Primary Care Commissioning Committee (PCCC)

Date: Tuesday 27 November 2018
Time: 9.00-10.50am
Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda number: 6

Report title: Local Enhanced Services (LES) Review Update

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

1. Purpose

The purpose of the paper is to update the Committee on progress with the LES review.

2. Recommendations

The Committee is asked to:

- Note the feedback received on draft specifications shared with the membership (attached at Appendix A) and the LMC contained in the main report
- Note the highlight report in Appendix B and the proposed next steps set out within the main report and the highlight report
- Note the options appraisal for anticoagulation (attached as Appendix C) and support the recommendation within the paper to offer a common basic level service across BNSSG and an advanced service only to those currently providing this in 2019/2020 whilst a full evaluation is made of the comparative merits between an entirely primary care led model and a partial primary care delivery model supported by secondary care provided dose monitoring.

3. Executive Summary

The main report sets out key progress in the last month and gives a summary of feedback received on the draft specifications shared with the membership during November noting that engagement is ongoing. The draft specifications shared in November are:

- Type 2 Diabetes Insulin Start LES
- Recognition and Management of People with Dementia and their Family/Carers in General Practices
- A revised draft of the specification for GP Practice Care Home Support

In addition to this the proposed specification to develop a community based DVT pathway with a LES for the primary care element is attached at Appendix A.

4. Financial resource implications

Financial resource implications have been considered as part of the options appraisal for anticoagulation. More financial information is needed to form a complete picture about the wider pathway and how the LES should develop beyond 2019/20.

5. Legal implications

There are no new legal implications to report to the Committee this month.

6. Risk implications

The key risks are set out in the Highlight Report in Appendix B.

7. Implications for health inequalities

The draft specifications seek to develop a common offer for people across BNSSG and reduce inequalities for our population.

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

The draft specifications in Appendix A align existing specifications and build on best practice and do not therefore represent significant change. Equality impact and quality impact screening will be undertaken to support the specifications prior to presentation to PCCC for final approval in January. These have already been completed for DVT.

9. Implications for Public Involvement

The draft specifications presented develop a consistent offer across BNSSG and seek to support the delivery of care closer to home which is consistent with what patients and people tell us they want to see. No formal public involvement has been undertaken to support the alignment of the specifications. This is planned to support the development of phase 3 of the Locality

Transformation Scheme. A service user group was involved in the development of the specification for DVT.

Agenda item: 6

Report title: LES Review Update

1. Background

Since the October report to the Committee the LES review has continued to develop draft specifications and to engage on these drafts with the membership at forums across BNSSG. Draft specifications have been developed for type 2 diabetes insulin starts and the recognition and management of people with dementia. In addition to this a revised draft of the specification for GP Practice Care Home Support was shared with the membership. These are attached within Appendix A for the Committee's review. Furthermore, the specification for the DVT pathway for patients presenting in general practice is attached within Appendix A. The DVT pathway has been approved by the CCG Governing Body, a procurement to support the pathway is underway and savings released from changes to the existing pathway will resource the new LES element of the pathway within primary care. This has been through an extensive process of engagement with the membership. The specification is being shared with PCCC so that the Committee is sighted on the full suite of specifications to be offered to practices from 1st April 2019.

This report seeks to give an overview of the engagement undertaken in the last month and a summary of the key points of feedback received to date. In the last month members of the LES Steering Group have presented the specifications at each of the 3 Bristol locality membership meetings and the North Somerset and South Gloucestershire meetings. In addition, the LMC board have reviewed the draft specifications and have provided detailed feedback on the specifications. Practices have continued to engage with and provide feedback on the specifications at forums and through direct feedback to the steering group. An increasing request from practices has been to have sight of the proposed tariffs in advance of final decisions being made by the Committee to be able to give us a better indication of deliverability from a provider perspective. It is proposed that an outline of indicative tariffs is shared with the membership in December prior to their publication in open session of the PCCC.

The final component of the November report to PCCC is to bring back an options appraisal to support the next steps and offer of a BNSSG anticoagulation LES. This is attached at Appendix C and recommends to PCCC that we should prioritise a BNSSG wide enhanced service for the basic level service (where a venous sample is taken at the GP practice which is then sent to secondary care) and retain a 'mixed economy' of dose monitoring within primary and secondary care whilst an audit is undertaken to support a longer-term review of clinical and cost effectiveness between the two approaches. The advanced level for dose monitoring would therefore only be open to practices currently providing this for 2019/20 pending the outcome of this review.

Following the establishment of a further LES for additional procedures in South Gloucestershire funded at 16p per patient the LES Steering Group is now undertaking a desk top review of the specification in the same way as all other specifications have been reviewed. This will come to the next Committee. The LES Steering Group has requested a final review of practice payments and

contracts by the contracting team to ensure that no other arrangements are in place which should fall within the scope of the review.

2. Type 2 Diabetes Insulin Start LES

The key points of feedback included a request to recognise existing competence when rolling this out to North Somerset and South Gloucestershire where practice nurses have already been trained, some concern from practices about their ability to release practice nurses to take part in training and the need to recognise that it may not feel viable to smaller practices who only have a few people per year who require insulin initiation. Practices discussed the need to retain support from community Diabetic Specialist Nurses where they did not feel able to sign up to the LES to prevent referring to secondary care for this. Some practices and the LMC expressed concern about the approach to funding (for example in Bristol a concern about specific payments for GLP1 no longer being included whilst in North Somerset some concern about payment for follow up no longer being included). The current proposal is that payment is available per insulin initiation and that ongoing care is considered part of routine treatment for a common condition. There was discussion about developing this as a locality solution and a recognition that this would work better to ensure whole population coverage. There was also a sense that the locality contracting model is now in development for Improved Access and that practices need time to focus on developing this in the first instance before diabetes is added to this approach. It is currently proposed that the LES is offered at either locality or practice level for April 2019 with a move to locality contracting from April 2020.

Practices discussed the importance of the wider pathway and developing support for managing more complex cases. The wider diabetes programme is seeking to develop more advice and guidance and virtual clinics supported by diabetes specialist nurses and secondary care. The importance of focusing on prevention and healthy lifestyles was advocated in addition to providing a good quality response to managing the condition.

3. Recognition and Management of People with Dementia and their Family/Carers in General Practices

The specification has been broadly welcomed. Practices in North Somerset and South Gloucestershire in particular have highlighted the need for resilient post diagnostic support and the need to look at pathways that are available for this across BNSSG. We will need to develop guidelines for practices in North Somerset and South Gloucestershire to be able to order direct access CT scans as is currently supported in Bristol. Practices will still need specialist support for complex cases. A request was made to consider how we could develop a care plan template that can support a range of needs and settings. There was also a suggestion about incorporating and encouraging practices to be dementia friends as part of the specification.

4. GP Practice Care Home Support

A revised service specification was shared with the membership which is now applicable to both care homes with and without nursing following significant membership feedback and PCCC support for both to be within scope. A number of additions have now been made to the specification which particularly focus on managing an outbreak of influenza and enhancing the medicines management aspects of the specification. For ease these sections are highlighted in yellow for the Committee to see and comment on.

Practices have welcomed the development of the specification to incorporate care homes without nursing. Points of feedback have included reviewing some of the timescales within the specification to consider working days rather than absolute numbers which won't account for weekends and bank holidays, reviewing whether there is a demonstrable need for weekly ward rounds and whether the frequency could be adjusted to fortnightly (particularly to accommodate an expansion of support to the number of homes) and adjusting the specification to recognise that GPs may provide leadership to a care home and may call on a multi-disciplinary team to support ward rounds and care planning. Practices have acknowledged that there would still be some work to do to map care homes to practices and the benefits of this will need to be communicated to residents of care homes. Practices have requested that we review and streamline reporting requirements for this specification. We are proposing developing a small project team with practice manager support to the clinical and managerial leads to take this forward. Discussion has taken place about the need for an escalation support package for people at risk of admission from community providers and the need to build the wider model into the community procurement.

5. DVT pathway for patients presenting in general practice

The purpose of this specification is to standardise the BNSSG DVT pathway for patients that present in general practice and to commission a quality pathway that is cost effective. This has been through an extensive process of engagement with the membership.

Over the past 18 months BNSSG CCG (and its predecessors) reviewed all the pathways and engaged with all the current providers identifying current issues and opportunities for the new pathway and developed a new service specification. The service specification was developed through discussions with the CCG clinical leads and with provider clinical and management staff involvement. The DVT service specification was discussed at each clinical commissioning membership forum in May 2018 where the GP commissioners broadly supported the pathway.

There are currently five different DVT pathways across BNSSG for patients who present in general practice with a suspected DVT all of which are funded differently.

The revised DVT pathway requires initial assessment in primary care using Wells Score and Point of Care D-Dimer (where appropriate), and where indicated direct access to scans provided by a specialist provider who will also manage all positive DVT patients. The management of the positive DVT patients will include initiation of treatment, patient education, further investigations where indicated (for unprovoked DVTs) and a management plan back to the GP which includes length of treatment, results of additional investigations and ongoing management plan.

The DVT pathway has been approved by the CCG Governing Body, a procurement to support the specialist element of the pathway is underway and savings released from changes to the existing pathway will support the new proposed LES element of the pathway within primary care.

6. Next Steps

The key next steps include:

- reviewing the specifications in light of feedback received
- completing Equality Impact/Patient and Public Involvement and Quality Impact Assessment screening for these final sets of specifications
- a clinician to clinician meeting between the LMC and CCG to discuss any areas of feedback and concern in early December.
- Completing a desk top review of the 16p 'basket of procedures' in South Gloucestershire to share at the next Committee
- Finalising proposed tariffs and proposed contract terms with a view to these being shared with the LES Steering Group, PCOG and the membership in advance of January PCCC.

7. Financial resource implications

As described in last month's paper to PCCC the financial modelling will need to both identify any savings made as a result of the recommendations of the review and any costs arising from spreading services across BNSSG. The output of this will then inform the resources available to support phase 3 of the Locality Transformation Scheme. The financial modelling will assess the impact on practice income as well as the CCG position. In addition, the CCG will need to consider how to approach new proposals for enhanced services and how these should be resourced where a need has been identified either as part of responding to national targets or to support new pathways developed through the STP. Where possible these should be aligned to the work of LTS phase 3 in the collaborative system design phase to agree new models of care between providers. A tariff has been proposed for DVT as the work to develop the specification and costing approach precedes the LES review.

8. Legal implications

There are no new legal implications to report to the Committee this month.

9. Risk implications

The key risks are set out in the Highlight Report in Appendix B.

10. Implications for health inequalities

The draft specifications seek to develop a common offer for people across BNSSG and reduce inequalities for our population.

