Service Specification No.	**Domain 1**
Service	**Atrial Fibrillation**
Commissioner Lead	**NHS East Lancashire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices in East Lancashire**
Period	**1st April 2016 – 31st March 2017**
Date of Review	**31 March 2017**

1. Population Needs

1.1 National/local context and evidence base

Atrial Fibrillation (AF) is the most common sustained adult cardia arrhythmia. There are currently over 1 million people diagnosed with AF in the UK, with many more (25-30%) who are thought to have the condition without it being diagnosed yet. The prevalence of AF increases with age, and to more than 15% in those aged 75 years and over. AF increases the risk of death, stroke, thromboembolic events, heart failure, vascular dementia, hospitalisations, reduced quality of life and diminished exercise capacity.

AF is costly in terms of increase mortality, morbidity and reduced quality of life. Within the UK, it is a condition that is not always managed well, with patients reporting inadequate explanations of their condition and treatment options.

Audits across the UK confirm that the use of anticoagulation to reduce the risk of AF related stroke is underutilised. AF related strokes are more debilitating, with those affected being less likely to get back to independent living and less likely to survive.

The most common presenting symptoms are palpitations, breathlessness, dizziness and syncope although as many as 25-30% do not have symptoms. Therefore, many fail to present for treatment, despite having a greatly elevated risk of stroke.

We are aware that there is significant variation between GP Practices in East Lancashire in the proportion of their patients with AF who remain undiagnosed.

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 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

- Reduction in the unwarranted variation in the reported prevalence of AF across General Practice in East Lancashire

- Improved outcomes for patients
- Improve patient experience

3. Scope

3.1 Aims and objectives of service

To identify unwarranted variation in the diagnosis of AF, where it exists, understand the causes of that variation and give consideration to improvement opportunities with a view to improving case finding in relation to Atrial Fibrillation.

3.2 Service description/care pathway

GP Practices participating in the AF element of the Quality Framework will:

- Identify a Clinical and an Administrative lead to be responsible for AF within the practice.
- Review benchmarked data provided by the CCG in relation to the recorded prevalence compared to the expected prevalence of AF for your practice population.
    - Clinicians at each practice will meet internally to discuss benchmarked data including identifying any unwarranted variation and the possible reasons for the variation.
- Attend quarterly Quality Improvement Workshops organised by the CCG which will support peer review of benchmarked data, the sharing of best practice and the development of local solutions.
- Use tools such as Aristotle/GRASP AF to search for codes that suggest probably or possible un-coded AF
- Undertake opportunistic pulse checking in settings where AF is more likely to be detected e.g. 0/65 Influenza Immunisation Clinics
- Ensure that all patients found to have an irregular pulse are offered a 12 lead ECG to determine rhythm
- To develop a robust protocol for the identification, diagnosis and appropriate management of people with AF

3.3 Population covered

The service provided shall be for all eligible patients who are registered with a GP practice in the NHS East Lancashire CCG geographical boundaries.

3.4 Interdependencies with other services

- NHS East Lancashire CCG

- Primary Care
- Cardiology Advice Service
- Local Acute Trusts (Secondary Care)

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The delivery of the commissioned service is underpinned by the appropriate standards, including but not limited to:

- **Atrial Fibrillation: Management NICE Guidelines (CG 180)(June 2014)**

4.2 Applicable standards set out in Guidance and/or issued by a competent body

As per the NHS Standard Contract.

4.3 Applicable local standards

The provider is required to maintain evidence of continuing professional development in relation to this service. This may be required to be produced as evidence for re-accreditation. Clinical updates/training could include supervised practice, liaison/clinical audit sessions or attendance at appropriate postgraduate meetings/lectures/events etc.

4.4 Monitoring and Reporting

The provider must supply the CCG with such information as it may reasonably request for the purposes of monitoring the provider's performance of its obligations under this service level agreement.

The provider shall monitor and provide, as requested, the following information as a minimum:

- Names of the clinical and administrative leads responsible for AF
- Number of patients recorded as having AF on the GP Clinical System (EMIS)
- Number of patients found to have an irregular pulse who have been offered a 12 lead ECG

5. Payment

Internal Practice Meeting =

Option 1

£225 (Based on 2 hour meeting with clinical and admin lead responsible for AF) (Flat rate per practice)(Total resource required £13,050

Option 2

£225 for a practice with an average list size of 6,000 patients (£225 / 6,000 x actual list size

= practice payment) e.g. A practice with a list size of 8,587 would receive £322 (Total resource required £14,850)

Attendance at East Lancs QI Workshop = ***£600*** (Based on £450 per workshop x 4 = £1800) (The total amount available for attending workshop will divided between the 3 identified clinical areas AF/COPD/Hypertension) (Flat rate per practice)

