NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

Primary Care Commissioning Committee (PCCC)

Date: Tuesday 29th January 2019
Time: 9-11am
Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda number: 7

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 this paper is to seek Committee approval for a set of recommendations and to brief the Committee on next steps and project closure.

2. Recommendations

The Committee is asked to:

- Note the progress and next steps set out within the main report and within the highlight report within Appendix 4.
- Approve the specification for GP Support to Care Homes in Appendix 1 and the offer of a one year contract with a move to a locality model from 1st April 2020
- Support the recommendation included within the main report to ask the Mental Health and Learning Disabilities transformation team to review the requirements for support to homes which cater for people with Learning Disabilities during 2019/2020
- Support the recommendation to conclude enhanced service payments for minor injuries services in South Gloucestershire and North Somerset from 1st April 2019 as set out in Appendix 2
- Note the proposed finance tariffs and analysis paper set out in Appendix 3 for the full set of specifications and approve the proposed tariffs
- Note and support the proposed project closure steps and the ongoing roles and responsibilities set out in section 4 of the main report

3. Executive Summary

The main report sets out key progress in the last month, sets out next steps and identifies future roles and responsibilities and proposals for formal project closure. The paper seeks approval for the GP Practice Support to Care Homes specification. In addition the Committee is asked to receive the report on the findings of the Minor Injuries Schemes and support the recommendation to conclude enhanced service payments for minor injuries services in South Gloucestershire and North Somerset from 1st April 2019. Appendix 3 sets out the proposed finance tariffs for the LES specifications to be offered from 1st April 2019 and the financial impact analysis at locality and CCG level. The Committee is asked to approve the tariffs within the paper.

4. Financial resource implications

Financial resource implications are set out in Appendix 3. Practice level impact analysis will be presented to the Committee in closed session.

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 4.

7. Implications for health inequalities

The 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)

Equality Impact Assessment (EIA) Screening has been completed for each of the LES service specifications presented. These EIA screening assessments were shared with the CCG's Inclusion Coordinator for comment and review. Minor amendments were made and the conclusion to not proceed to full EIA assessment for each LES was subsequently approved. The EIA screening documents are available upon request. This includes the LES for GP Practice Support to Care Homes under consideration by the Committee.

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. Public and Patient Involvement (PPI) Screening has been completed for each of the LES service specifications presented. These PPI screening assessments were shared with the CCG's PPI Lead for comment and review. The conclusion to not proceed to further PPI activity for each LES was subsequently approved. The PPI screening documents are available upon request. This includes the LES for GP Practice Support to Care Homes under consideration by the Committee.

Agenda item: 7

Report title: LES Review Update

1. Progress since last month

Since the 3rd January report to the Primary Care Commissioning Committee work has taken place to complete the specification for GP support to care homes, complete the financial modelling to give the overview of all tariffs and financial implications, conclude the evaluation of the Minor Injuries local enhanced services and propose next steps and ongoing governance arrangements for the LES as they are offered out to practices. Key messages from the Committee following the 3rd January were shared with the membership across BNSSG. Due to timing in concluding the work on care homes the revised specification has been circulated to practices by email with the proposed tariffs in advance of the Committee for any final comments. The evaluation of and recommendations for the future of the Minor Injury Local Enhanced Services are included within a separate paper attached as Appendix 2. Amendments to the specifications for Type 2 Diabetes Insulin Start LES and Recognition and support for people with dementia LES which were discussed at the last Committee have been made and the revised versions will be circulated to practices along with all the other specifications as part of the contracting process when we invite practices to submit their Expressions of Interest in February.

2. GP Practice Care Home Support

A revised specification for GP Practice Care Home Support is attached at Appendix 1. This has been amended in a few areas and the key changes have been highlighted in red. A meeting with the LMC and Public Health England has refined and clarified roles and responsibilities in supporting the flu pathway when an outbreak occurs within a care home setting and this is now included within an appendix to the LES. Responding to the flu outbreak is included within the proposed tariffs for care homes. The other changes to the specification centre around providing additional wording on medicines management reviews, in particular for end of life care and there have been some changes to the proposed frequency of ward rounds (weekly to fortnightly) and meetings with care home managers (monthly to quarterly) in response to feedback from practices.

On further investigation it has been established that 25 homes who provide for Learning Disabilities are covered under the existing LES arrangements as they are part of the list of homes on offer to practices. These account for 24% of all homes who provide for people with Learning Disabilities (105 in total). The 25 homes comprise of a mixture of homes, some of which are solely for people with LD and some which cater for older people and people with LD. The majority of these are provided for within the GP Practice Support to Residential Care Homes agreements in Bristol and South Gloucestershire. People with LD who have high health needs and are also at potential risk of admission should benefit from the same level of proactive care within a residential

setting. As such, the recommendation to the Committee is that these homes should continue to be on the list offered to practices. However, the LES Review Steering Group also recognises that the specifications for support to care homes do not make specific references to the needs of people with LD and in the longer term it may be more appropriate to develop a separate specification for support to these homes. It is recommended that the Mental Health and Learning Disabilities transformation team is asked to review this during 2019/2020.

Previous discussions at the Committee have highlighted patient choice in registration of GP. Whilst the specification promotes the mapping of a single GP practice per care home as this has been shown to improve co-ordination of care the specification also clearly states that ultimately it is patient choice as to whether to retain their GP.

The proposed tariffs for the GP Support to Care Homes specification are set out in Appendix 3. It is proposed that the GP Support to Care Homes contract is offered as a 1 year contract in view of the previous recommendations that this should move to a locality model from April 2020.

3. Minor Injuries

The evaluation of the Minor Injuries LES in South Gloucestershire and North Somerset has concluded. The detail of this is set out in Appendix 2. The paper seeks approval from the Committee to conclude enhanced service payments for minor injuries services in South Gloucestershire and North Somerset. The paper sets out the evidence and rationale for this and describes the future direction provided for within the BNSSG Urgent Care strategy. The paper also describes action being taken to equalise the provision within minor injury units by increasing the hours of operation at Yate Minor Injuries Unit.

4. Formal Project Closure and roles and responsibilities

Subject to approval of the key documents within the LES Report, the LES review is now drawing to a close. It is proposed that there will be one final meeting of the LES Review Steering Group to agree and review any outstanding actions and that the LES Review Steering Group is then stood down.

It is proposed that the offering of contracts and subsequent work to monitor the LES is now overseen by the Primary Care Quality, Resilience and Contracting group which is a sub group of PCOG. Progress in offering the LES and in monitoring LES take up and LES performance will form part of the Contracts and Performance Report to PCCC henceforth.

The following key responsibilities are proposed:

Medical	Primary Care	Area Team	Business	Finance

Directorate	Contracts Team		Intelligence	
Prepare final briefing for membership following PCCC	Final review of specifications	Promote new LES offer through locality fora	Develop reporting templates and data sets to support contract monitoring working with primary care contracts team	Set out payment process and timetable working with the contracts team – the same process to be used across BNSSG
Chair final meeting of LES Review Steering Group, develop lessons learnt and project closure	Send out specifications with Expressions of Interest Forms	Work with locality provider groups through LTS Phase 3 and primary care network development programme to support provider groups to develop locality operating model for diabetes, care homes and potentially DVT from April 2020		Ensure timely payments made to practices
Provide project support to work with primary care contracts team to finalise specifications and to work with contracts and BI to develop reporting EMIS	Prepare and send out contracts			Review expenditure against budget

templates				
	Monitor contract performance			Report to PCCC on LES finances within the Finance Report to PCCC
	Report to PCCC on contract performance via Contract and Performance Report			

These roles and responsibilities will be reviewed at the final meeting of the LES Steering Group.

5. Next Steps

The key next steps are as follows:

- Final review of specifications by contracts team
- EMIS templates and Search and Report functions to be developed to support specifications to be available and ready by 1st April 2019
- Final meeting of LES Steering Group in February to close down review and move LES offer to 'business as usual' contracting process
- Expressions of Interest to be sent out to practices and returned in February
- Promotion of LES offer to be shared via forums, Locality Leadership Groups and the GP Bulletin throughout February
- Contracts with practices to be prepared in March

6. Financial resource implications

Financial resource implications are set out in Appendix 3. This sets out the principles used in developing proposed tariffs and demonstrates the impact of these at CCG and locality level. The paper presents the impact of the changes in tariffs for the LES to be offered in 19/20. Practice level impact analysis is presented to the Committee in closed session. The one exception to this is GP Support to Care Homes where we are able to forecast and model at Area level (Bristol, South Gloucestershire and North Somerset) only at this stage. The Committee is asked to approve the proposed tariffs included within Appendix 3.

7. Legal implications

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

8. Risk implications

The key risks and mitigating actions are set out in the Highlight Report in Appendix 4.

9. Implications for health inequalities

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

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

Equality Impact Assessment (EIA) Screening has been completed for each of the LES service specifications presented. These EIA screening assessments were shared with the CCG's Inclusion Coordinator for comment and review. Minor amendments were made and the conclusion to not proceed to full EIA assessment for each LES was subsequently approved. The EIA screening documents are available upon request. This includes the LES for GP Practice Support to Care Homes under consideration by the Committee.

11. 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. Public and Patient Involvement (PPI) Screening has been completed for each of the LES service specifications presented. These PPI screening assessments were shared with the CCG's PPI Lead for comment and review. The conclusion to not proceed to further PPI activity for each LES was subsequently approved. The PPI screening documents are available upon request. This includes the LES for GP Practice Support to Care Homes under consideration by the Committee.

12. Recommendations

The Committee is asked to:

- Note the progress and next steps set out within the main report and within the highlight report within Appendix 4.

- Approve the specification for GP Support to Care Homes in Appendix 1 and the offer of a one year contract with a move to a locality model from 1st April 2020
- Support the recommendation included within the main report to ask the Mental Health and Learning Disabilities transformation team to review the requirements for support to homes which cater for people with Learning Disabilities during 2019/2020
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Appendices

Appendix 1 – GP Support to Care Homes Specification
Appendix 2 – LES Review Minor Injuries Service
Appendix 3 – LES Review approach to financial modelling
Appendix 4 – Highlight Report

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations.

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.
EMIS	An electronic patient record system and software used in primary care.

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	**Primary Care Contracts Team, NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices**
Period	**1st April 2019- 31st March 2020**
Date of Review	

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, fortnightly 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 service 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. It is expected that all patients as part of their initial assessment will have a registered GP of their choice.

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. Lead GP Practice will take the lead for clinical review of medicines. Wherever possible, medication review should be undertaken in conjunction with clinical community pharmacists.

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

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). This will take into account any cross organisational communication form regarding the patient's wishes regarding their treatment, such as the 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, particularly controlled drugs (every 3 months) by the GP and NH nurses for appropriateness, and the review should be clearly documented in the patient's care plan. If medication is deemed no longer necessary, it needs to be communicated to the community pharmacy so that it is removed from Medicine Administration Record (MAR) charts.
    - GP practices should be aware of which of their NH patients have been prescribed JIC medicines, and be able to generate a list of these patients from their records for review. These patients should be considered and reviewed as part of the GP practice's wider palliative care patient register.

