Reference: FOI.ICB-2425/149

Subject: Local Enhanced Services (LES)

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
1. What is your overall ICB population? 2. What is your final budget for local enhanced/commissioned services that are open for GP practices outside of the national GP contract? 3. Please fill in the attached Excel document, listing every LES/LCS that you are commissioning for GP practices.	Please refer to requesters template enclosed.

The information provided in this response is accurate as of 13 August 2024 and has been approved for release by Jenny Bowker, Deputy Director of Performance Delivery, Primary Care and Children's Services for NHS Bristol, North Somerset and South Gloucestershire ICB.

NAME OF LES/LCS	Total budget allocated 2023/24	Total budget allocated 2024/25	Eligible patients 2024/25 (estimate)	Maximum payment per eligible patient 2023/24	Maximum payment per eligible patient 2024/25	Link to full specification (if applicable)
ADHD LES	5,927.00	16,332.00		£41.74	£41.99	2024-26 FINAL LES ADHD Service Spec.docx
Anti-Coag LES	85,633.00	224,552.00		£162.88	£163.86	2024-25 Final LES Anticoagulation basic .docx; 2023-24 Final LES Anticoagulation Advanced.docx
Care Home Beds LES Top Up	482,404.00	461,350.00		£4.61	£4.61	2024-25 LES GP Support to Care Home.docx
Dementia LES	415,425.00	344,368.00	The ICB does not hold this information, however these services are available to all eligible adult population covered by each LES.	£172.04	£173.07	2024-26 LES Dementia Service Spec .docx
Diabetes LES	35,809.00	81,841.00		£178.15	£179.22	2024-25 Insulin initiation LES SPEC FINAL.docx
DVT	46,365.00	43,481.00		£40.72	£40.96	2024-26 Final DVT LES Service Specification.docx
NPT LES	599,304.00	640,756.00		£30.54	£30.72	2025-26 LES SPEC Specialist Medicines Monitoring
Phlebotomy LES	400,830.00	225,569.00		£5.71	£5.74	2024-26 Final LES Phlebotomy LES SPEC .docx
Inclisiran LES	-	8,611.00		£5.00	£5.00	Nov2023-25 LES SPEC Inclisiran Administration

Overall ICB population
1,018,140.51

1. SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	ADHDLES2426
Service	Adult Attention Deficit Hyperactivity Disorder (ADHD) Local Enhanced Service
Commissioner Lead	Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	
Period	1st June 2024 – 31st May 2026
Date of Review	January 2024

1. Population Needs

1.1 National/local context and evidence base

The BNSSG adult ADHD service is currently provided by Avon and Wiltshire Mental Health Partnership (AWP). Throughout 2019 the ICB worked with AWP to agree a new, more effective, service model. The new model proposed by AWP offers to increase the number of assessments completed by the service but this is predicated on AWP being able to free up capacity by;

- Discharging stable patients to primary care for annual reviews
- Non-complex transitions patients being discharged to primary care for annual review

The BNSSG Medicines Management Team has worked with AWP to draft new shared care protocols to facilitate this transfer of care.

https://remedy.bnssg.icb.nhs.uk/formulary-adult/scps/scps/

Right to Choose

We are aware of a number of Right to Choose providers for adult ADHD services.

The legal rights to choose of mental health provider and team apply when:

- the patient has an elective referral for a first outpatient appointment
- the patient is referred by a GP
- the referral is clinically appropriate

- the service and team are led by a consultant or a mental healthcare professional
- the provider has a commissioning contract with any Integrated Care Board (ICB) or NHS England for the required service

For patients wishing to choose a "Right to Choose" provider it is important the patient understands that the provider may not integrate with local BNSSG pathways and/or other services as the provider does not hold a contract directly with BNSSG ICB. It is advisable for the GP and patient to agree the most suitable provider as the referral must be "clinically appropriate" for the patient under choice framework.

ADHD (adult) (Remedy BNSSG ICB)

Private Diagnosis

Additionally, patients may have a diagnosis of ADHD made from private providers.

Any patient with a recognised (NICE compliant) diagnosis from a private provider is eligible to be included under this enhanced service once they have been assessed and discharged to primary care for management, if the GP practice is signed up to this LES. The private provider is responsible for the clinical assessment and monitoring of the patient for the length of time specified in the shared care protocol. This will ensure equity across the population.

Each individual practice will determine if they are happy to accept a patient with a private diagnosis and manage them under this local enhanced service.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

It is anticipated that patients that are receiving care as part of this enhanced service will benefit from having their treatment closer to home (in a primary care setting).

By primary care providers taking on this activity it is anticipated that this will significantly increase the capacity of AWP to work through the current long waiting list of ADHD assessments and complex reviews

3. Scope

3.1 Aims and objectives of service

As part of this enhanced service Primary Care providers are required to provide:

An annual review for any stable (adult) patient who has been discharged to Primary Care by AWP or a patient with a (NICE Compliant) recognised diagnosis from an alternative (NHS or non-NHS) provider.

Providers will be required to complete the annual review template as embedded in section 3.2 below.

Primary care provider will be notified of the patient via the normal discharge process. For patients you have coded as being diagnosed from a private provider (and you are content the diagnosis is secure) you must identify them for management under this LES and the shared care protocol.

An example discharge letter is contained for information below:

ADHD Letter v2.docx

3.2 Service description/care pathway

Under the terms of this enhanced service, patients will be due for an annual review following discharge from AWP (or other provider) in line with the shared care protocol, patients will also require an interim 6 month check to record:

BP		ADHD provider if titration taking place in clinic	If there is a clinically significant increase in blood pressure, monitor and treat as per usual unless it is felt that ADHD treatment benefits don't outweigh antihypertensive treatment requirement; discuss with ADHD provider/clinic to

	After each dose increase and every 6 months and at annual review.	At 6 monthly intervals: To be done by **primary care.** At annual review: To be done by **primary care.**	consider dose adjustment or alternative ADHD treatment
Pulse			NICE guidance suggest to investigate a resting tachycardia of > 120pbm; we suggest to monitor and possibly investigate a sustained resting tachycardia >100bpm; consider ECG; discuss with ADHD clinic.
Weight			If there is evidence of significant weight loss, measure BMI and discuss with patient as appropriate. Strategies to manage weight loss include: -Taking medication with or after food. -Additional meals/snacks early morning or late evening when stimulant effects have worn off. -Choosing high calorie foods of good nutritional value. -Taking a planned break from treatment or changing medication.

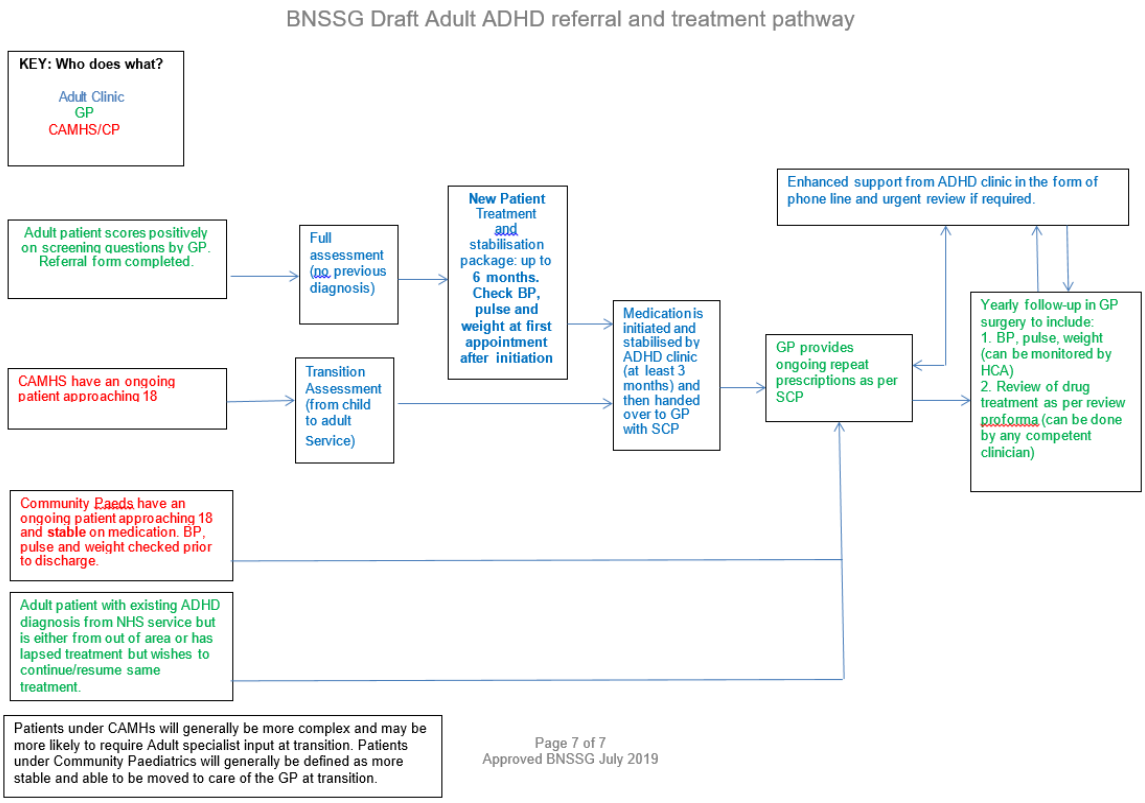
The annual review template is embedded below:

