Reference: FOI.ICB-2627/025

Subject: Locally Enhanced Service (LES) Scheme

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

<table>
<tr><th>QUESTION</th><th>RESPONSE</th></tr>
<tr><td>1. Does the ICB currently offer a Locally Enhanced Service (LES) incentive scheme—such as those for the management of long-term conditions, targeting of specific patient cohorts, or admission avoidance—to GP practices? If not currently in place, has a scheme of this nature been offered within the past five years?</td><td>Yes, the ICB currently commissions Local Enhanced Services (LES) for GP practices across BNSSG.</td></tr>
<tr><td>2. If so, please provide the scheme documentation shared with GP practices and administrators, or detailed information on the scheme's components, including:
Specific measurement (e.g. anticoagulant monitoring)
Patient cohort (e.g. patients currently taking Warfarin)
Business logic (e.g. QOF-like format), including:
Dataset specification
Patient/cohort selection criteria
Clinical (SNOMED) codes or code clusters
Indicator rules
Reporting template (e.g. a custom template used within the ICB for making a claim)</td><td>Please find enclosed the service specifications for the Local Enhanced Services listed below.

Please note that FOI requests and responses are publicly available and therefore personal information has been redacted. The ICB considers the names included in the enclosed document(s) to be personal information and therefore has applied a section 40 (Personal Information) exemption to this information.

<table><tr><td>Anticoagulation LES: Basic service</td></tr><tr><td>Anticoagulation LES: Advanced service</td></tr><tr><td>Type 2 Diabetes Insulin Start LES</td></tr></table></td></tr>
</table>

• Funding allocation for the measure (e.g. £1 per head of population, £1 per 1,000 blood clot patients)	GP Support to Care Home LES
	Community Phlebotomy Service
	Dementia
	DVT pathway for patients presenting in general practice
	Medicines Optimisation Prescribing Quality Scheme
	Severe Mental Illness – Physical Health Checks
	Teledermatology - image taking
	Weight Management – Tirzepatide prescribing and management in primary care LES
	Adult Attention Deficit Hyperactivity Disorder (ADHD) Annual Review LES
	Specialist Medicines Monitoring LES
	Physical Health Monitoring for Adults with Eating Disorders LES
	Supplementary Services LES
	FLU Antiviral LES
	Covid Medicines Delivery Unit (CMDU) Service LES
	North and West Bristol COPD Service
	Migrant Health LES

	The ICB considers the information relating to the payment structure for each service commercially sensitive and has therefore applied Section 43(2) to this information. Section 43(2) exempts from disclosure information which would, or would be likely to, prejudice the commercial interests of an organisation. The ICB considers the information relating to payment structure commercially sensitive. Section 43(2) is a qualified exemption and therefore the public interest test has been set out below. The public interest arguments in favour of disclosing the information include the ICB's responsibility to be transparent and accountable in its decision making. The ICB has a responsibility to demonstrate that the LES agreements represent good value for public funding. However, disclosing the information would potentially be detrimental to primary care budgets or future service considerations. The ICB has also considered that although funded through the NHS, GP Practices are private businesses and consider information regarding their finances to be confidential information. The ICB recognises that GP Practices expect financial information to be treated as confidential and therefore disclosure of the information may damage relationships between the ICB and GP Practices. The ICB believes that the public interest lies in maintaining the exemption as it is in the public interest for the ICB to be able to

	commission services at a good value to ensure that primary care services are available. Preserving good relationships with GP Practices enables the ICB to continue to deliver valuable and cost-effective services to patients. If these services were not delivered through primary care, there would be an activity increase across other local healthcare services which would impact the ability for other community and acute services to be delivered.
3. Please also provide details on the LES operational process from development through to payment claims, including: a. LES Development i. Who is responsible for defining the LES and its business logic? b. Data Extraction and Submission i. Who is responsible for preparing the data and submitting it to CQRS? ii. How is the data prepared and submitted for making a claim (e.g. CQRS portal)? Is the process manual or automated? iii. How is the reporting template developed and maintained? c. Payment Process i. How is the submitted data verified by the ICB or commissioner (e.g. validated against the business logic)? Is this verification manual or automated? ii. If no formal business logic is applied, how is the data validated? iii. Are there any audit processes in place? If so, how are these audits conducted?	a. LES Development i. Each LES has an assigned clinical, and commissioning lead responsible for the review and commissioning of the LES. Pathways and proposals are developed and presented to the LES Steering Group for discussion. The group reviews uptake and conducts mapping exercises to Identify opportunities that will contribute to the overarching system priorities and meet the needs of the local population. b. Data Extraction and Submission i. GP practices in BNSSG are required to record their LES activity via the EMIS system using SNOMED codes. The ICB does not currently use CQRS for the LES's. ii. The ICB's BI team is responsible for the data extraction from the EMIS system. Activity data from the EMIS system is used to inform the payments due to practices. Where a LES requires an alternative data recording, validation and payment process, this is clearly stated within the service specification.

	iii. Coded data e.g. prescribing, snomed, demographic, is identified which can be used to accurately monitor LES activity in collaboration with the GP federation and clinical leads. EMIS searches are then built to identify the activity. The criteria are clearly stated in the LES. Copies of the searches shared with GP surgeries and EMIS templates adapted/shared to support coding where applicable. c. Payment Process i. Practices are required to use the correct SNOMED codes for the services delivered under the LES's. The validity and accuracy of the EMIS data depends' on the practice's use of the appropriate SNOMED codes. The BI team are then able to perform the data extraction process to inform the payments due to practices. ii. N/A iii. The ICB's internal audit function has a rolling work programme to review all ICB spend
4. If locally enhanced service incentive schemes are not provided, has the ICB implemented any alternative schemes that supported GP practices with additional funding in the past 5 years? 5. If so could you please provide the details of those schemes?	Not applicable

The information provided in this response is accurate as of 10 June 2026 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.

1. SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	ADHDLES2527
Service	Adult Attention Deficit Hyperactivity Disorder (ADHD) Annual Review Local Enhanced Service
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st July 2025 – 31st March 2027
Date of Review	June 2025

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 efficient, 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 adult patients to primary care for ongoing prescribing and annual reviews
- Discharging stable patients who are about to transition to adult care from Community Paediatrics into Primary Care, for ongoing prescribing and annual reviews

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 growing number of Right to Choose providers for adult ADHD services.

The legal rights to choose a 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 with experience and expertise in the field of Adult ADHD
- 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 paramount for the GP to inform the patient at the outset of the referral about the standard of the assessment and any resulting treatment that will be required for primary care to offer the LES or shared care agreement. This guidance can be found on: ADHD (adult) (Remedy BNSSG ICB) **It is strongly recommended to avoid providers that are unable to deliver the complete care pathway**.

We also strongly recommend that you use the BNSSG shared care protocol linked below to share care with other providers to ensure they meet the criteria.

Private (this includes private providers as well as NHS funded private providers e.g. Right to Choose providers) Diagnosis

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

Any patient with a recognised diagnosis from a private provider is eligible to be included under this LES once they have concluded the diagnostic assessment, and medication stabilization pathway and shared care has been requested with General Practice.

A recognised diagnosis is defined as: (BNSSG agreed standards compliant - https://remedy.bnssg.icb.nhs.uk/adults/mental-health/adhd-adult/ under the heading 'transfer from other providers').

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. When this is no longer possible, the patient can be referred along the AWP ADHD Transfer of Care pathway outlined below to be accepted for ongoing shared care between AWP and General Practice.

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.

The GP practice can consult with the AWP ADHD specialist service for advice on whether quality standards are met.

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

By primary care providers taking on this activity it is anticipated that this will significantly enhance the quality of life for people living with ADHD and allow timely identification of holistic physical and mental health needs and treatment closer to home. There is also emerging evidence that this reduces frequent attendance in those with ADHD.

It also allows remuneration to general practice for taking on this work and 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 (BNSSG standard compliant) recognised diagnosis from an alternative (NHS or non-NHS) provider.

BNSSG Standard:

https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fremedy.bnssg.icb.nhs.uk%2Fmedia%2F4717%2Fadhd-clinic-standard-271120.docx&wdOrigin=BROWSELINK

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

Primary care providers will be notified in writing of the patient via the normal discharge processes from AWP. And usually for other providers a formal shared care request is made for transfer of care into General Practice.

For those practices not wishing to uptake the ADHD LES, annual review responsibilities will remain with the existing provider / prescriber.

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. These are the requirements of a practice:

Supply of Monthly prescriptions	• According to shared care protocol
Annual reviews (use annual review checklist)	• Patient completes annual review checklist • Health Care Assistant (HCA) checks weight, height, BMI, BP, pulse • Review by General Practitioner / Prescribing Pharmacist • Check and record therapeutic effects, adverse effects, co-morbidities • Action any needs from holistic health perspective and or seek further advice for medication changes required from AWP or other NHS /non NHS Provider.
6-monthly	• Patient attends surgery for BP, pulse and weight check – Covered under SMM LES. • (can be self-reported unless high risk e.g. patients with coexisting eating disorders)
Non-attendance	• Give second chance one month later • Consider additional reminder (SMS, etc.) • Consider stopping prescription until patient has made contact with GP surgery

	• Discuss with ADHD clinic if treatment gap more than 2 weeks
AWP ADHD clinic contact	• Opening Hours: Mo-Fri, 9am-5pm, preferred contact via email. • Telephone – 01275 796262 • Email: awp.specialisedadhdservices@nhs.net • Email/telephone support for primary care within two working days for urgent matters (remember: ADHD is not usually the cause of a crisis/emergency) • Urgent clinic reviews can be arranged if required, following a telephone consultation with the GP, within 5 working days. • Routine ADHD clinic reviews within 8 weeks

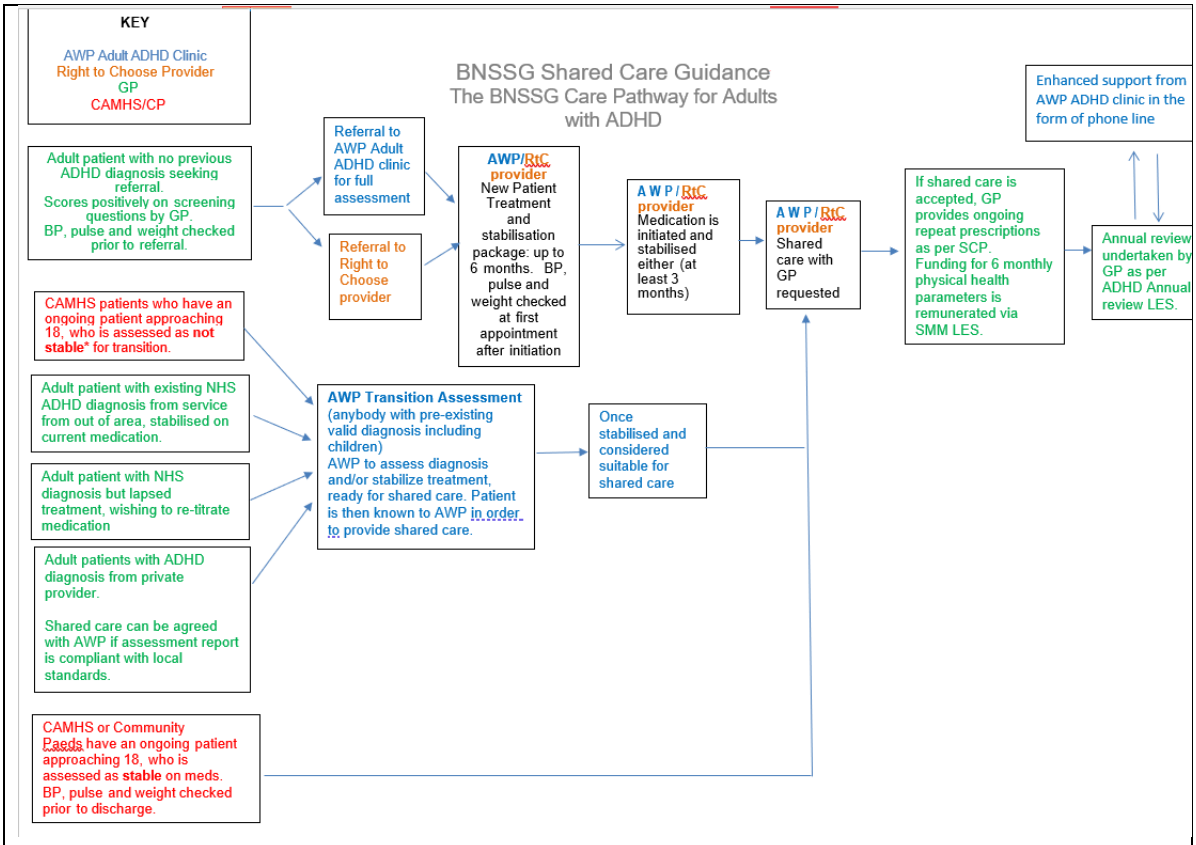
The annual review template is embedded below:

adhd-review-primary-care-template 2025.d

For support there is an annotated version for clinicians below:

adhd annual-review-primary

The full pathway is summarised below:



adhd Pathway for Annual Review LES 20

Practices will be paid for each completed adult ADHD annual review.

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 (BNSSG compliant) diagnosis from a private provider.

Please see LMC advice around acceptance of assessments from a private provider:
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Favonlmc.co.uk%2Fwp-content%2Fuploads%2F2025%2F01%2FResponding-to-Private-Healthcare-Requests.docx&wdOrigin=BROWSELINK

For those practices who chose to accept shared care with a private provider, we would recommend asking the provider to sign the BNSSG formulary shared care protocol rather than their own.

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 as described above.

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. Please see the corresponding paperwork for the alternative RTC and private providers.

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:

[redacted]

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.	AntiCogsAdv2425
Service	Anticoagulation LES: INR monitoring and vitamin K antagonist dosing – Advanced service
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st Mar 2027
Date of Review	January 2023
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

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

The commissioner will allocate payment as follows:

The sum for the advanced service includes an amount for the practice to purchase Coaguchek test strips (at approximately 16 strips per patient per year). For patients being monitored and dosed under this LES, additional strips must not be put on prescription, they must be ordered by the GP practice directly from Roche, where a pre-negotiated discount will be applied for all providers of BNSSG ICB.

<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	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st Mar 2027
Date of Review	January 2023
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

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)

The commissioner will allocate payment as follows:

- **Basic - £62.00 per patient per year**

How will Payments be Made and Calculated

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 *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 Aug 2026
Date of Review	January 2023
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

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.

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.	
Service	Covid Medicines Delivery Unit (CMDU) Service Specification for Provider of Primary Medical Services carrying out Clinical Eligibility Assessment and the prescribing of antivirals
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 January 2026- 31st March 2026
Date of Review	March 2027

1. Population Needs

1.1 National/local context and evidence base

Covid Medicine Delivery Units (CMDUs) are deployed nationally to provide access to COVID treatments for non-hospitalised patients believed to be at greatest risk of disease progression, hospitalisation or death.

During the Covid pandemic every NHS region was required to provide a 7-day service including bank holidays (or 5-6 day service with additional administrative and on-call clinical arrangements to enable patient contact, triage and treatment/ dispensing over the weekend to ensure patients do not miss the option of treatment within the confined treatment window) to ensure all referred patients can receive treatment within the necessary treatment window. This had to cover the entire ICB population aged 12 years and over the treatments must be accessible to all including those in prison and mental health care units.

A local decision has now been made to step down the provision to four times weekly.

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**	

3. Scope

3.1 Aims and objectives of service

To improve clinical outcomes in non-hospitalised patients with COVID-19 who are at high risk of progression to severe disease and/or death.

Objectives:

- CMDU to provide a Clinical Assessment Team comprising suitably qualified clinical staff, responsible for assessing high-risk, non-hospitalised COVID-19 patients and prescribing antiviral treatment where eligible.
- The CMDU Clinical Assessment Team will be prescribing a red traffic light status medication, therefore the prescribing will remain with the clinicians within the Clinical Assessment Team and where necessary with acute trust clinicians.

3.2 Service description

Referral process

GP practices, NHS 111, specialist hospital clinicians, the healthcare team from prisons and mental health facilities will refer patients into the CMDU service daily via email. A daily referral list will then be generated for clinical assessment to screen patients into the treatment programme.
Any potentially eligible children should be referred on to Bristol Children's Hospital via the designated email with a read receipt.

Clinical Assessment and Prescribing

Non-hospitalised patients are eligible where all of the following criteria are met:

- A positive Lateral Flow covid test result
- Symptomatic AND showing no signs of clinical recovery.
- AND meeting NICE criteria for patient eligibility.

There are currently two treatments available.
First line: Paxlovid (nirmatrelvir plus ritonavir) NICE TA878
Second line: Molnupiravir NICE TA 1056

Clinicians must also familiarise themselves with the individual drugs summary of product characteristics.

Once the referral has been made the patient will be temporarily registered on the Provider of CMDU's EMIS platform then triaged by the Clinical Assessment Team who will contact the patient. Those eligible will be offered treatment.

Special consideration needs to be taken regarding the interaction of antivirals with other medication.

Patients who have been identified for oral antiviral treatment following a triage by the Clinical Assessment Team will be prescribed treatment and the EPS system will be used to enable the medicine to be dispensed at a community pharmacy. The Provider will discuss and agree the most suitable community pharmacy that holds stock of the medicine required and is most easily accessible for the patient.

Clinicians must document that the clinical assessment has taken place and whether the individual is eligible for treatment or not. The clinician must document which medication has been prescribed.
A record will be created on the EMIS system.
Clinicians will complete template to include:
1. Clinical assessment and patient consent
2. Eligibility of treatment
3. Clinical treatment prescribed
4. Complete overarching data collection form to enable system wide collation of data of the service and send to designated central point

Once completed patient record will be saved, patient discharged and the contact closed.

Discharge from the service
Clinicians will ensure patients have guidance on where to access further support if required. This can include:

- GP appointment
- 111
- 999/ Acute hospital

Referrals to the Provider of Primary Medical Services will be reviewed Monday, Wednesday, Friday and Saturday (4 days per week service). There always needs to be competent staff member available to accept referrals.

3.3 Population covered

This service is for all patients registered with a practice within BNSSG or who reside in a prison or mental health facility within BNSSG who meet the criteria for Covid treatment.

3.4 Any acceptance and exclusion criteria and thresholds

Patients are not eligible if they meet any of these criteria:

- The pattern of clinical presentation indicates there is recovery rather than risk of deterioration.
- Require hospitalisation for Covid-19
- Have a new need for supplemental oxygen specifically for management of Covid-19 symptoms.
- Children <40kg
- Children <12 years of age
- Do not meet the NICE criteria for treatment
- Known hypersensitivity to active substance or excipients of individual medications

3.5 Finance

The CMDU provider will be remunerated based on the number of patients reviewed:
≤15 per week
16-26 per week
≥26 per week

An additional payment will be renumerated if CMDU operates on a Bank Holiday.