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

The draft specifications align existing specifications and build on best practice and do not therefore represent significant change. Equality Impact and quality impact screening is underway to support the specifications prior to presentation to PCCC for final approval in January. These have already been completed for DVT.

12. Consultation and Communication including Public Involvement

The draft specifications presented develop a consistent offer across BNSSG and seek to support the delivery of care closer to home which is consistent with what patients and people tell us they want to see. No formal public involvement has been undertaken to support the alignment of the specifications. This is planned to support the development of phase 3 of the Locality Transformation Scheme. Locality provider leads and patient and public involvement will be involved in the collaborative design events to develop future models of care for the identified priorities. A service user group was involved in the development of the BNSSG specification for DVT.

13. Recommendations

The Committee is asked to:

- Note the feedback received on draft specifications shared with the membership and the LMC contained in this report
- Discuss the draft specifications attached within Appendix A
- Note the highlight report in Appendix B and the proposed next steps set out within this report and the highlight report
- Approve the recommendation for the approach to anticoagulation in 2019/2020 as set out in the options appraisal in Appendix C

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

Appendices

Appendix A – Draft specifications

Appendix B – Highlight Report
Appendix C – Options Appraisal for Anticoagulation

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations.

Anticoagulation	Anticoagulants are medicines that help prevent blood clots. They're given to people at a high risk of getting clots, to reduce their chances of developing serious conditions such as strokes and heart attacks.
DVT	Deep Vein thrombosis- a formation of a blood clot in a deep vein, most commonly the legs.
LMC	Local Medical Committee - LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities.
Insulin	Insulin is a hormone made in the pancreas, which is an organ in the body that helps with digestion. Insulin helps the body use glucose (sugar) for energy. When people have diabetes they may need to take it as medication to help control their blood sugar levels.
GLP1	Drugs which have blood glucose-lowering effects and enhance the secretion of insulin

LOCAL ENHANCED SERVICE SPECIFICATION GP
Practice Care Home Support

NHS Standard Contract Service Profile Pack (1st April 2019 - 31st March 2020)

This Pack contains:

1. **Service Specification:** (to be inserted Schedule 2 Part A: Contract Particulars)
2. **Schedule of Invoicing:** (to be inserted Schedule 3 Part H: Contract Particulars)
3. **Monitoring Form:** (to be inserted Schedule 3 Part A: Contract Particulars)

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1. Service Specification:

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4, Mandatory but detail for local determination and agreement
Optional headings 5 – 7, Optional to use, detail for local determination and agreement

All subheadings for local determination and agreement

Service Specification No.	**TBC**
Service	**GP Practice Care Home Support**
Commissioner Lead	**Julie Kell**
Provider Lead	**GP Practices**
Period	**1st April 2019- 31st March 2020**
Date of Review	**October 2018**

1. Population Needs

1.1 National/local context and evidence base

Introduction

The purpose of this service specification is to provide a contractual framework for the provision of enhanced medical cover to residents of care homes . There is recognition nationally that this group of patients exhibit a greater need than that of the general population.

This service specification has been developed with reference to the NHS England framework for Enhanced Health in Care Homes. It allows and remunerates General Practices to take a proactive approach to caring for people in care homes, with an overall aim of improving the lives of those people. This includes personalised care planning, medicines optimisation, continuity of care and reducing inappropriate stays in hospital.

This service should be provided across Integrated Community Localities, in and out of hours, aligning with the other work across the CCG such as trusted assessment, Advanced Care Planning and multi-disciplinary (MDT) management of long term and ambulatory care sensitive conditions. An MDT approach will also include management of nutrition and hydration support.
Specifically, the enhanced service will include the principles of mapping practices to care homes, weekly ward rounds and comprehensive geriatric assessment.

Background
Enhanced support to care homes was previously delivered through a Primary Care Local Enhanced Service which was specific to the 3 previous CCGs. Since coming together as a single CCG, this enhanced seeks to unite the offer under a single Enhanced Service, reflecting national work and guidance from NHS England.

The CCG is in the process of reviewing the support that care homes receive from partner organisations, such as the frailty pathway, the Integrated Urgent Care and Clinical Advice Support pathway and the Integrated Care Bureau

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

It is expected that by delivering the Service, Providers will be able to deliver the following outcomes:

Maintain residents well being

Maintaining good health for residents

Choosing right place of death.

3. Scope

Aim

The overall aim of the Local Enhanced Service agreement is to improve the care and lives of people living in care homes – such as reducing inappropriate admissions and ensuring care is received where they need it and request it.

The GP Practice Care Homes Support Local Enhanced Service specification is a practice led initiative that requires GP practices to work together to rationalise the number of patients each has within each care home with the vision of having one GP

Practice per care home or per unit/floor for the larger care homes. Residents within a care home will be able to choose to move to the lead GP practice or stay with their own GP; however, it is anticipated that most will chose to be registered with the lead GP Practice because of the increased level of care provided.

To ensure that registered patients who are resident in Bristol, North Somerset and South Gloucestershire Care Homes are proactively managed within the Care Home to reduce inappropriate hospital admissions. GP Practices participating in this LES will be expected to deliver Advance Care Planning (ACP) and case management support to patients registered with a GP Practice and resident in a Bristol, North Somerset & South Gloucestershire Care Home.

GP practices providing this service will be expected to follow the End of Life Pathway, Advance Care Planning (ACP) to patients that have been aligned to GP Practices participating in this LES. Advance Care Planning (ACP) pathway is a discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included. This discussion should be documented, regularly reviewed, and communicated to key persons involved in their care. An ACP discussion might include:

- The individual's concerns and wishes
- Their important values and general goals for care
- Their understanding about the illness and prognosis
- Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these
- Provision of proactive care which should lead to a reduction in reactive care management.

Model of Care

1. Once moved to a locality model Bristol, North Somerset & South Gloucestershire practices will agree Lead GP Practice(s) that would take responsibility for providing GP service to named Care Homes as described in this LES.

2. Lead GP Practice will be expected to take responsibility for coordinating and co-operating with processes that ensure better patient care such as attending best interest meetings, providing written and not verbal instructions about administration of medicines.

3. Lead GP Practice aligned to Care Homes will be expected to work collaboratively with all the other services that input into care homes e.g. Community Nurses, Practice Nurses, Tissue Viability, District Nurses, Community pharmacists to ensure that communication systems are robust.

4. For the few residents who do not choose to register with the Lead GP Practice, the lead GP practice will be expected to liaise closely with the patient's GP Practice where it will result in improved clinical care. Lead GP Practice aligned to Care Homes will be expected to provide specific input and support to Care

Homes when the Care Home care pathways are fully developed further information will be provided by the CCG.

5. Lead GP Practice will take the lead for clinical review of medicines. Wherever possible, medication review should be undertaken in conjunction with clinical pharmacists. Both the CCG and North Somerset Community Partnership (NSCP) employ Care Homes Pharmacists to work with GP practices. Alternatively CCG practice based medicines optimisation pharmacists may provide support. Some practices have employed pharmacists who could support with this work.

   CCG/NSCP pharmaceutical teams will provide data to the CCG on reviews that they have been involved in with GP practices, detailing any clinical interventions or cost savings that have been achieved and this will be monitored as part of the KPIs.

6. Support the management of influenza outbreaks in care homes to reduced influenza associated morbidity and mortality and reducing further onward transmission of the influenza virus.

7. A named GP within the Lead GP Practice will encourage development of skills and continuous education and ensuring that appropriate systems are set up between the practice and the care homes.

Service Specification

As a minimum Lead GP Practices will provide the following support to Care Homes:

1. ACP including 6 monthly reviews that will be continually updated to measure the patients changes particularly as they approach End of Life (a continuous living document).Respect Form
2. Anticipatory Medicines (Just In Case Medicines, JIC) for end of life should be prescribed as appropriate for care home residents.
    - Prescribing JIC medicines should be done on an individual case by case basis, rather than as a routine part of a patient being admitted to a nursing home
    - JIC medicines should be regularly reviewed (every 3 months) by the GP and NH nurses for appropriateness, and the review should be clearly documented in the patient's care plan
    - GP practices should be aware of which of their NH patients have been prescribed JIC medicines,and be able to generate a list of these patients from their records for review. These patients should be considered and reviewed as part of the GP practice's wider palliative care patient register.

2. Lead GP Practice will be expected to undertake care review within one weeks of patient arriving at the care home.

3. Providing regular routine surgeries (Community Ward Rounds) plus urgent surgeries as needed in the Care Home. It is encouraged that practices invite clinical pharmacists on Community Ward Rounds in order to facilitate medication review and optimisation in order to provide pro-active care effectively the frequency of the ward rounds should be at least weekly some larger homes may

need more regular visits. The CCG would expect that frequency of Community Ward Rounds will be reviewed on an individual basis. Any home visits made outside of the Community Ward rounds will come under core Primary Medical Service.

4. The GP should attend with the care home manager a monthly shared learning and practice review of emergency admissions.

5. Medication reviews at least annually in line with NICE SC1 Managing medicines in care homes. Reviews should focus on medicines optimisation and, where appropriate, de-prescribing. Consider using a screening tool (for example, the STOPP/START tool in older people) to identify medicine-related safety concerns and medicines the person might benefit from but is not currently taking. Reviews should focus on safe prescribing, appropriate monitoring, prevention of medicines related adverse events/admissions, reducing medicines waste, and cost effective prescribing.

6. When PHE declare an influenza outbreak within a care home, a clinician is required to assess all exposed persons in at-risk groups for the need for antiviral treatment or prophylaxis and arrange for a patient specific antiviral supply. Antiviral therapy should be started within 36 or 48 hours of the onset of symptoms or contact with an index case dependent on the choice of medication being prescribed. The GP practice will respond within 12 hours, working inconjunction with Public Health England to reduced influenza associated morbidity and mortality and reducing further onward transmission of the influenza virus.

Eligibility Criteria

The person in a care home will be registered with a BNSSG GP Practice and resident in a BNSSG Care Home.

