

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	General Practice Enhanced Delivery Scheme
Commissioner Lead	<i>CCG CONTACT</i>
Provider Lead	<i>GP PRACTICE NAME & CONTACT</i>
Period	1 st April 2019 – 31 st March 2020
Date of Review	Annual

1. Population Needs

NATIONAL/LOCAL CONTEXT AND EVIDENCE BASE

1.1 National Context

The **Five Year Forward View** (5YFV) published in October 2014 highlights that the NHS values haven't changed, but the world has, so the NHS needs to adapt and evolve to meet the new challenges in today's world. The publication takes a longer view, setting out a vision of a better NHS and how the health service needs to change. It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders.

The 5YFV notes that the "foundation of NHS care will remain list-based primary care"; it is "one of the great strengths of the NHS" however it is under severe strain. The publication outlined a 'new deal' for GPs which called for more investment in primary care over the next five years whilst stabilizing core funding for general practice over the next two years.

Leading on from this, in April 2016 NHSE published the **General Practice Forward View**. This document lays out the strategic direction, through national investment and commitment in targeted areas, to stabilize and strengthen the general practice landscape. It recognizes that general practice faces increasingly unsustainable pressures and that general practice wants and needs to transform the way it provides services to reflect these growing challenges. It presents plans around investment, workforce, workload, practice infrastructure and care redesign that will be led nationally but delivered locally.

The House of Commons Committee of Public Accounts, **Access to General Practice in England** in March 2016 identified a consistent decline in access to GP appointments and significant variations in terms of who can access primary care services. The Kings Fund (May 2016) also argued that general practice is currently in a state of 'crisis' where increasing demand has not been met with increased funding and workforce planning. Both documents further highlight the immediate priorities for primary care development, as highlighted in the NHSE documents before them.

1.2 Local Context

The CCGs in Greater Nottingham have taken on delegated responsibilities for the commissioning, procurement and management of primary medical services. Each CCG has introduced an 'enhanced delivery scheme' for its constituent practices. These schemes have had similar ambitions around improving patient experience and outcomes, reducing unwarranted variation in clinical practice and engaging in activities to improve resource utilisation across the health community. However, there have also been significant differences in the schemes that are no longer desirable given the increased alignment of the CCGs and the move towards the development of an Integrated Care System in Greater Nottingham.

The Nottingham and Nottinghamshire Sustainability and Transformation Plan (STP) identifies the strengthening of primary, community, social care and services for carers as one of the priority areas for the period from 2016-21. Within this area the key things that relate to General Practice are:

- Building teams of professionals around general practice that will co-ordinate care for people with complex needs or long-term conditions
- Making sure that all citizens can get an appointment with a GP practice in their area, 8am to 8pm, seven days a week
- Increasing the early detection of illnesses, in particular in cancer and dementia

Greater Nottingham has been identified as one of the first eight designated Integrated Care Systems (ICS). The ICS will bring together the local NHS organisations and local authorities to deliver more integrated and effective care for patients. The local plans to develop an ICS recognise that the key enablers include increased capacity and capability in primary care. In addition, there will be a requirement for primary care providers to participate in system wide initiatives around improving quality and resource utilisation. Furthermore, moving to a collectivised model of General Practice is a necessary foundation upon which the ICS will be built and one which should ensure that a consistent offer is made to patients.

The General Practice Enhanced Delivery Scheme (GPEDS) has been introduced to support delivery of the STP and ICS, improving health outcomes and reducing health inequalities through the provision of high quality, consistent and value for money services that are patient-centred.

Historically there has been variation in core funding across the PMS and GMS practices within and across the CCGs. NHS England made clear in 2014 their national intentions to move to a position where all GP practices, whether GMS, PMS or APMS, can expect to receive the same core funding for providing the core services expected of all GP practices by 2020 / 21. The General Practice Enhanced Delivery Scheme will help to equalise payments to practices during the transition period, increasing capacity, capability and equity in funding levels.

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	
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

- Increased co-ordination of care
- Increased access and consistency of access to primary care services
- Improved detection and management of long term conditions
- Increased capacity and capability in primary care
- Consistent, system wide initiative to improve quality and resource utilization
- Supports General Practice to work more co-operatively and collectively

3. Scope

3.1 Aim And Objectives

The aim is to improve the resilience and quality of primary care by increasing investment, reducing unwarranted clinical variation, improving the management of patients and ensuring a minimum standard of care which patients can expect to receive from any GP practice that is delivering the enhanced delivery scheme.

OBJECTIVES

The objectives of the scheme are to:

- Improve access to GP services
- Reduce unwarranted clinical variation
- Improve the management of long term conditions
- Provide stability and increase the equity of funding received by GP practices
- Encourage and support practices to work at scale

3.2 Service Description / Care Pathway

SERVICE DESCRIPTION

The General Practice Enhanced Delivery Scheme is in two parts.

Part One is a set of minimum standards and expectations to support the enhanced delivery of good quality primary care services. It is a single framework above the core GMS / PMS / APMS contract, direct enhanced services, QOF and other locally commissioned primary medical services contracts. Practices who deliver this patient offer will deliver this alongside their core GMS / PMS / APMS contract.

This offer is available to all GP practices in Greater Nottingham to deliver as providers of primary medical care services.