3.6 Activity recording and monitoring

Activity monitoring will be via number of consultations and number of prescriptions issued via EMIS

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Nirmatrelvir plus Ritonavir NICE TA878
Molnupiravir NICE TA 1056

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

N/A

6. Location of Provider Premises

Mendip Vale Medical Practice
Concord Medical Centre

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 Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2027
Date of Review	January 2023
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

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	Feedback from people with dementia who have	Annual	To understand how people feel about the

	their GP practice understands their dementia and that they gain relevant information about their dementia.	experienced the service		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.

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	[redacted] / [redacted] 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
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

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

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 Specification

Service Specification No.	FluantiviralLES2528
Service	Suspected Influenza outbreak timely assessment and management in a community setting in BNSSG
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st April 2025 – 31st March 2028
Date of Review	Annual review to support future planning

1. Population Needs

1.1 National/local context and evidence base

Localised community outbreaks of influenza have the potential to cause significant illness among exposed persons in at-risk groups. NICE Technology Appraisal Guidance (TAG) recommends antiviral medicines are used during community influenza outbreaks among at-risk groups.

Underlying chronic health conditions and a reduced immune system response make elderly patients more vulnerable to infection. Respiratory infections may spread rapidly in closed settings e.g. boarding schools or care homes due to prolonged close contact between residents/pupils and staff. Hospitalisation rates for the elderly or those with other illnesses during influenza outbreaks can be high. Deaths are also a possiblity.

UK Health Security Agency's Health Protection Teams (UKHSA HPT) routinely receive reports of suspected influenza outbreaks, assess these and if indicated recommend the use of antivirals for exposed persons in at-risk groups. When UKHSA declare an influenza outbreak, a clinician is required to assess all exposed persons in at-risk groups for the need for antiviral treatment or prophylaxis and arrange for a patient specific antiviral supply.

From a contractual perspective, treatment of patients who are ill, or who believe themselves to be ill, with influenza like illness will fall within the definition of essential medical services in the GP contract. However, a distinction has to be made between those patients who are ill (or believe themselves to be ill) and those at risk patients who are not ill but for whom post-exposure prophylaxis with antiviral drugs has been recommended because of local contact with a person with influenza-like illness. Timely assessment and supply can also be affected by winter pressures.

This service therefore is intended to ensure the timely provision of antivirals to all appropriate patients.

This service will be required both during and outside of normal working hours, as for optimal benefit, antivirals must be supplied within a narrow time period from onset of symptoms, as per NICE TA 158 and 168.

In the unlikely event of an avian influenza outbreak, the provider may be asked to support with the prescribing of antiviral medications.

Out-of-season and during annual influenza season
The start and end date of the influenza season varies on an annual basis and as such there are no fixed dates for in-season and out-of-season influenza activity. The start and end of the influenza season will be declared by the Chief Medical Officer and Chief Pharmaceutical Officer from the Department of Health and Social Care and published on the CAS website https://www.cas.mhra.gov.uk/Home.aspx

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

Suspected influenza outbreak in a care home

An outbreak of an acute respiratory infection (ARI) is defined as 2 or more ARI or influenza-like illness (ILI) cases in epidemiologically-linked residents.

A 5-day window for case onset can be used as a pragmatic window for determining if there is an outbreak, noting that incubation and infectious periods can vary between respiratory viruses

For full information on the definition of a suspected influenza outbreak please refer to UKHSA guidance on Influenza-like illness (ILI): managing outbreaks in care homes https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes

For educational establishments (with younger populations) a suspected influenza outbreak will be declared when:

Two or more cases (as defined in guidance) attending the same school, with onset dates within a 5 day period and with epidemiological evidence of transmission within the school or educational setting (e.g. sports team, classroom, after school group). For full information on influenza outbreak definitions in schools please refer to UKHSA Guidance On suspected acute viral respiratory infections: managing outbreaks in schools https://www.gov.uk/government/publications/influenza-like-illness-ili-managing-outbreaks-in-schools/investigation-and-management-of-outbreaks-of-suspected-acute-viral-respiratory-infection-in-schools-guidance-for-health-protection-teams

Note: Other ARI pathogen detections should be taken into consideration in defining cause, noting cocirculation is possible.

When UKHSA declare a suspected influenza outbreak, a clinician is required to assess all those who are symptomatic and all those exposed persons in at-risk groups for the need for antiviral treatment or prophylaxis and arrange for a patient specific antiviral supply.

This service is designed to ensure clinicians will be quickly mobilised to repond to an influenza outbreak situation undertaking the patient assessments and arranging any necessary antiviral supply within the necessary timescales.

3. Scope

3.1 Aims and objectives of service

This service should apply in the following circumstances:

- Provide assessment and any subsequent prescribing of antivirals to care home residents when UKHSA have declared an outbreak. This applies to both during the flu season and outside of the season as well as both in and out of hours situations. It remains the responsibility of the patient's own GP or out of hours provider to assess any clinically unwell patients that may need further intervention than antivirals alone.
- In the unlikely event of an avian influenza outbreak, the provider may be asked to support with the prescribing of antiviral medications.

Aims:

- To ensure clinicians will be quickly mobilised to respond to an influenza outbreak situation, undertaking patient assessments, carrying out swabbing (where not already undertaken by the care home) and arranging antiviral supply within the necessary timescales leading to reduced influenza associated morbidity and mortality and reducing further onward transmission of influenza and reduce potential pressure on acute providers.

Objectives:

- To enable a single provider to rapidly respond at any time (inside or outside normal working hours and 'in season' and 'out of season') to a suspected influenza outbreak in a community setting e.g. care home, special school
- To provide rapid clinical assessment of exposed persons who may require antiviral therapy

- Undertake swabbing of patients undergoing clinical assessment for the detection of the presence of the influenza virus as per UKHSA recommendations for swabbing (where not already undertaken by the care home).
- To determine the appropriate and safest dose of antiviral therapy for the assessed patients, considering the patients renal function (see appendix 1)
- To arrange a legal prescription or patient specific direction to enable the patient to be administered antiviral therapy
- To arrange supply of antiviral medicines to those who require treatment or prophylaxis
- To provide patients/carers with the information they need to safely manage antiviral treatment
- To share data relating to individual patient assessment and antiviral therapy with the patients GP and other relevant health care professionals to support safe and effective care for the patient
- To provide the service to a high standard in a way that is convenient for patients and carers.

Service description/care pathway:

When a suspected influenza outbreak is declared in a community setting **UK Health Security Agency Health Protection Team will contact the service provider organisation with the following information**:

- Location and address of the out break
- Information about the community setting e.g. care home with nursing
- Relevant contacts at the outbreak location
- Approximate numbers of the individuals that require clinical assessment for antiviral treatment or prophylaxis
- Whether swabbing is required and details of who should be swabbed and how to obtain swabs

This information should then be provided to the service provider in a supportive follow up email.

UKHSA HPT will:

- Contact GP Provider to discuss outbreak including location and potential numbers involved.
- Advice for the provider organisation explaining what is required in terms of assessment and treatment/prophylaxis
- Provide a letter for staff affected by the outbreak.
- Provide advice regarding the treatment/prophylaxis of staff
- Advise care home managers about infection prevention and control measures for patients, staff and visitors including the use of PPE and risk assessment of staff who may experience complications if infected with the influenza virus.
- Provide a stock of swabs to the provider organisation.
- Take part in system EPRR exercises regarding outbreak management and ensure relevant learning is cascaded from outbreaks

The provider organisation is required to undertake the following:

- Liaise with the HPT regarding what is required
- Clinical assessment of symptomatic individuals who may require antiviral treatment within recommended time frames

- Clinical assessment of exposed individuals who may require antiviral prophylaxis within recommended time frames
- Out of season –clinical assessment of asymptomatic exposed staff in at risk groups who have not had this seasons flu vaccination (>14 days prior)
- In the occasional situation, where a care home is unable to undertake swabbing of patients undergoing clinical assessment for the detection of the presence of the influenza virus as per UKHSA recommendations for swabbing, the provider will undertake swabbing. (Viral swabs can be sent by UKHSA direct to the care home/school, or obtained from the local acute Trust microbiology dept.)
- To determine the appropriate and safest dose of antiviral therapy for the assessed patients, considering the patients renal function (see appendix 1)

- **Medication supply - during annual influenza season**
- The service provider will:
    - Liaise with community pharmacy/hospital pharmacy about antiviral supply so they can order appropriate quantities and strengths of antiviral medication.
    - Write a FP10 NHS prescription or Patient Specific Direction (PSD) if a hospital supply of antivirals required
    - Send all FP10 NHS prescriptions or PSD to the community pharmacy/hospital pharmacy to enable the pharmacy/pharmacies to supply the medication immediately
    - Liaise with community pharmacy/hospital pharmacy to ensure the antiviral medication will be couriered/delivered to the site of the out-break immediately
    - Community pharmacies are able to access urgent supplies through medicine wholesalers such as AAH and Alliance. However, if there are difficulties obtaining antiviral medication at community pharmacies during an out-of-hours response or due to large patient numbers, follow the directions for medication supply outside of influenza season (liaising with the University Hospital Bristol and Weston NHS Foundation Trust pharmacy and UKHSA).
- The provider will write a patient specific direction (PSD) in a format that assists the care home/ school to administer antiviral medication safely and according to standard operating procedures e.g. where necessary on the MAR chart in a care home setting.
- To provide patients/carers with the information they need to safely manage antiviral treatment
- To share data relating to patient assessment and antiviral therapy with the patients GP and other relevant health care professionals to support safe and effective care for the patient
- Communicate with the patients registered GP that the patient has been assessed and the outcome of that assessment within 12 hours
- Communicate with the patients registered GP which antiviral therapy has been supplied including dose and treatment duration within 12 hours
- Inform carers/patient/staff that if any exposed person develops Influenza Like Illness (ILI) symptoms while on antiviral prophylaxis, this should be reported to the patients' registered GP practice, who should consider changing the patient from prophylactic dose to treatment dose
- In the event of a secondary bacterial infection developing associated with the primary influenza infection which requires antibiotics, the patient will be referred to their GP for treatment.

Also refer to antiviral pathway flow chart in section 4.3

- **Medication supply - outside of influenza season**
- The provider will:
    - Liaise with HPT and University Hospital Bristol and Weston NHS Foundation Trust – Bristol Royal Infirmary Pharmacy department about antiviral medication supply
    - Write a Patient Specific Direction (PSD) on the form included in Appendix 2
    - Send all the Patient Specific Directions (PSD) to University Hospital Bristol and Weston NHS Foundation Trust – Bristol Royal Infirmary Pharmacy department to enable the pharmacy to supply the medication immediately
    - Liaise with University Hospital Bristol and Weston NHS Foundation Trust – Bristol Royal Infirmary Pharmacy department to ensure the antiviral medication will be couriered/delivered to the site of the out-break in a immediately. (Please note the ICB will be financially responsible for any costs associated with couriering and will reimburse the hospital for the costs).
    - If there is an issue with antiviral medication supply via University Hospital Bristol and Weston NHS Foundation Trust, then a community pharmacy could be contacted.

Also refer to antiviral pathway flow chart in section 4.3

The provider organisation will:

- Be available for this service from 8am - 8pm Monday - Sunday
- Already have access to elements of the patients General Practice held patient record including but not limited to medical history, recent and current medicines, allergies and recent test results including renal function
- Communicate with the patients registered GP that the patient has been assessed and the outcome of that assessment within 12 hours
- Communicate with the patients registered GP which antiviral therapy has been supplied including form, dose and treatment duration within 12 hours
- Liaise with the UKHSA HPT regarding the completion of the antiviral assessment and provision. Also inform BNSSG ICB within 5 working days via bnssg.pc.contracts@nhs.net and bnssg.medicines-optimisation@nhs.net of the patient numbers involved in the outbreak to support financial reimbursement.

Safety and Quality

The provider organisation will 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/

Provide their own staff with appropriate Personal Protective Equipment for safe working within the out-break environment.

3.3 Population covered

This service is for all patients for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

All individuals identified as at risk due to a community influenza out-break from will be included in this service.

3.5 Interdependence with other services/providers

Providers will need to:

- Share data for the purposes of audit and payment
- Share data for the purposes of patient safety and continuity of care
- Liaise with colleagues working for providers of clinical laboratory services where appropriate
- Liaise with colleagues in UK Health Security Agency's Health Protection Team (UKHSA HPT)
- Liaise with GP practices
- Liaise with the community or hospital pharmacies to manage antiviral supply
- Liaise with courier services to ensure appropriately labelled antiviral supply is delivered in a timely fashion to the patient/their carer
- Provide the commissioner with assurance they have in place a robust and tested Business Continuity Plan to manage the risks to the smooth running of the delivery of this service. Ensuring the service can continue in the event of a disruption including robust and tested contingencies for increased activity (due to increased demand and staff shortages).

Other Service Requirements:

Service period
This contact will run from 1st April 2025 to 31st March 2028.
Should either party wish to cease providing/commissioning this service they will give three months' notice in writing.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- **UKHSA Guidance: Influenza-like illness (ILI): managing outbreaks in care homes** Guidance for managing seasonal influenza, identifying pathogens and transmission routes for acute respiratory disease in care homes. Updated 24 July 2024 https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes

- **UKHSA Guidance: Influenza: treatment and prophylaxis using anti-viral agents -** Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza
- . https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents

- **UKHSA Guidance: Acute respiratory infections: investigating outbreaks and clusters in schools** Guidance to health protection teams on detecting flu in a community, and about running an outbreak investigation. https://www.gov.uk/government/publications/acute-respiratory-infections-investigating-outbreaks-and-clusters-in-schools

- **NICE: Amantadine, oseltamivir and zanamivir (Relenza) for the treatment of influenza**, National Institute for Health and Clinical Excellence (NICE) technology appraisal 168, February 2009 https://www.nice.org.uk/Guidance/ta168

- **NICE**: **Oseltamivir, amantadine (review) and zanamivir for the prophylaxis of influenza**, National Institute for Health and Clinical Excellence (NICE) technology appraisal 158, September 2008 https://www.nice.org.uk/Guidance/ta158

- **Centers for Disease Control and Prevention (CDC):** Interim Guidance on the Use of Antiviral Medications for Treatment of Human Infections with Novel Influenza A Viruses Associated with Severe Human Disease https://www.cdc.gov/bird-flu/hcp/novel-av-treatment-guidance/?CDC_AAref_Val=https://www.cdc.gov/flu/avianflu/novel-av-treatment-guidance.htm

- **Department for Environment, Food &Rural Affairs:** Avian influenza (bird flu), updated 13 December 2022 https://www.gov.uk/guidance/avian-influenza-bird-flu

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

The provider of this service will comply with the General Medical Council or Nursing and Midwifery Council standards of conduct, ethics and performance at all times.

4.3 Applicable local standards

BNSSG ICB Pathway for antiviral assessment and supply

BNSSG Influenza Antiviral Pathway Sep

Updated pathway to be added when any changes are required following agreement with HPT

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

5.3 Tariff

Payment will be:

An upfront sum to be invoiced to the ICB for each year of the service

This will enable a minimum of 3 GPs and 3APs to cover the service, with the flexibility to increase should the need arise.

All activity is to be recorded to support financial reimbursement and submitted to bnssg.pc.contracts@nhs.net on a monthly basis one month in arrears. The activity will be charged against the scale in table 1 and drawn down against the upfront sum presented above.

In the event of activity costing less than the upfront sum at the end of the contract period the funding is to be retained by the provider in recognition of the costs associated with the staff allocated to the service. In the event of activity costs exceeding the upfront sum during the contract period the provider will invoice the ICB for the balance due against the scale presented in the table below.

Table 1

Payment will be made, regardless of whether antivirals are ultimately prescribed as it is understood that some asymptomatic patients may not be suitable for antivirals and others may not consent to treatment.

A. Expected Annual Contract Values

As detailed in Schedule 3A

B. Notices to Aggregate / Disaggregate Payments

As detailed in Schedule 3A

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

As detailed in Schedule 3A

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

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

B. National Quality Requirements

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

C. Local Quality Requirements

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

D. Never Events

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

E. Commissioning for Quality and Innovation (CQUIN)

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

F. Local Incentive Scheme

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

G. Clostridium difficile

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

H. CQUIN Variations

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

SCHEDULE 5 - GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

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

Documents supplied by Commissioners

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

B1. Provider's Mandatory Material Sub-Contracts

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

B2. Provider's Permitted Material Sub-Contracts

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

C. IPR

Commissioner IPR

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

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

Provider IPR

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

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

A. Commissioner Roles and Responsibilities

As detailed in Section 2 – The Service Specification.

B. Partnership Agreements

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

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Recorded Variations

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

B. Reporting Requirements

Liaise with the UKHSA HPT regarding assessment and provision of antiviral medications. Also inform BNSSG ICB within 5 working days via bnssg.pc.contracts@nhs.net and bnssg.medicines-optimisation@nhs.net

C. Data Quality Improvement Plan

Not Applicable

D. Incidents Requiring Reporting Procedure

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 on the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/

E. Service Development and Improvement Plan

Not specifically required under this contract.

F. Surveys

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

Appendix 1

British Geriatric Society advice on antiviral prescribing

In November 2017, the British Geriatrics Society (BGS) issued advice about consideration of renal impairment in prescribing of antivirals in localised community outbreaks of seasonal influenza.

If an individual has a documented renal function within the last 6 months, which does not indicate renal impairment, the standard dose of oseltamivir antivirals can be prescribed. For individuals with a known renal impairment and where the prescriber has access to their renal function during an emergency outbreak, they can be prescribed an adjusted dose according to the UKHSA influenza guidelines or sources such as the British National Formulary (BNF) or summaries of product characteristics.

However, in an emergency outbreak response, where there is no information about the presence or absence of renal impairment (or lack of available routine renal function results from the past 6 months), there is a high likelihood of abnormal renal function in care home residents, so we would recommend a reduced daily dose of oseltamivir in all care home residents. This would be for a dose appropriate to creatinine clearance of 31 to 60 mL/min. We would not recommend routine measurement of renal function prior to treatment due to the logistical challenges of collecting bloods en masse in care home populations and the likely delays introduced by waiting for lab results to return in the community. Where time permits, checking renal function in specific patients at high risk of significant renal impairment, for example those on high dose diuretics, may be useful.