Interdependencies:

The GP's will work within existing pathways and future development work that includes:

Advance Care / Respect Plan

Red bag scheme (currently operating in Bristol, North Somerset in 5 homes)

Blue book (North Somerset NS)

Trusted assessment

Community residential care liaison team (NS)

Integrated Community localities

Frailty strategy

Joint work with Local Authorities LAs

Continuing Health Care CHC (and new national framework)

Market management of care homes

BNSSG Joint Formulary www.bnssgformulary.nhs.uk

End of Life and fast track EOL

Medicines Optimisation in Care Homes Programme

Healthy Weston Project

Clevedon care home nurse

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NHS England framework for Enhanced Health in Care Homes

https://www.england.nhs.uk/publication/the-framework-for-enhanced-health-in-care-homes/

NICE Managing Medicines in Care Homes https://www.nice.org.uk/guidance/sc1

NICE Multimorbidity:clinical assessment and management https://www.nice.org.uk/guidance/ng56

4.2 Applicable local standards

5. Contract Monitoring, Reporting and Financial Information

5.1 Outcomes, monitoring and evaluation

Quarterly Monitoring

The provider would be required to submit quarterly reporting describing:

- Number of community ward round undertaken by GP Practice
- Number of people with LTC with face to face reviews
- Number of patients seen within 7 days of admission to the home.
- Number of ACP undertaken
- Number of patients on ACP
- Number of medication reviews undertaken
- Number of residents prescribed Just In Case medication

Annual Monitoring Information

Practices will undertake six monthly reviews of emergency admissions. Review will cover what could have avoided the emergency admission, what will be done differently next time, minutes/forms to be shared with CCG to promote shared learning and to identify gaps in service.

Success criteria

- The success of the LES will be measured by reduction inappropriate emergency admission by Care Home. The CCG would review secondary care activity for emergency admission per nursing care home
- CCG/NSCP pharmacy teams will provide data to the CCG on medication reviews that have been effectively undertaken in conjunction with practices and any cost savings that have been achieved.

5.2 Financial Information

- Practices signing up to this LES will receive payment per ???? bed per care home that has been allocated to the GP Practice

5.3 Read Codes

Read codes to be inserted for:

- Resident in Care Home
- Resident in Nursing Home
- Medication review and Polypharmacy medication review

5.4 Fees Payable

The rate of payment for the contractual year is set at:

5.4.1 Basic Level

5.4.2 Enhanced Level

5.4.3 Incentive

5.4 Monitoring Schedule

Appendices

Appendix A: Standard Operating Procedure

Aim: This guide aims to set out ways of working which will enhance the communication and planning involved in coordinating the healthcare of BNSSG residents in care

homes . It has been influenced by examples of good practice which some homes and GP practices have developed and aims to enable others working in this area to use their learning.

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

This guide will set out recommended patterns of practice for:

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

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

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

	ordering processes for the benefit of all parties and to reduce medicines waste	
4.	**Urgent Care**	
4.1	Care Homes should coordinate all requests for visits through the Shift NH GP Liaison Nurse on each shift.	
4.2	The 'Prompt sheet – care home request for GP visit today' should be used for residents whose health needs are changing.	
4.3	If the GP is not going to do a visit on the day requested he/she should telephone the home to agree a plan for visit and on-going management of the problem.	
5	**Advance Planning**	
5.1	Monthly Coding meetings to be held in the home.	
5.2	Discuss need for Advanced Care Plan/TEP form in line with Resuscitation council guidelines, involving resident, family or IMCA, keep form in Nursing Home, take a copy back to surgery & ensure it is scanned to the residents GP record and record it on the EPACCS system .	
5.3	If necessary GP and Nursing Home to agree meetings with resident & or family to discuss advance care plan.	
5.4	Request anticipatory medications when thought to be entering the last weeks of life.	
6	**Care of the Dying**	
6.1	GP and nurse to engage with EOL pathway for the last days of life' and all current care plans and medications reviewed.	
7	**Care After Death**	
7.1	Provide after death care for family & provide information regarding bereavement services in line with the integrated care plan.	
7.2	Nursing Home notify GP of death and GP to record death on EMIS.	
7.3	GP to provide death certificate in a timely manner, usually within 24 hours (Monday to Friday) for expected deaths.	

Recognition and Management of People with Dementia and their Family/Carers in General Practices, Primary Care Service

NHS Standard Contract Service Profile Pack (2019-2020)

This Pack contains:

1. **Service Specification:** (to be inserted Schedule 2 Part A: Contract Particulars)
2. **Schedule of Invoicing:** (to be inserted Schedule 3 Part H: Contract Particulars)
3. **Monitoring Form:** (to be inserted Schedule 3 Part A: Contract Particulars)

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1. Service Specification:

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4, Mandatory but detail for local determination and agreement
Optional headings 5 – 7, Optional to use, detail for local determination and agreement

All subheadings for local determination and agreement

Service Specification No.	**TBC**
Service	**Recognition and Management of People with Dementia and their Family/Carers in General Practices**
Commissioner Lead	**TBC, NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group**
Provider Lead	**As per provider signatory**
Period	**1st April 2019 until 31st March 2020**
Date of Review	**1st September 2019**

1. Population Needs

1.1 National/local context and evidence base

Around 10,700 people across Bristol, North Somerset and South Gloucestershire are estimated to have dementia, however currently only around 67% of them have a diagnosis.

- In Bristol, around 4,200 people are estimated to have dementia, approximately 76% of them have a diagnosis.
- In North Somerset, around 3,300 people are estimated to have dementia, approximately 64% of them have a diagnosis.
- In South Gloucestershire, around 3,200 people are estimated to have dementia, approximately 62% of them have a diagnosis.

General Practitioners (GPs) have a crucial role in ensuring that early concerns about memory problems are detected and responded to.

Following national and local awareness raising campaigns, people are encouraged to express concerns about their memory at an earlier stage to ensure people get the right support as early as possible. It is envisaged that this will increase the demand on GP practice time. It is also recognised that assessing people and making a dementia diagnosis at an earlier stage could be more challenging.

The GP practice does not only have a key role in the diagnostic process, it also has an important role in following the person with dementia and their family/carers through the different stages of their condition to ensure all the support is available for the person's ongoing management of health and well-being.

Dementia is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, conducting health checks (for the person with dementia and their family/carers), ensuring people with dementia attend screening programs, advising on preventive actions, advanced decision making and contingency planning, and signposting people to local information, advice and support services as well as end of life care.

Dementia has been an increasing priority both locally and nationally over the past few years. There is evidence to suggest that a majority of patients and carers want a diagnosis and that diagnosis improves access to support and medication where indicated, and that support for carers enables patients to stay longer in their own homes.

This Service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

It is expected that by delivering the Service, Providers will be able to deliver the following outcomes:

Domain 2 Enhancing quality of life for people with long-term conditions

- ✓ There is a culture in primary care of dementia being viewed and managed as a long term condition

Domain 3 Helping people to recover from episodes of ill-health or following injury

- ✓ There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services

Domain 4 Ensuring people have a positive experience of care

- ✓ People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia

- ✓ Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break
- ✓ BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia

Domain 5 Treating and caring for people in safe environment and protecting them from avoidable harm

- ✓ An increased number of people with dementia receive a timely diagnosis of dementia in Primary Care

3. Scope

3.1 Aims and objectives of service

The Provider will work with the Commissioner to ensure that the Service meets the following aims and objectives:

- Ensure people with dementia and their family/carers receive the highest possible level of care
- Ensure each practice has a lead GP and lead practice nurse/health practitioner for dementia
- Increase the early recognition and diagnosis of dementia in every GP practice in BNSSG
- Enable secondary care to support primary care to make a diagnosis of dementia.
- Provide a recall and comprehensive review system for people who are initiated and stabilised on Cholinesterase Inhibitors and/or Memantine in Primary Care with advice and support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North Somerset and South Gloucestershire.
- Provide a comprehensive review process for people with dementia who are on anti-psychotic medication
- Practices should aim for GPs to diagnose dementia in the majority of straightforward cases. Patients with atypical presentations such as young, rapid onset, frontal and Lewy Body patients might expect to be diagnosed by or with the support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North Somerset and South Gloucestershire.
- Provide a holistic package of care to enable more people with dementia and their carers to live fuller lives and avoid crisis admissions.
- Enhance physical care and health promotion advice for all people and carers for people with dementia, especially regarding vascular dementia

3.2 Service description/care pathway

To participate in the Service, Providers are required to carry out the following:

3.2.1 Basic Level

Evidence must be collected during the year, to fulfil the basic requirement of the monitoring form (Schedule 3). If this is not completed, the Provider will be required to return the funding to the commissioner at the end of the year. Requirements are:

1. Having a named lead GP and a named practice nurse/health care practitioner for dementia

2. Named lead GP and named practice nurse/ other health care practitioner participate in yearly dementia training, provided or endorsed by Clinical Leads for Dementia; this could be in person or online and will be a maximum of half a day
3. The named lead GP for dementia to provide a structured update session on dementia for all the other GPs and practice staff at least once a year
4. Actively participate in evaluation of the service, this may include sending out surveys to patients/families and practice staff being interviewed
5. Record carers on the carers register and signpost carers for short breaks, evidenced by at least 6 monthly meetings with the Carers Support Workers,
    - In Bristol and South Gloucestershire this is provided through the Carers Support Centre. In Bristol there is also the Bristol City Council (BCC) Integrated Carers Team.
    - In North Somerset this is provided through the North Somerset Alzheimer's Society Dementia Support Worker Service.

3.2.2 Enhanced Level

Practices must evidence their participation in the basic section, via the monitoring form (Schedule 3) to be eligible to provide the enhanced level service. Providers should use the supplied EMIS template to carry out the diagnosis and enhanced review. Providers should:

- Undertake a diagnosis of uncomplicated dementia (Alzheimer's Disease or Vascular Dementia) within a Primary Care setting and provide appropriate post diagnostic support and signposting information
- Carry out enhanced reviews of people with dementia and their family/carer (using the agreed template or equivalent) that delivers review of all medication including cholinesterase inhibitors, Memantine and anti-psychotic medication

Create Care Plans for patients with dementia that where and when appropriate contain anticipation of End of Life Care Planning needs. This would include consideration and discussion of Do Not Artificially Resuscitate orders and a discussion about Preferred Place of Care / type of care preferably avoided (such as Hospital or ITU admission) These Care Plans should be developed using the Dementia EMIS template. For patients in the palliative care phase the appropriate additional shared care template should be used. Providers will need to consider how best to manage the reviews and may wish to work together to appoint a practice nurse to carry out all the reviews across a cluster of practices.

3.2.3 Detailed Description of the Enhanced Requirement

- Adopting the care pathway including management of people stable on dementia medication
- To undertake investigations as indicated in Section 4 and investigate any abnormalities to exclude potentially treatable causes
- To undertake a diagnosis of dementia and initiate medication in line with guidance provided in Section 4
- To complete a plan (or ensure the practice dementia navigator or AWP equivalent has) for the patient that includes relevant information including where to go for further support and signposting
- To note the diagnosis of dementia, if made in secondary care or by other providers and record accordingly with relevant read code
- To review every person diagnosed with dementia at least once a year (6 monthly if on dementia related medication, 3 monthly if on anti-psychotic medication), following the review template provided in the Dementia EMIS template.