Any practice wishing to deliver the Primary Care Enhanced Delivery Scheme has to agree to deliver all of the minimum standards and expectations in Part One of the Scheme.

The standards are detailed at Appendix A, and have been categorised into the following groups:

- **Access:** all practices will meet access standards in order to improve patient experience and resilience in the health and social care system
- **Service Delivery:** practices will make all of the services listed in the offer available to their patients, whether this is through directly delivering the services themselves or by sub-contracting with another organisation to ensure that their patients have access to these services. Appendix B provides further service specific detail on these services
- **Practice Engagement:** practices will be expected to engage with programmes of work to improve services and / or resource utilisation across the health community; increasingly this will involve working collaboratively with other practices, as part of a federation, and with other providers as part of Local Integrated Care Providers. Appendix C provides further detail on this element

Part Two will establish quality targets across 7 clinical domains for practices to achieve in order to improve the management of patients with long term conditions. Appendix D sets out the indicators and achievement ranges. Data will be collected automatically using GPRCC and real-time feedback provided to practices via eHealthScope.

The content of the General Practice Enhanced Delivery Scheme will be reviewed annually by commissioners to ensure that it remains fit for purpose.

COLLABORATIVE WORKING - SERVICE DELIVERY

Practices can choose to deliver some elements of this specification in collaboration and / or with third parties as sub-contracted providers.

Where providers are working collaboratively or sub-contracting with third parties the proposed approach must be approved by commissioners prior to commencement of the service.

Should there be any proposed changes to the delivery model e.g. a change in sub-contracted provider, the GP practice who is commissioned to deliver this patient offer is required to notify and receive agreement from the commissioner as soon as possible.

Where a GP practice chooses to sub-contract delivery of the standards to another provider, the GP practice is responsible for ensuring that:

- appropriate sub-contract agreements are in place in accordance with contractual requirements
- appropriate arrangements are in place which satisfy information governance requirements and ensure that data security will be maintained if patient information is to be transferred between the two parties;
- where the sub-contracted service is a clinical service, the GP practice is responsible for ensuring that appropriate arrangements are in place for the patient's record to be updated with the necessary clinical details as delivered by the sub-contracted provider;
- ensuring that good quality safe services are provided by the sub-contractor in line with the service specification.

COLLABORATIVE WORKING – PRACTICE ENGAGEMENT

Practices will be required to share commissioning and prescribing budgets at a locality GP group as this will increase the likelihood that practices will be able to work together to reduce clinical variation.

Where GP practices work collaboratively in a locality GP group the proposed grouping must be approved by commissioners prior to the commencement of the service. The expectation is that ordinarily locality GP groups will reflect the structure of the local GP Federation or possibly, in future, the local Primary Care Network.

Should there be any proposed changes to the arrangements, the GP practices affected are required to notify and receive agreement from the commissioner as soon as possible.

CARE PATHWAYS

Patients can benefit from these standards and receive these services from their own registered GP practice. For standards that involve delivery of clinical services it is the responsibility of the GP practice to determine the pathway for patients to access these services. Wherever possible, this should be aligned to how patients access their registered GP practice for core primary medical services.

If a GP practice chooses to sub-contract delivery of these standards and / or services to another provider it is the responsibility of the patient's registered GP practice to ensure an appropriate access pathway is agreed. This should be in line with the requirements for collaborative working as detailed above.

3.3 Population Covered

The General Practice Enhanced Delivery Scheme will be available to the registered population of all GP practices within Greater Nottingham who agreed to deliver the Scheme.

3.4 Any Acceptance And Exclusion Criteria And Thresholds

Appendix A details the minimum standards that must be delivered by any practice wishing to participate in the General Practice Enhanced Delivery Scheme.

Appendix B details acceptance and exclusion criteria for the Service Delivery element of the Scheme (where applicable).

3.5 Interdependence With Other Services/Providers

This service should be delivered alongside the GP practice's core GMS / PMS contract.

The GP practice is expected to work closely, as appropriate, with other service providers in the health community including (but not limited to):

- secondary care providers
- community care providers and other primary care providers
- the ambulance service
- local authorities
- nursing and residential homes
- voluntary sector providers

4. Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)

Practices must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any relevant standards.

4.2 Applicable Standards Set Out In Guidance And / Or Issued By A Competent Body (e.g. Royal Colleges)

Practices must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any relevant standards.

4.3 Applicable Local Standards

As detailed within the appendices.

5. Applicable Quality Requirements And CQUIN Goals

5.1 Applicable Quality Requirements

This is a patient focused quality driven offer; there are no additional quality requirements to be achieved.

5.2 Applicable CQUIN Goals (See Schedule 4 Part E)

Not applicable.

6. Location of Provider Premises

The Provider's Premises are located at **Practice address and any locations to be used by sub-contractors.**

Additional Information

(derived from the relevant contract schedules of the NHS Standard Contract)

Expected Annual Contract Value

The contract value for the General Practice Enhanced Delivery Scheme will be specific to each individual practice.

PART ONE

The funding attached to Part One is a differential payment to those practices receiving below £-- per weighted head of population as at 1st April 2019 (the final figure is to be confirmed but the indicative figure as at 1st April 2018 after MPIG / PMS Premium Deduction was £93.04). The payment is calculated by deducting the practice average global sum payment per weighted head of population from £-- and then multiplying the result by the practice's weighted list size.

