Appendix 1 – Enhanced Services now included within the NFF

1. Applicable Standards

National standards (e.g., NICE) and standards set out in guidance and/or issued by a competent body

1.1 The care of patients who require anticoagulation and enhanced drug monitoring, and where the practice has agreed, all other enhanced services now included within this service offer will be delivered in line with applicable national standards.

1.2 For the services as described in 1.1, the provider must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with all relevant standards including adherence to the relevant NICE guidelines where applicable.

Applicable local standards

1.3 As set out in this appendix and where relevant to the care pathway.

Infection Prevention and Control

1.4 Good infection prevention and prudent antimicrobial use are essential to ensure that people who use health and social care services receive safe and effective care. Providers must have infection control policies that are compliant with national guidelines and current handling protocols, including, but not limited to The Health and Social Care Act 2008 Hygiene Code, National Standard of Healthcare Cleanliness, and which takes into account:

- disposal of clinical waste
- needle stick incidents
- environmental cleanliness
- standard precautions, including hand washing
- Reference to lone worker policy especially for Domiciliary visits

1.5 Through local monitoring processes practices will:

- undertake mandatory surveillance of Healthcare Associated Infection (HCAI) organisms monitoring including Post Infection Review (PIR) within two weeks as per Public Health England guidelines where required for Clostridioides difficile, multi resistant gram-negative bloodstream infections, Meticillin-resistant Staphylococcus aureus and Meticillin- sensitive Staphylococcus aureus. PIRs shall be submitted to somicb.infectionpreventioncontrolteam@nhs.net
- demonstrate the competency of the designated practice IP&C Lead in accordance with RCN, NHS E&I IP&C Link/Champion guidelines and Infection Prevention Society Competency Framework. Guidelines can be found in the following links: Coronavirus » Every action counts (england.nhs.uk) and IPS Competencies Framework - https://www.ips.uk.net/ctool/background.php?t=SVE2TTlpcVJYclBpMU1POTBPeTljdz09 The Role of the Link Nurse in Infection Prevention and Control | Royal College of Nursing (rcn.org.uk) and
- attend ICB IP&C meetings by the practices designated IP&C lead or representative at required intervals.

Safeguarding

1.6 All staff working in this service area will be trained and competent in safeguarding children and adults as outlined in the Intercollegiate Guidance:

- **Children:** https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies
- **Looked After children:** https://www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge__skills_and_competence_of_healthcare_staff.pdf
- **Adults:** https://www.rcn.org.uk/professional-development/publications/pub-007069

In addition, all Providers will ensure compliance with Somerset ICB safeguarding adult and children procedures.

Significant/Adverse Events

1.7 The following section is applicable only to services relating to the care of patients referred to in who require anticoagulation and enhanced drug monitoring, and where the practice has agreed, all other enhanced services now included within this service offer.

1.8 The Department of Health emphasises 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.

1.9 The Provider should be aware of (and use as appropriate) the various reporting systems such as:

- The National Reporting and Learning System (NRLS). Reports to NRLS can be submitted electronically via the General Practice Patient Safely Incident Report Form, or the national GP e-form. If using the GP e-form please check the box to share your report with Somerset ICB.
- Learn from patient safety events (LFPSE). Record positive and negative patient safety events with the Learn from Patient Safety Events service.
- the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices, and
- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

1.10 In addition to their statutory obligations, the Provider will notify the Commissioner, and CQC, within 72 hours of being aware of the hospital admission or death of a patient, being treated by the Provider under the services listed in 1.7, where such admission or death, is or may be due to, the Providers treatment of the relevant underlying medical condition covered by the services listed in 1.7 via the email address below.

1.11 In addition to any regulatory requirements the ICB wishes the Provider to use a Significant Event Audit system (agreed with the Integrated Care Board) to facilitate the dissemination of learning, minimising risk and improving patient care and safety. Providers shall:

- Report all significant events relating to the services listed in 1.7 to the ICB within 2 working days of being brought to the attention of the Provider via somicb.significantevents@nhs.net
- Undertake a significant event audit (SEA) using a tool approved by the ICB and forward the completed SEA report to the ICB within one month of the event via https://nhssomerset.nhs.uk/for-clinicians/general-practice-significant-event-sea-and-serious-incident-support/

Consent

1.12 The following section is applicable only to services relating to the care of patients who require anticoagulation and enhanced drug monitoring, and where the practice has

agreed, all other enhanced services now included within this service offer.

1.13 In line with current national guidance, in each case the patient should be fully informed of the treatment options, risks and the treatment proposed by a person with the necessary knowledge and understanding of the care and treatment so that they can answer any questions about it. National guidelines suggest that written consent should be obtained from patients in certain circumstances or procedures that are deemed appropriate by the individual clinician. This should then be recorded with the relevant SNOMED code. If Providers have a specific query with regard to consent further guidance can be sought from the Somerset ICB Caldicott Guardian.

All Practices Provide:

2. Anti-Coagulation Initiation, Stabilisation and Monitoring

Anticoagulation therapy is required for people with a range of conditions, who are diagnosed in a range of settings. Atrial Fibrillation is the most common condition requiring anticoagulation and affects up to 2% of the population. Other conditions in which patients require anticoagulation therapy include Venous Thromboembolism (VTE), Deep Vein Thrombosis (DVT) and other disorders requiring cardioversion

This service provides for the safe monitoring of patients prescribed vitamin K antagonist oral anticoagulants such as Warfarin.

It also provides for the initiation and stabilisation of patients for Atrial Fibrillation and Venous Thromboembolism:

Initiation, Stabilisation	**Monitoring**
Atrial Fibrillation (AF)	Atrial Fibrillation (AF)
Venous Thromboembolism (VTE)	Venous Thromboembolism (VTE)
	Prosthetic Hearth Valves
	Cardiomyopathy
	Recurrent transient ischaemic attack
	Chronic rheumatic heart disease
	Antiphospholipid syndrome

This specification also supports additional monitoring requirements for patients prescribed a vitamin K antagonist pre and post operatively and pre and post cardioversion. Patients from out of area may be managed within this service. It is recommended that patients requiring more than one Point of Care Test (POCT) should be monitored using the Provider's Clinical Decision Support Software (CDSS).

The service shall be provided in normal surgery hours.

The Provider shall ensure that the Anti-Coagulation Initiation, Stabilisation and Monitoring Service (referred to as 'the Service' hereafter), includes:

- the initiation, stabilisation and monitoring of patients, by the Provider, undertaken in accordance with the latest guidance including that produced by the British Committee for Standards in Hematology and a practice Standard Operating Procedure (SOP)
- blood sampling (Capillary and Venous – as appropriate), testing and determining the INR
- anticoagulant dosing with prescribing in accordance with the latest guidance issued by the British Committee for Standards in Hematology and relevant AF National Institute for Clinical Excellence (NICE) guidance
- the minimisation of potential side effects of warfarin by utilizing regular monitoring to stabilise the International Normalised Ratio (INR) levels of patients while continuing to maximise the effective benefits of such treatment

- the maintenance of monitoring of patients within agreed levels, including Time in Therapeutic Range (TTR) – see 'Monitoring Requirements'
- regular review of the requirement for continuation of therapy
- discontinuation of therapy when appropriate, e.g. when changed to an alternative treatment such as Novel Oral Anticoagulants

Domiciliary visits to housebound patients who require anti-coagulation monitoring may be undertaken by others, on behalf of the Provider, for the purpose of blood sampling, testing and determining the INR. The Provider will be responsible for the subsequent dosing and prescribing. This also applies to patients in nursing and residential care homes.

The Provider shall nominate a GP as the clinical lead who will ensure that the service within the Practice is established in accordance with this specification and national guidance and recommendations. The name of the GP lead will be advised to the Commissioner.

Lines of accountability shall be clearly written into practice Standard Operating Procedures which shall cover but may not be limited to the following areas:

- initiation and stabilisation
- training / education for POCT and use of CDSS
- use of POCT equipment
- health and safety
- quality assurance
- maintenance
- accreditation
- record keeping
- audit
- adverse incident reporting

The Provider is clinically responsible for all patients, where accepted under their care, for anticoagulation initiation, stabilisation and monitoring. The Provider must ensure that explicit contingency plans are in place to cover absence for annual leave and sickness leave for both the running of clinics, supervision of staff and for advice to patients who have queries or problems.

The Provider shall deliver the service in accordance with the following criteria:

- Anticoagulation clinics will be held at least weekly or, have available appointments and domiciliary visits each week for a period sufficient to accommodate the number of patients requiring anticoagulation monitoring, in a timely manner.
- The management of clinics and appointments adheres to current and future guidance and recommendations.
- The Provider may agree not to provide a POCT service to housebound patients and opt into an alternative provision as arranged by the ICB. This alternative service does not include provision to patients in Nursing Homes.
- If a Nursing Home carries out a PoCT for anti-coagulation monitoring and reports the result to the General Practice responsible for the patients' dosage, the Provider of this service will:
    - Retain the clinical and medico-egal responsibility of PoCT
    - Receive assurance that the nursing home regime for PoCT meets the required clinical standards, especially in relation to staff competences, initial and external quality control.
- If an alternative provider undertakes INR testing on behalf of the commissioned provider, the commissioned provider must agree a protocol for the transfer of information using the standard template.
- A person with AF identified as requiring anticoagulation therapy shall be initiated as clinically appropriate and as soon as possible.
- An initial diagnosis and at least annually, an appropriate review of the registered patients health is carried out including checks for potential complications and as

necessary a review of the registered patients own monitoring records. This should include assessment of the patient's risk of major bleeding in the people who are starting or who have started anticoagulation therapy