- To initiate where appropriate (with advice if needed) and continue the prescribing of Cholinesterase Inhibitors (CEIs) or Memantine. The new BNSSG prescribing guidance confirms that GPs are able to initiate and follow up all three CEI's and memantine and drugs for BPSD. This is now an expected part of this Primary Care Service – GPs may want to seek advice about the prescribing from the dementia clinical staff but GPs will do the prescribing. For the purposes of this enhanced service with the benefit of the annual educational events. GPs are considered to have this 'specialist' knowledge.
- To notify the Dementia Wellbeing Service for Bristol or AWP for North Somerset or South Gloucestershire of any adverse drug reactions, deterioration in condition or any other clinical concerns regarding the person's health that cannot be managed in Primary Care

In order to qualify for payment the Provider must complete the work detailed above.

3.3 Population covered

This service is available to anyone who has suspected or confirmed dementia and is registered on the GP register.

3.4 Any acceptance and exclusion criteria and thresholds

This service is available to anyone who has suspected or confirmed dementia and is registered on the GP register and their needs can be best met in Primary Care.

3.5 Interdependence with other services/providers

This service is closely linked with Dementia Wellbeing Service in Bristol and AWP in North Somerset and South Gloucestershire who provide services in a community setting.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The National Institute for Health and Clinical Excellence (NICE) Dementia Quality Standards provides clinicians, managers and service users with a description of what a high quality dementia care should look like. The standards describe markers of high quality, cost-effective care that, when delivered collectively should contribute to improving the effectiveness, safety, experience and care for adults with dementia and their family/carers.

https://www.nice.org.uk/guidance/ng97

4.2 Applicable local standards

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group have a referral pathways tool to provide information for General Practitioners:

http://remedy.bnssgccg.nhs.uk/adults/dementia/

The following information is available for dementia:

- ✓ Pathway for diagnosis of dementia in Primary Care
- ✓ Guidelines for diagnosing Alzheimer's Disease in Primary Care
- ✓ Guidelines for prescribing and Reviewing Donepezil and Reviewing Memantine
- ✓ Guideline for Managing Behavioral and Psychiatric Disorder in People with Dementia

5. Contract Monitoring, Reporting and Financial Information

5.1 Outcomes, monitoring and evaluation

The Provider must provide NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) with such information as may be reasonably required to demonstrate that it has robust systems in place to deliver the Service.

The service will be measured against the service outcomes as defined in Section 2, using the key performance indicators which will be captured via monitoring forms and an online survey as set out in the table below:

Technical Guidance Reference	Quality Requirement / Outcome	Method of Measurement	Frequency	Used by Commissioner to evidence
Domain 2: Enhancing quality of life for people with long-term conditions				
NHS Outcome Domain 2	There is a culture in primary care of dementia being viewed and managed as a long term condition	Online Survey	Annual	The shift in opinion of dementia
Domain 3: Helping people to recover from episodes of ill-health or following injury				
NHS Outcome Domain 3	There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services	Monitoring form	Quarterly	Effectiveness of service specification
Domain 4 Ensuring people have a positive experience of care				
NHS Outcome Domain 4	People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia.	Feedback from people with dementia who have experienced the service	Annual	To understand how people feel about the management of their dementia
NHS Outcome Domain 4	Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break	Monitoring from integrated carers team and the Carers Support Centre	Quarterly	To understand the uptake of breaks
NHS Outcome Domain 4	BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia	Training attendance records	Annual	Confirming staff up to date with relevant training
Domain 5 Treating and caring for people in safe environment and protecting them from avoidable harm				

NHS Outcome Domain 5	An increased number of people with dementia receive a timely diagnosis of dementia in Primary Care	Monitoring form	Quarterly	To ensure the service is working effectively

Providers will be required to submit quarterly monitoring forms to the Commissioner in respect of this Service (Schedule 3). Submission of reporting data will trigger the payment for this Service.

Providers will be required to provide evidence of the basic requirements and the specific numbers of people supported under the Enhanced Level part of the agreement. Providers will be supplied with an EMIS template that will guide them through the review process. A random sample of review templates will be scrutinised annually.

Practice registers will be monitored in order to triangulate the payment process and to ensure appropriate payment of the incentive part.

An online survey will be sent out to gain feedback on the service to inform the following year.

5.2 Financial Information

Evidence must be collected during the year, to fulfil the basic requirement of the monitoring form. If this is not completed, the practice will be required to return the funding to the commissioner at the end of the year. Forms should be completed quarterly and submitted as per the schedule outlined in schedule 3 of the contract.

5.3 Read Codes

Read codes should be used for reporting, suggested read codes for the identification of people with dementia are the following:

"Alzheimer's disease unspecified"	Eu00z
"Multi-infarct dem'"	Eu011
"Alzheim' disease“	F110
"Lewy body dementia”	F116

5.4 Fees Payable

Payment arrangements to be confirmed.

5.5 Monitoring Schedule

Reporting is required on a quarterly basis. Information should be provided to PCS Returns on by the following: [insert BNSSG email address]

Quarter 2019/20	Deadline for submissions	Payment Date
Q1 April – June 2019		
Q2 July – Sept 2019		
Q3 Oct – Dec 2019		
Q4 Jan – March 2020		

1. Schedule of Invoicing:

NB: Submission should be within 7 working days of the month, as payment is based on the previous quarter:

Primary Care Service Name: **Recognition and Management of People with Dementia and their Family/Carers in General Practice**		
Service Specification number: **TBC**		
2019-2020	**Monitoring Form**	**Online Survey**
April		
May		
June		
July	✓	
August		
September		
October	✓	
November		
December		
January	✓	
February		
March		
April	✓	✓

2. Monitoring Form:

General Practice Dementia Care Service Specification 2019-2020

Quarter for Return	
Name of Person completing this form	
Practice name	
Practice code	**XX**

Month	1. Number of people with dementia diagnosed in primary care and not referred to other provider at all. (PCS claim)	2. Number of people with dementia NOT diagnosed by GP and referred to other provider for assessment and diagnosis (no PCS claim)	3. Number of people diagnosed with dementia in primary care and referred to other provider for ongoing support and/or advice (PCS claim)	4. Number of people reviewed in primary care using the enhanced review template
April				
May				
June				
July				
August				
September				
October				
November				
December				
January				
February				
March				
Total				

Month	Total number of people on the Dementia QoF disease register
April	
May	
June	
July	
August	
September	
October	
November	
December	
January	
February	
March	

Please return an electronic completed copy of this monitoring form to [insert BNSSG email address]
Payment is made quarterly upon receipt of the monitoring form
If you have any queries about this monitoring form please email [insert BNSSG email address]

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	
Service	Type 2 Diabetes Insulin Start LES
Commissioner Lead	
Provider Lead	
Period	2019/2020
Date of Review	September 2018

1. Population Needs

1.1 National/local context and evidence base

Type 2 diabetes is a chronic metabolic condition characterised by insulin resistance (that is, the body's inability to effectively use insulin) and insufficient pancreatic insulin production, resulting in high blood glucose levels (hyperglycaemia). Type 2 diabetes is commonly associated with obesity, physical inactivity, raised blood pressure, disturbed blood lipid levels and a tendency to develop thrombosis, and therefore is recognised to have an increased cardiovascular risk. It is associated with long-term microvascular and macrovascular complications, together with reduced quality of life and life expectancy.

This service should help to improve the quality of life for patients with Type 2 Diabetes Mellitus, improve the patient's understanding of his or her condition and reduce referrals to secondary care which will make the service more local and accessible to patients.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Diabetes Insulin initiation occupies an important place in the management of type 2 diabetes . The National Diabetes Audit has shown BNSSG as outliers for 'diabetes treated to target'. Skilled clinicians are required in general practice for recognising insulin as the clear next step and initiating it with confidence as part of normal work.

This enhanced service specification outlines the process for undertaking treatment initiations in primary care, reducing the need for patient referral to secondary care. It will necessitate additional training for some practice clinicians and as such, will help improve the general management of patients with type 2 diabetes.

This locally enhanced service is an example of integrated primary and community care, with simplified access points for patients to specialised services. It is the expectation of the CCG that practices will contract for locality working based on the consultation outputs of an alliance contracting model for the delivery of Improved access.

3. Scope

3.1 Aims and objectives of service

Aims:

To provide an insulin initiation service for patients with type 2 diabetes which is convenient to the patient and provides safe, high quality, evidence based effective care.

The service detailed in this service specification must have a designated lead within the practice/locality. In usual circumstances routine insulin initiation

and other non insulin injectable diabetes treatment initiation must be provided by the practice and its employed clinical staff and not by community or specialist nurses.

Objectives:

- To improve the quality of care provided in the community to patients with type 2 diabetes by making the service more accessible and responsive. .This is facilitated by the shift from secondary to primary care and removing the need for patients to travel to acute trusts to undergo Insulin Initiation
- This enhanced service will fund practices to identify and initiate patients suitable for Insulin initiation, (Hba1c> 57)
- Provide patients with education around lifestyle and self titration of insulin doses, which in turn will promote the self care agenda as vital in the management of long term conditions such as diabetes
- The frequency of appointments is agreed on an individual basis with the patient.
- To reduce HbA1c to agreed individualised targets
- To reduce the long term complications of diabetes
- To reduce non-elective hospital admissions in patients with diabetes.
- To work towards NHS BNSSG CCG's objectives of delivering care closer to home
- Improve outcomes for patients by optimising glycaemic control
- Facilitate intensification of therapy in primary care, when this requires parenteral therapy
- Improve adherence to the latest NICE guidance
- Deliver safe, effective, and sustainable treatment
- Evaluation the quality of care for patients with diabetes through regular audit process

3.2 Service description/care pathway

The insulins prescribed as part of this LES should be in line with the BNSSG Joint Formulary. Prescribers are also expected to follow the BNSSG guidelines for the prescribing of ancilliary devices for blood glucose monitoring.

The patient outcomes requiring monitoring as part of this LES are:

- Identification of patients who need intensification of their drug therapy for diabetes

- Have a designated diabetes lead within the practice.Intensify drug therapy in line with BNSSG formulary
- Optimise glycaemic control
- Frequency of episodes of hypoglycaemia including emergency admission
- Ensure a patient centred approach to the initiation of insulin therapy which empowers the person with type 2 diabetes to be actively involved in their treatment
- Ensure that cost-effective consumables are supplied to patients
- Patients initiated on insulin therapy are coded on the EmisWeb prescribing system with “66AH0 – conversion to insulin”
- Provide safe, high quality, evidence based effective care

When starting insulin therapy in adults with type 2 diabetes, primary care should offer to refer patients to a structured education programme, and provide 1 on 1 support to patients, employing active insulin dose titration that encompasses:

- injection technique, including rotating injection sites and avoiding repeated injections at the same point within sites
- continuing telephone and/or face to face support
- self-monitoring
- dose titration to target levels
- dietary understanding
- DVLA guidance (At a glance guide to the current medical standards of fitness to drive)
- Risks/causes and management of hypoglycaemia
- management of acute changes in glucose control
- support from an appropriately trained and experienced healthcare professional.

