of review:** March 2022
Lead Manager: Clare McInerney – Head of Programme, Ageing Well	**Lead Clinician:** Mike Jenkins
EMIS READ codes: One Care to confirm 2022/23 templates	**Activity DATA:** N/A – operating on block payments

2021/22 DATA (Q1-Q3)

Care Home beds	Apr-21		May-21		Jun-21		Jul-21		Aug-21		Sep-21		Oct-21		Nov-21		Dec-21		Jan-22		Feb-22		Mar-22	
	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds	Res Beds	Nurs Beds
	3,766	4,334	3,766	4,334	3,726	4,334	3,726	4,334	3,726	4,334	3,726	4,334	3,726	4,334	3,726	4,334	3,726	4,334	3,726	4,334	3,726	4,334	3,726	4,334
Care Home Premium DES	80,880.00		81,000.00		80,600.00		80,600.00		80,600.00		80,600.00		80,600.00		80,600.00		80,600.00		80,600.00		80,600.00		80,600.00	
Care Home LES Top-Up	38,509.15		35,902.94		35,126.34		37,815.64		37,039.05		37,234.63		40,838.61		40,038.93		39,239.25		38,510.93		37,764.06		37,104.26	

1	**Meets aims & objectives** What are the clinical aims and objectives of the service? • How is this / does this continue to align with system/LTP priorities? • Does this service promote the reduction of health inequalities? • Was an Equalities Impact Assessment undertaken to support the service? • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? • Does this work impact on existing or proposed pathway work? • Do we commission this service elsewhere? • Is it a duplication of services provided by other organisations? • In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?	**Objectives:** • **How is this / does this continue to align with system/LTP priorities?** The Care Home support LES aligns to the NHS England Enhanced Healthcare in Care Homes framework, which in turn has influenced a number of priorities in the system and NHS Long Term Plan around personalised care, advance care planning, integrated multi-disciplinary approach to supporting people in care homes, and is aligned to the NHSEI Ageing Well programme as one of the three pillars of delivery • **Does this service promote the reduction of health inequalities?** The aim is to provide equitable access to enhanced support for people in care homes. There is a risk of inequalities if the LES isn't taken up by some practices, potentially risking leaving some care homes without cover. • **Was an Equalities Impact Assessment undertaken to support the service?** YES • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? There is a potential for this to be delivered at a PCN level, recognising economies of scale of using specialised multi-disciplinary skills of care and health staff. On a practical level, since Covid there is a good opportunity to use secure video-consulting more for individual person reviews, and for secure teleconferencing software (eg Microsoft Teams) to facilitate MDT reviews and discussions, to reduce time travelling, reduce carbon footprint, and to cover multiple sites.

		• **Does this work impact on existing or proposed pathway work?** The approach to proactive personalised care, and anticipatory care complements many developing pathways around frailty, as part of the vision to make the community become the default setting of care. Primary care networks and integrated care partnerships are developing to provide more joined up care in the community. The Ageing Well programme's vision for holistic personalised care planning and social prescribing and implementation of a BNSSG wide Anticipatory Care strategy , urgent community response, the mobilisation of frailty hubs, development of front door frailty, and digital transformations initiatives all interlink with this pathway. • **Do we commission this service elsewhere?** People living in care homes are already registered with GPs, but the existence of the LES reflects the extra services required for people in care homes. The care home DES is nationally commissioned through the PCN network agreement. • **Is it a duplication of services provided by other organisations?** Sirona are contracted through the NHS standard contract alongside primary care to deliver the aims of the enhanced health in care homes framework. A care home development team already existing in North Somerset until April 2020 (which was provided by the then community provider, NSCP), and a temporary care home support service (providing a regular 'check in') was provided as a part of the Covid Pandemic response. Under the Ageing Well programme, there is a Care Home Hub mobilised to support homes that have significant levels of demand on non-elective activity in WGH. This has been funded in 2021/22 under strategic development funding for Ageing Well as an 'accelerator site' for the programme.

