Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

Primary Care Commissioning Committee (PCCC)

Date: 26th June 2018
Time: 9.30-12.00
Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda item: 9

Report title: Evaluation of Local Enhanced Services

Report Author: Jenny Bowker, Head of Primary Care Development
Report Sponsor: Martin Jones, Medical Director Primary Care & Commissioning

1. Purpose

To update the Primary Care Commissioning Committee (PCCC) on the outcome of the desk top review of Local Enhanced Services, seek approval for the recommendations and propose next steps.

2. Recommendations

The PCCC is asked to support the summary of recommendations included in Appendix A and note the content of the desktop reviews included in Appendix B. The PCCC is asked to discuss next steps, in particular, how we develop a locality offer to support the recommendations within the desk top review.

3. Background

This paper sets out the outcome of the desktop review which has been sponsored by the LES Review Steering Group. The methodology for the review was proposed and set out in the May Primary Care Commissioning Committee papers. In short, each Local Enhanced Service review was assigned a clinical and management lead and they were asked to complete the template shared at the PCCC in May, completed in Appendix B. The template asked leads to review objectives, evidence of effectiveness and value for money and to make comparisons across the 3 former CCGs where there were equivalent enhanced services. Leads have been supported by

business intelligence and finance who have provided information relating to cost comparisons with secondary care and impact on secondary care activity. Leads were then asked to put forward recommendations for the future of these enhanced services.

4. Key findings from the desktop review

There are a small number of Local Enhanced Services, which continue to be of value and that require very little amendment to align across the 3 areas. There are others that either need further review and/or which it is felt would be better delivered at locality level to ensure improved population coverage and to offer better value for money.

It was not possible for leads to complete all of the questions in the template as not all of the information was available to them. This has highlighted the need for a more robust and consistent methodology for developing Local Enhanced Services going forward and it is recommended that completion of this template informs their development going forward. Furthermore, there was variable evidence of monitoring and evaluation of the existing enhanced services and a key recommendation is that we develop more robust monitoring arrangements across all enhanced services going forward so that we can assure ourselves of value for money.

5. Next Steps

The key next steps are:

- Communication and engagement with practices at July membership meetings about the outcome of the desktop review
- Full financial and risk impact assessment to be completed by mid-July
- Phase 1 review outcomes to have new contract specifications/variations and notices provided by September for implementation by next April 2019
- Phase 2 further development of Locality Offer to be developed to align with this and be ready for implementation from next April 2019

6. Financial resource implications

Financial implications have been assessed within each desk top review. A complete finance impact assessment needs to be undertaken by mid-July which considers both the finance implications for the CCG and the financial impacts at practice level for the proposed changes across the enhanced services. It is currently proposed that a significant proportion of the current investment is reinvested at scale at a locality footprint and discussion with PCCC members about how we progress this is welcomed.

7. Legal implications

There are no legal implications at this stage. Decisions about the future of the services will be

made by the PCCC in order to assure that no Conflicts of Interest affect decision making. PCCC members will also need to be satisfied that decisions made fall within the scope of the CCG procurement rules.

8. Risk implications

Risks are captured within the desk top reviews for each enhanced service.

An overview of common risks for the review is provided below

Risk	Mitigation
CCG is not able to realise full benefits of the review to develop consistent, high quality and evidence based enhanced primary care which meets population needs and demonstrates value for money across BNSSG	• Communicate purpose of the review to stakeholders so that these are understood • Develop Equality Impact Assessments to assess implications for changes to enhanced services across BNSSG • Develop evaluation and monitoring metrics across all enhanced services going forward
Practice uncertainty about the future of their income streams leading to reductions in service	• Finance impact assessment to be undertaken at practice level. • Communication to membership meetings about outcome of the review • Align timing of contract changes with timing of new proposals being in place
Locality model not ready to take on at scale provision	• Agree framework and steps with Locality Providers to be ready to provide locality solutions

9. Implications for health inequalities

This is captured within the desk top review template.

10. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

This is captured within the desk top review template.

11. Consultation and Communication including Public Involvement

This is captured within the desk top review template.

12. Appendices

Appendix A – Summary of Desk Top Recommendations

Appendix B – Desk Top Reviews

Glossary of terms and abbreviations

Local Enhanced Service	Enhanced services are defined as primary medical services other than essential services, additional services or out-of-hours services. NHS England or CCGs commission these services across England.

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Appendix A – Evaluation of Local Enhanced Services

Summary of Recommendations from Desktop Review

Local Enhanced Service	Benefits of Enhanced Service	Recommendation	Monitoring
DVT	Offering a service local to patients and convenient for both clinicians and patients to access.	This should sit in primary care for safety reasons and patient choice. Aim to standardise pathways across BNSSG. New specification in development to be applied across BNSSG with single tariff for initial assessment to be offered to practices. Supports whole pathway review.	Evaluation plan is being developed
Anticoagulation	Deliver a safe service local to patients.	This should sit in primary care for safety reasons and patient choice. Aim to develop common specification and financial envelope for next April – NB noting that different pathways support this currently and this will need to be reviewed. Data with regards to NBT tariffs need further investigation.	Annual audit currently submitted to CCG – needs review and more robust evaluation.
Near Patient Testing	Deliver a safe service local to patients.	This should sit in primary care for safety reasons and patient choice; in	Annual audit currently submitted to CCG – needs

		the long term this service could be offered at locality level. Add denosumab to this to be consistent across BNSSG and remove from Supplementary Services. This can and should be aligned for specification and tariff for next April. Work starting to produce a framework for shared care for new drugs to reflect actual workload for practices so payments are realistic.	review and more robust evaluation and we need to obtain data from practices to ensure patients are getting a consistent safe service.
Insulin Initiation	Offers a more specialist service local to patients and; improves job satisfaction and career progression for primary care nursing team.	This should sit in primary care for safety reasons and patient choice. Standardise payments. Remove GLP1 payments in Bristol. The insulin initiation LES should be offered at scale, potentially at locality level across BNSSG from next April in order to ensure patients have a consistent sustainable service. NB currently on offer to individual practices in N Somerset and Bristol only. This may be covered by community services in S Glos, further investigation to check where this	Annual audit currently submitted to CCG – needs review and more robust evaluation.

		activity currently sits. Consider opportunities to link to future community services procurement.	
Care Homes with and without nursing	To standardise care offered to patients across BNSSG and ensure gold standard/best practice applied to deliver high quality care local to patients.	Needs wider review not just in the context of primary care, and new specification across BNSSG which links to Enhanced Care for Care Homes Framework. Recommend this goes into further Phase 2 review. Recommend that an at scale offer is developed. Recommend that opportunities to improve pathways continues at pace in support of winter planning for this year. This should sit with Integrated Care Steering Group which has GP representation to take this forward by October (for Winter planning).	To be developed. Standards set need to follow the British Geriatric Society model of care – very clear markers of what should be delivered in this framework so robust monitoring can be done.
Supplementary Services	This service acknowledges that care that has been moved appropriately out of secondary care into primary care is understood and quantified. This service should be offered equally across BNSSG local to patients.	This activity should sit with primary care. Recommend we align specification for April 2019 – remove denosumab and addition of insertion and removal of pessaries. Noting that tariff varies across the 3 areas, however, this is aligned to wider PMS review with	Recommend that we monitor and evaluate activity across practices in BNSSG going forward in order to ensure getting value for money and that patients are getting an equitable service across BNSSG; a monitoring process has been developed

		five year funding commitment given to practices. Total income per practice needs to be understood, not just reinvestment premium in isolation.	in N Somerset and S Glos so we can build on that to make it robust and activity can be interpreted.
Bristol Primary Care Agreement and South Gloucestershire Compact	Service offered local to patients and relevant to their needs. Allows practices to focus on their demographic and what would be most useful to them.	This activity should sit within primary care, local to patients. BPCAg has enabled many practices to employ staff to develop this qualitatively valuable service, so this needs to be reviewed carefully so as not to destabilise primary care. For both schemes we recommend re-invest in phase 3 of Locality Transformation Scheme in support of system priorities with clear evaluation framework in place. Recommend share good practice and examples of innovation across practices. Consider how we shape social prescribing/care navigation and self-care agenda across BNSSG. Recommend we develop a common approach to practice education and protected learning time across	BPCAg – practices/clusters were required to submit a plan for a proportion of the funding given and then were required to submit a 6 monthly report on their plan's progress. S Glos Compact - Monitoring on the current CGA element is via a claims form that is submitted and remunerated quarterly. More work needs to be done on the monitoring and evaluation of this service.

		BNSSG. Recommend we learn from what has worked well in previous versions of the Compact and complete the evaluation of the impact of Comprehensive Geriatric Assessments. We need to support conversations so that these services can be offered at locality level in the future to ensure sustainability and equity across BNSSG.	
Minor Injuries	This service ensures that more rurally located patients have access to care for minor injuries.	Further work to be done to understand this via an Equality Impact Assessment and a deeper dive into the activity generated by this service – is there a need for this service? If this service was not to be continued, would this activity be transferred elsewhere? It is not clear whether this specification is right for the health needs of our population, or evidence-based and therefore further work is required to answer these questions. The service has to be in line with the BNSSG aims of reinforcing self-care and patient	6 monthly patient feedback exercises and activity assessments.

		education and ensuring that patients have equity of access to appropriate services across BNSSG. Recommend report back to PCCC in September with outcome of this further work	
Dementia (Bristol only)	This service promotes GP education, improves diagnosis rates and provides timely assessment and treatment for patients locally to patients. It also develops better integrated services between primary and secondary care.	This activity should sit within primary care. Recommend roll out across BNSSG and continue at practice level. Evidence of higher diagnoses rates in Bristol due to the shift in moving this from secondary to primary care. Nationally recognised model of best practice and integral relationship with Dementia Wellbeing Service. Recommend post diagnostic support is reviewed in South Gloucestershire and North Somerset to align with Bristol.	Annual training for GPs; audits; monthly reports to show diagnosis; annual service evaluations. This is a well-established robust system.

Appendix B – Desk Top Review template

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Primary Care Service Name: **Standardised DVT service in BNSSG for patients presenting in general practice**		**Date of review:**	**1.6.18**	
Lead Manager: Andy Newton Becca Robinson		**Lead Clinician:**	**Pippa Stables**	
		Bristol	North Somerset	South Gloucestershire
1	**Meets aims & objectives** What are the clinical aims and objectives of the service? Are there key areas of good practice which we could roll out across BNSSG? How does this align with the CCG 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 or in line with other services? Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	To standardise the service across BNSSG. To ensure the new service follows NICE guidance. EIA done 23.5.17 Use of D-dimer testing in primary care where indicated to reduce the number of referrals to scan. Where scan required GP will refer direct to scan via ICE and anticoagulated the patient while waiting for scan to take place. ?D-dimer test outside of core GP contract. Practice point of care testing equipment funded by medicines optimisation		
2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	NICE guidance for DVT		
3	**Engagement** What feedback or engagement has there been in the development of	Review of current 5 services across BNSSG. Provider meeting. Individual trust meetings.		

	this service (clinical, patient and/or with other stakeholders)?	Clinical forum meetings with primary care. Clinical meeting with CCG and secondary care. GP Care patient support group engagement. DVT implementation Group set up for monthly meetings from June 18.
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	Estimated activity for BNSSG in 2016/17. Initial assessment in primary care 4,440. Ultra sound scans 3,829. Initiation of treatment for positive DVTs 700.
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	Current BNSSG DVT whole pathway costs £1.2M-£1.5M. Proposed future BNSSG DVT whole pathway costs £675K. Primary care costs for d-dimers at £30 per test anticipated to be done for 25% of 4,440 patients= £33,300 approx. If primary care not paid for d-dimers risk that there will be increased number of patients referred for ultra sound scan.
6	**Delivery Model**	
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	Nationally the service is provided in various ways. A number of different options for providing this service have been explored. The haematologists had clinical safety concerns with the other options proposed. There may be an opportunity in the future to bring the diagnostic scan and management of the positive DVTs into primary care with the haematologists support.
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 service could be provided without the practices being paid for D-dimer testing. Risk that more patients might be referred straight to scan.
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	An evaluation plan is in development.

9	**Invoicing process** What is the invoicing process and frequency?	Primary care in Bristol currently paid for d-dimer tests done at practice level via search and report quarterly.		
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	PCS:09 DVT assessment in primary care (17/18) Out of contract informal agreement until 30 September 2018 – will need a new NHS Standard Contract going forward		
11	**Summary of comparison of service across 3 areas**	Currently 5 pathways across BNSSG. South Gloucestershire and North Bristol refer to GP Care community service. South Bristol and some of North Somerset refer to UH Bristol DVT clinic. Some of North Somerset refer to either direct access to scan at Weston or to AEC pre scan and AEC see the patients with a positive DVT diagnosis to commence treatment. Review of DVT pathway commenced October 2016. Service redesign commenced April 2017.		
12	**Recommendations for future of service:** • Continue at practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	Proposed standardised DVT pathway draft service specification developed.  Draft BNSSG DVT pathway Service Spe Letters to be sent June 2018 to acute providers to ask if they are interested in delivering the DVT service. Primary care generally supportive of the pathway which was discussed at clinical forums in May 2018. Final proposal to commissioning exec 12th July for sign off. If the new DVT pathway is commissioned as an integrated primary and secondary care service then GP Care service will not be extended beyond 31st March 2019 when their current contract ends. Plan for a phased implementation from		

		September 2018 at Weston and from November at UH Bristol and NBT.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	The acute trusts may not agree to provide the integrated service – mitigation, CCG has been working with clinicians and managers at the 3 acute trusts. Formal letters asking if they are interested in providing the service to be sent to the trusts early June 2018. The trusts may not be able to set up the service in the proposed CCG timeframes - mitigation, implementation group set up and initial meeting planned for 7th June 2018 to discuss actions required should the acute trusts agree to deliver the service. The cost savings associated with the redesigned pathway may not be realised – mitigation, close monitoring of the new service KPIs once the pathway is implemented and a service evaluation is being developed.

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Appendix B – Desk Top Review template

Primary Care Service Name: **Anticoagulation**		**Date of review:**	04th June 2018	
Lead Manager: Johanna Topps		**Lead Clinician:**	Shaba Nabi, Prescribing Lead	
		Bristol	North Somerset	South Gloucestershire
1	**Meets aims & objectives** What are the clinical aims and objectives of the service?	**clinical aims and objectives** To ensure patients for whom treatment with a vitamin K antagonist in indicated get care that is safe, effective, and sustainable: 1. To identify the cohort of patients in each practice population for whom anticoagulation with a vitamin K antagonist is indicated, and maintain good clinical records for these patients 2. To provide these patients with treatment, and the information they need to adhere to that treatment 3. To monitor the safety and effectiveness of that treatment by ensuring that the INR of these patients can be measured at regular intervals at minimum inconvenience to patients 4. To ensure that these patients are taking an appropriate dose of treatment, in response to INR	**clinical aims and objectives** <u>Initiation LES</u> To improve the quality and accessibility of care to patients receiving on-going anticoagulation therapy, sustaining the shift from secondary to primary care. (ii)To improve the patients' experience by using near patient testing so that the Warfarin dose may be provided to the patient on the spot in the majority of cases. (iii)To utilize new technology such as dosing decision software i.e. INR Star. (iv)To meet NPSA guidance with respect to providing a safe anticoagulation service. (v)To provide continuing patient education in understanding their treatment in terms of the condition requiring Warfarin, target INR range, the effects of over or under anti-coagulation, diet, lifestyle and	**clinical aims and objectives** An anti-coagulation monitoring service is designed to be one in which: (i)Therapy should normally be initiated in secondary care, for recognized indications for specified lengths of time (ii)Maintenance of patients should be properly controlled (iii)The service to the patient is convenient (iv)The need for continuation of therapy is reviewed regularly (v)The therapy is discontinued when appropriate