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

4. Providing regular routine surgeries (Community Ward Rounds) plus urgent surgeries as needed in the Care Home. The GP practice can support these through a Multidisciplinary approach. It is encouraged that practices invite clinical pharmacists on Community Ward Rounds in order to facilitate medication review and optimisation. To provide pro-active care effectively the frequency of the ward rounds should be at least fortnightly, 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.

5. The GP or appropriate clinician should attend with the care home manager a quarterly shared learning and practice review of emergency admissions.

6. Medication reviews at least annually in line with NICE SC1 Managing medicines in care homes. Reviews should focus on medicines optimisation and polypharmacy. 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.

7. 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 48 hours of the onset of symptoms or contact with an index case dependent on the choice of medication being prescribed. The GP practice ideally needs to respond within 12 hours, working in conjunction with Public Health England to reduce influenza associated morbidity and mortality and reducing further onward transmission of the influenza virus. A pathway is attached which sets out roles and responsibilities when responding to a flu outbreak.

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 GPs 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

Quarterly reporting will be undertaken. An EMIS search and report template is being developed to extract the following:

- 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 practices code this as medicine review
- Number of residents prescribed Just In Case medication
- Resident in Care Home
- Resident in Nursing Home
- Medication review and Polypharmacy medication review
- Pick up fortnightly ward/board rounds and quarterly reviews with CH staff

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.

5.2 Financial Information

5.3 Read Codes

Data will be extracted via EMIS search and report. By signing up to this enhanced service you agree for the data to be extracted as required.

5.4 Fees Payable

Payment arrangements to be confirmed.

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 board round should take place on the same day at the same time each fortnight and be completed by a GP or appropriate clinician. This should be a mutually agreed time between the 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 fortnightly rounds should be coordinated by named senior nurse (***The CH GP Link Nurse***) at the nursing home. Residents requiring review at the GP/appropriate clinician round should be identified each week & if necessary routine tests completed (BP, urinalysis, temperature).	
1.3	Inform GP/appropriate clinician on the morning of the board 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 endeavour to see the patient in order to complete death certification.	GP practice
2	**New Residents**	
2.1	In preparation for the transfer of a new patient to the 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, including safe administration of medication.	
3.4	The care home will record the outcome of visits of all specialist healthcare professionals (e.g. tissue viability team) should be recorded in the residents health record and the GP informed of any changes to the care plan at the next round unless urgent.	
3.5	The GP practice to work with the Care homes to adopt homely remedies policies	
3.6	GP practices will engage with community pharmacy technicians and the care homes to streamline prescription ordering processes for the benefit of all parties and to reduce medicines waste	
4.	**Urgent Care**	
4.1	Care Homes should coordinate all requests for visits through the Shift NH GP Liaison Nurse on each shift.	
4.2	The 'Prompt sheet – care home request for GP visit today' should be used for residents whose health needs are changing.	
4.3	If the GP practice is not going to do a visit on the day requested he/she should telephone the home to agree a plan for visit and on-going management of the problem.	

4.4	Quarterly review with the Care Home manager including review of the ACP following emergency admission.	
5	**Advance Planning**	
5.1	Monthly Coding meetings to be held in the home.	
5.2	Discuss need for Advanced Care Plan/TEP form in line with Resuscitation council guidelines, involving resident, family or IMCA, keep form in Nursing Home, take a copy back to surgery & ensure it is scanned to the residents GP record and record it on the EPaCCS system. This Care Plan must use agreed communications across secondary care, primary care and community services, part of which is currently the ReSPECT documentation. https://www.respectprocess.org.uk/healthprofessionals	
5.3	If necessary GP or appropriate clinician and 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 or appropriate clinician and nurse to engage with EOL pathway for the last days of life' and all current care plans and medications reviewed.	
7	**Care After Death**	
7.1	Provide after death care for family & provide information regarding bereavement services in line with the integrated care plan.	
7.2	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.	

Appendix A

Management of localised community outbreaks of influenza across the BNSSG area (Updated January 2019)

1. Background

The majority of influenza outbreaks occur during the influenza season following the Chief Medical Officer's (CMO) alert authorising the prescribing of antivirals in primary care, however, a small number of outbreaks may occur in the 'out of season' period which is defined as the period when the levels of circulating influenza are not yet epidemiologically significant for the CMO to issue their alert authorising antiviral medications on FP10 prescription.

Where indicated, oseltamivir antiviral treatment for flu should be started as soon as possible, ideally within 48 hours of onset of symptoms. Therefore the process for clinical assessment and dispensing of antivirals needs to be completed in a very timely fashion. However there is evidence that oseltamivir treatment may reduce the risk of mortality even if started up to five days after onset, but this is an off-label use of oseltamivir (Tamiflu®) and requires clinical judgement. Prophylaxis should be started within 48 hours of exposure to a case; or after 48 hours on Public Health England (PHE) specialist advice only.

1.1 Procedures in an outbreak situation

In an outbreak situation CCG On-Call Director or Medicines Management Team input may be required by PHE Health Protection Team (HPT). The PHE Health Protection Team will have risk assessed the outbreak situation and made recommendations regarding the use of antivirals. Where PHE HPT are experiencing difficulties engaging GP practices or the GP out-of-hours service to deliver a timely response to the outbreak the CCG On-Call Director may be asked to engage in discussions with the GP practices. The pathways below should be followed by GP practices and those providing cover to GP services out-of-hours in order to guide the actions required to achieve assessment and supply of antiviral medications.

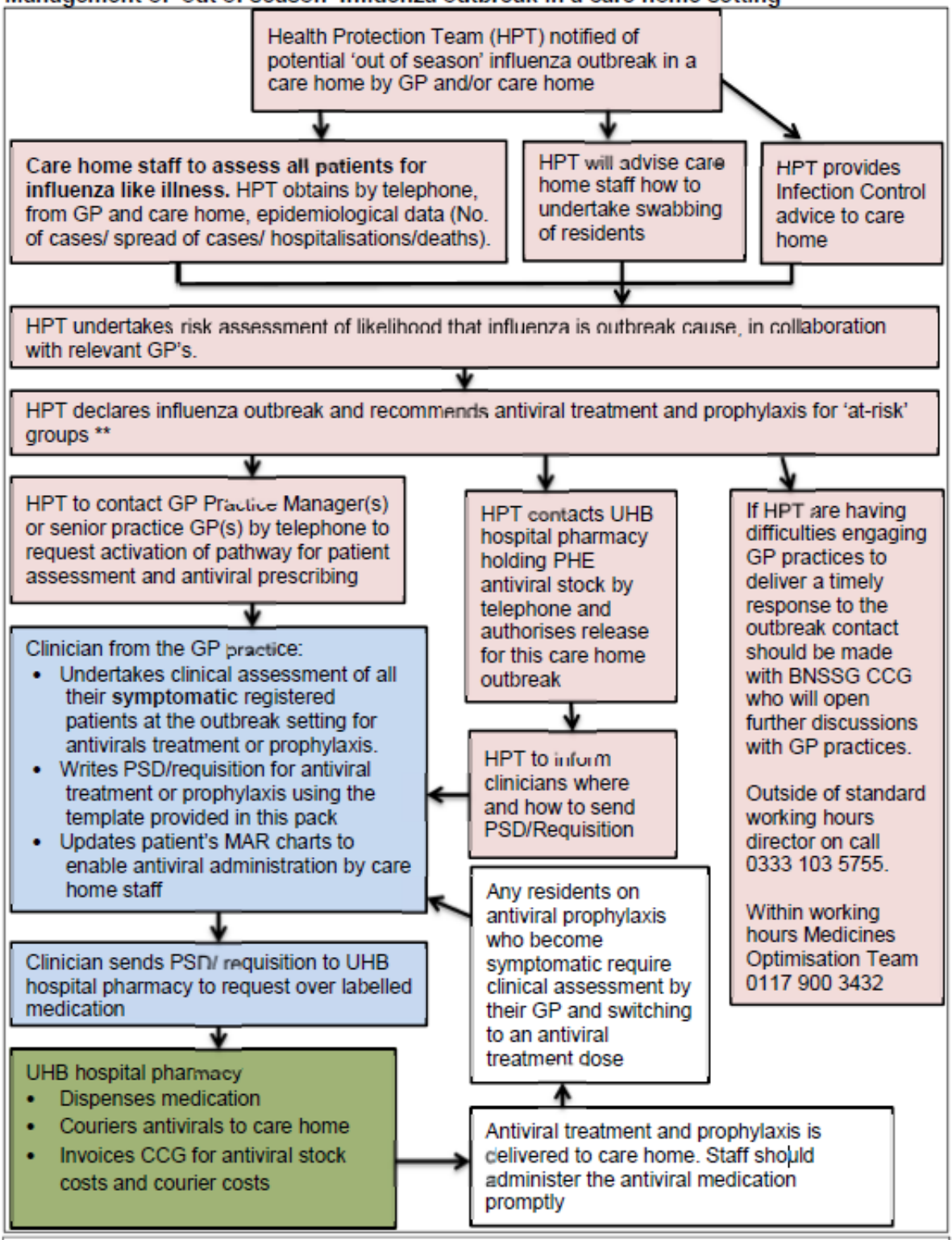
In an out of season outbreak situation, where antiviral medication is required, the PHE Health Protection Duty Team will authorise the release of the local PHE stocks of Oseltamivir (Tamiflu®) held at a local hospital trust for emergency use. The hospital has the facilities to over label these medications, which is important as the medication is not a single dose and this will therefore support medication administration. A requisition/ Patient Specific Direction (PSD) for the supply would be needed and the CCG will then be required to fund the costs of these antivirals as well as fund delivery to the care home if required. A template requisition/Patient Specific Direction (PSD) has been included in this pack.

In an out of season outbreak situation Zanamivir (Relenza®), an alternative antiviral for patients unable to have oseltamivir, is not kept in the PHE stockpile. This would not be the first line treatment option and could be ordered in by the hospital trust or could be accessed via a community pharmacy with a wholesale dealer's license if required.

Where GP practices are unable to achieve the necessary response in the timeframe required please contact the Medicines Optimisation Team 0117 900 3432 and speak with Johanna Topps, Liz Jonas or Dan Stephens who may be able to seek additional support.

Authors: D.Campbell, L.Rees, J. Topps, Medicines Optimisation Team . Thara Raj Consultant in Public Health, Bristol City Council/Public Health England.