The funding is paid for delivering **ALL** of the standards as per this contract.

The funding includes the cost of consumables and any other associated costs incurred when delivering these standards. The exception to this is H Pylori where NHS Nottingham City CCG will continue to pay for the Diabact UBT breath test kits from the Nottingham Community Services Pharmacy. See Appendix B H-Pylori service detail.

PART TWO

The practice is expected to improve the management of patients with long term conditions across seven clinical domains. The weighting for delivery of each clinical indicator is shown Appendix D. Assessment of delivery will be made on an individual GP practice basis.

The total target funding attached to Part Two will comprise a core of £1.50 per weighted head of population plus a further £1.50, adjusted for Long Term Condition prevalence ($£1.50 \times \text{Practice LTC prevalence} / \text{Average LTC prevalence}$). Thus total target funding will vary from around £2.10 to £3.60 per weighted head.

Total payment = % achievement / 100 x total target funding x weighted population

Timing And Amounts Of Payments

GP practices will be paid on a quarterly basis.

The CCG will automatically make the payment to the practice and a practice income statement will be issued which will show the value of the payment made. The payments will be scheduled around the following dates, a calendar of dates will be confirmed with providers:

- End April / early May - Q1 payment
- End July / early August - Q2 payment
- End October / early November - Q3 payment and any balancing payment for Q1 / Q2
- End June / early July – Q4 payment achievement of outcomes balancing payment

An estimated level of outcomes delivery will be set across the health community and quarterly payments will be made on this basis, with reconciliation against actual outcomes delivered taking place at year end. A balancing payment or funding reduction will then be implemented in June / July (end Q1) of the following year.

If a provider fails to meet the standards in Part One of this contract the non-compliance will be managed as outlined below and if not resolved this will include the application of a financial penalty with contract payments adjusted accordingly. This is set out in the "Management of non-compliance" section below.

Management Of Non-Compliance

Providers are required to deliver **all** of the standards within Part One of this contract in order to receive the contract values as referenced above. All standards must be being delivered within 3 months of the contract commencement date.

Where it is identified that a provider is not delivering the standards as per this specification the contract management process outlined in figure 1 will be followed.

It is acknowledged that there may at times be exceptional circumstances where a provider is unable to deliver the standards and / or reporting requirements as detailed within this specification. The GP practice is responsible for notifying the commissioner immediately as soon as they become aware and these will be reviewed on an individual basis. This is referenced in figure 1 below.

