Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

Primary Care Commissioning Committee (PCCC)

Date: Tuesday 30th October
Time: 9.00-11.00
Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda number: 6

Report title: Local Enhanced Services (LES) Review Update

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

1. Purpose

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

2. Recommendations

The Committee is asked to:

- Note the feedback received on draft specifications shared with the membership and the LMC contained in the main report
- Discuss the draft GP Practice Care Homes With Nursing Support specification in Appendix A
- Note the highlight report in Appendix B and the proposed next steps set out within the main report and the highlight report

3. Executive Summary

The main report sets out key progress in the last month and gives a summary of feedback received on the draft specifications to date noting that engagement is ongoing. It should be noted that the timeline for presenting final specifications to the Committee has been adjusted to 3rd January 2019 as it was not possible to establish a quorate meeting of the Committee in December. The timelines in the Highlight Report have been adjusted to reflect this.

4. Financial resource implications

At the last Committee meeting it was agreed that the complete financial analysis will be presented to the Committee at the end of the year. It has not been possible to establish a quorate meeting of the Committee in December so this will now take place on the 3rd January 2019.

5. Legal implications

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

6. Risk implications

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

7. Implications for health inequalities

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

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

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

9. Implications for Public Involvement

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

Agenda item: 6

Report title: LES Review Update

1. Background

At the last meeting of the Committee 3 draft specifications were presented to the Committee and it was agreed that the specifications should be shared with member practices for engagement. These specifications were Anticoagulation, Near Patient Testing (to be renamed Specialist Medicines Monitoring) and Supplementary Services. This report seeks to give an overview of the engagement undertaken in the last month and a summary of the key points of feedback received to date. In addition, it should be noted that the LES Review Steering Group supported early consultation with member practices in the development of the specification for support to care homes with nursing and this too has been shared at membership meetings with a view to giving further time to develop this. The draft GP Practice Care Homes With Nursing Support specification is attached at Appendix A for discussion with the Committee.

In the last month members of the LES Steering Group have presented the specifications at each of the 3 Bristol locality membership meetings and the North Somerset and South Gloucestershire meetings. Furthermore discussions on the specifications have been held at the practice manager meetings in South Bristol and South Gloucestershire. In addition, the LMC board have reviewed the draft specifications and have provided detailed feedback on each of the specifications. A timetable is in place to engage with both the membership and the LMC on the next set of specifications (diabetes and dementia) as detailed in the Highlight Report. In talking to practices they understood the rationale not to set out proposed tariffs at this stage and also advised that it was difficult for them to give a view about the viability of the proposed services from a provider perspective until they can see these and assess whether they would cover their costs. Our approach to costing will need to assess this in order to mitigate the risk of practices not wishing to sign up to the new specifications in the New Year. Requests have also been made to ensure consistency of contract term which is a key principle of the LES review and to give consideration to length of contract term.

2. Anticoagulation

The key point of discussion with member practices has been in relation to the advanced service and whether this is something that practices feel should be undertaken in primary care across BNSSG. The predominant feedback received from South Bristol, South Gloucestershire and North Bristol (Inner City and East is currently being approached more formally about this) is that this wouldn't be most effectively supported by individual practices. The falling number of patients on warfarin led to viability concerns, even if potentially delivered at locality level. An options benefits appraisal will be presented to PCCC with the final specification, however, on the basis of this feedback it is clearly most likely to recommend that the basic service be made available across

BNSSG with a consistent specification and that the advanced service only be offered to those currently undertaking it. We will then need to conduct a more robust review of clinical quality and cost effectiveness comparisons between those monitored in primary care (as is currently the case in North Somerset and the 2 practices within Bristol) and those within secondary care to determine whether or not we need a uniform approach to this across BNSSG. This has been signalled to the acute trusts within our commissioning intentions for next year.

3. Specialist Medicines Monitoring

Practices have welcomed the proposed change of name from Near Patient Testing to Specialist Medicines Monitoring. Practices have welcomed a framework whereby additional drugs moving to shared care can be added and would like to know more about this.