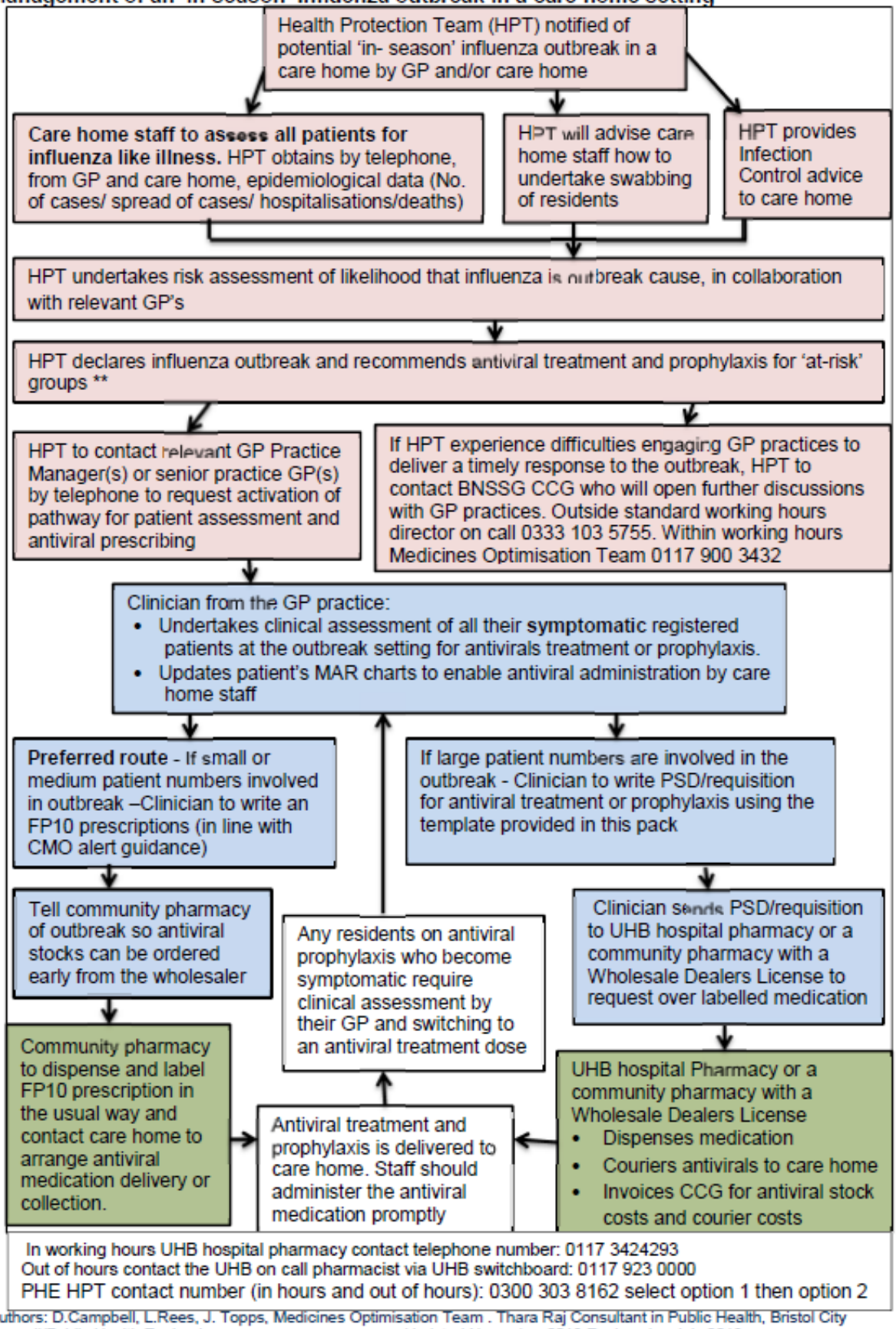
Management of 'out of season' Influenza outbreak in a care home setting



In working hours UHB hospital pharmacy contact telephone number: 0117 3424293
Out of hours contact the UHB on call pharmacist via UHB switchboard: 0117 923 0000
PHE HPT contact number (in hours and out of hours): 0300 303 8162 select option 1 then option 2

Authors: D.Campbell, L.Rees, J. Topps, Medicines Optimisation Team . Thara Raj Consultant in Public Health, Bristol City Council/Public Health England.
Updated November 2018 Review due July 2019

Management of an 'in-season' Influenza outbreak in a care home setting



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Updated November 2018 Review due July 2019

Care Home Provider Pathway for suspected influenza outbreaks in Care Homes in working hours and out-of-hours

Care Home resident(s) are identified with influenza like symptoms. Where influenza is suspected the care home should notify the relevant GP practice and the Public Health England Health Protection Team. The HPT contact number (in and out of working hours) is: 0300 303 8162 select option 1 then option 2

Care home staff to assess all residents for influenza like illness

The HPT will obtain information from the care home to allow the HPT to risk assesses the situation. Care Home staff will need to swab a small number of patients to confirm the outbreak cause. The HPT can advise the care home on infection control measures.

HPT declares influenza outbreak and advises GP practice to visit the care home and assess all their **symptomatic** registered patients at the care home and prescribe antiviral treatment and prophylaxis for 'at-risk' groups **

Patient assessment by a clinician from the practice should be undertaken in a timely manner as antiviral medication (oseltamivir) is required as soon as possible. Oseltamivir should start within 48 hours of onset of symptoms (or where prophylaxis required within 48 hours of exposure to a case. Oseltamivir may be started after 48 hours on specialist HPT advice. If following assessment the clinician decides to prescribe antivirals the dose may need to be adjusted for impaired or suspected impaired renal function. The British Geriatric Society provides advice on antiviral prescribing for care home residents (see page 7).

'Out of season' Influenza outbreak
GP practice clinician writes PSD/requisition for antiviral treatment or prophylaxis using the template provided in this pack. Clinician sends PSD/ requisition to UHB hospital pharmacy to request over labelled medication. GP practice clinician updates patient's MAR charts to enable antiviral administration by care home staff.
'In-season' Influenza outbreak
Preferred route - If small or medium patient numbers involved in outbreak – GP practice clinician to write an FP10 prescriptions and endorse SLS. **Care homes must notify their preferred community pharmacy before FP10's are ready so antiviral stocks can be ordered early from the wholesaler.** Pharmacies providing the Specialist Medicines Enhanced Service do hold a small amount of antiviral medication for more information. https://www.bnssgformulary.nhs.uk/Others/ If out-of-hours or there are difficulties obtaining medication due to large patient numbers involved in outbreak the GP practice clinician can writes PSD/requisition for antiviral treatment or prophylaxis using the template provided in this pack and send to UHB hospital pharmacy or a community pharmacy with a Wholesale Dealers License to request over labelled medication. GP practice clinician updates patient's MAR charts to enable antiviral administration by care home staff.

FP10 - Community Pharmacy to dispense the FP10 prescription in the usual way and discuss medication delivery or collection with care home.

PSD/requisition - UHB hospital Pharmacy or a community pharmacy with a Wholesale Dealers License should dispenses medication, couriers antivirals to care home and invoice CCG for antiviral stock costs and courier costs

Antiviral treatment and prophylaxis is delivered to care home. Staff should administer the antiviral medication promptly

Any residents on antiviral prophylaxis who become symptomatic require clinical assessment by their GP and switching to an antiviral treatment dose

Authors: D.Campbell, L.Rees, J. Topps, Medicines Optimisation Team . Thara Raj Consultant in Public Health, Bristol City Council/Public Health England. Updated November 2018 Review due July 2019

FOR URGENT ATTENTION
In-patient Pharmacy
Floor level Three
Bristol Royal Infirmary (Zone A)
University Hospital Bristol
Marlborough Street
Bristol
BS1 3NU

Prescriber Address

Date

Patient Specific Direction (PSD)

Please arrange for the supply of:

Antiviral Medication Name	Strength	Formulation

For the following patients:

Patient Name	Date Of Birth	NHS Number	Route	Dosage/ Frequency	Duration

These medicines are required as part of the urgent management of an influenza outbreak declared by PHE Avon Gloucestershire and Wiltshire Health Protection Team (telephone 0300 303 8162 option 1 then option 2) at the following location:

Name of care home	
Address of care home	
Telephone contact details for care home	

Prescriber name	
Prescriber signature	
Category of registered health professional e.g. Pharmacist, GP, Nurse	
Professional Registration number	

Renal Function

Extract from page 28 of the PHE Guidance: Influenza-like illness (ILI): managing outbreaks in care homes Guidance for managing seasonal influenza, identifying pathogens and transmission routes for acute respiratory disease in care homes.
https://www.gov.uk/government/publications/acuterespiratory-disease-managing-outbreaks-in-care-homes

British Geriatric Society advice on antiviral prescribing

Advice from The British Geriatrics Society Community Geriatrics SIG, November 2017 about consideration of renal impairment in prescribing of antivirals in localised community outbreaks of seasonal influenza.

In situations where an individual has a documented renal function within the last 6 months indicating no renal impairment, then they can be prescribed the standard dose of antivirals. For those individuals with a known renal impairment and where the prescriber has access to the renal function results in an emergency outbreak, then they can be prescribed an adjusted dose according to existing guidance. However, in those emergency outbreak responses where there is no information about the presence or absence of renal impairment (or lack of available routine renal function results from the past 6 months), there is a high likelihood of abnormal renal function in care home residents, so we would recommend a reduced daily dose of oseltamivir in all care home residents. This would be for a dose appropriate to CrCl of 31-60 mL/min . We would not recommend routine measurement of renal function prior to treatment due to the logistical challenges of collecting bloods en masse in care home populations and the likely delays introduced by waiting for lab results to return in the community. Where time permits, checking renal function in specific patients at high risk of significant renal impairment, for example those on high dose diuretics, may be useful.

The importance of vaccination in care home populations, and of vaccinating staff, is to be reinforced. Importantly, vaccination provides an opportunity for less hurried conversations, with families of those care home patients who lack capacity to consent to therapy, to consider the relative merits of antiviral therapy in advance. It would be useful to discuss in advance, with residents' families, the rationale for antiviral therapy in the event of outbreaks and asks them to consider whether their relative would have been likely to want to opt out of such an approach. This would help to anticipate any issues relating to care home residents' lack capacity to consent. Clinicians are advised to consider this in relation to their own local polices on capacity to consent.

Inhaled Zanamivir should be primarily used for cognitively intact residents requiring antiviral therapy, such as those with recognised renal dysfunction or with suspected or confirmed oseltamivir-resistant influenza.

This advice was kindly facilitated by the SIG Chair, Dr Adam Gordon, Clinical Associate Professor in Medicine of Older People - University of Nottingham.

Definitions:

Case definition for influenza – Flu like illness usually starts rapidly with a fever/temperature >37.8ºC PLUS one or more of the following symptoms: cough (with or without sputum), sore throat, hoarseness, nasal discharge or congestion, shortness of breath, wheezing, sneezing OR an acute deterioration in physical or mental ability without other known cause.

Clinical Risk Groups **
People 'at risk' in the context of influenza outbreak are defined as those who have one of more of the following: chronic respiratory disease (including asthma & chronic obstructive pulmonary disease), chronic heart disease, chronic renal disease, chronic liver disease, chronic neurological conditions, diabetes mellitus, aged 65 years or older, might be immunosuppressed.

Out of season influenza period – this refers to the period when the levels of circulating influenza are not yet epidemiologically significant for the Chief Medical Officer (CMO) to issue their alert authorising antiviral medications on FP10 prescription.

In season influenza period – this refers to the period when the levels of circulating influenza are epidemiologically significant and the Chief Medical Officer (CMO) has issued an alert authorising antiviral medications on FP10 prescription.

Over labelled medication – This refers to medicines which have a pre-printed label containing dosage instructions and other information. They are given directly to patients following the addition of the individual patient's name and the date being added to the pack.