Figure 1

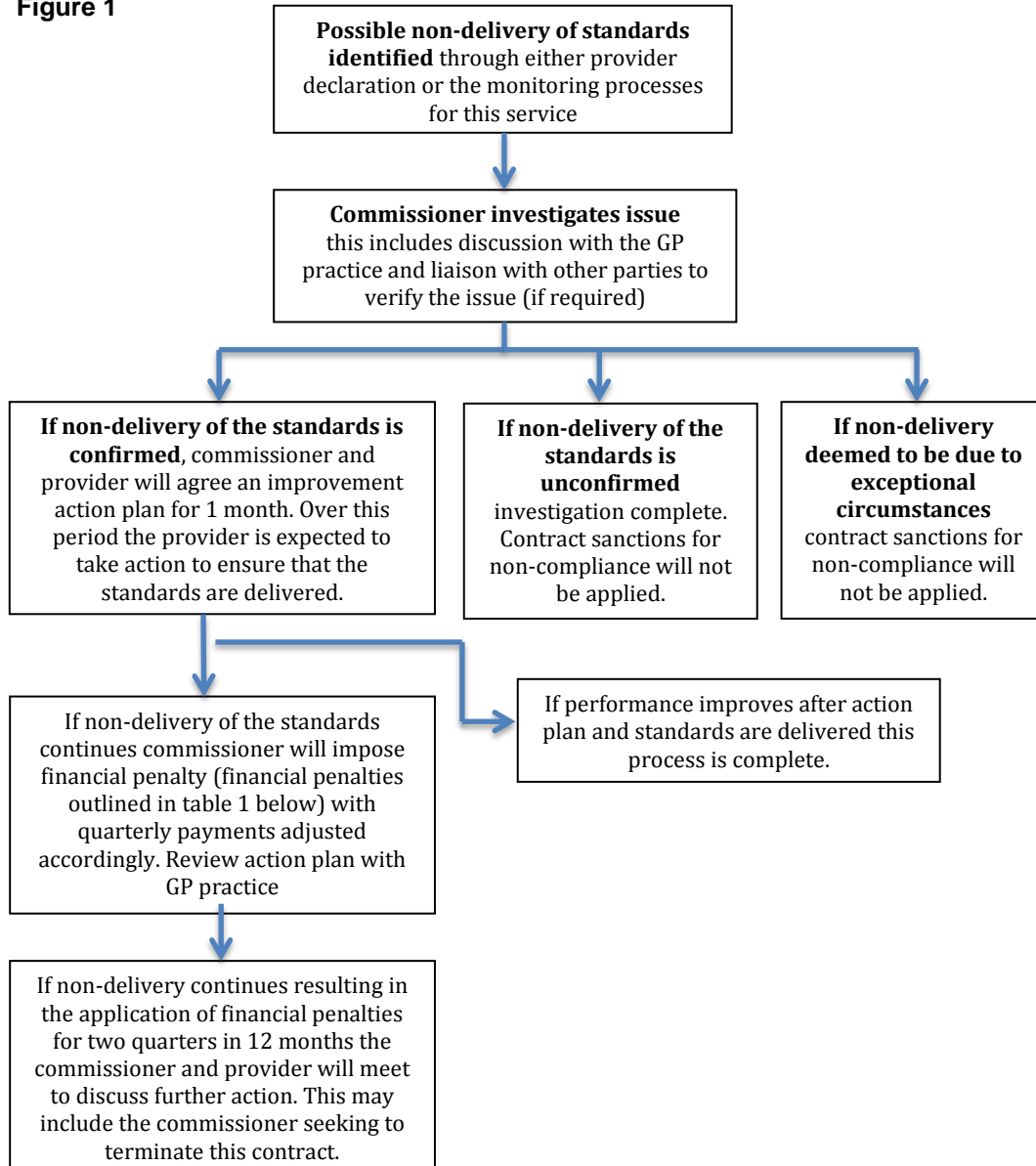


Table 1: Financial penalties

The penalties have been weighted, should a provider fail to deliver one or more of the standards within these sections then a financial penalty equivalent to the below weightings may be applied to the quarterly payment:

- **ACCESS** – up to a maximum of 40% of the payment and up to a 50% reduction in access to the funding attached to Part Two of the Scheme (paid quarterly)
- **SERVICE DELIVERY** – up to a maximum of 40% of the payment and up to a 50% reduction in access to the funding attached to Part Two of the Scheme (paid quarterly)
- **PRACTICE ENGAGEMENT** – up to a maximum of 20% of the payment and up to a 50% reduction in access to the funding attached to Part Two of the Scheme (paid quarterly)

Local Quality And Local Reporting Requirements

The following framework will be applied to monitor this service:

- **Initial Assessment** – All practices will be expected to explain how they intend to deliver Part One of the Enhanced Delivery Scheme for their patients in an initial assessment document prior to the start of the service. Commissioners will provide a template document for this assessment. These assessment documents will be reviewed by Commissioners and if insufficient assurances are provided with regards to service delivery, this will be raised with the practice. If assurances cannot be provided the practice will not be eligible to sign up to this offer.
- **Annual Assurance Statement** – All providers will be required to submit an annual assurance statement for the year which includes a declaration confirming compliance against the service specification. Commissioners will provide a template for this statement and this will need to be submitted annually by the 30th April.

Where providers anticipate that they are unable to adhere to these standards, they must notify commissioners immediately.

- **In-year reporting** – For some standards there may be a need for in year reporting and / or other information returns to be provided to the CCG (detailed in Appendices).
- **Contract Meetings** - All standards will be reviewed during meetings held with each provider by the relevant CCG. These meetings will take place during the year. Where the CCG is made aware of non-compliance with any of the standards (including through anecdotal feedback) this will be raised immediately with the provider and an additional meeting may be required.

APPENDIX A – Part One: Access Standards

Category	Ref.	Standard / Requirement	KPI Threshold & Method of Assessment
Access	A1	<p>Patients must have access to services during core hours of 8:00am to 6:30pm Monday to Friday (No half day or lunchtime closures). As a minimum this requires:</p> <ul style="list-style-type: none"> - Practice reception is staffed and accessible for patients, face to face and by telephone - There should be a consistent provision of clinical services throughout the week with a mixture of pre-bookable and urgent appointments available - Practices are permitted to close for pre-arranged CCG organised education sessions (e.g. PLT sessions) and practices are permitted to work together through relationships and alliances with neighbouring practices to ensure the consistent availability of clinical services. 	Practice self-report and spot check audits by CCG or nominated organisation commissioned on CCG's behalf.
	A2	Endeavour to deliver routine / non-urgent appointments with a clinician, or ensure other appropriate clinical contact is offered within 5 working days.	Practice self-report, NHS Digital appointment extraction and spot check audits by CCG or nominated organisation commissioned on CCG's behalf.
	A3	Offer direct access (no ring back) to routine appointments up to a minimum of 2 weeks in advance.	
	A4	Urgent appointments (urgent is defined by the patient until clinically assessed by the practice e.g. telephone triage) are available on the same day.	
	A5	Provide a separate direct line for health professionals and ensure calls are answered in a timely fashion and provided with an appropriate response. Where possible transfer calls directly to a GP; where this isn't possible arrange a timely call back from a GP to the health professional. The call back should happen within a time frame where the advice from the GP is able to support the health professional in the development of a management plan for the patient.	Practice self-report, and feedback from partner organisations.
	A6	Having a fair share* of patients in nursing and residential homes and work with the CCG and their neighbouring practices to align themselves with specific nursing and residential homes in order to improve consistency and reduce duplication of effort.	Practice self-report, CCG information and feedback from partner organisations.

*Fair share based upon weighted population list size

APPENDIX B – Part One: Service Delivery Requirements

The provider will ensure their patients have access to the following services as part of this Primary Care Enhanced Delivery Scheme.