		results and/or dosage instructions that are obtained 5. To ensure that patients with very high or very low INR results are managed appropriately 6. To ensure that patients who do not regularly achieve therapeutic INRs are reviewed and alternative therapy considered 7. To provide the service to a high standard in a way that is convenient for patients. 8. To ensure that providers of care work together to share data to support safe and effective care for the patient in all settings. 9. To evaluate the quality of care through a regular audit process, effecting change when required to achieve planned goals. **Basic service (Level 1)** The practice provides a phlebotomy service so that venous blood is obtained from patients for whom they are prescribing a vitamin K antagonist at appropriate intervals. The venous blood sample is supplied to a secondary care organisation so that they can measure the PT, calculate the INR and the appropriate dosage, and communicate this to the patient and practice. **Advanced service (Level 4)** The practice provides a point-of-care service so that a finger-prick blood	drug interactions. (vi)To give optimum care in terms of INR control. (vii)To advise on the anticoagulation therapy regimen prior to surgery or dental procedures. (viii)To evaluate the quality of care through a regular audit process, effecting change when required to achieve planned goals. <u>Monitoring LES</u> (i)To improve the quality and accessibility of care to patients receiving on-going anticoagulation therapy, sustaining the shift from secondary to primary care. (ii)To improve the patients' experience by using near patient testing so that the Warfarin dose may be provided to the patient on the spot in the majority of cases. (iii)To utilize new technology such as dosing decision software i.e. INR Star. (iv)To meet NPSA guidance with respect to providing a safe anticoagulation service. (v)To provide continuing patient education in understanding their treatment in terms of the condition requiring Warfarin, target INR range, the effects of over or under anti-coagulation, diet, lifestyle and drug interactions. (vi)To give optimum care in terms of INR control. (vii)To advise on the	

		sample is obtained from patients for whom they are prescribing a vitamin K antagonist at appropriate intervals, with the INR and appropriate dosage being calculated at the time.	anticoagulation therapy regimen prior to surgery or dental procedures. (viii)To evaluate the quality of care through a regular audit process, effecting change when required to achieve planned goals.	
	Are there key areas of good practice which we could roll out across BNSSG? How does this align with the CCG 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 or in line with other services? Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	**Are there key areas of good practice which we could roll out across BNSSG?** Using EMIS Search and Report to assist with payment as per the Bristol LES could be advantageous to streamline payment. Undertaking an annual audit of the provided service would ensure the quality of the service commissioned. Spreading the use of near patient testing rather than venous blood sample testing. **How does this align with the CCG priorities?** This link 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 – the GP would probably have to undertake the blood tests even if the dosing was undertaken by an NHS hospital service. Changing the delivery model to locality based may negatively affect the distances patients have to travel for anticoagulation management. **Was an Equalities Impact Assessment undertaken to support the service?** Unknown **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 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. De-commissioning hospital services would be necessary as well as commission localities to do this work. It aligns to locality 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'. **Do we commission this service elsewhere?** UHB and NBT **Is it a duplication or in line with other services?** The LES provides a similar service to the NHS Trusts but closer to home and has the benefit of face to face patient contact with a practice staff member and electronic health records are available to check for acute current illness and recent medication changes which may impact on treatment dosing management. Changing the delivery model to locality based may negatively affect the distances patients have to travel for anticoagulation management. **Do we have the remit to commission this service?** Yes **In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?** Unknown, 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 amount of patients on therapy increased hospitals were commissioned to undertake the activity. However following the NPSA alert in 2007 there was a move across BNSSG to repatriate this activity to GP practices.		
2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	a) To address variation in quality - Annual audit using a combination of practice annual data submission and Emis (Search&Report) data. b) Bristol locality report written up by Medicines Optimisation Team (MOT) however not all practices return audit. Learning informs improvement in practice, however no contractual action taken against providers who do not return audit.	<u>Initiation & Monitoring LES</u> a) To address variation in quality - Practices asked to undertake monthly and annual audit related to NPSA safety indicators for oral anticoagulants b) None – submissions not received/reviewed by CCG	a)To address variation in quality - Annual review by practice against the NPSA audit criteria and LES criteria. Audit criteria/template not supplied b) None identified. It is understood that submissions are not received/reviewed by CCG

		Competency BNSSG CCG does not have evidence that there is a sufficient level of competency amongst practice staff delivering this service.	**Competency** BNSSG CCG does not have evidence that there is a sufficient level of competency amongst practice staff delivering this service.	**Competency** BNSSG CCG does not have evidence that there is a sufficient level of competency amongst practice staff delivering this service.
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	Unknown	Unknown – Inherited from PCT. Developed in 2008 following alert from the National Patient Safety Agency.	Unknown
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	Demand is falling due to the emergence of the alternative NOAC medications however there is still a need for warfarin/anticoagulants to be safely monitored in the community. Uptake across practices – 45 (98%) Number of patients on warfarin in Bristol locality (12A) = 5470 Unknown how many people access the service	Demand is falling due to the emergence of the alternative NOAC medications however there is still a need for warfarin/anticoagulants to be safely monitored in the community Uptake across practices – 18 (100%) Number of patients on warfarin in North Somerset locality (11T) = 4346 Unknown how many people access the service	Demand is falling due to the emergence of the alternative NOAC medications however there is still a need for warfarin/anticoagulants to be safely monitored in the community Uptake across practices – 25 (100%) Number of patients on warfarin in south Glos locality (12A) = 4244 Unknown how many people access the service
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	£14.25 per patient per quarter for level 1, £30 per patient per quarter for level 4. 2017/18 Total Spend = £165K	Initiation on Warfarin: Ambulatory - £125.00 once only Domiciliary - £115.16 once only Ongoing management: Ambulatory - £42.48 per quarter Domiciliary - £27.72 per quarter Total Spend 2017/18 = £471K	£15 per patient per quarter using warfarin. No payment for the first 10 patients. Payment to provide testing & monitoring of bloods Total Spend 2017/18 = £102K

6	**Delivery Model**			
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	UHB currently also provides a warfarin monitoring service for Bristol locality patients: Previously 2,600 patients @block £150k = £58 per pt/yr Currently 1,271 patients @block £150k = £118 per pt/yr. There is potential to reduce the block payment for this service due to falling numbers. I believe the current information technology would accommodate this being delivered within the localities to patients in all the locality practices. 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.	WAHT: Minimal activity The North Somerset model for fully ambulatory patients costs £170 per patient per year. This is similar to the current annual costs of a level 1 service (venous sample only) at a Bristol GP practice and UHB undertaking anticoagulation management (Level 1 is £57 + £118 at UHB current block rate = £175) I believe the current information technology would accommodate this being delivered within the localities to patients in all the locality practices. 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	NBT: NBT currently also provides a warfarin monitoring service. Unknown costs presently I believe the current information technology would accommodate this being delivered within the localities to patients in all the locality practices. 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.

			variation in quality.	
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 patients taking warfarin therapy would still need to have regular blood tests and to receive dosing advice following each blood test. Decommissioning is likely to result in patients being registered with an alternative anticoagulation service. This is currently available at NBT or UHB for vitamin-K anticoagulation management. Decommissioning the current service would have a significant effect on these services as capacity would need to be increased. BNSSG CCG may still be funding a higher capacity due to the trend of a fall in warfarin use and known subsequent fall in patient numbers at UHB. WAHT no longer runs an anticoagulation clinic, thus contract negotiations and investment may be required to develop a warfarin management service if desired at this location. North Somerset Practices and some Bristol practice will have invested in coagu-check INR machines circa. £400 and registration with NEQAS for quality control. It is unknown whether a health inequalities impact assessment was undertaken. Decommissioning is not expected to affect the viability of the current GP practice providers although practices in North Somerset have employed staff to run this locally enhanced service.		
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	Annual audit using a combination of practice annual data submission and Emis (Search&Report) data required by LES, however not all practices return audit and no contractual action taken against providers who do not return audit. Last audit returned at the end of 2014/15 by 57% of practices.	<u>Initiation & Monitoring LES</u> Monthly and annual audit related to NPSA safety indicators for oral anticoagulants required by LES, however submissions not received/reviewed by CCG consistently	Annual review by practice against the NPSA audit criteria and LES criteria required by LES. Audit criteria/template not supplied to practice and it is understood that submissions are not received/reviewed by CCG
9	**Invoicing process** What is the invoicing process and frequency?	Paid monthly In arrears on receipt of monitoring information	Paid monthly In arrears on receipt of monitoring information	Paid quarterly in arrears on receipt of monitoring information
10	**Service Level Agreement**	Bristol	North Somerset	South Gloucestershire

	Is there a contract or Service Level Agreement? What is the notice period?	NHS Standard Contract – variation to be issued to extend to 31st March 2019	NHS Standard Contract – variation to be issued to extend to 31st March 2019	NHS Standard Contract – variation to be issued to extend to 31st March 2019
11	**Summary of comparison of service across 3 areas**	All three LES' have similar objectives and similar quality requirements.		
12	**Recommendations for future of service:** • Continue at practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	We recommend keeping a LES and • in the short term: - Further work is needed to develop a common approach at practice level including aligning for tariff and specification across BNSSG. - The CCG needs to be clear on audits required and process in place within the MO team to review these - the block contract with UHB reviewed and reduced based on diminishing numbers - The contract with NBT reviewed indetail - contract value established • in the longer term to scope and commission a consistent model across localities using a near patient testing model. 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. The quality and safety of the currently commissioned service is not being robustly reviewed and as such BNSSG CCG does not currently receive assurance from providers that the service provided is of the standard expected as set out in the contract particulars.		
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	Risk - Developing a locality model of delivery includes risk of deskilling 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 UHB and NBT for the anticoagulant monitoring service they currently provide.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Appendix B – Desk Top Review template

Primary Care Service Name: Near Patient Testing		**Date of review:** 7th June 2018		
Lead Manager: Johanna Topps		**Lead Clinician:** Shaba Nabi, Prescribing Lead		
		Bristol	North Somerset	South Gloucestershire
1	**Meets aims & objectives** What are the clinical aims and objectives of the service?	**clinical aims and objectives** To ensure patients for whom treatment with specified drugs with significant monitoring requirements get care that is safe, effective, and sustainable • To identify the cohort of patients in each practice population that are prescribed specified drugs, and maintain good clinical records for these patients • To provide these patients with treatment, and the information they need to adhere to that treatment • To monitor the safety and effectiveness of that treatment by performing investigations at regular intervals at minimum inconvenience to patients • To ensure that these patients are taking an appropriate dose of treatment • To ensure that patients are	**clinical aims and objectives** • Minimise risk • Monitor for adverse drug reactions (ADRs) • Intervene and stop long term complications • Encourage adherence (by prescribers to Shared Care Protocols (SCP) and by patients to the medication taking and medication regime) The near patient testing service is designed to be one in which: (i) therapy should only be started for recognised indications for specified lengths of time (ii) maintenance of patients first stabilised in the secondary care setting should be properly controlled. If the GP is not confident to undertake the prescriber or drug monitoring roles	**clinical aims and objectives** The near patient testing service is designed to be one in which: (i)therapy should only be started for recognized indications for specified lengths of time (ii)maintenance of patients first established in the secondary care setting should be properly controlled (iii)the service to the patient is convenient (iv)the need for continuation of therapy is reviewed regularly (v)the therapy is discontinued when appropriate (vi)the use of resources by the National Health Service is efficient

		managed appropriately according to the results of those investigations • To provide the service to a high standard in a way that is convenient for patients. • To ensure that providers of care work together to share data to support safe and effective care for the patient in all settings. • To evaluate the quality of care through a regular audit process, effecting change when required to achieve planned goals Currently the medicines included: (a) Azathioprine (oral) (b) Leflunomide (oral) (c) Mercaptopurine (oral) (d) Methotrexate (oral and parenteral) (e) Penicillamine (oral) (f) Sodium aurothiomalate (parenteral) (g) Sulfasalazine (oral) Denosumab is included in the supplementary basket in Bristol.	then they are under no obligation to do so. In such an event the total clinical responsibility for the Patient for the diagnosed condition remains with the secondary care consultant (iii) the service to the patient is convenient (iv) the need for continuation of therapy is reviewed regularly (v) the therapy is discontinued when appropriate (vi) the use of resources by the National Health Service is efficient The medications included may be subject to change. Currently the medicines included are: a) Azathioprine (Imuran) b) Denosumab (Prolia) 60mg/ml c) Leflunomide (Arava) d) Mercaptopurine (Puri-Nethol, Xaluprine) e) Methotrexate subcutaneous injection (Metoject) and/or oral f) Penicillamine (Distamine) g) Sodium aurothiomalate (Myocrisin) h) Sulfasalazine (Salazopyrin)	Drugs involved are: (a) Penicillamine (b) Auranofin (c) Sulphasalazine (d) Methotrexate (e) Sodium Aurothiomalate (f) Azathioprine (g) Leflunomide
	Are there key areas of good practice which we could roll out across	**Are there key areas of good practice which we could roll out across BNSSG?** Mercaptopurine (oral) - spread to South Glos area		

	BNSSG? How does this align with the CCG 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 or in line with other services? Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	Auranofin – remove as not included in the BNSSG formulary Denosumab (Prolia) 60mg/ml - spread to Bristol and South Glos Consider inclusion of other BNSSG formulary medications that require enhanced regular monitoring and link to traffic light status of drugs and shared care protocol requirements Review Shared Care Protocols for all the drugs on NPT LES to unify, where possible, regardless of indication to ensure clinically unnecessary over testing does not occur. Using EMIS Search and Report to assist with payment as per the Bristol and North Somerset LES would be advantageous to streamline payment. Undertaking an annual audit of the provided service would ensure the quality of the service commissioned. Methotrexate booklet distribution to be included as part to of the LES criteria. **How does this align with the CCG priorities?** 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. This LES is designed to improve medicines safety in primary care by monitoring the safety and effectiveness of treatments by performing investigations at regular intervals at minimum inconvenience to patients. This leads to safe high quality care being delivered closer to home. **Does this service promote the reduction of health inequalities?** No, the service was not set up to reduce health inequalities; however what it does is allow care closer to home. **Was an Equalities Impact Assessment undertaken to support the service?** Unknown. This has been adapted from a national DES, so may have been done nationally 10-15 years ago **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 model of service delivery. **Does this work impact on existing or proposed pathway work?** Secondary care / primary care shared care **Do we commission this service elsewhere?** NHS acute Trusts undertake this activity until the patients are stable, once stable patients can be transferred to GP practices for continuing management.

		Is it a duplication or in line with other services? Not a duplication of activity elsewhere in the health system. **Do we have the remit to commission this service?** Yes **In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?** This is a specialised blood test monitoring service for highly specialised medications and is not part of the core contract.		
2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	Annual audit using a combination of practice submission and Emis (Search&Report) data. Bristol locality report written up by Medicines Optimisation Team (MOT) however not all practices return audit. Learning informs improvement in practice, however no contractual action taken against providers who do not return audit. 67 % returned audit in 2014/15 **<u>Competency</u>** BNSSG CCG does not have evidence that there is a sufficient level of competency amongst practice staff delivering this service.	**Annual review** The Provider should conduct an annual review of the service. Form included in LES. The annual review should cover: (a) information on the number of patients being monitored and their clinical condition (b) details as to any computer-assisted decision-making equipment used and arrangements for internal and external quality assurance e.g. Methotrexate alerts (c) details of training and education relevant to the drug monitoring service ensuring all health care professionals involved in the service understand all aspects of patient care covered by this LES e.g. how to access the SCP; understand why the frequency of testing happens; how to interpret abnormal	**Annual review** All practices involved in the scheme should perform an annual review and submit an annual report which could include: a) Brief details as to arrangements for each of the aspects highlighted in the LES b) Details as to any computer-assisted decision-making equipment used and arrangements for internal and external quality assurance c) Details as to any near-patient testing equipment used and arrangements for internal and external quality assurance d) details of training and education relevant to the drug monitoring service

			bloods; what action to take if side-effects occur including whether the drug was stopped and if there was any related harm (this list is not exhaustive) (d) details of the standard used for the control of the relevant condition if not in line with the SCP (e) assurance that any staff member responsible for prescribing must have developed the necessary skills to prescribe safely (f) significant event audits of issues arising from this service (details and numbers) (g) details of the process to identify and manage non-attenders **<u>Competency</u>** BNSSG CCG does not have evidence that there is a sufficient level of competency amongst practice staff delivering this service.	e) details of the standards used for the control of the relevant condition f) assurance that any staff member responsible for prescribing must have developed the necessary skills to prescribe safely **<u>Competency</u>** BNSSG CCG does not have evidence that there is a sufficient level of competency amongst practice staff delivering this service.
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	Unknown	Unknown	Unknown
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	Unknown how many people access the service	Unknown how many people access the service	Unknown how many people access the service