Time to identify potentially un-coded AF patients (Based on an average of 4 hours = £450 x 58 practices = £26,100 / 396,000 = ***£0.07*** per weighted patient

Time to undertake opportunistic pulse checking as a price per weighted patient –

Option 1

(Based on East Lancs average of 16.63% of patients being 0/65 years of age. 63,000 pts 0/65 x 2 mins / 60 mins = 2,100 hours per annum x £25 per hour = £52,500 / 396,000 = ***£0.13*** per weighted patient)

Option 2

(Based on East Lancs average of 16.63% of patients being 0/65 years of age. 63,000 pts 0/65 x 3 mins / 60 mins = 3,150 hours per annum x £25 per hour = £78,750 / 396,000 = ***£0.20*** per weighted patient)

ECG funded through ECG LES.

Total amount available for this element of the framework = ***£126,450 - £156,570***

Total available for an average practices with a weighted list size of 6,000 patients = **£2,025 - £2445**

This will be paid in 9 equal monthly payments through 2016/17

Service Specification No.	**Domain 1**
Service	**Hypertension**
Commissioner Lead	**NHS East Lancashire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices in East Lancashire**
Period	**1st April 2016 – 31st March 2017**
Date of Review	**31 March 2017**

1. Population Needs

1.1 National/local context and evidence base

High Blood Pressure (Hypertension) is one of the leading risk factors for premature death and disability, and can lead to conditions including stroke, heart attack, heart failure, chronic kidney disease and dementia. A blood pressure reading over 140/90mmHg indicates hypertension, which should be confirmed by tests on separate occasions to reach a diagnosis.

Diseases caused by high blood pressure cost the NHS over £2 billion every year. By reducing the blood pressure of the nation as a whole, £850 million of NHS and social care spend could be avoided over ten years.

In NHS East Lancashire CCG only 54.4% of the number of people estimated to have Hypertension actually has a diagnosis.

Adult should have their blood pressure measured at least once every five years. Once tested, NICE recommends that adults are re-measured within five years and, more frequently for people with high normal blood pressure or in high risk groups. Blood pressure can be highly variable, so a diagnosis of hypertension should never be based on a single test and should normally be confirmed by ambulatory (24 hour monitoring) or home testing.

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 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

- Reduction in the unwarranted variation in the reported prevalence of Hypertension across General Practice in East Lancashire
- Improved outcomes for patients
- Improve patient experience

3. Scope

3.1 Aims and objectives of service

To identify unwarranted variation in the diagnosis of hypertension, where it exists, understand the causes of that variation and give consideration to improvement opportunities with a view to improving case finding in relation to Hypertension.

3.2 Service description/care pathway

GP Practices participating in the Hypertension element of the Quality Framework will:

- Identify a Clinical and an Administrative lead to be responsible for Hypertension within the practice.
- Review benchmarked data provided by the CCG in relation to the recorded prevalence compared to the expected prevalence of Hypertension for your practice population.
    - Clinicians at each practice will meet internally to discuss benchmarked data including identifying any unwarranted variation and the possible reasons for the variation.
- Attend quarterly Quality Improvement Workshops organised by the CCG which will support peer review of benchmarked data, the sharing of best practice, the identification of training needs and the development of local solutions.
- Increase detection of Hypertension through;
    - More frequent opportunistic testing in primary care, achieved through using a wider range of staff and integrating testing into the management of long term conditions.
    - Targeting high risk groups and deprived groups.Searching for and recalling patients with a historic single high reading with no evidence of follow up
- Ensure that all patients with a blood pressure reading greater than 140/90 have a 24 hour ABPM or HBPM in line with the ABPM Service Specification
- To develop a robust protocol for the identification, diagnosis and appropriate management of people with Hypertension

3.3 Population covered

The service provided shall be for all eligible patients who are registered with a GP practice in the NHS East Lancashire CCG geographical boundaries.

3.4 Interdependencies with other services

- NHS East Lancashire CCG
- Primary Care
- Local Acute Trusts (Secondary Care)

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The delivery of the commissioned service is underpinned by the appropriate standards, including but not limited to:

- **Hypertension in Adult: Diagnosis and Management (CG 127) (August 2011)**

4.2 Applicable standards set out in Guidance and/or issued by a competent body

As per the NHS Standard Contract.

4.3 Applicable local standards

The provider is required to maintain evidence of continuing professional development in relation to this service. This may be required to be produced as evidence for re-accreditation. Clinical updates/training could include supervised practice, liaison/clinical audit sessions or attendance at appropriate postgraduate meetings/lectures/events etc.