Annual review form-290120-d.docx

For support there is an annotated version for clinicians below:

ADHD-annual review v1.1comment

The full pathway is summarised below:



Practices will be paid £41.74 for each completed adult ADHD annual review. The interim 6 month check (BP, Pulse, Weight) can be delivered by an appropriate health care professional.

The annual review can be face to face or held virtually.

3.3 Population covered

This service is available to all adult ADHD patients registered with a BNSSG GP practice who have been deemed 'stable' and discharged from AWP or any patient with a recognised (NICE compliant) diagnosis from a private provider.

3.4 Any acceptance and exclusion criteria and thresholds

The scope of this LES extends to patients who have been deemed stable and formally discharged from AWP to Primary Care or any other patient with a recognised diagnosis from an alternative provider.

If a primary care provider needs to refer a patient back to AWP, there is a clear process for this described in the discharge letter.

3.5 Interdependence with other services/providers

AWP will be responsible for discharging patients deemed stable that are appropriate for this enhanced service.

The process for referring back to AWP is contained within the discharge letter.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

https://www.nice.org.uk/guidance/ng87

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

Not Applicable

4.3 Applicable local standards

The ICB will use EMIS Web Search and Report to export data from practice systems relating to numbers of patients the service have been seen monthly. By signing up to this enhanced service you agree for the data be extracted as required.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4)

Not applicable

6. Location of Provider Premises

The Provider's Premises are located at:

xxxxx

SCHEDULE 3 – PAYMENT

A. Local Prices

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original data extraction date

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	**SNOMED Description ID**
ADHD (attention deficit hyperactivity disorder) annual review	**1551761000000116**
Attention deficit hyperactivity disorder annual review	**1551611000000112**

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

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Monthly extract used by ICB to inform quarterly payment	**All service specs**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	InclisiranLES2425
Service	Administration of inclisiran injection in primary care LES
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st November 2023 to 31st May 2025
Date of Review	November 2023

1. Population Needs

1.1 National/local context and evidence base

Following publication of a NICE TA733 for inclisiran, arrangements for provision were approved nationally that agreed inclisiran would be available for prescribing and administration in Primary care.

GPs were able to claim £55/injection administered which included an additional £10 to the drug cost to the NHS. However, from April 2023 GPs can only claim £50/injection through this route, reducing the additional payment to £5.

This Local Enhanced Service specification outlines a parenteral administration service for inclisiran to provide £5 per injection administration to Practices so that a total of £10 (£5 national + £5 BNSSG ICB) additional payment is available overall whilst we await national steer and review.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	

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

2.2 Local defined outcomes

1. The number of injections of inclisiran administered per Practice where inclisiran is a BNSSG Joint Formulary approved option in line with the NICE TA733 for treating primary hypercholesterolaemia or mixed dyslipidaemia.
2. Inclisiran is an option to support a reduction in cardiovascular risk factors and improved patient outcomes. It is the first of a new type of cholesterol-lowering treatment to boost the liver's ability to remove LDL-cholesterol from the blood. It is given by subcutaneous injection, either on its own or alongside statins or other cholesterol-lowering drugs. The recommended dose is 284 mg Inclisiran loading dose at 0 months and 3 months, then long-term maintenance every 6 months. Currently it is licensed for administration by a Healthcare Professional, not the patient. No additional monitoring is required.

3. Scope

3.1 Aims and objectives of service

To ensure adults in whom inclisiran is a therapeutic option receive treatment in line with national and local guidelines.

Objectives:

1. GP practices are supported to initiate and continue on-going prescribing and administration of inclisiran for patients, improving overall long-term morbidity risk.
2. To reduce inequality to inclisiran access across BNSSG.
3. Easier access to administration for patients.
4. GPs are compensated for additional workload.

3.2 Service description/care pathway

Inclisiran is included in the BNSSG Joint Formulary and the BNSSG Management of Blood Lipid Levels guidelines. GP Practices may initiate and continue prescribing.

Inclisiran has a blue Traffic Light Status (TLS) and is appropriate for prescribing throughout the ICS within the competencies of the prescriber.

It is licensed for administration by a Healthcare Professional, not the patient.

No additional monitoring is required.

Formulary : Adult (Remedy BNSSG ICB)

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

- Assurance that a robust re-call system is in place to ensure recall of patients for the necessary administration.
- Assurance that there is a process to identify and manage patients not engaging with the necessary administration interval including cessation of prescriptions.
- The practices current standard operating procedure for the above activities as part of the review of practice monitoring activity.
- Share information with BNSSG ICB about significant events, including root cause analyses, involving inclisiran. Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/
- Number of patients monitored each quarter as part of this LES if EMIS Search and Report becomes unavailable.

How Will Activity Data be Obtained?

BNSSG ICB will obtain information on the number of patients issued with an NHS prescription for inclisiran with the assumption that this is then administered by the surgery. Prescription issues under this LES will use EMIS Search and Report. By signing up to this enhanced service you agree for the data be extracted as required.

3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

Any patients having inclisiran administration provided by another care provider are excluded from this LES.

3.5 Interdependence with other services/providers

N/A

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The following guidance from NICE:

- Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia (TA733).
- Cardiovascular disease:risk assessment and reduction, including lipd modification CG181
- NHS England Quality and Outcomes Framework guidance for 2023/24

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

- RCGP and BMA statement: Information on the proposal for the prescription of inclisiran in primary care settings

4.3 Applicable local standards

- BNSSG Management of Blood Lipid Levels
- Inclisiran Clinical Guidelines

2. Cardiovascular System Guidelines (Remedy BNSSG ICB)

5. Applicable quality requirements and CQUIN goals

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

N/A

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

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

A. Local Prices

Inclisiran injection administration from 1 November 2023 to 31 October 2024

Payments will be made quarterly in arrears.

Practices will be remunerated on the number of NHS prescription issues for inclisiran by the surgery per quarter.

Practices will be paid £5 for each inclisiran injection. The dosing schedule is 0 months and 3 months, then long-term maintenance every 6 months.

SCHEDULE 4 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Quarterly extract used by ICB to inform payment	**All service specs**

Inclisiran

EMIS Web search criteria for calculating LES payment:-
Number of practice payments is assessed using an aggregate report which searches within all patients (including deducted and deceased) and who have been issued with an NHS prescription of inclisiran by the surgery during the search period. The report counts the number of prescription issues during the search period.

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.

- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

EMIS Web Specialist Medicines Monitoring LES Search file:-

To be confirmed by ICB

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	AntiCogsAdv2425
Service	Anticoagulation LES: INR monitoring and vitamin K antagonist dosing – Advanced service
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2025
Date of Review	January 2023

1. Population Needs

1.1 National/local context and evidence base

This Local Enhanced Service specification outlines both an Internationalised normalised ratio (INR) monitoring and Vitamin K antagonist dosing service for patients recieving vitamin K antagonists medications. Vitamin K antagonists have a valuable role in blood clot and stroke prevention, with regular monitoring required to prevent adverse effects.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓

Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Anticoagulants: Warfarin and Phenindione are included in the BNSSG Joint Formulary and are therefore appropriate for prescribing in primary care. Acenocoumarol is non-formulary but included in this LES to cover the small number of patients who are unable to take Warfarin or Phenindione.

Experience demonstrates that patients are more likely to engage with a regular monitoring service for the long-term that is provided in an organised manner in a convenient location such as closer to home in primary care. Appropriate and vigilant monitoring during therapy is required to minimise the risk of adverse effects.

3. Scope

3.1 Aims and objectives of service

Aims:

To ensure adults and children who need initiation on a Vitamin K antagonist or are receiving maintenance treatment with a vitamin K antagonist get care that is safe, effective and sustainable.

Objectives:

- To safely initiate and maintain suitable patients on vitamin K antagonist therapy.
- To provide patients receiving a vitamin K antagonist with the information they need to safely manage their treatment.
- To improve patient education in relation to their condition, understanding of their treatment, target INR range, the effects of over or under anticoagulation, the effect of diet changes, affects on lifestyle and the importance of interactions with other medications.
- To monitor the safety and effectiveness of vitamin K antagonist treatment by ensuring the INR is measured at appropriate regular intervals.
- To ensure the dose of vitamin K antagonist is amended as required in response to INR test results.

- To ensure that patients with very high or very low INR results are managed appropriately, in collaboration with specialists where necessary.
- To ensure that patients who do not regularly achieve therapeutic INRs are reviewed and appropriate action is taken to improve the patients 'time in therapeutic range'.
- To provide the service to a high standard in a way that is convenient for patients.
- To ensure that providers of care work together and share data relating to anticoagulation to support safe and effective care for the patient .
- To evaluate the quality of care through a regular audit process, effecting change when required to improve the service provided.

3.2 Service description/care pathway

Across BNSSG different care pathway models have been in operation for vitamin K anticoagulation monitoring and dosing. This LES is intended to formalise the offer from BNSSG ICB to practices for the continuation of the vitamin K antiocoagulant monitoring service and dosing service.

GP practices are required to continue to deliver the same level of service they were providing in September 2018. This is the local enhanced service specification for the advanced service.

Description of the advanced service:
The GP practice provides a service obtaining finger-prick blood samples from patients using point-of-care INR testing technology to determine the patients INR test result.

The GP practice uses appropriately governed anticoagulant management software, to help make decisions on the appropriate dosage of vitamin K antagonist and communicate the required dosage to the patient.

GP practice to provide a robust recall sytem for patients prescribed vitamin K antagonist therapy to ensure INR is monitored at the frequency recommended by the dosing clinician and patients not engaging with INR monitoring are identified and managed, including temporary cessation of prescription supply.

GP practice to have clinical treatment pathways inplace to appropriately manage patients who are have very high, or very low INR results

GP practices must ensure the INR is being monitored as per the clinicians recommendation and that the INR level is safe before issuing repeat prescriptions for vitamin K anticoagulants.

Ensure patients receiving vitamin K anticoagulants receive an annual medication review to consider whether anticoagulation therapy is still indicated and appropriately managed, including a review of time in therapeutic range.

GP practices are required to maintain records for those patients prescribed vitamin K antagonist therapy that details (for each patient):

- The target INR range
- The intended duration of therapy

GP practices are required to ensure that patients prescribed vitamin K antagonist therapy hold an Oral Anticoagulant Therapy booklet and anticoagulant alert card (provided to practices free of charge by NHS England), and also ensure that patients and where appropriate their carers understand. A checklist for patient information is provided in appendix 1:

Anticoagulation
LES appendix 1.0 Ap

- Why they require anticoagulation treatment
- The importance of adherence to treatment and monitoring
- The consequences of sub-therapeutic treatment, and overdose
- Restrictions on diet, and lifestyle
- The possibility, and consequences of drug interactions

GP practices are required to submit during quarter two a review of their monitoring and dosing service as per the provided template.

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

EMIS Web Search and Report will be used to export data from practice systems relating to numbers of patients the service has been provided for in each quarter. By signing up to this enhanced service you agree for the data be exatracted as required.

3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

Only patients currently being prescribed warfarin, acenocoumarol or phenindione by a clinican at the practice with which they are registered will be included in this service.

3.5 Interdependence with other services/providers

Providers will need to:

- Share data via EMIS (Enterprise/Search and Report) for the purposes of audit and payment
- Share data via Connecting Care for the purposes of patient safety
- Liaise with colleagues working for providers of clinical laboratory services where appropriate
- Liaise with colleagues working for providers of anticoagulation dosing services where appropriate

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE guidance: Atrial fibrillation: diagnosis and management NG196
Overview | Atrial fibrillation: diagnosis and management | Guidance | NICE

NICE guidance: Venous thromboembolism in adults: diagnosis and management https://www.nice.org.uk/guidance/qs29

NICE guidance: Atrial fibrillation and heart valve disease: self-monitoring coagulation status using point-of-care coagulometers

https://www.nice.org.uk/guidance/dg14

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

Oral Anticoagulation with Warfarin - 4th Edition. Keeling , Baglin T, Tait C, Watson H, Perry D, Baglin C, Kitchen S, Makris M; British Committee for Standards in Haematology. Br J Haematol. 2011 Aug;154(3):311-24

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

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

GP practices are required to submit during quarter two submit a review of the practices vitamin K antagonist anticoagulation monitoring as per the provided template.

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

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

A. Local Prices

The payment will be made at the end of end of each financial quarter and will be SOLELY based on extraction of following clinical codes

Anticoagulation

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of

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

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

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original data extraction date

<u>How will Payments be Made and Calculated</u>

The number of patients will be calculated based on a current medication course for warfarin, warfarin sodium, phenindione or acenocoumarol that have had at least 1 documented INR measurement (42QE) in the last 100 days.

The total number of patients receiving vitamin k antagonist therapy in each quarter will be multiplied by the appropriate level of payment and divided by four to provide a quarterly payment value.

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
Patients prescribed warfarin (or acenocoumarol /phenindione) have a documented INR target or INR range	100%	Completion of Audit form [EMBED]	Standard Contract Management	Annual return due by 1 December in each contract year	LES_01_Anticoagulation_Advanced_1920
Number of audited patients with INRs > 5 but ≤ 8 on one or more occasion	10% or less		Standard Contract Management	Annual return due by 1 December in each contract year	LES_01_Anticoagulation_Advanced_1920
Number of audited patients on with INRs > 8 on one or more occasion	5% or less		Standard Contract Management	Annual return due by 1 December in each contract year	LES_01_Anticoagulation_Advanced_1920
There a mechanism in place in the practice to deal with DNA's (for warfarin (or acenocoumarol /phenindione) monitoring)	100%		Standard Contract Management	Annual return due by 1 December in each contract year	LES_01_Anticoagulation_Advanced_1920

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
A yearly venous sample is taken at the same time as the Coaguchek to ensure accuracy for patients with Antiphospholipid Syndrome.	100%	Completion of audit form		Annual return due by 1 December in each contract year	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Quarterly extract used by ICB to inform payment	**All service specs**
Submission of template to review monitoring and dosing for anticoagulation	Quarter 2	Template  Anticoagulant Advanced Audit tem	By 1 December, due each contract year	**Anticoagulation_Advanced**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	AntiCogsLES2425
Service	Anticoagulation LES: INR monitoring and vitamin K anticoagulant dosing – Basic service
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2025
Date of Review	January 2023

1. Population Needs

1.1 National/local context and evidence base

This Local Enhanced Service specification outlines both an Internationalised normalised ratio (INR) monitoring and Vitamin K antagonist dosing service for patients recieving vitamin K antagonists medications. Vitamin K antagonists have a valuable role in blood clot and stroke prevention, with regular monitoring required to prevent adverse effects.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓

Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Anticoagulants: Warfarin and Phenindione are included in the BNSSG Joint Formulary and are therefore appropriate for prescribing in primary care. Acenocoumarol is non-formulary but included in this LES to cover the small number of patients who are unable to take warfarin or Phenindione.