- The use of clinical decision support system software and any in house POCT testing equipment must meet the standards set by the medicine and healthcare products regulatory agency.
- For the purpose of this service stable is define as three consecutive INR results in target range.
- Offer and provide education to all patients in understanding their treatment in terms of their condition requiring warfarin, target range for INR, the effects of under/over anticoagulation, diet, lifestyle and drug interactions, where a patent has been initiated on a vitamin K antagonist by secondary care and discharged for ongoing monitoring with the service, it is the hospital responsibility to provide the patient with relevant information and education before discharge. The provider should be assured this has been undertaken.
- All patients (and/or their carers and support staff when appropriate) should receive advice on the appropriate management and prevention of complications for their condition; including the provision of patient held booklets.
- The provider will prepare individual management plans with patients which give diagnosis planned duration and target range to be maintained during therapy. This shall be record in the patient held record.
- Where the patient is under the care of a hospital then the provider must ensure it adheres to any agreed local protocol that exists between the provider and the hospital.
- Ensure that systematic call and recall of registered patient on the register takes place as detailed in the guidance by British committee of standard in hematology.
- Practices should take reasonable steps to contact patients who fail to attend a clinic or appointment. The provider should monitor regular non-attendance of patients and take reasonable steps to ensure that regular testing takes place and to assess and risk over anti-coagulation. Where, in such circumstances, the provider is considering discontinuation of treatment, it may be beneficial to seek advice.
- If a patient required vitamin K for over anticoagulation this should be arranged by discussion with a suitable clinician in the appropriate hematology department. The practice should also complete a report via medications incident reporting system.
- In the event of failure of the blood testing equipment for a period longer than 24 hours the Provider will liaise with the equipment provider to determine whether replacement equipment can be obtained. Should this not be feasible, then the Provider will:
    - utilise the services of an alternative Somerset provider of this service or
    - take a venous blood sample and send it for INR analysis inform the ICB within 48 hours of the action and the date when normal service will resume.
- In the event of failure of CDSS software for a period of longer than 48 hours, the provider will:
    - Utilise the services of an alternative Somerset provider of this service or
    - take a venous blood sample and send it for INR analysis
    - inform their Commissioner at ICB within 48 hours of the action and the date when the Service will resume. The provider may continue to use the blood testing equipment during the initial 48 hour period where in the opinion of the practitioner patient safety may be compromised by the complete withdrawal of the service.
- All patients receiving anticoagulation therapy should be reviewed at least once a year, including but not necessarily limited to the following:
    - Reassessment of stroke or VTE risk
    - Reassessment of bleeding risk (the HAS-BLED score is recommended by NICE
    - Assessment of renal function with U&Es and FBC tests to ensure there is a record of measurement of renal failure (egfr) and any signs of anaemia
    - Incidence of adverse events relating to anticoagulation therapy since last review
    - Assessment of compliance against the patients TTR

It is recognised that patients requiring cardioversion or other similar future interventions and those requiring elective surgery may require additional monitoring as advised by secondary care, pre and post operatively. Patients undergoing cardioversion may require more intensive monitoring before and after a procedure and in accordance with a protocol agreed with the patient's Cardiologist.

The patient should be fully informed of the treatment options, risk and the treatment being proposed, consented and willing to participate.

People prescribed anticoagulation therapy should be involved in the decisions about their ongoing medication and given high-quality information about anticoagulants to enable them to make fully informed decisions regarding their ongoing care.

Practices should encourage, consider and report any patient feedback (positive and negative) on the service that they provide and use it to improve the care provided to patients, particularly if there are plans to alter the way a service is delivered or accessed.

The Provider shall ensure that each member of staff undertaking Point of Care Testing has received appropriate training approved by the ICB. It is an expectation that all staff undertaking POCT should review their training competency every 2 years (24 months) to ensure they remain compliant.

At the end of every 24 month period following initial accreditation all staff providing the POCT service should undertake the following questionnaire;
https://www.surveymonkey.co.uk/r/N83JPCC

It is the responsibility of the provider to ensure this self-assessment questionnaire is undertaken and an appropriate process should be implemented in all providers to monitor clinician training accreditation and expiry.

This questionnaire will determine whether or not that at the end of every 24 month period each person delivering the POCT service needs to attend the appropriate training course provided by South-West Pathology Services (SPS) on behalf of Somerset ICB.
There are a number of important caveats to the self-assessment training questionnaire that overrule it being deemed not necessary for a clinician to attend the training course, these are as follows;

- Any new starters at a provider organisation MUST undertake the training provided by SPS and cannot be trained by an existing member of staff to ensure compliance.
- If there are any significant changes to the training course provided by SPS (clinical processes/governance) will waiver the right for clinicians to complete the self-assessment questionnaire and will automatically require them to undertake the training at their next expiry interval. SPS are required to inform Somerset ICB of any significant changes to this effect.

The Lead GP shall ensure that all staff involved in providing this service shall have their role and competencies reviewed as part of the annual appraisal process to identify any further training needs. If, by exception, staff have not attended the approved training the GP Lead shall be able to evidence that the individual is suitably qualified to conduct POCT.
Appropriate training is summarised below:

- By providing this service the Lead GP confirms he/she has the knowledge and experience or mentoring support in place to undertake this Service.
- Nurses and other non-prescribing clinical staff will attend the approved courses provided by or, on behalf of the ICB or, by exception, have demonstrated that they have the knowledge and experience to undertake this Service.

Training shall include but not necessarily be limited to:

- Sample requirement and specimen collection
- Sample preparation

- Stability of sample and reagents
- Analysis measurement
- Maintenance, calibration and cleaning of instrument
- Appropriate use of equipment and consequences of inappropriate use
- Reporting results
- Knowledge of normal and abnormal results in the event of an abnormal results
- Performance of quality control
- Documentation of test and quality control results
- Health and safety
- Determining the INR
- Patient education
- Drug interactions with Vit K antagonists

All members of the Provider team conducting POCT will have completed the appropriate training from the manufacturer or supplier of their chosen testing equipment and Clinical Decision Support Software (CDSS) (this may take the form of an E-training module) or, receive training from a clinician who has previously undertaken training from the manufacturer or supplier.

The ICB will require evidence of the training completed including equipment via somicb.generalpractice@nhs.net and equipment cascade training to be available.

Providers should ensure that they are familiar with current national guidance on workforce competencies.

The Provider will be familiar with the MHRA Patient Safety Alert 'Improving medical device incident reporting and learning.

The Provider will ensure that when undertaking point of care testing in the surgery or clinic, it uses appropriate CDSS in order to maintain the INR levels within the therapeutic range, extend the time between INR tests and effectively manage anticoagulation records facilitating service audit. Each patient will receive printed information from the clinical decision support system software or, written information confirming their INR reading and dosage before leaving the surgery or clinic.

The Provider will ensure that when undertaking point of care testing during a domiciliary visit or, if an alternative provider undertakes the testing on behalf of the commissioned provider, the results should be recorded in the patient's handheld record at the time of testing. This should subsequently be recorded using the clinical decision support system software within (24) hours of the test in order, to verify the dosage and maintain up to date patient records. If the clinical decision support system software recommends any changes in dosing this should be notified to the patient before the next dose of oral treatment is due.

The Provider will ensure that in the event of the failure of the blood testing equipment for more than 24 hours, the Provider will liaise with the equipment provider to determine whether replacement equipment can be obtained. Should this not be feasible, then the Provider will:

- utilise the services of an alternative Somerset provider of this service or,
- take a venous blood sample and send it for INR analysis inform the ICB within 48 hours of the action and the date when normal service will resume.

The Provider will ensure that in the event of failure of the clinical decision support system software the Provider will, within 48 hours either rectify the fault, or

- utilise the services of an alternative Somerset provider of this service or,
- take a venous blood sample and send it for INR analysis
- inform their Commissioner at ICB within 48 hours of the action and the date when the Service will resume. The provider may continue to use the blood testing equipment during the initial 48 hour period where in the opinion of the practitioner patient safety

may be compromised by the complete withdrawal of the service.

Patient information received at the Practice following discharge from hospital, concerning vitamin K antagonist dosing, should be reviewed, and acted upon in a timely manner.

In the event of a patient requiring vitamin K for over anticoagulation, this should be reported as an incident.

Quality assurance must be carried out in accordance with recommendations of the British Committee for Standards in Hematology.

Internal quality assurance checks and the cleaning of equipment must be carried in accordance with the manufacturers' instructions on each day that the equipment is used prior to their use on that day.

Strips and reagents must be stored in accordance with manufacturer's guidance. If refrigeration is required, the reagents or strips stored must have temperature checks recorded on each working day.

External quality assurance checks must be conducted every two months to verify the accuracy of blood testing machinery and dosing. The Provider will need to be registered with an approved External Quality Assurance organisation that provides testing samples for the blood testing of equipment used.

Any External Quality Assurance organisation used to test blood as part of the Anti-Coagulation Monitoring Service has established quality assurance schemes in place and is accredited by Clinical Pathology Accreditation (UK) Ltd.

A Standard Operating Procedure is in in place which meets the requirements of the MHRA guidance document Management and Use of IVD Point of Care Test Devices.

Providers must have infection control policies that are compliant with national guidelines and current handling protocols, including but not limited to The Health and Social Care Act 2008 Hygiene Code and which takes into account:

- disposal of clinical waste
- needle stick incidents
- environmental cleanliness
- standard precautions, including hand washing
- reference to lone worker policy especially for domiciliary visits
- Providers must ensure that all staff undertaking point of care testing have an up to date Hepatitis B vaccination.

The Provider shall carry out continuous monitoring of patients against the safety indicators for anticoagulation services developed by the National Patient Safety Agency (NPSA) and the British Committee for Standards in Hematology and have processes in place to respond to any trends/issues identified.

Overall patient results against the selected NPSA indicators in Table 1, will be reported to the Support Service commissioned by the ICB* at the end of each quarter. The months for submission are therefore July; October; January; and April (Note: Data collection will be undertaken remotely by the Support Service and shared with the Commissioner as soon as possible).

*Presently provided by Somerset Pathology Services which currently also manages the External Quality Control process provided by WEQAS (Wales External Quality Assessment Scheme) and provides regular training workshops.

Practices shall aim to achieve the key performance indicators as set out in Table 1 below. Where there is a trend or significant variance from a KPI, the commissioner may require the

Provider to share its remedial action plan.

Table 1: Safety Indicators for patients Prescribed Oral Vit K Antagonists for anticoagulation treatment.