4.4 Monitoring and Reporting

The provider must supply the CCG with such information as it may reasonably request for the purposes of monitoring the provider's performance of its obligations under this service level agreement.

The provider shall monitor and provide, as requested, the following information as a minimum:

- Names of the clinical administrative leads responsible for Hypertension
- Number of patients recorded as having Hypertension on the GP Clinical System (EMIS)
- Number of patients found to have BP greater then 140/90 who have been offered a 24 hours ABPM or HBPM

5. Payment

Internal Practice Meeting =

Option 1

£225 (Based on 2 hour meeting with clinical and admin lead responsible for Hypertension) (Flat rate per practice)(Total resource required £13,050)

Option 2

£225 for a practice with an average list size of 6,000 patients (£225 / 6,000 x actual list size = practice payment) e.g. A practice with a list size of 8,587 would receive £322 (Total resource required £14,850)Attendance at East Lancs QI Workshop = ***£600*** (Based on £450 per workshop x 4 = £1800) (The total amount available for attending workshop will divided

between the 3 identified clinical areas AF/COPD/Hypertension) (Flat rate per practice)

Time to search for and identify patients with undiagnosed Hypertension (Based on an average of 4 hours = £450 x 58 practices = £26,100 / 396,000 = ***£0.07*** per weighted patient

More frequent opportunistic testing and targeting of high risk and deprived groups

25,000 (approx. 6% of the population) x 5mins / 60 mins = 2083 hours per annum x £25 per hour = £52,083 / 396,000 = ***£0.13*** per weighted patient)

ABPM/HBPM funded through the ABPM LES.

Total amount available for this element of the framework = ***£126,450 - £128,250***

Total available for an average practices with a weighted list size of 6,000 patients = £1605 - **£2,025**

This will be paid in 9 equal monthly payments through 2016/17

Service Specification No.	**Domain 1**
Service	**COPD**
Commissioner Lead	**NHS East Lancashire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices in East Lancashire**
Period	**1st April 2016 – 31st March 2017**
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

COPD is a disease of the lungs that is characterised by airflow obstruction or limitation. It is now the most widely used term by clinicians for the conditions in people with airflow obstruction who were previously diagnosed as having chronic bronchitis or emphysema or chronic unremitting asthma. The airflow obstruction is usually progressive, not fully reversible (unlike asthma) and does not change markedly over several months. It is treatable, but not curable; early diagnosis and treatment can markedly slow decline in lung function and hence lengthen the period in which someone can enjoy an active life.

Premature mortality from COPD in the UK was almost twice as high as the European average in 2008. In addition COPD is the second most common cause of emergency admission to hospital and is one of the most costly diseases in terms of acute hospital care in England.

COPD kills about 25,000 people a year in England and Wales. Recent figures showed that COPD accounted for 4.8% of all deaths in England between 2007 and 2009. It is the fifth biggest killer disease in the UK. Numbers of deaths from COPD increase with age, as the lungs become more obstructed over time. In the UK, deaths from COPD are very low in the age range 0-40 (less than 500 per year) but much higher in the 75+ age range for both males and females (about 20,000 per year).There are around 835,000 people currently diagnosed with COPD in the UK and an estimated 2,200,000 people with COPD who remain undiagnosed, which is equivalent to 13% of the population of England aged 35 and over. **(**An Outcomes Strategy for COPD and Asthma: NHS Companion Document (Department of Health, 2012)

The health gains achieved by stopping smoking are indisputable. For COPD, stopping smoking is of proven benefit in terms of interfering with disease progression and should be recognised as a treatment, not just as a way of preventing disease. Stopping smoking also benefits other conditions such as cancer, cardiovascular disease, diabetes and osteoporosis. Stop smoking services should offer a long-term programme that is flexible enough to deal with an individual's needs. It can take as many as seven or eight attempts for a smoker to quit, therefore programmes need to consider this and have robust systems to follow up those that have used the service and offer further help if needed.(NICE Guideline PH10 Nov13)

Influenza immunisation has been recommended in the UK since the late 1960s, with the aim of directly protecting those in clinical risk groups who are at a higher risk of influenza associated morbidity and mortality.

The flu vaccine is strongly recommended for people of all ages with COPD and especially

for older people. This is because they are particularly at risk of getting more serious problems if they catch flu.(NICE Guideline NG6 March 2015)

The most recent estimate suggests that there are 10,394 patients in East Lancashire with COPD (Public Health Observatory, 2011) however in March 2015 there were only 9,125 patients recorded as having COPD on GP Practice QOF Registers. In addition the national document, An Outcomes Strategy for COPD and Asthma (Department of Health, 2011), suggests that over 25% of people with a diagnostic label of COPD have been wrongly diagnosed, usually associated with poorly-performed spirometry.