The importance of vaccination in both care home residents and staff is to be reinforced. Importantly, vaccination provides an opportunity for additional conversations, with families of care home patients who lack capacity to consent to therapy, to consider the relative merits of antiviral therapy in advance. It would be useful to discuss in advance, with residents' families, the rationale for antiviral therapy in the event of outbreaks and to determine whether their relative would have been likely to want to opt out of such an approach. This would help to anticipate any issues relating to care home residents' lack capacity to consent. Clinicians are advised to consider this in relation to their own local polices on capacity to consent.
Inhaled zanamivir should be primarily used for cognitively intact residents requiring antiviral therapy, such as those with recognised renal dysfunction or with suspected or confirmed oseltamivir-resistant influenza.

This advice was facilitated by Adam Gordon, of the University of Nottingham and BGS.

Reference: UKHSA, Management of acute respiratory infection outbreaks in care homes guidance, Appendix 3, July 2024

Appendix 2

Patient Specific Direction (PSD) Template
FOR URGENT ATTENTION
In-patient Pharmacy
Floor level Three
Bristol Royal Infirmary (Zone A)
University Hospitals Bristol and Weston (UHBW)
Marlborough Street
Bristol
BS1 3NU

Prescriber address:

Date:

Patient Specific Direction (PSD)
Please arrange for the supply of:

Antiviral Medication Name	Medication Strength	Medication Formulation

For the following patients:

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

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

Name of care home / school (where applicable)			
Patient address (e.g. care home / school)			
Telephone contact details for care home/school			
Prescriber name (PRINT)		**Prescriber signature**	
Prescriber GP Practice/ Organisation			
Qualification of registered health professional e.g. GP or NMP		**Professional Registration number**	
Prescriber contact number		**Expiry Date of PSD**	

**Please use a separate PSD for each different formulation or strength of medication. All details with wet signature must fit on one page. More than one signed PSD may be required **

Patient Specific Direction (PSD) Template
FOR URGENT ATTENTION
BNSSG Community pharmacy

Prescriber Address:

Date:

Patient Specific Direction (PSD)
Please arrange for the supply of:

Antiviral Medication Name	Medication Strength	Medication Formulation

For the following patients:

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

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

Name of care home / school (where applicable)			
Patient address (e.g. care home / school)			
Telephone contact details for care home/school			
Prescriber name (PRINT)		**Prescriber signature**	
Prescriber GP Practice/ Organisation			
Qualification of registered health professional e.g. GP or NMP		**Professional Registration number**	
Prescriber contact number		**Expiry Date of PSD**	

**Please use a separate PSD for each different formulation or strength of medication. All details with wet signature must fit on one page. More than one signed PSD may be required **

Patient Specific Direction (PSD) Template – Avian Influenza
FOR URGENT ATTENTION

In-patient Pharmacy
Floor level Three
Bristol Royal Infirmary (Zone A)
University Hospitals Bristol and Weston (UHBW)
Marlborough Street
Bristol
BS1 3NU

Prescriber Address:

Date

Patient Specific Direction (PSD)

Please arrange for the supply of:

Antiviral Medication Name	Strength	Formulation

For the following patients:

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

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

Name of outbreak location (where applicable)			
Patient address (e.g. poultry farm/ game estate/ wild bird reserve)			
Telephone contact details for outbreak location			
Prescriber name (PRINT)			
Prescriber signature			
Prescriber GP Practice/ Organisation			
Qualification of registered health professional e.g. GP or NMP		**Professional Registration number**	
Prescriber contact number			
Expiry date of PSD			

**Please use a separate PSD for each different formulation or strength of medication. All details with wet signature must fit on one page. More than one signed PSD may be required **

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	CareHomeLES2425
Service	Care Home 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 – 31 May 2025
Date of Review	Currently under review
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

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)

The tariff per bed per annum
Paid monthly

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 Specifications

Service Specification No.	TBC
Service	Medicines Optimisation Prescribing Quality Scheme 2026/27
Commissioner Lead	Medicines Optimisation Team, NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st April 2026 to 31st March 2027
Date of Review	N/A

1. Population Needs

The BNSSG ICB Medicines Optimisation Prescribing Quality Scheme (PQS) is offered to all GP practices with the aim of improving the quality, safety and ensuring best value for primary care prescribing.

The scheme is a 12-month scheme where it is requested that practices focus the first few months of the year on ensuring cost effective prescribing in key areas, as directed by the ICB Medicines Optimisation Team, to enable savings to be continued throughout the year. Quality projects will be available in the first quarter and practices should plan the implementation of these projects as soon as possible to maximise outcomes. The payment to practices and the value of the scheme will be up to £1 per patient as per previous years.

The Prescribing Quality Scheme for 2026/27 has been developed whilst considering the response needed to support primary care with ongoing system pressures to ensure quality and safety with all medicines prescribed. Where possible the PQS has been aligned to the Strategic Commissioning Population Health Plan and supports national and local priorities. The PQS is expected to be an enhancement and complement long term conditions management in primary care, but not duplicate work funded through other mechanisms such as Quality Outcomes Framework (QOF).

The BNSSG Medicines Optimisation Team recognises the significant variation in prescribing between practices due to many influencing factors. These factors can include age and gender of patient, as reflected in the ASTRO-PU, but other factors such as deprivation and disease prevalence also influence prescribing patterns. We wish to work closely with GP practices to understand and reduce any unwarranted prescribing variation,

which will achieve both financial stability and best practice prescribing. BNSSG ICB Medicines Optimisation Team are also committed to working towards reducing health inequalities. Projects will consider health inequalities and aim to identify actions that can be taken to support reducing the impact of health inequalities.

The BNSSG Joint Formulary is the evidence-based list of commissioned medicines, and it is expected all prescribers across all sectors within BNSSG support and adhere to this.

Medicines directly or indirectly account for approximately 25% of carbon emissions within the NHS. Most of these emissions result from the manufacture, procurement, transport and use of medicines. Effective medicines optimisation can have beneficial environmental impacts for the NHS such as:

- Reducing waste and prescribing, for example by reducing inappropriate polypharmacy through structured medication reviews and therefore demand and manufacturing of unnecessary medicines.
- Supporting patients to be treated in the right setting to reduce avoidable appointments.
- Where appropriate, through shared cared decision with patients, switching medicines to suitable alternatives with lower carbon footprint.

As part of the PQS, practices may be requested to respond to unplanned or adhoc medicines optimisation work such as safety alerts or in year identified saving opportunities. The Medicines Optimisation Team has factored this in when planning projects as part of this year's PQS and will review any additional requests and work with practices to ensure workload is manageable.

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**	✓

3. Scope

3.1 Aims and objectives of service

The aims and objectives of this service are:

- To improve the quality and safety of primary care prescribing
- To reduce unwarranted prescribing variation, reduce inequalities and improve consistency in care and outcomes.
- Reduce avoidable harms from medicines for the population.
- Ensure best value for primary care prescribing
- To achieve primary care prescribing budget balance and support the ICB to achieve the overall control total budget.
- Support ICB priorities to improve outcomes for long term conditions and reduce avoidable admissions.

3.2 Service description

For 2026/27 the scheme will consist of two parts. Each part should be undertaken by practices to achieve the full scheme outcomes.

The different sections of the scheme have a quality, safety or cost-saving focus, or a combination of all of these:

Part One: Achieving Financial Balance
Part Two: Quality and Safety Projects

Prioritisation

Cost saving work will be identified for implementation throughout the year by the BNSSG Medicines Optimisation Team and will need to be prioritised by the ICB Medicines Optimisation Pharmacist (MOP).

ICB MOPs will support each practice with safe, evidence-based and cost-effective prescribing. This will include activities such as reviewing BNSSG Formulary red drugs, high-cost drugs, unlicensed 'specials' along with brand switching. These tasks are in addition to supporting the practice to undertake the quality projects of the Prescribing Quality Scheme.

Principal Pharmacists will ensure that they are in contact with practices and prescribing leads, along with GP/PCN and ICB employed pharmacists throughout the year to support them to achieve all aspects of the Prescribing Quality Scheme.

To deliver a successful scheme, it will be important to:

- Design, share and implement a clear communication pathway across the practice and PCN to ensure that all health care professionals work closely together for shared agreed outcomes. The MOP and Practice Communications Plan template should be completed and submitted to the ICB by the end of quarter 1.
- Ensure the ICB medicines optimisation pharmacist is embedded within the practice, having regular meetings with the prescribing

lead and a clear communication pathway with the wider practice team to ensure project outcomes are sustained.

Part One – Achieving Financial Balance

The ICB primary care prescribing budget for 2026/27 has been adjusted from 2025/26 primary care spend to cover demographic growth and anticipated prescribing growth. A savings target has been applied to give an overall primary care prescribing budget for the year. It is vital that there is financial stability within the ICB and control of prescribing costs is always a key focus.

The Medicine Optimisation team will continue to identify potential cost saving activities throughout the year and communicate these to the MOPs directly supported by the EMIS Cost Saving Dashboard or through project documentation. This will ensure that the most cost-effective choices are being prescribed, and that best value from the medicines is being achieved. The Cost Saving Dashboard found on EMIS will be updated for 2026/27 to identify the most significant savings opportunities through switches that the MOPs will be reviewing and actioning following agreement with the practice. A document has also been produced to explain these switches and they will also be supported by messages on Scriptswitch. This work should be prioritised for implementation with the aim of aiding practices to prescribe within their allocated budget.

Cost-saving activities will include, but are not limited to, the list below.

- Working through and actioning switches highlighted on the Cost Saving Dashboard.
- Engagement and acceptance of Scriptswitch (SS) messages relating to most cost-effective prescribing choices – The Medicines Optimisation Team will provide regular feedback to practices on their SS performance.
- Switching to biosimilar insulins where appropriate
- Continued review of medicines which are part of the NHSE 'drugs of low priority for NHS funding' guidance (NHS England » Items which should not be routinely prescribed in primary care)
- Supporting the self-care agenda and following the BNSSG self care guidance for prescribers. and NHS England conditions for which OTC items should not be routinely prescribed in primary care guidance (NHS England » Policy guidance: conditions for which over the counter items should not be routinely prescribed in primary care)
- Ensuring the appropriate cost-effective prescribing of appliances as guided by the Medicines Optimisation Team including formulary adherence and cost-effective switches.
- Initiating and where appropriate switching to apixaban or rivaroxaban as the direct-acting oral anticoagulants (DOACs) with

the lowest acquisition cost, for the treatment of people with non-valvular atrial fibrillation (AF).

- Reviewing methylphenidate prescribing to ensure it is consistent with local guidance and provides the best value for our population.
- Cost-effective inhaler prescribing
- Review of dipeptidyl peptidase 4 (DPP-4) inhibitors in treatment of diabetes and switch to most cost-effective product (sitagliptin)
- Encouraging branded prescribing of enoxaparin to ensure consistency of device for patients and promoting Inhixa® as the most cost-effective brand.
- Vitamin B12 review to ensure prescribing aligns with national guidance
- Initiating and, where clinically appropriate, switching to dapagliflozin as the sodium-glucose transporter 2 inhibitor (SGLT2i) with lowest acquisition cost for heart failure and diabetes.
- Switch to most cost-effective brand of denosumab.
- Review of flash glucose monitor use to check ongoing prescribing aligns with national and local guidance
- Optimisation Team including review of areas where practices benchmark high across BNSSG or nationally. These will be tailored to individual practices or PCNs.
- Implementation of BNSSG ICB medicines prescribing guidelines and policies. This includes the adherence to the BNSSG Joint Formulary and prescribing as per the Traffic Light System. Adherence to the formulary will be monitored, with an aim to achieving a minimum of 90% adherence of all prescribing.

Part Two – Quality & Safety Projects

Practices will be requested to complete projects that align with local priorities. Where practices benchmark favorably for a project and have identified another specific area the practice/PCN would like to focus on, this should be discussed with the Principal Pharmacist to agree if the project is suitable and the intended outputs. Standard criteria and documentation for listed projects will be produced by the Medicines Optimisation Team, but practices will be required to design and develop their own project criteria and documentation if they choose to review a local priority.

ICB MOPs will continue to coordinate the quality projects and support practices to complete them. However, the MOPs will be tasked with prioritising cost-saving work throughout the year. It is requested that the practice prescribing lead and MOP meet early in the year once the projects are available to agree how each project will be undertaken and continue to meet regularly throughout the year to review progress of projects. A project lead clinician should be identified to be responsible for completion of each project area with the MOP acting as support specifically around the searches and initial data collection.

Each of the projects below will have a written project pack (including relevant EMIS web searches) and a template for submission detailing outcomes of the project and will act as evidence of completion of the review.

If a practice feels that a particular project below offers limited value to their practice demographics it may be possible for the practice to undertake a different project specific to them. This would have to be agreed by the ICB Medicines Optimisation Team.

Projects Summaries	
Review area & remuneration	**Quality improvement project**
Medicines Safety	This project aims to continue to promote medicines safety and reduce the potential harm associated with medicines. Safety work will include: • A review of the Eclipse amber 'admission avoidance' alerts to identify patients at risk of harm from their medicines. • Continued use and embedding of Eclipse Radar, a risk stratification tool to review patients highlighted as potentially at risk from their medicines. Expecting all practices to have a robust process in place for reviewing these high-risk patients • Discontinuation of insulin detemir (Levemir®) Penfill cartridges and Flexpen – review of patients and change to an alternative insulin
Respiratory	**Chronic Obstructive Pulmonary Disease (COPD)** Holistic review of high-risk patients to optimise treatment, including smoking cessation, referral to pulmonary rehabilitation, vaccinations and optimising inhaler therapy. This project will also include a review of patients prescribing long-term antibiotics for prevention of exacerbations to ensure they remain clinically appropriate and promote good antimicrobial stewardship.

Polypharmacy	**Structured Medication Reviews (SMRs)** This project will aim to improve patient safety and outcomes by optimising medication use, reducing harm from problematic polypharmacy, reducing costs and empowering patients through shared decision making, leading to better adherence and potentially avoiding hospital admissions. Use of Eclipse Live will be encouraged to risk stratify patients that would most benefit from an SMR. Practices may also use their own local data and intelligence to identify a suitable cohort for review.
Cardiovascular - Heart Failure	A project to promote and embed the updated NICE chronic heart failure guidelines for adults. Risk stratifying patients and reviewing higher risk patients to encourage the four-pillar medication approach (ACE inhibitor, beta-blocker, SGLT2i and MRA) in accordance with the most up to date evidence base.
Standard projects will be produced for these topics by the Medicines Optimisation Team, however, if there are specific areas which a PCN or practice would like to focus on these should be discussed your Principal Pharmacist and the project will need to developed and written by the practice/PCN.	

3.3 Population covered

This LES is available for all BNSSG GP Practices, and the projects will provide details for eligible for patient cohorts.

3.4 Any acceptance and exclusion criteria and thresholds

Exclusion criteria and thresholds will be provided for each individual project.

3.5 Finance

Funding for the Prescribing Quality Scheme equates to per patient on the practice list (payment will be split between different parts of the scheme).

Where payment is based on registered patient numbers at the GP practice, the patient numbers used will be those registered on ePACT2 in September 2026 (mid-point in the year).

While demographic growth has been added as part of the budget setting methodology for 2026/27, any significant changes in practice population in-

year will be taken into consideration. The budget setting methodology will use weighted population to allow for better comparison; however actual population will also be reviewed to ensure fairness. Practice size will be reviewed in September 2026, comparing this to March 2026 list size to consider significant changes in patient list size.

Calculations of payments due for achievements for the 2026/27 scheme will be made during June/July 2027 when full year ePACT2 prescribing monitoring data is available.

Practices, supported by the ICB Medicines Optimisation Pharmacists (MOPs) will need to continue to work to maximise potential savings by prescribing efficiently. MOPs working in each practice will continue to work closely with practice prescribing leads and PCN/practice members to identify and target areas of cost saving and items growth reduction.

If practices/PCNs are signed up to the repeat prescribing hub scheme and are also participating in the PQS then they will receive the financial payment for whichever scheme (i.e financial aspect of the PQS or the hub savings) gives the larger of the two payments, minus hub set up costs (for both parties), but not payments for both. Practices signed up to the repeat prescribing hub will continue to receive payment for completed quality and safety projects from the PQS.

Payment for Part One

Practices will be paid **per registered patient**.

For 2026/27 all GP practices will be set a 'fair share' prescribing budget.

The methodology for setting this budget considers as many factors as possible which create prescribing variation between practices. The methodology creates a percentage of the whole budget each practice will be allocated (taking into account their list size, demographics, disease prevalence and prescribing of High-Cost Drugs).

Further information regarding the full budget setting methodology can be obtained from the Medicines Optimisation Team.

For those practices not achieving the fair share budget set, a review of their achievement in the cost saving work that has been directed by the ICB will also be undertaken. This will include a review of the savings potential that the practice could engage in and how this impacts their overall financial position. A part payment of this element of the scheme will be paid based on the achievement of work (80%) related to the Cost Saving Dashboard, completion of key cost saving projects and adherence to the formulary (most practices are already achieving this), which will be reviewed at the end of the year. The Medicines Optimisation Team will develop some key Performance Indicators to measure this achievement against which will be transparent for all practices who can work towards achieving these, which will contribute to their achievement of financial balance. This part payment will remunerate the practices for their engagement in this work, ensuring

they have been making cost effective choices and switches for these medications. Practice Prescribing Leads should engage with their Medicine Optimisation Pharmacists on a regular basis and discuss the latest financial position.

Payment Schedule for part One:

	Pence per registered patient
Achieve 26/27 allocated budget	
Up to 0.5% over the allocated budget	
>0.5% - 1% over the allocated budget	
>1% over the allocated budget but achievement of cost saving KPIs	

Payment Schedule for Part Two.

Project	**Payment**
Medicines Safety Projects (inc. Eclipse RADAR)	per registered patient
Discontinuation of insulin detemir (Levemir®)	per switch
Respiratory (COPD)	per registered patient
Polypharmacy SMRs	per registered patient
Heart Failure	per registered patient

Prescribing Quality Scheme payments

Payments for the scheme will be made to practices that have achieved objectives and met the targets set for each of the parts of the scheme.

All payments under the scheme will go into the general practice funds and not to individuals. The awards will be awarded to practices proportional to practice list size based on the practice population figure held by the NHS business Services Authority for September 2026.

Payment through the scheme should be reinvested to improve the quality of patient care and experience at the practice.

3.6 Activity recording and monitoring

Each project will contain details of the information that should be shared and submitted to the ICB. This will include evidence required and a provided proforma that should be completed at the end of the project. All submissions should be emailed to bnssg.medicines-optimisation@nhs.net.

For relevant projects practices will be provided with prescribing data to monitor progress.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

This information will be available in each project document

4.3 Applicable local standards

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

5. Applicable quality requirements and CQUIN goals

N/A

6. Location of Provider Premises

A. Service Specifications

Service Specification No.	MigrantHealthLES2526
Service	Migrant Health Support for GP Practices
Commissioner Lead	Primary Care Contracts Team Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	Migrant Health Assigned GP Practice
Period	Sep 2025 – Sep 2026
Date of Review	Aug 2025
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

1. Population Needs

1.1 National/local context and evidence base

Asylum seekers are a vulnerable cohort requiring prompt access to healthcare services to address their health needs. In order to reduce potential risks, providing timely registrations for service users to support access to care is essential.