		• **In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?** The definition of what is required from the core GP contract isn't explicit in terms of what. The LES reflects the increased complexity of many people living in care homes and the increased intensity of guidance which has been developed over the last decade for people living in care homes, with frailty, multi-morbidity and complex needs.
2	**Evidence base and patient access** What evidence base is there to support that this meets local population health need and/or addresses variation in quality	The service specification is based around the NHS England Enhanced Healthcare in Care homes guidance. Local evidence to identify need is the existence of 290 care homes across BNSSG, with a variety of complexity, emergencies admissions, and prescribing
3	**Impact of COVID on LES Delivery** • How has COVID impacted the way this LES can be delivered e.g. switch from face to face to remote delivery? • Does the specification need to be updated to reflect these changes?	Since Covid there is a good opportunity to use secure video-consulting more for individual person reviews, and for secure teleconferencing software (eg Microsoft Teams) to facilitate MDT reviews and discussions, to reduce time travelling, reduce carbon footprint, and to cover multiple sites. Covid has also brought advance care planning, in particular the use of ReSPECT, in sharp focus with increasing numbers of ReSPECT discussions being performed. This is good progress, but it important to ensure this is done in a person-centred, personalised way.
4	**Engagement and patient feedback.** What feedback or engagement has there been in the provision/delivery of this service (clinical, patient and/or with other stakeholders)?	. Awaiting confirmation from complaints

	How could this be incorporated into spec development going forward?	
5	**Specification content** • Do any changes need to be made to the specification based on the evaluation or any other developments? *This should include changes in clinical guidance such as updates to NICE links in the current specification **Please pay particular attention to any links and embedded documents Y/N – if yes, please outline	Care Home LES currently: 1. Anticipatory Medicines (Just In Case Medicines, JIC) for end of life should be prescribed as appropriate for care home residents. • Prescribing JIC medicines should be done on an individual case by case basis, rather than as a routine part of a patient being admitted to a care home. • JIC medicines should be regularly reviewed, particularly controlled drugs (every 3 months) by the GP and NH nurses for appropriateness, and the review should be clearly documented in the patient's care plan. If medication is deemed no longer necessary, it needs to be communicated to the community pharmacy so that it is removed from Medicine Administration Record (MAR) charts. • GP practices should be aware of which of their NH patients have been prescribed JIC medicines, and be able to generate a list of these patients from their records for review. These patients should be considered and reviewed as part of the GP practice's wider palliative care patient register. 2. The GP or appropriate clinician should attend with the care home manager a quarterly shared learning and practice review of emergency admissions. 3. If a death is anticipated, the covering GP should endeavour to see the patient in order to complete death certification.
6	**Delivery Model** • To ensure best quality and value what footprint is this service best delivered at e.g. Practice / PCN / Locality • For the answer above please state why	This is best delivered at Integrated Care Partnership level, reflecting and building upon the establishment and progress of the PCNs working at scale.

7	**What would be the impact of decommissioning this service?** • What are the implications for patients? • Is there an impact on other stakeholders, premises, equipment etc.? • Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? • Would decommissioning affect the viability of a provider?	• **What are the implications for patients?** There may be move away from following the guidance in EHCH. • **Is there an impact on other stakeholders, premises, equipment etc.?** It may put pressure on other providers, eg community services. • **Was a health inequalities impact assessment ever undertaken to support the service and has this been considered?** Not done at locality level • **Would decommissioning affect the viability of a provider?** Not quantifiable at present
8	**Evaluation** • What monitoring takes place and how often is it reported? • Have any audits taken place to assess effectiveness?	
10	**Data Challenges** • Have there been any data extract challenges in relation to this enhanced service?	None received.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>11</td><td>EMIS extraction

• Are there any changes recommended to the searches? (please describe changes and why they are needed)</td><td>ReSPECT template.</td></tr>
<tr><td>12</td><td>Recommendations for future of service:

• Continue at practice level OR
• Continue at PCN or locality level
• Minor amendments required
• Service no longer needed or a priority for investment across BNSSG

Please provide justification for recommendation</td><td>Continue at PCN level in line with the DES in line with EHCH engagement process.
Utilise Qtr 1 2022/23 for the feedback to EHCH questionnaire tore-develop service specification based on the outcomes to ensure above and beyond scope.
<table><tr><th>Key Priority for 21/22</th><th></th></tr><tr><td>Falls, strength and balance</td><td>Does the MDT offer rehab and reablement following a period of isolation and deconditioning as well early identification and management of risk?</td></tr><tr><td>Dementia and Older Peoples Mental Health</td><td>Does the MDT offer equitable access to clinical expertise alongside diagnosis, education and training?</td></tr><tr><td>High quality palliative and end of life care</td><td>Does the MDT offer education and skills; linking to care planning and working collaboratively with health, care and VCSE?</td></tr><tr><td>Wound Care and Pressure Ulcer Prevention</td><td>Does the MDT offer equitable access to clinical expertise alongside support and training in wound care?</td></tr><tr><td>Care and Support Planning</td><td>Is the MDT working towards the ambition for a single plan in a digital format, accessible to the right people?</td></tr><tr><td>Digital enablement and inclusion</td><td>Has the MDT supported Care Homes to embed the digital skills and capabilities to adopt tools for information sharing and improved shared care?</td></tr><tr><td rowspan="2">Additional Regional Priorities</td><td>Hydration / Oral Health; do residents have access to relevant primary and community care services?</td></tr><tr><td>Does the Clinical Lead oversee the implementation of the service and provide MDT leadership and continuous improvement?</td></tr></table>
Draft EHCH Questionnaire 0803</td></tr>
<tr><td>13</td><td>Risk Assessment</td><td>All care homes are aligned. Any issues that arise with alignment will be dealt with on a case by case basis</td></tr>
</table>

	Please provide a summary of any risks arising from recommendations and any proposals for mitigation	

Appendix A: Standard Operating Procedure

Aim: This guide aims to set out ways of working which will enhance the communication and planning involved in coordinating the healthcare of BNSSG residents in care homes. It has been influenced by examples of good practice which some homes and GP practices have developed and aims to enable others working in this area to use their learning.

This guide sets out key actions which set the foundation to good healthcare management of Care Home residents. Care coordination is most effective when 1 GP practice links with a care home if for any reason this is not possible, there should be a maximum of 1 or 2 GP practices providing care for the residents of the home.

This guide will set out recommended patterns of practice for:

a. Collaborative team working
b. Routine monitoring of the healthcare needs of patients,
c. The development of anticipatory plans to manage deteriorating health situations

d. To manage unanticipated health crises

	Key Actions	Responsibility
1	**General Principles**	
1.1	A ward round should take place on the same day at the same time each fortnight and be completed by a GP or appropriate clinician. This should be a mutually agreed time between the care home and the GP practice. If necessary this should be on more than 1 day if the home has a large number of beds all cared for by the same GP practice	
1.2	The fortnightly rounds should be coordinated by named senior nurse (***The CH GP Link Nurse***) at the care home. Residents requiring review at the GP/appropriate clinician round should be identified each week & if necessary routine tests completed (BP, urinalysis, temperature).	
1.3	Inform GP/appropriate clinician on the morning of the ward round; a) List the residents requiring review b) State the reason review is required c) Give the results of tests done	
1.4	***Named CH GP*** to liaise with Care Home & routinely visit. When a GP is on leave s/he must arrange a replacement to cover. If a death is anticipated, the covering GP should endeavour to see the patient in order to complete death certification.	GP practice
2	**New Residents**	