In addition it was suggested that anti-psychotics medicines prescribing (included within the Supplementary Services specification) and monitoring would benefit from shared care protocols and standardisation to help manage risk. Any new anti-psychotic medication agreed clinically safe for shared care would be added to this framework. Practices have accepted the proposed change in payment structure from a per patient basis to a basis by which payment is structured based on frequency of testing per year.

4. Supplementary Services

There has been some concern raised at a number of the items included within the specification. This has largely been reflected by parts of the Bristol membership and also represented by the LMC. A concern has been raised about increasing the specification (also known locally as the basket) to include ear syringing as currently included in both the South Gloucestershire and North Somerset specifications. There are also concerns raised about the interface with midwifery services which we need to clarify. There have been calls to review the approach to funding the specification to move to payment for an item of service. The funding is currently provided by the PMS reinvestment pot and has been redistributed as part of a 5 year funding agreement with practices to move to more equalised funding and a more equalised offer to patients across all practices. There are also concerns about the totality of work represented by the contents of the ‘basket’ and the need to review the content. A key factor that will enable a more in-depth review of the specification is to generate a list of agreed EMIS codes so that we can get a sense of the activity across practices. This may also help us to identify whether in future some of the content may be best managed at a locality rather than individual practice level. Some of the concerns raised by practices reflect a wider concern about increasing workload in relation to supporting people’s care that may have been initiated within another provider and there is further work to reach agreement locally about how these pathways should be collectively managed.

In South Gloucestershire member practices questioned what was happening about their pre-existing 'basket' enhanced service. This is an additional specification paid at 16 p per patient and which had not been included within the scope of the review as members of the steering group were unaware of it. We are currently investigating this further as this will need to formally come within the scope of the review.

5. GP Practice Support to Care Homes with Nursing

Practices and the LMC welcome the concept of specifications to support care homes. One of the key discussion points was to ask the membership about their views for support to care homes with nursing and support to care homes without nursing. There are two different enhanced services in Bristol for these and in South Gloucestershire the enhanced service covers both those with and without nursing. In South Gloucestershire and parts of the Bristol membership there was strong support for the continued input to both care homes with and without nursing, particularly as care homes without nursing may have increasingly frail residents without otherwise having access to health expertise. North Somerset are currently only funded to support care homes with nursing and the view was that extension to care homes without nursing could be beneficial if it could be appropriately remunerated for the increase in work in supporting both care homes with and without nursing.

Practices welcomed the proposal for simplified reporting and an EMIS template to support this. Practices felt that some of the proposed content needed refining (e.g. clarifying that nursing homes have a duty to ensure that their staff are appropriately trained and reviewing some of the proposed timescales for tasks). There was also a view that the proposed content needed to be costed appropriately and any proposed increase in workload would need to be remunerated and for some the proposed specification represents an increase. It was agreed that we need to be clear about what the role of GPs in supporting care homes is and how other professionals can also provide support – e.g. pharmacists.

The LES Steering Group is now in the process of reviewing how to incorporate the feedback to generate a revised specification for engagement with practices. We also need to develop a costing model to support the specification and assess how this could be applied to both care homes with and without nursing with a cost benefit analysis. It is recognised that support to care homes will also be considered as we develop our procurement of community services and we may need to retain some flexibility in approach over the next 2 years. The Committee is invited to discuss the draft specification and consider the approach to supporting both care homes with and without nursing.

6. Next Steps

The key next steps are to develop and engage with the membership, the LMC and the Committee on draft specifications for Diabetes and Dementia and to present the specification to the Committee for DVT which has been approved through Commissioning Executive and Governing Body as part of a wider redesign of pathways. This will take place during November and December as outlined in the Highlight Report.

Work is underway to review the existing draft specifications in light of feedback received as outlined in this paper before they are presented to the Committee for final approval. Further work is needed to develop the approach to care homes.

Clarification of the payment to South Gloucestershire for an additional 'basket' of procedures will be sought and recommendations will be made to Committee about the approach to this.