It is therefore very important to ensure that access to Primary Care is provided in a consistent way to support equality of access to services, regardless of where the interim accommodation is located.

This service specification aims to provide asylum seekers at the Initial Accommodation Centres (IAC) with a fair and equal access to primary medical services specifically for this cohort, and their dependents arriving at the below listed hotels across BNSSG regardless of their country of origin.

Assigned GP Practice	Hotel
Broadmead Medical Centre	Brigstow Hotel
Bridge View Medical Centre	Mercure Holland Hotel
Bridge View Medical Centre	Brigstow Hotel

Bedminster Family Practice	Brigstow Hotel
Montpelier Health Centre	Holiday Inn Hotel, Bond Street
Mendip Vale Medical Centre	Windford Mannor Hotel (Historical Agreement)
Concord Medical Centre	Holiday Inn Hotel, Filton (Closed in March 2025 until further notice)
Stoke Gifford Medical Centre	Holiday Inn Hotel, Filton (Closed in March 2025 until further notice)

Asylum seekers encounter numerous health issues similar to those experienced by the UK population; however, many of these vulnerable groups have experienced significant trauma and historically faced significant barriers to accessing health services. Individuals from these backgrounds often struggle with language barriers and limited understanding of the UK healthcare system.

Patients who are temporarily housed in Initial Accommodation Centers should have their health needs generally considered in the same way as those of the primary medical care permanent residents plus an uplift in service provision to reflect the public health and acute care needs of these vulnerable patient cohort.

The service is aimed at providing locally assigned GP practices with additional support to manage this patient group.

1.2 Service Aims and Desired Outcomes

- GP registration is critical to enable the creation of primary care health records which support onward care for this population when they are moved and register with other GP practices.

- The funding for this service is to help practices provide a seamless and supported access to Primary Care Services, which includes a managed registration process with an equitable access to both the core and enhanced services. This will be achieved by continuing to provide timely registration for migrants, whilst keeping families registered together at the same practice.

- This specification has also been put in place in recognition of the additional clinical and administrative pressures placed on primary care, given the complexity of the asylum seekers and the volume of throughput in delivering health services for this patient population.

- Additionally, registration with General Practice allows referrals to, and coordination with the wider healthcare services.

- General practice also plays a key role in assessing and managing the health needs of migrant populations. While their health needs should generally be considered in the same way as any other patients, there needs to be an uplift in service provision due to the extra time and workload placed on practices.

- Reporting of completed registrations.

- Managing safeguarding concerns and support for vulnerable adults & children.

- Work on reducing the high rates of did not attend (DNA) which impacts on other service delivery.

2. Service Description

- Participating GP practices to register migrant health patients arriving in migrant Health hotels across BNSSG.

- Ensure all patients in this cohort have access to locally commissioned interpretation services as appropriate to their language needs

- Work collaboratively with local agencies where needed to ensure that patients in this cohort are provided with the services they need or are entitled to, e.g. Local Authority services (especially children and adult social care, and public health).

3. Outcomes

3.1 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**	✓

3.2 Local defined outcomes

The purpose of this service is to support the delivery of an improved access to integrated health and social care services for asylum seekers.

As a minimum, the benefits to patients are expected to include:

• Provide a preventative and proactive health and care offer for asylum seekers.
• Prevent the need for escalation so that individuals do not require acute admission to either a physical or mental health hospital.
• Improved equality of access to community healthcare services.
• An equitable, patient focused and easily accessible service.
• Promotion of self-care and preventative measures to improve health and wellbeing of asylum seekers.
• Multi-agency partnership working is strengthened to deliver better health outcomes for asylum seekers.
• Continuity of care in a safe and trusted environment.
• Collaborative working with local agencies to ensure a joined-up service.
• Address health inequalities experienced by asylum seekers.
• Reduce avoidable unplanned secondary care admissions.

4. Scope

4.1 Population Covered

This service is for all asylum seeker patients registered with a participating practice.

4.2 Any acceptance and exclusion criteria and thresholds

Asylum seekers arriving in migrant health hotels across BNSSG.

4.3 Finance

The registering GP practice will receive **payment** for each asylum seeker registered permanently with the practice.

4.4 Activity recording and claim process

All migrant health patient registrations will be processed using the standard GP registration process.

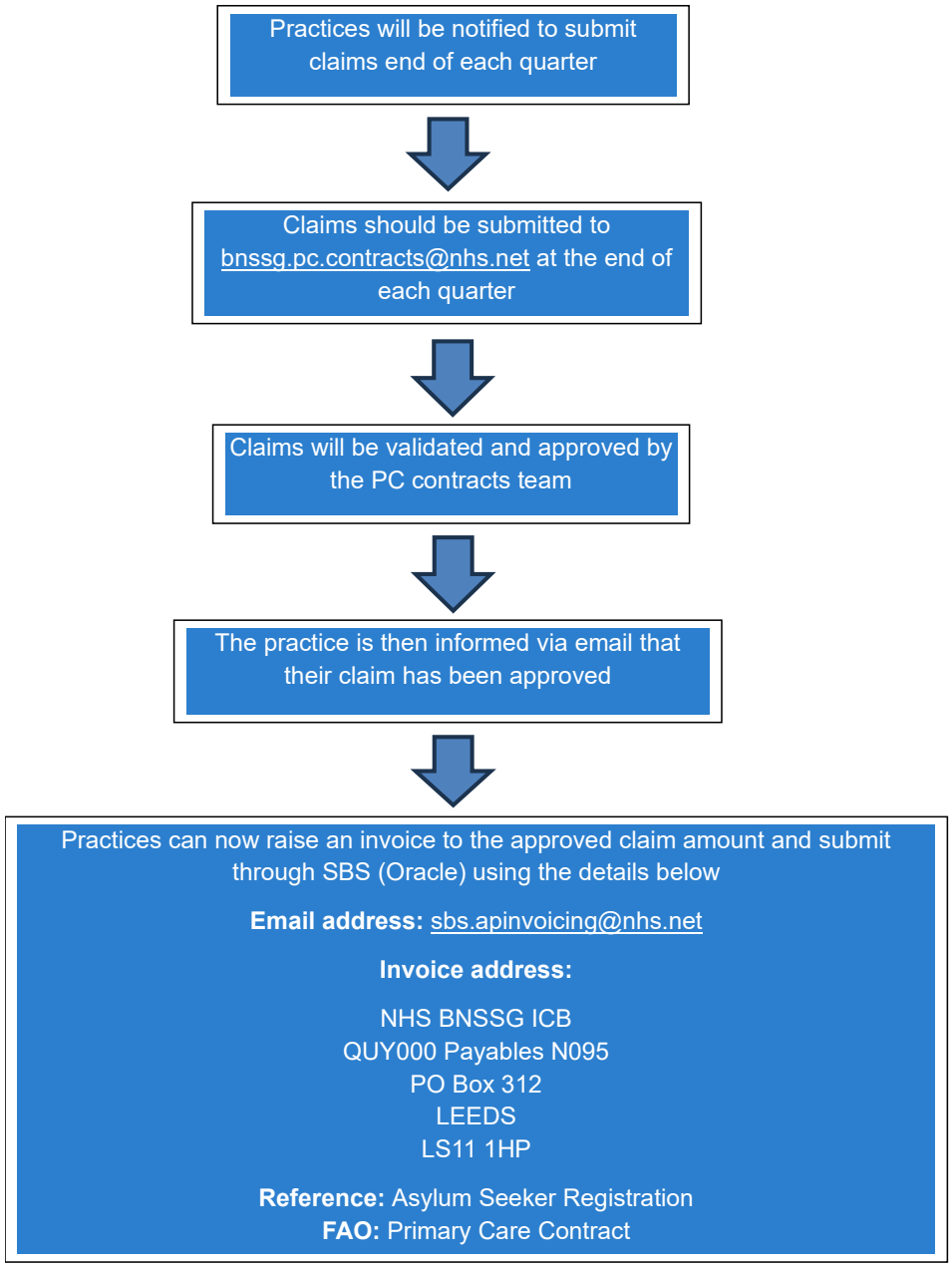
The attached claim form will be used to claim for registrations done.

Claim Template.xlsx

- 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).

Step-by-step guide for the new claim process



5. Applicable Service Standards

5.1 Applicable national standards (e.g. NICE)

- To ensure the practice is demonstrating adherence to safeguarding adults and children legislation and policies in this area and completion of relevant training.
- To ensure the practice is demonstrating adherence to safeguarding adults and children legislation and policies in this area and completion of relevant training.
- Compliance with:
    - The Care Act 2014 and accompanying Statutory Guidance
    - Children Working Together to Safeguard Children 2018
    - The NHS Safeguarding Accountability and Assurance Framework 2019

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

- Homeless and Inclusion Health standards for commissioners and service providers
- CQC - Registration and treatment of asylum seekers, refugees and other migrants
- Follow the guidance in the NHS England leaflet for asylum seekers and refugees; How to Register with a Doctor (GP) – Gateway Reference 06277
- Advisory Council on the Misuse of Drugs Report 2019

6. Applicable quality requirements and CQUIN goals

N/A

7. Location of Provider Premises

Premises of the participating GP practice

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	COPDLES2630
Service	North and West Bristol COPD Service
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	Hannah Midwinter
Period	2025/26 - 2030
Date of Review	March 2027

1. Population Needs

NWB slides for J Medhurst 05.02.24 v1

COPD Project Summary 03-04-25 V

Circa.2,000 people are currently diagnosed with COPD across North & West Bristol GP surgeries (early 2025).

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**	✓

3. Scope

3.1 Aims and objectives of service

The aim of the Chronic Obstructive Pulmonary Disease (COPD) Project is to improve wellbeing and health outcomes of adults living with COPD in North and West Bristol.
The North and West Bristol Locality Partnership is seeking to implement a community-based programme of education and peer support for people living with COPD, providing early intervention activity which is integrated into a larger COPD pathway. The outline of the project has been co-designed by clinical and non-clinical partners and people with lived experience. The Lead Provider (iCareiMove) will be responsible for delivering all aspects of the COPD project in North and West Bristol, utilising recognised co-production approaches, tools and techniques to further develop this initiative.

The COPD Project consists of three components:

1. Co-produced **Multi-Agency COPD Information Sessions**
2. Linked COPD **Peer Support provision**
3. A **COPD Passport**

Within the wider COPD project there is a large element of working with General Practice and OneCare to ensure the right patients are contacted and sent information. There will need to be a search made of practice lists to engage people with the service, and to also run outcome measures where possible. This Local Enhanced Service (LES) allows North & West Bristol practices to be involved in the project and run reports 'in-house'.

Circa.2,000 people are currently diagnosed with COPD in North & West Bristol GP surgeries (early 2025).

3.2 Service description / Standard Operating Procedures

This does not replace other COPD support offers e.g., Sirona's Respiratory Teams: Respiratory – Sirona care & health NHS services

The process, as agreed by clinicians across Bristol North Somerset and South Gloucestershire (BNSSG) and developed by North & West Bristol Clinical Directors in June 2025, will be as follows:

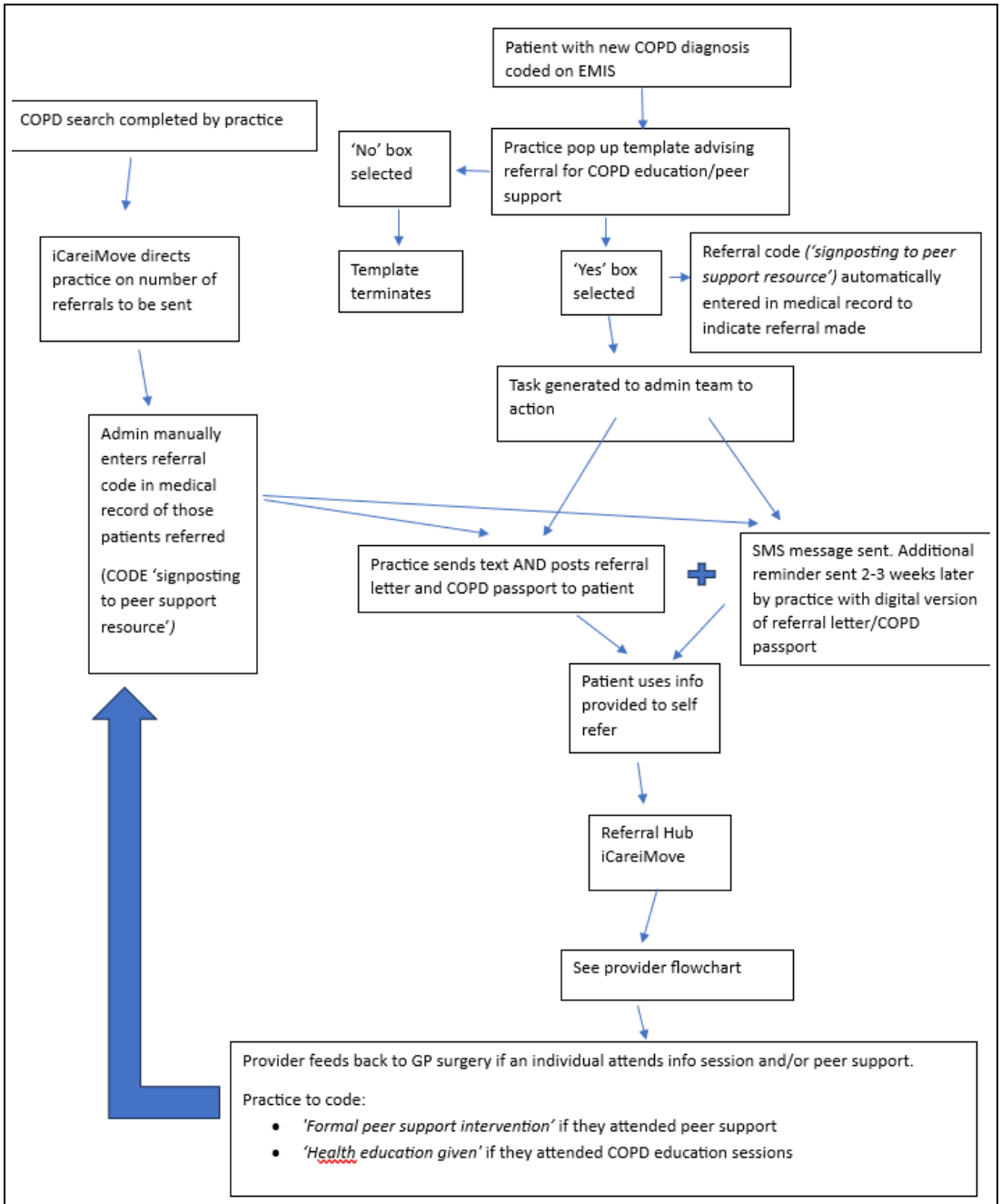
1. A search to identify all patients who have ever been diagnosed with COPD has ascertained current numbers for each surgery.
2. A report will be run to provide a COPD patient list to each practice, presenting the following information:
    - Name
    - NHS Number
    - EMIS Number
    - Address
    - Contact details – email address, phone numbers
    - Diagnosis code
    - Date of diagnosis code

3. iCareiMove provides invites, passport and capacity/details of upcoming information sessions to GP surgery. iCareiMove instructs each individual GP surgery regarding how many invites and COPD passports to send.
4. GP surgery sends hard copy invitation letters and COPD passports to patients, in addition to an SMS with this information and a preset delayed SMS reminder. The code 'signposting to peer support resource' will be manually recorded in the patient notes.
5. Patients self-refer via iCareiMove's referral hub (phone number, email and weblink to be provided).
6. After initial invites, clinicians will refer into the COPD service opportunistically, at the time of diagnosis. A pop-up protocol will be triggered when a patient is newly diagnosed with COPD, to inform the user of this patient's eligibility for referral. This will lead the user to the question 'Will you be referring this patient?', with a 'yes' or 'no' response option. The 'no' answer will end the protocol. The 'yes' answer will add the code of 'signposting to peer support resource' to the patient's record. Those who are on the COPD QOF register, with 'signposting to peer support resource' code will allow payment via the EMIS search. This will generate a task and end the protocol.
7. How-to guides for all reporting will ensure practices know how to record and track activity in line with the LES/payment.
8. iCareiMove will communicate to practices attendance figures and relevant feedback (if consent has been received from patient to share information back to GP surgery).
9. GP surgery administrator records attendance code on patient record: '*Formal peer support intervention'* if individual has attended peer support group, and *'health education given'* if they have attended an information/education session.

The flow chart on the following page outlines the above process for referral and feedback into the GP records.

Please note that patient information should not be passed to the Lead Provider. Communication should be from practices to patients and headed with GP surgery headers, as appropriate.

The Lead Provider will also promote the sessions and manage bookings.



3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial. This service will be for adults in the North and West Bristol Locality; living in or registered with a GP Practice based in North and West Bristol.

Healthwest PCN:	**Affinity PCN:**	**Northern Arc:**	**Mendip Vale** *(also North Somerset & South Glos practices*	**Phoenix:**
• Pembroke Road surgery	• Fallodon Way	• Pioneer Medical group		• Gloucester Road Medical Centre

• Student Health Service • The Family Practice • White-ladies Medical Group	Medical Centre • Westbury on Trym Primary Care Centre	• Shire-hampton group Practice	*within this PCN):* • Southmead & Henbury Family Practice • Sea Mill Surgery • Monks Park Surgery	• Horfield Health Centre • Greenway Community Practice

All purple practices on BNSSG tube map

3.4 Any acceptance and exclusion criteria and thresholds

Practices outside North and West Bristol Locality.

3.5 Finance

A one-off engagement fee of per practice is available in year 1. This aims to cover engagement in the Lead Provider's mobilisation, especially regarding demand management and referral routes into the service; and how the project will feed back into individual's patient records.

In addition to a one-off engagement fee, there is a total for all North & West Bristol practices per person contacted. Communication with practices (from the Integrated Care Board) will be required if this budget is fully utilised before financial year-end. Total funding available across 3 years.

The following funding will be available for the delivery of all elements herein:

Costings have been approximated at per patient with a maximum of 156 contacts per quarter across all North and West Bristol GPs. This amounts to an average of approximately 10 per practice, per quarter (note that distribution may not be even).

Payment

A quarterly EMIS search and report will be run by the ICB Business Intelligence Team to extract the relevant data (based on numbers of those on COPD QOF register, and who the have 'signposting to peer support resource' SNOEMED code. This will be used by the ICB to inform the quarterly payments to practices.