Patient Specific Direction (PSD) - A Patient Specific Direction (PSD) is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.

Patient Group Direction (PGD) – These are documents which allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription.

Wholesale Dealers License (WSD License) - To sell or supply medicines to anyone other than the patient using the medicine, including the bulk supply of medicines you need a wholesaler licence – also known as a wholesale dealer licence or wholesale distribution authorisation. In relation to this paper this would refer to pharmacies that can over label medication and supply in bulk. Not all community pharmacies have this license.

Supportive National Guidance:

NICE Technology Appraisals (TA158 and 168) recommend that during localised outbreaks of influenza in the out of season period, antivirals may be used for treatment or post-exposure prophylaxis in at-risk people living in long-term residential or nursing homes, whether or not they are vaccinated.
https://www.nice.org.uk/Guidance/ta158
https://www.nice.org.uk/Guidance/ta168

PHE guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza, Version 9.0, October 2018
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/648758/PHE_guidance_antivirals_influenza_201718_FINAL.pdf

PHE guidelines on the management of outbreaks of influenza-like illness (ILI) in care homes, version 4.0, October 2018
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/664972/Influenzalike_illness_in_care_homes.pdf

Evidence for effectiveness of Antiviral Treatment

Expert opinion on neuraminidase inhibitors for the prevention and treatment of influenza - review of recent systematic reviews and meta-analyses
https://ecdc.europa.eu/en/publications-data/expert-opinion-neuraminidase-inhibitorsprevention-and-treatment-influenza-review

Executive Summary:
The neuraminidase inhibitors oseltamivir and zanamivir, currently authorised in the European Union/European Economic Area for treatment and prophylaxis of influenza disease (including seasonal, pandemic and zoonotic influenza), have been the subject of debate concerning their effectiveness and safety, and as a consequence, also the appropriateness of stockpiling these drugs for use in future influenza pandemics.

Three large systematic reviews and meta-analyses assessing efficacy, effectiveness and safety of two licensed neuraminidase inhibitors, oral oseltamivir and inhaled zanamivir, were reviewed: The 2014 Cochrane Collaboration report (Jefferson et al.), the 2015 MUGAS study (Dobson et al.) and the 2014 PRIDE study (Muthuri et al.). Additional reviews and studies were considered where appropriate.

The reviews by Jefferson et al. and Dobson et al. conclude that, for adults, oseltamivir decreases the time to first alleviation of symptoms of influenza-like illness (ILI) by 16.8 hours (95% CI 8.4–25.1) and 17.8 hours (95% CI 27.1 to 9.3), respectively. The time to alleviation of all symptoms among the sub-population with laboratory confirmed influenza infection was decreased by 25.2 hours 95% CI 16.0–36.2 in the Dobson et al. analysis.

Additional analyses within the Jefferson et al. and Dobson et al. reviews documented a statistically significant reduction in patient-reported pneumonia, a reduction in lower respiratory tract infections and a decrease in hospital admissions following influenza diagnosis among oseltamivir-treated groups.

All three reviews point to the importance of initiating treatment early, ideally within 48 hours (within 36 hours in the case of zanamivir in children) of onset of symptoms.

With regard to prophylaxis, the review by Jefferson et al. assessing pre- or post-exposure prophylactic oseltamivir observed a 3.05% reduction in absolute risk for laboratoryconfirmed influenza A among groups receiving oseltamivir in four RCTs (RR 0.45; 95% CI 0.30–0.67). The trials were conducted in ambulatory community members and nursing home residents. Similarly, Okoli et al. reported an association in an RCT between reduction in laboratory-confirmed influenza A(H1N1) infection and prophylactic treatment with oseltamivir (OR 0.11; 95% CI 0.06–0.20), and in four observational studies of zanamivir (0.23; 95% CI 0.16–0.35).

The most commonly reported adverse effect was an increased risk of nausea and vomiting; Jefferson et al. reported the risk in adults receiving oseltamivir for vomiting (RR 2.43; CI 95% 1.75–3.38) and children (1.70; 95% CI 1.23–2.35), and Dobson et al. in adults (RR 2.43; 95% CI 1.83–3.23).

Limitations were identified for all three systematic reviews and meta-analyses.
While the reviews considered for this expert opinion add to the evidence on the beneficial and adverse impacts of neuraminidase inhibitors, it is clear that further studies are needed to strengthen the evidence base overall.

This ECDC expert opinion confirms earlier assessments by ECDC and national authorities that there is no significant new evidence from RCTs to support any changes to the approved indications and recommended use of neuraminidase inhibitors in EU/EEA Member States.

Available evidence provides support for the use of NAIs as prophylaxis and treatment and thus they can be considered a reasonable public health measure during seasonal influenza outbreaks, pandemics and zoonotic outbreaks caused by susceptible influenza virus strains.

Agenda item: 7 Appendix 2

Report title: LES Review – Minor Injuries Service

1. Background

This paper considers the current Minor Injuries Enhanced Services in BNSSG, and recommends a future direction based on learning from the pilot service in South Gloucestershire and the enhanced service in North Somerset. This review is set within the context of implementation of the BNSSG Urgent Care Strategy across the area.

The paper makes a recommendation to the Committee to cease enhanced payments to practices for minor injuries at the end of March 2019. In addition, the paper describes how urgent care services are being developed and enhanced, informed in part by the outcomes of minor injuries enhanced services, to address the needs of the population in each locality and across BNSSG.

2. The LES Review

All Local Enhanced Services in BNSSG have been subject to a desktop review, and findings and recommendations reported to PCCC in recent months. The desktop review for the minor injuries enhanced services is attached as Appendix 2.1, and includes detail of the operation and scope of the service.

2.1. Summary Findings of the desktop review – South Gloucestershire

This pilot was introduced in April 2016 and offered to all practices in South Gloucestershire. The aim of the pilot was to provide 'in-hours' (8.30am and 6.30pm Monday to Friday) minor injury provision for local populations as an alternative to attending A&E.

The initial desktop review established a number of key themes:

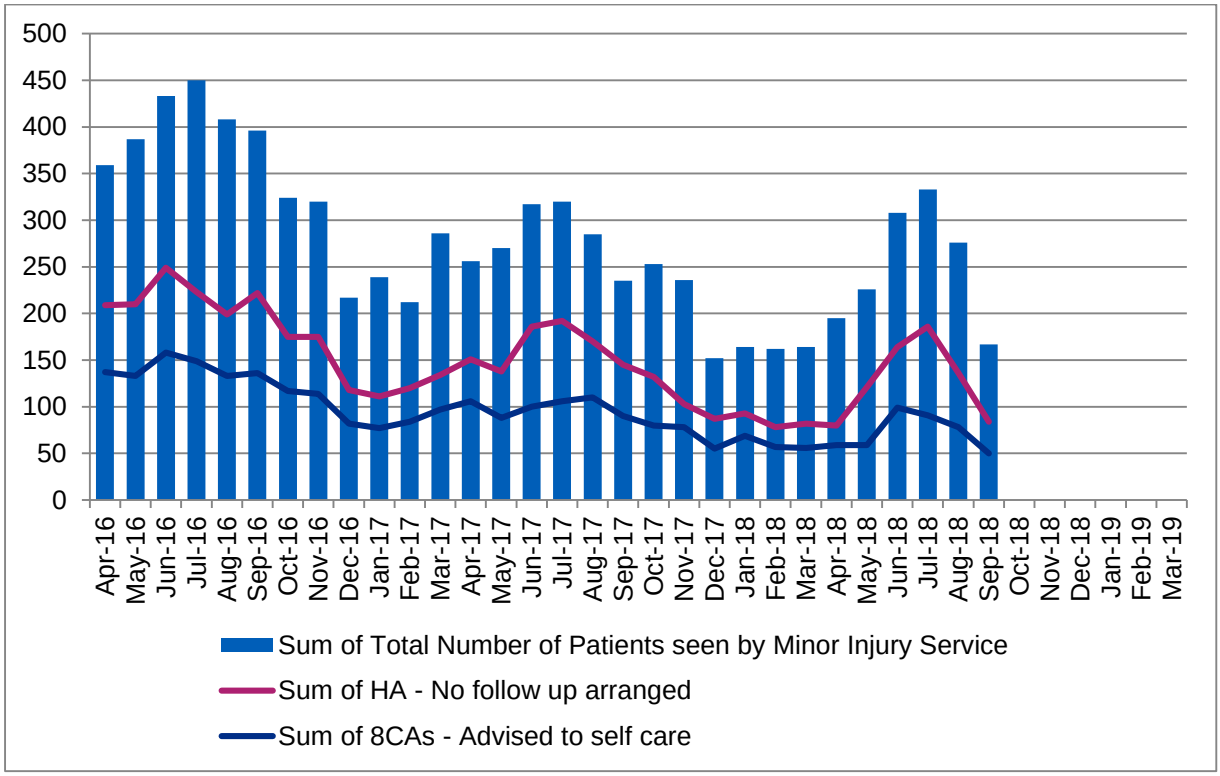
- Service Utilisation and Impact on the Urgent Care System
- High proportion of patients referred to Self- Care
- Cost Effectiveness
    - There is a net cost of providing the service in South Gloucestershire of £378,443p.a. This cost equates to circa double the cost per attendance of an A&E/MIU attendance for a similar case-mix
- Equity of Access
- High patient satisfaction: 99% of patients responding to a patient survey were happy with the treatment they received.

Following discussion of the desktop review at PCCC in June 2018 it was agreed to undertake analysis of more up-to-date activity data for the MIS scheme in South Gloucestershire and for the review to be considered in the context of the BNSSG Urgent Care Strategy. The findings of this further analysis are detailed below:

2.1.1 Service Utilisation

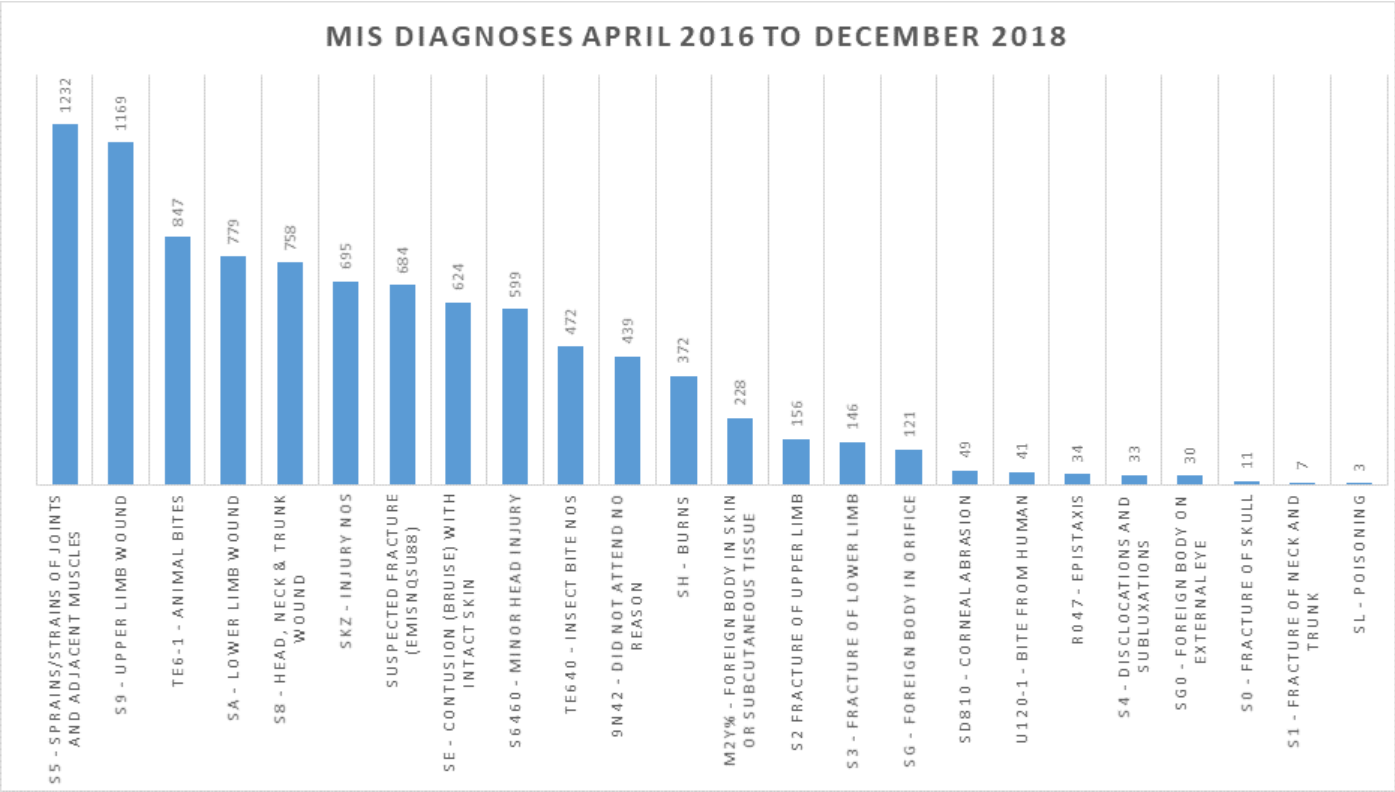
- The average number of attendances per month between September 2017 and September 2018 is 220, with some seasonal fluctuation and higher attendances in the summer months (Figure A).
- The average percentage of people advised to self-care during this period was 38%.
- Key diagnoses continue to be sprains and suspected fractures, wounds, bumps, abrasions and animal bites (Figure B)

Figure A: South Gloucestershire Minor Injuries Enhanced Service activity April 2016 – September 2018[1]



[1] EMIS Codes: HA – no follow up arranged, 8CA – advised to self-care

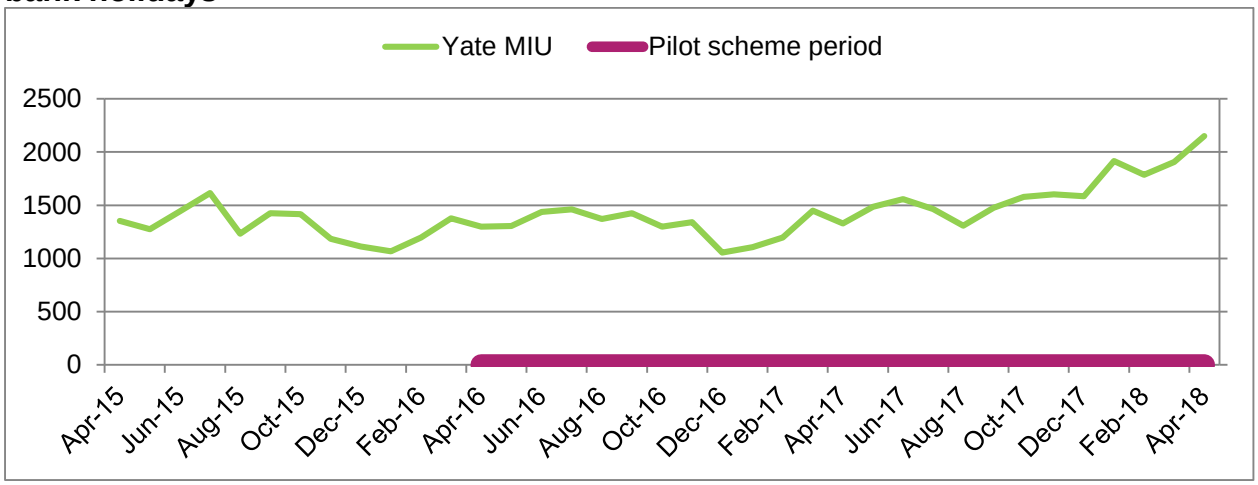
Figure B: MIS Diagnosis April 2016 – December 2018: Number of patients by diagnosis category



2.1.2 Impact on the Urgent Care System

Figure C, below highlights that whilst during the first year of the scheme attendances at Yate MIU were relatively stable these started to increase from April 2017 and the increase has continued.

Figure C: Monthly attendances at Yate MIU Monday to Friday in-hours and excluding bank holidays



Analysis has also been undertaken to understand the relative minor injury activity across BNSSG including Minor Injury activity at Emergency Departments and at Minor Injuries Units (N.B. the data excludes South Bristol Community Hospital which will impact on the South locality numbers and rates).

Figure D: MIU attendances and minor attendances at A&E departments Actual attendances by month by Locality

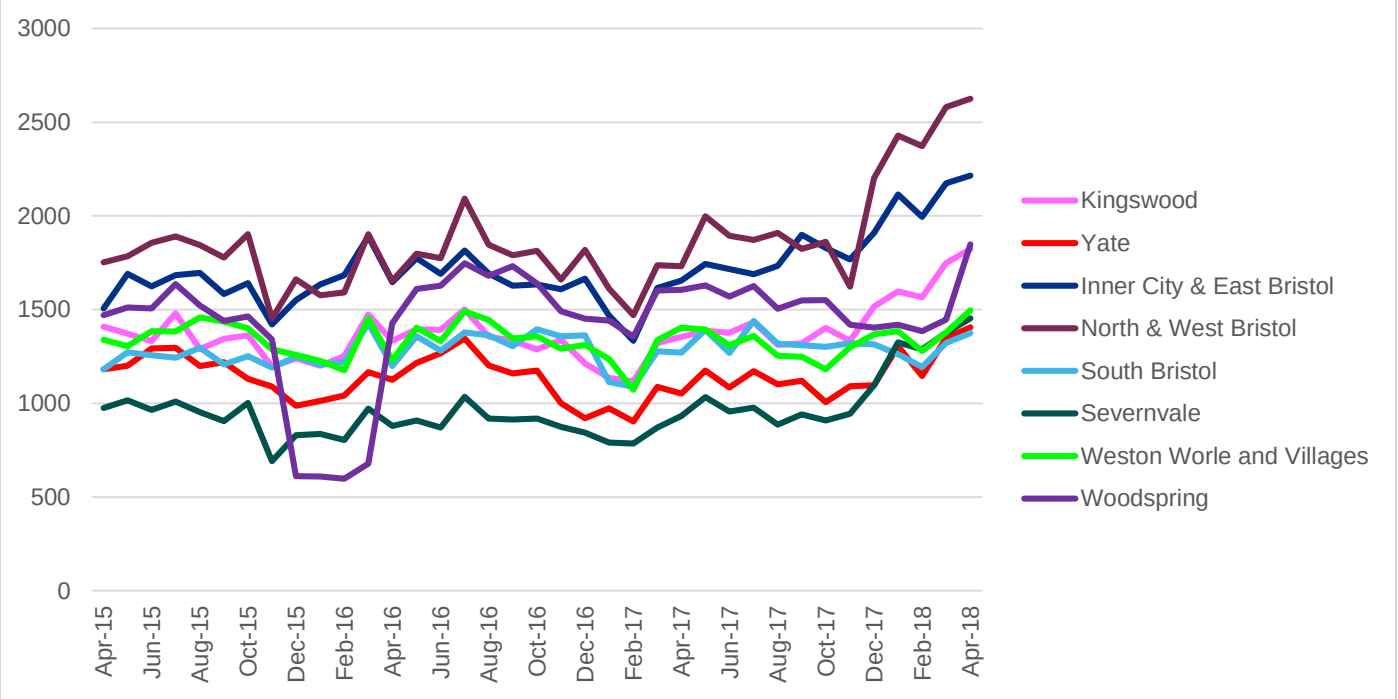
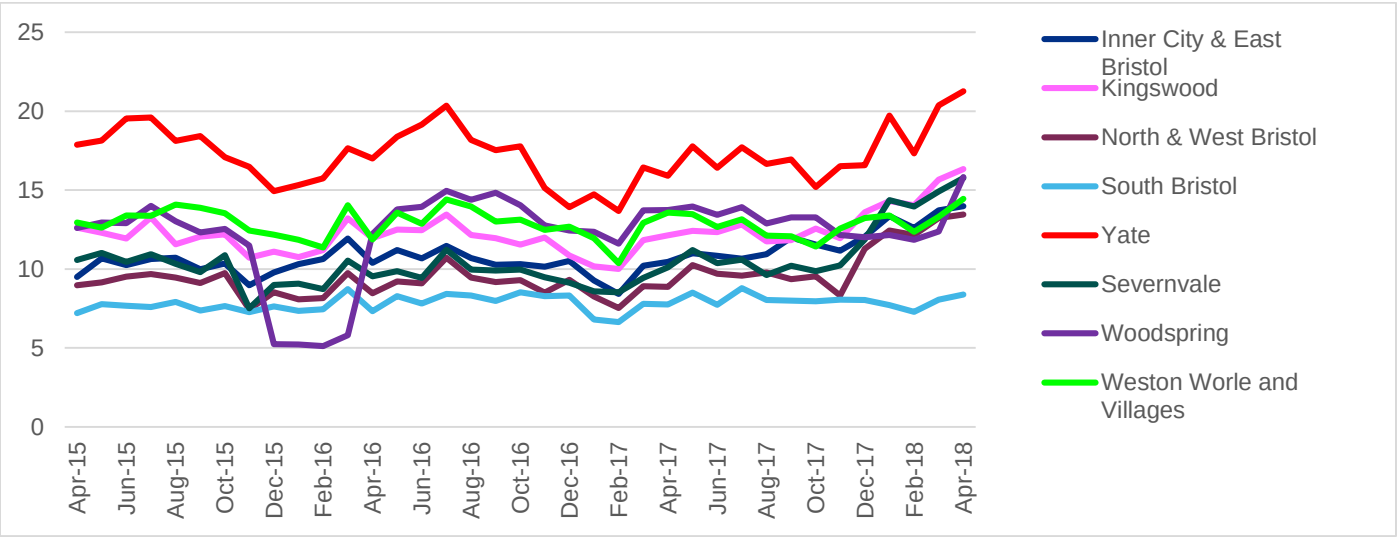


Figure E: Attendances per 1000 population by month by Locality



Whilst these charts indicate a reduction in total numbers attending MIUs and A&E minors between July 2016 and February 2017 for Yate (which has been quoted in previous reports) this does not show a clear trend line that can be attributed to the Minor Injuries Scheme –