	Reporting Requirements	KPI standard
New Patients		
1	Patients must follow an agreed initiation including protocol	95%
2	All incidences f patients suffering major bleeds in the first month of therapy are reported by the SEA reporting system	95%
3	Percentage of patients issues with patient held information and written dosage instructions at start of therapy	95%
		Established Patients
4	Percentage of patients developing INR ≥ 5.0.	<5%
5	Percentage of patients developing INRs ≥ 8.0.	<0.5%
6	Percentage of patient time in therapeutic range (if this is not measurable because of inadequate decision/support software then secondary measure of percentage of INRs in range should be used).	≥65%
7	Percentage of INRs > 1.0 INR unit below target (e.g. percentage of INRs < 1.5 for patients with target INR of 2.5).	<5%
8	Percentage of patients with unknown stop date, where relevant.	<5%

The Provider shall conduct an annual review of the Service in order to inform best practice and assist in the identification of training requirements. The review shall include:

- The name of the GP Lead
- Annual performance against the safety indicators as detailed at Table 1, together with any action taken where there a trend or significant variance from a KPI has been identified.
- Information on the number of patients being monitored, the indications of anticoagulation, e.g. DVT etc., and the duration of treatment
- Information on the number/percentage of patients with appropriate clinical information
- e.g. diagnosis, target INR and last dosing record
- Details of any computer-assisted decision-making equipment used and arrangements for internal and external quality assurance
- Details of training and education relevant to (including undertaking the self-assessment questionnaire) the Service received by practitioners and staff, to provide assurance that all healthcare professionals undertaking Point of Care Testing, have the appropriate competencies; and
- Confirmation that the Practice Standard Operating Procedures are valid, and up to date
- Percentage of patients suffering adverse outcomes categorised by type, such as a major bleed.
- A review of significant events and practice reporting

Activity data shall be submitted to the Commissioner quarterly using the monitoring template provided and submitted by the 10th working day of the following month after the end of a quarter. The months for submission are therefore July; October; January; and April.

The Provider will ensure that the following data is collected and recorded for all patients for the Service:

- An up-to-date register of all registered patients using the Service, indicating patient name, date of birth, and the indication and length of treatment, including the target International Normalised Ratio: blood test result (INR) as recommended by the British Committee for Standards in Hematology and National Patient Safety Agency;

- Adequate records of Vitamin K administration, including relevant known information, as appropriate, including for example, the number of bleeding episodes requiring hospital admission and deaths related to the prescribing of anti-coagulants;
- Maintaining records of and acting upon the outcomes of the quality assurance tests completed, for internal quality control each day POCT equipment is used and for external quality control, 2 monthly.

All clinical information is recorded in the registered patient's own GP held lifelong record, including the completion of the record that the registered patient is on anticoagulation treatment, the drugs used and the level and duration of dosage. Where a patient ceases to be on anticoagulation treatment then the patient record should be duly updated and in the event of an adverse incident all relevant information must be recorded.

Patients must be prescribed a vitamin K antagonist oral anticoagulant, be aged 18 and over and be:

- a registered patient with the Provider
- a registered patient of any Somerset GP practice which has sub-contracted the service by the Provider
- a patient from out of area, by exception

The following patient groups are excluded from this service:

- people who are self-testing and self-monitoring their INR.
- people who are under 18 years of age

This service will be provided as part of an integrated model of care with community care, Out of Hours, Ambulatory Care Clinics and secondary care to ensure patients receive joined up care.

In particular, where other Providers undertake POCT on behalf of the Service Provider, it is essential that a robust form of communication is used between the 2 parties. The example template (follows) was developed by Somerset Foundation Trust (SFT) for the transfer of information between District Nurses and GPs.

Anticoagulation POCT Report Form

COMMUNITY NURSE/HEALTHCARE ASSISTANT TO COMPLETE

PATIENTS NAME:	
DATE OF BIRTH:	NHS No:
ADDRESS:	GP:
	NAME OF SURGERY:
TELEPHONE:	
ALTERNATIVE CONTACT:	
NAME:	TELEPHONE:
TELEPHONE:	

PLEASE COMPLETE BEFORE TEST

How have you been since last test e.g. abnormal bleeding, bruising (If yes please state)	
Have there been any changes in medication (stopping or starting) including over the counter medicines and alternative remedies? (if yes please state)	
What dose of warfarin have you been taking?	
Have you missed or forgotten your warfarin? (Please give details)	

TEST RESULTS

Name of person doing test:			
Date of Test:	Result of Test:	Result of Retest (if abnormal result)	Venous Test YES/NO (delete)
	Strip Code No.		
	Strip Date	**TEST RESULT ENTERED IN PT'S HAND HELD RECORD**	

DOCTOR/PRACTICE NURSE TO COMPLETE **FAX TO: **** ********

Date/Time Result Seen:	New Dose:	Date of Retest:
Date and Time pt contacted:	By Whom:	

COMMUNITY NURSE/HEALTHCARE ASSISTANT TO COMPLETE

District Nurse Federation / HUB:

3. Enhanced Drug Monitoring

The treatment of several diseases within the fields of medicine, such as rheumatology and atrial fibrillation, are increasingly reliant on drugs that, while clinically effective, need regular blood monitoring. This is due to the potentially serious side-effects that these drugs can occasionally cause. It has been shown that the incidence of side-effects can be reduced significantly if this monitoring is carried out in a well organised way, close to the Service User's home.

The British Society of Rheumatologists has revised its guidance for the monitoring of immunomodulatory therapies to standardise and simplify the monitoring for these drugs. Appendix 1 in this specification provides the individual drug monitoring requirements which are being commissioned. It also includes guidance on the drug monitoring requirement for Dronedarone, used to prevent recurrence of atrial fibrillation, or to lower ventricular rate.

Providers should note that the individual drugs Summary of Product Characteristics (SPC) may specify more intense drug monitoring than this enhanced service specification. The level of monitoring commissioned has been set upon what is deemed safe and practical for the overwhelming majority of Service Users prescribed one of the drugs specified.

Prescribers are recommended to take into account the individual Service Users co-morbidities and co-prescribed medication when deciding whether to monitor Service Users more frequently than set out in the enhanced service. Consideration should be given to increased monitoring in Service Users newly initiated, after a dose increase, with impaired renal function or on combinations of two drugs in the enhanced service or another drug likely to increase the need for monitoring.

The Enhanced Drug Monitoring Service is designed to be one in which:

- therapy is only started for recognised indications and for specified lengths of time
- maintenance of Service Users who have not first been stabilised in the secondary care setting can be undertaken safely in primary care with a shared care approach between consultant and GP.
- the service to the Service User is convenient
- the need for continuation of therapy is reviewed regularly
- the therapy is discontinued when appropriate, including discussing any reported side-effects with the relevant secondary care department (e.g. rheumatology) if necessary
- any necessary monitoring is undertaken as commissioned, the GP gives due consideration to additional monitoring if recommended by the secondary care consultant or is clinically indicated, and
- the use of resources by the National Health Service is efficient

The Enhanced Drug Monitoring service includes the provision/non provision of the following drugs:

Included	**Not included**
Immunomodulatory Therapies such as:	*Monitoring of drugs not listed to the left, such as:*
Sulfasalazine	Chlorambucil
Azathioprine	Ciclosporin
Penicillamine	Etanercept
Leflunomide	Infliximab
Oral Methotrexate	Other biological drugs
Sodium Aurothiomalate (Myocrisin)	
Hydroxychloroquine	
Mercaptopurine	
Other Drugs such as:	
Dronedarone	

The Provider shall ensure that the Enhanced Drug Monitoring Service includes but is not limited to:

- ensuring that all newly diagnosed Service Users (and/or their carers and support staff when appropriate) receive appropriate education and advice on management, and prevention of, secondary complications of their condition, including the provision of written information
- ensuring that the systematic call and recall of Service Users is taking place
- ensuring that all Service Users (and/or their carers and support staff when appropriate) are informed of how to access appropriate and relevant information
- preparing an individual management plan with the Service User, which gives the diagnosis, planned duration, the monitoring timetable and, if appropriate, the therapeutic range to be obtained
- referring Service Users promptly to other necessary services and to the relevant support agencies, when clinically appropriate, using locally agreed shared care guidelines, link provided in above, where these exist and in line with any Summary of Product Characteristics datasheets available at www.medicines.org.uk
- working with other professionals when appropriate (Including but not limited to secondary care)
- developing and maintaining an up-to-date register of all Service Users, indicating Service User name, date of birth, the indication for treatment, duration of treatment and last hospital appointment
- maintaining adequate records of the performance and results, incorporating appropriate known information. This shall include all known information relating to any significant events e.g. hospital admissions and death of which the provider has been notified.
- Community nursing services staff are only able to take samples for those housebound Service Users already on their caseload.
- Any blood tests results obtained under this specification must be added to the patient practice record

Revised guidance around the monitoring immunomodulatory therapies to standardise and simplify the monitoring for these drugs. Please follow the below link for the individual drug monitoring requirements which are being commissioned. Practices will be required to follow the guidance for Immunomodulatory therapies in rheumatology/gastroenterology and dermatology conditions -DMARDS and Dronedarone. https://nhssomerset.nhs.uk/prescribing-and-medicines-management/shared-care/

Practitioners delivering the service are aware and have access to copies of the latest shared care protocols. A link to the protocols is above.

The Provider shall confirm quarterly that:

- Rheumatology and Dermatology patients starting treatment or after dose increase should receive FBC, Creatinine, LFT and Albumin tests/monitoring:

    - Every 2 weeks until stable for 6 weeks then every month for 3 months.

- Gastroenterology patients starting treatment or after dose increase should receive FBC, Creatinine, LFT and Albumin tests/monitoring:
    - Every 2 weeks until stable for 8 weeks, repeat again in another 4 weeks then maintenance monitoring every 12 weeks.

Practices will confirm the number of patients and test conducted for each via CQRS Local on an annual basis.

The ICB may check this information against the data on Eclipse to ensure safety of service delivery. Should there be any variation, the ICB may ask for further information, as the ICB are aware that patients may be monitored elsewhere, or not agreed to their data being shared. If the practice is aware of this, practices should include this detail in their return.

Practices will confirm through data, that all patients have been monitored as per the specification.