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 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

- To improve respiratory health and wellbeing and minimise inequalities
- Reduction in the unwarranted variation in the reported prevalence of COPD across General Practice in East Lancashire
- People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.
- Improved outcomes for patients
- Improve patient experience

3. Scope

3.1 Aims and objectives of service

- Early, prompt and accurate diagnosis of people with COPD
- Maximise the utilisation of evidence-based, cost-effective interventions for people with COPD including smoking cessation and pneumonia and influenza vaccination
- Undertake a baseline assessment of spirometry services
- Develop a hospital marker which will be used to ensure that people with COPD who attend urgent care services or are admitted to hospital, are offered follow-up by a respiratory specialist

3.2 Service description/care pathway

GP Practices participating in the COPD element of the Quality Framework will:

1. Identify a Clinical and an Administrative lead to be responsible for COPD within the practice.

2. Review benchmarked data provided by the CCG and identify unwarranted variation in relation to:
    a. The recorded prevalence compared to the expected prevalence of COPD for your practice population.
    b. The recording of smoking status
    c. The recording of smoking cessations advice
    d. The recording of referrals to a smoking cessation service
    e. The recording of attendance a smoking cessation service
    f. The recording of pneumonia and flu immunisation uptake in people with COPD (With and without exception codes)

3. Clinicians at each practice will meet internally to discuss benchmarked data including identifying any unwarranted variation and the possible reasons for the variation.
4. Participate in a baseline audit of spirometry services.
5. Attend quarterly Quality Improvement Workshops organised by the CCG which will support peer review of benchmarked data, the sharing of best practice and the development of local solutions.
6. All practices develop a plan to improve unwarranted variation in COPD diagnosis and register size, smoking status and pneumonia and influenza vaccination rates.
7. Identify people whose treatment history and symptoms suggest that COPD may have been missed, and those currently diagnosed with COPD without a clear diagnosis

8. Develop a robust protocol for the identification, diagnosis and appropriate management of people with COPD

3.3 Population covered

The service provided shall be for all eligible patients who are registered with a GP practice in the NHS East Lancashire CCG geographical boundaries.

3.4 Interdependencies with other services

9. NHS East Lancashire CCG
10. Primary Care
11. Local Acute Trusts (Secondary Care)

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The delivery of the commissioned service is underpinned by the appropriate standards, including but not limited to:

- **NICE Quality Standard for COPD (2011 and updated in 2016)**
- **NICE Clinical Guideline 101 (2010 and currently under revision)**
- **An Outcomes Strategy for COPD and Asthma: NHS Companion Document (Department of Health, 2012)**

4.2 Applicable standards set out in Guidance and/or issued by a competent body

As per the NHS Standard Contract.

4.3 Applicable local standards

The provider is required to maintain evidence of continuing professional development in relation to this service. This may be required to be produced as evidence for re-accreditation. Clinical updates/training could include supervised practice, liaison/clinical audit sessions or attendance at appropriate postgraduate meetings/lectures/events etc.

4.4 Monitoring and Reporting

The provider must supply the CCG with such information as it may reasonably request for the purposes of monitoring the provider's performance of its obligations under this service level agreement.

The provider shall monitor and provide, as requested, the following information as a minimum:

- Names of the clinical administrative leads responsible for COPD
- Number of patients recorded as having:
  - COPD on the GP Clinical System (EMIS)
  - Smoking status
  - Smoking cessations advice
  - Been referred to a smoking cessation service
  - Attended a smoking cessation service
  - Been offered a flu vaccination
  - Received a flu vaccination (With and without exception codes)

5. Payment

Internal Practice Meeting = ***£225*** (Based on 2 hour meeting with clinical and admin lead responsible for COPD) (Flat rate per practice)

Attendance at East Lancs QI Workshop = ***£600*** (Based on £450 per workshop x 4 = £1800) (The total amount available for attending workshop will divided between the 3 identified clinical areas AF/COPD/Hypertension) (Flat rate per practice)

Time to identify potentially un-coded or missed coded COPD patients (Based on an average of 8 hours = £900 x 58 practices = £52,200 / 396,000 = ***£0.14*** per weighted patient

Total amount available for this element of the framework = **£100,050**

Total available for an average practice with a weighted list size of 6,000 patients = **£1665**

This will be paid in 9 equal monthly payments through 2016/17

Service Specification No.	**3**
Service	**Near Patient Testing for High Risk / Amber Drugs Level 2 (Shared Care)**
Commissioner Lead	**NHS East Lancashire CCG**
Provider Lead	
Period	**April 1st 2016 – 31st March 2017**
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

It is important for patient care that there is a clear understanding of where clinical and prescribing responsibility rests between Specialists (*) and GPs. The East Lancashire Traffic Light scheme for medicines aims to support this, by providing guidance on who should initiate and then continue the prescribing of certain medicines. Medicines that have been designated with an AMBER traffic light level 2 are defined as follows:

AMBER Traffic Light (Level 2 Medicines)

These medicines are considered suitable for GP prescribing following specialist initiation of therapy and patient stabilisation, with on-going communication between GP and Specialist. Such medicines require intensive monitoring and to qualify must be designated so by the East Lancashire Medicines Management Board.