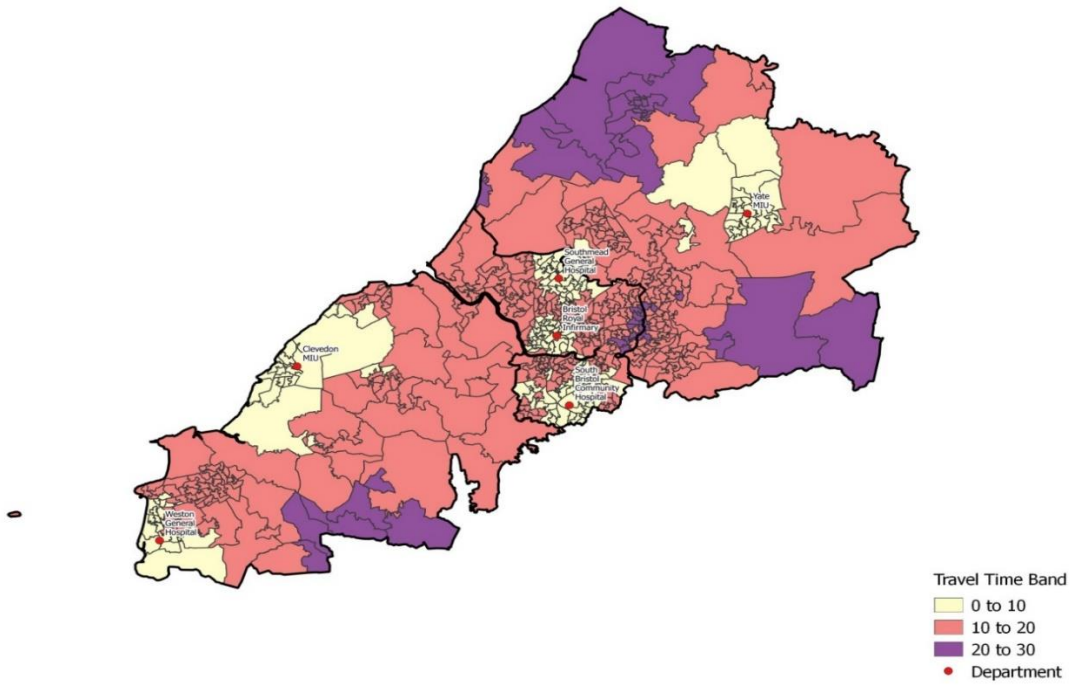
particularly looking at the activity over the entire period from April 2015 and the increase in activity since February 2017 in both the Yate and Kingswood localities. The trend lines are not dissimilar to those for the localities across BNSSG both for actual number and attendances per 1,000 population. Figure E also highlights that even with the Minor Injury Local Enhanced Service pilot, Yate has a higher rate per 1,000 population attendance (reflective of proximity of the MIU) and Kingswood is comparable to other localities in BNSSG where there is not a minor injuries enhanced service in place. The Minor Injuries pilot has therefore not had an impact on reducing demand at A&E departments or the Minor Injury Unit.

2.1.3 Equity of Access

Analysis has also been undertaken to assess whether the service meets demographic need, as the case for introducing minor injury local enhanced services in North Somerset and South Gloucestershire was made at least in part to reflect rurality and distance to travel to locations for treatment of minor injuries.

Figure F demonstrates that all of the BNSSG population has access to a Minor Injury setting (including Emergency Department minors) within a 20-30 minute drive by private vehicle within the BNSSG area.

Figure F: Average travel time to minor injury setting, BNSSG



2.2. Findings of the desktop review – North Somerset

The North Somerset Minor Injuries service is much smaller in scale. It is on offer to 5 practices. These are:

- Heywood Family Practice
- Portishead Medical Group
- Mendip Vale Medical Practice
- Tyntesfield Medical Group
- Winscombe Surgery

Practices providing this service are paid a set annual retainer for "lower level" procedures and then a £50 per activity fee for activities on a set list of "higher level" procedures. The annual budget for the North Somerset minor injuries LES is £43,968. Practices do not report the number of "lower level" procedures they undertake, but they do report the number and type of "higher level" procedures. In 16/17 there were a total of 157 claims for the higher level procedures at a value of £7,850.00. Between April 2017 and September 2018 there were 223 claims for the higher value procedures at a value of £11,350. 170 of these "higher level" procedures are classified as screening for neurological disorders and were provided by 2 of the 5 practices. All 5 practices continue to be paid the annual retainer for the lower level procedures.

Four out of 5 of the practices within the scheme are located within the Woodspring locality (Winscombe is the exception). As can be seen from Figure E there is no discernible difference between the A&E minor and Minor Injuries attendances rate for this locality when compared to other localities in BNSSG.

As a smaller scheme, the North Somerset LES has not been subject to the same analysis as in South Gloucestershire. It should be noted that 3 of the 5 practices are located within the distance profile of 10-20 minutes' drive to a minor injury setting on the map of travel times. The 2 practices accounting for the significant proportion of higher level claims are located within a 10-20 minute drive to a minor injury setting.

2.3 Developing Urgent Care Services in BNSSG

Whilst the Enhanced Services have not proved financially sustainable in terms of value for money, components of the scheme have been successful and will be incorporated into the further development of urgent care services. There is now an Urgent Care Strategy in place across BNSSG which focusses on integrated services, targeted prevention, simplification of pathways and consistency of service provision for our population. The outcomes of the pilot have informed local discussions on delivery of the Urgent Care Strategy in BNSSG.

Key components of the development of Urgent Care services include:

- Promotion of self-care, including digital advice and guidance, and advice and support through community pharmacies,

- Enhanced access to GP services through the implementation of locality based Improved Access services (expanded weekend and evening appointments) for the whole of the population. A proportion of these appointments will be pre-bookable through 111 from 1st April 2019
- Implementation of a new integrated Urgent Care Clinical Assessment Service (IUC/CAS) from 2nd April 2019 will transform the way in which our population can access urgent care services. The new service will bring together the services provided by 111 and GP out of hours services and provide a comprehensive Clinical Assessment Service designed to close every call with either advice, an electronic prescription, or with a booked appointment in the best service to treat,
- Integrated**/**Networked Assessment Function: in our future system, clinicians at the first point of contact with a patient should all have the same access to diagnostics, expert advice and assessment which would allow them to reach a management plan for a growing number of patients without the need for a hospital stay.
    - As part of the Minor Injuries Enhanced service, patients referred by South Gloucestershire GPs for urgent x-ray at Yate MIU or Cossham Hospital are given an urgent same day x-ray report (known as "hot reporting.) This aspect of the pilot has been highly valued by South Gloucestershire practices and is proposed to be maintained going forward and expanded to cover the North Bristol NHS Trust catchment. Conversations to align this across the system need to take place.
- Urgent Treatment Centres Plan: Walk-in urgent treatment services (including Minor Injury Units) should be simplified and offer consistency of opening hours, services available and branding.
    - The CCG is working with Sirona and North Bristol NHS Trust to increase the hours of operation of the Yate Minor Injuries Unit, to be consistent to those offered in other minor injuries settings, i.e. South Bristol Community Hospital and Clevedon MIU. This will also include increasing the availability of X-ray facilities to match the hours of operation of the Unit. The CCG's Commissioning Executive has agreed in principle to increase the opening hours of Yate MIU to 0800 – 2000, 7 days a week (including Bank Holidays). This will also enable the unit to reduce the frequency of early closures and to be able to cope better with surges in demand.
    - The CCG is currently working with Sirona and NBT to confirm an implementation plan, including the recruitment of additional staff, and is anticipating that the new service hours will commence in April 2019.
    - In addition, and as part of the development of Yate Minor Injuries Unit, we will explore the interface with IUC/CAS and the potential for streamlining patient experience by offering bookable slots. This is a feature we are developing for all our Urgent Care Treatment Centres and Minor Injury Units across BNSSG.

2.4 Summary

There has been learning derived from the Minor Injury enhanced services which is being incorporated into the further development of urgent care services across BNSSG. However, this review has established the enhanced services themselves have not had an impact on reducing demand on attendances at A&E departments or Minor Injury Units and have not been a cost effective or equitable model of provision.

The services now being commissioned and implemented under the Urgent Care Strategy will now ensure a consistent, equitable and simplified pathway for the whole population of BNSSG.

3. Financial resource implications

There is a net cost of £378,443 p.a.to the CCG of providing the South Gloucestershire Minor Injuries pilot service, and a cost of £43,968 p.a. for the North Somerset service. This cost equates to circa double the cost per attendance of an A&E/MIU attendance for a similar case-mix

The Minor Injuries LES schemes do not demonstrate value for money and this resource could be better used to support other services, e.g. implementation of the urgent care strategy, and the implications of the LES review. The financial impact on individual practices of the withdrawal of the enhanced payments for minor injuries will be taken into account as part of the overall impact of the LES review.

4. Legal implications

There are no legal implications arising from this paper.

5. Risk implications

There is a risk that as the schemes are concluded additional pressure could be placed on ED departments through increased A&E attendances. This would be mitigated through the implementation of key elements of the Urgent Care Strategy, including extended and consistent opening hours of Yate MIU, GP Improved Access and the launch of the new IUC/CAS service.

6. Implications for health inequalities

As previously outlined the maps of travel distance times suggest the populations across BNSSG have access to a Minor Injury access point within a 30-minute drive (accepting that this may vary in peak travel times). The Minor Injuries local enhanced services are potentially providing more access for a part of our population than for others and the evaluation does not indicate that it would represent value for money to reproduce this across BNSSG.

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

An equalities impact assessment needs to be developed to support the development of urgent care solutions in the respective localities.

8. Consultation and Communication including Public Involvement

There has been work to promote the Minor Injuries pilot service in South Gloucestershire. This has taken the form of press releases part-way through the scheme, patient information leaflets (attached to some of the practice websites), a briefing to Health and Overview Scrutiny Committee and it is listed in our current BNSSG guide to NHS services for patients. A South Gloucestershire HealthWatch GP survey of 234 people published in February 2018 found that no respondents mentioned the GP based minor injuries service.

The development of alternative pathways requires clear and consistent public messaging on how best to access services. There will be communications workstreams to support the introduction of the IUC/CAS and the expansion of services at Yate Minor Injuries Unit.

South Gloucestershire's Health Overview and Scrutiny Committee received an update on the Urgent Care Strategy at its meeting in January 2019 and will be briefed further on the specific plans set out in this paper at its meeting in March 2019.

9. Conclusions

The findings of this review demonstrate that the minor injuries enhanced service schemes do not represent value for money or deliver sustained system impact and are therefore not enhanced service payment schemes which we would wish to reproduce across BNSSG. The Committee is therefore asked to support these findings and support a decision to conclude both the North Somerset and South Gloucestershire Enhanced Service schemes. Both schemes are due to expire in March 2019. Practices have been notified that the schemes are under the LES review and are aware that they were unlikely to be rolled forward.