By agreeing to participate in this LES the practice will also be required to provide the following information:

- Share information with BNSSG CCG about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG CCG online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/
- Agree to extraction of data to monitor the number of insulin initiations in patients with type 2 diabetes via EMIS Search and Report

- Agree to the extraction of data to monitor the below outcome measures;

Diabetes Clinical and Social Outcome Measures
LTC 3 - Potential Years of Life Lost (PYLL) in people with diabetes
LTC14 Smoking in people with diabetes
LTC15 Obesity in people with diabetes
LTC16 Episodes of ill health requiring emergency admission in people with diabetes
LTC17 Days disrupted by care in people with diabetes
LTC19 Acute symptoms related to diabetes control
LTC23 Acute Kidney Injury (AKI) in people with diabetes
LTC53 Lower limb amputation in people with diabetes
LTC54 End-Stage Renal Failure (ESRF) in people with diabetes
LTC55 Blindness in people with diabetes
LTC57 Age at onset of first stroke in people with diabetes
LC58 Age at onset of first MI in people with diabetes

Initial Training: To ensure staff have the appropriate skills to deliver this Enhanced Service and are familiar with current treatments, the following pre-requisites for training apply to this LES:

- Practice Nurses/Clinical Pharmacists- completion of a diabetes diploma, is advised before attending the 3 day locally run insulin initiation training facilitated by the Community Diabetes specialist team, or evidence of further training in diabetes if from outside of area. During 2019 clinicians will be directed to complete 'Care of the adult with diabetes' module available from the University of the West of England (UWE). https://courses.uwe.ac.uk/UZTR3Q203/care-of-the-adult-with-diabetes

- GPs- At least one GP from each locality (who will clinically support the initiating clinician) to attend a 2 day insulin initiation and diabetes management course, or have evidence of attending an equivalent course in the last 2 years.

Assessment of Competency: All practititioners undertaking initiation of insulin shall have up to 10 supervised initiations assessed by the Community Diabetes Nurse Specialist and will be advised when they are deemed competent to initiate without supervision. The Practice will not be eligible for payment until competency has been assessed and confirmed.

3.3 Population covered

This service is for all patients registered with a GP in BNSSG.

3.4 Any acceptance and exclusion criteria and thresholds

The following exclusions will apply:

- Patients under the age of 16
- Patients with Type 1 Diabetes
- Patients with CKD 4 or worse (consultation with diabetes specialist and or renal team required)
- Patients with Gestational diabetes
- Patients with complex complications (unless agreed with secondary care there is appropriate communication mechanisms in place between primary and secondary care)
- Patients who have previously been initiated on insulin

3.5 Interdependence with other services/providers

Community based diabetes specialist services who deliver training and support for clincians to be able to sign up to this LES. If practices do not sign up there will be an expectation for this service to be delivered by the locality in order to meet the needs of the population.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The following guidance from NICE:

Type 2 diabetes in adults: management. NICE Guideline 28 (December 2015)
http://www.nice.org.uk/guidance/ng28

NICE Diabetes quality standards:
http://publications.nice.org.uk/diabetes-in-adults-quality-standard-qs6/list-of-statements

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- https://learning.bmj.com/learning/module-intro/insulin-diabetes-primary-care.html?locale=en_GB&moduleId=10053288

- https://www.rcn.org.uk/clinical-topics/diabetes/professional-resources
  Starting injectable treatment in adults with Type 2 diabetes (2013

4.3 Applicable local standards

- The Bristol, North Somerset, & South Gloucestershire (BNSSG) Joint Formulary https://www.bnssgformulary.nhs.uk/
- BNSSG Type 1 diabetic blood glucose monitoring guidance https://www.bnssgformulary.nhs.uk/6-Endocrine-system-Guidelines/
- BNSSG Type 2 diabetic blood glucose monitoring https://www.bnssgformulary.nhs.uk/6-Endocrine-system-Guidelines/

  The Community Diabetic Nurse Specialist is to be consulted if there are any doubts about the appropriateness of commencing a patient on insulin

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

A. Local Prices

What will be Paid For?

Practices will receive one payment for each patient initiated onto insulin therapy.

How will Payments be Made and Calculated

The total number of patients initiated onto insulin therapy each quarter will be multiplied by the appropriate level of payment .

From 1st April 2019 payment will be transferred to practices on a quarterly basis.

How Will Activity Data be Obtained?
BNSSG CCG will obtain information on the number of patients being initiated onto insulin therapy under this LES using Emis Search and Report.

A. Expected Annual Contract Values

This will vary as per payment schedule set out in schedule 3A

B. Notices to Aggregate / Disaggregate Payments

As detailed in Schedule 3A

C. Timing and Amounts of Payments in First and/or Final Contract Year

As detailed in Schedule 3A

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

B. National Quality Requirements

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

C. Local Quality Requirements

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

D. Never Events

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

E. Commissioning for Quality and Innovation (CQUIN)

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

F. Local Incentive Scheme

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

G. Clostridium difficile

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

H. CQUIN Variations

There are no specific requirements relating to this contract beyond those already in place for providers delivering general or personal medical services and those detailed in Section 2 - The Service Specification.

SCHEDULE 5 - GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Nothing required beyond any documents specified in Section 2 – The Service Specification.

Documents supplied by Commissioners

Nothing required beyond any documents specified in Section 2 – The Service Specification.

B1. Provider's Mandatory Material Sub-Contracts

Provision of these services is not to be subcontracted without prior written consent from the commissioning party.

B2. Provider's Permitted Material Sub-Contracts

Provision of these services is not to be subcontracted without prior written consent from the commissioning party.

C. IPR

Commissioner IPR

Licensing of any IPR would be subject to a review on a case by case basis to ensure compliance with Department of Health guidance and codes of practice.

Where information shared between parties is commercial in confidence it will be respected and treated as such by the other party.

Provider IPR

Licensing of any IPR would be subject to a review on a case by case basis to ensure compliance with Department of Health guidance and codes of practice.

Where information shared between parties is commercial in confidence it will be respected and treated as such by the other party.

A. Commissioner Roles and Responsibilities

As detailed in Section 2 – The Service Specification.

B. Partnership Agreements

The provider may not partner with another organisation to deliver this service without prior written consent from the commissioning party.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Recorded Variations

N/A This is the first issue of this contract.

B. Reporting Requirements

BNSSG CCG will obtain information on the number of patients being monitored under this LES using Emis Search and Report.

By agreeing to participate in this LES the practice will also be required to provide the following information:

- Assurance that a robust re-call system is in place to ensure recall of patients for the necessary monitoring
- Assurance that there is a process to identify and manage patients not engaging with the necessary monitoring including cessation of prescriptions supply.
- During quarter two submit a review of practice monitoring activity as per the provided template
- The practices current standard operating procedure for the above activities as part of the review of practice monitoring activity

- Share information with BNSSG CCG about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG CCG online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/
- Number of patients monitored each quarter as part of this LES if Emis Search and Report becomes unavailable.

C. Data Quality Improvement Plan

Not Applicable

D. Incidents Requiring Reporting Procedure

Share information with BNSSG CCG about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of the clinician being made aware on the incident and should be shared using the BNSSG CCG online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/

E. Service Development and Improvement Plan

Not specifically required under this contract.

F. Surveys

No requirement beyond those already in place under GMS, PMS or APMS contract and any requirements set out in Section 2 – The Service Specification.

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Bristol, North Somerset and South Gloucestershire Deep Vein Thrombosis (DVT) pathway

Service Specification

Service Specification No.	
Service	**DVT pathway for patients presenting in general practice**
Commissioner Lead	**Andy Newton, Head of Planned Care** **Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group**
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context

1.1.1 This specification sets out a model for a service for initial assessment of people presenting at their GP practice with a suspected DVT, direct access to ultra sound scan where indicated and initiation of treatment for those with a positive DVT by clinicians with specialist knowledge for patients registered with a Bristol, North Somerset, South Gloucestershire (BNSSG) GP practice or classified as a temporary resident.

1.1.2 This specification is designed to cover the clinical care of the patient.

1.1.3 Deep venous thrombosis is the formation of a blood clot in a vein that is deep inside a part of the body, usually the legs. DVT mainly affects the large veins in the lower leg and thigh. The clot can block blood flow and cause swelling and pain. If the clot dislodges and travels in the blood to the pulmonary arteries this can result in a potentially fatal pulmonary embolism.

1.1.4 National DVT data suggests an incidence of 1:1,000 per annum. Whilst accurate figures for numbers of suspected DVTs presenting in primary care are difficult to find, studies of referral of swollen legs/suspected DVT have shown conversion rates from suspicion to proven to be between 33% and 50%, highlighting the high proportion of suspected cases which result in an alternative diagnosis.

1.1.5 None of the clinical features of DVT are sufficiently specific to allow definite diagnosis of the condition. Patients presenting with a painful swollen limb that after clinical assessment is suspected to be a DVT need to have the possibility of a DVT confirmed or excluded before further investigations as to the cause can take place.

1.1.6 Diagnostic tests (i.e. ultrasound scans) will be undertaken as direct access in this pathway.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

It is expected that by delivering the service, providers will be able to deliver the following outcomes:

- To ensure patients are clinically assessed appropriately by their GP and suitable patients are referred for a direct assess scan as per NICE guidance.
- To enable patients with low risk for DVT to have DVT ruled out at their GP surgery
- To ensure clear communication between the patient and the clinician in relation to DVT care
- To provide a positive experience for patients presenting at their GP practice with a suspected DVT
- Provision of an integrated service which ensures fast access to all necessary tests and expertise, minimising the number of hand offs between clinical teams.
- To provide care according to NICE recommended pathways
- To provide consistent care and best practice across BNSSG for patients who are diagnosed with a DVT
- To provide a quality service that is cost effective

3. Scope

3.1 Aims of the service:

The aim is to establish a Bristol, North Somerset and South Gloucestershire (BNSSG) DVT pathway for adults presenting in general practice with a suspected DVT.