GPs are not advised to take on prescribing of these medicines unless they have been adequately informed by letter of their responsibilities with regards to monitoring, side effects and interactions and are happy to take on the prescribing responsibility.

Where a locally approved prescribing guidance document exists this should accompany this letter which outlines these responsibilities. GPs should then inform Secondary Care of their intentions as soon as possible by letter, and then arrange the transfer of care as necessary.

Therefore, it is essential that a transfer of care involving medicines that a GP would not normally be familiar with should not take place without the 'sharing of information with the individual GP and their mutual agreement to the transfer of care'. This information is best provided in the form of an approved shared care protocol. The concept of drugs that GPs would not routinely initiate and therefore would not normally be familiar with is encompassed in *Dept. of Health EL(91)127 "Responsibility for prescribing between Hospitals and GPs*' http://www.elmmb.nhs.uk/shared-care/

Additionally certain medications that might be initiated in primary care have monitoring requirements that must be fulfilled in order to ensure patient safety. These high risk drugs are included in this specification in order to ensure that patients receiving these treatments are getting the necessary and appropriate monitoring in order to achieve the best clinical outcomes.

(*) Specialists are those clinicians working within Secondary Care at Consultant grade, or GPs with a specialist interest (GPwSI) working in Primary Care prescribing only within their speciality.

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 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

- To ensure care is delivered in a timely manner and in a convenient location closer to the patient's home
- Improved patient experience
- Reduced need for onward referral.

3. Scope

3.1 Aims and objectives of service

The aims of the service are to offer near patient testing of medications deemed high risk and also AMBER drugs level 2. The service will offer enhanced aspects of clinical care to the patient,

Certain high risk medications which require annual monitoring including antipsychotics, carbimazole, hydroxychloroquine, mesalazine, NSAID's, phenytoin, propylthiouracil, sirolimus and tacrolimus fall outside this service specification as it would be expected that the annual monitoring for these drugs is undertaken as a core part of the individuals annual review.

Service Aims:

- The service to the patient is convenient whilst remaining clinically safe
- Patients receive the necessary and appropriate monitoring at the right time.
- All clinicians involved are confident in accepting the legal and clinical responsibility associated with the prescribing of these medicines
- Therapy should only be stated for recognised indications for specified lengths of time
- Maintenance of patients first stabilised in the secondary care setting should be properly controlled
- Monitoring of patients therapy is managed through their GP practice, standardising the provision and use of blood test monitoring
- The need for continuation of therapy is reviewed regularly by the specialist
- The therapy is discontinued when appropriate
- The use of the resources by the National Health Service is efficient

3.2 Service description/care pathway

This service will provide near patient testing associated with the prescribing of medicines designated as AMBER light level 2 or considered to be high risk and requiring more frequent monitoring than on an annual basis. (See Appendix A).
This service includes drugs for rheumatology patients commenced on DMARDS plus medicines designated locally as requiring intensive monitoring.

The provider must ensure that all newly diagnosed/treated patients (and/or their carers, where appropriate) receive appropriate education and advice on the management and prevention of secondary complications of their condition. This should include written information, where appropriate.

The provider must ensure that all patients (and/or their carers and support staff, where appropriate) are informed of how to access appropriate and relevant information.

The provider must ensure that all patients have an individual management plan which gives the reason for the treatment, the planned duration, the monitoring timetable and, if appropriate, the therapeutic range to be obtained. This information should all be included within the clinical record.

3.3 Population covered

The service is to be provided for all eligible residents of East Lancashire that are registered with an East Lancashire GP.

3.4 Any acceptance and exclusion criteria

All patients must be registered with a GP practice in East Lancashire those that are not will be excluded from this service.

Lithium (also designated a level 2 amber medicine) is excluded from this specification as monitoring is funded via the QOF.

3.5 Interdependencies with other services

Staff involved with the provision of this service must work together with other professionals where appropriate. The provider should refer patients to other appropriate services and to relevant support agencies using locally agreed guidelines.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The delivery of the commissioned service is underpinned by the appropriate standards including but not limited to:

- *Dept. of Health EL(91)127 "Responsibility for prescribing between Hospitals and GPs*'
- Care Quality Commission Standards
- Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance
- Relevant safeguarding standards.