5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	**Uptake 46 (100%)** £21.31 per patient per quarter Total Spend 2017/18: £296K	**Uptake 17 (94%)** £21.25 per patient per quarter Total Spend 2017/18: £186K	**Uptake 25 (100%)** £18.75 per patient per quarter Total Spend 2017/18: £165K
6	**Delivery Model**			
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	This activity along with the associated prescribing could be returned to secondary care however this would require commissioning or re-negotiation and would be against the CCG direction of travel. The blood monitoring alone could probably not be safely delivered by another provider unless they had access to the patients' medical records and test results and could influence whether medication is issued by the patients practice without the practice having to undertake additional paperwork. I believe the current information technology would accommodate this being delivered within the localities to patients in all the locality practices. The impact of this potential change on cost is unknown. The quality of the service may be improved by upskilling a smaller group of healthcare professionals but in practice this is unproven.		
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 patients taking the listed therapies would need to have regular blood tests to assess the safety of their treatment. I anticipate that many GP practices would refuse to continue to provide the service if the LES was withdrawn. Decommissioning would result in the blood test monitoring and possibly the associated prescribing being returned to secondary care. This would impact on the capacity of secondary care services (e.g. rheumatology and dermatology) and patient safety could potentially be compromised. It is unknown whether a health inequalities impact assessment was undertaken. Decommissioning would result in substantial practice income loss and could potentially impact on staff employed to do phlebotomy in practices. GP practice providers would not undertake this workload/activity without payment.		
It could go 8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to	Annual audit using a combination of practice submission and Emis (Search&Report) data.	Annual review. Form included in LES but submission not received/reviewed by CCG.	Annual review by practice criteria suggested in the LES. Audit criteria/template not supplied to practice and it is understood that

	assess effectiveness?	Bristol locality report written up by Medicines Optimisation Team (MOT) however not all practices return audit. Learning informs improvement in practice, however no contractual action taken against providers who do not return audit. 67 % returned audit in 2014/15		submissions are not received/reviewed by CCG
9	**Invoicing process** What is the invoicing process and frequency?	Paid monthly In arrears on receipt of monitoring information	Paid monthly In arrears on receipt of monitoring information	Paid quarterly in arrears on receipt of monitoring information
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	Bristol Yes NHS Standard contract – variation to be issued to extend to 31st March 2019	North Somerset Yes NHS Standard contract – variation to be issued to extend to 31st March 2019	South Gloucestershire Yes NHS Standard contract – variation to be issued to extend to 31st March 2019
11	**Summary of comparison of service across 3 areas**	All three LES' have similar objectives and similar quality requirements but do include different medications.		
12	**Recommendations for future of service:** • Continue at practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or	We recommend this is continued at practice level but further work is needed to develop a common approach at practice level including aligning for tariff, medications included and specification across BNSSG. Further formulary based work is then needed to develop a payment and monitoring framework for other drugs requiring monitoring more than annually. Linking the framework for other drugs to the LES could safely allow care closer to home where primary care is deemed an appropriate clinical setting for drug monitoring to be undertaken. The quality and safety of the commissioned service is not being robustly reviewed and as such BNSSG CCG does not currently receive assurance from providers that the service provided is of the standard expected as set out in the contract particulars. Evidence shows that keeping this work stream in primary care where the patient receives most of their health care can be done both safely and effectively		

	a priority for investment across BNSSG Please provide justification for recommendation	
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	Risk - Increased cost to the CCG of this LES, due to the addition of further medications and the need for annual review of medications included to ensure safety of medication monitoring in an appropriate setting. Mitigation – Review payments made elsewhere in the local healthcare system for this activity.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Appendix B – Desk Top Review template

Primary Care Service Name: **Insulin LES**		**Date of review:**	**7/6/18**	
Lead Manager: **Gillian Cook & Jo Topps**		**Lead Clinician:** **John Moore**		
		Bristol	North Somerset	South Gloucestershire
1	**Meets aims & objectives** What are the clinical aims and objectives of the service? Are there key areas of good practice which we could roll out across BNSSG? How does this align with the CCG 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	**Clinical Aims and Objectives (from LES)** **Aims and objectives of service** The provider will work with the commissioner to ensure that the service meets the following aims and objectives: **Aims of the service include:** • Improve outcomes for patients by achieving good 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 **Objective of the service include:**	**Clinical Aims and Objectives (from LES)** The purpose of the service is to reward the provider for undertaking treatment initiations in house, reducing the need for patient referral to secondary care. It will necessitate additional training for some practice nurses and GPs and as such, will help improve the general management of patients with diabetes. The principal aims are to: • Improve the quality and accessibility of care to patients with diabetes by	No Diabetes Insulin Initiation LES

	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 or in line with other services? Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	• Identify patients who need their intensification of their drug therapy for diabetes • Intensify drug therapy in line with NICE guidance • Improve glycaemic control leading to fewer complications • Reduce in emergency admissions due to hypoglycaemia • Ensure a patient centred approach to the initiation of insulin therapy which empowers the person with diabetes to be actively involved in their treatment • Ensure that the use of human insulin in maximised (in preference to analogue insulin) • Ensure that patients are initiated on a GLP-1 mimetic are reviewed in line with NICE guidance, with treatment discontinued as necessary • Ensure that cost-effective consumables are supplied to patients **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 nurses The aim of this LES is to encourage practices to ensure their staff are well	facilitating the shift from secondary to primary care and removing the need for patients to travel to acute trusts to undergo Insulin initiation • Improve the patient experience by providing more services closer to home by practitioners whom they know • Promote the self-care agenda and patient education as vital in the management of long term conditions such as diabetes • Evaluate the quality of care for patients with diabetes through a 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 nurses The aim of this LES is to	

		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. Skilled nurses in practice recognising insulin or GLP1 as the clear next step and initiating it with confidence as part of normal work helps to remove clinical inertia. Local quality service – not secondary care Practice Nurses and GPs have to have attended insulin training and update Service pre-dates 2013-inherited from PCT. **CCG Priorities** This is an example of integrated primary and community care, with simplified access points for patients to specialised services **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.	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. Skilled nurses in practice recognising insulin or GLP1 as the clear next step and initiating it with confidence as part of normal work helps to remove clinical inertia. Local quality service – not secondary care Practice Nurses and GPs have to have attended insulin training and update Service pre-dates 2013-inherited from PCT. **CCG Priorities** This is an example of integrated primary and community care, with simplified access points for patients to specialised services	

		• Practices will have more background knowledge of social circumstances to make the care more holistic for the patient. **EIA** Not known if EIA was completed. Service pre-dates 2013-inherited from PCT **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. **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	**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. **EIA** Not known if EIA was completed. Service pre-dates 2013-inherited from PCT **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.	

			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** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	**Bristol** Medicines optimisation team ask for feedback from practices regarding activity and quality (CPD, etc). 49% of practices returned their feedback forms 16/17. Issues are addressed by general training for all practices. There is no contractual monitoring in place. **North Somerset** NSCP have in the past monitored the insulin initiation scheme, but this has not been reported to the CCG since the outcomes contract has been in place between NSCCG and NSCP. It is not currently known if there are variations in quality as this is not monitored effectively across BNSSG. **Competency** BNSSG CCG does not have evidence that there is sufficient level of competency amongst practice staff delivering this service. CPD that staff undertake is not always accredited by recognised body. Nearly all Bristol practices engaged with the LES 98%; 72% NS – in SG at least 9 practices currently refer to the community Diabetes Specialist Nurse (DSN) service for insulin and or GLP1 starts. It is not known if any of the practices in SG refer to secondary care for insulin start. More evidence is required. The Bristol LES is monitored by EMIS S+R and includes prescribing in line with formulary for insulins, needles, test strips etc including discontinuing GLP1s if ineffective – this is not currently within NS. It could be helpful to compare prescribing info for Bristol, NS and SG to check impact of this.	

		The CCG IAF ranks diabetes as 'inadequate' in Bristol and 'needs improvement' in North Somerset and South Gloucestershire. This is based on the uptake of patient diabetes structured education and treatment targets (HbA1c, blood pressure and cholesterol).		
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	The level of engagement whilst this service was being developed is not known as the LES pre-dates the formation of CCGs.		
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	Numbers accessing service in Bristol not known. Cost of insulin/GLP1 starts for BNSSG: £91K budget for BNSSG 18/19 Bristol: £250 for insulin initiation; GLP1 initiation £120; Estimated spend £70K Bristol: GP practices signed up: 45 (98%); **(Initial outpatient appointment (UHB) £213 with £89 follow up: cost of annual insulin initiation in secondary care £302)** Trend: It is likely that this demand will increase due to the	Numbers of insulin initiation for NS 2016-17 = 89 and 2017-18 = 50 16/17 estimated spend on LES £20K North Somerset £225 per insulin start; and no additional payment in NS for GLP1 but expected to provide this service as part of the insulin LES NS: GP practices signed up 13 (72%); Trend: It is likely that this demand will increase due to the increasing number of people with diabetes in BNSSG.	Numbers in South Glos unknown Trend: It is likely that this demand will increase due to the increasing number of people with diabetes in BNSSG.

		increasing number of people with diabetes in BNSSG.		
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	£120 per GLP-1 initiation. £250 per insulin initiation Total Spend 2017/18: £78K	Insulin initiation £175, 6 month review £50 Total Spend 2017/18: £12K (13 practices signed up)	n/a
6	**Delivery Model**			
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	**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. **Could this service be delivered at scale across practices?** This service could be delivered at scale via localities with staff maintaining competences (eg practice nurses, practice pharmacists, practice paramedics) in each locality. **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.		
7	**What would be the impact of**	**Implications for Patients** Patients may not be able to access this service close to home.		

	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?	Practice nurses would become de-skilled. There would be a negative impact on patient experience. Secondary care and/or community diabetes services would be stretched further. It is unknown if any practices in primary care in South Glos refer to secondary care for this work. There is evidence that SG practices refer to the community DSN service. There is an inequality in reward for practices if some practices keep their nurses trained and allow them to spend the considerable time required for a safe insulin start (several appointments) but other practices instead refer to community DSN to see patient for insulin start. There would be no incentive for practices to remain upskilled and continue this service. Withdrawing the LES re GLP1s may result in people remaining on ineffective treatment for a prolonged period. However the LES in place and not quality controlled may result in people remaining on ineffective treatment for a prolonged period. **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. **Health Inequalities Impact Assessment** It is not known whether this was completed as this pre-dates CCGs **Would Decommissioning Affect the Viability of the Provider** Decommissioning would not affect the viability of primary care but there is a danger that the DSN service would become over stretched if all insulin initiations were transferred to community providers or secondary care.		
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken	Bristol – EMIS S+R and practice annual audit returns (only 49% of practices return this information to the CCG and practices are not penalised as a result)	NS – paper record completed for each start, but not reported to CCG	SG no monitoring

	place to assess effectiveness?			
9	**Invoicing process** What is the invoicing process and frequency?	Paid monthly In arrears on receipt of monitoring information	Paid monthly In arrears on receipt of monitoring information	
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	Bristol NHS Standard Contract – variation to be issued to extend to 31st March 2019	North Somerset NHS Standard Contract – variation to be issued to extend to 31st March 2019	
11	**Summary of comparison of service across 3 areas**	Bristol – insulin and GLP1 starts are funded NS insulin start and 6/12 follow up funded. GLP1 starts are initiated by practice at no charge SG not funded		
12	**Recommendations for future of service:** • Continue at practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work	Further work needed to develop a common approach for April and develop the service for delivery 'at scale' for April 2019. We would recommend consideration to stop or greatly reduce the payment for GLP1s as very little clinical input is required over what is felt to be part of the core contract. Justification: • Service could be delivered at locality level reducing variation in service and allowing quality to be closely monitored in each area • Upskilling of primary care staff through cascade of knowledge from community DSNs, as currently exists through virtual clinics will increase resilience and sustainability • This service supports BNSSG CCGs priorities. This locally enhanced service is an example of integrated primary and community care, with simplified access points for patients to specialised services		

	needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	Risk: There is a risk that there will be an increased cost to the CCG. Mitigation: Whilst the community providers are paid via block contract, this will continue to be a risk. However it is unknown how many patients currently attend NBT from South Glos for insulin initiation, and this practice could result in a saving. Risk: The locality model could result in a risk that there will not be sufficiently qualified nurses to deliver this LES if experts within the locality leave. Mitigation: Expertise must be cascaded in the practice and other HCPs apart from nurses eg pharmacists and paramedics are included in upskilling and delivering service through rotation. Including part-time workers will ensure the service is not 1 person dependent to ensure resilience and sustainability.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

1. Appendix B – Desk Top Review template

Primary Care Service Name: **Care homes LES**		**Date of review:** **5/6/18**		
Lead Manager: **Julie Kell**		**Lead Clinician:** **Michael Jenkins**		
		Bristol	**North Somerset**	**South Gloucestershire**
1	**Meets aims & objectives** What are the clinical aims and objectives of the service?	**Aims and objectives** **With Nursing** This service aims to deliver the British Geriatric Society model of delivering enhanced care in care homes with nursing (refer to Section 4of the LES). The recommendations state that the service should deliver the following components: 1. Comprehensive assessment of new residents on admission and the development of patient-centered care plan in conjunction with the care provider. 2. Prompt recognition of residents requiring imminent end of life care and ensuring that end of life care plans and anticipatory prescribing are in place. 3. Assessments to include medication review in partnership with the community/care home's pharmacist at least every 6 month. A medication	**Aims and objectives** **Without Nursing** The principle aims of this enhanced service are to: 1. Recognize the high dependency of this group of patients on primary care services and support GPs to provide enhanced primary care services to this group; 2. Ensure older people residing in nursing homes have equitable access to primary care services; 3. Reduce the number of patients admitted from nursing home to hospital to die, unless this is the patient's preferred place for end of life care.	**Aims and objectives** **Without Nursing** No Aim & Objectives, but does have outcomes: The Care Home LES intends to: 1. Reduce inappropriate admissions to secondary care 2. Reduce attendances at the Emergency Department 3. Reduce out of hours consultations with Brisdoc 4. Reduce 999 calls 5. Improve relationships between nursing homes and primary care 6. Improve quality of medical care for nursing home residents

		review should also be completed following discharge from an acute hospital admission within 48 hours of the transition from acute care. 4. Ensuring and reviewing appropriate risk assessments working in collaboration with the Provider 5. Creation of an advanced care plan for acute events including clinical information to accompany an acute hospital admission if admission is necessary. 6. Reliable systems with appropriate support tools to enable effective telephone conversation and use of out of hours referrals 7. Regular scheduled visits by an appropriately commissioned GP or specialist nurse *(who has the high level skills to deliver this work)* to review particular residents with new needs, perform routine reviews and to liaise with other health and social care professionals *(and families)* 8. Clarification of referral pathways and response times for specialist input including community rehabilitation services A robust interdisciplinary and interagency clinical governance system which promotes quality improvement and involves care home manager and relevant staff. It should also allow for review of individual cases involving complaints and adverse incidents as well as monitoring		

		chosen outcome measures, **Without nursing** This service aims to deliver the relevant aspects of the British Geriatric Society model of care for delivering enhanced care in care homes http://www.bgs.org.uk/campaigns/carehomes/quest_quality_care_homes.pdf. This model does not ask for the same level of input as of that in care homes with nursing, as the complexity of residents within a care home without nursing is reduced, compared to those residents in the care homes with nursing. This specification therefore reflects the reduced requirements for this cohort of residents. At the heart of this service specification is the need to move from delivering reactive care to delivering pro-active care. This is one of the areas that deliver a significant enhancement in what is required from within the standard GMS/PMS/APMS contract and the Avoiding Unplanned Admissions DES. The below identifies the key requirements of the service and identifies whether they are funded within this service, or within the DES. **Funded within this Service Specification:** 1. Comprehensive assessment of new residents on admission to the home		

		within one month of admission that includes a falls risk assessment in conjunction with the home. 2. Regular scheduled visits, at least monthly or if clinically appropriate more regularly, by a GP or specialist nurse (who has the high level skills to deliver this work) to review particular residents with new needs, perform routine reviews and to liaise with other health and social care professionals (and families). 3. Assessments to include medication review in partnership with the community/care home's pharmacist at least every 6 month. 4. Prompt recognition of residents requiring imminent end of life care. 5. Liaison with the Care Home (Care Home) to ensure that there are clear pathways in place to refer to specialist services e.g. district nursing, Occupational Therapy, Social Care. 6. Develop a robust interdisciplinary and inter-agency clinical governance system which promotes quality improvement and involves the care home manager and relevant staff. It should also allow for review of individual cases involving complaints and adverse incidents as well as monitoring of chosen outcome measures.		