3.6 Activity recording and monitoring

Reporting

As part of the LES, GPs must provide data where required for reports agreed. If further searches/administration is required, this will need to be funded appropriately.

It is expected that each GP surgery will contact approximately 10 patients per quarter for this project. Numbers undertaken will depend on the distribution of those diagnosed with COPD. **Maximum of 156 patients to be contacted across all North & West Bristol GP surgeries per quarter.**

Monitoring and Evaluation

Please see service specification (*available on request)*. The Lead Provider will monitor the journey of participants, including

- people invited to attend an Information Session
- those who registered to attend
- those who attended
- People who participated in the Peer Support offer

Where possible, feedback will be gained at every stage to ascertain reasons for drop out and overall attrition. This will be shared with GP practices, as required.

Outcomes

Short, Medium and Long-Term Outcomes

Please see service specification (*available on request)* for wider outcomes of this service.

All reports and communications to be sent to North and West Bristol Locality Partnership - bnssg.nandwbristollp@nhs.net

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

N/A

4.3 Applicable local standards

The service will be regularly reviewed against quality standards, so that the North and West Bristol Locality Partnership Team can be satisfied that a quality service is being provided.

5. Applicable quality requirements and CQUIN goals

N/A

6. Location of Provider Premises
North and West Bristol GP practices

Service Specification

Service Specification No.	EatingDisorderLES2627
Service	Physical Health Monitoring for Adults with Eating Disorders
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st January 2026 – 31st March 2027
Date of Review	February 2027

1. Population Needs

1.1 Introduction

The Integrated Care Board (ICB) for the NHS in Bristol, North Somerset, and South Gloucestershire is committed to improving the health and well-being, reducing inequalities, and providing integrated services to our community's one million residents.

The development of a Local Enhanced Service for adults with Eating Disorders is to provide a commissioned pathway to support community based monitoring for adults with this mental health condition. This pathway is developed in conjunction with general practice and AWP as the local mental health provider. AWP will retain clinical supervision of all patients and provide physical health monitoring for those categorised as “urgent” and requiring weekly monitoring.

Eating disorders have the highest mortality rate of all mental health conditions and therefore regular monitoring and a safe pathway is key to supporting people with these conditions.

2. Benefits and Outcomes

2.1 Benefits and Outcomes of Framework

A fundamental objective of Physical Health Monitoring LES is to provide a safe and co-ordinated approach for this pathway with clear responsibilities described and shared between general practice and AWP. This will enable individuals to be appropriately supported for and cared for in the community whilst having their overall care supervised by specialists.

BNSSG ICS is committed to:

- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money and

- supporting broader social and economic development for our community's one million residents.

This LES will improve outcomes in population health and tackle inequalities in outcomes, experience and access by providing a consistent framework and pathway to support the monitoring of adults with eating disorders.

2.2 NHS Outcomes Framework Domains & Indicators

The following domains are met by this LES.

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	✓

2.3. Local Defined Outcomes

2.3.1. Improved Access
- Services are responsive to patient needs.

2.3.2. Improved Health Outcomes
- Coordinated care offered to patients.

2.3.3. Reduced Health Inequalities
- Consistent primary care offers to BNSSG patients over and above core GMS/PMS/APMS service provision.
- Reduction in variation through funded pathway
- Better management of healthcare and clear pathways to respond to escalation in conditions
- Improved accuracy of activity by introducing coding via this LES

2.3.4. Improved Qualitative Metrics (Value for Money)
- Patient and user experience feedback to be provided as part of evaluation of this pathway to inform commissioning intentions beyond year 1
- Provider (general practice and AWP) feedback to be provided as part of evaluation of this pathway to inform commissioning intentions beyond year 1

3. Scope

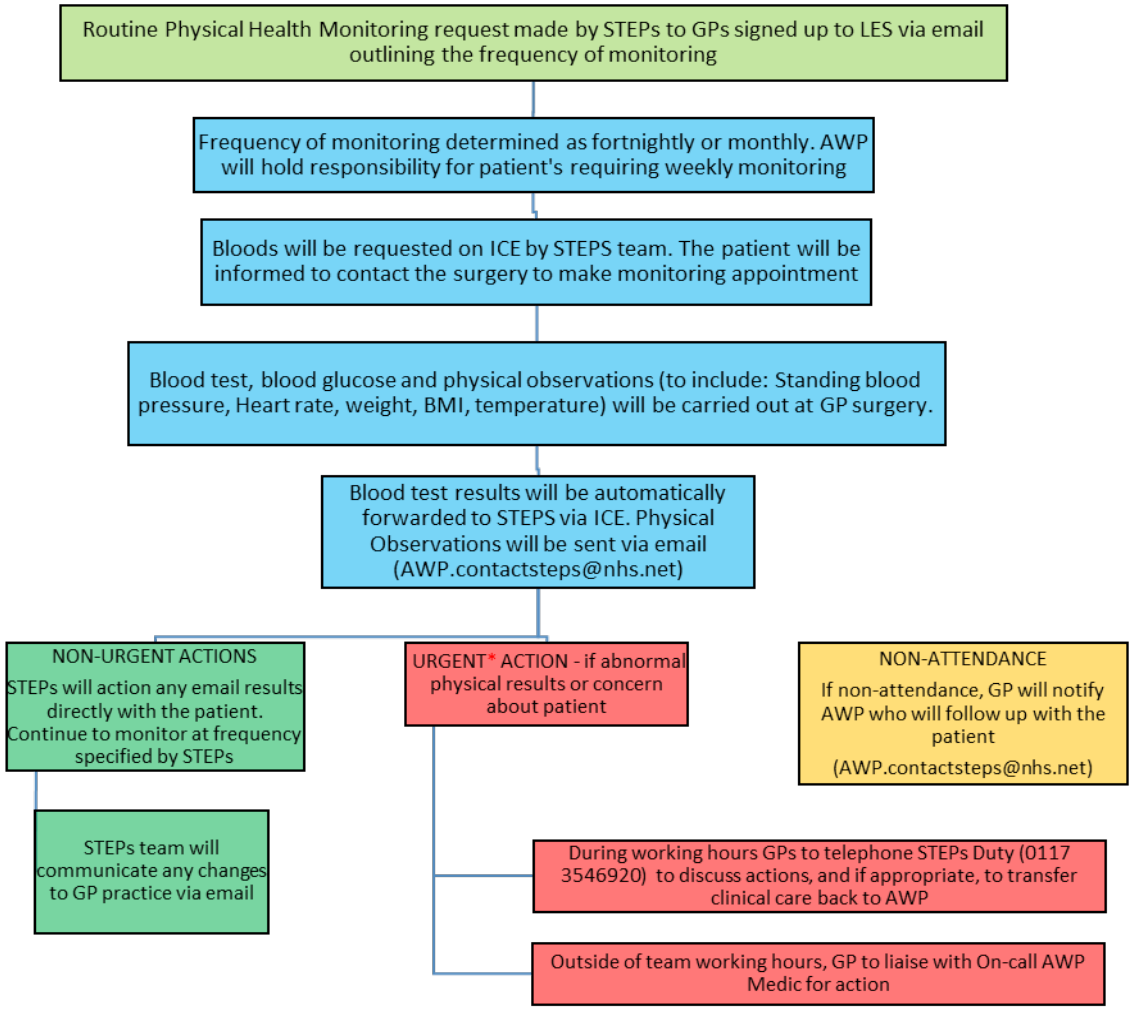
3.1 Aims and objectives of service.

The objective of the Physical Health Monitoring for people with Eating Disorders LES is to provide a unified and improved service offer to BNSSG patients that goes beyond the fundamental obligations of the General Medical Services Contract (GMS), Personal Medical

Services Contract (PMS), or Alternative Provider Medical Services (APMS). This enhanced service aims to offer high-quality and responsive care for all eligible patients of the practice. Eligible patients are those aged 18 or over with eating disorders under the active caseload of AWP eating disorders team (STEPS)

3.2 Service description / care pathways

Practices will be expected to operate according to the pathway set out below:

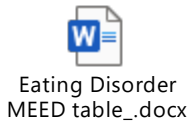


*Definitions of Routine vs Complex/Urgent

If a patient is risk rated as green on MEED guidance then this would be considered as Routine and suitable for physical health tests to be undertaken in a primary care setting. If a patient is scoring at amber or red or if there are significant clinical concerns then this would

be considered as complex/urgent on the pathway and therefore physical health monitoring will be retained by AWP STEPS or transferred back to AWP STEPS.

Please see embedded document for definitions of Green/Amber/Red


Eating Disorder MEED table_.docx

AWP will have clinical responsibility for downgrading patients to green/routine and will be responsible for providing the parameters for upgrading the patient.

Practices will be expected to undertake the following tests routinely for a physical health monitoring appointment at the frequency set out by STEPS:

- Blood tests, blood glucose, standing blood pressure, heart rate, weight, BMI, temperature

- ECGs will be required when there is Severe Bradycardia with a heart rate <40bpm, Really low potassium<2.5mmol/L and in the context of the patient reporting an abnormality with the heart rhythm (arrhythmia). Practices will be expected to undertake these (but not interpret them) and this has been included within the unit cost. The number of ECG requests will be monitored to evaluate the requirement for this.
- The unit cost provides for HCA support to the monitoring with GP interpretation time

Patients that do not attend should be notified to AWP who will follow up with the patient and AWP will record requests made and results received to monitor and provide a “fail safe” where patients are not contacting the practice to initiate monitoring or not attending the practice once initiated. Practices are requested to mark those results returned by email as High Importance where results fall within Red and Amber parameters.

How Will Activity Data be Obtained?

Data will be extracted from the GP IT system and reported to the LES Steering Group on a quarterly basis. Where practices do not take up the LES, the ICB will seek coverage for the population from within BNSSG General Practice in the first instance and failing this will seek provision support from AWP.

By opting for this enhanced service, you consent to the monthly extraction and quarterly monitoring of this data. Monitoring activity data will support an evaluation of the LES to make recommendations about the future commissioning of this pathway. Activity data will be used to automate payment to practices on a price per activity basis**.** Data should be recorded using the ‘Medical emergencies in Eating Disorders (MEED) Risk assessment Framework’ code and an EMIS template will be provided.

3.3 Population Covered

All patients registered with the practice who are under the care of AWP STEPS.

3.4 Any acceptance and exclusion criteria

Children under the age of 18 are excluded from this LES and an alternative pathway has been commissioned.

3.5 Any interdependencies with other services / providers

AWP and the STEPs service

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Eating disorders: recognition and treatment

Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers

-

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

MEED guidance

college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf

4.3 Applicable local standards

Remedy guidelines

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

As detailed in the specification

5.2 Applicable CQUIN goals

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

GP Practices premises

SCHEDULE 3 – PAYMENT

A. Local Prices

Payments will be made quarterly in arrears. Practices will be paid per physical health monitoring appointment

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**
EMIS search and report will be run by BNSSG ICB to extract the relevant data. In signing up to this LES practices agree to sharing this data. **Medical emergencies in Eating Disorders (MEED) Risk assessment Framework** code to be used to code each physical health monitoring appointment for people aged 18 and over with Eating Disorders under the active caseload of STEPs during the reporting period **SNOMED Description ID 3696631000000115**	Quarterly	EMIS Search and Report	Monthly extract used by ICB to inform quarterly payment	Payments and evaluation of pathway
Patient experience survey	Annual	Suggested format to be provided	Issued in October 26	Evaluation of pathway
Provider feedback	After initial quarter of	Discussion at GPCB or	By December 26	Evaluation of pathway

	activity and again at year end	locality forums		

- 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 2 – THE SERVICES

A. Service Specifications

Service Specification No.	SMILes2526
Service	Severe Mental Illness – Physical Health Checks
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1/4/2025 – 31/3/2026
Date of Review	March 2025

1. Population Needs

People with severe mental illness (SMI) face one of the largest health inequalities in the country. They are less likely to have their physical health needs met than the population as a whole, they die on average 15 to 20 years earlier and two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer. The population has considerably higher incidence of smoking, obesity, diabetes and COPD. Despite this, people with severe mental illness have not consistently been offered physical health assessments, nor supported to access information and advice or take up tests and interventions that reduce their risk of preventable conditions.

The BNSSG SMI cohort in 2024/25 was 7,920 people, approximately 2,330 of this cohort are under secondary mental health care.

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**	✓

This LES aims to reduce the health inequality experienced by people on the SMI register by supporting BNSSG GP practices to provide annual physical health checks for this cohort.

3. Scope

3.1 Aims and objectives of service

The purpose of the SMI annual physical health check is to identify any emerging health difficulties and provide interventions to address them in order to improve the physical health of the cohort and to reduce the substantial health inequality. The health checks therefore are not an end in themselves and must be followed up with any necessary action identified by their results. This includes onward referral for further tests, screenings or treatment as appropriate, as well as referral/signposting to local community-based health improvement interventions.

This is a payment by results scheme to incentivise GP practices to deliver larger numbers of SMI physical health checks for people on the SMI registers. They will receive payments on the achievement of two specific performance targets at the end March 2026. The NHSE target for BNSSG in 25/26 is that 75% of people on SMI registers will receive a full annual physical health check. Note that it is the intention of this year's scheme to incentivise achievement of this target by GP practices, not to pay practices for every check completed.

It is expected that the money is used by GP practices to purchase/boost capacity/resources to improve the physical health of the cohort. Within this, there is no specific stipulation as to how GP practices should use the payments, as it is important that they have the freedom to use them to maximise any opportunities to improve the physical health of the patients on their SMI registers, and take into consideration the particular demographics of their locality.

Funding is ring fenced exclusively for use by GP practices to fund work to support the delivery of the SMI physical health checks.Possible uses of the funding include:

- Recruiting (or extending the hours of HCA, Nurse, social prescriber, health navigator etc roles).
- Specific outreach to ethnic minority communities.

- Providing home visits or off-site locations for health checks.
- Peer support.
- Partnership work with local voluntary sector partners to support engagement/health improvement.

3.2 Service description / Standard Operating Procedures

BNSSG GP practices have (by signing the Local Enhanced Service) agreed to commit to achievement/focus on the following priority goals:

- To support improvement of practice and completion of severe mental illness (SMI) physical health checks – using the funding as an enabler to resource service improvement requirements.
- To meet or exceed NHS England's 2025/26 (75%) target in relation to the proportion of the SMI register that have had full sets of annual physical health checks.
- To ensure that all staff directly involved in the booking, delivery or follow-up of SMI physical health checks receive appropriate training.
- To ensure that, where the results of the health checks identify a need for onward referrals for further treatment, screening and health improvement interventions, these actions are taken and recorded into EMIS.
- To ensure that clear and consistent information is provided to patients in invitations to, and all explanations of, the SMI physical health checks (whether given in writing or verbally over the phone) in order that all patients know:
    - The correct name of the health check – the 'SMI annual physical health check'.
    - Its purpose.
    - What it comprises.
    - What they will get out of it.
    - What improvements in health it should lead to.
- In order to bring about greater consistency, a single letter and accompanying leaflet have been co-produced by people with lived experience and clinical leads which has been published by One Care to practices as an EMIS template, and is called *'ICB BNSSG SMI HC invitation letter and leaflet'*. This should be used by all practices as the standard letter, or as the basis of invitations made via a phone call. N.B. SMS Text messages are best used as reminders as they do not allow space for detailed explanations.
- To ensure that all patients have their (written and spoken) language preferences recorded, and letters, phone calls, text messages and the health check itself are translated/interpreted accordingly.
- To establish methods of engagement that include offering alternative locations for physical health checks to patients who don't typically

visit the surgery. This could be home visits, a room in a voluntary sector or a community building.
- To increase take-up of flu vaccinations.
- To increase take-up of COVID vaccinations.
- To increase take-up of cancer screening.

3.3 Population covered

This service is for all BNSSG patients on the NHSE-mandated SMI register. This includes people with a diagnosis of schizophrenia, bipolar affective disorder or other psychoses.

3.4 Any acceptance and exclusion criteria and thresholds

This service is for all BNSSG patients on the NHSE-mandated SMI register. This includes people with a diagnosis of schizophrenia, bipolar affective disorder or other psychoses.

3.5 Finance

- The amount available to each GP practice will be proportionately distributed according to their practice's SMI register size set at the data extraction in April 2025 (Appendix 1).
- All funding attached to this Local Enhanced Service is non-recurrent and should not be used to fund commitments running beyond the 2025/26 financial year.
- Payments will be made in two tranches:
    - **Tranche 1**

    50% of the GP practice's allocation will be paid upfront without expectation of achievement of any target.

    - **Tranche 2**

    In order for the ICB to pay the remaining 50% of the GP practice's funding allocation, the following conditions will apply:
        - **Tranche 2a** - The completion of physical health checks for 60% of patients on the GP practice's SMI register at the end of March 2026 will attract payment of 25% of its allocation.
        - **Tranche 2b** - The completion of physical health checks for 70% of patients on the GP practice's SMI register (NHSE national target figure) at the end of March 2026 will attract the final 25% of its allocation.
- On the year end data extraction, any unspent funding (due to any GP practices not reaching the 60% or 70% targets) will be distributed

proportionally amongst those GP practices that have exceeded the 70% target as an additional reward.

- ICB Finance will operate a single payment run for Tranche 2 funding in early April 2026.

3.6 Activity recording and monitoring

Health checks - For each patient on the SMI register, all 6 health checks (described in Appendix 2) must be completed and recorded into EMIS.

Data - The following (established) agreements on data extraction and sharing apply to this contract:

- Data will be used to track the number of health checks achieved by each GP practice
- Monthly running of practice level EMIS search & report for SMI health checks
- Practice level reporting (via the LES report on Power BI) will only be shared with the following:
    - GP practices
    - The SMI Physical Health Improvement Steering Group
    - ICB Mental Health Performance and Delivery.
- PCN and Locality level data and the ICB summaries (with no practice level information) will only be shared with the following:
    - PCN leads
    - AWP physical health leads
    - ICB Mental Health Performance and Delivery.
- The monthly data will show for each practice / PCN / Locality Partnership (LP):
    - The number of people on the SMI register
    - SMI prevalence
    - The number of complete sets (all 6) of health checks
    - The percentage of the total BNSSG register size held
    - The percentage of the register who have had a complete set of 6 health checks
    - The percentage of the register who have had each of the 6 health checks
- Recording template - Due to variations in different templates available within EMIS, we recommend the use of the Ardens template as it incorporates the six mandated health checks, and also supports inclusion of a greater range of health issues including cancer screening as well as the recording of follow-up referrals and activities.

- The search used – different EMIS searches can cause confusion by bringing up different numbers of people on SMI registers. The ICB uses the 'EMIS search & report'. Using this search will bring the results that are most similar to those that the ICB uses for its data extraction. The search group is:
- 69. Severe Mental Illness Physical Health v2
    - In development – SNOMED based searches

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NHS England 2025/26 target: 75% of the SMI register have had full sets of annual physical health checks.