4.2 Applicable standards set out in Guidance and/or issued by a competent body

As per the NHS Standard Contract.

Record Keeping and Information Keeping

The provider must be able to produce an up-to-date register of all patients receiving a medicine as outlined in Appendix A; including patient name, date of birth and the initiation and duration of treatment, including the last hospital appointment.

The provider must maintain adequate records of the service provided including all regular monitoring, dates of attendance, issues arising from treatment and incorporating all known information relating to

any significant events e.g. hospital admissions, death of which the practice has been notified.

Patients' records should be assigned the relevant Read Code to allow relevant audits to be conducted. Patients who are prescribed a drug listed in Appendix A and who receive the monitoring and/or adjustment of therapy by the practice should be read coded differently to those patients who receive their monitoring and adjustment by Secondary/Tertiary Care

Where patients are receiving monitoring with or without adjustment of therapy by the practice and payment is being claimed under this local enhanced service the following Read Code should be used:

66P7 High Risk Drug Monitoring – Primary Care

Where patients are receiving monitoring with or without adjustment of therapy by secondary/tertiary care and therefore payment is not being claimed under this local enhanced service the following Read Code should be used:

66P8 High Risk Drug Monitoring – Shared Care

Where treatment is stopped the following Read Code should be used:

66P6 High Risk Treatment Stopped

The provider must ensure that a systematic call and recall of patients on the practice register is taking place.

All providers of NHS commissioned care should use the latest NHS Information Governance Toolkit to assist in implementation and assessment of compliance with policy and legal requirements.

Full records of all procedures, screening and tests should be maintained in such a way that aggregated data and details of individual patients are readily accessible. Practices should regularly audit and peer review outcomes.

Practices must ensure that details of the patient's monitoring are included in his or her lifelong record. If the patient is not registered with the practice, then the practice must send this information to the patient's registered practice for inclusion in the patient notes.

4.3 Applicable local standards

Prescribing by a Primary Care prescriber of an Amber level 2 drug should normally be carried out in accordance with the guidance provided in the East Lancashire Monitoring Guidelines and/or the shared care protocol (where available) for that drug.

East Lancashire Monitoring Guidelines for AMBER level 2 drugs can be found online at:

http://www.elmmb.nhs.uk/guidelines/other-clinical-guidelines/

These guidelines provide best practice guidance for monitoring these drugs, with information accrued from a variety of sources.

Adherence to them will not ensure a successful outcome in every case. The ultimate judgement regarding a particular clinical result must be made by the doctor in light of the clinical data presented by the patient and the diagnostic and treatment options available.

A provider may be accepted for the provision of the service if it has a partner, employee or sub-contractor who has the necessary skills and experience to undertake the required patient monitoring.

Providers undertaking this service will be required to demonstrate a continuing sustained level of activity, conduct regular audits, be appraised on what they do and take part in necessary supportive activities.

The provider is required to maintain evidence of continuing professional development in relation to

this service specification. This may be produced as evidence for re-accreditation. Clinical updates/training could include supervised practice, liaison/clinical audit sessions or attendance at appropriate post-graduate meetings/lectures/events etc

Infection Control

The provider will have access and adhere to national and local guidance in relation to infection prevention and control principles and protocols.

The provider will ensure that up to date infection prevention and control policies are written, reviewed and adhered to by all staff.

The environment must be clean, clutter free and sterile items stored appropriately i.e. not on the floor. A cleaning schedule will be in place and monitored by the provider.

All clinical staff will adhere to standard precautions. Personal protective equipment must be available and clinical staff to don appropriate personal protective equipment in accordance with national guidance.

Staff must attend infection prevention and control training annually. Training manual to be available.

An infection prevention and control audit or a self assessment will be undertaken by the provider annually.

Sharps will be stored, handled and disposed of at the point of source in accordance with national guidance. This process will be monitored by the provider.

All needlestick injuries will be treated as a significant event and will be investigated by the provider.

Premises and Equipment

The provider will ensure that the premises used for the provision of the service are:

- suitable for the delivery of those services; and
- sufficient to meet the reasonable needs of the patients.

The provider shall provide all of the required clinical equipment. This equipment shall be maintained in accordance with manufacturers' guidance and best practice and, where appropriate, recalibrated annually.

Business Continuity

The provider must ensure that adequate arrangements are in place for continuity of the service in the event of staffing shortages, facilities and system failures appropriate to the service.

Significant Events

The Department of Health emphasizes the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.

The provider must have systems in place for documenting and learning from significant events, including reporting as appropriate.