The service should not be offered to patients whose care is not suitable for Primary Care management.

Practices continue to provide where already commissioned to do so as at end 31 March 2024:

4. Diabetes Insulin Initiation

The model of care for adult patients with diabetes, aims to increase the capacity of the healthcare system as a whole to meet the needs of growing numbers of people with diabetes, with care provided in the right place at the right time and with the right amount of expertise.

The service offers General Practices to enhance the level of care they provide to their patients with type 2 diabetes within primary care. Patients should be offered the choice of being referred to an Insulin Initiation Service delivered by their practice, where this is available, or by the Diabetes Intermediate Care.

Contribute to the achievement of the targets for the Somerset ICB area as a whole set out in the performance framework for the model of care by:

- providing additional resources to practices to enable them to start their patients on insulin thereby enabling patients the option of having more of their diabetes care in the practice setting
- contributing to the achievement of targets for improved glycaemic control

Practices are required to satisfy the following criteria:

- hold a GMS/PMS contract
- have a minimum of 2 healthcare professionals (GP and Practice Nurse) trained and accredited to provide the service
- participating in the National Diabetes Audit
  agree to participate in Somerset training programmes on diabetes care once

Healthcare professionals will be required to be familiar with the wider care pathways for patients with diabetes and to work cooperatively with the Somerset Specialist Nursing and Dietetics Service.

An accredited practice healthcare professional will carry out the following:

- assessment of patient suitability for insulin initiation in accordance with best practice
- referral to the Somerset Specialist Nursing and Dietetics Service for dietetic assessment at a level as provided by a specialist diabetes dietician
- consideration of other alternative treatments to improve glycaemic control, such as lifestyle and other medication
- initiation and ongoing adjustment of insulin
- educating patient and carers on self-management and self-adjustment of insulin doses
- providing lifestyle modification and weight management advise
- providing social and psychological support
- providing in hour advice and support for patients as required
- keep appropriate records
- liaising with diabetes specialist nurse service for advice in the event of difficulties in glycaemic control

the service will be provided to patient with Type 2 diabetes who satisfy the following criteria:

- are not achieving HbA1c targets with maximum tolerated oral combination therapy
- do not have other reasons for requiring hospital assessment
- are over the age of 18 years
- are not pregnant

- the patient or carer is deemed capable of safely managing their insulin, including being able to undertake home blood glucose monitoring, inject insulin and adjust their own dose
- express an intention to start insulin, having been advised of what this involved an risks associated with the treatment and being aware of the choice of provider available
- have received a specialist dietic assessment, education and lifestyle advise prior to insulin initiation

If the insulin initiation does not result in adequate glycaemic control the patient may need onward referral to the Somerset specialist nursing and dietetics service.

The practice should meet the somerset specialist nursing and dietetics service clinical lead mid-year to review the patients performance and address any issues such as further training.

The service will be delivered in accordance with the national service framework delivery strategy for diabetes and the NICE guidance on Type 2 diabetes.

Practices must keep accurate and comprehensive records for all their patients started on insulin, including:

- service username
- general practitioner
- service suer NHS number
- service user date of birth
- ethnicity
- HbA1c level prior to insulin treatment and approximately at 3/6/12 months following initiation
- Details of adverse events associated with treatment
- Where treatment provided
- Details of any onwards referral to somerset specialist nursing and dietetics service/ specialist level 3 services
- Diabetes medication
- Agreed care plans

To be eligible to deliver the Service Practices must have a minimum of two health care professionals (GP and Practice Nurse) who are accredited to provide insulin initiation to the practice's patients, having successfully completed a Meeting Educational Requirements, Improving Treatment (MERIT) course in insulin initiation, or equivalent (as agreed with the clinical lead for the level 2 service), and having been assessed by the Somerset Specialist Nursing and Dietetics Service as competent to deliver the service. The MERIT courses are based on the Skills for Health Competency Framework and lasts for 3 days. There is no charge to practices for this course.

Assessment for accreditation will take the form of 'observed practice' based on a competency framework with a Diabetes Specialist Nurse which will take place for the first five initiations or until the Diabetes Specialist Nurse is assured that the practitioner is delivering the appropriate standard of care.

Renewal of the service will be subject to evidence of relevant continuing professional development (MERIT update – 1 day per annum or equivalent) and maintenance of a satisfactory standard of service delivery as assessed by the Diabetes Specialist Nursing and Dietetics Service.

Participating practices will be required to conduct an annual review which should include as a minimum an audit of:

- patients continuing on insulin at six months from initiation
- the % patients at different levels of HbA1C (7 or less, 8 or less and or less)

The audit will be made available at the request of the commissioner.

4. Minor Injuries

This service will be commissioned in the context of reforming emergency care services and reducing pressure on Accident and Emergency departments. For the majority of areas minor injuries services are provided from Minor Injury Units (MIUs) at Community Hospitals.

Injuries and wounds over 48 hours old should usually be dealt with through normal primary care services as should any lesion of a non-traumatic origin. By definition such cases are usually the self-presenting "walking wounded" and ambulance cases are not usually accepted except by individual prior agreement between the doctor and the attending ambulance personnel. Patients treated under this service would generally be those that would be referred to another provider in the absence of this service.

This enhanced service will include:

- initial triage including immediately necessary clinical action to staunch haemorrhage and prevent further exacerbation of the injury
- history taking, relevant clinical examination, documentation
- wound assessment to ascertain suitability for locally based treatment and immediate wound dressing and toilet where indicated
- appropriate and timely referral and/or follow up arrangements. This should include advice on prevention including referral to falls service where appropriate
- adequate facilities including premises and equipment, as are necessary to enable the proper provision of minor injury services including facilities for cardiopulmonary resuscitation
- registered nurses to provide care and support to patients undergoing minor injury services
- maintenance of infection control standards, to include use of single use instruments where the skin has been broken
- transmission of all tissue removed by minor surgery for histological examination where appropriate
- maintenance of records of all procedures
- audit at regular intervals
- any complications arising from any procedure should be recorded
- other topics for audit include clinical outcomes, rates of infection, patient satisfaction and unexpected or incomplete excision of basal cell tumours or malignant pigmented lesions. This should be completed in addition to the Minor Surgery enhanced service audit where that service is provided
- child protection - in any suspected case of non-accidental injury in a child the Somerset Safeguarding Children's Board guidance should be followed.

Included	**Not Included** **(Patients should be referred onto the appropriate destination)**
lacerations capable of closure by simple techniques (stripping, gluing, suturing)	Any patient presenting with a wound or injury over 48 hours old should be treated as part of routine primary medical services.
minor dislocations of phalanges	999 call (unless attending crew speak directly to the doctor)
removal of foreign bodies from ears, noses etc. (see exclusions below)	any patient who cannot be discharged home after treatment
non-penetrating superficial ocular foreign bodies	actual or suspected overdose
following blows to the head where there has been no loss of consciousness	any patient with airway, breathing, circulatory or neurological compromise (unless known to the practice and management plan in place)
recent (under 48 hours) minor eye injury	penetrating eye injury
partial thickness thermal burns or scalds involving broken skin	blows to the head with loss of consciousness or extremes of age

not over 1 inch diameter	sudden collapse or fall in a public place
not involving the hands, feet, face, neck, genital areas	accidental ingestion, poisoning, fume or smoke inhalation
foreign bodies superficially embedded in tissues	full thickness burns
minor trauma to hands, limbs or feet where it is suspected that there is a strain or sprain	chemical, biological, or radioactive contamination injured patients
	burns caused by electric shock
	partial thickness burns over 3cm diameter or involving: o injuries to organs of special sense o injuries to the face, neck, hands, feet or genitalia
	new or unexpected bleeding from any body orifice if profuse
	foreign bodies impacted in bodily orifices, especially in children
	foreign bodies deeply embedded in tissues
	trauma to hands, limbs or feet substantially affecting function
	penetrating injuries to the head, torso, abdomen
	lacerating/penetrating injuries involving nerve, artery or tendon damage

Patients in the following categories are not appropriate for treatment by the Minor Injury Service these should be treated under routine primary medical services:

1. injuries not amenable to simple domestic first aid
2. injuries that have occurred over 48 hours prior to the consultation
3. referrals to other services where appropriate
4. patients requiring immediate and necessary treatment

Providers will have in place processes to ensure that doctors providing minor injury services have:

1. Current minor surgery experience, or
2. Recent accident and emergency experience, or
3. Equivalent training which satisfies relevant appraisal and revalidation procedures
4. Annual basic life support training and be competent in resuscitation and, as for other areas of clinical practice, have responsibility for ensuring that their skills are regularly updated. Evidence of this training and updating will be required as part of the providers annual review process.
5. Demonstrated a continuing sustained level of activity, conduct audit data and take part in appropriate educational activities.

Nurses assisting in providing the service should be appropriately trained and competent taking into consideration their professional accountability and the Nursing and Midwifery Council (NMC) guideline on the scope of professional practice. This will include training associated with anaphylaxis and basic life support as a minimum.

Each consultation should be recorded in the patient's lifelong medical record using the appropriate codes.

Where the patient is known to have attended Accident and Emergency following the minor injury consultation, a record of this should be made – the Provider should determine whether this episode should have been counted as an immediate and necessary treatment rather than a minor injury.

The Provider will make available on request an annual audit which should provide information on case mix, outcome and potentially identifying when there were the highest levels of demand.

Information regarding the number of consultations should be recorded annually via CQRS Local.