The objectives are to:

- improve patient care and experience by minimising the number of hand offs between clinical teams, to direct access scans
- reduce unnecessary referrals, investigations and treatment
- reduce variation in DVT assessment and management across BNSSG and provide a consistent approach
- provide a quality service that is cost effective
- support primary care through the use of a fast and easy to use electronic referral mechanism for requesting urgent scans, and for electronic reporting of scan outcomes integrated into the GP clinical system
- provide ultrasound and outpatient services at a minimum of 3 locations, using locations which minimise travel times for patients from across Bristol, North Somerset and South Gloucestershire

- **3.2 Service outline**

The BNSSG DVT service will provide initial assessment at the patients GP practice with the use of d-dimer testing to support exclusion of individuals unlikely to have a DVT. Where a DVT is likely patients will be referred for a direct access ultrasound scan. For patients who are confirmed as having a positive DVT they will be managed by a clinician with specialist knowledge in an outpatient DVT service where appropriate treatment will be commenced. For individuals who have an unprovoked DVT further investigations will be undertaken by the specialist clinician as appropriate (including cancer screening) and results followed up by the specialist, plus follow up appointments as required. Patients who have a negative DVT diagnosis following ultrasound scan will be followed up by their GP practice.

3.2.1 The pathway is as follows:

Phase 1 – Initial assessment – in patients GP practice

Assessment of general medical history and a physical examination of patients to exclude other causes. If DVT is suspected, use of the two-level DVT Wells score to estimate the clinical probability of DVT.

- In the event of a high two-level Wells score (2 or more), the GP practice will refer the patient for direct access ultrasound scan in order to confirm or exclude a DVT diagnosis (no d-dimer test necessary).
- Where the two-level Wells score indicates (0 or 1), the GP practice will do a d-dimer test to inform whether or not referral to ultrasound scan is indicated.
- Clinical judgement plays a key part in patient assessment and any patient can be referred direct for ultrasound scan when deemed clinically appropriate.

The GP practice can either:

- Perform a point of care d-dimer test using kits from practice stock, noting the small possibility of a ‘false negative’ result, estimated to be roughly 2% based on local

experience.

Or

- Undertake a d-dimer test by drawing venous blood and sending this to the laboratory for assay, noting the small possibility of a 'false negative' result suggested to be less than 1%. The GP practice will be responsible for reviewing and informing the patient of the d-dimer results as well as anticoagulating the patient until the d-dimer result is available and a GP can act on the result.

D-dimers should not be performed in:

- pregnant women
- individuals who are post-operative
- individuals that have been symptomatic for 2 or more weeks
- individuals already taking anticoagulation treatment

Anticoagulation with oral NOAC/DOAC treatment (e.g. Rivaroxaban or Apixaban) or parenteral treatment (e.g. Enoxaparin) or standby scripts will be provided by the GP practice for patients and continue:

- until the venous d-dimer result is available, and a clinician is able to act on that result

and

- while awaiting the ultrasound scan if it is not available within 4 hours of referral

Any prescriptions for anticoagulation should be kept to the minimum number of days required to cover until the patient has their ultrasound scan (e.g. 2 days in the week and 3 days over a weekend).

The BNSSG Health Community currently uses the ICE (Integrated Clinical Environment) system for the majority of diagnostic requests. This system provides fast and easy access for the GP as part of the consultation. As the system is used for most other requests, the requesting of scans in this way minimises additional steps and knowledge for the referrer and no additional referral information is required. Urgent requests are immediately identified by the scan provider, and the outcome of the scan is communicated back to the practice and directly into EMIS automatically using this system. The Provider must use ICE or a system with the demonstrably equivalent level of local functionality and integration.

Referral to direct access ultrasound scans will identify the need for an urgent scan. The referral information will include an up to date patient phone number to enable the patient to be contacted to arrange the scan appointment. Patients will be given information by their general practice confirming where the scan will be provided, who will contact them to inform them about the scan appointment and who they can contact for scan information.

General practice will complete the EMIS DVT template to record each patient contact to enable payment for the d-dimers and audit of this service.

The Out of Hours service will follow the same pathway and the process for referral to direct access scans will be agreed with the specialist provider.

Phase 2 – Ultrasound scan provision
Patients will be scanned the same day and within 4 hours where possible. Scans will be provided at least six days a week excluding bank holidays.

The scan provider will be alerted to the electronic referral, and contact the patient by phone within 2 hours of receiving the urgent referral within working hours or by 10am the next working day to confirm the scan appointment time.

If the scan provider is unable to contact the patient (having tried 2/3 times over a 2 hour period) they will inform the GP practice by phone.

Primary care will give patients the scan provider contact number and recommend they contact the provider if they have not heard from them within 4 hours of referral within working hours or by 11am the next working day.

If a patient phones the scan provider and the provider has no record of the GP urgent scan request the provider will ask the patient to contact their own GP to re-refer.

If patients do not attend their scanning appointment, the provider will phone the patient to try and rebook them and if they are unable to contact the patient they will phone the GP practice the same day to inform them that the patient has not attended.

The ultra-sonographer will provide full leg scans, upper limb scanning and scans for pregnant and breast feeding women.

Following the scan the ultra-sonographer immediately tells the patient the scan result and documents the scan outcome to inform the GP. The outcome information will be returned electronically to the GP via a system which automatically updates the EMIS patient record (e.g. this is currently undertaken on ICE for the majority of diagnostic tests in BNSSG).

If the ultrasound confirms a positive DVT then proceed to Phase 3.

If the ultrasound results are negative the patient will be reminded by the ultra-sonographer to contact their GP practice for further investigations/care as appropriate and to stop their anticoagulation if they were put on a prophylactic dose pre scan.

If the ultrasound results are inconclusive or the ultra-sonographer has concerns about the scan they will immediately (and on the same day) refer the patient onto the outpatient DVT service for a clinical management decision and consultant haematology support if required (available on the same day).

If incidental findings are seen on the ultrasound the scan provider will contact the GP practice by phone to inform them and complete the scan outcome document.

Phase 3 – Initiation of treatment – outpatient DVT service
Patients who have a positive DVT diagnosis following their ultrasound scan will be immediately (and on the same day) referred onto the outpatient DVT service provided 6 days a week, excluding bank holidays, to commence appropriate treatment. For individuals who have an unprovoked DVT further investigations will be undertaken by the outpatient DVT service (including cancer screening, access to X-Ray and Haematology expertise as required), results followed up by the clinical specialists plus follow up appointments as required.

Up to two follow ups will be arranged as required prior to referring the patient back to their GP (these could be telephone or face to face follow ups).

Warfarin management - Patients who require warfarin for the management of their DVT may require additional follow ups to achieve therapeutic International Normalised Ratio (INR) before referral back to primary care.

The outpatient DVT service will provide medication for the first 28 days of treatment.

The specialist clinicians will complete the DVT management plan template for the GP confirming the diagnosis, treatment including length of treatment, any further investigations done and results of these tests and the future plan.

3.2.2 Pathway activity

Estimated provider activity for 2017/18, these numbers are approximate.

Phase	GP Care	UH Bristol	Weston	BNSSG total
Phase 1 Initial assessment	1755			
Phase 2 Ultra sound scan	1488	1325	690	3,503
Phase 3 Initiation of treatment	233	378	103	714

3.2.3 Service budget

Phase 1 – Initial assessment

Payment to general practice for each d-dimer will be £30 plus a payment of £10 for each point of care testing kit used.

Phase 2 – Ultrasound scan

Payment to scan provider for scans at national radiology ultrasound scan tariff of £65

Phase 3 – Management of positive DVTs

For patients diagnosed with a DVT, use of the general medical new patient outpatient tariff at £190 which includes acute medication for the full course of treatment or 28 days' supply of medication

Follow ups at the general medicine tariff of £95 each follow up appointment
Non face to face/telephone follow ups of £65 (general medicine tariff of £95 minus £30)

3.2.4 Inclusion criteria

Any patient or temporary residents registered with a GP in Bristol, North Somerset or South Gloucestershire.

Pregnant women will also be referred for a direct access scan but will be anti-coagulated with parenteral treatment (e.g. Enoxaparin) while awaiting the ultrasound scan if it is not available within 4 hours of referral.

3.2.5 Exclusion criteria

Patients presenting with the following exclusion criteria should be referred immediately to secondary care as they are currently:

- Primary diagnosis of pulmonary embolism
- Patients under 18 years of age
- Housebound patients with significant manual handling implications e.g. requiring hoisting. The provider will need to ensure that the needs of eligible housebound patients are taken into account within the specified timescales. If housebound patients require scanning transport should be arranged for them by the current process.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The applicable national standards are as follows:

- Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (2012 updated 2015) NICE guideline CG144
- Rivaroxaban for the treatment of deep vein thrombosis and prevention of recurrent deep vein thrombosis and pulmonary embolism (2012) NICE technology appraisal guidance 261
- Apixaban for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism (2015) NICE technology appraisal guidance 341

4.2 Applicable Local Standards

Standard	KPI	Target
Patient Safety	Patients scanned within 24 hours of urgent referral	90%
	Patients waiting longer than 4 hours for a scan from the time of referral commenced on NOAC/DOAC/parenteral treatment (e.g. Enoxaparin) by primary care.	100%
	Patients meeting exclusion criteria referred immediately to secondary care (within 4 hours)	100%
	DVT management plan template completed by specialist clinician for GPs confirming the diagnosis, treatment including length of treatment, any further investigations done and results of these tests and the future plan for all patients with a positive DVT.	100%
Clinical Effectiveness	Scans performed within 48 hours of urgent request (excluding BH)	100%
	Evidence of d-dimer test by primary care where wells test score is 1 or 0	100%
Patient Experience	Scans performed within 48 hours of urgent request (excluding BH)	100%
	Did not attend rate – percentage of patients who did not attend for ultrasound scan	=<5%

4.3 Supervision, Training & Education

All providers delivering this service are responsible for ensuring that their staff are adequately trained and competent to deliver the service safely for patients.

5. Contract Monitoring, Reporting and Financial Information

5.1 Outcomes, contract monitoring and evaluation

General practice (in hours) will record:

- Each episode of care on the EMIS DVT template on the practice system, which will enable audit and evaluation to determine the effectiveness of the service.
- The relevant EMIS Code to enable payment to the practice for each d-dimer test done.