It is recognised that patients will continue to present to primary care for minor injuries through their GP practice, where they will either be treated, advised to self-care or triaged to an alternative urgent care service. Increased availability of primary care at evenings, weekends and bank holidays through Improved Access will support people to use primary care appropriately, as will support, advice and direct booking through the IUC/CAS. Maintenance, and potential expansion to north Bristol of the hot x-ray reporting service will support practices in dealing effectively and swiftly with minor injuries which present in primary care.

Urgent Care Services will continue to be developed in line with the BNSSG Urgent Care Strategy to ensure a simplified, consistent and high quality pathway.

10. Recommendations

PCCC is asked to:

- note the updated findings contained within this report
- note the plans to develop urgent care services, building on the learning from the minor injuries enhanced services and in alignment with the BNSSG Urgent Care Strategy

- agree to conclude enhanced service payments for minor injuries services in South Gloucestershire and North Somerset

Report Author: **Jenny Bowker, Head of Primary Care Development and Lindsay Gee, Head of Locality Planning**
Report Sponsor: **Martin Jones Medical Director and David Jarrett, Area Director, South Gloucestershire**

Appendices

2.1 Desktop review

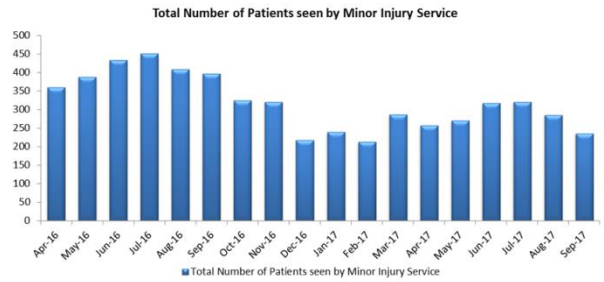
Agenda Item Number 7

Appendix 2.2 – Desk Top Review v2

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

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

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

4	**Capacity & Demand** How many people access the service? What is the trend in demand? What is the uptake across practices?	 • Attendance to the South Gloucestershire MIS has fluctuated throughout the pilot period, rising steadily through year 1 quarter 1 and early quarter 2, seeing peak attendances, in excess of 400 patients per month through the summer months of June, July and August. • Year 2 saw a steady rise through quarter 1 and again peaking in the summer months of June and July, but at much lower numbers than in year 1, at 317 and 320 respectively and then declining slightly towards the end of year 2 Quarter 2. As a much smaller scheme, activity for the North Somerset service has not been analysed to the same extent
5	**Financial Appraisal** What is the cost of delivering the service? What are we paying for the service? What would be the costs of not delivering the service?	**South Gloucestershire** £3.5K per annum Mgmt. and admin. £0.60 per patient Service delivery. £0.05 per patient consumables. Staggered payment for reduction in MIU/A&E attendances from practice Total Spend 2017/187 £350K **North Somerset** Practices providing this service are paid a set annual retainer for “lower level” procedures and then a £50 per activity fee for activities on a set list of “higher level” procedures. The annual budget for the North Somerset minor injuries LES is £43,968. Practices do not report the number of “lower level” procedures they undertake, but they do report the number and type of “higher level” procedures. In 16/17 there were a total of 157 claims at a

		value of £7,850.00
6	**Delivery Model**	
	Could this service be delivered by another provider? Could this service be delivered at scale across practices? How would this impact on quality of service delivery and the cost of service delivery?	Further work needs to be done to understand where this activity would go should there be changes to this service – it is anticipated that a significant proportion of people could be supported with self-care, seen by their practice as part of the core contract and/or within improved access hours, attend their local pharmacy and in some instances attend a local Minor Injuries Unit.
7	**What would be the impact of decommissioning this service?** What are the implications for patients? Is there an impact on other stakeholders, premises, equipment etc? Was a health inequalities impact assessment ever undertaken to support the service and has this been considered? Would decommissioning affect the viability of a provider?	South Glos and North Somerset patients may be required to travel further for minor injuries treatment. Decommissioning would not have an impact on premises or the viability of providers. Impact on individual practices will be considered as part of discussions on the overall impact of the LES review.
8	**Evaluation** What monitoring takes place and how often is it reported? Have any audits taken place to assess effectiveness?	**South Gloucestershire** 6 month appraisals of activity and patient feedback. Last appraisal undertaken January 2018 There is some variation in practice take up of the scheme and numbers of patients seen by minor injuries service at each practice. **Minor Injuries Service - Cost Benefit Analysis April 2016 – September 2017:** Total Fixed Costs (Training/ Equipment and Consumables/ Practice Fees/ Practice Bonus): **£411,219.80** % change in the rate per 1000 attending A&E in hours from the 25 South Glos practices: **-4% (Target : -10% each year)** Total reduction in A&E / Yate MIU attendances from the 25 South Glos practices: **482**

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

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

Agenda Item 7 Appendix 3

Title: LES Review approach to financial modelling
Author: Jenny Bowker & Rob Ayerst

1. Background

The LES specifications have all now been reviewed and new revised BNSSG wide specifications have been developed and shared with the membership for:

- Anticoagulation
- Recognition and support for people with dementia
- Insulin Initiation
- Specialised Medicines Monitoring (formerly known as Near Patient Testing)
- Supplementary Services
- GP Practice Support to Care Homes
- DVT pathway for patients presenting in general practice

.
The following enhanced services have been reviewed and decisions have been made not to continue with these from April 2019:

- Bristol Primary Care Agreement
- South Gloucestershire Compact

The evaluation of the Minor Injuries LES schemes in South Gloucestershire and North Somerset has been concluded and a recommendation not to continue these is included within the papers to the 29th January Committee. For the purpose of this paper it is assumed that this recommendation has been supported.

The decisions for the Bristol Primary Care Agreement and South Gloucestershire Compact have been made in public meeting of the PCCC and formally notified to practices.

It was agreed at the September PCCC meeting that financial tariffs would be considered as a package at the conclusion of the review period so that decisions could be made considering the combined impact on the CCG and on practices.

2. Financial Modelling

The general approach and principles used to underpin the financial modelling is set out below:

- Developing a consistent tariff for each LES with consideration of the following factors:
  - Overall cost to CCG
  - Requirement to set tariff at a level that will incentivise practice sign up whilst providing a value for money service
  - Likely impact on practice level income, and risk of de-stabilising individual practices
- Developing more sophisticated costing structures to reflect workload where possible
- Comparison of equivalent activity in secondary care to test Value for Money
- Recognition that LES funding is a contribution to providing an enhanced level of service, and should not be a duplicate payment for service covered in core contracts

3. Current LES Tariffs (2018/19) v Proposed LES Tariffs (from 1st April 2019)

Table 1

	Current Tariffs (2018/19)			Proposed Tariff (2019/20)
Anti-Coagulation LES	**NHS Bristol**	**NHS North Somerset**	**NHS South Gloucestershire**	**BNSSG**
Basic Level (Level 1)	£57	-	£60 *	£57
Advanced Level (Level 4)	£120	-	-	£160
Active ambulatory patients	-	£170	-	-
Active domiciliary patients	-	£111	-	-
New ambulatory patients	-	£125	-	-
New domiciliary patients	-	£115	-	-

* no payment for first 10 patients

Dementia LES	**NHS Bristol**	**NHS North Somerset**	**NHS South Gloucestershire**	**BNSSG**
Practice Sign Up	£515	Not Currently Offered	Not Currently Offered	£515
Diagnoses	£169			£169
Review	£41			£41

Insulin Initiation LES	NHS Bristol	NHS North Somerset	NHS South Gloucestershire	BNSSG
Insulin Initiation	£250	£175	Not Currently Offered	£175
Insulin Follow-Up / Review	-	£50		Removed from specification
GLP-1 Initiation	£120	-		

Specialised Medicines Monitoring LES	NHS Bristol	NHS North Somerset	NHS South Gloucestershire	BNSSG
Per Patient, per quarter	£85.24	£85.00	£75.00	See Below

GP Practice Support to Care Homes	NHS Bristol	NHS North Somerset	NHS South Gloucestershire	BNSSG
Nursing Home price per bed per annum	£235	£242	£200	£230
Residential Home price per bed per annum	£153		£100	£120

DVT pathway for patients presenting in general practice – new for 19/20	NHS Bristol	NHS North Somerset	NHS South Gloucestershire	BNSSG
	£25 or £35 depending on whether venous or POC			£30 per assessment of DVT and £10 for each Point Of Care testing kit used

Specialised Medicines Monitoring LES Payment Structure:
Table 2

Payment Level	Amount of annual monitoring	Drugs currently included	Practice Payment	Practice Payment (quarterly)
0	1		None as considered part of annual patient disease monitoring and management	None as considered part of annual patient disease monitoring and management
1	2-3	Denosumab (Prolia)	£50.00	£12.50
2	4-5	Azathioprin	£70.00	£17.50
		Leflunomide		
		Sodium aurothiomalate		
		Methotrexate		
		Penicillamine (Nephrology)		
3	6-8	Mercaptopurine (oral)	£100.00	£25.00
		Sulfasalazine (oral)		
4	9-12	Penicillamine (Rhuematology)	£120.00	£30.00

Practices will in addition be paid an annual sum of £350 per 10,000 patients to reflect that there will be a number of new patients initiated onto the medications covered by the LES that will initially require additional monitoring, before they are stabilised, over and above the payment level above, resulting in increased costs in the first year of a patient being initiated onto a drug.

GP Practice Support to Care Homes LES Payment Structure

Whilst a single specification has been developed it is recommended that a two tier payment is offered to support the difference in acuity between Nursing Home and Residential Homes. This is line with the approach of other CCGs who have developed a single specification with tiered payments. This LES is to be offered for 1 year only with this funding moving to a locality model from April 2020. A two tiered payment most closely mirrors existing payment arrangements for this interim year.