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

6. Location of Provider Premises

Any BNSSG GP Practice.

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	SMM LES 2427
Service	Specialist Medicines Monitoring LES
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	6th January 2025 – 31st March 2027
Date of Review	March 2027
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate.

1. Population Needs

1.1 National/local context and evidence base

This Local Enhanced Service specification outlines a specialised medicines monitoring service for certain medicines as listed below. 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). As well as the

individual SCPs for Methylphenidate, Atomoxetine, Guanfacine, Lisdexamphetamine an additional guideline has been produced for children to support general practice and highlights how results need to be communicated to the clinical team. Guidance for Monitoring of Attention Deficit Hyperactivity Disorder (ADHD) Medication in children and young people (<18 years). Mesalazine prescribing guidance is available for Mesalazine.

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:
https://remedy.bnssg.icb.nhs.uk/formulary-adult/scps/scps/
https://remedy.bnssg.icb.nhs.uk/formulary-paediatric/paediatric-shared-care-protocols/scps/

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. Dapsone
12. Methylphenidate (adults and children)
13. Lisdexamfetamine (adults and children)
14. Dexamfetamine (adults only)
15. Atomoxetine (adults and children)
16. Guanfacine (adults and children)
17. Lithium

18. Mesalazine
19. Bicalutamide
20. Testosterone gel (year 1 only when initiated by primary care menopause specialists)

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 extracted 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 (NG129)
- Ulcerative colitis: management (NG130)
- Attention deficit hyperactivity disorder: diagnosis and management (NG87)
- Bipolar disorder: assessment and management (CG185)
- Prostate cancer: diagnosis and management (NG131)

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,

- British Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adults. Lamb CA, Kennedy NA, Raine T, et al. 2019;68:s1-s106.

4.3 Applicable local standards

BNSSG Shared Care Protocols (SCPs) and prescribing guidance

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

https://remedy.bnssg.icb.nhs.uk/formulary-paediatric/paediatric-shared-care-protocols/scps/

BNSSG Mesalazine IBD Prescribing Guidance

Guidance for Monitoring of Attention Deficit Hyperactivity Disorder (ADHD) Medication in children and young people (<18 years)

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. 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)		
		Testosterone (injection) – male hypogonadism Payment in first year of treatment only		
		Methylphenidate adults and children over ten years old		
		Lisdexamfetamine adults and children over ten years old		
		Dexamfetamine adults only		
		Atomoxetine adults and children over ten years old		
		Guanfacine adults and children over ten years old		
		Lithium		

		Mesalazine (first year only)		
		Bicalutamide		
2	4-5	Azathioprine Leflunomide Methotrexate Penicillamine (Nephrology) Cinacalcet (Endocrinology) Mycophenolate Dapsone Testosterone gel (year 1 only when initiated by primary care menopause specialists) Methylphenidate children under ten years old Lisdexamfetamine children under ten years old Atomoxetine children under ten years old Guanfacine children under ten years old		
3	6-8	Mercaptopurine (oral) Sulfasalazine (oral) Payment in first year of treatment only		
4	9-12	Penicillamine (Rheumatology)		

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>Atomoxetine</u>

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

<u>Atomoxetine</u>

- All patients (including deducted and deceased) who have been issued with an NHS prescription of atomoxetine by the surgery during the search period AND are 10-17 years old.

Atomoxetine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of atomoxetine by the surgery during the search period AND are 0-9 years old.

Azathioprine

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

Bicalutamide

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

Cinacalcet

- 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.

Dexamfetamine

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

Clinical Code Description	**SNOMED Description ID**
Attention deficit hyperactivity disorder (or child codes)	2158158016

Guanfacine

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

Guanfacine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of guanfacine by the surgery during the search period AND are age 10-17 years old.

Guanfacine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of guanfacine by the surgery during the search period AND are age 0-9 years old.

Leflunomide

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

Lisdexamfetamine

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

Lisdexamfetamine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of lisdexamfetamine by the surgery during the search period AND are aged 10-17 years old

Lisdexamfetamine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of lisdexamfetamine by the surgery during the search period AND are aged 0-9 years old

Lithium

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

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.

Methylphenidate

All patients (including deducted and deceased) who have been issued with an NHS prescription of methylphenidate by the surgery during the search period AND are 18 years and over

Methylphenidate

All patients (including deducted and deceased) who have been issued with an NHS prescription of methylphenidate by the surgery during the search period AND are aged 10-17 years old

Methylphenidate

All patients (including deducted and deceased) who have been issued with an NHS prescription of methylphenidate by the surgery during the search period AND are aged 0-9 years

Mesalazine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of mezalazine by the surgery during the search period AND DON'T have a prescription issue of mesalazine > 12 months and < 24 months previously AND are 18 years and over.

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 gel

All female patients (including deducted and deceased) who have been issued with an NHS prescription of Tostran 2% gel or Testogel 1% gel by the surgery during the search period AND DON'T have a prescription issue of testosterone > 12 months and < 24 months previously

Testosterone injection (male hypogonadism)

- All patients (including deducted and deceased) who have been issued with an NHS prescription of testosterone injection (Sustanon or Nebido as per SCP) 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.

Service Specifications

Service Specification No.	2
Service	Supplementary Services LES
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	BNSSG GP Practices
Period	3 + 2 years starting 1 April 2024
Date of Review	March 2024 – next review due by April 2027

1. Population Needs

1.1 Introduction

The Integrated Care Board (ICB) for the NHS in Bristol, North Somerset, and South Gloucestershire is committed to improving the health and well-being, reducing inequalities, and providing integrated services to our community's one million residents.

The development of a revised Supplementary Services Offer to BNSSG practices will help to support this.

1.2 Background

The BNSSG Supplementary Services Offer for General Practice plays a pivotal role in outlining the range of services that go beyond the essential GMS/PMS/APMS contract and is intended to address the healthcare requirements of the local community via General Practice.

It's important to note that this scheme is not designed to be overly prescriptive in how it is executed. While individual General Practices retain the primary responsibility for service delivery under their contracts, the Framework affords them the flexibility to engage in independent, negotiated sub-contracting arrangements and/or collaborate as PCNs to offer services to the population. This allows practices to deliver services at scale or, if they choose, to enlist fully accredited alternative service providers to carry out specific elements of service provision on their behalf.

1.4 National/Local Context

In January 2014, NHS England area teams initiated a two-year review of local Personal Medical Services (PMS) agreements, concluding in March 2016. In 2015, the three former Bristol, North Somerset and South Gloucestershire CCGs made the decision to utilise the PMS Premium funding for the purpose of investing in a Supplementary Services specification. The specification was developed in collaboration with the LMC (Local Medical

Committee) and NHS England, and its implementation was planned over a five-year timeframe, with a review scheduled after two years.

Following the merger of the CCGs, Bristol, North Somerset, and South Gloucestershire (BNSSG) CCG allocated £2.4 million towards Local Enhanced Services. Additionally, an extra £9,166,642 was earmarked for the Supplementary Services specification and the South Gloucestershire Basket, as part of a 5-year PMS reinvestment agreement that concluded on March 31st, 2021.

Recognising the significant financial value of these schemes and the need to deliver care closer to home, the BNSSG CCG Primary Care Commissioning Committee (PCCC) agreed in September 2020 to extend the timeline for the review. Consequently, practices received payments at the same rates in 2021/2022 as in 2020/2021 under these agreements. The review was concluded in March 2024 and the specification and allocation was agreed by BNSSG ICB Board for implementation from April 2024.

2. Benefits and Outcomes

2.1 Benefits and Outcomes of Framework

A fundamental objective of the Supplementary Services LES is to ensure that service delivery yields tangible benefits and positive outcomes for patients throughout the entirety of BNSSG, while also aligning with the priorities of the ICB.

BNSSG ICS is committed to:

- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money and
- supporting broader social and economic development for our community's one million residents.

The objectives of the review were as described below:

- The ICB is not looking to and would not be realising any savings from this LES. The pot of money is ringfenced for General Practice.
- Understand and seek to mitigate any impact on practice resilience.
- Put in place a fair funding agreement across all practices BNSSG.
- The aim is to develop a revised offer that reflects a consistent, high quality, evidence based enhanced primary care service which meets population needs, addresses inequity of access, improves health outcomes, and offers value for BNSSG.

2.2 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	✓

2.3. Local Defined Outcomes

2.3.1. Improved Access
- Services are responsive to patient needs.

2.3.2. Improved Health Outcomes
- Holistic and coordinated care offered to patients.

2.3.3. Reduced Health Inequalities
- Consistent primary care offers to BNSSG patients over and above core GMS/PMS/APMS service provision.
- Reduction in variation
- Earlier detection of illness and better management
- Improved accuracy of activity recording by practice

2.3.4. Improved Qualitative Metrics (Value for Money)
- Delivery of evidence-based care.
- Delivery of efficient and high-quality health services, leading to improved clinical efficiency
- Overall improvement in the health and wellbeing of the BNSSG population

3. Scope

3.1 Aims and objectives of service.

The objective of the Supplementary Services LES is to provide a unified and improved service offer to BNSSG patients that goes beyond the fundamental obligations of the General Medical Services Contract (GMS), Personal Medical Services Contract (PMS), or Alternative Provider Medical Services (APMS). This enhanced service aims to offer high-quality and responsive care for all eligible patients of the practice.

3.2 Service description / care pathways

Practices will be expected to offer all services in the basket to the whole of their eligible population. Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate

with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied. Data will be extracted by the ICB BI team and reported through to the LES Steering Group.

Practices are expected to deliver the activity within the specification using regularly calibrated and serviced equipment where appropriate and ensure staff are appropriately trained.

Practices are required, where it is appropriate for the needs of all eligible patients, to undertake the following:

1. **Phlebotomy initiated by primary care.**

Rationale	The aim of the service is to: Provide an accessible primary care-initiated phlebotomy service for patients within a general practice setting. Deliver a service local to 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 Improve the monitoring and management of Long-Term Conditions and to investigate patients appropriately
Delivery	Practices to provide a primary care-initiated phlebotomy service for all eligible patients over 12 years old and follow local pathways for onward referral below this age, should practice staff not be trained in phlebotomy of younger patients. Time frames and location for delivery should be clinically appropriate in accordance with the specific clinical requirements of the patient. To support the delivery of a quality assured service, practices are encouraged to comply with evidence based best practice guidelines for the taking, storage and transportation of blood samples to ensure valid, reproducible, and accurate results. This intervention can also be delivered through practices working together. **Transition Arrangements:** Practices not currently delivering a primary care-based phlebotomy-initiated service will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements. Practices will be required to provide evidence of subcontracting arrangements if service not in place.

	ICB Assurance: Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied to record all primary care-initiated activity regardless of the age of the patient.
Outputs/Outcomes	By commissioning a primary care-based phlebotomy service, it is anticipated that the following outcomes will be achieved: • Improved patient experience of phlebotomy services • Delivery of a local service that is closer to the patient's home. • Timely access to blood testing and reporting within the primary care environment. • Supporting the delivery of diagnostic tests closer to the patient's home • Supporting the delivery of holistic care
References	WHO guidelines on drawing blood: best practices in phlebotomy. World Health Organisation 2010; These guidelines were produced to improve the quality of blood specimens and the safety of phlebotomy for health workers and patients, by promoting best practice in phlebotomy.

2. Dressings including compression therapy and post-operative wound care

Rationale	The Non-Complex Wound Management service aims to provide primary care wound management at practice premises for non-complex wounds and dressings. This supports ICB strategic commissioning intentions for high-quality, patient-centered care close to home. The service focuses on preventing, assessing, and treating wounds to optimise healing, reduce the burden on patients and care providers, and minimize complications. By delivering compression therapy wraps closer to home, the service aims to enhance timely access to care, promote shared care, and empower patients to have autonomy over their treatment while ensuring awareness of the processes involved.
Delivery	Practices will provide a quality assured service that includes: • Managing post-operative wounds and wound infections • Simple venous leg ulcer management

		• Providing assurance on the processes and protocols that are in place to ensure patients are receiving timely access to wound care management. • Skin damage including pressure injury management. Local pathways can be found on Remedy: Tissue Viability/Wound Care Service (Remedy BNSSG ICB) Appropriate onward advice should be sought if a patient has a wound that is deteriorating, complex or failing to heal from the Tissue Viability Team in Sirona. A treatment plan will be devised to support the practice team in continuing to manage the patient. All dressing recommendations/initiations must be in accordance with NICE guidelines and local guidance. Please see Remedy https://remedy.bnssg.icb.nhs.uk/adults/dermatology/leg-ulcer/ for definition of complex wounds **Transition Arrangements:** Practices not currently delivering a Non-Complex Wound Management service will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements. Practices will be required to provide evidence of subcontracting arrangements if service not in place. This intervention can be provided by Practices working together e.g. use of leg clubs. **ICB Assurance**: Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied.
	Outputs/Outcomes	Expected Outcomes and Benefits The benefit of the service is to improve the quality of life for people requiring management of their wounds through the delivery of clinically effective care and advice which reduces the risk of recurrent infection and promotes independence. The service will help to deliver this objective by:

	• Delivering a timely, effective, and personalised wound management and healing service in a safe environment. • Improving local symptoms such as reducing pain and improving healing rates through the use of appropriate treatment in accordance with best practice, published guidance and clinical evidence and reducing unnecessary or inappropriate use of dressings and wound care products in a primary care setting. • Detecting, and where appropriate treating, any infection to prevent deterioration of the wound or systemic involvement. • Providing appropriate patient education so that patients may make informed choices and fully participate in their care and improve concordance. • Promoting the use of individualised care management plans for all patients with communication at the point of discharge to patients, carers and healthcare professionals that promotes long term leg care and reduces the risk of recurrence. • Preventing unnecessary referrals and admissions to community or specialist services, urgent care centres, hospital or nursing homes. Where onward referrals are necessary, completing these in a clinically appropriate timeframe.
References	Wound care is expensive and can cause immeasurable stress and inconvenience to patients and their significant others. It is therefore in the best interest of the patient, their significant others and the NHS as a whole that wounds are expertly assessed, managed and healed in the quickest timeframe possible (Holistic wound assessment in primary care. Cornforth A. Br J Community Nurs. 2013). Accurate wound assessment and an understanding of the complexities of wound management is essential in ensuring that cost-effective and evidence-based interventions are used. The results of the wound assessment will determine the treatment prescribed, and practitioners need to ensure they have the essential skills required to plan, implement and evaluate care on an individual basis. (Wound assessment in primary care. Nursing in Practice. Atkin, L ,2013). https://remedy.bnssg.icb.nhs.uk/adults/dermatology/tissue-viabilitywound-care-service/

3. Doppler for assessment of peripheral vascular disease and pre-compression therapy

Rationale	Doppler assessments prior to compression therapy or for the diagnosis of peripheral vascular disease in general practice supports early diagnosis, personalised care, accessibility,

		and efficient resource utilisation, ultimately contributing to better patient outcomes and overall healthcare effectiveness.
	Delivery	All patients presenting with a lower leg wound that has failed to heal within a clinical reasonable time (Remedy specifies 2 weeks) require a lower limb and Doppler assessment to identify the aetiology of the wound and detect any underlying arterial disease. Compression should not be applied until a full assessment and ABPI has taken place and should be delivered by appropriately trained clinicians. https://remedy.bnssg.icb.nhs.uk/adults/dermatology/leg-ulcer/ • Conduct a thorough patient history and physical examination, identifying those at risk for vascular issues. • Use Doppler devices to evaluate blood flow, aiding in the diagnosis and severity determination of peripheral vascular disease. • Discuss findings with patients, explaining the importance of managing vascular conditions and potential interventions. • Determine the type and level of compression based on Doppler findings, educate patients, and provide guidance on proper application. • Schedule regular appointments to monitor treatment effectiveness and adjust plans as needed. • Consider specialist referrals when necessary and collaborate with other healthcare professionals for comprehensive care This intervention can also be delivered through practices working together. **Transition Arrangements** Practices not currently delivering a Doppler for assessment of peripheral vascular disease and pre-compression therapy have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements. Practices will be required to provide evidence of subcontracting arrangements if service not in place. **ICB Assurance:** Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied.
	Outputs/Outcomes	Expected Outcomes and Benefits

	This integrated approach in primary care ensures timely and personalized management of peripheral vascular diseases, promoting patient-centred and effective healthcare delivery Appropriate referrals/management of ulcers
References	https://remedy.bnssg.icb.nhs.uk/adults/dermatology/leg-ulcer/ https://cks.nice.org.uk/topics/leg-ulcer-venous/management/venous-leg-ulcers/

4. Primary Care requested ECG

Rationale	Providing a 12-lead stable patient ECG interpretation service in primary care aims to prevent unnecessary hospital referrals for routine 12-lead ECGs and minimize interpretation delays. The service supports patient diagnosis, ongoing assessment, monitoring, and management of those with a pre-existing condition in primary care. Practices are not expected to perform ECGs for patients presenting with acute chest pain. As part of this service specification, practices are not commissioned to provide an ECG recording or interpretation service for any other Provider.
Delivery	Practices will provide a 12 lead ECG recording and interpretation service for primary care-initiated requests to all eligible patients over the age of 16 years. This intervention can also be delivered through practices working together. The ECG Recording Service is for stable patients only and should not delay any proposed admission to hospital. The service should be delivered, and ECGs interpreted in a clinically appropriate time frame according to the specific needs of the patient. Interpretation of ECG can be done within general practice or referred to specialist if needed for interpretation. ECGs should be performed in line with best practice and clinical indication. Practices should be able to demonstrate that they have a process in place for agreed follow up (where required) and to inform the patient of findings. This intervention can also be delivered through practices working together. **Transition Arrangements** Practices not currently delivering a primary care based 12 lead ECG recording and interpretation service will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements. Practices will be required to provide:

	• Evidence of subcontracting arrangements to deliver 12 lead ECG recording and/or Interpretation if unable to provide the service in practice • Evidence of practice protocol (including timescales) for delivering an ECG recording and interpretation service and patient follow up (where required) to advise findings. **ICB Assurance:**Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied.
Outputs/Outcomes	Expected Outcomes and Benefits Commissioning a primary care service for 12-lead ECG recording and interpretation aims to achieve several local outcomes, including improved access to 12-lead ECG diagnostics, increased routine interpretation in primary care, reduced referrals to secondary care, enhanced patient experience, equitable service delivery, optimal patient settings for diagnosis and treatment, early identification of conditions, provider accreditation assurance, minimised waiting times for diagnosis and treatment (supporting improved health outcomes such as for Atrial Fibrillation), and a streamlined approach to cardiac disease diagnosis or exclusion
References	There is increasing desire among service commissioners to treat arrhythmia in primary care. Accurate interpretation of the electrocardiogram (ECG) is fundamental to this. (Begg G, et al Electrocardiogram interpretation and arrhythmia management: a primary and secondary care survey. The British Journal of General Practice. 2016). Electrocardiography in addition to history taking and physical examination, may be an important tool in primary care. It can reduce considerably the number of unnecessary referrals. (Electrocardiography in primary care; is it useful? F.H Rutten, et al, International Journal of Cardiology, July 2000).