	Are there key areas of good practice which we could roll out across BNSSG?	**Areas of good practice** High level objectives are linked to the British Geriatric Society model of care. Monitoring and evaluation framework is outcomes based, but the claim form doesn't specific/ demonstrate the outcome (although is better than S Glos). Is clear on what is covered by the LES and what is covered by BPCag.	**Areas of good practice:** North Somerset is completed on an NHS standard contract. Therefore have specific details around schedules/ governance. Clear form for reporting – reports activity (visits etc.) and outcomes – e.g. EOL plans Clearly defined pathway.	**Area of good practice:** Good clear definition of requirements and the expectation such as face to face weekly assessment, which enables monitoring.
	How does this align with the CCG priorities?	**How does this align with the CCG priorities?** Bristol – both LESs measured against the NHS outcomes framework domains. None of the 3 take any responsibility for Delayed Transfers Of Care (DTOCs) or the 91 days re-admission targets	**How does this align with the CCG priorities?** Uses NHS Outcomes Framework and locally defined outcomes (such as strengthening relationships between practices and care homes).	**How does this align with the CCG priorities?** Defines local outcomes – eg reduction in inappropriate admissions, but doesn't mention national domains.
	Does this service promote the reduction of health inequalities? **Was an Equalities Impact Assessment**	**Does this service promote the reduction of health inequalities?** Care homes without Nursing – defines the population covered, and the differences between Care Homes with Nursing. No evidence of an EIA.	**Does this service promote the reduction of health inequalities?** NS – the aims recognise the high dependent group of patients.	**Does this service promote the reduction of health inequalities?** S Glos does mention variability of service to the homes No evidence of EIA

	undertaken to support the service?		No evidence of EIA.	completed.
	Do we commission this service elsewhere? Is it a duplication or in line with other services? Do we have the remit to commission this service?	**Commission this service elsewhere** Bristol Care Homes without Nursing also references services provided through the BPCAG All – core work within GMS/ PMS.	**Commission this service elsewhere** Clevedon practice have a care home nurse NS has a residential care home support team – not overlapping with LES. In winter 2018-2019 – winter pressures money to extend this.	**Commission this service elsewhere** None evidenced
	Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)?	Having completed a preliminary literature review and found the following – which are examples of good practice elsewhere. • http://www.croydonccg.nhs.uk/about-us/Governing%20body/Governing%20Boday%20Papers/24-09-13/Enclosure%209%20-%20Appendix_G_-_GP_Practice_Care_Home_Support_Local_Enhanced_Service.pdf • **Local** Enhanced Service for Care **of Patients resident in** www.bgs.org.uk/campaigns/**carehomes**/South_staffordshire.pdf · • Locally Commissioned Service GP Cover **of Nursing ...**		

		• https://gps.camdenccg.nhs.uk/cdn/serve/downloads/1452133464-915d • Evidence review on partnership working between **GPs,** care **...** • https://www.scie.org.uk/publications/guides/guide52/fi**les/gp**... · • Developing Enhanced Primary Care Services **for Residents of ...** • https://www.kingsfund.org.uk/sites/fi**les**/kf/media/Developing... · • https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-clinical-input-to-care-homes.pdf
	Does this work impact on existing or proposed pathway work?	**Impact on existing or proposed pathway work** TEP form scheme. Red bag scheme (piloted in 2 Bristol, 3 NS, 0 SG) Blue book (NS) Trusted assessment Community residential care liaison team (NS) Integrated Community localities (STP) Frailty strategy Joint work with LAs Continuing Health Care (and new national framework) Market management of care homes EOL and fast track EOL. Care homes pharmacist Healthy Weston Project Clevedon care home nurse
	In what ways above and beyond what GP practices does the	It is difficult to ascertain as to where core services stops and enhanced services starts – any new specifications should define what is expected in the GMS / PMS contract and what is enhanced, and any deliverables.

	proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	SG considers what is expected under the GMS/ PMS contract: The following paragraphs are included in core GMS/PMS contracts. The contractor: • Must provide the service described in the clauses (essential services) at such times, within core hours, as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for its patients to access such services throughout the core hours in case of emergency. • Must provide services required for the management of the contractor's registered patients and temporary residents who are, or believe themselves to be ill, with conditions from which recovery is generally expected; terminally ill; or suffering from chronic disease and delivered in the manner determined by the Contractor in discussion with the patient. • "Management" includes offering a consultation and, where appropriate, physical examination for the purpose of identifying the need, if any, for treatment or further investigation; and the making available of such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient's treatment and care. • It also states that the contractor must provide appropriate ongoing treatment and care to all registered patients and temporary residents taking account of their specific needs including: the provision of advice in connection with the patient's health, including relevant health promotion advice; and the referral of the patient for other services under the Act. • The contractor must provide primary medical services required in core hours for the immediately necessary treatment of any person to whom the Contractor has been requested to provide treatment owing to an accident or emergency at any place in its practice area. "Emergency" includes any medical emergency whether or not related to services provided under the agreement." above and beyond what GP practices The GMS/PMS contract is quite generalised in its definition of services for patients (e.g. not specifying completing a TEP form or visiting a patient on discharge from hospital). Identifying a managing frailty is covered under contract. Therefore we would expect the local enhanced service to more specific deliverables

2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	For BNSSG - We don't have the access to the business cases that formed the basis of these enhanced services. Therefore the correlation between need and capacity is not defined. It is also not clear whether we have: • The full list of care homes • The full list of numbers of patients with or without nurses • Whether homes are high for admissions. • Whether high admissions are due to complexity, or for example poor staffing levels, or poor engagement from GP practices. Bristol – have defined the number of beds in the care homes. For BNSSG – these LESs have been in existence for 14 years or more, (although they have been amended) – there is a lack of evidence to demonstrate the need at start, although it is fairly indisputable that care homes (and in particular admissions from care homes is a significant impact on the system). There is national evidence (see literature review and BGS guidance) for assertive management of people in care home to improve outcomes – in particular EOL/ advance planning and medication reviews by a pharmacist. NS only covers nursing homes – so no enhanced service for residential homes. Each care home may have a number of GPs involved in that care home. Within the spec there is no evidence to support it meets local needs.		
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	**Feedback Bristol**: Without Nursing – describes interdependencies – i.e. people they have worked closely with. Offers training for care home staff. Spec shows engagement with stakeholders, via a workshop.	**Feedback NS;** States no interdependencies with other providers.	**Feedback SG** LMC and practices Feedback obtained from care homes.

4	**Capacity & Demand** **What is the uptake across practices?**	**What is the uptake?** No list of practices that aren't involved in the LES But a number of gaps for linked practices.	**What is the uptake?** The excel spreadsheet- we feel there are far more care homes than this in NS. Many gaps in the linked practices 7 practices not part of the LES. The 2 Clevedon practices have a separate care home nurse liaison which is funded separately.	**What is the uptake?** SG – spreadsheet (in appendix) in incomplete to show which care homes link to practices. SG – 8 practices are not part of the LES
	How many people access the service? **What is the trend in demand?**	How many people access the service? BNSSG – we have been provided with some data: Numbers of care homes With or without nursing Number of beds Gp practice alignment to homes However, this doesn't seem complete so a more thorough review of the beds is needed. NSSG - Difficult to say – we would expect a capacity – demand tool to reflect level of need, rather than just numbers of patients. NS – in Healthy Weston, there has been an attempt to rationalise the care home to single GP practices		
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	Nursing Homes - £58.75 per bed per quarter for standard bed, £125 per bed per quarter for fast flow bed. Care Homes - £38.25 per bed per quarter. Total Spend 2017/18: £470K	£242 pa per FN bed Total Spend 2017/18: £154K	Nursing Homes - £50 per patient per quarter. £50 per patient p/a for a level 2 home. £100 per patient p/a per residential home bed. Total Spend 2017/18: £169K

6	**Delivery Model**			
	Could this service be delivered by another provider?	Could this service be delivered by another provider? Yes. It is possible for the enhanced aspects of the service to be delivered by one provider or an alternative provider. Or – it could be in partnership within a locality, joint working with the community provider – for example a GP and pharmacist linking up to optimise prescribing in care homes, or for example – a mental health provider linking with a community nurse to manage challenging behaviour in dementia. Delivery by a non-GP provider would require good flow of information and access to records.		
	Could this service be delivered at scale across practices?	**Could this service be delivered at scale across practices?** Yes. We feel this could be offered at scale with practices sharing expertise such as GPs with interest in frailty or prescribing. However, it is also amenable to a multi-disciplinary approach with community, social care and mental health providers. More radically, integrated localities could pro-actively work with acute hospitals to facilitate discharge from hospitals to reduce DTOCs – 'a medical trusted assessment' – e.g. primary care designated to go into hospitals to pull out patients.		
	How would this impact on quality of service delivery and the cost of service delivery?	**Impact on delivery** Integration/ at scale – reduce the variability of care delivered within a locality. Dementia – pro-active management of challenging behaviour – reduced use of sedatives/ anti-psychotics Evidence based practice in the use of medicines and nutritional supplements. EOL – Improving advance care planning/ TEPs will reduce the number of people dying in hospital Actively facilitating discharge: reduces de-conditioning and reduces DTOCs costs.		
7	**What would be the impact of decommissioning**	The evidence review shows that proactive management and support to care homes can prevent avoidable admissions (e.g. for EOL care) and reduce DTOCs. The evidence shows it is good for the system and good for patients.		

	this service? **What are the implications for patients?**	This is outlined in the NHSE – 7 elements of EHCH (Enhanced health in care homes) vanguards. We need to understand whether regular visits and building up relationships with the homes, has a significant impact on outcomes. If decommissioned, then there will be a loss of the named GP/ continuity/ relational benefits to care home residents		
	Is there an impact on other stakeholders, premises, equipment etc.?	**Impact on other stakeholders**: If decommissioning results in increased admissions, then impact on ambulance and acute providers. Impact on general practice and community services – both in-hours and out-of-hours.		
	Was a health inequalities impact assessment ever undertaken to support the service and has this been considered?	Health in equalities No EIAs available to us for this desktop review.		
	Would decommissioning affect the viability of a provider?	Not known – would depend on the amount of income generated – some practices may have large populations. However, withdrawal of the service would result in clinician time taken up, so some level of offset. It may be argued that some practices may continue, for example, the visits unfunded to help their ongoing relationship with care homes.		
8	**Evaluation** **What monitoring takes place and how often is it reported?** **Have any audits taken place to assess effectiveness?**	**Bristol:** Reporting form available – which is submitted monthly. No formal evaluation provided nor any completed returns No audit available to us.	**N Somerset:** Monthly returned via excel spreadsheet. No evaluation provided. No audit available to us.	**S Glos** Reported quarterly. No reports received. No audit available to us

9	**Invoicing process** What is the invoicing process and frequency?	Paid monthly In arrears on receipt of monitoring information	Paid monthly In arrears on receipt of monitoring information	Paid quarterly in arrears on receipt of monitoring information
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	NHS Standard Contract – variation to be issued to extend to 31st March 2019. 2 separate specs care homes with / care homes without practices are signed up to both, none or 1	NHS Standard Contract – variation to be issued to extend to 31st March 2019	Not clear if covered in contract – confirmation required and variation as per Bristol and North Somerset
11	**Summary of comparison of service across 3 areas**	On evaluation of the 3 LES there are many common themes, including: Continuity (regular visits, named GP etc) EOL and advanced care planning Medication reviews Regular reporting No care home need identified individual, or as a locality Unable to obtain formal evaluations, nor EIAs, nor details of outcomes via the returns. Differences include: Payment mechanisms (number of beds, NS – via funded beds only) Price per bed Expectations of the visit Expectations of the reporting and monitoring differs There is debate to be considered about what are core primary care, what is funded through BPCag and what is enhanced. There is evidence to support enhanced health in care homes, but this could be achieved through a different commissioning approach – via localities/ at scale, or even through alternative providers.		

	Recommendations for future of service: • **Continue at practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR** • **Further work needed to develop a common approach for April AND/OR** • **Develop service for at scale delivery for April OR** • **Service no longer needed or a priority for investment across BNSSG** **Please provide justification for recommendation**	We feel that this service should be developed for delivery at scale across a locality, to include aligning with the other work across the CCG (such as trusted assessment, TEP etc.) We feel that management of chronic conditions to reduce risk of ambulatory sensitives admissions should be considered in a future spec We recommend that any service is built on the 7 core elements of the EHCH model, including high quality Medication reviews. The specific aims should be to provide **continuity of care for residents, timely medicines reviews, access to hydration and nutrition support, and streamlined referral to out-of-hours services and urgent care**. Specifically, mapping practices to care homes, weekly ward rounds and comprehensive geriatric assessment (CGA is not part of any current LES).

13	**Risk Assessment** **Please provide a summary of any risks arising from recommendations and any proposals for mitigation**	**Risk**: Financially destabilising practices if funding withdrawn or reduced. **Mitigation** Need clearer understand of which practice receive high levels of funding (and proportion of their total income) **Risk**: loss of engagement and participation in care home enhanced care **Mitigation:** task and finish to co-produce new enhanced services with all stakeholders including GPs **Risk**: financial risk for CCG if areas with lower activity are brought up to higher activity levels. **Mitigation**: development of a cost-effective service specification across BNSSG based on areas of need and equality. **Risk**: lower activity reducing tariff income to acute providers **Mitigation**: to fully cost the care home support model to include all elements, and include funding initiatives from acute providers.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Appendix B – Desk Top Review template

Primary Care Service Name: Supplementary services		**Date of review:**	**5/6/18**	
Lead Manager: Jenny Bowker		**Lead Clinician:**	**Geeta Iyer**	
		Bristol	North Somerset	South Gloucestershire
		BNSSG wide response		
1	**Meets aims & objectives** What are the clinical aims and objectives of the service? Are there key areas of good practice which we could roll out across BNSSG? How does this align with the CCG priorities? Does this service promote the reduction of health inequalities? 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	To provide care for patients out of hospital; this is more financially efficient and convenient for patients. This aligns with CCG priorities. Some of these services could be provided at scale thereby reducing inequalities across practices, ensuring services were available to all patients, and reducing the impact of staff sickness/resource issues on the service. This service is not commissioned elsewhere and is not duplicated. This LES is for non-housebound patients; housebound patients have a service provided by the District Nurses for some of this activity. AWP will also still give depos to the patients who remain on their caseload due to their clinical condition. The activity in the service has been defined as being over and above what is included in the core contract as this is work that has developed and shifted to primary care. The LES was developed as part of the PMS review undertaken by each CCG across BNSSG and work to develop the specification was closely aligned across the 3 CCGs. The specifications need little amendment to achieve consistency across BNSSG. The PMS review sought to equalise funding within each CCG recognising that practice funding differentials had grown and that we needed to support a fairer distribution of income. As part of the review funding was used to reinvest in primary care across BNSSG and the Supplementary Services LES was part of this package of investment, recognising an increasing workload in primary care. Practices received a 5 year funding commitment from the CCGs documenting the impact of the PMS review which was phased over this period and which included the reinvestment premium which supports this LES. We are now 3 years into the 5 year funding transition. The Supplementary Services LES includes the following services:	

	on existing or proposed pathway work? Do we commission this service elsewhere? Is it a duplication or in line with other services? Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	• Phlebotomy (this does not include requests from acute sector when the patient is under their care and not been discharged, unless prior arrangement has been made or under another arrangement e.g.: shared care) • Removal of post op stitches, dressings and wound checks (staple remover to be provided by secondary care) • Wound care including 3 and 4 layer bandaging • Follow up of patients and ongoing monitoring (excluding QOF) as per agreed pathway or where there is clear agreement between the GP and secondary care physician • Management of chronic diseases within primary care • Routine ECGs, spirometry, nebulising and pulse oximetry • Glucose Tolerance Testing (antenatal) – interpretation and follow-up results remain the responsibility of the requesting clinician. The CCG will work with service leads to agree the future pathway • Support to midwifery services including prescribing when not initiated by the consultant. The CCG will work with service leads to agree the future pathway • Doppler scanning for vascular assessment of lower limbs • Delivery of Gonadotrophin-releasing hormone antagonist (GnRH analogies/LNRH) treatment under an agreed practice shared care protocol once patient has stabilised • 24 hour BPs including home BP monitoring • Depo injections as agreed under Shared Care Protocols for stable mental health patients • Tests and procedures required under referral pathways e.g. ear syringing or NHS fertility • Processing referrals for Criteria Based Access (CBA) and Interventions Not Normally Funded (INNF) where requested by primary care in accordance with BNSSG policy • Support for carers including signposting to voluntary sector support services • Child protection and adult safeguarding work towards the safe management and co-ordination of vulnerable patients in line with national and local requirements • Managing routine post-natal checks (excludes immediate maternal and baby checks from rapid discharge patients and home deliveries) • Responding to requests from agreed 3rd party service providers for verifying up to date patient call up lists e.g. screening services such as breast, bowel and retinopathy		
2	**Evidence base** What evidence base is there to support a) that this meets local	A variety of activity is covered in this LES that reflects Best Practice and advances in medical care. A small number of the included	As Bristol	As Bristol

	population health need and/or addresses variation in quality b) that it is effective in doing so	requirements could be considered part of core work such as management of chronic diseases and the requirement to support safeguarding as a condition of holding a contract in the NHS. An initial desk top search has revealed that Dorset include PSA follow up and secondary care phlebotomy (but not via PMS review). Primary Care Offer/basket arrangements for similar services are also provided by Brighton & Hove, Wiltshire CCG and Gloucestershire CCG. These are locally commissioned services, rather than linked to the PMS review. Swindon CCG has developed individual Local Enhanced Services for wound care, phlebotomy, and MRSA screening.		
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	This basket has been developed without patient engagement but with some practice consultation (PMs), and LMC involvement. (Secondary care should be consulted.)	The non-core activity was discussed at membership meetings and had LMC engagement.	The non-core activity was discussed at membership meetings and had LMC engagement.
4	**Capacity & Demand** How many people access the service? What is the trend in demand?	Data not available – we do not think any audits of baseline activity were undertaken.	Data not available – we do not think any audits of baseline activity were undertaken.	Data not available – we do not think any audits of baseline activity were undertaken.