2.1	In preparation for the transfer of a new patient to the care home the Lead Nurse/ Manager from the Care Home should get detailed medical and social information. This should include identification of those who will support the new resident with decisions, an extensive medical history and any advance decisions already made.	
2.2	A new patient assessment should be carried out jointly between GP & a senior member of the Care Home team within one week of moving to Care Home. The medicine review should include optimisation and the discontinuation of any unnecessary medicines. Family member involvement should be considered. The GP and care staff should arrange to meet the resident and/or his/her family to discuss the need for DNACPR if appropriate.	
2.3	Identify & record route for making healthcare decisions if no capacity, e.g. Power of attorney, IMCA.	
2.4	An individualised plan of disease management will be agreed, (e.g. frequency of blood glucose, BP, weight monitoring).	
3	**Routine Care and Disease Monitoring**	
3.1	Delivery of routine monitoring of health needs set out in the agreed care plan	
3.2	At least 6 monthly multi-disciplinary reviews ideally with a clinical pharmacist; including stopping any unnecessary medicines and considering the need for specialist review and on-going discussion of the advance care plan.	
3.3	Care home staff to coordinate and monitor agreed plan, including safe administration of medication.	
3.4	The care home will record the outcome of visits of all specialist healthcare professionals (e.g. tissue viability team) should be recorded in the residents health record and the GP informed of any changes to the care plan at the next round unless urgent.	
3.5	The GP practice to work with the Care homes to adopt homely remedies policies	
3.6	GP practices will engage with community pharmacy technicians and the care homes to streamline prescription ordering processes for the benefit of all parties and to reduce medicines waste	
4.	**Urgent Care**	

4.1	Care Homes should coordinate all requests for visits through the Shift NH GP Liaison Nurse on each shift.	
4.2	The 'Prompt sheet – care home request for GP visit today' should be used for residents whose health needs are changing.	
4.3	If the GP practice is not going to do a visit on the day requested he/she should telephone the home to agree a plan for visit and on-going management of the problem.	
4.4	Quarterly review with the Care Home manager including review of the ACP following emergency admission.	
5	**Advance Planning**	
5.1	Monthly Coding meetings to be held in the home.	
5.2	Discuss need for Advanced Care Plan/TEP form in line with Resuscitation council guidelines, involving resident, family or IMCA, keep form in Care Home, take a copy back to surgery & ensure it is scanned to the residents GP record and record it on the EPaCCS system. This Care Plan must use agreed communications across secondary care, primary care and community services, part of which is currently the ReSPECT documentation. https://www.respectprocess.org.uk/healthprofessionals	
5.3	If necessary GP or appropriate clinician and Care Home to agree meetings with resident & or family to discuss advance care plan.	
5.4	Request anticipatory medications when thought to be entering the last weeks of life.	
6	**Care of the Dying**	
6.1	GP or appropriate clinician and nurse to engage with EOL pathway for the last days of life' and all current care plans and medications reviewed.	
7	**Care After Death**	

7.1	Provide after death care for family & provide information regarding bereavement services in line with the integrated care plan.	
7.2	Care Home notify GP of death and GP to record death on EMIS.	
7.3	GP to provide death certificate in a timely manner, usually within 24 hours (Monday to Friday) for expected deaths.	

To be submitted by PCN

Show snapshot of homes aligned to the PCN

- This will tell us how many homes / how many practices supporting each / how many beds

For each home aligned to the PCN:

1. What % of your aligned care homes receive a weekly home round
2. For those that do not please briefly explain why (FREE TEXT)
3. For each home do you have consistent staff that make up the MDT?
4. Please describe the roles / skill mix / WTE that make up your MDT
5. Does your MDT have consistent medical input from a GP or geriatrician?
6. What is your approach to determining the frequency and form of this input (FREE TEXT)
7. Approximates:
8. What % of patients have a personalised care and support plan developed and agreed within seven working days of admission to the home?
9. What % of patients have a personalised care and support plan developed and agreed within seven working days of re-admission to the home following a hospital admission?
10. What (if any) are the barriers to having PCSPs in place within 7 days (free text)
11. Are plans routinely developed with the patient / carer?
12. Are personalised care support plans based on the principles and domains of a Comprehensive Geriatric Assessment?
13. Do you have a process to identify and make use of existing assessments that have taken place outside of the home, reflecting their goals and make all reasonable efforts to support delivery of the plan?
14. Do you have a mechanism to identify learning opportunities?
15. Do you participate or engage in locally organised shared learning opportunities as capacity allows?
16. Please describe how you support with a patient's discharge from hospital and transfers of care between settings (Free Text)
17. What support are you receiving from other partners (e.g. Sirona)
18. Are there any examples of best practice you would like to share (FREE TEXT)