For all services outlined below:

- The service will have contingency plans in place for the continued provision of the service in the event of breakdown of equipment, key staff absence or supply chain problems.
- Medicines handling activities (e.g. procurement, storage, dispensing and disposal) will be covered by standard operating procedures and will be safe and in line with current legislation, licensing requirements local guidelines and formulas and good practice including National Guidelines.
- The practice will comply with requests from the commissioner to provide information as it may reasonably request for the purposes of monitoring the performance of the practice's obligations under this service.
- For all clinical interventions delivered appropriate entries will be recorded in the patients' medical record, the records will be auditable and the patient's registered GP practice is responsible for obtaining the necessary consent from the patient for delivery of the service.
- If the patient is not registered with the provider providing this service, the registered GP practice must ensure that the provider has all the relevant information to provide safe and effective care. Similarly, the provider must ensure that the patient's registered practice is given all appropriate clinical details for inclusion in the patient's record.
- Where the clinical intervention produces a test result e.g. Phlebotomy test result, ECG result etc. all results should be read promptly and the appropriate action taken by the patient's registered GP.
- Each service should have agreed protocols and standard operating procedures that are reviewed regularly (at least annually), these must include infection control and needle-stick injury management where required.

APPENDIX B – Part One: Service Delivery Requirements

Category	Ref.	Standard / Requirement	KPI Threshold & Method of Assessment
Service Delivery*		* Practices will deliver or facilitate access to the following services. These services will be provided by appropriately qualified, trained and competent individuals, either in the practice or by arrangement with another provider	<p>Payment will be based on service availability rather than service volume.</p> <p>The commissioner reserves the right to request additional ad-hoc reporting from all practices. Commissioners will allow appropriate notice periods for providers to respond to the request for information.</p>
	S1	Ear Irrigation	
	S2	Treatment Room Services	
	S3	Management Of Minor Injury	
	S4	Ongoing Compression Bandaging (for those patients who require this service having completed their course of treatment in the Leg Ulcer Clinic)	
	S5	ECG Monitoring and Interpretation	
	S6	H Pylori	
	S7	PSA Monitoring	
	S8	Phlebotomy Adults (12 years +)	
	S9	Phlebotomy Domiciliary	
	S10	Spirometry	

FURTHER INFORMATION ON SPECIFIC SERVICES

S1 – Ear Irrigation

All registered patients aged 12+ years will have access to an ear irrigation service.

It is the responsibility of a clinician at the patients' registered practice to make the decision whether ear irrigation is clinically indicated, following assessment of the patient and checking that there are no contraindications to irrigation.

Ear Irrigation will be provided by an appropriately trained clinician in Ear Care and delivered from an appropriately equipped treatment room. The provider of the Ear Irrigation service will check that the patient has no contraindications to irrigation before treatment and provide any consumables required to deliver the service.

S2 – Treatment Room Services

All registered patients will have access to a minor injury and wound care treatment room service for patients requiring minor interventions including (but not exclusively confined to):

Appropriate Injuries Service

- Management of minor lacerations capable of closure by simple techniques as clinical appropriate. (A minor laceration is defined as not requiring subcuticular repair or closure and can be completed using simple closure techniques)
- Management of partial thickness thermal burns and scalds including broken skin not over 1 inch in diameter, not involving hands, feet, neck, face, genital area
- Minor trauma to hands, limbs or feet. (A minor trauma is defined as a trauma that has occurred within the last 48 hours and can be treated immediately without the requirement for an X-ray or referral to an orthopaedic clinic).

Postoperative Care for patients able to attend a clinic

- Dressing changes
- Suture removal
- Wound examination to check healing process

Dressings service

- Dressings to arterial leg ulcers
- Dressings to venous leg ulcers

The minor injuries and wound care treatment room service will be provided by an appropriately trained clinician and delivered from an appropriately equipped treatment room.

Dressings or products required to deliver the service should be patient specific and ordered via an FP10 prescription, if the practice are providing the service.

The service will be compliant with relevant guidelines and standards, including:

- Wound Care Product Formulary
- Pressure Ulcer Prevention and Treatment Guidelines

The service must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any of the relevant Standards including adherence to the relevant NICE guidelines, for example:

- Simple Wound Management and Suturing
- Lacerations
- Bites – human and animal NICE – CKS
- Debriding Agents used to Treat Surgical Wounds
- CG92 Venous thromboembolism – reducing the risk: NICE guidelines
- CG74 Surgical Site Infection

S3 – Management Of Minor Injury

GP practices are required to provide minor injury services to their patients.

Minor injury is considered to be an injury which is not serious or life threatening and can be assessed and in most cases treated by a healthcare professional in primary care. Following assessment and simple actions patients could often manage these injuries themselves.

Examples include sprains, strains, minor head injuries and minor musculoskeletal injuries.

Small cuts/grazes, minor burns and scalds, insect and animal bites are also classed as conditions that should be managed in primary care.

Serious medical emergencies including serious head injury, severe blood loss, severe allergic reaction etc. should continue to be directed to the appropriate urgent care services including the Urgent Care Centre and A&E where appropriate.