	What is the uptake across practices?			
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	**2017/18 Total Spend:** **£3,022K**	**2017/18 Total Spend:** **£858K**	**2017/18 Total Spend:** **£1,015K**
6	**Delivery Model**			
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	Some of the services could be delivered at scale. This would have to be carefully thought out if the practices were not to be destabilised, but it would help with practice resource issues and service continuity, although patient choice would be reduced and services would not be as local.	As Bristol	As Bristol
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	Either some services to go back to secondary care with associated increased costs, and destabilisation of practices as PMS premium not reinvested, or an alternative provider to be found via a tendering process. Patients would be affected and their care would become less local and possibly more expensive.	As Bristol	As Bristol

	impact assessment ever undertaken to support the service and has this been considered? Would decommissioning affect the viability of a provider?			
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	No monitoring. We can going forwards provide practices with an approved code list in order to audit/extract the data on activity undertaken.	Returns submitted by the majority of practices but not for the last year. Those who submitted action plans did complete those actions.	No monitoring
9	**Invoicing process** What is the invoicing process and frequency?	Paid in 12 instalments, in arrears, with an annual return done by practices.	Paid in 12 instalments, in arrears, with an annual return done by practices.	Paid in 12 instalments, in arrears, with an annual return done by practices.
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	Yes – 3 months	Yes – 6 months – contract variations could go through relatively quickly	Yes - 6 months – contract variations could go through relatively quickly
11	**Summary of comparison of service across 3 areas**	Bristol has denosumab included (as NS has this in NPT LES), and NS and SG mention safeguarding. There is a wide differential between areas regarding the payment for this LES (~£12 Bristol, ~£9 SG and ~£5 NS). All 3 LESs state that if the services to be provided are more specialised, the practices can plan to do this over 5y. NS and SG request submission of a delivery plan year on year.		
12	**Recommendations for future of service:** • Continue at	Further work is needed to develop a common approach. There is a clear need for this activity in primary care but we have to work out the best way of delivering this service. This LES needs a robust reporting and monitoring method and clear communication with practices along the way due to the potential for destabilisation. We can work to a July deadline to align content (add denosumab to NPT ES, add vaginal		

	practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	pessary sizing/change with associated training for GPs/nurses, potentially add providing prescriptions on behalf of secondary care unless EPS can be introduced to the Acutes), but to align the tariff across localities would require a phase 2 approach as it is integral to the 5 year funding commitment made to each practice across BNSSG as part of the wider PMS review to move to a fairer total funding distribution across practices. The recommendation from the desktop review is to align the specification and develop more robust and consistent monitoring arrangements across BNSSG.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for	• Practice resilience and viability with potential withdrawal from delivering non-contracted activity and system / financial impact ○ ***Outcome needs of review needs to be communicated in effective and timely manner*** • Destabilisation of primary care if the payment is reduced if the tariff is aligned • Patients/secondary care not understanding who is responsible for activity ○ ***specification to clearly set out expectations for activity in primary care***

	mitigation	

Appendix B – Desk Top Review template

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Primary Care Service Name: Bristol Primary Care Agreement		**Date of review:**	
Lead Manager: Ros Hussey/Joe Poole		**Lead Clinician:**	**Alison Bolam**
		Bristol only (not commissioned from South Glos and North Somerset)	
1	**Meets aims & objectives** What are the clinical aims and objectives of the service? Are there key areas of good practice which we could roll out across BNSSG? How does this align with the CCG 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 or in line with other services? Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	Bristol Primary Care Agreement (BPCAg) is not a single service it was intended as a transformational contract, designed to incentivise change in primary care in line with the CCG primary care strategy. It incentivised practices to work individually, in clusters and locality wide across a number of key area; acute care, planned care, long term conditions/self-care, mental health and end of life. Each area had an overarching ambition and practices developed plans linked to these quantitative and qualitative ambitions which were; a. Reduce non-elective admissions by 0.5% each year for 3 years b. Reduce number of acute occupied bed days by 6% per annum c. 5% reduction in known palliative care patients dying in hospital d. 3% reduction in secondary care admissions at UHB by over-65's as a result of falls e. Maintain elective admissions/outpatients at 2013/14 levels (except where the Planned Care Steering Group has identified significant outliers, in which case targeted reductions) f. Improved level of GP knowledge g. Improved level of GP confidence in management mental healthcare h. Improve use of self-care and social prescribing Practices received funding based on their population aged over 75, as well as a small amount of mental health funding based on their practice population and funding to attend a maximum of 6 education sessions per year (£200 per session).	

		A review of the projects undertaken as part of the BPCAg is included in Appendix 3.
2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	There is clear evidence that a number of the ambitions of BPCAg remain priorities for the CCG e.g. reducing non-elective admissions and occupied bed days. There is little hard data to demonstrate a direct correlation between BPCAg and improvements in the delivery of its ambitions. For example, the ambition to reduce non-elective admissions by 0.5% each year of the scheme has not been achieved with a rise in rates across the board. The rise in admissions amongst over 75s group targeted by BPCAg was slower than elsewhere and slower than anticipated (see Appendix 1) but even this cannot be reliably attributed to the scheme. Similarly, there has been a reduction in Occupied Bed Days but it is not possible to link this to BPCAg as opposed to a number of other activities with the same ambition carried out across the CCG during that time. Some of the other ambitions are more difficult to measure ("Improved levels of GP knowledge") To a degree BPCAg purposefully built in flexibility of approach in some areas to allow practices to innovate and to reflect the local health needs of their population but the consequence of this was less evidence of specific outcomes being achieved.
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	BPCAg service specification was developed with the relevant CCG steering group for the area e.g. urgent care, planned care, mental health, long term conditions. Steering groups made up of clinical and managerial representatives from CCG and relevant providers, including patient representation e.g. to develop the self care element of BPCAg required close collaborative working with Bristol City Council, the Care Forum and voluntary sector organisations and gaining feedback from practices. The service specification was annually refreshed and signed off formally by Governing Body/Finance Review Committee. In order for the practices to develop and

		implement their projects and plans, this required collaboratively working with key community providers, secondary care providers, voluntary sector organisations and consulting with and gaining feedback from their patients.
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	BPCAg is not a single service, it is a transformational contract which incentivised practices to work individually, in clusters and locality wide to develop and implement plans linked to the ambitions outlined earlier. 100% of Bristol practices signed up to this contract. Bristol practice patient population is approximately 500k.
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	Total yearly value of BPCAg contract for 2017/18 is £1,651,746; • £1,457,100 (Over 75s funding) – £50 per patient over 75's* • £125,046 (Mental Health Funding) – 25p per patient* • £58,800 (Practice Education) - £200 per session maximum 6 sessions per practice • £9,800 (Mental Health Education Session - £200 per practice *Based on January 2017 practice population Total Spend 2017/18: £1,857K
6	**Delivery Model**	
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	BPCAg is essentially a collection of Locally Enhanced Services, mostly based around a registered list, so could not be provided by another provider. Some elements of the BPCAg project work and services developed by practices have already been scaled up and delivered at cluster level e.g. (ANP Home Visiting Service, Leg Ulcer Club, employment of Community Resource Lead across a cluster of practices) but further consideration could be given to how these and other elements could be delivered on a locality level.
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	There are a number of risks associated with decommissioning of the BPCAg. Broadly, practices are facing unprecedented pressure in terms of patient demand, capacity,

	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?	workforce and finances, with an increasing number at risk. The BPCAg contract has been a key additional source of income for practices and, in some cases, ending it might impact on their organisational stability. In addition the end of this contract could have immediate implications for those practices who have employed staff to support their BPCAg efforts – see Appendix 2. Currently 33.115 wte are employed using BPCAg funds. The loss of this income could impact on practice resilience, reducing their capacity to cope with increases in demand, due to the loss of BPCAg funded staff. This may also affect patients' ability to access primary care services, placing more pressure on the practice and their staff and the health system as a whole.
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	Practices were required to produce a plan detailing how their over 75's money would be spent and report against this plan every six months. A summary of these reports for each locality including recommendations where presented to the moderation panel for agreement, with formal sign off at the Finance Review Committee before the next 6 month payments were released to practices. In January 2018 a review of BPCAg was conducted looking at the qualitative and qualitative data available and whether the ambitions where met. See Appendix 3 and 4 for the detailed reports on the review. In summary for the quantitative measures (a to e) Bristol, in line with national picture, has seen a rise rather than fall in non-elective and elective admissions, albeit the rate of the rise in over 75's has been slower. There has been a reduction in occupied bed days but it is not possible to definitively link this reduction to BPCAg. The qualitative ambitions (f to h) shows an increase in, for example, mental health knowledge, employment of Community Resource Leads (CRLs) to re-direct patients where appropriate to other services and locality wide programmes of work including pharmacy network programme in ICE, the early home visits programmes in N&W and South localities and joint geriatrician/GP clinic for older people in South Bristol. There are

		numerous wide ranging projects which have some self-reported patient benefit e.g. memory cafés. Self-care element of BPCAg was particularly well developed by most practices, who quickly adopting the idea of CRLs to help divert appropriate patients to sources of help and advice. Locality wide CRL networks are now in place. BPCAg has certainly been a significant driver in encouraging practices to work collaboratively in clusters and at locality level to develop and deliver specific projects and services but to a large extent this approach has now been established and indeed superseded by the move towards a locality focus funded through other sources.
9	**Invoicing process** What is the invoicing process and frequency?	Invoicing N/A Practices paid on a 6 monthly basis which was moved to quarterly in 17/18 to align with the other enhanced services.
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	The BPCAg specification is refreshed each year and signed off via appropriate CCG governance routes. It is then shared with practices who sign-up to delivering the requirements. The BPCAg was a 3 year funded agreement which formally came to an end March 2018. Practices were notified of an extension until September 2018. Many employ staff using the money so it will be important to confirm as soon as possible how resources will be deployed in future.
11	**Summary of comparison of service across 3 areas**	BPCAg not applicable to North Somerset or South Glos.
12	**Recommendations for future of service:** • Continue at practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR	It is not recommended that the contract continues in its current form for the longer term but there are a number of projects which should be considered for further development and introduction across BNSSG for example the social prescribing work carried out by the Care Coordinator/Community Navigator/Community Resource Lead/Health Champion roles. The non-prescriptive approach taken by BPCAg removed the risk from innovation and has enabled GP practices to trial new roles

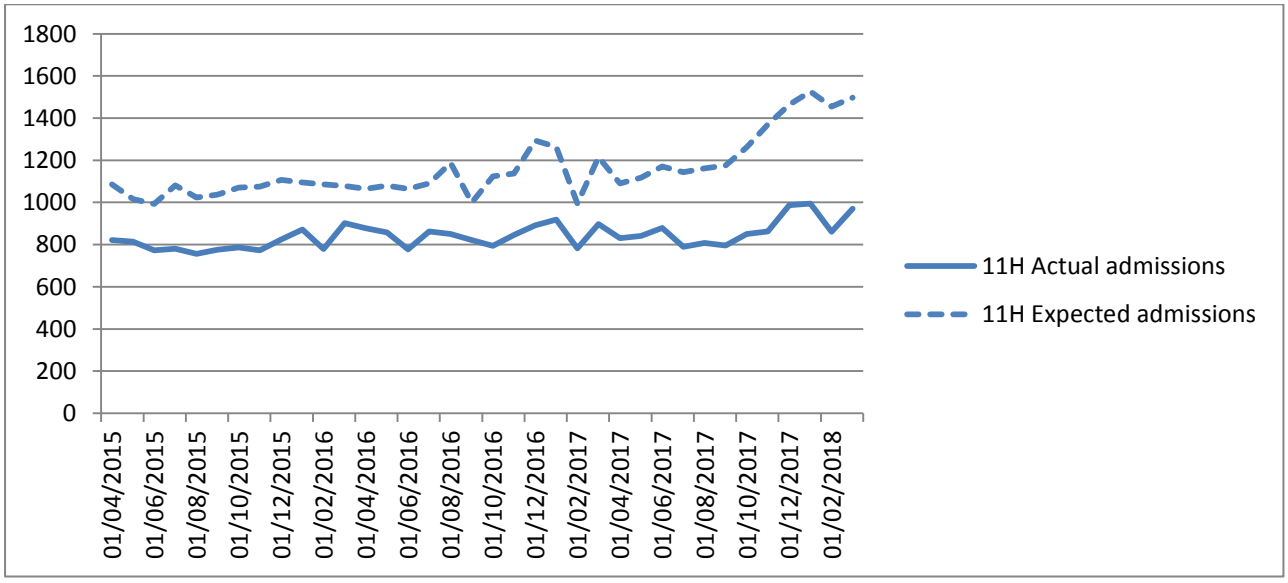
	• Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	and ways of working. The review of BPCAg should also consider how to disseminate the learning from these projects to all practices across BNSSG and how to enable future innovation removing the risk short-term enabling practices to look further at new ways of working and developing new models of care. The Locality Transformation Scheme will be a key contributor to delivering this. In addition, consideration should be given to the continuation of the educational element of the scheme which provided backfill for GP attendance at (predominantly) CCG organised educational events in support of new pathways etc.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	**Risk** **Practice Resilience and Viability** Income levels received via BPCAg vary dramatically from 4k to nearly 60k per annum, dependent upon the number of over 75s registered. For some practices this will represent a considerable proportion of their overall income. In the context of the ongoing impact of the PMS review, changes to service charges and increasing demand there is a risk that a small number of practices could be destabilised. **Mitigation** ➢ The impact of any funding withdrawal is included on the CCG Primary Care Dashboard alongside other factors that could impact on practice stability ➢ Ensure practices are aware of other potential sources of income that might offset this funding (e.g. via LTS, IA and any new Enhanced Services that fall out of phase 2 of the review process) ➢ Engage potentially vulnerable providers in the wider CCG programme of support (e.g. S96, Locality Transformation Managers, Time for Care etc.)
		<u>Reduced Service Offer</u> BPCAg incentives practices to focus efforts on addressing some of the key concerns of the steering groups that existed at the time of its inception (planned care, urgent care, LTCs, self-care, end-of-life and mental health) and there is a risk that by decommissioning BPCAg focus on these areas will be lost.

		Mitigation ➢ There is little hard evidence of improved outcomes for patients as a direct result of the initiatives incentivised via BPCAG ➢ Where there is evidence of system or patient benefit resulting from particular aspects of the scheme (e.g. CRLs/self-care) it is recommended these are picked up elsewhere (perhaps via a separate ES) ➢ Some elements would be better suited to a locality approach and could be taken forward by the Locality Provider Vehicles via the LTS process ➢ Some elements are now explicitly being funded elsewhere (e.g. winter planning)
		Employed Staff Historically, BPCAg participants have (at least partially) been asked to justify the income they have received via the scheme in terms of staff they have employed using the funding. There is a real risk that the staff they have employed using BPCAg funding may cease to be employed. A list of these staff are included in Appendix 2 **Mitigation** ➢ Much of the rationale for supporting the employment of staff was to "pump prime" the introduction of new ways of working in general practice, such as sharing staff across practices or employing CRLs to reroute patients away from GPs where appropriate. However, much of this work is core GMS/PMS business (albeit addressing growing demand) so should not be funded indefinitely once the model has been proved to improve business efficiency ➢ The intention has always been that the BPCAg would run for three years. This period concluded 31st March 2018. As a result participants have planned for the cessation of this funding and have associated staff on appropriate contracts.
		Reduced Innovation The largely non-prescriptive approach taken by BPCAg removed the risk from innovation and has enabled GP practices to trial new roles

		and ways of working. There is a risk that by only commissioning enhanced services with a clear service spec and outcomes at the outset that we risk stifling innovative approaches from our providers to some of the system challenges (e.g. RACOP). **Mitigation** ➢ Innovation being encouraged via the LTS and Locality Provider Vehicles ➢ Share drafts of proposed Enhanced Services with the membership prior to sign-off to gather ideas

Appendix 1

Working on the assumption that N Somerset can be used as a base comparator (as there is no LES specifically targeting this population group):
Expected admissions for Bristol CCG were calculated using N Somerset actual admissions adjusted for population size.
A comparison to actual admissions shows a considerable difference.
Note that this could be due to other reasons, and is not necessarily the impact of BPCaG.