Data reconciliation

Please can you validate the data screenshot from the PCN dashboard for the EHCH domains

If the data is not accurate are you able to understand why?

Desk Top Review template – FEBRUARY 2022

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Local Enhanced Service Name: Specialist Medicines Monitoring LES

Contractual notice period of LES: N/A contract ends 31 March 2022

Date of review: March 2022

Lead Manager: Sasha Beresford

Lead Clinician: Shaba Nabi

EMIS clinical codes:

Specialist Meds Monitoring

EMIS Web search criteria for calculating LES payment:-

Azathioprine

All patients (including deducted and deceased) who have been issued with an NHS prescription of azathioprine by the surgery during the search period.

Cinacalcet

All patients (including deducted and deceased) who have been issued with an NHS prescription of cinacalcet by the surgery during the search period AND are 18 years or older AND have any of the following coded diagnoses

Clinical Code Description	SNOMED Description ID
Hyperparathyroidism	111289013
Ectopic hyperparathyroidism	49080014
Primary hyperparathyroidism	60663012
Familial hyperparathyroidism	356183018
Normocalcemic primary hyperparathyroidism	4024743018
Parathyroid hyperplasia	16008014

Denosumab

All patients (including deducted and deceased) who have been issued with an NHS prescription of denosumab by the surgery during the search period.

Leflunomide

Financial Appraisal

- What is the cost of delivering the service (current forecast outturn)?
- What are we paying for the service (tariff)?
- What would be the costs of not delivering the service?
- Are there any risks of duplicate payments across other contracted services?

	Budget	Q1 block	Q2 activity	Q3 actual	Q4 projected	FOT
Spec MM	509,556	127,389	140,510	139,400	140,510	547,809

If this service is not delivered and patients are not monitored safely on these high risk medications there is a clinical risk to patients that may result in adverse health outcomes and/or hospitalisation that could have been prevented.

All patients (including deducted and deceased) who have been issued with an NHS prescription of leflunomide by the surgery during the search period.

Mercaptopurine

All patients (including deducted and deceased) who have been issued with an NHS prescription of mercaptopurine by the surgery during the search period.

Methotrexate

All patients (including deducted and deceased) who have been issued with an NHS prescription of methotrexate by the surgery during the search period.

Mycophenolate

All patients (including deducted and deceased) who have been issued with an NHS prescription of mycophenolate by the surgery during the search period AND are 18 years or older.

Penicillamine

All patients (including deducted and deceased) who have been issued with an NHS prescription of penicillamine by the surgery during the search period AND have any of the following coded diagnoses

Clinical Code Description	SNOMED Description ID
Cystinuria (or child codes)	140962014

OR

Clinical Code Description	SNOMED Description ID
Rheumatoid arthritis (or child codes)	116082011
Inflammatory polyarthropathy (or child codes)	2548331017
Rheumatoid arthritis and other inflammatory polyarthropathy (or child codes)	168751000006115

Sulfasalazine

All patients (including deducted and deceased) who have been issued with an NHS prescription of sulfasalazine by the surgery during the search period AND the first issue date in the associated EMIS Web sulfasalazine medication course is ≤ 1 year before the start of the search period.