S4 – Ongoing Compression Bandaging For Those Patients Who Require This Service Having Completed Their Course Of Treatment In The Leg Ulcer Clinic

Ambulant patients with leg ulcers will be seen in the leg ulcer clinic for up to 20 weeks; the majority (around 90%) of patients will have healed or be progressing well towards healing at the point of discharge from the leg ulcer clinic. A minority of patients will require ongoing compression bandaging following discharge from the leg ulcer clinic; the practice will ensure that patients requiring ongoing compression bandaging have access to an appropriate service to meet their needs:

The service should be delivered by a person with the appropriate training and competencies

- the service is delivered from appropriate premises and with access to the appropriate equipment
- dressings are provided in accordance with the wound care formulary
- any additional prescribing costs for this will be taken into account when monitoring the practices prescribing budget

S5 – ECG

All registered patients aged 18+ years will have access to a primary care based timely ECG recording service for routine screening of symptomatic patients.

This service is for ambulant patients who are able to attend the practice, undress and get unaided onto an examination couch. A carer may assist.

The service is for patients who need ECGs as part of their management plan. **This service is not for emergency ECGs** – e.g. acute chest pain. Patients requiring an immediate or emergency ECG should be referred through the appropriate patient pathways to secondary care for urgent assessment.

ECGs will be provided by trained, competent staff. All equipment used will be maintained and calibrated in accordance with the manufacturers guidelines. It is the responsibility of the GP practice or agreed sub-contractor to cover the cost of this.

It is the responsibility of the GP practice or agreed sub-contractor to interpret the results of the ECG test. ECG results should be read promptly following the test and acted upon accordingly within a timely manner.

Providers must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any of the relevant Standards including adherence to the relevant NICE guidelines, including:

- CG95 - Chest pain of recent onset

S6 – H Pylori - Provision of Carbon-13 urea breath testing for Helicobacter pylori in patients with dyspepsia post eradication with triple therapy

Registered patients who are under Patient Specific Directive (PSD) will have access to the provision of the H. Pylori breath test.

Patients must meet the test criteria and it is recommended that the Test Checklist and Procedure Form available on the pathways website are completed with patient prior to test.

The breath test service protocol available on the pathways website should be followed.

The service uses Diabact UBT breath test kits which are designated as a Prescription Only Medicines (POM), which can be ordered via FP10.

Exclusion criteria and thresholds

- Patients under the age of 18 years.
- Patients that have not fulfilled the criteria i.e. have had antibiotics within the last 28 days or PPIs within the last 14 days.
- Patients that cannot swallow a tablet (the size of a paracetamol tablet) – these patients cannot be given DIABACT UBT.
- Patients who are pregnant or suspect they might be.
- Breastfeeding mothers (pregnant and breastfeeding patients are excluded from eradication therapy, so do not test routinely).

Applicable national standards

Providers must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any of the relevant Standards including adherence to the relevant NICE guidelines, including:

- NICE Guidance (CG184). Dyspepsia: management of adults with dyspepsia in primary care, August 2004 (amended June 2005)

S7 - PSA

All registered patients with a confirmed diagnosis of prostate cancer will have access to a community based PSA monitoring service for investigations and follow up arising from the management of patients in primary care or for secondary care where the provider agrees to do so.

The provider will:

- Ensure following and recording of the local pathways, treatment based on NICE guidance, and referral to secondary care services if appropriate
- Ensure face to face follow-up appointments are carried out to review symptoms. PSA results may be discussed at that consultation or by telephone follow-up
- Ensure an appropriate entry is recorded electronically in the lifelong patient record, including dates of any tests, hormone therapy administered (including batch number) the subsequent results and any adverse reactions to the drug
- Prescribe and administer GnRH on a 3-6 monthly basis for patients requiring gonadorelin therapy
- Ensure follow up of patients who do not attend at the required interval for a repeat injection are contacted at least three times by different means; by letter initially, telephone and then final letter posted by recorded delivery. If the patient does not wish to attend, the reason must be documented
- Ensure that specialist advice is sought regarding any complications of treatment

Referral route

Following a confirmed diagnosis by secondary care all patients that meet the desired criteria will be discharged back to their registered GP who will closely monitor these patients within a primary care setting following the agreed pathways.

Response time & detail and prioritisation

As per local agreed pathway following NICE guidelines. See PSA Pathways for Primary Care document available on F12.

Any additional acceptance and exclusion criteria and thresholds

- The service accepts patients who secondary care have discharged and agreed meet the criteria for the service.

S8 – Phlebotomy Adults (12 years +)

The practice will make available all urgent and routine phlebotomy over and above their fair share (based upon the practice's weighted population list size) of any activity commissioned from a community phlebotomy service (where applicable).

All registered patients aged 12+ will have access to a phlebotomy service encompassing all blood sampling for investigations and follow up arising from the management of patients in primary care or for secondary care where the provider agrees to do so. The service will deliver a clinic based service for patients requiring blood testing.

The provider shall:

- Ensure each time blood is taken an appropriate entry is recorded in the lifelong patient record, including the date the sample was taken, what tests the blood was sent for and the subsequent result.
- Record the test in the patient's record using appropriate coding. Providers should use one of two codes, 41D0 or XaEJK (blood sample taken), depending on the clinical system.
- Ensure the safe storage of blood samples, ready for transportation to the Pathology laboratory for analysis. Ensure blood samples are stored in a safe clinical environment prior to transportation to the local pathology department.
- Advise the GP within acceptable timescale if it has not been possible to take blood

Ensure each patient is given, if they wish, information in writing detailing what their blood tests are for, how to get the results of their test, how long they are likely to wait, and who to contact with any queries by the service provider.

The provider must have appropriate protocols in place for infection control and needle-stick injury management.