Financial modelling to support the development of the next set of specifications continues. This next stage of financial modelling is key. It will need to both identify any savings made as a result of the recommendations of the review and any costs arising from spreading services across BNSSG. The output of this will then inform the resources available to support phase 3 of the Locality Transformation Scheme. The financial modelling will assess the impact on practice income as well as the CCG position. In addition, the CCG will need to consider how to approach new proposals for enhanced services and how these should be resourced where a need has been identified either as part of responding to national targets or to support new pathways developed through the STP. Where possible these should be aligned to the work of LTS phase 3 in the collaborative system design phase to agree new models of care between providers.

7. Financial resource implications

At the last Committee meeting it was agreed that the complete financial analysis will be presented to the Committee at the end of the year. It has not been possible to establish a quorate meeting of the Committee in December so this will now take place on the 3rd January 2019.

8. Legal implications

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

9. Risk implications

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

10. Implications for health inequalities

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

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

The draft specifications align existing specifications and build on best practice and do not therefore represent significant change. Equality Impact and quality impact screening will be undertaken to support the specifications prior to presentation to PCCC for final approval in January.

12. Consultation and Communication including Public Involvement

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

13. Recommendations

The Committee is asked to:

- Note the feedback received on draft specifications shared with the membership and the LMC contained in this report
- Discuss the draft GP Practice Care Homes With Nursing Support specification in Appendix A
- Note the highlight report in Appendix B and the proposed next steps set out within this report and the highlight report

Report Author: Jenny Bowker, Head of Primary Care Development
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Appendices

Appendix A - Specification for support to care homes with nursing
Appendix B – Highlight Report

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations.

Anticoagulation	Anticoagulants are medicines that help prevent blood clots. They're given to people at a high risk of getting clots, to reduce their chances of developing serious conditions such as strokes and heart attacks.

Near Patient Testing	This is defined as an investigation taken at the time of the consultation with instant availability of results to make immediate and informed decisions about patient care.
Supplementary Services	The name for a local enhanced service that identifies a range of investigations/treatments/procedures to be offered consistently in primary care funded as a result of a wider review into the funding of practices called the PMS review.
EMIS	An electronic patient record system and software used in primary care.
DVT	Deep Vein thrombosis- a formation of a blood clot in a deep vein, most commonly the legs.

LOCAL ENHANCED SERVICE SPECIFICATION GP
Practice Care Home Support

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

This Pack contains:

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

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1. Service Specification:

SCHEDULE 2 – THE SERVICES

A. Service Specifications

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

All subheadings for local determination and agreement

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

1. Population Needs

1.1 National/local context and evidence base

Introduction

The purpose of this service specification is to provide a contractual framework for the provision of enhanced medical cover to residents of care homes (WITH NURSING COVER). 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, Treatment Escalation Planning and multi-disciplinary (MDT) management of long term and ambulatory care sensitive conditions. An MDT approach will also include management of nutrition and hydration support.
Specifically, the enhanced service will include the principles of mapping practices to care homes, weekly ward rounds and comprehensive geriatric assessment.

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

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

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

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

2.2 Local defined outcomes

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

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 being receive care 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 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 because of the increased level of care provided.

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

GP practices providing this service will be expected to follow the End of Life Pathway, Advance Care Planning (ACP) to patients that have been aligned to GP Practices participating in this LES. Advance Care Planning (ACP) pathway is a discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included. It is recommended that with the individual's agreement this discussion is 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 attending best interest meetings, providing written and not verbal instructions about crushing 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, TV, District Nurses, Community pharmacists to ensure that communication systems are robust.

4. For the few residents who do not choose to register with the Lead GP Practice, the lead GP practice will be expected to liaise closely with the patient's GP Practice where it will result in improved clinical care. Lead GP Practice aligned to Care Homes will be expected to provide specific input and support to Care Homes when the Care Home care pathways are fully developed further information will be provided by the CCG.

5. Lead GP Practice will take the lead for clinical review of medicines (in conjunction with the pharmacy team. CCG pharmaceutical team will provide data to the CCG on reviews that have been effectively undertaken and any cost savings that have been achieved and this will be monitored as part of the KPIs.

6. A named GP within the Lead GP Practice will be responsible for developing skills and continuous education and ensuring that appropriate systems are set up between the practice and the care homes.

Service Specification

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

1. ACP including annual 6 monthly reviews that will be continually updated to measure the patients changes particularly as they approach End of Life (a continuous living document).