5. Spirometry

Rationale	Spirometry is the recommended objective test performed to identify abnormalities in lung volumes and air flow in children (5-16) and adults. It is used in conjunction with physical assessment, history taking, blood tests and x-rays, The aim of the spirometry service is to exclude or confirm a diagnosis of COPD or Asthma enabling timely diagnosis and treatment closer to home.

	Delivery	Practices to provide spirometry testing to confirm diagnosis of COPD or Asthma by completing a reversibility test and signpost patients to appropriate support services when diagnosed. It is recognised that Asthma can also be diagnosed by other alternative tests to spirometry. The service should be delivered by appropriately trained clinicians and have appropriate quality assurance processes in place. Practices should use a device that provides the full range of measurement. **Referral to secondary care** Appropriate reasons for referral into secondary care services can be found on Remedy: https://remedy.bnssg.icb.nhs.uk/adults/respiratory/spirometry-and-lung-function-tests/ **Transition Arrangements** Practices not currently delivering a primary care-based spirometry service will have a 12 month lead in time during this transition period to ensure they have a device that provides the full range of measurement and that practice based clinicians are trained to an appropriate level with quality assurance processes in place Practices may liaise with the LMC for support on training. This intervention can also be delivered through practices working together. Practices will be required to provide the following: 1. Evidence of skills and relevant accreditation to deliver a spirometry service 2. Evidence of skills or subcontracting arrangements to deliver a spirometry diagnostic service ICB Assurance: Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied.
	Outputs/Outcomes	Expected Outcomes and Benefits Spirometry testing plays a crucial role in diagnosing, managing, and monitoring respiratory conditions, ultimately improving patient outcomes and quality of life
	References	Spirometry is the recommended objective test performed to identify abnormalities in lung volumes and air flow. It is used in conjunction with physical assessment, history taking, blood tests and x-rays, to exclude or confirm particular types of lung disease, enabling timely diagnosis and treatment. To be valid

	spirometry that is used for diagnosis must be quality-assured and should only be performed by people who have been trained and assessed to ARTP2 or equivalent standards by recognised training bodies in the performance and interpretation of spirometry. Without this overall quality assurance, the accuracy of the diagnosis cannot be relied on. (A Guide to Performing Quality Assured Diagnostic Spirometry. Source: British Lung Foundation; British Thoracic Society, 2013) https://patient.info/doctor/spirometry-pro

6. Delivery of Gonadotrophin-releasing hormone antagonist (GnRH analogues/ LHRH) treatment (e;g Triptorelin, Goserelin) for prostate cancer

Rationale	Deliver GnRH analogues to give patients convenient access to treatment for prostate cancer.
Delivery	Foster collaboration between primary care and secondary care for comprehensive care. Have a call/recall system and a system to follow up any missed appointments. **Transition Arrangement** Practices not currently delivering a Gonadotrophin-releasing hormone antagonist (GnRH analogues/ LHRH) treatment (e;g Triptorelin, Goserelin) for prostate cancer will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements. Ensure healthcare providers are trained in proper injection techniques and adhere to established guidelines. Ensure proficient injection technique, including proper site selection and aseptic procedures. Equip the setting for emergencies and train providers in recognising and responding to adverse reactions ICB Assurance: Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied.
Outputs/Outcomes	Expected Outcomes and Benefits • GnRH analogues play a crucial role in the long-term management of prostate cancer, helping to maintain disease control and prevent recurrence after primary treatments closer to home. • Offering GnRH analogue treatment provides patients with a well-established, effective, and generally well-tolerated therapeutic option, contributing to patient-centred care in prostate cancer management.
References	https://prostatecanceruk.org/prostate-information-and-support/treatments/hormone-

	therapy#:~:text=GnRH%20antagonists%20(gonadotrophin%2Dreleasing%20hormone,has%20spread%20to%20the%20bones . https://cks.nice.org.uk/topics/prostate-cancer/management/management/

7. 24-hour BPs or offer home BP monitoring

Rationale	The service is to provide a primary care-based blood pressure measurement service through either ambulatory 24-hour blood pressure measurement or, if more practical and would avoid long waits, to offer home blood pressure measurement for a patient to diagnose hypertension and support management.
Delivery	To provide a primary care-initiated Blood Pressure Monitoring Service (either though Home Monitoring or 24-hour ABPM Monitoring) for all appropriate patients in general practice in a timely and convenient manner to support the diagnosis, management and control of blood pressure. This intervention can also be delivered through sub-contracting arrangements. Practices are also expected to work with community pharmacies who can now provide blood pressure monitoring services to support identification of hypertensive patients and reviews of existing patients as part of the nationally commissioned hypertension case-finding (HCF) service. Practices are expected to communicate with their community pharmacy in relation to capacity and agree a referral route with them. The gold standard diagnostics for hypertension is ABPM as per NICE guidance 2023. However, should ABPM not be available in the practice or community pharmacy in a reasonable timescale then the use of HBPM should be considered in order to reduce the risk of delay in starting treatment. **Transition Arrangement** Practices not currently delivering a 24-hour BPs or offer home BP monitoring will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements. This intervention can also be delivered through practices working together. **ICB Assurance**: Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this

	template is finalised. In the meantime, please continue to use the codes we have already supplied.
Outputs/Outcomes	Expected Outcomes and Benefits Hypertension is associated with a higher risk of cardiovascular events. Setting blood pressure to recommended levels aims to promote primary and secondary prevention of cardiovascular disease, and to lower the risk of cardiovascular events.
References	People with suspected hypertension should be offered ambulatory blood pressure monitoring (ABPM) to confirm a diagnosis of hypertension. ABPM is the most accurate method for confirming a diagnosis of hypertension, and its use should reduce unnecessary treatment in people who do not have true hypertension. ABPM has also been shown to be superior to other methods of multiple blood pressure measurement for predicting blood pressure-related clinical events (NICE Quality Statement). The option of Home Blood Pressure Monitoring as an alternative to ABPM 24 hour should also be offered.

8. Anti-psychotic depot injections

Rationale	Administering antipsychotic depot injections to stable mental health patients in primary care facilitates community-based care, allowing patients to receive treatment in familiar and accessible settings. This can contribute to increased engagement and continuity of care. The aim is to improve treatment adherence, preventing relapses, reducing hospitalisations, and ultimately enhancing the overall well-being of individuals with psychotic disorders
Delivery	Ensure healthcare providers are trained in proper injection techniques and adhere to established guidelines. Ensure proficient injection technique, including proper site selection and aseptic procedures. Equip the setting for emergencies and train providers in recognising and responding to adverse reactions. Collaborate with mental health specialists for consultation and referral. Educate patients about the injection process, potential side effects, and the importance of follow-up. Maintain accurate records of injections, including doses and patient responses. Report adverse events to regulatory authorities as part of pharmacovigilance efforts. Establish a clear pathway for practices to go back to AWP, ensuring that practices know how to escalate concerns. **Transition Arrangements**

	Practices not currently delivering Anti-psychotic depot injections will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements. Practices will be required to provide evidence of subcontracting arrangements if service not in place. **ICB Assurance**: Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied.
Outputs/Outcomes	Expected Outcomes and Benefits Ensure these patients are on the Severe Mental Illness practice registers and are invited for an annual physical health check. Increased patient adherence to antipsychotic treatment due to the consistent and convenient nature of depot injections. Enhanced control and stability of psychotic symptoms, reducing the risk of relapses and hospitalizations. Improved overall quality of mental health care by providing a comprehensive and patient-centred approach. Higher patient satisfaction resulting from reduced treatment burden and improved symptom management. Decreased hospital admissions due to better maintenance of therapeutic drug levels and prevention of crises.

9. Prescribing for community midwives

Rationale	GPs prescribing for community midwives is driven by the need for seamless, collaborative, and efficient care in managing maternal health. It supports timely access to medications, fosters collaboration between healthcare professionals, and contributes to the overall well-being of pregnant women receiving care in community settings.

	Delivery	GPs in primary care may engage in limited prescribing for community midwives, typically focusing on medications directly related to maternal and newborn care. The scope of prescribing for community midwives can vary but it is expected that midwifery teams will be developed to prescribe independently. Prescriptions should exclude medications that can be obtained over the counter. Some examples of prescribing activities for community midwives in primary care include: Prescribing essential prenatal vitamins and supplements, such as folic acid or iron, to support maternal and foetal health during pregnancy. Prescribing antibiotics for the treatment of minor infections, such as urinary tract infections or vaginal infections, which can occur during pregnancy. Prescribing pain relief medications, such as paracetamol, for mild to moderate pain relief during pregnancy or postpartum. Prescribing antiemetic medications to alleviate nausea and vomiting commonly experienced by pregnant women. Prescribing topical preparations, such as creams or ointments, for minor skin conditions or irritations during pregnancy. Prescribing medications for specific pregnancy-related conditions, such as gestational diabetes or gestational hypertension, in collaboration with obstetricians or other specialists Prescribing medications for postpartum care, including pain relief medications or treatments for perineal discomfort. Prescribing medications to address common breastfeeding issues, such as nipple pain or mastitis. This dees not include medications for labour at home or anticoagulation for pregnant women at risk. **Transition Arrangement** Practices not currently prescribing for community midwives will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements.
	Outputs/Outcomes	Expected Outcomes and Benefits Swift access to essential medications for immediate maternal and newborn care.

	Supports a holistic approach to maternal care beyond birthing. Continuity: Promotes continuity of care with midwives managing routine cases seamlessly. Enhances patient-centred care by offering comprehensive services. Reduced Referrals: Lessens dependence on immediate referrals for minor health issues. Provides convenience for patients, receiving medications during routine visits. Facilitates collaboration with other healthcare professionals.

10. Ear Wax Removal

Rationale	Ear wax removal to improve hearing loss or other symptoms, subject to clinician assessment or to aid diagnosis with a service provided close to home.
Delivery	NICE recommends that ear irrigation (flushing the wax out using water) using an electronic irrigator, microsuction (using a vacuum to suck the wax out under a microscope), or another method of earwax removal (such as manual removal using a probe) may also be considered if the expertise is available, there are no contraindications to the methods, and the correct equipment for the procedure is used. This should be performed by trained staff. **Criteria for ear wax removal in primary care include**: Presence of hearing aids, with ear wax removal required to prevent interference with the proper functioning of the devices. Patients with significant learning disabilities and people with impaired communication and dementia. Need for accurate diagnostic assessments, such as audiometry or tympanometry, where ear wax removal is necessary for accurate results. **Transition Arrangement** Practices not currently offering ear wax removal will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements. Practices will be required to provide evidence of subcontracting arrangements if service not in place.

		ICB Assurance: Data should be recorded using the relevant Ardens templates for that specific activity (e.g. wound care) as they contain the correct codes. We are in the process of updating the Ardens template which contains all BNSSG LES codes. We will communicate with practices once this template is finalised. In the meantime, please continue to use the codes we have already supplied.
	Outputs/Outcomes	Expected Outcomes and Benefits • Removal of impacted earwax can lead to immediate improvement in hearing, addressing symptoms of hearing loss or muffled sounds. • Relief from Discomfort and resolution of Tinnitus: • Removal of earwax may alleviate or reduce symptoms of tinnitus (ringing or buzzing in the ears). • Earwax removal helps prevent complications such as ear infections, which may occur when wax buildup creates a favourable environment for bacterial growth. • Facilitation of Diagnostic Assessments • Improved Effectiveness of Hearing Aids • Prevention of Self-Removal Complications • Clearer Diagnostic Visuals • Earwax removal in primary care reduces the need for unnecessary referrals to specialists, streamlining patient care and minimizing healthcare system burdens.

How Will Activity Data be Obtained?

Data will be extracted from the GP IT system and reported to the LES Steering Group on a quarterly basis. Where practices do not take up the LES, the ICB will seek coverage for the population from within BNSSG General Practice and will monitor impacts on other healthcare partners through the LES Steering Group.

By opting for this enhanced service, you consent to the extraction and quarterly monitoring of this data.

In cases of disparities in activity data, the ICB will commit to the following actions:

1. **Assess Variations**: Identify areas of service provision where variations exist, whether in terms of quality, access, or outcomes. This may involve data analysis and feedback from service users.

2. **Quality Improvement**: Implement quality improvement initiatives to address identified variations. These may involve process enhancements, training, and performance monitoring.
3. **Communication**: Communicate the efforts to address variations with patients and the general public in partnership with HealthWatch. and offer educational resources to patients and the public about what to expect from healthcare services and how to navigate the system effectively.
4. **Monitor and Adapt**: Monitor and evaluate the impact of efforts to reduce variations in service provision. Adapt strategies as needed to achieve better consistency and higher quality in healthcare services.

3.3 Population Covered

All patients registered with the practice as relevant to the service.

3.4 Any acceptance and exclusion criteria

N/A

3.5 Any interdependencies with other services / providers

Sirona
Community Pharmacies

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- As detailed in Section 3.2

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

As detailed in Section 3.2

4.3 Applicable local standards

Remedy guidelines

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

As detailed in the specification

5.2 Applicable CQUIN goals

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

GP Practices premises

SCHEDULE 3 – PAYMENT

A. Local Prices

Payments will be made to all practices at the new rates from April 2024 and the ICB will recover payments to practices which choose not to sign up.

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
Declaration of intent to provide all services in the Basket with details of any transition plans in the first year. Please see link in the Appendix for completion and submission to the ICB. Please also exception report any service disruption lasting longer than four weeks using the template attached in the appendix,	Each contract year	Completion of template	10th May 2024	**Supplementary Services**

Appendix

Declaration of Intent and Action Plan required by the 10th of May 2024

Supplementary Services EOI 2024-25

Exception Report Form

SUPPLEMENTARY SERVICES EXCEPTION

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	TeledermLES2628
Service	Teledermatology - Image taking
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board
Provider Lead	As per provider signatory
Period	1st April 2026 – 31st March 2028
Date of Review	March 2028

1. Population Needs
1.1 National/local context and evidence base This Local Enhanced Service is provided to patients who have been clinically assessed by their GP, or other primary care clinician, and the patient meets the criteria for referral to a skin cancer pathway as set out by NICE. Patients who are considered suitable for the service, should be offered access to the teledermatology service. The service aims to provide virtual assessment and diagnosis for patients with a new or changing skin lesion. The service captures digital images of urgent suspected skin cancers (USC) to diagnose, monitor or assess skin conditions without the patient being physically present. A high quality teledermatology service, as part of locally agreed pan-system redesign of dermatology services, can support transformation of services and elective recovery. In 2023/24 there were close to 14,000 USC skin referrals from primary care to secondary care in BNSSG. That number increases on an annual basis in line with the increasing incidence of skin cancers and growing public awareness of the risks and signs of skin cancer. The LES pertains specifically to work required to capture and refer dermoscopic and macroscopic images to inform referrals. It does not include payment for any requirement for follow up appointments or treatment following discharge.

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

Locally collected evidence demonstrates that image capture in primary care can reduce the number of patients who travel to hospital for an assessment (and diagnosis) by around 80%. That reduction also supports a more efficient cancer pathway and faster diagnosis.

On the basis of Cancer Research UK data (1 in 36 UK males and 1 in 47 UK females will be diagnosed with melanoma skin cancer in their lifetime) – that equates to a significant proportion of BNSSG's population.

3. Scope

3.1 Aims and objectives of service

Aims:
To ensure adults with a suspected skin cancer have access to safe and effective services.

Objectives:
To safely provide all suitable patients with access to remote assessment of suspected skin cancers.

To support shorter waiting times for the diagnosis and treatment of cancer and to reduce the time it takes for patients who do not have cancer to have cancer ruled out. That will include:

- Meeting the cancer faster diagnosis standard so that patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days

- Continuing to reduce the number of patients waiting over 62 days for treatment
- To increase the provision of services in the community and to resource primary care to support those services.

3.2 Service description/care pathway

A core part of primary care is the assessment of skin lesions and the onward referral of patients who have lesions where skin cancer is suspected.

This local enhanced service specification is for the provision of image capture and upload ahead of that referral being made.

This LES is intended to formalise the offer from BNSSG ICB to practices to enable access to virtual secondary care assessment of suspected skin cancers. Access is provided on the basis that:

- Patients are assessed by a clinician before a decision to refer is made
- All referrals on this pathway include the agreed image set; localising, macroscopic and dermoscopic images.
- Image capture is undertaken in primary care by a member of staff who has been trained in image capture
- Image files are attached to eRS referrals to enable virtual assessment in secondary care
- A referral letter and patient questionnaire is attached to the referral

Across BNSSG there is a well-established teledermatology eRS Advice and Guidance pathway however this service is not for the urgent assessment of suspected cancers.

Description of the basic service:
The GP practice provides a clinical assessment of a patient's skin lesion or abnormal area of skin.

The lesion is measured and may be examined with a dermatoscope. If the GP (or other primary care clinician) decides that a cancer referral is required, then a referral form is completed.

The patient is then seen by a member of staff in the PCN who has received training to capture images of the skin lesion.

Photos should be taken as follows:

- With a dermatology camera provided to the PCN for the purposes of delivering the service
- A photo of the referral indicating the patient name and/or NHS number.

- A general photograph of the skin lesion to show where it is located on the body
- A close up photograph of the skin lesion with a measure to show the size
- Close up dermoscopic photograph(s)

Further guidance on how to photograph skin lesions is provided below:


Training Document V5.pdf

The USC teledermatology service will assess photos of up to **two** lesions. Only lesions which have been assessed and a decision to refer made by a primary care clinician should be photographed.

Any skin lesions that have not been assessed by a primary care clinician with a decision to refer made should not be photographed. Patients asking about other skin lesions in their photography appointment should be directed to ask their primary care clinician.

Images should be uploaded to EMIS and to eRS with the competed Suspected Skin Cancer Referral Form.

By signing up to this enhanced service you agree to be paid based on the number of referrals sent on the **USC Teledermatology pathway** with images attached to a completed referral form.

ICB eRS data will be used to inform payment each quarter to practices. That data exchange is intended to minimize burden on primary care. Should dispute arise about income earned EMIS data should be extracted and made available to the ICB.