Maintain a stock of suitable phlebotomy containers and ensure the correct usage.

Ensure blood samples are stored in a safe clinical environment prior to transportation to the local pathology department.

Where the patient is identified as high risk by the referrer (i.e.HIV/MRSA positive) this should be clearly marked on the referral form/blood sample bag and the necessary precautions taken.

Additional exclusion criteria

The following blood tests are not considered appropriate within the community and are therefore excluded from the service's remit:

- Cross matching

The services includes GTT phlebotomy tests, however, GTT phlebotomy tests in pregnant women is excluded. This is the responsibility of secondary care providers to organise and fund as part of the maternity pathway tariff.

Applicable standards

- Staff performing the phlebotomy service should be adequately trained and supervised as determined by the provider.
- The staff undertaking the procedure must have verified Hepatitis B protection.
- Staff undertaking the procedure must have suitable indemnity.

NICE

Providers must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any of the relevant Standards including adherence to the relevant NICE guidelines, including:

- CG139 Section 1.1.2 Hand decontamination
- CG139 Section 1.1.4 Safe use and disposal of sharps

S9 – Phlebotomy Domiciliary

The practice will make available all urgent and routine phlebotomy over and above their fair share (based upon the practice's weighted population list size) of any activity commissioned from a community phlebotomy service.

All registered patients who are housebound and unable to attend a phlebotomy clinic will have access to a domiciliary phlebotomy service. The service encompasses all blood sampling for investigations and follow ups arising from the management of patients that are house bound.

The service shall:

- Ensure all referrals and requests for a planned home visit are checked for eligibility; the following questions should be asked for all planned home visit requests:
 - Has the patient a disability that prevents them from attending the surgery?
 - The patient doesn't attend surgery for other services?
 - Is the patient in a care/nursing home or housebound?
 - Is the patient oxygen dependent and cannot use ambulatory oxygen?
 - Is the patient severely mentally incapacitated and attending surgery would cause undue anxiety?
- Ensure that if a patient does not fall into one of these categories then a planned home visit request should be declined.
- Maximise efficiency to the service by contacting all patients scheduled for a planned home visit on the day of the visit to confirm who will be attending.
- Ensure the safe storage of blood samples, ready for transportation to the Pathology laboratory for analysis. Ensure blood samples are stored in a safe clinical environment prior to transportation to the local pathology department.
- Providers should ensure that appropriate safety measures are addressed i.e.:
 - Arrangements for bed bound patients who may not be able to answer the front door
 - Governance arrangements around security where key code access to patients homes is given
 - Requirement to advise GP within acceptable timescale that it has not been possible to take blood
 - Clarification of procedures/accountability for ensuring patient is not injured/collapsed at home
- Ensure each time blood is taken an appropriate entry is recorded in the lifelong patient record, including the date the sample was taken, what tests the blood was sent for and the subsequent result.
- Record the test in the patient's record using appropriate coding. Providers should use one of two codes, 41D0 or XaEJK (blood sample taken), depending on the clinical system.
- Maintain a stock of suitable phlebotomy containers and ensure the correct usage.

Where the patient is identified as high risk by the referrer (i.e.HIV/MRSA positive) this should be clearly marked on the referral form/blood sample bag and the necessary precautions taken.

Appointments must be prioritised based on clinical need and response times for patient visits should be appropriate to the clinical need.

Additional acceptance and exclusion criteria and thresholds

The following blood tests are not considered appropriate within the community and are therefore excluded from the service's remit:

- Cross matching

Applicable national standards

- Staff performing the domiciliary phlebotomy service should be adequately trained and supervised as determined by the provider.
- The staff undertaking the procedure must have verified Hepatitis B protection.
- Staff undertaking the procedure must have suitable indemnity.

Providers must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any of the relevant Standards including adherence to the relevant NICE guidelines, including:

- CG139 Section 1.1.2 Hand decontamination
- CG139 Section 1.1.4 Safe use and disposal of sharps

S10 – Spirometry

All registered patients will have access to a primary care based timely spirometry service for the accurate diagnosis of COPD. All identified patients should be referred to the appropriate competent person, ensuring patients are advised to stop taking medication which may prevent spirometry being performed, as appropriate to the individual patient.

The content of the spirometry procedure should include:

- An appropriate review of patients health, including checks for potential contra-indications, that the patient is safe to undergo the test and meets the criteria
- Clear instructions forwarded to patients who will be attending for spirometry testing e.g. inhaler advice, clinically stable, loose clothing, what the tests involves and length of time to carry out the test
- Interpretation of the results
- Results of patients diagnosed with COPD are classified and recorded (including scanning of hard copies where generated) as mild, moderate, severe or very severe
- Prescribed and administered medication, where & as appropriate
- For patients who smoke, onward referrals to the smoking cessation service should also be offered at the point of diagnosis.

Reversibility Testing

In most patients, routine spirometric reversibility testing is not necessary as a part of the diagnostic process or to plan initial therapy with bronchodilators or corticosteroids. However in some cases reversibility testing may need to be undertaken if asthma is suspected. In all cases spirometry results should be recorded & interpreted and this should be documented.

Workforce and Equipment

Health care professionals who perform spirometry and interpret the results will have completed an approved competency-based training course in spirometry; be assessed as competent and be expected to keep their skills up to date.