The provider should be aware of the various reporting systems, such as:

- the National Patient Safety Agency National Reporting and Learning System
- the Medicines and Healthcare Products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system) and accidents involving medical devices

- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

In addition to their statutory obligations, the provider should give notification, within 72 hours of the information becoming known to him/her, of all emergency admissions or deaths of any patient treated by the provider under this service, where such admission or death is, or may be due, to the providers treatment of the relevant underlying medical condition covered by this specification.

Monitoring and Reporting

The provider must supply the CCG with such information as it may reasonably request for the purposes of monitoring the provider's performance of its obligations under this service level agreement.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Payment should only be claimed for those patients who receive near patient testing and monitoring by the practice, including taking clinically appropriate action in response to results and patient response.

Patients who receive their monitoring of therapy and subsequent adjustments in secondary/tertiary care should be read coded in a different manner and payment should not be claimed.

The provider will receive payments based on the intensity of testing required.

- For drugs that require up to and including 3 monthly tests an annual fee of £70.00 per patient per year will be paid.

- For drugs that require between 3 and 6 monthly testing an annual fee of £35 will be paid.
- It is expected that drugs requiring 12 monthly monitoring are reviewed as part of the core annual clinical review so will not attract an additional payment.

- Payments will be made in 4 equal quarterly payments of £17.50 per patient for individuals on medication requiring 3 monthly monitoring and £8.75 per quarter per patient for those requiring 6 monthly monitoring.

This will be based on the number of patients on the practice's register at the beginning of the year.
The practice is not required to submit a monthly claim in respect of this service.
For patients receiving more than one of these drugs, only one payment per patient will be made.

In addition to the above fees, where a domiciliary visit to a housebound patient is required (and is

provided by a member of the practice team) an additional fee of £4.00 per visit will be paid for each separate address visited on that day.

The provider is required to submit a claim in respect of any domiciliary visits to the Commissioning Support Unit, via the services spreadsheet, to enhancedserviceslcsu@nhs.net by the 10th of the month following the date on which the visit was undertaken.

The above payment is to cover:

- all staff time involved in undertaking the procedure
- disposables/consumables associated with undertaking the procedure
- all sterilisation/maintenance/calibration/servicing/repair/replacement and insurance of equipment.

Service Specification No.	**Domain 3: Care Closer to Home**
Service	**Improving Access to General Practice and Proactive Case Management**
Commissioner Lead	**NHS East Lancashire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices in East Lancashire**
Period	**1st July 2016 – 31st March 2017**
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

There is significant coverage in the media about how the public struggle to access their GP. Popular stories include difficulties with getting through on the phone, or booking an appointment at a convenient time.

A patient's ease of access to their Practice, and preferred GP, can affect their quality of care and health outcomes (The King's Fund, 2012). Research suggests that high levels of patient satisfaction with access to Primary Care correlates with higher QOF scores, and also with lower rates of emergency hospital admission (Kontopantelis et al, 2010). Other studies show that inadequate capacity in General Practice can lead to unmet health needs, and also to an increase in demand for Accident & Emergency (A&E), and other hospital services (Rosen 2014).

Although data from the National GP Survey (Ipsos MORI, 2016) shows that 70.3% of people report finding it easy to get through to someone at their GP surgery on the telephone, 25.8% report the opposite, saying it is not easy. The proportion finding it easy to get through to someone on the phone has decreased over recent years, having been 76.6% in December 2012, 73.9% in December 2013 and 71.8% in January 2015.

The majority of patients (85.0%) were able to get an appointment to see or speak to someone last time they tried, including around one in eight (12.1%) who had to call back closer to, or on the day they wanted the appointment in order to achieve this. One in ten patients (11.0%) were unable to arrange a time to see or speak to someone when they last tried to do so. Results are similar to January 2015, when 85.4% of patients said they were able to get an appointment, but slightly lower than December 2013 (86.1%).

Of those patients who got an appointment, three quarters (74.7%) got an appointment to see a GP at the surgery, and one in five (20.7%) got an appointment to see a nurse. Fewer patients got an appointment to speak to a GP on the phone (7.7%), speak to a nurse on the phone (0.8%), or a home visit (1.1%). Only 0.6% of patients got an appointment to see a GP or nurse at another surgery, and less than 0.5% had a consultation online, for example using Skype.

Recent analysis of attendances at Royal Blackburn Hospital Urgent Care Centre has found that the majority of attendance in the UCC could be better managed through an alternative pathway including through a person's general practice or through outpatients. Approximately 30% of people who attended the UCC stated they did so because either a GP appointment was not available or they had booked an appointment but did not want to wait for it.