Experience demonstrates that patients are more likely to engage with a regular monitoring service for the long-term that is provided in an organised manner in a convenient location such as closer to home in primary care. Appropriate and vigilant monitoring during therapy is required to minimise the risk of adverse effects.

3. Scope

3.1 Aims and objectives of service

Aims:

To ensure adults and children who need initiation on a Vitamin K antagonist or are receiving maintenance treatment with a vitamin K antagonist get care that is safe, effective and sustainable.

Objectives:

To safely initiate and maintain suitable patients on vitamin K antagonist therapy.

To provide patients receiving a vitamin K antagonist with the information they need to safely manage their treatment.

To improve patient education in relation to their condition, understanding of their treatment, target INR range, the effects of over or under anticoagulation, the effect of diet changes, affects on lifestyle and the importance of interactions with other medications.

To monitor the safety and effectiveness of vitamin K antagonist treatment by ensuring the INR is measured at appropriate regular intervals.

To ensure the GP practice collaborates with specialists when necessary to assist in the management of patients with very high INR results.

To ensure that patients who do not regularly achieve therapeutic INRs are reviewed and appropriate action is taken to improve the patients 'time in therapeutic range'.

To provide the service to a high standard in a way that is convenient for patients.

To ensure that providers of care work together and share data relating to anticoagulation to support safe and effective care for the patient.

3.2 Service description/care pathway

Across BNSSG different care pathway models have been in operation for vitamin K anticoagulation monitoring and dosing. This LES is intended to formalise the offer from BNSSG ICB to practices for the continuation of the vitamin K antiocoagulant monitoring service.

GP practices are required to continue to deliver the same level of service they were providing in September 2018. This is the local enhanced service specification for the advanced service.

Description of the basic service:
The GP practice provides a phlebotomy service obtaining venous blood samples from patients prescribed a vitamin K antagonist.

The venous blood sample is supplied to a secondary care organistation to establish the patients INR and for the secondary care organistation to make decisions on the appropriate dosage of vitamin K antagonists and communicate the required dosage to the patient.

GP practices must ensure the INR is being monitored as per the INR clinics recommendation and that the INR level is safe before issuing repeat prescriptions for vitamin K anticoagulants

GP practices will liaise as necessary with the patient's vitamin K antagonist dosing clinic to discuss patient care issues such as regular elevated INRs or poor time in therapeutic range.

Ensure patients receiving vitamin K anticoagulants receive an annual medication review to consider whether anticoagulation therapy is still indicated and appropriately managed, including a review of time in therapeutic range.

GP practices are required to maintain records for those patients prescribed vitamin K antagonist therapy that details (for each patient):

- The target INR range
- The intended duration of therapy

GP practices are required to ensure that patients prescribed vitamin K antagonist therapy hold an Oral Anticoagulant Therapy booklet and anticoagulant alert card (provided to practices free of charge by NHS England), and also ensure that patients and where appropriate their carers understand:

- Why they require anticoagulation treatment
- The importance of adherence to treatment and monitoring
- The consequences of sub-therapeutic treatment, and overdose
- Restrictions on diet, and lifestyle
- The possibility, and consequences of drug interactions

A checklist for patient information is provided in appendix 1.

Anticoagulation
LES appendix 1.0 Ap

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

EMIS Web Search and Report will be used to export data from practice systems relating to numbers of patients the service has been provided for in each quarter. By signing up to this enhanced service you agree for the data be extracted as required.

3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

Only patients currently being prescribed warfarin, acenocoumarol or phenindione by a clinican at the practice with which they are registered will

be included in this service. The GP practice staff are expected to have demonstrated competence in taking venous blood samples in children aged under 12 years. Where competency to deliver this service to those aged under twelve is not available at the practice, the ICB contracts team should be informed to enable payments under this LES for those aged under twelve years to be temporarily suspended until competency has been achieved.

3.5 Interdependence with other services/providers

Providers will need to:

- Share data via EMIS (Enterprise/Search and Report) for the purposes of audit and payment
- Share data via Connecting Care for the purposes of patient safety
- Liaise with colleagues working for providers of clinical laboratory services where appropriate
- Liaise with colleagues working for providers of anticoagulation dosing services where appropriate

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE guidance: Atrial fibrillation: diagnosis and management NG196
Overview | Atrial fibrillation: diagnosis and management | Guidance | NICE

NICE guidance: Venous thromboembolism in adults: diagnosis and management https://www.nice.org.uk/guidance/qs29

NICE guidance: Atrial fibrillation and heart valve disease: self-monitoring coagulation status using point-of-care coagulometers

https://www.nice.org.uk/guidance/dg14

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

Oral Anticoagulation with Warfarin - 4th Edition. Keeling , Baglin T, Tait C, Watson H, Perry D, Baglin C, Kitchen S, Makris M; British Committee for Standards in Haematology. Br J Haematol. 2011 Aug;154(3):311-24

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

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

N/A.

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

N/A

SCHEDULE 3 – PAYMENT

A. Local Prices

Anticoagulation

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

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

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

Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.

As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.

Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

<u>How will Payments be Made and Calculated</u>

The number of patients will be calculated based on a current medication course for warfarin, warfarin sodium, phenindione or acenocoumarol that have had at least 1 documented INR measurement (42QE) in the last 100 days.

The total number of patients receiving vitamin k antagonist therapy in each quarter will be multiplied by the appropriate level of payment and divided by four to provide a quarterly payment value.

Where competency to deliver this service to those aged under twelve is not available at the practice, the ICB contracts team should be informed to enable payments under this LES for

those aged under twelve years to be temporarily suspended until competency has been achieved.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Quarterly extract used by ICB to inform payment	**All service specs**

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	SecondaryPhleb2426
Service	**Community Phlebotomy Service 2023/24** ***excluding routine sampling for warfarin monitoring ,drugs in shared care agreements or under the specialist meds monitoring LES, and clozapine and STEPS for now***
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2026
Date of Review	January 2023

1. Population Needs

1.1 National/local context and evidence base

Primary care has been responding to secondary care requests for bloods for many years, outside of formal protocols and thus far, this work has been unfunded. To date, the system has been unable to agree a formal arrangement to manage and fund this work. Additional challenges have been raised in relation to the handover of requests and results, due to a lack of interface between the different digital systems at acute trusts, the community provider, and practices. Therefore phlebotomy carried out in general practice at the request of secondary care has resulted in blood results being returned to the GP rather than the specialist requesting the test. The clinical responsibility has therefore rested with the GP rather than the consultant, with the latter being best placed to both interpret the results and hold that risk.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓

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

2.2 Local defined outcomes

- Provide a timely service for phlebotomy related conditions in a primary care setting which are cost effective and equal to or exceed the services provided in secondary care
- To provide a resilient service for patients and the system
- Satisfy local demand from patients
- To offer patients a choice of appointment times and locations as close to their home as possible
- To deliver the shortest pathway possible, compatible with best outcomes for patients
- Help relieve the pressure on secondary care services
- Improve the monitoring and management of Long Term Chronic illness of those under secondary care supervision

3. Scope

3.1 Aims and objectives of service

This service model describes an enhanced service for Primary Care Phlebotomy. This service described is beyond the requirements of the core GMS / PMS / APMS contract.

3.2 Service description / Standard Operating Procedures V13 – Delegated phlebotomy for secondary care (Appendix 1 - below)

It has been developed over 12 months with multiple iterations and involved discussions with primary care, local trusts, patients and the ICB and the LMC

Appendix 1 details how General Practice will manage the blood tests taken on behalf of secondary care Trusts under this enhanced service.

Standard Operating procedure V13(1).doc

Escalation process

The aim of the service is to provide additional system wide phlebotomy resilience.

An escalation process has been developed and will be embedded as a part of the Pilot service. Please refer to the attachment below.