A detailed description of the service provided is provided below:


USC skin 2WW referral - Operationa

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

Inclusion

- Over 18
- Patient consents to the referral and is given information re process/PIL
- If unable to consent then best interests decision is made for referral
- Lesion must be accessible for photography i.e. not under bandages

Exclusion criteria

- Three or more lesions
- Lesion previously reviewed by teledermatology service unless photo review requested
- Total body skin examination/full skin check is not included/possible NB this is not routinely offered by dermatology apart from in certain circumstances
- Any melanomas unintentionally biopsied in primary care should be referred directly for face to face review

3.5 Interdependence with other services/providers

Providers will need to:

- Upload image files to EMIS and then to eRS via the usual referral process for secondary care review via the following eRS services:

  DO NOT ATTEND Teledemratology SKIN Urgent Cancer – Bristol Royal Infirmary RA7

  Or

  DO NOT ATTEND Teledermatology SKIN Urgent Suspected Cancer – Southmead RVJ

- Track time between booked appointments (clinical assessment at first appointment and image capture at a second appointment) for the purposes of reporting to ensure effective management of cancer pathways. **That time should not exceed 5 days.**

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Suspected cancer: recognition and referral - NG12

NHS England » A teledermatology roadmap: implementing safe and effective teledermatology triage pathways and processes

NHS England – Implementing a timed skin cancer diagnostic pathway

NHS England - Dermatology digital playbook

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

Teledermatology - British Association of Dermatologists

Teledermatology Service Standards

4.3 Applicable local standards

Standard Operating Guidance – included at figure one.

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

eReferral Services

Payment will be made to Practices who have signed up to the LES on the basis of referrals made to the **teledermatology eRS services** with the agreed image set. On that basis secondary care data will be available to record delivery of contracted activity.

Practices entering into this contract agree to be paid on the basis of ICB eRS data demonstrating referrals received to the. That data is available by practice. However practices should also keep accurate records (via EMIS) to ensure a full and proper audit trail is available to evidence booked appointments to ensure that activity is delivered in line with the service specification in order to:

- Evidence patients have been seen within the 5 days
- Inform any dispute about the level of activity undertaken

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)

How will Payments be Made and Calculated

Payment will be made where the following four requirements have been met:

1. A patient has been assessed by a clinician in primary care and a clinical decision has been made that an urgent suspected cancer referral should be made
2. A Suspected Skin Cancer Referral Form has been completed by the clinician
3. The patient's lesion(s) have been photographed by a trained member of staff in the PCN areas
4. The referral form and the agreed image set are submitted to secondary care via eRS to the USC Teledermatology Service

Payment will then be made on that basis to provide:

- 15 minutes of administrative time per patient referred – to support appointment booking and the upload of images (costed at a rate of per/hour the top point of a Band 4 and an increase of the employer NI contributions) - per activity (image capture).
- 15 minutes of staff time to capture images per patient referred (costed at a rate of per/hour the top point of a Band 4) - per activity (referral and image upload)
- This LES introduces a requirement to work across practices within a PCN. An additional payment per referral is therefore provided to support work to develop models of care across Primary Care Networks and to allow primary care opportunity to work flexibly where this is feasible taking into account geographical considerations and postcodes of inequality to ensure equity of access for patients.

For each activity (image capture) the following amounts will also be made:

In addition to these payments dermatology cameras will be provided to each PCN and training for image capture will be made available by either UHBW or NBT medical illustration teams. A singular payment is available (as set out below) to backfill staff undertaking training.

Practice level quarterly review of referral quality will be undertaken. If more than 30% of referrals from a practice sent on the USC Teledermatology pathway do not have the requisite images or the images are not of sufficient quality to enable virtual assessment then payment will be paused while a review takes place to identify and resolve the cause.

Equipment maintenance provision will also be made available, and practices should contact medical illustration to note any requirements.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
ERS data will be provided by ICB to inform payment. Any PCN choosing to submit their own data should provide data extracted from EMIS to describe all referrals made with images on the correct eRS pathway.	Quarterly	eRS	Quarterly extract used by ICB to inform payment	**All service specs**
All practices will be required to report on the dates of first patient appointment with a primary care clinician and the date of image capture.	Annual	EMIS	Quarterly extract used by ICB to provide oversight of cancer waiting times.	**All service specs**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	InsulinStartLES2425
Service	Type 2 Diabetes Insulin Start LES
Commissioner Lead	[redacted] 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
Payment Rate	The payment rate was updated in September 2025 to reflect the 2025/26 uplift rate. All other information has not been updated

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

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 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/	Ongoing	Datix	April	**Insulin LES**

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**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	TirzepatideLES2526
Service	**Weight Management – tirzepatide prescribing and management in primary care** This Local Enhanced Service specification outlines a service to provide payment to Practices to deliver tirzepatide to NHS England (NHSE) priority cohort 1 in year 1 alongside wrap-around care. Note that this LES will be reviewed for continuation into year 2 and subsequent years.
Commissioner Lead	[redacted] NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	23rd June 2025 to 22nd June 2026
Date of Review	May 2025

1. Population Needs

1.1 National/local context and evidence base

This Local Enhanced Service specification outlines the delivery of tirzepatide in primary care for weight management and obesity in accordance with the NICE TA1026 and the NHSE funding variation cohort prioritisation for primary care in year 1 of implementation.

In December 2024, NICE TA1026 recommended tirzepatide (Mounjaro) as an option for managing overweight and obesity, alongside a reduced-calorie diet and increased physical activity in adults, only if they have:

- an initial body mass index (BMI) of at least 32.5kg/m2 for certain ethnic backgrounds and 35 kg/m2 for other ethnic backgrounds,
- at least 1 weight-related comorbidity.

However, NHSE have issued a funding variation for the implementation of tirzepatide in primary care within 180 days (23 June 25), with a narrower cohort of patients eligible than NICE TA1026 above, initially prioritising those facing the most significant weight-related comorbidities. This is the primary care **Year 1, priority cohort 1.**
The eligibility criteria for the NHSE primary care Year 1, cohort 1 is as follows:

- BMI ≥ 40* and
- ≥ 4 'qualifying' comorbidities** – hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus

Note:
*Use a lower BMI threshold (usually reduced by 2.5 kg/m^2) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds
** Qualifying comorbidities defined as :

NHSE Tirzepatide qualifying co-morbidities for cohorts	
1. Established atherosclerotic cardiovascular disease (ASCVD)	Ischaemic heart disease, Cerebrovascular disease, Peripheral vascular disease, Heart failure
2. Hypertension	Established diagnosis of hypertension requiring blood pressure lowering therapy
3. Dyslipidaemia	Treated with lipid-lowering therapy, **or** with low density lipoprotein (LDL) ≥ 4.1mmol/L, **or** fasting (where possible) triglycerides ≥ 1.7mmol/L
4. Obstructive Sleep Apnoea (OSA)	Established diagnosis of OSA (sleep clinic confirmation via sleep study) **and** treatment indicated i.e. meets criteria for CPAP or equivalent

Wraparound care (WAC) is mandated by NICE alongside tirzepatide prescribing and should encompass, nutrition and dietetic advice, physical activity and functional movement, behavioural support and lifestyle change tools. NHSE have commissioned an interim WAC provider to allow systems to mobilise a weight management service in primary care through the NHSE Diabetes Prevention Programme (NDPP); in BNSSG this is Living Well Taking Control. Patients will be provided with Behavioural Support for Obesity Prescribing (BSOP) accessed from primary care as a 9-month programme. Patients will be offered a choice of three delivery models:

1. Face to face group sessions – traditional format with peer interaction within community settings
2. Remote digital groups sessions – live, interactive support via video conferencing
3. Fully digital delivery – self guided App or wed-based model that allows flexible support

Practices must refer patients to Living Well Taking Control using the BSOP referral form that is available on Remedy.

The proposed Primary Care Pathway for Year 1 is described in **Appendix 1** below.

It is anticipated that patients receiving care as part of this enhanced service will benefit from having their treatment closer to home (in a primary care setting) and improved access to medical treatment for weight loss and obesity supporting existing Specialist Weight Management Services waiting lists.

This LES specification outlines a service to provide funding to Practices to deliver tirzepatide to the NHSE primary care year 1, cohort 1 alongside wrap-around care (WAC) in **year 1** of implementation.

This is a new primary care service and the model of care and payment structure will be reviewed with Practice support for year 2 and subsequent years. This process will be iterative and we will work to continually refine the model of care over the coming years, considering the capacity within primary care.

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 Defined outcomes

1. Number of patients assessed for eligibility for Tirzepatide (Mounjaro®) in the primary care setting.
2. Number of patients assessed for eligibility for Tirzepatide (Mounjaro®) who meet the NHSE priority cohort 1 eligibility criteria.
3. Number of patients commenced Tirzepatide (Mounjaro®) who meet the NHSE priority cohort 1 eligibility criteria.
4. Number of patients referred to wraparound care (WAC).
5. The number of prescriptions issued per Practice, for tirzepatide where used in line with BNSSG Joint Formulary and NICE TA1026 and as per NHS England primary care priority cohort 1.
6. Number of patients assessed at 6 months who have lost more than 5% of their baseline body weight on the highest tolerated dose.
7. Number of patients stopped Tirzepatide (Mounjaro®) – note – if less than 5% of the initial weight has been lost after 6 months on the highest tolerated dose, decide whether to continue treatment, taking into account the benefits and risks of treatment for the person and document reasons for stopping.
8. Work with ICB and BNSSG Weight Management Group to collect patient reported outcome measures (PROMS) through an agreed mechanism such as a patient questionnaire.

3. Scope

3.1 Aims and objectives of service

Aims

1. To ensure eligible adults in whom tirzepatide is a therapeutic option receive treatment in line with national and local guidelines.
2. To ensure the drug treatment, physical monitoring and wraparound care (WAC) is delivered safely, effectively and sustainably.
3. To provide equitable access to tirzepatide for weight management and obesity across BNSSG.

Objectives

1. GP practices to identify eligible patients, take bloods where appropriate and review, provide patient education and training on administration, initiate and continue appropriate on-going prescribing of tirzepatide for eligible patients, improving overall long-term morbidity risk and improve health outcomes.
2. To ensure that an **appropriately trained healthcare professional** undertakes the initial assessment and decision to continue. This is defined as completion of the SWMS-led webinar (recorded)
   and demonstrates clinical competence to prescribe in weight management.
3. To refer patients to WAC and ensure patient engagement with the 9-month programme to support continued prescribing*****.
4. To appropriately record 6 month review - if less than 5% of the initial weight from baseline has been lost on the highest tolerated dose, the decision to continue tirzepatide, taking into account the benefits and risks of treatment for the person.
5. To provide patients receiving tirzepatide with the information they need to safely manage their treatment and improve patient education in relation to their condition.
6. To appropriately record the decision to continue treatment at 12 months taking into account maintained or further weight loss.
7. To reduce inequality to tirzepatide access across BNSSG. Practices will be provided with support with searches to identify patients.
8. To monitor the safety and effectiveness of tirzepatide medication at appropriate intervals delivered alongside WAC.
9. To ensure the dose of tirzepatide is amended as appropriate in response to ongoing monitoring.
10. To provide the service to a high standard in a way that is convenient for patients.
11. To ensure that multidisciplinary providers of care work together and share data to support safe and effective care for the patient.
12. To incorporate the tirzepatide GP IT template into EMIS and use as a clinical tool to capture consultation and outcomes using the suite of SMOMED codes for tirzepatide to allow the ICB to extract the required data.
13. To ensure reasons for stopping are adequately documented and all suspected adverse drug reactions are reported via the yellow card scheme.
14. To record patient outcomes to enable evaluation of the quality of care through a regular audit process, effecting change when required to improve the service provided.

*****Note: We expect most patients will engage with WAC delivered by the BSOP programme, however where they are not, a pragmatic approach on a case-by-case basis should be taken as patients may have different barriers to engagement. If a patient can demonstrate that they are making their own lifestyle adjustments (e.g. going to the gym, using different lifestyle Apps to

support their journey) that this would be reasonable to document. Consideration of the weight related outcome at 6 months (loss of at least 5% of initial body weight) and maintenance of weight loss or further weight loss at the 12-month review are opportunities to review continued prescribing. This approach is supported by the BNSSG Weight Management Group.

3.2 Service description/care pathway

Tirzepatide is recommended as an option for managing overweight and obesity, alongside a reduced-calorie diet and increased physical activity in adults. Provision of wraparound care (WAC) – diet, access to behaviour change and physical activity advice – is mandated by NICE alongside tirzepatide.

Tirzepatide is included in the BNSSG Joint Formulary. GP Practices may initiate and continue prescribing in eligible patients.

Tirzepatide has a Green Traffic Light Status (TLS) when prescribed for weight management and is appropriate for prescribing throughout the ICS within the competencies of the prescriber.

It is licensed for subcutaneous administration, once weekly, and can be self-administered by the patient after appropriate counselling.

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 monitoring.
- Assurance that there is a process to identify and manage patients not engaging with the necessary review, monitoring and WAC 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 uptake, outcomes and 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 initiated, reviewed and referred to WAC each quarter as part of this LES if EMIS Search and Report becomes unavailable.
- Named Practice Lead – to support implementation of this new service.

How Will Activity Data be Obtained?

The NHS England National Obesity Team requests ICBs to provide information on the following data points:

1. Number of patients assessed for eligibility
2. Number of patients commenced Tirzepatide
3. Number of patients referred to wraparound care (WAC)

4. Number of patients stopped Tirzepatide

For 1 and 2 above, NHSE requests a breakdown by the comorbidities patients are presenting with according to the cohorting set out in NHS England's Funding Variation (ASCVD, Type 2 Diabetes, Dyslipidaemia, Obstructive Sleep Aponea, and Hypertension).

Associated SNOMED codes are available nationally and uploaded to EMIS.

ICBs are further requested to report the figures above with a breakdown on:

a. Ethnic background (Asian, Black, Mixed, Other, White, unknown)
b. Index of Multiple Deprivation (IMD)
c. Sex: the sex the patient is registered as at birth.
d. Severe Mental Illness (SMI)
e. Learning Disability (LD)

Additionally the ICB will monitor patient outcomes, this will be worked through with practices as soon as possible.

A GP IT template will be provided, further details to follow.

Data will be obtained using EMIS Search and Report. By signing up to this enhanced service you agree for the data be extracted by the ICB 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. Eligibility criteria is as per NHS England commissioning guidance set out to ensure prioritisation of NHS resources in line with population need and to ensure that patients with the greatest clinical need are prioritised.

Searches will be provided (embedded in below Word document) to Practices to help identify patients within the primary care cohort 1 for assessment of eligibility. The ICB will also support Practices with searches to support identification of inequalities within patient populations.

Tirzepatide Cohort 1 Patient Case Findi

Practices signed up to this LES will cover registered patients within own Practice and for patients registered outside of the Practice where there is agreement between Practices to do so. In this instance the ICB will support the covering Practice to ensure that renumeration reflects the number of off-register patients seen as per the LES payments detailed.

3.4 Any acceptance and exclusion criteria and thresholds

Any patients receiving tirzepatide for weight loss provided by another NHS care provider are excluded from this LES.

Patients who have sought private treatment who would have been eligible under cohort 1 on initiation of tirzepatide could receive treatment at the discretion of practice – see FAQs - to follow.

3.5 Interdependence with other services/providers

Providers will need to:

1. Share data via EMIS (Enterprise/Search and Report) for the purposes of audit and payment.
2. Share data via local systems such as Connecting Care for the purposes of patient safety.
3. Liaise with colleagues working for providers of wraparound care services where appropriate.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The following guidance from NICE:

- Tirzepatide for managing overweight and obesity (TA1026).
- Overweight and obesity management (NG246)
- Obesity in adults: prevention and lifestyle weight management programmes (QS111)
- Obesity: clinical assessment and management (QS127)

The following guidance from NHS England:

Medicines for obesity

- Interim commissioning guidance: implementation of the NICE technology appraisal TA1026 and th funding variation of tirzepatide for the management of obesity. 27 March 25

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

N/A

4.3 Applicable local standards

Formulary : Adult (Remedy BNSSG ICB)

Supporting NHS England documents

09.06.2025_NHS_Tirzepatide_narrative.pdf

NHS England commissioning guidance - **implementation of the NICE technology appraisal TA1026 and the NICE funding variation for tirzepatide (Mounjaro®) for the management of obesity**

NHSE funding variation

NICE TA1026 Tirzepatide for managing overweight and obesity

5. Applicable quality requirements and CQUIN goals

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

Use the suite of SMOMED codes applicable to tirzepatide and support data extraction by ICB through EMIS Search and Report to monitor tirzepatide implementation.

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

Payments will be made quarterly in arrears.

Practices will be paid per patient per year (year 1 of treatment) for patient's initiated on tirzepatide. This will be front loaded to reflect implementation and titration in the first 6 months and maintenance in the following 6 months up to the first year.

Payments will be made quarterly in arrears:

- First 6 months
- Second 6 months

If a patient stops tirzepatide, Practices will be paid up to and inclusive of the quarter within which the patient stopped treatment.

An additional one-off payment in 2025-26 per practice will be paid to allow for backfill for training, attending webinar training or watching recorded webinar and practice set up costs such as setting up SOPs, recall systems, agreeing a named practice lead etc. This payment is for Year 1 only.

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 for payment	Quarterly Tirzepatide LES Q1 25-26 Searches (Issu	EMIS Search and report	Quarterly extract used by ICB to inform payment	**All service specs**

- 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 search criteria for calculating LES payment:

To identify patients in their first 6 months of treatment
All patients (including deducted and deceased) aged 18+ who have been issued with an NHS prescription of tirzepatide by the surgery during the search period **AND** who have been coded with any of

Clinical Code Description	**SNOMED Description ID**
National Health Service obesity medication pathway started	2049081000000113
NHS obesity medication pathway started	2049081000000116

AND who have not had a prescription for tirzepatide 6+ months before the latest tirzepatide prescription issue.

To identify patients beyond their first 6 months of treatment
All patients (including deducted and deceased) aged 18+ who have been issued with an NHS prescription of tirzepatide by the surgery during the search period **AND** who have been coded with any of

Clinical Code Description	**SNOMED Description ID**
National Health Service obesity medication pathway started	2049081000000113
NHS obesity medication pathway started	2049081000000116

AND are not included in the search results of patients in their first 6 months of treatment.

The search period runs from 23rd June 25 to 22nd June 26 taken quarterly.

Appendix 1

Proposed Pathway - Tirzepatide for weight management

- Initial F2F assessment (suitably trained HCP):
  - Check eligibility, bloods taken and reviewed
  - patient education/consent, training on administration
  - referral to WAC digital provider

- Monthly contact during titration phase (does not need to be F2F):
  - check ADRs, prescribe appropriate dose/quantity; check adherence with WAC

- At 6 months, F2F review (suitably trained HCP):
  - If ≥5% of initial body weight not lost after 6 months, at highest tolerated dose, reassess appropriateness of continuing

- Annual F2F review (suitably trained HCP):
  - reassess appropriateness of continuing, check adherence with WAC