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

3. Providing regular routine surgeries (Community Ward Rounds) plus urgent surgeries as needed in the Care Home. Community Ward Rounds are to be completed with a member of the pharmacy team until such time as all residents have had their medicines optimised. In order to provide pro-active care effectively the frequency of the ward rounds should be at least weekly some larger homes may need more regular visits. The CCG would expect that frequency of Community Ward Rounds ward rounds will be reviewed on an individual basis. Any home visits made outside of the Community Ward rounds will come under core Primary Medical Service.

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

5. Medication reviews, including optimisation and, where possible, de-prescribing, with a focus primary on safe prescribing, secondary prevention, reducing prescribing waste, and cost effective prescribing.

Eligibility Criteria

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

Interdependencies:

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

Treatment Escalation 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

End of Life and fast track EOL

Care homes pharmacist – bid for funding

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/

4.2 Applicable local standards

5. Contract Monitoring, Reporting and Financial Information

5.1 Outcomes, monitoring and evaluation

Quarterly Monitoring

The provider would be required to submit quarterly reporting describing:

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

Annual Monitoring Information

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

Success criteria

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

5.2 Financial Information

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

5.3 Read Codes

5.4 Fees Payable

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

5.4.1 Basic Level

5.4.2 Enhanced Level

5.4.3 Incentive

5.4 Monitoring Schedule

Appendices

Appendix A: Standard Operating Procedure

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

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

This guide will set out recommended patterns of practice for:

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

	Key Actions	Responsibility
1	**General Principles**	
1.1	A GP round should take place on the same day at the same time each week. This should be a mutually agreed time between the nursing home and the GP practice. If necessary this should be on more than 1 day if the home has a large number of beds all cared for by the same GP practice	
1.2	The weekly rounds should be coordinated by named senior nurse (***The NH GP Link Nurse***) at the nursing home. Residents requiring review at the GP round should be identified each week & if necessary routine tests completed (BP, urinalysis, temperature).	
1.3	Inform GP on the morning of the GP round; a) List the residents requiring review b) State the reason review is required c) Give the results of tests done	
1.4	***Named NH 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 areas identified such as must be covered. 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	6 monthly multi-disciplinary reviews with the pharmacist; including stopping any unnecessary medicines and considering the need for specialist review and on-going discussion of the advance care plan.	
3.3	Nursing home staff to coordinate and monitor agreed plan.	
3.4	The care home will record the outcome of visits of all specialist healthcare professionals (e.g. tissue viability team) should be recorded in the residents health record and the GP informed of any changes to the care plan at the next GP round unless urgent.	
3.5	Care homes to adopt homely remedies policy.	
4.	**Urgent Care**	
4.1	Nursing Homes should coordinate all requests for visits through the Shift NH GP Liaison Nurse on each shift.	
4.2	The ‘Prompt sheet – nursing home request for GP visit today’ should be used for residents whose health needs are changing.	

4.3	If the GP is not going to do a visit on the day requested he/she should telephone the home to agree a plan for visit and on-going management of the problem.	
5	**Advance Planning**	
5.1	Monthly Coding meetings to be held in the home.	
5.2	Discuss need for TEP form in line with Resuscitation council guidelines, involving resident, family or IMCA, keep form in Nursing Home, take a copy back to surgery & ensure it is scanned to the residents GP record and record it on the EPACCS system .	
5.3	If necessary GP and Nursing Home to agree meetings with resident & or family to discuss advance care plan.	
5.4	Request anticipatory medications when thought to be entering the last weeks of life.	
6	**Care of the Dying**	
6.1	GP and nurse to engage with EOL pathway for the last days of life' and all current care plans and medications reviewed.	
7	**Care After Death**	
7.1	Provide after death care for family & provide information regarding bereavement services in line with the integrated care plan.	
7.2	Nursing Home notify GP of death and GP to record death on EMIS.	
7.3	GP to provide death certificate in a timely manner within 24 hours for expected deaths.	