Testosterone Injection (hypogonadism)

All patients (including deducted and deceased) who have been issued with an NHS prescription of testosterone injection by the surgery during the search period AND have any of the following coded diagnoses

Clinical Code Description	SNOMED Description ID
Hypogonadism (or child codes)	80201014

AND DON'T have a prescription issue of injectable testosterone > 9 months previously.

Testosterone gel (menopause)

All female patients (including deducted and deceased) who have been issued with an NHS prescription of testosterone gel (Tostran or Testogel as per SCP) by the surgery during the search period AND have a clinical code for menopause or bilateral oophorectomy.

2020/21 DATA

BNSSG CCG's Specialist Medicines LES scheme for 2020-21

Data Items	Q1	Q2	Q3	Q4
Azathioprine	1,538	1,544	1,535	1,511
Cinacalcet	1	6	13	24
Denosumab	453	491	442	478
Leflunomide	343	354	343	346
Mercaptopurine	136	131	131	136
Methotrexate	4,557	4,650	4,728	4,788
Penicillamine	8	9	7	7
Sodium Aurothiomalate	0	0	0	0
Sulfasalazine	273	284	270	306

2021/22 DATA (Q1-Q3)

BNSSG CCG's Specialist Medicines LES scheme for 2021-22

Data Items	Q1	Q2	Q3	Q4
Azathioprine	1548	1574	1497	
Cinacalcet	37	51	44	
Denosumab	476	479	485	
Leflunomide	352	353	345	
Mercaptopurine	131	130	135	
Methotrexate	4873	4917	4948	
Penicillamine	6	6	5	
Sodium Aurothiomalate	0	0	0	
Sulfasalazine	435	449	441	

Addition for 22/23
Testosterone injection (hypogonadism only)
Testosterone gel (early menopause or surgical menpause only)

Removal for 22/23
Sodium Aurothiomalate – not routinely used and now a Red drug on the BNSSG Joint Formulary

1	**Meets aims & objectives** What are the clinical aims and objectives of the service? • How is this / does this continue to align with system/LTP priorities? • Does this service promote the reduction of health inequalities? • Was an Equalities Impact Assessment undertaken to support the service? • Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)? • Does this work impact on existing or proposed pathway work? • Do we commission this service elsewhere? • Is it a duplication of services provided by other organisations?	**Objectives:** • To provide patients with the information they need to safely manage their treatment. • To monitor the safety and effectiveness of treatment by performing defined investigations monitoring at defined regular intervals. • To ensure that patients are managed appropriately, in collaboration with specialists where necessary, according to the results of the defined investigations. • To provide these patients with optimised treatment.

	• In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the core GP contract?	• To provide a therapy monitoring service close to the patient. • To evaluate the quality of care delivered through an annual review process and to effect change when required to improve the service provided. This continues to align with the Medicines Optimisation quality and safety agenda to ensure patients taking high risk drugs are monitored appropriately to reduce the risk of side effects and harm and to support the best outcomes of treatment. This service applies to all patients taking the medicines within the spec. and aims to reduce a variation in practice and harmonise high-risk drug blood test monitoring, supporting shared care for these medicines. There are IT solutions to support monitoring of these drugs but this would require significant investment including staffing resource and training. This approach is consistent with the national picture. Monitoring of these medicines ties in with the phlebotomy workstream supporting GPs to manage Amber shared care drugs. This service isn't commissioned elsewhere. There is an increasing demand on GPs to undertake more Amber shared care drugs as medicines become more complicated.
2	**Evidence base and patient access** What evidence base is there to support that this meets local population health need and/or addresses variation in quality	**4.1 Applicable national standards (eg NICE)** The following guidance from NICE: • Psoriasis: assessment and management (CG153)