It is expected that where a practice is unable to provide a service (for whatever reason) its patients will be seen by other practices within its PCN. Where this is not possible patients should be passed to the escalation provider “who will receive payment”

Phlebotomy escalation.pptx

3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

Please refer to **Standard Operating Procedures V13 – Delegated phlebotomy for secondary care**

3.5 Finance

Agreement has been reached to fund the activity on a price per blood test basis of **£5.71**

Payment by ICB to practice through LES (monthly monitoring, quarterly payment).

To be eligible for payment the practice must use the below SNOMED code: Cut-off dates for back-dated coding of activity will need to be agreed in line with usual contract terms. This would be monthly extraction aligned to other existing primary care activity recording processes.

165791000000107 - phlebotomy generated in secondary care done by practice

3.6 Activity recording and monitoring

- EMIS protocol capturing monitoring requirements have been developed and all participating providers are expected to utilise it
- Practices will be responsible for recording the volume of secondary care requested bloods, including specialty of requestor
- Acute providers can estimate activity volumes based on deferred requests on ICE, but this will not be a completely accurate picture since it will include other requests. As such, practice recorded data will be recognised as definitive for billing.
- The minimum data required will be:
    - Number of tests undertaken/month (recorded using the specific code)
    - Demographics of the patient – age / gender / ethnicity
    - By practice (as above, or minimum aggregation depending on sensitivity)
    - Clinical specialty to be added
- By signing up to this enhanced service you are giving permission for the ICB to extract the relevant reporting data for activity monitoring and to inform payment.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Please refer to Standard Operating Procedures V13 – Delegated phlebotomy for secondary care

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

6. Location of Provider Premises

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**DementiaLES2426**
Service	**Recognition and Management of People with Dementia and their Family/Carers in General Practices**
Commissioner Lead	**Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire ICB**
Provider Lead	**As per provider signatory**
Period	**1st June 2024 – 31st May 2026**
Date of Review	**January 2023**

1. Population Needs

1.1 National/local context and evidence base

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

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

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

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

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

Dementia is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, conducting health checks (for the person with dementia and their family/carers), ensuring people with dementia attend screening programs, advising on preventive actions, advanced decision making

and contingency planning, and signposting people to local information, advice and support services as well as end of life care.

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

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

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

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

2.2 Local defined outcomes

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

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

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

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

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

Domain 4 Ensuring people have a positive experience of care

- ✓ People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia
- ✓ Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break
- ✓ BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia

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

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

3. Scope

3.1 Aims and objectives of service

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

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

3.2 Service description/care pathway

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

1. Having a named lead GP and a named practice nurse/health care practitioner for dementia.
2. Named lead GP and named practice nurse/ other health care practitioner participate in yearly dementia training, provided or endorsed by Clinical Leads for Dementia; this could be in person or online and will be a maximum of half a day.
3. The named lead GP for dementia to provide a structured update session on dementia for all the other GPs and practice staff at least once a year.
4. Actively participate in evaluation of the service, this may include sending out surveys to patients/families and practice staff being interviewed.

5. Record carers on the carers register and signpost carers for short breaks, evidenced by at least 6 monthly meetings with the Carers Support Workers,
    - In Bristol and South Gloucestershire this is provided through the Carers Support Centre. In Bristol there is also the Bristol City Council (BCC) Integrated Carers Team.
    - In North Somerset this is provided through the North Somerset Alzheimer's Society Dementia Support Worker Service.
6. :Undertake a diagnosis of uncomplicated dementia (Alzheimer's Disease or Vascular Dementia) within a Primary Care setting and provide appropriate post diagnostic support and signposting information using the supplied EMIS template

7. Carry out reviews of people with dementia and their family/carer (using the agreed template or equivalent) that delivers review of all medication including cholinesterase inhibitors, Memantine and anti-psychotic medication using the supplied EMIS template

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

3.2.1 Detailed Description of the Requirement

- Adopting the care pathway including management of people stable on dementia medication.
- To undertake investigations as indicated in Section 4 and investigate any abnormalities to exclude potentially treatable causes.
- To undertake a diagnosis of dementia and initiate medication in line with guidance provided in Section 4.
- To complete a plan (or ensure the practice dementia navigator or AWP equivalent has) for the patient that includes relevant information including where to go for further support and signposting.
- To note the diagnosis of dementia, if made in secondary care or by other providers and record accordingly with relevant read code.
- To review every person diagnosed with dementia at least once a year (6 monthly if on dementia related medication, 3 monthly if on anti-psychotic medication), following the review template provided in the Dementia EMIS template.
- To initiate where appropriate (with advice if needed) and continue the prescribing of Cholinesterase Inhibitors (CEIs) or Memantine. The new BNSSG prescribing guidance confirms that GPs are able to initiate and follow up all three CEI's and Memantine and drugs for BPSD. This is now an expected

part of this Primary Care Service – GPs may want to seek advice about the prescribing from the dementia clinical staff however GPs will do the prescribing. For the purposes of this enhanced service with the benefit of the annual educational events GPs are considered to have this 'specialist' knowledge.

- To notify the Dementia Wellbeing Service for Bristol or AWP for North Somerset or South Gloucestershire of any adverse drug reactions, deterioration in condition or any other clinical concerns regarding the person's health that cannot be managed in Primary Care

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

3.3 Population covered

This service is available to anyone who has suspected or confirmed dementia registered with the GP practice.

3.4 Any acceptance and exclusion criteria and thresholds

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

3.5 Interdependence with other services/providers

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

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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

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

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

N/A

4.3 Applicable local standards

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

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

The following information is available for dementia:

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

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

N/A

5.2 Applicable CQUIN goals (See schedule 4D)

N/A

Outcomes, monitoring and evaluation

By signing up to this enhanced service the Provider agrees to complete the EMIS template and allow BNSSG to extract data as required.

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

Technical Guidance Reference	Quality Requirement / Outcome	Method of Measurement	Frequency	Used by Commissioner to evidence
Domain 2: Enhancing quality of life for people with long-term conditions				
NHS Outcome Domain 2	There is a culture in primary care of dementia being viewed and managed as a long term condition	Online Survey	Annual	The shift in opinion of dementia
Domain 3: Helping people to recover from episodes of ill-health or following injury				
NHS Outcome Domain 3	There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services	Monitoring form	Quarterly	Effectiveness of service specification
Domain 4 Ensuring people have a positive experience of care				
NHS Outcome Domain 4	People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia.	Feedback from people with dementia who have experienced the service	Annual	To understand how people feel about the management of their dementia

NHS Outcome Domain 4	Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break	Monitoring from the 3 Local Authority carers teams and the Carers Support Centre	Quarterly	To understand the uptake of breaks
NHS Outcome Domain 4	BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia	Training attendance records	Annual	Confirming staff up to date with relevant training
Domain 5 Treating and caring for people in safe environment and protecting them from avoidable harm				
NHS Outcome Domain 5	An increased number of people with dementia receive a timely diagnosis of dementia in Primary Care	Monitoring form	Quarterly	To ensure the service is working effectively

Appropriate coding and use of template in EMIS will allow BNSSG to extract data to calculate payment. Payments will be made on a quarterly basis but data will be extracted monthly for monitoring purposes.

Providers will be required to provide evidence of the requirements and the specific numbers of people supported under the agreement. Providers will be supplied with an EMIS template that will guide them through the review process. A random sample of review templates will be scrutinised annually. Practice registers will be monitored in order to triangulate the payment process and to ensure appropriate payment of the incentive part.
An online survey will be sent out to gain feedback on the service to inform the following year.

5.3 Read Codes

Data will be extracted via EMIS search and report. By signing up to this enhanced service you agree for the data be extracted as required. Read codes should be used for reporting, suggested read codes for the identification of people with dementia are the following:

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

SCHEDULE 3 – PAYMENT

A. Local Prices

Dementia

Dementia Diagnosis

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of the codes from the QOF (V48 Release 1.5) Dementia Register (DEM001) where the earliest coding is within the search period AND the consultation type was not 'Scanned document' AND the patient has any of the below codes added in the nine months prior to the end of the search period AND the consultation type where the codes were added (except for a GPCOG or Assessment for dementia code) was not 'scanned document'.