Relevant SNOMED Codes:

Consent ID: 198241000000100 Description ID: 298631000000113	Consent for procedure
Consent ID: 184476006 Description ID:284689012	Incision
Consent ID: 184477002 Description ID:284690015	Excision
Consent ID: 265681006 Description ID:394541011	Suturing (head or neck)
Consent ID: 391906003 Description ID:1485896011	Suturing (other site)
Consent ID: 182531007 Description ID:282155011	Dressing
Consent ID: 53570002 Description ID:89069010	Foreign body removal (external eye) / Foreign body removal (eye)
Consent ID: 302421003 Description ID:444094013	Foreign body removal (general)
Consent ID: 125666000 Description ID:473548016	Burns
Use term ‘Sprain’ or ‘strain’	Sprains/strains (location to be noted in text or subset of codes)
1. Consent ID: 7581004 Description ID:13532018 2. Consent ID: 62635000 Description ID:104100012 3. Consent ID: 78598000 Description ID:130427012	Minor eye injury 1. Superficial injury of the conjunctiva 2. Superficial injury of the cornea 3. Superficial injury of the eye
Consent ID: 274164006 Description ID:409932013	Minor head injury
Consent ID: 312608009 Description ID:456360013	Laceration
1. Consent ID: 183444007 Description ID:283512014 2. Consent ID: 84147100000610 Description ID:84147100000611	1 Referral for further care 2 Referral activity

5. Fitting of Ambulatory ECG machines

Ambulatory ECG monitoring is part of the diagnostic process for a number of conditions which commonly present to general practitioners. The purpose is to identify abnormalities of heart rhythm (arrhythmia) with the potential to cause symptoms or harm.

The aim of having an open access ambulatory ECG service is to provide general practitioners with a community based diagnostic service and reduce the need to refer to secondary care cardiology for this diagnostic service as part of an outpatient attendance.

The practice will, working closely with Somerset Foundation Trust (SFT), provide a practice based ambulatory ECG machine fitting service.

The practice will provide a confirmation receipt of the referral form within 24 hours of the referring practice sending the referral or where appropriate, return any incomplete forms. An incomplete form would be any that do not include patient identifiable information or emergency contact numbers. A 12 lead ECG must be done by the referring practice prior to referral.

The patient will be contacted by the practice delivering this service within 7 working days of receipt of the general practitioner referral. The practice should try to call the patient 3 times. Should the practice be unable to contact the patient on the 4th attempt, a message should be left on the answer machine. The patient should be asked to contact the practice to make an appointment within the next 3 days. Should the patient not make contact, this cycle must be followed again. Consent to leave an answer machine message must be obtained from the patient by the referring practice.

Should demand exceed capacity then the fitting practices are not required to contact patients within 7 working days as long as they are providing a minimum of 48 hours of ECG recordings per week.

From initial contact, the patient must then be offered a twenty minute appointment for fitting of the ambulatory ECG machine and patient education/counselling within 8 working days of contacting the patient.

Each device is subject to a maximum of 72 hours per week, and practices are required to provide the level of service that meets the demand.

The patient should be encouraged to self-remove the machine and return to the practice. It is expected that majority of patients will self-remove; however, where this is not appropriate, the patient will be given a ten minute follow up appointment with an HCA for removal of the machine. At all times the practice should put into place systems to ensure that all machines are returned and accounted for. The machines will remain the property of SFT all times. They are responsible for the maintenance and the practice is responsible for arranging the annual service testing with SFT.

The data card will be sent to SFT along with a copy of the referral form within one working day of the monitor being returned to the surgery. Prior to posting, the referral form should be emailed to SFT on clinical.investigations@ydh.nhs.uk. For SFT, a copy of the referral form should be included in with the data card. This will allow all data cards to be accounted for.

SFT will confirm receipt of the reader card via secure electronic mail to the practice within

24 working hours and by return internal post, also within 24 hours, send the practice a replacement blank data card.

If the practice does not receive electronic verification of receipt of the data card within 72 hours of sending the card, then the practice will be required to contact SFT to confirm receipt of the card.

SFT will provide the interpretation of the ECG data and recommendations as to the significance of the findings. A summary report will be emailed to the referring general

practitioner of the practice where the patient is registered, and a full report will be sent by secure email. This report will be sent to the practice within 10 working days of receipt of the data card. There is no requirement on the host practice to receive or communicate the results of the ambulatory ECG unless the patient is also registered at the provider practice.

If there is a requirement for an urgent follow up, SFT will contact the referring GP practice directly.

It is accepted that adherence to the time targets included in this Service Agreement are subject to adequate equipment being available to the practice at any given time. The ICB will continuously monitor the service wait times. Should wait times significantly exceed the expected targets, the ICB will liaise with the practice further to understand how best to provide support.

Ambulatory ECG machines supplied must be in good working order and Providers shall ensure they are appropriately serviced annually by the Medical Electronics Department at Yeovil District Hospital.

The practice will receive referrals from other NHS Somerset ICB GP practices. Referrals must be sent electronically on the specified template.

The criteria for eligible patients are:

- Non-critical symptoms suggestive of paroxysmal arrhythmia not identified by a standard 12 lead ECG and be of sufficient frequency to be picked up in the timeframe of the monitoring
- Over the age of 18
- Be compliant to wear a monitor for the required time-frame
- Be able to travel to the providing practice and return the monitor in a timely way

The practice will identify two healthcare professionals to provide the service. This will allow cover for holidays and sickness absence.

Where it is not possible for both health care professionals to be trained at the same time, it will be acceptable for one to be trained initially on the proviso that a second health care professional receives the training within the following month, on a date to be agreed with SFT.

All practice staff involved in fitting the Ambulatory ECG machines must attend training which will be provided by SFT prior to delivery of the service. Cascade training must not take place within the practice.

The practice staff will be trained in the fitting and removal of machines and the operation of the software.

As part of this agreement, the practice agrees to participate, where required, in any service evaluation or audit of the service and where necessary will provide any reasonable information required to allow that service evaluation or audit to be carried out.

The provider must have processes in place to carry out continuous monitoring of the service and have processes in place to be able to respond to any trends/issues identified.

The practice should provide a quarterly breakdown of the activity undertaken via CQRS local within the reporting timescales. This is to ensure that the ICB are aware of any issues within the service. All columns should be completed. Should the practice be unable to complete any of the information, please detail the reasoning in the comments column.

6. Unscheduled Care Service

The main aims of the service are to:

- Provide an accessible and responsive same day service offering an alternative to Accident and Emergency department (A&E) attendance,
- Provide a multidisciplinary and innovative care service according to patient need,
- To provide an affordable and sustainable same day service,
- Provide a positive patient experience for patients accessing unscheduled care,
- Better understand urgent demand need in primary care by collating data on capacity and demand within primary care from a large single site practice,
- To explore opportunities to improve access to unscheduled care by working creatively and innovatively and to share the learning with the Commissioner.

Patients should be allowed to make the decision of whether their need is urgent rather than relying on triage as experience shows that patients will attend an Emergency Department if they feel their condition is urgent and they are blocked from receiving assessment elsewhere.

The service allows an accurate picture of same day demand in general practice to be established, as all on the day service provision is delivered from a dedicated area by a dedicated team.

The Unscheduled Care service is operational Monday to Friday between 0800-1830, with limited access, based on patient defined need, from 1730-1830 hours to allow 60 minutes for the service to close down.

Patient's attending the Unscheduled Care Service will be seen by a Health Care Assistant and/or a Nurse Prescriber/Practitioner and/or a GP according to need.

Service will be provided according to patient need, that is, telephone access, face to face or home visiting service, where the GP has agreed the request is appropriate and will include urgent testing (blood tests and ECG's).

Patients accessing the Unscheduled Care Service will be:

- assessed within 2 hours if attending the service
- telephoned within 4 hours if requiring a telephone consultation
- be visited at home within 4 hours of the request, where the request is deemed appropriate by the GP

Patients requesting services best delivered elsewhere or attending inappropriately will be informed, educated and sign posted accordingly.

Patients should not attend the unscheduled care service for follow up appointments. Patients who require follow up as a direct result of their attendance in this Service, will be referred back to the practice for an appointment with their usual/registered GP in a priority slot.

Liaison with other care providers (for example Ambulance Services, District Nursing Team, Nursing Homes, Residential Care Homes) in the delivery of integrated care shall be undertaken as appropriate.

Where appropriate, the patient should be fully informed of the treatment options, risk and the treatment being proposed, consented and willing to participate.

The Provider shall undertake continuous monitoring of the Service and have processes in place to respond to any trends/issues identified.

The outcomes/learning from continuous improvement projects will be reported to the Commissioner as soon as possible and at least annually.

Activity will be provided annually, 10 days after the end of the financial year via CQRS Local:

- The number of patients managed in the service, per month

- The number and percentage of patients attending the service who were seen within 2 hours
- The average patient wait for those attending the Service
- The number of visits undertaken per month
- The number of telephone consultations per month

Key Performance Indicator: 95% of patients attending the Service will be seen within two hours

7. Gynaecology Management Service

The aim of this service is to provide a high quality, cost effective enhanced service to women in an environment which is sensitive to their needs, closer to home and will:

- help patients achieve improved quality of life, social function and dignity,
- promote patient's ability and confidence around self-management of gynaecology conditions,
- minimise the need for secondary care services and promote care closer to home for patients,
- minimise waiting times for gynaecological conditions that can be treated in a community setting,
- help work up patients who require advance treatment in secondary care as per National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) Guidelines.

In doing this, the Service will aid with the:

- early identification, investigation, and treatment of gynaecological symptoms,
- safe, clinically effective prescribing of appropriate medications,
- reduction in the number of inappropriate outpatient and inpatient investigations,
- improved patient awareness of their conditions and an increase in self-management,
- improved access to specialist secondary care assessment.

The service enables patients to be managed in practice by the Provider without the need for inappropriate secondary care onward referral.

The key elements of the service will include the assessment, investigation, and management of patients with the following:

- Pelvic floor dysfunction
- Female incontinence
- Heavy/irregular menstrual bleeding
- Non-cancer related post-menopausal bleeding, pre-sterilisation counselling
- Undertaking of pipelle biopsy
- Insertion/extraction of ring pessaries
- Enhanced Provera prescribing
- Enhanced Mirena prescribing and management.

Available to females over the age of 16 registered with the practice.

Patients attend their GP with a gynaecological problem:

- The vast majority of gynaecological problems will be resolved with advice and simple treatment within primary care. A minority may require further investigation such as blood tests, swabs, smears which will be managed within the Service.
- Where the Gynaecology Management Service is unable to manage and treat the patient, the patient will be referred to the patient's choice of secondary care provider.

The patient's GP will refer the patient to the in-house service and the Provider will ensure that the patient is seen in clinic within two weeks of referral.

