FINAL VERSION
AMENDED FEBRUARY 2022

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

CCG LOCAL COMMISSIONING AGREEMENT

2020 - 2023

Delivering together

CONTENTS PAGE NUMBER

APPENDICES

1. Purpose of the Agreement

The purpose of this agreement is to outline the Primary Care Commissioning Intentions for 2020-2023, which aligns to the Long-Term Plan of providing care for patients closer to home, in the community. Encouraging more collaboration between GP's, Practice teams and community services as 'Primary Care Networks' to increase service provision, jointly, to plan and deliver service which meet the needs of communities.

2. Duration of the Agreement

This agreement is for a period of 3 years, commencing from **1st April 2020** and ending on the **31st March 2023.** Details of the services included in this agreement are outlined in the Appendices attached to this document. All services are subject to change during this 3-year period, in agreement with the LMC, which may arise as a result of clinical or quality improvements. Sufficient notice will be given to GP Practices in order for practices to accommodate any required changes.

3. Background

This agreement specifically outlines the services being commissioned by General Practice as 'local enhanced services' which are defined as primary medical services other than essential services, additional services or out of hours services. In addition, the Medicines Optimisation priorities, previously commissioned under the Quality and Engagement Framework (QEF), are included within this agreement.

This agreement also reflects the feedback received from the Big Conversation with Primary Care, which highlighted that General Practice requires:

- Financial certainty
- Less reporting, although understand the need to measure activity and outcomes
- No short notice or in year changes that are not communicated in a timely fashion
- A requirement for protected time

4. Aim

Financial Certainty
There is a commitment to guarantee the level of investment of CCG discretionary funding for the next three years by utilising monies from other parts of the system to support general practice. This includes reinvestment of PMS rebasing monies (6.2m) which is ring fenced for investment back into Primary Care and CCG local investment of (3.5m)

The overall local investment budget for 2020/21 will increase by 4% which is more than the increase applied to our Acute providers. Where appropriate, the aim is for 100% population coverage and practices will be supported if, in order to achieve this, they opt to sub contract to other providers in the local system, such as neighbouring practices, PCN or GP Federations.

Reporting
Activity reporting will be reduced to every 6 months. In order to ease the reporting burden for Practices, there will be the option for practices to take up the offer of a central data extraction by our Primary Care Information Team for the majority of service specifications.

Protected Time

The CCG recognises the importance of clinical governance time to practices and will be working with the LMC and practices over the coming months to see how we might want to fund and organise this locally**.**

5. Requirements for Service Delivery

The following points should be taken into account for each service specification outlined in the Appendices:

5.1 Call and Recall

Practices are to ensure that a systemic call and recall of patients is in place where appropriate.

5.2 Record keeping

Practices are required to maintain adequate records of the service provided, incorporating all known information relating to any significant events e.g. hospital admissions, death of which the practice has been notified.

5.3 Referral to other services

Practices are expected to work and liaise with secondary care providers for referral into their services where required. The service should develop close links with secondary care and community providers. Mechanisms should be in place for the transfer of any patients suffering complications.

5.4 Professional Links

Practices are required to work together with other professionals when appropriate. Any health professionals involved in the care of patients in the programme should be appropriately trained.

5.5 Non-Registered Patients

The Practice will need to be clear how to manage the services for Non registered patients. For example, advise them to contact their own practice for the results and sign post to another delegated provider.

5.6 Satisfactory Facilities

There is a requirement to ensure that the services are carried out in approved premises. Providers should have such facilities as are necessary to enable them to provide the service in a safe and effective environment to the recognised standards that relate to the service.

5.7 Sterilization & Infection Control

It is the responsibility of GP Practices to ensure that appropriate arrangements are in place for infection control and decontamination in premises where these procedures are undertaken. Practices must have infection control policies that are compliant with national guidelines.

6. Accreditation

Practices are required to ensure that any healthcare professional who is involved in performing or assisting in any procedure outlined within the Appendices, has the evidence of necessary experience, skills and training with regards to said procedure, taking into consideration their professional accountability and any relevant guidelines on the scope of professional practice, such as the Nursing and Midwifery Council (NMC). Those doctors who have previously provided similar services outlined in this agreement and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

7. Payment Arrangements

Practices will be commissioned in the first instance against their commissioned levels of activity and the indicative budget for the provision of each service for the forthcoming year. Practices will receive monthly payments based on the total indicative budget for the year. If necessary, any financial adjustments will be made mid-year and year end to take into account actual activity undertaken during the financial year.