All equipment used will be maintained and calibrated in accordance with the manufacturers guidelines. It is the responsibility of the GP practice or agreed sub-contractor to cover the cost of this.

Providers must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any of the relevant Standards including adherence to the relevant NICE guidelines.

APPENDIX C – Part One: Practice Engagement Requirements

Category	Ref.	Standard / Requirement	Method of Assessment
Practice Engagement	C1	All practices will adhere to national guidance, locally developed pathways, templates and policies (e.g. Procedures of Limited Clinical Value Policy) in commissioned and delivered services (available on F12).	<p>Practice self-reporting and CCG monitoring information: MDT meetings and peer review meetings to be recorded on eHealthscope and reported to the CCG.</p> <p>The commissioner reserves the right to request additional ad-hoc reporting from all practices.</p> <p>Commissioners will allow appropriate notice periods for providers to respond to the request for information.</p>
	C2	Practices will be expected to support established and agreed collectivised working within their locality and: <ul style="list-style-type: none"> • share and compare information regarding clinical variation • implement actions arising from peer discussion • contribute to the design and implementation of population based services 	
	C3	Support practice MDT meetings, to review patients at risk of admission or clinical deterioration, in partnership with community services. Practices must: <ul style="list-style-type: none"> • ensure practice MDT meetings are scheduled on, at least, a monthly basis • ensure appropriate representation at practice MDT meetings, i.e. at least 1 GP and practice manager • record and implement agreed actions following the MDT meetings • adopt agreed (by the health community) best practice in the management of MDT meetings • ensure GP available to discuss cases with care coordinator, as required. 	
	C4	Support practice visits from CCG leads (incl. medicines management leads) to improve practice quality and financial performance. Practices must: <ul style="list-style-type: none"> • ensure a timely response to a request from the CCG for a practice visit to take place • ensure appropriate representation at practice visits • review the available information on practice quality and financial performance prior to the meeting • implement agreed actions following the practice visit and update the CCG on progress as required 	
	C5	Support the annual patient survey, discuss the results with Patient Participation Group and agree appropriate actions.	
	C6	Carry out prospective peer review of referrals. Practices must ensure: <ul style="list-style-type: none"> • prospective peer review takes place for ALL routine referrals made by GP Registrars or GP Locums • that they have a process in place for discussing complex cases prior to referral. This should happen at least once a week, especially in larger practices • where a practice is unable to appropriately peer review relevant referrals internally they will work with neighbouring practices to facilitate this • all referrals comply with pathways and processes agreed across the health community (see F12) 	

APPENDIX D – Part Two: Targets to Improve Management of Long Term Conditions

Indicator	Description	% achievement	% reward
COPD 1	% COPD patients with MRC grading recorded in last 12 months	70-90	5
COPD 2	% COPD patients with MRC grade 3+ who have offered pulmonary rehab in past 24 months	60-80	5
	<i>Rationale: Pulmonary rehab improves dyspnoea, exercise tolerance and health status in COPD compared with usual care (NICE guideline NG115; BTS guideline 2013)</i>		
HF 1	% HF patients with NYHA grading recorded in last 12 months	70-90	5
HF 2	% HF patients with NYHA grade 3+ who have offered HF rehab in past 24 months	60-80	5
	<i>Rationale: Cardiac rehab reduces HF hospitalisation and improves quality of life compared to usual care (NICE guideline NG108; National Clinical Guideline RCP 2010)</i>		
SMI 1	% patients with SMI (not in remission) with a record of BMI, blood pressure, cholesterol, blood glucose or HbA1c, alcohol, and smoking status in the past 12 months	30-60	15
	<i>Rationale: Patients with SMI have significantly worse physical health outcomes. This compound indicator aligns with national indicators for improving health in patients with SMI (NICE guidelines CG178 and 185)</i>		
AF 2	% patients with AF receiving anticoagulation (stretch target cf QOF)	75-90	10
	<i>Rationale: Anticoagulation in patients with CHA2DS2-VASC score of 1 or above (2 for women), taking account of bleeding risk, significantly reduces stroke risk (NICE Guideline CG180)</i>		
FRAIL 1	% patients with Electronic Frailty Index (EFI) >0.36 (coded as Severe Frailty) w Frailty Template completed within the last 12 months (which must include: detailed medicines review, falls risk)	50-80	15
	<i>Rationale: Follows best practice guidelines (NICE Guideline NG56). Stopping unnecessary medicines and managing falls risk reduces risk of emergency admission.</i>		
ASTH 1	% patients with asthma with review and Full Care Plan within the last 12 months (to include PEFR, symptom review, Rx review, treatment and escalation plan)	40-70	20
	<i>Rationale: Inadequate asthma reviews and lack of Personalised Asthma Action Plans was associated with a significantly increased risk of sudden death (National Confidential Enquiry into Asthma Deaths 2015).</i>		
DM 1	% patients with Type 2 diabetes who, in the last 12 months, have recorded BP <140/80; HbA1c <64mmol/mol; Chol <5mmol/l; smoking cessation advice (for current smokers)	30-50	20
	<i>Rationale: These measures have been shown to correlate with reduced progression to ischaemic heart disease and leg amputation and associated mortality/morbidity (NICE guideline NG28)</i>		

Data to be collected automatically via GP Repository for Clinical Care (GPRCC)