Appendix 2

Summary of Employed Practice Staff funded by BPCAg funding

Role	WTE
Clinical	
GP	2.1
Locum	0.25
Nurse	1.6
Advanced Nurse Practitioner	6.45
Primary Care Practitioner	2.25
Health Care Assistant	3.3
Paramedic	0.5
Physiotherapist	0.2
Pharmacist	3.58
Mental Health	2
Non-clinical	
Community Resource Lead (Self Care)	2.385
Community Navigator (Self Care)	4.94
Patient Champion (Self Care)	1
Administrator	2.56
Total WTE	**33.115**

32 out of 47 (68%) Bristol practices currently employ staff using BPCAg funding.

Appendix 3

Bristol Primary Care Agreement – Review
Verity Jowett, Business & Project Manager, Localities Team

29 January 2018

1. Background

The Bristol Primary Care Agreement (BPCAg) was set up in October 2014 as a 3 year contract with a total value of £1.7m. The contract incentivised practices to work individually, in clusters and Locality-wide across a number of key areas. It is a mechanism by which the Bristol Clinical Commissioning Group (CCG) seeks to contract with and invest in primary care so that people can be treated closer to home.

BPCAg was set up with a number of ambitions. These were:

- Reduce non-elective admissions by 0.5% each year for 3 years
- Reduce number of acute occupied bed days by 6% per annum
- 5% reduction in known palliative care patients dying in hospital
- 3% reduction in secondary care admissions at UHB by over-65s as a result of falls
- Maintain elective admissions/outpatients at 2013/14 levels (except where the Planned Care Steering Group has identified significant outliers, in which case targeted reductions)
- Improved level of GP knowledge
- Improved level of GP confidence in managing mental healthcare
- Improve use of self-care and social prescribing

In addition, BPCAg was intended as a transformational contract, designed to incentivise change in primary care in line with the CCG primary care strategy.

Practices received funding based on their population aged over 75 (between £4k and £58k per practice). They were required to produce a plan detailing how this money would be spent and to report against this plan every six months.

2. Challenges of Review

Due to the way BPCAg was set up, there is a large amount of qualitative data and quantitative reports for individual practice level projects. However, on a Bristol wide scale there were a number of barriers to quantitative review. These included:

- Limited access to baseline data
- Difficulty linking changes in ambition targets to action taken under BPCAg e.g. admissions can also be affected by out of hours processes, public health work or changes in secondary care criteria etc.

- Activity designed to change behaviour is likely to have a longer-term impact and won't affect hospital activity in the short-term.

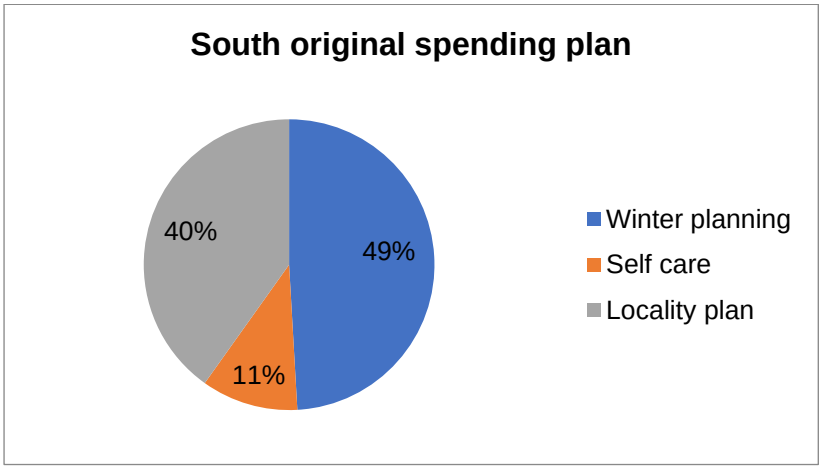
This report combines a basic review of the quantitative data with key highlights drawn from the practice reports. These include numerous examples of innovative practice which could be individually evaluated with more time.

3. Planned expenditure

The BPCAg plans were undertaken on a locality basis, with each locality taking a different approach.

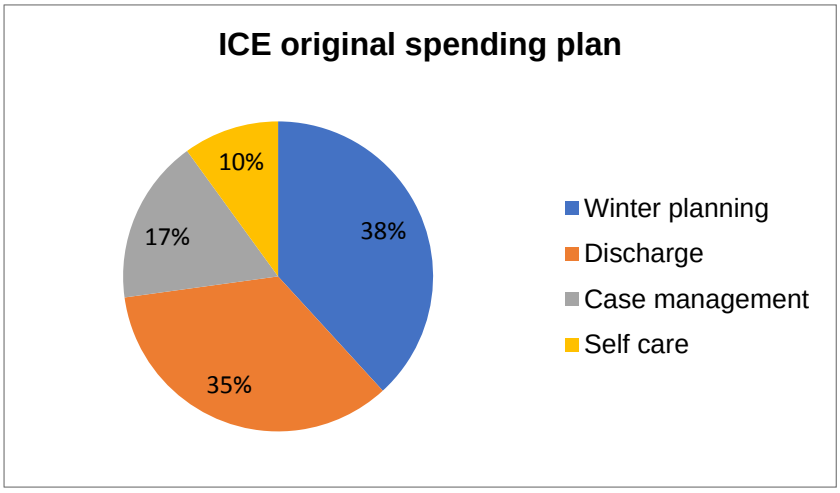
South Locality

The South Locality took a joint approach, with 40% of their funding being committed to the locality plan. As can be seen below, the majority of the money at practice level was spent on winter planning, with the balance being spent on self-care.



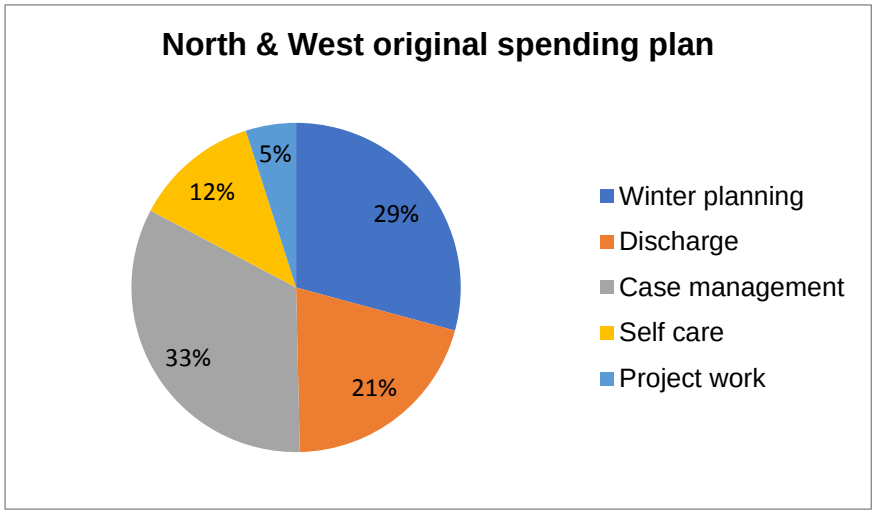
ICE Locality

The ICE locality planned their spending at a practice level. As can be seen below, the majority of the money was spent on winter planning and discharge.



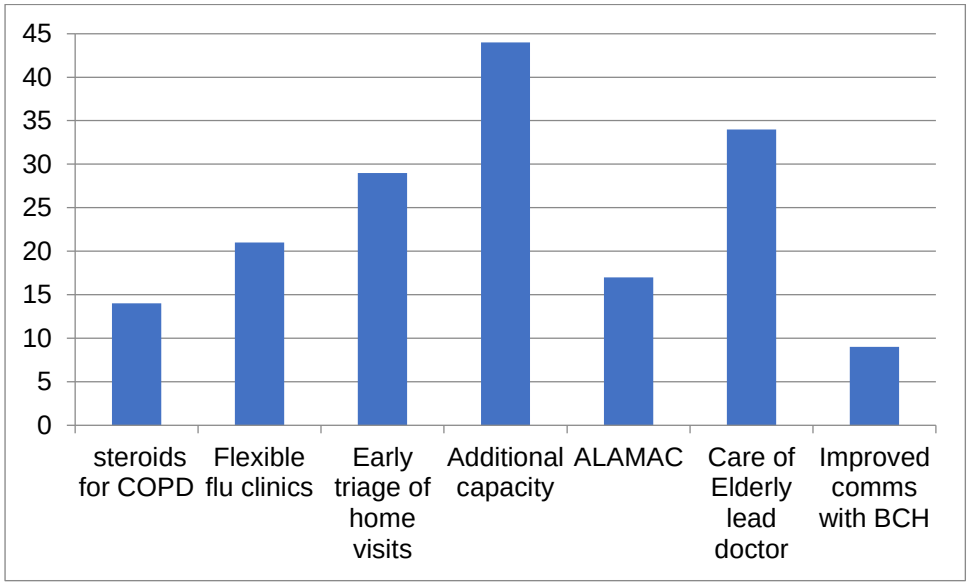
North and West Locality

The North and West locality took a similar approach to ICE but with some clusters choosing to dedicate a proportion of their funding to joint projects or roles.



Initial spending

In 2015, the progress reports were used to measure the activities being undertaken. The most popular activities are shown below. In addition, all practices were committed to the Gold Standard Framework for end of life and virtually all practices were participating in the 'Ask 3 Questions' scheme.



Alongside this, all the South practices were engaged as a locality in:

- The development of the South Frailty Pathway and a frailty education event
- Rapid access clinic for older people (RACOP)

- Development of GP plus role
- Email advice line between GPs and Elderly Care consultant
- The Advanced Nurse Practitioner early home visit plan.

4. Ambition measures

A detailed breakdown of the information is available for each of the quantitative ambitions. It should be noted that these performance measures do not directly link to BPCAg and will be affected both positively and negatively by external factors. It is also important to note that the majority of work undertaken by BPCAg relates to long-term behavioural change and support so may not have an immediate impact on hospital activity.

The outcomes are summarised below:

Reduce non-elective admissions (NEL) by 0.5% each year for 3 years

This ambition was not achieved and non-elective admissions have been increasing each year. However, the rate of growth has been slowing and further analysis of this would be useful. A more detailed review could look at expected rates of admissions to identify if these have been improved on. A number of practices have been monitoring readmissions following the involvement of care-coordinators and may be willing to share this data.

Reduce number of acute occupied bed days (Length of Stay, LOS) by 6% per annum

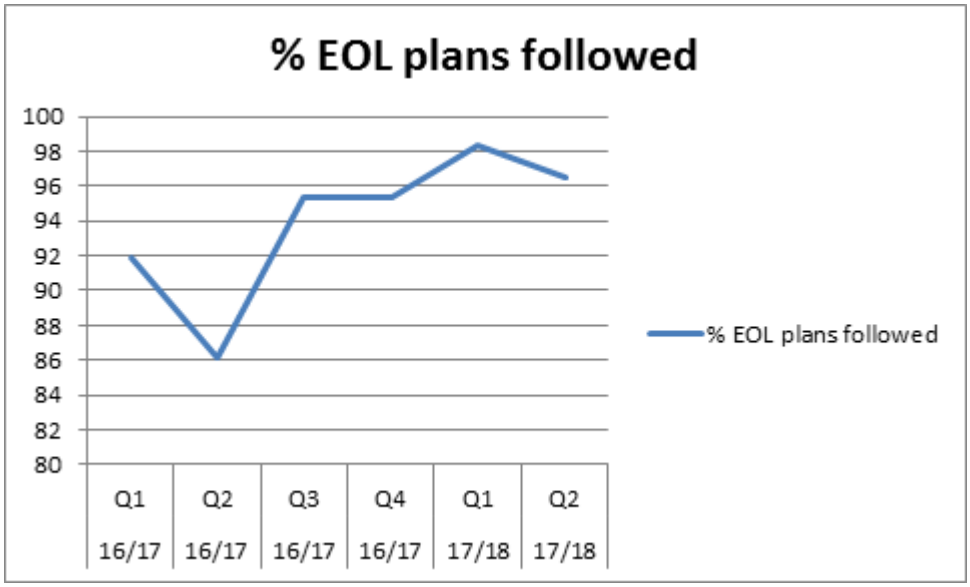
The ambition has been partially achieved. The average length of stay has fallen each year during BPCAg but not always at the rate described. It is not possible to link this reduction to BPCAg and there are a number of other activities in place within the CCG which could contribute to this.

5% reduction in known palliative care patients dying in hospital

The data currently available shows the number of people with a palliative care diagnosis dying in hospital, as a proportion of all people with a palliative care diagnosis admitted to hospital. In other words, any patient where an admission has been avoided is excluded. Therefore it is not possible to measure performance against this ambition.

It has been highlighted by both practices and the BNSSG R&D team that this measure does not link to ‘good deaths’ or ‘death in preferred place’ as patients may choose to die in hospital. However, the ambition was set due to the high levels of deaths in hospital in Bristol compared to the number of people wishing to die at home.

The CCG has been monitoring deaths in care homes since Q1 2016/17 and can demonstrate that the percentage of end of life plans (EOLs) followed has increased over this time. Without review, it is not possible to say whether this is significant or whether any part of this change can be attributed to BPCAg rather than other work.



3% reduction in secondary care admissions at UHB by over-65s as a result of falls

While this ambition has not been achieved, the first seven months of 2017/18 show a fall in admissions compared to the same period in the previous year. This may not be significant, or it may reflect the impact of a number of falls reductions projects including:

- Physiotherapy led exercise classes for frail/elderly patients
- Falls awareness promotion in practices

It is proposed that falls related admissions continue to be monitored and if the trend continues a more in-depth review of falls reduction projects is carried out.

Maintain elective admissions/outpatients at 2013/14 levels

This ambition has not been achieved and admissions and appointments continue to rise. However, it is noticeable that outpatient appointments for over 75s have been growing at a much slower rate than for all ages. It is recommended that a more thorough review of this could be carried out, including comparison to national trends.

Individual practices have kept records of changes in admissions patterns. For example, a practice in the Healthcare West cluster has worked closely with their local nursing home to reduce admissions. While only 6 months data is available for 17/18 it does appear to show a large drop (wider care home admissions data shows there is little seasonal variation).

	2015-16	**2016-17**	**2017-18 (Apr-Sep)**
No. of residents	20	17	18
A&E attendances	23	24	7
Admissions	15	18	6

Improved GP Knowledge

There is no objective measure for this ambition but individual projects have raised GP knowledge of specific subject areas. In particular, the Rapid Access Clinic for Older People (RACOP) offered GPs in South locality practices the opportunity to work directly with the consultant geriatricians leading the clinic and the wider multi-disciplinary team (MDT) staffing the service. The scheme provided the opportunity for GPs to refresh their skills and improve their knowledge.

Improved level of GP confidence in managing mental healthcare

In addition to the core BPCAg funding for over 75s, practices also received an average of £2,572 for mental health activities including completion of a patient audit covering 30 patients referred into mental health services and those prescribed injectable neuroleptics.

The BPCAg approach encouraged practices to work closely with their Avon and Wiltshire Mental Health Partnership (AWP) link consultant. 31% of practices now believe they have an excellent relationship with their link, with much smaller numbers describing concerns. One practice in the Affinity cluster felt this was explicitly linked to BPCAg: :

'As a direct result of the BPCAG mental health work we have developed a good relationship with our link psychiatrist'.

An annual mental health education session has been held through BPCAg. The 2017 event had extremely good feedback[i] and the results of the discussion are being fed into the mental health Sustainability and Transformation Partnership (STP) work by Dr David Soodeen.

Social prescribing

There is an EMIS code to collect data on social prescribing. It cannot currently be used to measure achievement of this ambition as it is still being introduced consistently in many practices.

However, all practices have a community resource lead (CRL) of some form and these roles are well embedded in practices. This was mandated as part of BPCAg. CRL networks have been established and feedback from these has been very positive.

Community resources are an important support for patient health. Practices and patients benefit from being well-informed about local groups which support wellbeing. Staff often live in the local community and have enthusiasm for having an extended role, receiving and disseminating information via intranet, website, meetings and patient participation groups.