Project Highlight Report

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care

Approach to commissioning Local Enhanced Services (LES) across BNSSG

Overall Summary			
Report Date	16.10.18		
Project Name	Approach to commissioning Local Enhanced Services (LES) across BNSSG		
Report Author	Jenny Bowker – Head of Primary Care Development Heather Allward – Programme Officer		
Start Date	April 2018	End Date	April 2019
Overall Project Status	On target	Previous Project Status	On target
Explanation of Project Status	Work is underway to prepare for new specifications and we are currently projected to be on target for 1st April 2019 completion date. We have refreshed our timescales to work towards 3rd January 2019 PCCC meeting to approve the final set of specifications. This now means that a few of the specifications now have a longer timescale compared to what was reported in the highlight report last month to be presented to PCCC in draft format and to complete membership engagement. Diabetes and dementia specifications are now scheduled to be presented in draft format to PCCC in November.		
Achievements for Current Period	• Contracts for 2018/19 have been issued to practices including in year reporting requirements. • Membership engagement on draft service specifications for NPT, Anticoagulation and Supplementary Services took place in October. • LMC board members have reviewed and commented on first set of specifications. Process agreed with LMC for review of next specifications • Draft service specification for Care Homes presented to PCCC for further engagement. • Work is in progress to complete financial modelling of recommendations for the CCG and for the impact at practice level.		

Tasks and Milestones

- Develop FAQ for practices to answer common queries across BNSSG and to support November membership meetings.
- Contracting model to support locality delivery of enhanced services for April 2019 to be developed and recommended to Primary Care Operational Group (PCOG) then PCCC on 3rd January.
- Final specifications for 19/20 for all services to be approved at PCCC on 3rd January following review at PCOG.

Contracting timeframes for 19/20 LES':

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

Near Patient Testing (NPT), Anticoagulation, Supplementary Services

- Draft aligned specifications and tariff approved for membership engagement by PCCC on 25.09.18.
- Notice has been served to North Somerset and South Gloucestershire practices for Supplementary Services and in Bristol the contract expires at the end of the current financial year.
- Membership engagement on draft service specifications for NPT, Anticoagulation and Supplementary Services took place in October.
- EIA/QIA screening to be completed by 31st October.

Dementia

- Draft BNSSG dementia service specification to be recommended for membership engagement at November PCCC.
- Membership engagement on draft service specification in November and December
- EIA/QIA screening to be completed by 30th November.

DVT

- Service specification and procurement approach approved on 04.09, contract anticipated to be awarded in December 2018.
- DVT service specification for the LES element of the pathway to be recommended for approval at November PCCC. There has already been significant membership engagement for DVT LES.

Diabetes

- Draft service specification for diabetes to be recommended for membership engagement at November PCCC.
- Draft service specification to be reviewed at Diabetes Programme Board on 25.10.18.
- Draft service specification to be discussed at STP integrated care steering group on 21.11.18
- Membership engagement on draft service specification in November and December
- EIA/QIA screening to be completed by 30th November.

Minor Injuries

- Activity data for the previous year has now been obtained.
- Paper including recommendations to be presented at November PCCC.

Care Homes with and without nursing

- First draft service specification for care homes reviewed at LES Review Steering Group 18.09.18.
- Draft service specification to be discussed at STP integrated care steering group
- Draft service specification for care homes to be recommended for membership engagement at October PCCC.
- Membership engagement on draft service specification has taken place in October, and is proposed to continue in November.
- EIA/QIA screening to be completed in November.

Locality Transformation Scheme (LTS) Phase 3

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

As set out in the paper shared with PCCC in September, a collaborative faculty is being established in November to plan the system wide design events, the first of which is a Frailty event taking place in December.

Risks

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

	across practices. • A paper outlining the proposed approach to support commissioning of locality delivery of improved access is on the agenda for October PCCC. • Proposals for the approach to Diabetes will need to be considered at PCCC in November.
LES review proposals pose a financial risk either to the CCG or to individual practices	• Financial modelling to support individual enhanced service specifications will be undertaken, however, no final decisions will be made until we can cost the combined implications for the suite of new specifications – both for the CCG and for individual practices

Issues

- Financial modelling of new services is dependent on the development of service specifications for 2019/20 and these are being developed between September and December. Financial modelling data to be presented at PCCC between September and December will need to be updated once the work on all LES specifications has concluded.