The Service will be provided by appropriately trained health care professionals.

Appointments will be offered on an ad hoc basis, and the length of appointment will be determined by gynaecological condition.

The Provider will ensure appropriate systems are in place to measure the quality and performance of the service on a continuous basis. Processes should also be in place to monitor, review and implement relevant best practice guidance.

The Provider will also complete an annual audit including, but not limited to:

- Waiting time including number of patients seen > two weeks (target >95% within 2 weeks)
- Number of patients seen by appointment type i.e., ring pessaries/pipelle biopsy, assessment of menstrual disorders and assessment of pelvic floor investigations
- Number and percentage of patients managed within the service without onward referral (target >95% without onward referral)
- Number of patients fitted with contraceptive devices
- Number of any onward referrals and the reason for referral
- Any procedural complications and whether these were preventable (including infection rates).

The annual audit should be made available to the commissioner upon request.

8. Advanced Learning Disabilities

This service is designed to complement the existing comprehensive learning disabilities health check service and provide additional resource and support to the students and carers of Lufton College, a residential learning disabilities and further education establishment.

Work together with the college to provide a specialist health service for students with learning disabilities, helping to increase student independence through addressing their health needs and encouraging and supporting individuals to better manage their health.

Provide the students and their carers with the right information and support to meet their clinical need at the right time and in the right way for the individual student.

Many students have communication difficulties and rely on a number of aids to facilitate communication and also, the support of their care workers. This necessitates a higher level of student/patient engagement by healthcare professionals and in turn appointment times tend to be longer than standard.

Students should feel that they had been listened to, treated with respect and dignity and have positively contributed to their care planning.

Consideration should be given to the student's knowledge and skill to self-manage any conditions identified including their understanding of expected health outcomes.

Available to all students identified with learning disabilities resident at Lufton College and all are invited to register as permanent patients at Penn Hill Surgery.

The service is located at the Penn Hill surgery. Three 30 minute GP appointments are allocated to students of Lufton College per week as well as ad hoc appointments as and when required.

The influenza vaccination programme is held on-campus at Lufton College once per academic year.

Blood conditions monitoring and medication.

- The Provider will ensure that students with conditions requiring blood monitoring and medication are assessed when registering with the GP practice and appropriate care plans are agreed incorporating timings of additional investigations such as annual Thyroid blood tests in Down's Syndrome students.
- The Provider will ensure that all students have their Hepatitis B status assessed when registering with the GP Practice. The Provider will decide on an appropriate course of treatment following this assessment.

Anxiety reduction work/individual coaching

- The Provider will implement a number of techniques to help with developing patient confidence so that blood testing/immunisation may be carried out, for example inviting students to observe a series of appointments (typically three sessions) in the phlebotomy room to help ease anxieties.

Sexual Health and Contraceptive Advice service

- The Provider will provide a full sexual health and contraceptive advice service and will be responsible for assessment of patient capacity before commencing recommended treatment and ongoing compliance with any recommended treatment.

Training support to college

- The Provider will work in partnership with the Lufton College care and management team to identify areas of unmet healthcare need or predicted future need for particular student cohorts. Once needs have been identified, these will be met through provision of a training support package agreed with the college and delivered on-site by a suitably qualified healthcare professional.

Influenza vaccination clinic

- The Provider will run an annual influenza clinic on-campus with the aim of delivering a comprehensive immunisation programme within a familiar setting reducing anxiety and stress for the student cohort attending.

Prescribing and Drugs Management

- Additional support for prescribing and drugs management will be provided for the college and on-site care teams if required.

Transition of care from residential to non-residential

- The Provider will facilitate students remaining resident in the Yeovil locality a transitional health check to help with the adjustment from a residential to community setting. Many students have a significant number of comorbidities and are often in supported.

The Provider will ensure appropriate systems are in place to measure the quality and performance of the service on a continuous basis. Processes should also be in place to monitor, review and implement relevant best practice guidance.

The Provider will also complete an annual audit including, but not limited to:

- Number of students seen
- Type of appointment (i.e., Influenza vaccination, transition appointment, anxiety reduction, coaching)
- Number of training sessions delivered
- Number of students attending influenza vaccination clinic
- Number of students receiving Hepatitis B testing and subsequent vaccination if appropriate

The annual audit should be made available to the commissioner upon request.

Elements previously incentivised through Primary Care Improvement Scheme (PCIS) up to end 31 March 2024

9. Specified Non-Core Contract Work

It is recognised both nationally and locally, that since the introduction of the GMS contract in 2004, there has been an increase in the range of activity that primary care is requested to undertake on behalf of other organisations. This activity includes:

- Blood pressure, pulse and blood test requests (blood test requests should only be performed where the activity was initiated by primary care or as part of an agreed pathway, which includes services commissioned through this specification e.g. pre and post op care)
- Removal of stitches, dressings and wound checks
- Follow-up of patients and ongoing monitoring that has already transferred to primary care
- ECGs

To facilitate effective triage of 2WW referrals, practices shall have processes in place to ensure all essential blood tests are carried out by the next working day following referral or as is appropriate.

Care Pathways

10. The provision of Long-Acting Antipsychotic Injections in adult patients

Patient with a diagnosis of schizophrenia and other psychoses should only be used in patients who are unable to tolerate conventional depot antipsychotics; or as a switch from oral antipsychotics; or who have responded to atypical antipsychotics but who have a history of poor adherence with oral treatment. The service covers those patients suitable for shared care with a long-acting antipsychotic injection have reduced relapse rates through better adherence to treatment (both as a consequence of less side effects and availability as a long-acting injection) to improve clinical outcome and reduce psychiatric re-admission rates.

The purpose of this service is to continue care, closer to home, in primary care for:

- those patients prescribed a long-acting antipsychotic injection with a diagnosis of schizophrenia and other psychoses who have shown either a positive response to oral treatment but for whom concordance with oral therapy is poor or as a switch from one on formulary oral/injectable antipsychotic

- patients who are unable to tolerate conventional depot antipsychotics or who have responded to atypical antipsychotics but who have a history of poor adherence with oral treatment

General Practitioner (GP) providers are required to work with the Psychiatric Service and Community Psychiatric Nurse to ensure the approved shared care agreement is followed (see https://nhssomerset.nhs.uk/prescribing-and-medicines-management/shared-care/).

This enhanced service also intends to ensure that patients receiving a long-acting antipsychotic injection in primary care receive comprehensive care in line with best practice guidance for patients with a mental health condition.

Specifically the enhanced service requires that:

- adherence to and maintenance of infection prevention & control national policy standards, The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance and local Aseptic Non Touch Technique (ANTT) policy (single use equipment where sterile equipment is required

and appropriate environmental decontamination as according to the National Standards of Healthcare Cleanliness 2021).

- each patient receiving a long-acting antipsychotic injection must be on the Provider register of people with schizophrenia, bipolar affective disorder and other psychoses
- the GP provider must have a system to identify and follow up patients who do not attend their appointment for administering a long-acting antipsychotic injection
- each patient receiving a long-acting antipsychotic injection must have a comprehensive care plan documented in their records coving the issues and actions as set out in the current Quality and Outcomes Framework (QOF) guidance for patients on the register of schizophrenia, bipolar affective disorder and other psychoses
- each patient receiving a long-acting antipsychotic injection must receive a minimum level two medication review at least annually
- each patient receiving a long-acting antipsychotic injection must receive, prior to commencing therapy in primary care, a baseline health assessment to include as a minimum:
    - assessment of any issue relating to alcohol or drug use the patient may have
    - a review of the patients smoking status and discussion of support available to the patient should they wish to stop smoking
    - a Cardiovascular Disease risk assessment including blood pressure check and cholesterol check if clinically indicated
    - recording of their Body Mass Index (BMI)
    - a diabetes risk assessment including blood glucose check or HbA1C check if clinically indicated
    - discussion on sexual health issues and cervical screening if clinically appropriate
- each patient receiving a long-acting antipsychotic injection must receive a health assessment initially at six months and then annually as a minimum thereafter, covering as a minimum:
    - assessment of any issue relating to alcohol or drug use the patient may have
    - a review of the patients smoking status and discussion of support available to the patient should they wish to stop smoking
    - a Cardiovascular Disease risk assessment including blood pressure check and cholesterol check if clinically indicated
    - recording of their Body Mass Index (BMI)
    - a diabetes risk assessment including Blood glucose check or HbA1C check if clinically indicated
    - discussion on sexual health issues and Cervical screening if clinically appropriate
- the Provider should check that the patient has received the appropriate written information via secondary care which should ensure that all newly diagnosed/treated

patients (and/or their carers when appropriate) are supported through receiving appropriate education and advice on management of and prevention of secondary complications of their condition

- the GP provider should provide continuing information for patients. This should ensure that all patients (and/or their carers and support staff when appropriate) are informed of how to access appropriate and relevant information

If a doctor, nurse, pharmacist or patient suspects that an adverse reaction to a long acting antipsychotic injection has occurred, it should be reported to the Commission on Human Medicines (CHM) using the Yellow Card spontaneous reporting scheme: https://yellowcard.mhra.gov.uk/.

11. Neonatal checks

Should be undertaken in the Service User's home in cases of home confinement or where the check was not completed prior to the discharge of the baby from hospital.

In accordance with the NHS England Neonatal and Infant Hepatitis B Immunisation Protocol, where a baby is identified as at risk of Hepatitis B Providers shall ensure that mothers are informed of the protocol and immunisation schedule and are signposted to access this service appropriately. https://www.england.nhs.uk/south/info-professional/public-health/immunisations/hepatitis-b/

* Please note that the administering of the vaccination does not form part of this service specification.