Clinical Code Description	SNOMED Description ID
Assessment for dementia	2247561000000112
TYM (Test Your Memory) test total score	3637929018
Mini-Cog test score	3289307011
Mini-Addenbrooke's cognitive examination score	2015691000006116
Addenbrooke's cognitive examination-III score	2015461000006110
Addenbrooke's cognitive examination revised - score	1554191000000113
General practitioner assessment of cognition patient score	1667281000000112
GPCOG (general practitioner assessment of cognition) score	1667301000000113
6CIT (Six Item Cognitive Impairment Test) total score	2718871000000119

Dementia Review

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Review of dementia advance care plan	1906941000006119
Review of dementia advance care plan	2742991000000115
Dementia care plan reviewed	2439631000000113
Review of dementia care plan	1996991000000118

where the code was added within the search period.

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date).

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Monthly extract used by ICB to inform quarterly payment	**All service specs**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	**DVTLES2426**
Service	**DVT pathway for patients presenting in general practice**
Commissioner Lead	**Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)**
Provider Lead	
Period	**1st June 2024 – 31st May 2026**
Date of Review	**January 2023**

1. Population Needs

1.1 National/local context

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

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

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

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

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

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

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

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

2.2 Local defined outcomes

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

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

3. Scope

3.1 Aims and objectives of the service:

Aims:

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

Objectives:

- improve patient care and experience by minimising the number of hand offs between clinical teams, to direct access scans
- reduce unnecessary referrals, investigations and treatment

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

3.2 Service description / care pathway

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

The pathway is as follows:

Phase 1 – Initial assessment – in patients GP practice
Assessment of general medical history and a physical examination of patients to exclude other causes. If DVT is suspected, use of the two-level DVT Wells score to estimate the clinical probability of DVT.

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

For the enhanced payment applicable to this phase the GP practice can either:

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

Or

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

of the d-dimer results as well as anticoagulating the patient until the d-dimer result is available and a GP can act on the result.

- Practices must complete the relevant EMIS template (to be provided) which will ensure read codes are applied and will provide the source for the calculation of payment.
- By signing up to this enhanced service you agree for the data be extracted as required.

D-dimers should not be performed in:

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

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

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

and

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

Any prescriptions for anticoagulation should be kept to the minimum number of days required to cover until the patient has their ultrasound scan (e.g. 7 days).

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

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

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

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

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

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

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

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

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

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

The ultra-sonographer will provide full leg scans for patients including pregnant & breast feeding women who present in primary care with a suspected lower limb DVT.

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

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

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

If the ultrasound results are inconclusive or the ultra-sonographer has concerns about the scan they will immediately (and on the same day) refer the patient onto the outpatient DVT service for a clinical management decision and consultant haematology support if required (available on the same day).If the patient requires a rescan, GP Care will prescribe additional anticoagulation to cover the patient until the results are known

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

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

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

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

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

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

Supervision, Training & Education

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

3.3 Population Covered

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

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

3.4 Any Acceptance or Exclusion Criteria

Patients presenting with the following exclusion criteria should be referred immediately to secondary care in line with current practice:

- Patients with a primary diagnosis of pulmonary embolism

- Patients under 18 years of age
- Housebound patients with significant manual handling implications e.g. requiring hoisting. The provider will need to ensure that the needs of eligible housebound patients are taken into account within the specified timescales.
- If housebound patients require scanning transport should be arranged for them by the current process.
- Other disease process or acutely ill patient that requires admission to secondary care
- Weigh over 165kg

3.5 Interdependence with other services / providers

N/A

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The applicable national standards are as follows:

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

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

N/A

4.2 Applicable Local Standards

N/A

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

N/A

5.2 Applicable CQUIN goals (See Schedule 4D)

N/A

5.3 Outcomes, contract monitoring and evaluation (see schedule 6A)

General practice (in hours) will record:

- Each episode of care on the EMIS DVT template on the practice system, which will enable audit and evaluation to determine the effectiveness of the service.

- The relevant EMIS Code to enable payment to the practice for each d-dimer test done.

General practice out of hours will record:

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

Scan provider will record:

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

Outpatient DVT service will record:

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

The objectives of the evaluation are:

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

In addition to the above the evaluation also needs to:

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

Appendix 1 – Pathway and Two level DVT Wells score

DVT Appendix 1.docx

SCHEDULE 3 – PAYMENT

A. Local Prices

DVT

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of

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

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

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original data extraction date

Quarterly payment following EMIS extract

Phase 1 – Initial assessment

Payment to general practice for each d-dimer will **be £30.54 plus a payment for each point of care testing kit used £10.18.**

Phase 2 and 3 – are not applicable to the LES and only as described in the service specification

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Monthly extract used by ICB to inform quarterly payment	**All service specs**

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**GP Support to Care Home LES**
Commissioner Lead	**Primary Care Contracts Team, NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices**
Period	**1st June 2024 – 31 May 2025**
Date of Review	***Currently under the review***

1. Population Needs

1.1 National/local context and evidence base

The purpose of this service specification is to provide a contractual framework for the Local Enhanced Service element of the GP Support to Care homes service.

The Network Contract DES and requirements for relevant providers of community physical and mental health services within the NHS Standard Contract establish a consistent, national, model for the Enhanced Health in Care Homes (EHCH) service. Commissioners, PCNs and other providers should consider these requirements as a minimum standard. The Enhanced Health in Care Homes requirements remain of vital importance during the COVID-19 outbreak, to support the organisation and delivery of a coordinated service to care home residents, many of whom will be at very high risk of a severe negative impact (directly or indirectly) from COVID-19. Good practice is described in the EHCH Framework which will supports the implementation of a mature EHCH service.

It was agreed that following a desktop review the elements of the LES that were considered beyond the scope of the DES would be separately commissioned under this enhanced service.

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

3.1 Aims and objectives of service

The overall aim of the Local Enhanced Service agreement is to improve the care and lives of people living in care homes building on the aims of the Enhanced health in care homes DES and in line with the framework.

In addition the objectives are 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.
- Ensure the appropriate management of Just in Case medications
- Ensure that quarterly meetings are held with the care home to share best practice and learning.
- GP to provide death certificate in a timely manner, usually within 24 hours (Monday to Friday) for expected deaths

3.2 Service description/care pathway

The delivery of this enhanced service directly links to PCN care home alignment. The PCN will determine how their care homes are supported and therefore, which GP practice will support the home and deliver the aims of this enhanced service.

Service Specification

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

1. Anticipatory Medicines (Just In Case Medicines, JIC) for end of life should be prescribed as appropriate for care home residents.
    - Prescribing JIC medicines should be done on an individual case by case basis, rather than as a routine part of a patient being admitted to a care home.
    - JIC medicines should be regularly reviewed, particularly controlled drugs (every 3 months) by the GP and NH nurses for appropriateness, and the

review should be clearly documented in the patient's care plan. If medication is deemed no longer necessary, it needs to be communicated to the community pharmacy so that it is removed from Medicine Administration Record (MAR) charts.
    - GP practices should be aware of which of their NH patients have been prescribed JIC medicines, and be able to generate a list of these patients from their records for review. These patients should be considered and reviewed as part of the GP practice's wider palliative care patient register.
2. The GP or appropriate clinician should attend with the care home manager a quarterly shared learning and practice review of emergency admissions.
3. If a death is anticipated, the covering GP should endeavour to see the patient in order to complete death certification.

3.3 Population covered

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

3.4 Any acceptance and exclusion criteria and thresholds

As above

3.5 Interdependence with other services/providers

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/

https://www.england.nhs.uk/wp-content/uploads/2020/03/Network-Contract-DES-Guidance-2020-21-October-update-.pdf

https://www.england.nhs.uk/publication/des-contract-specification-2020-21-pcn-entitlements-and-requirements/

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

N/A

4.2 Applicable local standards

N/A

5. Contract Monitoring, Reporting and Financial Information

5.1 Outcomes, monitoring and evaluation

Quarterly Monitoring (Schedule 6A)

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

Annual Monitoring Information (Schedule 6A)

Practices will undertake quarterly reviews of emergency admissions as part of the review process with the home. 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.