General practice out of hours will record:

- Each episode of care to enable audit and evaluation to determine the effectiveness of the service

Scan provider will record:

- Number of urgent scan referrals
- Scan outcomes
- Numbers/percentage of patients who did not attend for their ultrasound scan

Outpatient DVT service will record:

- Treatment initiation

- Screening for unprovoked DVTs as appropriate including cancer screening
- Management plan on template for primary care

The objectives of the evaluation are:

1. To understand if the BNSSG DVT pathway is safe
2. To understand patients' experiences of the DVT pathway
3. To understand the effectiveness of the DVT pathway

In addition to the above the evaluation also needs to:

4. To understand the activity in each phase of the pathway
    a) Phase 1 - initial assessment
    b) Phase 2 – ultrasound scan
    c) Phase 3 – management of positive DVT
5. To understand how much the DVT integrated pathway costs

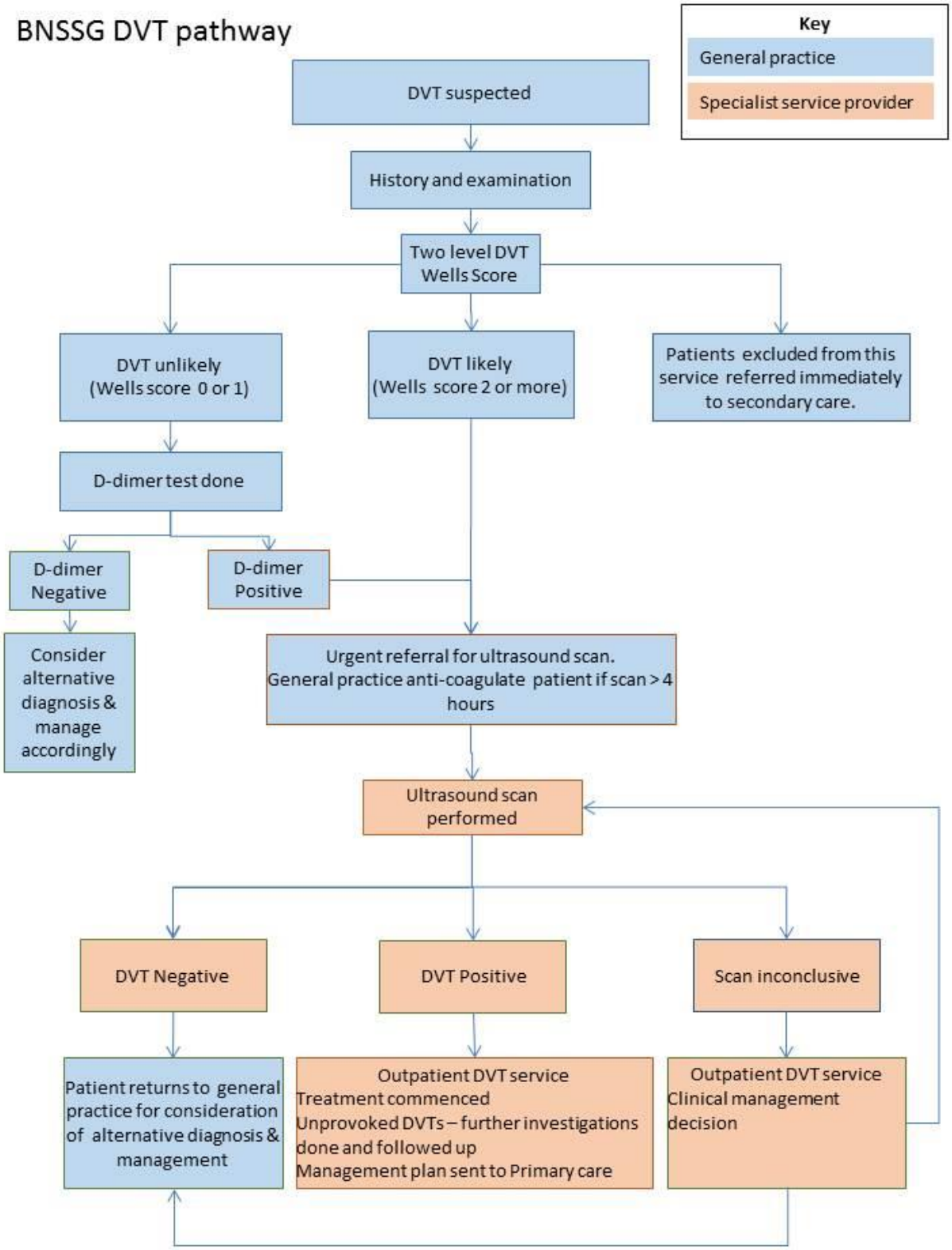
5.2 Financial information

The service budget has been proposed using 2017/18 service numbers.

See Service budget 3.2.3 for finance details

6. Appendices

6.1 Appendix 1 - BNSSG integrated DVT pathway flow chart



6.2 Appendix 2 – Two level DVT Wells score

Two-level DVT Wells score

Clinical feature	Points	Patient score
Active cancer (treatment ongoing, within 6 months, or palliative)	1	
Paralysis, paresis or recent plaster immobilisation of the lower extremities	1	
Recently bedridden for 3 days or more or major surgery within 12 weeks requiring general or regional anaesthesia	1	
Localised tenderness along the distribution of the deep venous system	1	
Entire leg swollen	1	
Calf swelling at least 3 cm larger than asymptomatic side	1	
Pitting oedema confined to the symptomatic leg	1	
Collateral superficial veins (non-varicose)	1	
Previously documented DVT	1	
An alternative diagnosis is at least as likely as DVT	−2	
Clinical probability simplified score		
DVT *likely*	2 points or more	
DVT *unlikely*	1 point or less	

Adapted with permission from:

- Wells PS et al. (2003) Evaluation of D-dimer in the diagnosis of suspected deep-vein thrombosis.

Date	Version	Author	Comments
3.4.18	V0.1	Becca Robinson	Draft BNSSG integrated DVT pathway developed in collaboration with Andy Newton, Pippa Stables.
5.4.18	V0.2	Becca Robinson	Updated following meeting with Andy Newton
9.4.18	V0.3	Becca Robinson	Updated following comments from Andy Newton

10.4.18	V0.4	Becca Robinson	Updated following meeting with Kate Davies, CCG Medicines Management
16.4.18	V0.5	Becca Robinson	Further review and update of service specification
19.4.18	V0.6	Becca Robinson	Updated following comments from Debbie Campbell, CCG medicines management
19.4.18	V0.7	Becca Robinson	Updated following meeting with Pippa Stables, clinical lead
21.5.18	V0.8	Becca Robinson	Following feedback from primary and secondary care
24.5.18	V0.9	Becca Robinson	Following feedback from Andy Newton
31.5.18	V0.10	Becca Robinson	Following CCG project meeting with Andy Newton and Pippa Stables
7.6.18	V0.11	Becca Robinson	Updates following DVT Implementation Group Meeting
14.6.18	V0.12	Becca Robinson	Updated following meeting with Mike Pingstone from CSU Procurement department
14.6.18	V0.13	Becca Robinson	Updated following discussion with Andy Newton
18.6.18	V0.14	Andy Newton	Updated following discussion with Mike Pingstone
25.6.18	V0.15	Becca Robinson	Updated following discussion with Andy Newton
16.8.18	V1.0	Becca Robinson	Small amends following feedback from Commissioning Executive Team meeting on 9.8.18
22.8.18	V1.1	Becca Robinson	Updated activity data with 2017/18 numbers

Project Highlight Report

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care

Approach to commissioning Local Enhanced Services (LES) across BNSSG

Overall Summary			
Report Date	21.11.18		
Project Name	Approach to commissioning Local Enhanced Services (LES) across BNSSG		
Report Author	Jenny Bowker – Head of Primary Care Development Heather Allward – Programme Officer		
Start Date	April 2018	End Date	April 2019
Overall Project Status	On target	Previous Project Status	On target
Explanation of Project Status	Work is underway to prepare for new specifications and we are currently projected to be on target for 1st April 2019 completion date. We have refreshed our timescales to work towards 3rd January 2019 PCCC meeting to approve the final set of specifications.		
Achievements for Current Period	• Membership engagement on draft service specifications for Care Homes (revised version), Dementia and Diabetes took place in November. • An FAQ document has been developed for practices to answer common queries across BNSSG and to support November membership meetings. • LMC board members have reviewed and commented on first set of specifications. Process agreed with LMC for review of next specifications. A meeting has been established for 4th December for a clinical discussion about the specifications between the LMC and the CCG. • Draft service specification for Dementia and Diabetes presented to PCCC for discussion and to highlight feedback received through engagement with membership. • Work is in progress to complete financial modelling of recommendations for the CCG and for the impact at practice level.		

Tasks and Milestones

- Contracting model to support locality delivery of enhanced services for April 2019 to be developed and recommended to Primary Care Operational Group (PCOG) then PCCC on 3rd January.
- Final specifications for 19/20 for all services to be approved at PCCC on 3rd January following review at PCOG.

Contracting timeframes for 19/20 LES':

- Final service specifications to be sent to practices by the end of January 2019
- EOIs sent out 1st February, due 28th February
- Contracts built between 1st-22nd March
- Practices to sign and return contracts week commencing 25 March ready for 1st April 2019.

Near Patient Testing (NPT), Anticoagulation, Supplementary Services

- Draft aligned specifications and tariff approved for membership engagement by PCCC on 25.09.18.
- Notice has been served to North Somerset and South Gloucestershire practices for Supplementary Services and in Bristol the contract expires at the end of the current financial year.
- Membership engagement on draft service specifications for NPT, Anticoagulation and Supplementary Services took place in October.
- EIA/QIA/PPI screening for NPT, Anticoagulation and Supplementary Services has been completed and is being reviewed by the CCG leads for these areas.

Dementia

- Draft BNSSG Dementia service specification to be discussed at November PCCC.
- Membership engagement on draft service specification took place in November and is proposed to continue in December.
- EIA/QIA/PPI screening to be completed by 30th November.

DVT

- Service specification and procurement approach approved on 04.09, contract anticipated to be awarded in December 2018.
- DVT service specification for the LES element of the pathway to be shared with the committee at November PCCC. There has already been significant membership engagement for DVT LES.
- Tariffs for this have already been developed over the past year.

Diabetes

- Draft service specification reviewed at Diabetes Programme Board on 25.10.18.
- Draft service specification for diabetes to be shared at November PCCC.
- Membership engagement on draft service specification took place in November and is proposed to continue in December.
- EIA/QIA/PPI screening to be completed by 30th November.

Minor Injuries

- Activity data for the previous year has now been obtained.
- Progress report to be shared with PCCC in closed session in November with recommendations for next steps to be shared with PCCC in open session in the new year.

Care Homes with and without nursing

- Draft service specification approved for further engagement by PCCC in October.
- Membership engagement on draft service specification took place in October and a revised version has been shared with the membership in November.
- Draft service specification to be discussed at STP integrated care steering group on 21.11.18.
- EIA/QIA/PPI screening to be completed by 30th November.

South Gloucestershire Basket

- Desktop review to be completed and shared with PCCC on January 3rd.