The following requirements are sourced from the National Institute for Clinical Excellence (NICE):

- the aims of any physical examination should be fully explained and the results shared with the parents and recorded in the postnatal care plan and the personal child health record

- a complete examination of the baby should take place within 72 hours of birth

- the examination should incorporate a review of parental concerns and the baby's medical history should also be reviewed including: family, maternal, antenatal and perinatal history; fetal, neonatal and infant history including any previously plotted birth-weight and head circumference; whether the baby has passed meconium and urine (and urine stream in a boy). Appropriate recommendations made by the NHS National Screening Committee should also be carried out https://www.gov.uk/topic/population-screening-programmes and https://legacyscreening.phe.org.uk/screening-recommendations.php

Specific details for the physical examination are as below, checking the baby's:

- appearance including colour, breathing, behaviour, activity and posture

- head (including fontanelles), face, nose, mouth including palate, ears, neck and general symmetry of head and facial features. Measure and plot head circumference

- eyes; check opacities and red reflex

- neck and clavicles, limbs, hands, feet and digits; assess proportions and symmetry

- heart; check position, heart rate, rhythm and sounds, murmurs and femoral pulse volume

- lungs; check effort, rate and lung sounds

- abdomen; check shape and palpate to identify any organomegaly; also check condition of umbilical cord
- genitalia and anus; check for completeness and patency and undescended testes in males
- spine; inspect and palpate bony structures and check integrity of the skin
- skin; note colour and texture as well as any birthmarks or rashes
- central nervous system; observe tone, behaviour, movements and posture. Elicit newborn reflexes only if concerned
- hips; check symmetry of the limbs and skin folds (perform Barlow and Ortolani's manoeuvres)
- cry; note sound
- weight; measure and plot

The newborn blood spot test should be offered to parents when their baby is five to eight days old.

Guidance on the outcomes can be sought via the Somerset Pink Book or a paediatrician.

NIPE Guidance

Newborn and infant physical examination (NIPE) screening programme handbook - GOV.UK (www.gov.uk)

12. Pre and Post-Operative Care

Should be provided in the context of service user-centred care, reducing unnecessary visits to secondary care, and reducing hospital acquired infections.

The following list gives guidance on the types of care that would be included within the scope of pre and post-operative care, and is not comprehensive:

- Blood tests
- Electrocardiogram
- Methicillin-resistant Staphylococcus aureus (MRSA) screens, including decolonisation, antibiotic treatment and rescreens in accordance with guidance in respect of positive Methicillin-resistant Staphylococcus aureus (MRSA) results
- suture or clip removal
- wound assessment and wound dressings in accordance with the ICB Wound Care Formulary and Wound Care Policy / Methicillin-resistant Staphylococcus aureus (MRSA) Wound Care Policy
- baseline observation: pulse, blood pressure and temperature, height, weight, nutritional assessment, social assessment

This enhanced service will fund:

- adequate facilities including premises and equipment, as are necessary to enable the proper provision of pre and post-operative care including facilities for

cardiopulmonary resuscitation

- appropriately trained health care professionals to undertake the tasks listed above to provide care and support to Service Users undergoing care

- adherence to and maintenance of infection prevention & control national policy standards, The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance and local Aseptic Non Touch Technique (ANTT) policy (single use equipment where sterile equipment is required and appropriate environmental decontamination as according to the National Standards of Healthcare Cleanliness 2021).

- all drugs, dressings (in accordance with Trust Wound Care Formulary), appliances and necessary equipment to perform the care

- provision of information to Service Users as appropriate to their specific care

- maintenance of records of all care / procedures, consent and transfer of outcomes of pre op care to Service User's Consultant, or as directed

13. Hepatitis B vaccinations for 'at risk groups'

Should only be offered to patients in the 'at risk' groups defined as the family, high risk sexual behaviour, high risk drug use, people living in residential or nursing home setting and people receiving renal dialysis or with liver disorder. New-born babies of Hepititis B mothers are excluded from this service.

The service should only be offered to those patients in the 'at risk' groups ensuring that:

- service users meet the appropriate criteria
- reasonable adjustments are made to meet the needs of patients who have a disability.

This service should be provided in line with the Department of Health guidance on Hepatitis B vaccination in Chapter 18 of the Green Book, which can be found at https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18.

The Provider will take all reasonable steps to ensure that the lifelong medical records held by an at-risk patient's GP are kept up-to-date with regard to his or her immunisation status, and in particular include:

- any refusal of an offer of vaccination
- where an offer of vaccination was accepted:
    - details of the consent to the vaccination or immunisation (where a person has consented on an at-risk patient's behalf, that person's relationship to the at risk patient must also be recorded[1])
    - the batch number, expiry date and title of the vaccine
    - the date of administration of the vaccine
    - where two vaccines are administered in close succession, the route of administration and the injection site of each vaccine

[1] Refer to the *Mental Capacity Act* if necessary to ensure consent is appropriately obtained

- any contraindications to the vaccination or immunisation
- any adverse reactions to the vaccination or immunisation

Where patients fail to attend for vaccination it is recommended that they are followed up to ensure that their needs are reviewed to ensure the call/recall system is working effectively.

'AT RISK' GROUPS FOR HEPATITIS B VACCINATION

Family group:

- Foster parents
- Adopting parents of positive child or child from high risk country
- Close family or sexual partners of someone with hepatitis B

High risk sexual behaviour group:

Genito Urinary Medical Services offer a vaccination programme to this group. GP Providers should provide advice and signpost to Genito Urinary Medicine Services, or provide opportunistic vaccination where GP staff are competent.

- Men who have sex with men
- Sex workers
- Frequent sexual partners
- Sexual partners of any of the above

High risk drug use group:

The Drug & Alcohol Action Team have specialist Blood Borne Virus workers who offer a vaccination programme to this group. GP Providers should provide advice and signpost to the Drug & Alcohol Action Team, or to a GP providing the Substance Misuse LES:

- Injecting drug users
- Close household members of infected injecting drug users

People living in residential care or nursing home settings:

- People with Learning Difficulties living in a residential care or nursing home setting

People receiving Renal Dialysis or with Liver disease

- Where these have not transferred from primary to secondary care as per local arrangements

The following at risk groups are NOT covered:

- People travelling to high risk areas
- People at occupational health risk
- People suffering a needle stick injury
- People living in institutions
- Patients in a custodial/prison setting

- People with the following medical conditions (secondary care are responsible for vaccination):
    - Frequent blood transfusion

14. The provision of electronic ear irrigation as part of the ear wax pathway[2].

Practices will support prevention and self-care in the first instance. Where appropriate, a trained health care professional (HCP) will offer removal of ear wax for adults if contributing to hearing loss (and not contra-indicated.) The patient will be advised to use pre-treatment wax softeners [1], for a period beforehand before the HCP undertakes up to two attempts at ear irrigation using an electronic irrigator [2].

The service should be provided in line with Somerset ICBs current Ear Wax Removal Criteria Based Access (CBA) Policy https://nhssomerset.nhs.uk/for-clinicians/interventions-not-normally-funded-innf/ and NICE Guidance 98 Hearing Loss in adults: assessment and management https://www.nice.org.uk/guidance/NG98

Ear wax may be wet or dry and is a normal physiological substance that protects the ear canal. It has several functions including aiding removal of keratin from the ear canal (earwax naturally migrates out of the ear, aided by the movement of the jaw.) It cleans, lubricates, and protects the lining of the ear canal, trapping dirt and repelling water.

Excessive build-up of ear wax can develop in some people, the wax can become impacted. Although wax frequently obscures the view of the tympanic membrane it does not usually cause hearing impairment.

It is only when the wax is impacted into the deeper canal against the tympanic membrane (often caused by attempts to clean out the ear with a cotton bud, or by the repeated insertion of a hearing aid mould) that it is likely to cause a hearing impairment.

This service can be accessed by patients registered with a Somerset GP practice aged over 18 years of age.

When should ear wax be removed:

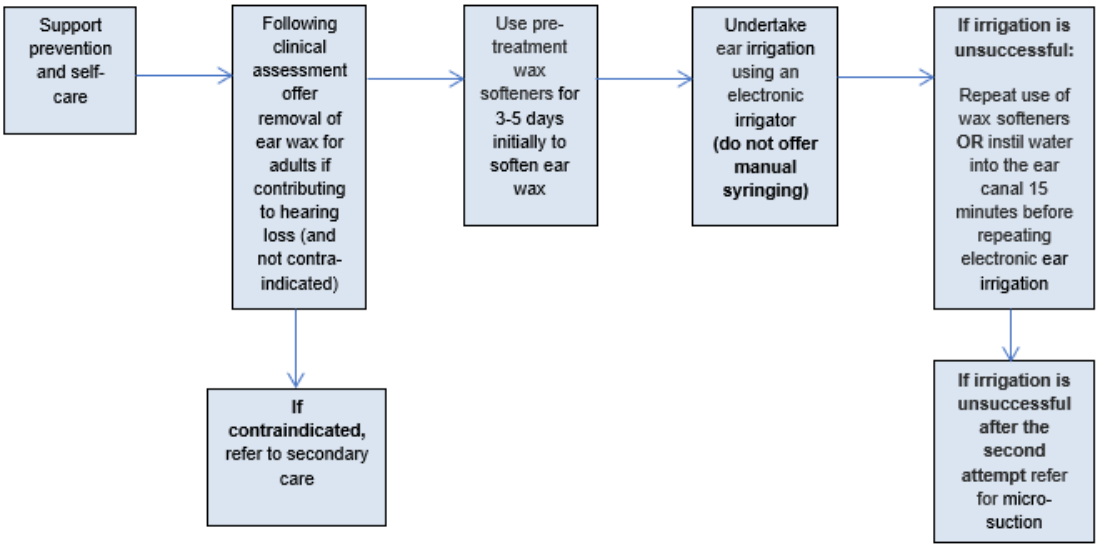
1. If earwax is totally occluding the ear canal and any of the following are present:
    - Hearing loss
    - Earache
    - Tinnitus
    - Vertigo
    - Cough suspected to be due to earwax

2. If the tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis.

3. If the person wears a hearing aid, wax is present and an impression needs to be taken of the ear canal for a mould, or if wax is causing the hearing aid to whistle.

4. **Note:** Manual syringing should not be used to remove ear wax as per the above referenced NICE Guidance 98 paragraph 1.2.2.

[2] Do not offer adults manual syringing to remove ear wax as per the above referenced NICE Guidance 98 paragraph 1.2.2



Do not use manual syringing (it is a requirement of this service specification that ear wax irrigation is undertaken using an electronic irrigator).