2018/19 Care Home LES Current Care Home Coverage & 2018/19 Forecast Expenditure

Table 3

				Current LES Coverage?					
	TOTAL			Yes		No		2018/19 Tariffs / Forecast Spend	
	Number of Care Homes	Number of Care Home Beds	Current % LES Coverage (% of Beds covered by	Number of Care Homes	Number of Care Home Beds	Number of Care Homes	Number of Care Home Beds	Current Tariff (2018/19)	Current FOT (2018/19)
Nursing Home									
Bristol, City of	38	2,008	81%	27	1,628	11	380	£235	£382,580
North Somerset	35	1,522	53%	19	814	16	708	£242	£196,988
South Gloucestershire	22	958	73%	15	697	7	261	£200	£139,400
Care Home with Nursing Total	**95**	**4,488**	**70%**	**61**	**3,139**	**34**	**1,349**		**£718,968**
Residential Home									
Bristol, City of	73	910	43%	27	388	46	522	£153	£59,364
North Somerset	69	1,393	5%	3	74	66	1,319	£0	£0
South Gloucestershire	56	1,013	64%	26	648	30	365	£100	£64,800
Care Home Without Nursing Total	**198**	**3,316**	**33%**	**56**	**1,110**	**142**	**2,206**		**£124,164**
All Care Homes									
Bristol, City of	111	2,918	69%	54	2,016	57	902		£441,944
North Somerset	104	2,915	30%	22	888	82	2,027		£196,988
South Gloucestershire	78	1,971	68%	41	1,345	37	626		£204,200
Grand Total	**293**	**7,804**	**54%**	**117**	**4,249**	**176**	**3,555**		**£843,132**

2019/20 Proposed Tariff & Modelled Uptake Options

Table 4

2019/20 Proposed Tariff & Modelled Uptake Options

	2019/20 Proposed Tariff & Modelled Uptake Options					CCG Impact			
	Proposed Tariff	A	B	C	D	A	B	C	D
Nursing Home		100%	85%	70%	Current				
Bristol, City of	£230	£461,840	£392,564	£323,288	£374,440	£79,260	£9,984	-£59,292	-£8,140
North Somerset	£230	£350,060	£297,551	£245,042	£187,220	£153,072	£100,563	£48,054	-£9,768
South Gloucestershire	£230	£220,340	£187,289	£154,238	£160,310	£80,940	£47,889	£14,838	£20,910
Care Home with Nursing Total		**£1,032,240**	**£877,404**	**£722,568**	**£721,970**				
Residential Home		100%	65%	50%	Current *				
Bristol, City of	£120	£109,200	£70,980	£54,600	£46,560	£49,836	£11,616	-£4,764	-£12,804
North Somerset	£120	£167,160	£108,654	£83,580	£83,580	£167,160	£108,654	£83,580	£83,580
South Gloucestershire	£120	£121,560	£79,014	£60,780	£77,760	£56,760	£14,214	-£4,020	£12,960
Care Home Without Nursing Total		**£397,920**	**£258,648**	**£198,960**	**£207,900**				
All Care Homes									
Bristol, City of		£571,040	£463,544	£377,888	£421,000	£129,096	£21,600	-£64,056	-£20,944
North Somerset		£517,220	£406,205	£328,622	£270,800	£320,232	£209,217	£131,634	£73,812
South Gloucestershire		£341,900	£266,303	£215,018	£238,070	£137,700	£62,103	£10,818	£33,870
		£1,430,160	**£1,136,052**	**£921,528**	**£929,870**	**£587,028**	**£292,920**	**£78,396**	**£86,738**

*Current assumes existing S Glos and Bristol rates of take up for Nursing Home and residential, existing North Somerset take up rate for Nursing Homes and 50% take up of Residential Homes (average of existing take up rates for S Glos and Bristol)

Option A represents full coverage of all beds and the financial impact of this. It is thought unlikely that this will be achieved given existing take up rates and that the true financial impact is much more likely to be between Options B and C. For the purpose of modelling the overall forecast outturn across the LES Option B has been assumed.

Whilst it is possible to map the forecast impact at Area level it is difficult to forecast this at practice level as practice mapping to all care homes is a requirement of the specification and it would be complex to map practices and then make assumptions about take up rates. As a result this is only shown at Area level. It is proposed that practices are sent a financial modelling tool which will allow them to insert their proposed LES values and calculate their income for all of the LES including GP Practice Support to Care Homes.

4. Forecast Impact of 2019/20 LES proposed tariffs (Locality Level)

Proposed revised tariffs have been applied to forecast 2018/19 activity levels to calculate the impact in total cost to the CCG, and the potential income change to practices (summarised in the table below at locality level).

A number of assumptions have been made in this modelling, which are outlined below:

- Where Practices are already signed up to Local Enhanced Services, 2018/19 forecast activity has been used as the basis for modelling 2019/20 reimbursements, ensuring **only tariff changes are reflected** in changes to CCG cost / practice income.
- For the newly offered LES: Recognition and support for people with dementia in North Somerset and South Gloucestershire; Insulin Initiation in South Gloucestershire; DVT pathway for patients presenting in general practice across BNSSG 100% GP practice take up has been assumed
- For GP Practice Support to Care Homes as described above Option B is assumed and the impact has been shown in the Area line.
- No changes have been made to the supplementary services LES tariffs and for this reason it is not included in the table below

Table 5

Row Labels	1. Anti-Coagulation	2. Dementia	3. Insulin Initiation	4. Near Patient Testing	5. Support to Care Homes (Option B)	6. DVT	Forecast Income Change based on Proposed 2019/20 Tariffs
Bristol							
Inner City & East Bristol	£2,480	£0	-£15,765	£345	£0	£6,989	-£5,951
North & West Bristol	£3,560	£0	-£8,355	£105	£0	£8,029	£3,338
South Bristol	£10,000	£0	-£14,955	-£572	£0	£7,369	£1,842
Bristol Total	**£16,040**	**£0**	**-£39,075**	**-£122**	**£21,600**	**£22,386**	**£20,829**
North Somerset							
Woodspring	-£7,595	£42,922	-£1,017	-£7,149	£0	£5,223	£32,383
Worle Weston Villages	-£5,708	£43,954	-£250	-£7,103	£0	£5,086	£35,979
North Somerset Total	**-£13,303**	**£86,876**	**-£1,267**	**-£14,252**	**£209,217**	**£10,309**	**£277,579**
South Gloucestershire							
SG Locality	£13,680	£94,143	£19,600	£16,269	£0	£11,305	£154,997
South Gloucestershire Total	**£13,680**	**£94,143**	**£19,600**	**£16,269**	**£62,103**	**£11,305**	**£217,100**
Grand Total	**£16,417**	**£181,019**	**-£20,742**	**£1,895**	**£292,920**	**£44,000**	**£515,509**

The £515k increase in investment in the LES can be afforded from the £1.7 million which has been released from the cessation of the Bristol Primary Care Agreement and the Compact in South Gloucestershire. The investment in the new DVT LES is also offset by savings made from the existing care pathway. Offering the suite of LES across BNSSG will provide consistency and value for money by supporting more people to have their care in a community setting.

5. 2019/20 Operational Plan

The NHS Operational Planning and Contracting Guidance 2019/20 has now been published. This requires CCGs to commit £1.50/head recurrently to developing and maintaining primary care networks so that the target of 100% coverage of practices within primary care networks is achieved as soon as is possible and by 30 June 2019 at the latest. For BNSSG this equates to an investment of just over £1.3 million. The guidance also indicates that further guidance on primary care networks will be forthcoming. In addition, the Long Term plan has signalled that real terms investment in primary medical and community services should grow faster than CCGs overall revenue growth. Locally the investment in primary care networks will be focused through the Locality Transformation Scheme. Furthermore, there will be continued GPFV investment in primary care in 19/20 including £6 per head for Improved Access and additional investment in primary care resilience. As part of achieving overall financial balance the CCG has a savings target of £1million to be found recurrently from the primary care budget. A paper will come back to the Committee in February which will demonstrate budget setting for next year and the overall investment and savings profile.

6. Risk and Mitigations

Key risks:

Activity Changes / Practice Sign Up
All modelling is based on 2018/19 Q1 and Q2 activity data and practice claims where available, or 2017/18 full year activity. Changes to activity levels in 2019/20 will change both overall cost to the CCG, and practice level income.

7. Next Steps

- Once the proposed tariffs are approved the payment and reporting schedules for each specification will be completed prior to issue to practices
- A finance modelling tool can be provided to practices in February along with the contracting Expressions of Interest process which will support practices to model their potential income

8. Summary and Recommendations

Recommendations:

- The Committee is asked to note the proposed finance tariffs and financial analysis for the full set of specifications and approve the proposed tariffs

Agenda Item 7 Appendix 4

Approach to commissioning Local Enhanced Services (LES) across BNSSG – Highlight Report

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Overall Summary			
Report Date	18/01/2019	Report Author	Heather Allward
Overall Status	On Target	Previous Programme Status	On Target
Explanation for Overall Status	All Project areas are on track and achievable		

Main Achievements This Period	• Specifications for Dementia and Insulin Initiation LES' have been amended following recommendations from PCCC at the meeting held on 3rd January.
	• DVT period moved to 1 year
	• Further work has been undertaken to prepare the following for PCCC on 29 January:
	  ○ Care Homes LES specification
	  ○ Tariff proposals and financial impact
	  ○ Recommendations for Minor Injuries LES
	  ○ Practice level financial impact analysis (closed session)
	  ○ Project closure and contract review proposals		

Planned Progress Next Period	• Final Service Specifications to be circulated to practices • Expressions of Interest to be sent out and returned in February • Promotion of LES offer to be shared via forums, LLGs and GP Bulletin throughout February		

Due in next 30 days

Description	Start Date	Date for Completion	Progress Update	Status
Minor Injuries - Present recommendation for next steps at PCCC		29/01/2019	02.01.19 - Recommendations for next steps to be shared with PCCC in open session on January 29th.	On Target
Final specification and tariff for Care Homes to be presented for approval to 29th January PCCC		29/01/2019	18.01.19 - work underway to prepare specification and tariff for PCCC 29.01.19.	On Target
Project closure and contract review proposals to be developed for 29th January PCCC.		29/01/2019		On Target

Final service specifications to be sent to practices by end of January 2019	21/01/2019	31/01/2019	18.01.19 - to be actioned following discussion at PCCC 29.01.19 where Care Homes specification due to be discussed.	On Target

Risks

Description	Unmitigated Score	Mitigating Action	Mitigated Score	Progress on Mitigating actions
Practice uncertainty about the future of their income streams	**12**	• 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. • Write to practices to confirm the position for local enhanced services for this financial year by 03.08.18.	**9**	07.01.19 - as agreed as PCCC: Proposals for Care Homes specification and tariff to be presented to PCCC on 29th January. 18.01.19 - practice level impact assessments are being produced for closed session PCCC on 29.01.19.
There is a risk that the locality model may not be ready to take on at scale provision.	**9**	• Agree framework and steps with Locality Providers to be ready to provide locality solutions • Paper on LTS phase 3 sets out next steps for developing and strengthening integrated community localities to be 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.	**9**	07.01.19 - Proposals for all LES contracts will be offered at practice level for April 2019 with the expectation that Care Homes and Diabetes move to a locality commissioned service from April 2020. Work to develop the locality commissioning contractual framework is underway.
LES review proposals pose a financial risk either to the CCG or to individual practices	**12**	• 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 • Financial modelling to be discussed at Executive Team on 5th December.	**12**	07.12.18 - Discussion took place at Exec Team on 5th December. Discussion at Exec Team on full set of tariffs on 23rd January. 07.01.19 - Proposals for Care Homes specification and tariff to be presented to PCCC on 29th January.

There is a risk that a number of practices will not sign up to the new LES offers	**12**	• Membership engagement has been undertaken for all specifications across BNSSG • Financial impact assessment tool to be shared with practices in February. • Continued promotion of LES offer at forums, through Locality Leadership Groups (LLGs) and GP Bulletin. • Monitoring of EOIs received for the LES' to be overseen by the Primary Care Contracting subgroup of PCOG throughout February.	**9**	

Issues

Description	Progress on Actions	Resolution Date
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.	07.01.19 - 'LES Review approach to financial modelling' paper included as appendix to main report Jan PCCC 3rd January, noting progress and next steps. 21.01.19 – Final set of financial modelling to be presented at PCCC on 29th January.	21/12/2018
In relation to the Care Homes LES, developing accurate financial forecasting for the practices and CCG is impacted by practice take up and practice mapping to care homes which is a requirement of the specification.	21.01.19 – Financial modelling is presented at area level.	