Locality Transformation Scheme (LTS) Phase 3

The LTS Phase 3 paper to PCCC in September set out next steps for developing and strengthening integrated community localities and this is overseen by the STP integrated care steering group.

As set out in the paper shared with PCCC in September, a series of system wide design events is being planned, the first of which is a Frailty event taking place in December.

Risks

	Mitigation
Practice uncertainty about the future of their income streams and engagement in the review	• Finance impact assessment to be undertaken at practice level. • Ongoing communication to membership meetings about outcome of the review and development of new offer for 1st April 2019. • Practices have received confirmation of the position for local enhanced services for the current financial year. • Final agreement of specifications and tariff at PCCC on 3rd January to allow time for practices to plan for the new financial year.
Locality model not ready to take on at scale provision	• Agree framework and steps with Locality Providers to be ready to provide locality solutions • Paper on LTS phase 3 presented in September set out next steps for developing and strengthening integrated community localities and is overseen by the STP integrated care steering group. • LMC is able to provide advice to locality

	provider vehicles on developing indemnity agreements to support staff working across practices. • A paper outlining the proposed approach to support commissioning of locality delivery of improved access was presented to PCCC in October and is now being discussed with Locality Provider groups throughout November. • Proposals for the approach to Diabetes will need to be considered at PCCC in November. Proposal is now to offer the Diabetes LES as either a practice or locality commissioned service from April 2019, with a view to it becoming a locality commissioned service from April 2020.
LES review proposals pose a financial risk either to the CCG or to individual practices	• Financial modelling to support individual enhanced service specifications will be undertaken, however, no final decisions will be made until we can cost the combined implications for the suite of new specifications – both for the CCG and for individual practices

Issues

- Financial modelling of new services is dependent on the development of service specifications for 2019/20 and these are being developed between September and December.

Appendix C

Options Appraisal Anticoagulation Monitoring and Dosing

1. Purpose

To consider the options for anticoagulation monitoring and dosing across BNSSG further to the discussion held at the 25th September Primary Care Commissioning Committee meeting about the draft specification for Anticoagulation and the complexities within the current pathways.

2. Proposals for consideration

The following options have been put forward for consideration

Option 1. Weston and Worle and Woodspring localities being offered an advanced service (using a coaguchek to monitor INR then dosing using INR star) and South Gloucestershire and the Bristol localities being offered a basic service (taking venous blood samples for INR to be checked in secondary care and then a secondary care clinic dosing) apart from the practices that are already offering an advanced service (status quo)

Option 2. Offer an advanced level service to all practices/localities (using a coaguchek to monitor INR then dosing using INR star) across BNSSG

Option 3. Offer a basic level service (taking venous blood samples for INR to be checked in secondary care and then a secondary care clinic dosing) across BNSSG.

3. Background

Vitamin K antagonists (warfarin, phenindione and acenocoumarol) have a valuable role in blood clot and stroke prevention. Regular monitoring of INR (International Normalised Ratio) is required to prevent adverse effects.
There are currently two different pathways (and local enhanced service options) for anticoagulation monitoring across BNSSG.

Basic level service provided by the GP practice where a venous sample is taken at the GP practice which is then sent to secondary care. An anticoagulant service is funded in University Hospitals Bristol (UHB) and North Bristol NHS trust (NBT) that review the INR and dose the anticoagulant. In UHB this is commissioned as part of a block contract that sits outside the payment by results tariff at a value of £150,000 per annum. In North Bristol NHS Trust this activity is provided within the payment by results tariff framework. We need to track the pathway of individual patient records in order to identify how this activity is coded and therefore charged to the CCG. Currently, the cost of this service is unknown and needs to be established.

Advanced level service provided by the GP practice where a coaguchek machine is used to check an INR using a finger-prick blood sample. This INR is then reviewed and dosed within the practice using a computer system called INRstar. An advanced level service is offered in North Somerset (where all practices undertake this level of service) and Bristol (where two practices offer this level of service). There is one practice in South Gloucestershire, where currently only the basic level service is offered, that offer the advanced level services without a LES payment. Most of the Bristol and South Gloucestershire practices provide a basic level service.

The number of patients on Vitamin K antagonists has been reducing significantly over recent years due to the increased use of Direct Oral Anti-Coagulants (DOAC). In quarter three and quarter four 2017/18 there were 7,208 patients receiving a vitamin K antagonist across BNSSG. This figure reduced by 20 percent in quarter one and two 2018/19 to 5,766.

Number of patients prescribed vitamin K antagonist across BNSSG by locality in Q1 and Q2 2018/19		
Basic service provided by GP practice	Inner city and East	477
	North and West	646
	South Bristol	740
	South Gloucester	1536
Advanced service provided by GP practice	North and West	39
	South Bristol	156
	Woodspring	1304
	Weston and Worle	820
	South Gloucester	48
Total number of patients	**BNSSG**	**5766**

Number of patients under the responsibility of the secondary care anticoagulation service as at October 2018	
North Bristol NHS Trust	2469
University Hospitals Bristol	1148
Weston General Hospital	0
Total number of patients	**3617**

4. Benefits and Risks

	Benefits	Risks
Option 1 Status quo, basic level service Bristol and South Gloucestershire (with the exception of practices already offering the advanced service) and advanced level service North Somerset	• Little appetite for change when discussed at locality membership meetings. • No change for practices. • Little known about the clinical effectiveness of both services so difficult to assess the differences. • Full financial model is not known for both the services therefore it is difficult to recommend one above another.	• Not a unity of approach across BNSSG. Little known about the clinical effectiveness of both services so difficult to assess the differences.
Option 2 Advanced level service across BNSSG	• Unity of approach across BNSSG. • Decommissioning anticoagulant clinics in UHBristol and NBT. With the block contract for anticoagulation dosing at UHBristol and the reducing numbers of patient this may be financially sensible. • Only paying for patients that are on vitamin K antagonists not as part of a block contract. • The advanced service may be considered faster for patients as they have their INR checked and dosed whist they are in the practice. • Not having to have a venous blood sample taken may be considered better by patients.	• Little appetite for change when discussed at locality membership meetings in Bristol and South Gloucestershire. • GP staff will need retraining on anticoagulant dosing where a basic level service is currently offered. It will take time to upskill practice staff and ensure safe governance systems in place • The amount paid for the NBT service is not fully understood therefore it cannot be guaranteed that the full package will stop being paid. • It is unknown if the advanced service (GP practices dosing) is clinically better than the basic service (secondary care specialist clinics dosing). • INR star dosing software

		will need to be funded across all BNSSG practices
Option 3 Basic service across BNSSG	Unity of approach across BNSSG. Saving a small amount of GP practice time. Dosing expertise at UHBristol and NBT utilised	• A change in service provision in North Somerset would need a patient consultation and unlikely to be popular with patients. • Little appetite for change when discussed at clinical forum in North Somerset. • Deskilling of GPs and practice staff in North Somerset (and a few in Bristol and South Glos). • Increase laboratory workload. • Weston general is not commissioned to provide an anticoagulant dosing service, this would either have to be re-commissioned or a process that North Somerset INRs be dosed by the existing clinics at UHBristol and NBT designed. • The financial implication for increasing the number of patients to NBT is unknown. • It is unknown whether using the secondary care clinic gives better clinical outcomes than GP dosing. • Staff employed in practice to provide service may mean redundancy costs if level 4 service is stopped.

5. Financial Impact

LES Financial Impact

The trend for reduction in numbers of patients receiving a vitamin k antagonist heavily impacts these figures. At suggested LES payment rates for 2019/20 (basic £57/patient, advanced £160/patient) the financial impact (when compared to 17/18 full year costs of £701k) to the LES financial envelope would be as follows.

Option		**Estimated LES costs 2019/20***	**Change compared to 2017/18 LES**
Option 1	Status quo, 20 advanced level practices	£573K	£128K reduction
Option 2	100% advanced level practices	£923K	£222K increase
Option 3	No advance level practices	£329K	£372K reduction

*Based on the number of patients in Q1 and Q2 2018/19 prescribed a vitamin K antagonist.

Sensitivity analysis would need to be undertaken to assess the likely take up by practices and refine the financial forecasting further.

Non-LES Financial Impact

Both the basic and advanced service has a financial implication to the CCG in addition to the Local Enhanced Service cost.

Option		Non-tariff financial expenditure	Non-tariff financial savings
Option 1	Status quo, 20 advanced level practices	Basic level – payment for venous INR blood tests, payment for anticoagulant dosing clinics (currently unknown NBT, UHB £150,000/year.)	
		Advanced service – payment for INR star computer software in North Somerset = £17,798 / year	
Option 2	100% advanced level practices	INR star computer software across all practices (cost to be confirmed)	Payment for venous INR blood tests. Payment for anticoagulant dosing clinics at UHBristol (£150,000/year) and NBT (unknown).

Option 3	No advance level practices	Payment for venous INR blood tests. Payment for anticoagulant dosing clinics to cover all of BNSSG (unknown). Potential increase in cost of blood collections from North Somerset	Payment for INR star across North Somerset = £17,798 / year

The current costs and therefore potential future costs are unknown for the anticoagulant services at NBT. It is understood a review is planned over the next 6 months to move towards an activity based payment system for pathology services at NBT and UHB. The outcome of these changes will better inform the financial impact of the various options on BNSSG CCG. In addition the CCG has signalled as part of its commissioning intentions to providers the intention to conduct a review and comparison of the anticoagulation services and pathways to understand cost and clinical effectiveness. This will need to be supported by an audit within the services.

6. Clinical Implications

It is unknown which option is clinically most appropriate. The services currently offered in BNSSG have not been reviewed for clinical suitability, quality, safety or success. A clinical review of these services reviewing measures such as time-in-therapeutic-range and number of adverse events such as extremely elevated or very low INR is needed.

7. Stakeholder Consultation

The Locality Membership Groups have been consulted about the potential change to anticoagulant monitoring and dosing service at meetings and the LES steering group has been involved in the options discussion. Patients have not been consulted and they will need to be if the service was changing. This is particularly important in North Somerset where the speed of dosing would be changed if a switch to the basic service occurred.

8. Recommendation

It is recommended that option1 – status quo – is accepted as the preferred outcome for April 2019.

This recommendation is due to restrictions in knowledge about the different services. It is unknown which service is clinically more successful and the financial implications of both are not fully

known. There is also not the appetite currently by GP practices to change the level of service they provide, particularly given the reducing numbers and the impact this will have on planning to provide a clinically and financially viable service over time.

It is recommended that work is undertaken to fully understand the financial implication to the CCG of the different services and the clinical benefits and risks of each service so a robust and comprehensive options appraisal can be presented for consideration and discussion to inform LES developments for April 2020.