Do not use ear irrigation to remove wax for people with:

- A history of any previous problem with irrigation (pain, perforation, severe vertigo).
- Current perforation of the tympanic membrane.
- A history of perforation of the tympanic membrane in the last 12 months. Not all experts would agree with this — some would advise that any history of a perforation at any time, even one that has been surgically repaired, is a contraindication to irrigation because a healed perforation may have a thin area which would be more prone to re-perforation.
- Grommets in place.
- A history of any ear surgery (except extruded grommets within the last 18 months, with subsequent discharge from an Ear Nose and Throat department).
- A mucus discharge from the ear (which may indicate an undiagnosed perforation) within the past 12 months.
- A history of a middle ear infection in the previous 6 weeks.
- Cleft palate, whether repaired or not.
- Acute otitis externa with an oedematous ear canal and painful pinna.
- Presence of a foreign body, including vegetable matter, in the ear. Hygroscopic matter, such as peas or lentils, will expand on contact with water making removal more difficult.
- Hearing in only one ear if it is the ear to be treated, as there is a remote chance that irrigation could cause permanent deafness

When to refer

If two attempts at electronic ear irrigation in primary care have been unsuccessful the patient should be referred for microsuction in line with Somerset ICBs current Ear Wax Removal CBA Policy.

15. Enhanced Physical health checks for patients diagnosed with Serious Mental Illness (SMI)

In line with the ICBs commitment to support practices to undertake a comprehensive health check for 50-90%[3] of their registered population diagnosed with SMI as part of QOF; practices will positively and continuously support patients by undertaking the additional elements not reported through QOF. Where justified and clinically appropriate, practices will enhance the patients personalised care plan by involving the patient, their family, carers and wider agencies to complete the following:

- Completing an assessment of nutritional status, diet, and level of physical activity (nutrition/diet status + physical activity/exercise) status
- Completing an assessment of use of illicit substance/non prescribed drugs (substance misuse status)
- Completing medicines reconciliation or review
- Initiating follow-up interventions where indicated by the physical health check
- Initiating access to national screening programmes (breast cancer, bowel cancer, cervical cancer)
- Completing a general physical health enquiry including sexual health and oral health assessment, in line with commissioning guidance, clinical evidence, and consensus to help address the elevated rates of sexual and oral health complications observed across the SMI cohort.

Practices will also have access to the NHSE&I Mental Health train the trainer initiative which is focused on improving the quality of SMI health checks providing better outcomes for patients. Practices can individually or collectively as a PCN nominate an individual(s) to attend the dedicated training events and commit to undertake cascade training for health care practitioners who compete health checks. Practices will have access to a peer support network and additional resources via the Charlie Waller Trust: https://charliewaller.org/

Practices are encouraged to use the Ardens template accessed via the EMIS clinical system to contemporaneously record the patient annual physical health check. Alternatively, practices should code the elements of the physical health check completed using the SNOMED codes.

16. Diabetes Service Development

Focused primarily around prevention and condition management. Practices will support system development of prevention through implementing a series of requirements. These requirements include having a non-diabetic hyperglycaemia register in place, and actively encouraging patients to sign up to My Diabetes My Way to support on-going condition management. Additionally, practices will host and participate in at least one virtual staff clinic with specialist input. These should focus on managing high risk patients. In addition to QOF achievement thresholds, practices will ensure all patients have been offered interventions to achieve all the NICE recommended treatment targets as per the following guidance: https://www.england.nhs.uk/diabetes/treatment-care/

Practices will also identify team members in the practice responsible for diabetes foot checks (including a pulse check to check blood is still flowing to the diabetic foot) and complete the E-learning modules.

In order to ensure full compliance, practices are required to:

- Have a Non-diabetic Hyperglycaemia (NDH) register in place to record patients
- Refer patients at risk of developing diabetes to prevention programme
- Review patients on the NHS register annually
- Participate in and actively encourage people to sign up to My Diabetes My Way https://somerset.mydiabetes.com/

[3] QOF achievement thresholds: MH002 40 – 90% and MH003, MH006, MH007, MH011, MH012 and SMOK002 50 – 90% https://www.england.nhs.uk/wp-content/uploads/2021/03/B0456-update-on-quality-outcomes-framework-changes-for-21-22-.pdf

- Ensure the practice has access to a diabetes peer support group for patients (practice or Primary Care Network level)
- Practices will host and participate in at least one virtual staff clinics with specialist input. They should focus on managing high risk patients
- In addition to QOF achievement thresholds, practices will ensure all patients have been offered interventions to achieve all the NICE recommended treatment targets as per the following guidance: https://www.england.nhs.uk/diabetes/treatment-care/
- Identify team members in the practice responsible for diabetes foot checks (including a pulse check to check blood is still flowing to the diabetic foot) and complete the E-learning modules.

Peer Support Groups

Providers should ensure that patient peer support groups are available to patients, with information on upcoming groups being advertised within the practice in addition to patient signposting upon diagnosis.

The topic of conversation at each meeting should either be set by the provider or by patient consensus to ensure a valuable session. At minimum, there should be one patient peer group available per Primary Care Network; however should demand be sufficient providers may wish to run groups at practice level. Providers should work together as a Primary Care Network to decide whether to operate at PCN or individual practice level.

Somerset currently has one GP Clinical Champion and we are recruiting to a second. The GP Champions review variation and facilitate quality improvement.

17. Improvements in Quality and Resource Utilisation – Medicines Management

1. Install and use the latest version of the Somerset ICB formulary onto your GP system
2. Install and use the EMIS web protocols designed by the medicines management team to support correct formulary choices
3. Install and use the EMIS web protocols designed by the medicines management team linked to safer prescribing
4. Review all CAS and patient safety alerts then take appropriate timely action as per guidance https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-91-patient-safety-alerts
5. Install and review on a regular basis (ideally weekly) Eclipse Live and the patient safety alerts generated in order to prevent patient harm and improve patient outcomes
6. Arrange for patients on long term medicines (e.g., DOACs) to have at least an annual blood test where clinically indicated to ensure the dose of their medicine is still safe and causing no harm, where clinically indicated. Additional guidance can be found here: https://www.sps.nhs.uk/category/medicines-tools/medicines-monitoring/
7. Practice will work with medicines management and PCN teams to take all reasonable steps to reduce the carbon footprint of medicines optimisation including inhalers and de-prescribing products more suitable for selfcare or where risks outweigh benefits (e.g., high anticholinergic burden and opiates for non-palliative pain) contributing towards a ‘Green NHS’ and delivering a ‘Net Zero’ National Health Service.

18. Collaboration with Commissioners

Practices should enable discussions to take place with other key stakeholders to ensure primary care has a strong voice in redesigning the health and care system.

The ICB wishes to work collaboratively with providers to improve access to general practice and reduce waiting times. Practices may wish to utilise resources available through the Access Improvement Programme.

Practices will promote self-care linked with development of websites. Each practice will be required to include a link on its website to reliable self-care information such as www.nhs.uk

and to discuss with its Patient Participation Group (PPG) how the PPG can support the promotion of self-care and implement any recommendations.

Continue with participation in the Clinical Practice Research Datalink (CPRD) and participate with national clinical data information extractions to be used to support research.

19. Quality Improvement

In order to build on the implementation of NEWS2, practices will support the roll out of RESTORE2 (a document including NEWS2 and SBARD) as part of an urgent care pathway for patients in nursing and residential homes.

Practices (individually or as part of a PCN) will support the roll out of RESTORE2 in nursing and residential care homes as part of the clinical pathway for nursing home patients in need of acute/critical care.

Use NEWS2 observations scores (via RESTORE2), where clinically appropriate, when transferring critically ill patients from nursing and residential care homes into emergency care.

Practices will continue to promote a person-centred approach, which includes personalised care planning for patients with long term conditions. STEPs help to facilitate discussions between patient and clinician formalising a clear plan which should be actioned should a patient's condition exacerbate. This may be undertaken as an individual practice or as part of a PCN.

STEPs shall be considered for those patients who in their GPs clinical judgement would benefit from such anticipatory care planning. Practices will utilise the STEP template available through EMIS.

There is no minimum/expected number of STEPs and the measurement will not impact on the payment process of PCIS. However, practices (Or PCNs) may be required to produce an end of year self-assessment of STEP usage/activities, including learning to be shared with the system and highlighting improvements made in the quality of STEPs or their use)

PCNs (or individual Practices) will also be required to undertake an annual quality audit at the request of the Commissioner if there are significant system concerns raised in regard to the PCN or practices STEP processes. Further discussions may also be held with the PCN or practice where numbers are static/no STEPs are being developed or there are significant quality concerns raised. As part of this annual quality audit, practices shall review all deaths of registered population to determine if, where a clinically appropriate, a STEP was in place.

Primary care providers make an important contribution to the sustainability of the health system by delivering proactive co-ordinated care that avoids admission to hospital wherever possible.

Recommendations from the ICS health and care strategy support reduced utilisation of hospital care through better integrated out of hospital care. The main purpose of this investment is to deliver the new model, but in the short term there is a need to sustain the health system. Practices will have responsibility for reviewing emergency admissions and developing plans to address and reduce, where possible, unwarranted variation. The ICB can provide additional data upon request to support development of action plans.

20. Primary Care Initiatives

The NHS has pledged as part of "for a greener NHS" to reduce its carbon footprint and become more environmentally friendly. To help support this ambition practices are asked to improve the sustainability of Primary Care in Somerset by;

- Maintain the Royal College of General Practitioners (RCGP) Green Impact Bronze level at https://www.greenimpact.org.uk/giforhealth/register (registration code 134)
- Aspire to achieve Silver, Gold or Carbon Level

The ICB reserves the right to request evidence of RCGP accreditation level.

Practices are also encouraged to share and promote any additional local changes to support climate change and sustainability as part of the greener NHS campaign - https://www.england.nhs.uk/greenernhs/national-ambition/

The practice is required to have a designated Carers Champion. The role should be a formal part of a person's job, with time allowed to carry out the role effectively. The Carers Champion will:

- Link with the Carers Support Service
- Encourage accurate processes for identification of carers
- Ensure information for carers is available (leaflets/ website)