		• Spondyloarthritis in over 16s: diagnosis and management (NG65) • Denosumab for the prevention of osteoporotic fractures in postmenopausal women (TA204) • Rheumatoid arthritis in adults: management (NG100) • Crohn's disease: management (CG152) • Ulcerative colitis: management (CG166) **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)** • British Association of Dermatologists' guidelines for the safe and effective prescribing of azathioprine 2011. Meggitt SJ, Anstey AV, Mohd Mustapa MF, Reynolds NJ, Wakelin S. Br J Dermatol 2011; 165; 711-734. • British Association of Dermatologists' guidelines for the safe and effective prescribing of methotrexate for skin disease 2016. Warren R.B., Weatherhead S.C., Smith C.H., Exton L.S., Mohd Mustapa M.F., Kirby B., Yesudian P.D. Br J Dermatol 2016; 175: 23-44. • BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs. BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs. Jo Ledingham, Nicola Gullick, Katherine Irving, Rachel Gorodkin,

		Melissa Aris, Jean Burke, Patrick Gordon, Dimitrios Christidis, Sarah Galloway, Eranga Hayes, Andrew Jeffries, Scott Mercer, Janice Mooney, Sander van Leuven, James Galloway, on behalf of the BSR and BHPR Standards, Guidelines and Audit Working Group. Rheumatology, Volume 56, Issue 6, 1 June 2017, Pages 865–868, **4.3 Applicable local standards** BNSSG Shared Care Protocols (SCPs) http://www.bnssgformulary.nhs.uk/Shared-Care-Protocols/
3	**Impact of COVID on LES Delivery** • How has COVID impacted the way this LES can be delivered e.g. switch from face to face to remote delivery? • Does the specification need to be updated to reflect these changes?	Patients will still need to present to Practice for a venous blood sample. To support Practice's during the pandemic a guideline for the monitoring of these drugs was pulled together to support reduced, but safe monitoring of these drugs. This will need to be considered within the audit for 22/23. https://remedy.bnssgccg.nhs.uk/media/4143/blood-monitoring-for-high-risk-drugsv18.pdf
4	**Engagement and patient feedback.** What feedback or engagement has there been in the provision/delivery of this service (clinical, patient and/or with other stakeholders)? How could this be incorporated into spec development going forward?	No patient complaints have been received. 22/23 audit will be written up and shared with Practices.
5	**Specification content**	Mycophenolate and cinacalcet added 20/21. Testosterone gel/injection added 22/23.

	• Do any changes need to be made to the specification based on the evaluation or any other developments? *This should include changes in clinical guidance such as updates to NICE links in the current specification **Please pay particular attention to any links and embedded documents Y/N – if yes, please outline	Additional drugs may be added in year where the BNSSG Joint Formulary Group approved an amber shared care protocol drug that is a high-risk medicine requiring specific monitoring. It is likely that this will be in the region of 2-3 per year. For approval through PCOG and PCCC. Any updates to national guidance will be checked. Anticipated little change.
6	**Delivery Model** • To ensure best quality and value what footprint is this service best delivered at e.g. Practice / PCN / Locality • For the answer above please state why	Practice – to ensure that each practice has safe systems in place to ensure that patients taking these specialist medicines are managed safely, with the appropriate monitoring to support on-going prescribing.
7	**What would be the impact of decommissioning this service?** • What are the implications for patients? • Is there an impact on other stakeholders, premises, equipment etc.? • Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? • Would decommissioning affect the viability of a provider?	Potential for patients to be at increased risk of harm where Practices do not provide assurance for having safe monitoring systems in place.
8	**Evaluation** • What monitoring takes place and how often is it reported? • Have any audits taken place to assess effectiveness?	21/22 audits were suspended in light the COVID 19 pandemic. Plan to audit 22/23.

10	**Data Challenges** • Have there been any data extract challenges in relation to this enhanced service?	Yes there have been challenges on the data extracts. These are being worked through
11	**EMIS extraction** • Are there any changes recommended to the searches? (please describe changes and why they are needed)	Changes to incorporate the additional drugs added to/removed from the service spec.
12	**Recommendations for future of service:** • Continue at practice level OR • Continue at PCN or locality level • Minor amendments required • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	Continue at Practice level and minor amendments required to continue to evaluate and provide assurance that patients are being managed safely.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	None noted.