From an individual patient perspective the action taken by the CRL can have a huge impact and has the potential to reduce the risk of admission / development of health

concerns at a later date. Examples of individual patient contact provided by practice CRLs include:

- Arranging for We Care & Repair to fit rails in the home of a 74 year old patient who had recently fallen and sustained an injury and was concerned about a repeat occurrence.
- Responding to a pharmacist's concern about a single mother struggling with 2 children, one with very challenging behaviour as a result of autism, and arranging a benefits check and support from the carers support service.
- Arranging for an older patient, who was her husband's sole carer, by organising the district nurse to deliver his medication during this time
- Supporting a retired patient whose husband had been in hospital for months and who was financially distressed as a result to access a Foodbank in the first instance and longer-term support.
- The Pioneer care-coordinator worked with NBT on the issue of late notification of deaths, which had been causing undue distress to recently bereaved families leading to a junior doctor training issue being picked up.

Practices have also provided feedback from patients regarding the CRL service including:

"Please can I offer a massive "Thank you" for all the help and attention you have given dad over the years. The kindness of you and your team, especially CRL (Who I've never met), flies in the face of all negative reports in the media regarding the NHS"

5. Cluster Working

One of the areas where BPCAg can be linked to an improvement is in driving cluster working. Prior to BPCAg being set up there were no formal links between clusters and practices could be described as working in 'silos'. BPCAg gave Practices the incentive to meet within local Clusters at GP, Practice Manager, Nurse and Administration levels and has been the most significant driver in encouraging Practices to work collaboratively across the City.

Clusters report regular meetings engaging community providers, the third sector and secondary care. For some clusters these are structured meetings with Bristol Community Health (BCH) looking at themes including wound management and long-term conditions.

As detailed in the next section, several clusters are employing joint roles. Other examples of innovative practice include:

- The practice that achieved the highest uptake of flu vaccines in 16/17 produced written guidance for their cluster to disseminate this learning for 17/18.
- A cluster developed an EMIS template which all practices adopted and which includes social prescribing to community organisations.
- Another cluster is currently collating frailty data with a view to developing a cluster-wide approach.

- Clusters have undertaken process reviews of their administration, jointly scoping and implementing document management processes and texting of results. One practice reported a 50% reduction in correspondence coming through to GPs for action following implementation of the cluster process and the use of text messages to send 3237 results in six months, saving GP and reception call time.
- Working with the University of the West of England (UWE) to offer 8 week placements for student nurses with the cluster.

Through BPCAg practices have seen the benefits of collaborative working and built links across clusters, which supports the move to locality thinking as part of the LTS.

6. New roles

Practices were given a significant level of freedom to develop new roles both at practice and cluster level. It is not possible to measure the number of roles at this time due to inconsistency in reporting. Practices are being asked to provide exact information. The most common new roles are listed below:

Pharmacist

A number of practices have employed pharmacists either individually or at a cluster level. These pharmacists are carrying out three broad areas of work: medicines management reviews, running clinics (medicines queries, hypertension clinics, etc.), and paperwork activities such as repeat prescriptions and discharge reviews to reduce GP workload. These release GP time to other activities. More detailed evidence has been supplied and could form the basis of learning to be shared with other practices.

To evaluate this further, several practices have provided data on their pharmacists activities. Medicines management could also be asked whether medicines reviews described have contributed to savings.

Care Coordinator / Community Resource Lead (CRL)

While these are two different roles, the terms are used interchangeably by some practices. The CRL focus is on self-care/social prescribing, while the care coordinators may take a more active role in discharges or admissions avoidance. One practice uses care coordinators to visit care homes prior to the GP visit in order to handle any admin queries and make more efficient use of GP time. This work is described in the social prescribing section above.

Advanced Nurse Practitioner (ANP)

These posts are in addition to the South Locality ANP project. Practices predominantly use their ANPs for demand management, as part of a team approach to seeing patients.

Releasing capacity upwards

Roles like the phlebotomist and the apprentice administrators were explicitly appointed to release capacity elsewhere in the practice. For example, the apprentice administrator in one practice allowed receptionists to be trained as phlebotomists, releasing nurse time.

7. Winter Planning

As can be seen from the planned expenditure in section 3, winter planning was a core component of all practice's BPCAg plans. In some cases this involved the use of additional partner or locum GP sessions to manage demand. However, as BPCAg has progressed, more innovative approaches have been developed including:

- Acute demand management teams developed in many practices supporting the duty doctor, including care coordinators, ANPs, pharmacists and paramedics.
- Use of local papers to provide self-care advice including management of coughs and colds in a regular column.
- The "poorly poppets" session held for new parents helping them to manage minor childhood illnesses at home.
- Dedicated over 75s appointments for each GP, so over 75s always see their own GP and problems can be more easily monitored over time.
- Ongoing project developing 100% telephone triage and joint GP/nurse working, with regular review.
- New appointment management system which has, according to one practice in the COLIN cluster 'radically transformed' the practices management of demand.
- Development of frailty registers and proactive management of these patients.
- One practice was nominated for a Royal College of General Practitioners (RCGP) bright ideas award for the redesign of their appointment system.
- Releasing capacity up the system by employing apprentice administrators and training receptionists in phlebotomy.
- Early morning GP home visits.
- Increasing use of social media.

8. GP Resilience

A number of the projects undertaken through BPCAg have linked directly to the 10 high impact changes and provided support to GPs. The introduction of new roles and administration processes have made an impact on GP workload. Examples include:

- A practice in the Health Care West cluster state a 50% reduction in correspondence coming through for GPs for review or action following enhanced training of the admin team and involvement of the pharmacist.
- A practice in the Northern Arc Cluster provided a detailed breakdown of work completed by their pharmacist which would otherwise have gone to the GP. This included an average 930 repeat prescriptions and 86 hospital discharge summaries per month.

As new roles have been introduced several practices have introduced daily huddles or multi-disciplinary team catch-ups. As well as improving management of the care pathway, these meetings provide support for the team. The Family Practice practice manager stated:

'It drags people out of their rooms reducing isolation. It has helped build a supportive cohesive team. Our trainees and junior salaried Drs particularly find it useful, they feel better supported.'

9. Conclusion

It is believed that BPCAg has successfully acted as a lever enabling groups of practices to think and act as clusters to deliver programmes of work. This will in turn facilitate easier transition to the MDT working principles of the Locality Transformation Scheme. However, it is not possible to demonstrate whether the BPCAg contract made a significant impact on the original ambitions, the learning from this process should be embedded in the development of new contracts.

Lessons learned

- When ambitions are set baseline data should be taken and it should be clear how the activity in the contract links to the ambition. This should include a prediction of how targets will change over time e.g. if there is an increasing trend in activity then a target of 0 growth may still reflect a positive impact.
- Practice returns should be structured so that it is clear what work has been completed as part of that contract and which has been supported by other funding streams
- For ease of analysis quantitative data should be collected alongside qualitative data. If a contract supports individual projects, practices should be asked to assess impact against common measurable criteria.
- Qualitative analysis needs to be planned several months in advance and with designated resource.

Recommendations

It is not recommended that the contract continue in its current form in the longer term. There are a number of projects which could be considered for ongoing support (these are the subject of separate reports). These include:

- The ANP home visiting pilot carried out by the South locality.
- The introduction of care coordinator and community resource lead roles.

The non-prescriptive approach taken by BPCAg removed the risk from innovation and has enabled GP practices to trial new roles and ways of working. A number of these projects have led to significant time or cost savings for GP practices, or better ways of delivering their core services and now they have been proven any ongoing costs should come from the practice budget. However, the review of BPCAg should consider:

- How to disseminate the learning from these projects to all practices across BNSSG, including evidence supporting the changes.
- How to enable future innovation by removing the risk short-term, enabling practices to look further at new ways of working. The Locality Transformation Scheme will be a key contributor to delivering this.

The localities team are currently in talks with BNSSG R&D about holding a lunch and learn seminar to share the learning amongst practices.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Appendix B – Desk Top Review template

Primary Care Service Name: **South Gloucestershire Compact**		**Date of review:** **05.06.18**
Lead Manager: **Ruth Thomas**		**Lead Clinician:** **Dr Jon Hayes (South Gloucestershire LLG)** **Dr Kirsty Alexander (North & West Bristol LLG)**
		South Gloucestershire
1	**Meets aims & objectives** What are the clinical aims and objectives of the service?	<u>Background</u> The South Gloucestershire Compact formed part of the South Gloucestershire CCG's Constitution. It had a number of key elements that attracted payments. Element 1 - sign-up – practices were required to commit to support a list of 12 commitments in the sign-up form, for example, referral analysis; medicines management / effective prescribing; opportunistic falls screening for >65s. These commitments were about the practices supporting the CCG's approach and working collaboratively with the CCG and other partner organisations, rather than delivering activity that was monitored or evaluated, and was a flat payment of £5,000 per practice per annum Element 2 – remuneration for membership and Protected Learning Time (PLT) meetings (membership meetings are out of scope of this review, PLT are in scope as part of a wider discussion around GP / practice education) Element 3 – N/A (attendance of three practice managers at membership meetings, fallen into disuse)

	Are there key areas of good practice which we could roll out across BNSSG? How does this align with the CCG priorities? Does this service promote the reduction of health inequalities?	Element 4 - core performance element – this element changed in focus each year, with the SG Clinical Operational Executive agreeing the area of focus: 2013-2014 – Dementia diagnosis & Integrated Care Planning for Dementia 2014-2015 – Risk Stratification & Falls Assessments 2015-2016 – Using NBT ICE for 2WW Colorectal Referrals/Brain-type Natriuretic Peptide (BNP) Testing/Referral monitoring to secondary care 2016-2018 – Comprehensive Geriatric Assessments – 2 year programme Each Compact lasted for one year, with the exception of the current Comprehensive Geriatric Assessment (CGA) programme which was due to run for two years (2015-16-201718). For the current contract, each practice is paid for 20 CGAs @ £450 per CGA. Element 5 - discretionary/proportional performance element – additional activity that practices could undertake, for example, currently practices can deliver a set number of additional CGAs over the 20 based on their list size @ £450 per CGA. The common aim of the Compact across the years has been to pump prime initiatives, to support changes in culture and to support system integration. Element 4, the core performance element, has tended to involve data collection, with each practice submitting a quarterly return in order for evaluation of performance monitoring to be carried out. For example, with NT pro BNP, data analysis showed an increase in referrals once the Compact has been instituted. The area of focus of the Compact was agreed by the South Gloucestershire Clinical Operational Executive, which alongside clinical and executive leads included lay representation. The ability to flex the Compact has some benefit in terms of being able to respond to respond to CCG/system priorities whilst giving the practices assurance over income as the total amount available remained consistent. In addition the annual basis of the incentive programme meant the CCG was not committed to a longstanding payment which may become irrelevant as commissioning priorities change. Elements of the Compact potentially support a reduction in health inequalities, for example, the commitment to review referral data, and practices undertook to provide referral

		data/activity in order to support any CCG-led evaluations.
	Was an Equalities Impact Assessment undertaken to support the service?	The composition of the South Gloucestershire population varies, with most of the population in the Bristol urban fringe, pushing out to more rural locations as you move northwards. The Compact's current inability to flex to respond to this local variation in population has been raised, i.e. the continued focus on the frail and elderly via the CGA programme, however this was intended to be a two-year time-limited project, and although CGAs do admittedly concentrate on a specific cohort (as does dementia diagnosis) other areas e.g diagnostics and pathway work are more condition specific. No EIAs were carried out to support the Compact.
	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?	The changing focus of the Compact meant that it was and could be used to support pathways work. Each annual focus of the Compact had a shortform specification including the evidence base for the focus, the expectations / requirements for delivery and any monitoring arrangements. For example, for the current CGA project the evidence base around CGAs is clearly articulated alongside a move to providing more care in the community and local difficulties in recruiting geriatricians. Training was provided to practice staff alongside EMIS templates and reporting tools. What is less clear is plans for evaluation of effectiveness of the project. However, the work around CGA's is not representative of the goals and aims of the compact in more general terms. The importance is that the practice incentive payments can be used to further enhance the implementation and utilisation of clinical tools within pathways which support priorities within the commissioning intentions within any one year. The flexibility of the process means that emphasis can be increased or if necessary lessened depending on the commissioning priorities required.
	Do we commission this service elsewhere?	CGAs are carried out by acute trusts and would generate a cost per case tariff, however the practice-delivered CGAs looked partly to assess patients meeting particular criteria in order to prevent further deterioration e.g falls, so the cohorts are likely to be different.
	Is it a duplication or in line with other services?	
	Do we have the remit to commission this service?	The compact allowed the CCG assurance that existing intentions would be supported by the practices. Although " trust " was important between the CCG and the member practices the compact was not solely a relationship exercise as initiatives were chosen on a well -

	In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	researched business case where savings could be projected on the degree of engagement and implementation. Throughout the process communication ensures that the practices understood the mutual benefit of achieving the targets set.
2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	As mentioned above, the changing focus of the Compact had service specifications that articulated the evidence base and included some of these elements. Evaluation of some areas of focus was comprehensive, for example the NT pro BNP, where the increased usage of the test can be translated into real savings (the comparison of this test with Bristol practices over identical time periods strongly suggests the Compact created real changes in clinical behaviour). It is also worth noting that the performance related element of the compact was supported by regular communications and protected learning events / membership meetings. The evaluation of the two year CGA programme needs to be carried out and a new Clinical Lead identified. As examples, the 201516 Compact focussed on NT pro BNP, and a subsequent reduction on echocardiograms of 74% was evidenced, and on faecal calprotectin where colonoscopies were subsequently halved. Please see the Annex for details of activity and savings.
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	The Compact was agreed and annually refreshed by the South Gloucestershire Clinical Operational Executive, which alongside clinical and executive leads included lay representation.
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	For the current CGA programme, practices were remunerated for delivering 1181 CGAs across the two year period. The number of CGAs 'available' to practices was set using list size. Uptake across practices was strong however as previously stated some practices report that the continued focus on CGAs does not support their demographics.
5	**Financial Appraisal** What is the cost of delivering the	£5,000 for sign up, £450 per Comprehensive Geriatric Assessment £250 x 9 attendance at meetings plus £650 bonus for 100% attendance

	service? What are we paying for the service? What would be the costs of not delivering the service?	Total Spend 2017/18: £470K
6	**Delivery Model**	
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	The Compact could not be delivered by another provider. Yes it could be delivered at scale depending on which initiative was chosen. The Compact in itself does not limit scope, and indeed it allows flexibility of scale. When seeking feedback from practices, it is talked about as ethos rather than a defined initiative.
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 Compact provides a consistent income stream for practices which in all probability has been built into their baselines. Whilst the focus of the Compact or its successor may need to change, the implications of withdrawing funding at this scale need to be understood in line with the work on resilience and vulnerability. It is also worth noting that practices currently deliver activity that is above their core contract that they are not specifically contracted/remunerated to deliver (for example, hospital-initiated phlebotomy), so any withdrawal of funding may have wider system consequences if they need to re-evaluate their offering to patients. Decommissioning is likely to directly affect the viability of a small number of providers.
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	Monitoring on the current CGA element is via a claims form that is submitted and remunerated quarterly. There have been reviews on effectiveness of Element 4. The current CGA programme was timebound for two years and was not planned to be extended for a third year.
9	**Invoicing process** What is the invoicing process and frequency?	As above
10	**Service Level Agreement**	Excel spreadsheet with requirements, no formal contract in place. Due to the clinical

	Is there a contract or Service Level Agreement? What is the notice period?	element of the comprehensive geriatric assessment this would need to be on an NHS Standard Contract short form going forward.
11	**Summary of comparison of service across 3 areas**	The Compact has some similarities with the Bristol Primary Care Agreement, in that it underpins the relationship with the membership, looks to support transformational change and supports general practice in line with the GPFV. However the Compact was also directly supported by the Protected Learning Time sessions, which in turn could also inform the content of the Compact (e.g. CGAs came from PLT). The key message is that education / PLT can underpin cultural change.
12	**Recommendations for future of service:** • Continue at practice level and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	The recommended option is that further work is needed to develop a common approach on our key 'asks' from the membership both as commissioners and providers. We are well-versed in primary care being the bedrock of the NHS and the need to support a vibrant and thriving primary care sector, and we know the sector is struggling on a number of fronts including financially. The Locality Transformation Scheme is now in place and has a key role in developing and pump priming new integrated models of care, and there is a need to align these initiatives to aid delivery of CCG and system priorities and adopting more integrated pathways. A Compact-type approach with changing areas of focus has some advantages in terms of landing new pathways and models of care (e.g. diabetes) and being nimble in its ability to respond to commissioning priorities and supporting education / cultural mindset change. A renewed focus on evaluation and managing the benefits would be helpful. With the development of the provider locality vehicles we could start to use such a process on a larger scale to develop flexible outcomes-based models and their delivery.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations	There are a number of risks to be mindful of: • Membership engagement and support • Membership support in landing new pathways / models of care and integrated working