SCHEDULE 3 – PAYMENT

A. Local Prices

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the CCG may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

This will be divided by 4 and paid quarterly. If a practice cannot submit evidence that fortnightly ward rounds / a quarterly review has been undertaken with each home it is signed up to support a reduction in the quarterly payment will be made as follows:

-20% for failure to undertake fortnightly ward rounds
-5% for failure to undertake quarterly review

The reduction will only be made against the payment due for the home for which the criteria has not been met.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG CCG to extract the relevant data	Quarterly	EMIS Search and report	Monthly extract	**All service specs**
Review of Emergency Admissions	Six Monthly	Audit template to be provided	Sep / March	**Care Homes**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	SSM LES 2426
Service	Specialist Medicines Monitoring LES
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2026
Date of Review	April 2024

1. Population Needs

1.1 National/local context and evidence base

This Local Enhanced Service specification outlines a specialised monitoring service for certain immunosuppressants and anti-inflammatory treatments. Immunosuppressants and anti-inflammatory treatments occupy an important place in the management of many autoimmune and inflammatory diseases. All treatments used have the potential for harm as well as benefit. Appropriate and vigilant monitoring during therapy is required to minimise the risk of adverse effects and maintain patient safety.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	

Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

All of the drugs covered by this service are appropriate for shared care between a specialist and a GP practice. The BNSSG Joint Formulary contains Shared Care Protocols (SCPs) which offer guidance in this respect. Experience demonstrates that patients are more likely to engage with a regular monitoring service for their long-term condition that is provided in an organised manner in a convenient location such as closer to home in primary care. Appropriate and vigilant monitoring during therapy is required to minimise the risk of adverse effects.

3. Scope

3.1 Aims and objectives of service

To ensure adults and children treated with certain drugs with specific monitoring requirements are monitored by a service that is safe, effective, sustainable and closer to home.

Objectives:

1. To provide patients with the information they need to safely manage their treatment.
2. To monitor the safety and effectiveness of treatment by performing defined investigations monitoring at defined regular intervals.
3. To ensure that patients are managed appropriately, in collaboration with specialists where necessary, according to the results of the defined investigations.
4. To provide these patients with optimised treatment.
5. To provide a therapy monitoring service close to the patient.
6. To evaluate the quality of care delivered through an annual review process and to effect change when required to improve the service provided.

3.2 Service description/care pathway

All of the drugs covered by this service are included in the BNSSG Joint Formulary and are appropriate for shared care between a specialist and a GP practice. The BNSSG Joint Formulary contains Shared Care Protocols

(SCPs) which offer guidance in this respect. Regular monitoring and/or administration is required as part of the BNSSG Shared Care Protocol (SCP).

GP practices are required to ensure that the correct monitoring and investigations are done, at the correct frequency according to the SCP and/or specialist advice, and the results of the investigations are reviewed and appropriate action is taken as required, including amendment of the current prescription. Monitoring is predominantly undertaken using blood tests, however other monitoring is also required for some of the included medications as set out in the Shared Care Protocols (SCPs).

The latest versions of the Shared Care Protocols (SCPs) are available from: http://www.bnssgformulary.nhs.uk/Shared-Care-Protocols/

The medications subject to this LES will be subject to change. As new drugs are deemed suitable for shared care according to the BNSSG Formulary and a shared care protocol (SCP) is put in place amendments may be made to the list below.

The medicines currently requiring monitoring as part of this LES are:

1. Azathioprine
2. Denosumab (Prolia) 60mg/ml
3. Leflunomide
4. Mercaptopurine
5. Methotrexate
6. Penicillamine
7. Sulfasalazine
8. Mycophenolate
9. Cinacalcet
10. Testosterone injections (male hypogonadism)
11. Testosterone gel (Menopause)
12. Dapsone

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

- Assurance that a robust re-call system is in place to ensure recall of patients for the necessary monitoring.

- Assurance that there is a process to identify and manage patients not engaging with the necessary monitoring including cessation of prescriptions.
- By the 1st of December each year submit a review of practice monitoring activity as per the provided template in schedule 6A
- The practices current standard operating procedure for the above activities as part of the review of practice monitoring activity.
- Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/
- Number of patients monitored each quarter as part of this LES if EMIS Search and Report becomes unavailable.

How Will Activity Data be Obtained?

BNSSG ICB will obtain information on the number of patients being treated with the relevant medication and being monitored under this LES using EMIS Search and Report. By signing up to this enhanced service you agree for the data be exatracted as required.
Introduction of the Eclipse Live prescribing safety tool will alert prescribers to patients who have triggered one of the 14 PINCER indicators which would include the inadequate monitoring of methotrexate. This tool should further enhance practices ability to improve prescribing safety.

3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

Any patients having all of the necessary monitoring for these medications provided by another care provider are excluded from this LES.

3.5 Interdependence with other services/providers

N/A

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The following guidance from NICE:

- Psoriasis: assessment and management (CG153)
- Spondyloarthritis in over 16s: diagnosis and management (NG65)
- Denosumab for the prevention of osteoporotic fractures in postmenopausal women (TA204)
- Rheumatoid arthritis in adults: management (NG100)
- Crohn's disease: management (CG152)
- Ulcerative colitis: management (CG166)

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

- British Association of Dermatologists' guidelines for the safe and effective prescribing of azathioprine 2011. Meggitt SJ, Anstey AV, Mohd Mustapa MF, Reynolds NJ, Wakelin S. Br J Dermatol 2011; 165; 711-734.

- British Association of Dermatologists' guidelines for the safe and effective prescribing of methotrexate for skin disease 2016. Warren R.B., Weatherhead S.C., Smith C.H., Exton L.S., Mohd Mustapa M.F., Kirby B., Yesudian P.D. Br J Dermatol 2016; 175: 23-44.

- BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs. BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs. Jo Ledingham, Nicola Gullick, Katherine Irving, Rachel Gorodkin, Melissa Aris, Jean Burke, Patrick Gordon, Dimitrios Christidis, Sarah Galloway, Eranga Hayes, Andrew Jeffries, Scott Mercer, Janice Mooney, Sander van Leuven, James Galloway, on behalf of the BSR and BHPR Standards, Guidelines and Audit Working Group. Rheumatology, Volume 56, Issue 6, 1 June 2017, Pages 865–868,

4.3 Applicable local standards

BNSSG Shared Care Protocols (SCPs)
https://remedy.bnssgICB.nhs.uk/formulary-adult/scps/scps/
https://remedy.bnssgICB.nhs.uk/formulary-paediatric/paediatric-shared-care-protocols/scps/

5. Applicable quality requirements and CQUIN goals

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

By the 1st of December each year submit a review of practice monitoring activity as per the provided audit template

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

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

Following a one off annual payment, payments will be made quarterly in arrears

Practices will be remunerated using the following scale (per patient per quarter) which reflects the increased workload of more frequent monitoring. New medicines may be added into this schedule when deemed suitable for shared care according to the BNSSG Formulary and a shared care protocol (SCP) is in place.

Practices will also be paid an annual sum of £356.30 per 10,000 patients. This sum reflects that for certain medications in certain situations additional monitoring may be required above that accounted for in the structure below. This sum also reflects the patients newly initiated onto the medications covered by this LES each year and that some of these medications have increased monitoring requirements during year one of therapy

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
		Testosterone (injection) – male hypogonadism Payment in first year of treatment only		
		Testosterone gel - menopause		
2	4-5	Azathioprine	£70.00	£17.50
		Leflunomide		
		Methotrexate		
		Penicillamine (Nephrology)		
		Cinacalcet (Endocrinology)		
		Mycophenolate		

		Dapsone		
3	6-8	Mercaptopurine (oral) Sulfasalazine (oral) Payment in first year of treatment only	£100.00	£25.00
4	9-12	Penicillamine (Rhuematology)	£120.00	£30.00

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Quarterly extract used by ICB to inform payment	**All service specs**
During <u>quarter three</u> submit a review of practice monitoring activity as per the provided template	Quarter 3	Template	By 1 December, due each contract year	**SMM LES**

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

Specialist Meds Monitoring

EMIS Web search criteria for calculating LES payment:-

<u>Azathioprine</u>

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

<u>Cinacalcet</u>

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

Clinical Code Description	**SNOMED Description ID**

Hyperparathyroidism	111289013
Ectopic hyperparathyroidism	49080014
Primary hyperparathyroidism	60663012
Familial hyperparathyroidism	356183018
Normocalcemic primary hyperparathyroidism	4024743018
Parathyroid hyperplasia	16008014

Dapsone

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

Denosumab

- All patients (including deducted and deceased) who have been issued with an NHS prescription of denosumab 60mg/ml by the surgery during the search period.