Paragraph proactive case management
Proactive identification and case management of patients clinically led through existing

primary care relationships helps to reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. The aim of this standard would be to help understand and improve this position, supported by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions, improving patient care, supporting general practice capacity and delivering a new model of care, with primary care access supported by joined up community, social and voluntary sector services.

The aim of this approach is to understand practice compliance to the DES, with the overall aim of improving and providing more personalised support to patients most at risk of unplanned admission, readmission and A&E attendances to help them better manage their health. In order to assist in achieving this overall aim, we would look to monitor compliance against the following:

a. increasing practice availability via timely telephone access supporting the development of a future Pathfinder model for East Lancashire;

b. identify patients who are at high risk of avoidable unplanned admissions, establish a minimum two per cent case management register and proactively manage these patients utilising community capacity through the neighbourhood based Integrated neighbourhood Team and MDT approach;

c. develop personalised care plans with any new patients on the case management register or, for all patients already on the register undertaking at least one care review in the last 12 months. The development or review of care plans will be undertaken with the patient and where applicable, their carer and with input through the INT capacity through the MDT approach.

d. Ensure development of a palliative care register, establishment of regular GSF meetings and utilisation of EPACCS to support EoL patients

e. undertake internal practice reviews of emergency admissions and A&E attendances.

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 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

- To meet East Lancs CCG vision of more primary and community based services, which are more integrated and deliver less variation.
- To meet the vision and improve quality as outlined in the CCG Primary Care Development Strategy

- Primary Care Development is one of three key drivers for the CCG's transformation, as such it interfaces with the four cases for change and the outcomes for each of those are dependent on progression with the way in which primary care services are delivered

3. Scope

3.1 Aims and objectives of service

The aims of this standard are to improve access to general practice for people of East Lancashire by ensuring all East Lancashire practices are open during core hours 8.00am – 6.30pm Monday to Friday by April 2017. Open will be defined as having access to a receptionist face to face and on the telephone.

and

To reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission, including those on an EoL pathway

3.2 Service description/care pathway

During 2016/17 all practices are required to:

- Identify a lead who is responsible for reviewing access and proactive case management within the practice.
- Review published access information (NHS Choices) against actual opening times.
- Meet internally to review:
    - access arrangements including identifying gaps in provision, possible reasons for the gaps and opportunities to improve access.
    - delivery of the Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people DES.
- Attend quarterly Quality Improvement Workshops organised by the CCG which will support peer review of access arrangements, proactive case management and development of practice plans.
- All practices review their access arrangements to ensure that these meet the needs of the practice population.
- All practices develop a plan to improve access arrangements and delivery of the Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people DES.

3.3 Population covered

The service provided shall be for all eligible patients who are registered with a GP practice in the NHS East Lancashire CCG geographical boundaries.

3.4 Interdependencies with other services

- NHS East Lancashire CCG
- Primary Care
- Local Acute Trusts (Secondary Care)
- Community Service Trusts

- Mental Health Trusts
- Ambulance Trusts
- The New Model Of Care regarding additional appointments under consultation April-July 2016

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The delivery of the commissioned service is underpinned by the appropriate standards, including but not limited to:

- GMS Contract
- APMS Contract
- PMS Contract

4.2 Applicable standards set out in Guidance and/or issued by a competent body

As per the NHS Standard Contract.

4.3 Applicable local standards

- Enhanced Service for Avoiding Unplanned Admissions

The provider is required to maintain evidence of continuing professional development in relation to this service. This may be required to be produced as evidence for re-accreditation. Clinical updates/training could include supervised practice, liaison/clinical audit sessions or attendance at appropriate postgraduate meetings/lectures/events etc.

4.4 Monitoring and Reporting

The provider must supply the CCG with such information as it may reasonably request for the purposes of monitoring the provider's performance of its obligations under this service level agreement.

The provider shall monitor and provide, as requested, the following information as a minimum:

- As per the service description/ care pathway
- To confirm in writing that they are opening 8am-6.30pm Monday to Friday, both at the surgery door and on the telephone, with no lunch or half day closures
- To confirm that NHS 111 DOS and their own practice website shows up to date opening times

5. Payment

Internal Practice Meeting =

Option 1

£225 (Based on 2 hour meeting with clinical and admin lead responsible for AF) (Flat rate

per practice)(Total resource required £13,050

Option 2

£225 for a practice with an average list size of 6,000 patients (£225 / 6,000 x actual list size = practice payment) e.g. A practice with a list size of 8,587 would receive £322 (Total resource required £14,850)

Attendance at East Lancs QI Workshop = ***£600*** (Based on £450 per workshop x 4 = £1800) (The total amount available for attending workshop will divided between the 3 identified clinical areas AF/COPD/Hypertension) (Flat rate per practice)

Total amount available for this element of the framework =£47,859 - £49,650

1.