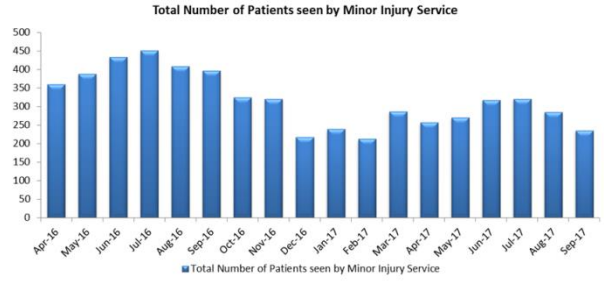
	and any proposals for mitigation	• Practice resilience and viability • Practice 'pullback' from delivering non-contracted activity (NCA) and system / financial impact

Appendix B – Desk Top Review template

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Primary Care Service Name: **South Glos Minor Injuries Service**		**Date of review:**	**01/06/18**	
Lead Manager: **Peter May**		**Lead Clinician:**	**Lesley Ward**	
		~~Bristol~~	**North Somerset**	**South Gloucestershire**
1	**Meets aims & objectives** What are the clinical aims and objectives of the service? Are there key areas of good practice which we could roll out across BNSSG? How does this align with the CCG 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 or in line with other services? Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	**South Glos Only** Minor Injuries Service at GP practices introduced in South Glos as an alternative to a Minor Injuries Unit at Cossham. The aim of the MIS was to provide 'in-hours' (8.30am and 6.30pm Monday to Friday) minor injury provision for local populations as an alternative to attending A&E. The minor injury service in GP practices accept South Gloucestershire patients presenting with a range of minor injuries including: sprains and strains; cuts and grazes ; minor fractures ; minor head injuries ; wound infections; minor burns and scalds; bites – insect, animal and human etc. Patients access the service through contacting their GP practice over the phone. Each participating practice received additional funding and training in order to deliver this enhanced service. Practice nurses were trained to deliver the service, with support from GP. **North Somerset** • A contract held with 5 GP practices to provide a service for patients who do not live nearby to an A&E or MIU and whose injuries are of low enough severity that they could be dealt with in a GP practice. • The five practices are: Heywood Family Practice Portishead Medical Group Mendip Vale Medical Practice Tyntesfield Medical Group Winscombe Surgery		

		Across both areas there is a potential for duplication of activity that practices are already providing under a GP contract In addition, a similar service is provided at Yate MIU, South Bristol Community Hospital and Clevedon Community Hospital
2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	South Gloucestershire: Patient Surveys completed at practices and collated by CCG April 2016 – Sept 2017: • Patient feedback was received from 692 /12% of patients and was very positive. • 99% of responding patients agreed or strongly agreed that they were happy with the treatment they received. • 98% of responding patients agreed or strongly agreed that they would recommend the MIS to family and friends. • 60% of responding patients (328 of 544) would have attended A&E or a MIU if the MIS had not been available. • After experiencing the MIS, 80% of responding patients (423 of 529) said they will attend the MIS / their GP practice next time they suffer a minor injury • After experiencing the MIS, only 4% of responding patients (22 of 529) said they will attend A&E next time they suffer a minor injury High numbers of people attending (35%) are advised to self-care. A certain number of patients indicated that if the service wasn't there they wouldn't have done anything. An Equalities Impact Assessment is needed to assess how this approach compares to the provision for people across BNSSG.
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	**South Gloucestershire** Regular reporting to South Glos Health Oversight and Scrutiny Committee (HOSC). Presentation to Improving Patient Experience Forum (IPEF).

		Patient Quality Audit undertaken by the BNSSG Quality team.
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	 • Attendance to the South Gloucestershire MIS has fluctuated throughout the pilot period, rising steadily through year 1 quarter 1 and early quarter 2, seeing peak attendances, in excess of 400 patients per month through the summer months of June, July and August. • Year 2 saw a steady rise through quarter 1 and again peaking in the summer months of June and July, but at much lower numbers than in year 1, at 317 and 320 respectively and then declining slightly towards the end of year 2 Quarter 2. More work needs to be done to capture capacity and demand activity for the North Somerset service.
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	**South Gloucestershire** £3.5K per annum Mgmt. and admin. £0.60 per patient Service delivery. £0.05 per patient consumables. Staggered payment for reduction in MIU/A&E attendances from practice Total Spend 2017/187 £350K **North Somerset** Practices providing this service are paid a set annual retainer for “lower level” procedures and then a £50 per activity fee for activities on a set list of “higher level” procedures. The annual budget for the North Somerset minor injuries LES is £43,968. Practices do not report the number of “lower level” procedures they undertake, but they do report the number and type of “higher level” procedures.

		In 16/17 there were a total of 157 claims at a value of £7,850.00
6	**Delivery Model**	
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	Further work needs to be done to understand where this activity would go should there be changes to this service – it is anticipated that a significant proportion of people could be supported with self-care, seen by their practice as part of the core contract and/or within improved access hours, attend their local pharmacy and in some instances attend a local Minor Injuries Unit.
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?	South Glos and North Somerset patients may be required to travel further for minor injuries treatment. Decommissioning would not have an impact on premises or the viability of providers
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	**South Gloucestershire** 6 month appraisals of activity and patient feedback. Last appraisal undertaken January 2018 There is some variation in practice take up of the scheme and numbers of patients seen by minor injuries service at each practice. **Minor Injuries Service - Cost Benefit Analysis April 2016 – September 2017:** Total Fixed Costs (Training/ Equipment and Consumables/ Practice Fees/ Practice Bonus): **£411,219.80** % change in the rate per 1000 attending A&E in hours from the 25 South Glos practices: **-4% (Target : -10% each year)** Total reduction in A&E / Yate MIU attendances

		from the 25 South Glos practices: **482** Total saving from reduction in A&E/ MIU activity (assuming minimum A&E tariff of £68): **£32,776** Total net cost of minor injuries service: **£378,443.80** *Summary:* The data shows a 4% decrease (April-September year on year change) in the rate of A&E/MIU attendances 'in hours' from South Glos GP practices. This is against a target of a 10% reduction in attendances per year. (Caution should be taken with these figures and causality with the MIS cannot be inferred.) Overall financial benefits of the minor injuries service are small in comparison to the cost of running the service. Further information on cost benefit analysis is needed for the North Somerset service
9	**Invoicing process** What is the invoicing process and frequency?	**South Gloucestershire** Payment is made up of 5 parts. - Management time and service administration is paid quarterly at £3500 per annum. - Service Delivery eg nursing time, gp time, onward referrals is paid quarterly at 15p per patient. - Practice nurse shadowing is paid on an adhoc basis at £150 per nurse attendance or £600 per GP attendance. - Consumables top up is paid at the end of the financial year at 5p per patient. - Performance payment to be paid on evidence of reduction in minor attendances at MIU and A&E.
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	NHS Standard Contract – extension to be issued to March 2019
11	**Summary of comparison of service across 3 areas**	
12	**Recommendations for future of service:** • Continue at practice level	BNSSG places a great emphasis on self-care and patient empowerment and education. Evidence has shown that patients have accessed this service as it was offered whereas

	and align for tariff and specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	before self-care would have been their first route for a significant proportion of people so it is a service that is generating activity. Further work needs to be done to understand the support that this LES offers to patients in rural areas. This is not an equitable service across BNSSG so an Equalities Impact Assessment needs to be done to evaluate this. Further work needs to be done to understand who is accessing the service so we can understand how best we can support these needs going forwards.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	

Appendix B – Desk Top Review template

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Primary Care Service Name:		**Date of review:**	**12th June 2018**	
Lead Manager: Emma Moody, Grace Elias		**Lead Clinician:**	**Dr Pippa Stables**	
		Bristol	North Somerset	South Gloucestershire
1	**Meets aims & objectives** What are the clinical aims and objectives of the service? Are there key areas of good practice which we could roll out across BNSSG?	The clinical aim of the service is to manage the diagnosis and review of people with dementia in primary care. This enhanced service is integral to the successful running of the Dementia Wellbeing Service in the Bristol Area and the sustained achievement of the dementia diagnosis rate. Current system pathways would support successful roll out of the Bristol LES model across South Glos and North Somerset. South Glos already promotes GP diagnosis education , delivered via training sessions by Peter Bagshaw. However as this does not sit within a LES framework there is no push for GPs to attend. In Bristol when GPs raised concerns of work-shift (secondary/community to primary care) they could be referred to the LES. In addition, when told they were now the care coordinator for people with dementia, they have the benefit of a practice lead, Dementia Practitioner and Dementia Navigator. The LES has clear interdependencies with the		

		Dementia Wellbeing Service. The Dementia Wellbeing Service (DWS) also has potential to roll out across BNSSG, now that there is a developed way of working, recruiting and training of navigators. The navigator role has far reaching potential for more targeted admission prevention work. Thought could be given to a roll out of the different elements of the service rather than a whole sale recommissioning. Bristol has consistently seen achievement of dementia diagnosis rates and the Dementia LES has been an integral part of delivering this. Provision in North Somerset, where GPs were paid for work similar to that in the LES, has recently ceased. This has led to a marked increase in referral to assessment time in the memory service. In the absence of a robust LES, NS and SG have never seen the diagnosis rates Bristol has achieved – see below		
	How does this align with the CCG priorities?	The work aligns with supporting the financial recovery plan, as the economic evaluation conducted by UWE demonstrated it was more cost effective to diagnose patients in primary care than secondary care. It will also align with work coming out of developing the mental health strategy. The work also aligns with National policy / NHSE ambitions. The overarching priority for the next 6 months is to establish BNSSG credibility; this model has been very successful in Bristol and has enabled the CCG to have national credibility		

		for its work. Delivering this service across the area, is likely to build on that further.		
	Does this service promote the reduction of health inequalities? Was an Equalities Impact Assessment undertaken to support the service?	By upskilling GPs on the signs and symptoms of dementia and equipping them with the tools to diagnose "straightforward" dementias the service supports the reduction of health inequalities. There is a GP champion skilled in each practice who is able to diagnose dementia and therefore able to support colleagues. If a GP is not confident about the diagnosis or a practice is not signed up to the scheme, then the Dementia Wellbeing Service remains in place to provide this. As part of the GP education programme training on improving diagnosis within BME communities is being delivered in 7 inner city practices. The training will actively address the issue of BME populations receiving late diagnosis and therefore not receiving timely support.		
	Are there other ways of delivering the aims and objectives of the service that we should consider (e.g. best practice from elsewhere)?	The dementia care pathway in Bristol has been seen as one of the best practice models throughout the South West. The dementia pathway has been used in regional and national case studies, with commissioners and clinicians sharing the Bristol model.		
	Does this work impact on existing or proposed pathway work? Do we commission this service elsewhere? Is it a duplication or in line with other services?	No, it would not impact on any proposed pathway work. We commission the Dementia Wellbeing service to diagnosis complex dementias and NBT neurology diagnose rare dementias.		

	Do we have the remit to commission this service? In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	Yes we have the remit to commission the service. Diagnosis of dementia is not a core part of the GMS/PMS contract. Without the funding to support the work, GPs would cease to offer this service and all referrals would return to secondary care.		
2	**Evidence base** What evidence base is there to support a) that this meets local population health need and/or addresses variation in quality b) that it is effective in doing so	A full evaluation of the service was commissioned by UWE during its first year of implementation. An audit was conducted that demonstrated good GP uptake of the template for diagnosis and review and a high standard of GP care. Further research into GP diagnosis is being undertaken at University of Bristol by Sam Creavin.		
3	**Engagement** What feedback or engagement has there been in the development of this service (clinical, patient and/or with other stakeholders)?	There was significant engagement across the whole of Bristol in developing this model. It involved patients, carers and clinicians. Primary and secondary care clinicians worked together to design this model, with secondary care providing the training. Engagement took place with all Locality Forums. Primary care were clear they had become deskilled at managing dementia and this new model meant they were able to build their confidence again. Beginning with a one year pilot of 11 practices the scheme spread to almost all Bristol practices. People with dementia and their carers strongly advocated for receiving a diagnosis quickly. The implementation of this		

		service saw a significant reduction in waiting times for secondary care.		
4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	Bristol Diagnosis rates 17/18 76.4% Against prevalence of 4183 65.5% North Somerset Against prevalence of 3307 62.3% South Glos Against prevalence of 3178 Number of diagnoses made in primary care in 2017-18: Q1 149 Q2 159 Q3 170 Q4 135 Number of reviews carried out in primary care in 2017-18 Q1 294 Q2 362 Q3 504 Q4 563 38 practices participate in this LES.		
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	Basic Level: The Provider will receive a £515.11 payment for signing up to the Service. Enhanced Level The Provider will receive: £169.00 per diagnosis of dementia made in primary care £41.25 per person per yearly enhanced review Incentive The practice will be paid £206 for improving diagnosis rate by 5% on the previous year, or by achieving or maintaining > = 65% diagnosis rate against expected prevalence.		

		2017-18 total spend was £217K		
6	**Delivery Model**			
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	No and not without significant disruption and negative impact on diagnosis rate. The enhanced service is delivered by primary care as its aim was all about people being supported by their local practice to receive their diagnosis, building on the good relationships people have in place already. Care of the person with dementia needs to be integral to their holistic care as they become frail. Yes it could be delivered at scale across a number of practices – this could build the specialist expertise further; however there is a risk that GPs could become deskilled, as they were several years ago, when all diagnoses were made in secondary care. Familiarity is also key for people with dementia so having diagnosis take place in their local surgery, in an environment they know, with GPs and nurses who they have relationships with, is a critical factor. GP confidence makes a big difference in patient experience. The LES builds confidence through education and support and 'ownership'.		
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?	It would have a very significant impact if it was decommissioned. Patients would return to be referred back to secondary care to receive their diagnosis, regardless of the complexity. GPs have been purposefully engaged in this work, and paid for work that would have been		

		delivered by secondary care. Our secondary care service would become stretched, develop a waiting list and diagnosis rates fall. Decommissioning would not affect the viability of the GP practices, as the amount per practice is relatively small, however if would impact on the Dementia Wellbeing Services, provided by Devon Partnership Trust and would require recommissioning elements of the dementia pathway.		
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	Practices are required to submit monthly returns of number of people diagnosed and number of people reviewed. Audits have in the past been undertaken and practice visits carried out by the clinical lead. There is a requirement to complete end of year surveys and evaluations of the service. Practices must also participate in training on a yearly basis, compliance of which is monitored.		
9	**Invoicing process** What is the invoicing process and frequency?	Monthly basis through Exeter system.		
10	**Service Level Agreement** Is there a contract or Service Level Agreement? What is the notice period?	Yes a service specification is part of the NHS Standard contract that is held between the CCG and each practice.		
11	**Summary of comparison of service across 3 areas**	North Somerset does not provide this service. South Glos have encouraged GPs to undertake diagnoses, but without any formal contractual levers in place, or ability to scrutinise effectiveness of model or audit the outcomes.		
12	**Recommendations for future of service:** • Continue at practice level and align for tariff and	Continue at practice level and roll out across BNSSG. So much of the benefit of this comes from the GP practice knowing their patients and making the		

	specification across BNSSG with proposals for this in place for June OR • Further work needed to develop a common approach for April AND/OR • Develop service for at scale delivery for April OR • Service no longer needed or a priority for investment across BNSSG Please provide justification for recommendation	diagnosis slowly, over a number of visits in the local practice, in a familiar setting. Years of work has gone into redesigning the pathway, taking dementia from a secondary care illness to one primarily led by primary care but supported by secondary care. This approach has been picked up at a national level and has changed NICE guidelines.
13	**Risk Assessment** Please provide a summary of any risks arising from recommendations and any proposals for mitigation	Given the shift of work from secondary care to primary care that has happened over recent years, practices may be averse to taking on this work unless supported to do so *Discussions will need to take place at a locality level, led by clinicians who have been involved in this work to date. The locality structure within BNSSG would support this approach. Benefits to patients and practices will be clearly explained. Currently there are a number of criteria to meet to refer to secondary care, to make the diagnosis, the explanation that delivering this LES will speed up the process and reduce waiting list times, will be a key part of the implementation. The CCG is able to evidence the success of the model in Bristol to support roll out.* Practice capacity may affect the ability to attend training. *By paying the sign up fee practices will be able to cover backfill.* GPs do not feel well enough equipped to make the diagnosis. *Training will be provided to upskill GPs. The secondary care service will still take on any complex cases to diagnose.* Difference in level of post diagnostic support once diagnosis in Primary Care is given. *The CCG will review post diagnostic support available in NS and South Glos to align with Bristol as part of the Mental Health Strategy.*