Leflunomide

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

Mercaptopurine

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

Methotrexate

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

Mycophenolate

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

Penicillamine

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

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

- OR

Clinical Code Description	**SNOMED Description ID**
Rheumatoid arthritis (or child codes)	116082011

Inflammatory polyarthropathy (or child codes)	2548331017
Rheumatoid arthritis and other inflammatory polyarthropathy (or child codes)	168751000006115

Sulfasalazine

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

Testosterone injection (male hypogonadism)

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

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

- AND DON'T have a prescription issue of testosterone > 9 months previously.
- Testosterone gel (female menopause)
- All female patients (including deducted and deceased) who have been issued with an NHS prescription of testosterone gel (Tostran, Testim or Testogel as per SCP) by the surgery during the search period AND have a clinical code for menopause added when they were 45 or younger and/or bilateral oophorectomy at any age.

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	InsulinStartLES2425
Service	Type 2 Diabetes Insulin Start LES
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2025
Date of Review	April 2024

1. Population Needs

1.1 National/local context and evidence base

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

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

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

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

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

This service is an example of integrated primary and community care, with simplified access points for patients to specialised services.

3. Scope

3.1 Aims and objectives of service

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

The service detailed in this service specification must have a designated lead within the practice/locality. In usual circumstances routine insulin initiation and other non insulin injectable diabetes treatment initiation must be provided by the practice and its employed clinical staff and not by community or specialist nurses.

Objectives:

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

3.2 Service description/care pathway

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

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

- Identification of patients who need intensification of their drug therapy for diabetes
- Have a designated diabetes lead within the practice.
- Intensify drug therapy in line with BNSSG formulary
- Optimise glycaemic control

- Frequency of episodes of hypoglycaemia including emergency admission
- Ensure a patient centred approach to the initiation of insulin therapy which empowers the person with type 2 diabetes to be actively involved in their treatment
- Ensure that cost-effective consumables are supplied to patients
- Patients initiated on insulin therapy are coded on the EmisWeb prescribing system with

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

- Provide safe, high quality, evidence based effective care

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

- Injection technique, including rotating injection sites and avoiding repeated injections at the same point within sites
- Continuing telephone and/or face to face support
- Self-monitoring
- Dose titration to target levels
- Dietary and lifestyle advice
- Insulin storage
- DVLA guidance (At a glance guide to the current medical standards of fitness to drive)
- Risks/causes and management of hypoglycaemia
- Management of acute changes in glucose control
- Advice regarding management during illness
- Support from an appropriately trained and experienced healthcare professional.

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

- Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES.

Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/

- Agree to extraction of data to monitor the number of insulin initiations in patients with type 2 diabetes via EMIS Search and Report

BNSSG ICB will obtain information on the number of patients being initiated onto insulin therapy under this LES using Emis Search and Report. By signing up to this enhanced service you agree for the data be extracted as required.

Data extracted will be used to assess delivery of the following measures:

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

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

- Practice Nurses/Clinical Pharmacists - completion of the 2 day locally run insulin initiation programme facilitated by the Community Diabetes specialist team, or evidence of further training in diabetes if from outside of area. Prior to taking on insulin initiation training it is expected that a certain level of diabetes care competence has been achieved, this would normally include an accredited module in diabetes course received from an accredited training provider. Examples include:
  - 'Care of the adult with diabetes' module available from the University of the West of England (UWE). https://courses.uwe.ac.uk/UZTR3Q203/care-of-the-adult-with-diabetes
  - Diploma level education available from:
    - Education for Health

https://www.educationforhealth.org/education/z-courses/

- Primary Care Training Centre: https://www.primarycaretraining.co.uk/training/

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

Assessment of Competency: All practitioners undertaking initiation of insulin shall have up to 10 supervised initiations assessed by the Community Diabetes Nurse Specialist and will be advised when they are deemed competent to initiate without supervision (the number of supervised initiations will depend on the competence of the practitioner). The Practice will not be eligible for payment until competency has been assessed and confirmed, at which point a certificate will be issued.

Ongoing Diabetes CPD- PNs/clinical pharmacists and GPs who initiate insulin are expected to maintain their skills by attending diabetes CPD annually either virtual, national or local meeting/conference

Ongoing advice and guidance – for support with clinical decisions and complex patients practice teams are encouraged to telephone/email the Sirona Diabetes Advice and Guidance service

The service, which is for healthcare professionals only, is available between 8am-5pm, Monday-Friday and run by a team of Community Diabetes Specialists.

For queries requiring same day response, call 0300 124 5908.

For routine advice and guidance, e-mail sirona.diabetesadvice@nhs.net. Please include details of the situation, background, assessment and proposed recommendation requiring advice and guidance review.

3.3 Population covered

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

3.4 Any acceptance and exclusion criteria and thresholds

The following exclusions will apply:

- Patients under the age of 16
- Patients with Type 1 Diabetes

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

3.5 Interdependence with other services/providers

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

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following guidance from NICE:

- Type 2 diabetes in adults: management. NICE Guideline 28 (June 22) http://www.nice.org.uk/guidance/ng28

- NICE Diabetes quality standards: Overview | Type 2 diabetes in adults | Quality standards | NICE

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

- https://www.rcn.org.uk/clinical-topics/diabetes/professional-resources Starting injectable treatment in adults with Type 2 diabetes (3rd edition). This resource requires an RCN login to access.

4.3 Applicable local standards

- The Bristol, North Somerset, & South Gloucestershire (BNSSG) Joint Formulary https://www.bnssgformulary.nhs.uk/

- BNSSG Type 1 diabetic blood glucose monitoring guidance https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/6-endocrine-system-guidelines/
- BNSSG Type 2 diabetic blood glucose monitoring https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/6-endocrine-system-guidelines/

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

Reporting Requirements

BNSSG ICB will obtain information on the number of patients being monitored under this LES using Emis Search and Report. By signing up to this enhanced service you agree for the data be extracted as required.

By agreeing to participate in this LES the practice will also be required to provide the information detailed in schedule 6A

5. Applicable quality requirements and CQUIN goals

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

N/A

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

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

A. Local Prices

Insulin Initiation

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

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

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

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

Payment frequency is Quarterly in arrears.

What will be Paid For?
Practices will receive one payment for each patient initiated onto insulin therapy.

How will Payments be Made and Calculated

The total number of patients initiated onto insulin therapy each quarter will be multiplied by the appropriate level of payment **£175**

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Provide assurance that a robust re-call system is in place to ensure recall of patients for the necessary monitoring	April each contract year	Declaration with contract sign up	April	**Insulin LES**
Assurance that there is a process to identify and manage patients not engaging with the necessary monitoring including cessation of prescriptions supply.	April each contract year	Declaration with contract sign up	April	**Insulin LES**
During quarter three submit a review of practice monitoring activity as per the provided template	Quarter 3	Template 2425 Insulin initiation LES audit FINAL versic EMIS Web Search Insulin Initiation LES Audit.xml	By 1 December, due each contract year	**Insulin LES**
The practices current standard operating procedure for the above activities as part of the review of practice monitoring activity	April each contract year	Declaration with contract sign up	April	**Insulin LES**
Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of	Ongoing	Datix	April	**Insulin LES**

the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/				
Number of patients monitored each quarter as part of this LES if Emis Search and Report becomes unavailable.	If required	TBC as required	April	**Insulin LES**