8. Activity Reporting

Coding

Practices are required to record relevant activity using specified coding for the majority of the services.

Practices will be provided with code lists that will contain up to date SNOMED coding to assist practices with data recording via their chosen method(s).

Reports for 2020/2021 onwards will be provided in SNOMED. This will ensure that any additional SNOMED codes within records are picked up within reports as well as the mapped Read2 and CTV3 codes that practices have been used to recording. This does not change how practices enter data into clinical system records but ensures all relevant data can be reported on.

Reporting

Practices will be required to submit their Commissioning Statements on a 6 monthly basis to capccg.enhancedservices@nhs.net

- **1st submission** - activity undertaken during 1st April 2020 - 30th September 2020 should be submitted by **15th October 2020**

- **2nd submission** - activity undertaken during 1st October 2020 – 31st March 2021 should be submitted by **15th April 2021**

Practices will have the option for their enhanced service activity data to be extracted centrally and should indicate whether they wish to take up this offer by ticking the relevant box on the Application Form.

For Practices that opt for centralised data reporting and where data is coded into clinical records, this data will be collected on behalf of practices via our Primary Care IT Team to make the reporting process quicker and easier for practices. The details of the reporting criteria will also be provided alongside the agreed code lists. All reports that will be run in SystmOne and EMIS Web to collate the activity returns will be visible to all practices, and practices will be able to run these, and other provided reports, in order to monitor their progress and have clear visibility of their six monthly activity figures.

Non-Coded Activity

Where a service specification requires reporting or audit from another system (e.g. Medicines Optimisation) or a textual return, practices will need to provide these on the relevant reporting template.

At the current time, the Nursing Home and Residential Home Services will need to be reported by practices; this may change once the details of the DES become available which may influence future recording and reporting requirements.

For any queries and support regarding recording, Read, CTV3 and SNOMED codes, or queries about central reporting of activity data, please contact capccg.primarycareinformation@nhs.net

9. Payment Verification

Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available and Practices are encouraged to utilise Practice computer systems to enable this condition to be met.

10. Performance

The CCG reserves the right to suspend the commissioning of this service where there are concerns around compliance and patient safety.

11. Safeguarding Adults

It is important that practices protect adults from avoidable harm (as defined in Safeguarding Adults guidelines) including safeguarding training, training on the Mental Capacity Act and Deprivation of Liberty. A Safeguarding lead should be identified in each practice.

12. Care Quality Commission (CQC)

The provider must meet CQC standards and where appropriate be registered with the Care Quality Commission (CQC). The standards and the relevant services are contained in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2014.

13. Termination of Agreement

Should either party wish to terminate this agreement, a minimum period of 3 months' notice must be provided in writing.

14. Signatories to the Agreement

Practices wishing to participate in this agreement are required to indicate which services they wish to deliver by ticking the relevant box on the application form, sign and submit to the CCG for consideration.

APPENDIX 1 – TREATMENT ROOM SERVICES

1. BACKGROUND

There is currently an increasing workload demand on General Practice, particularly from a growing population with complex health needs. Government policy continues to move services into the community placing yet more pressure on overstretched GP services.

NHS England announced their intention to equalise practice core funding levels resulting in a gradual, but for some practices, quite a significant reduction in baseline funding which has forced practices to review non contractual service provision (non – core unfunded services).

Cambridgeshire and Peterborough CCG remain committed to supporting Primary Care to deliver the continuation of existing service provision to its population by delivering high quality, safe and effective value for money services.

The Treatment Room services fall into the category of 'non-core' unfunded services and feedback from patients and primary care providers suggests a preference for these services to remain as a list base service delivered within Primary Care setting. The CCG has been working with the LMC to put in place alternative arrangements so that all patients can continue to have access to these services to ensure continuity of valuable primary care list-based services.

2. AIM OF SERVICE

This locally commissioned service was developed in recognition of the unfunded work undertaken in General Practice.

3. SERVICE OUTLINE

The purpose of this agreement is to prevent a gap in service provision to patients, therefore Practices that sign up to this agreement will be required to ensure their registered patients have access to all of the following services:

Clinical Interventions	Definition
Simple Dressings *** excludes patients who have received treatment under the Minor Surgery and/or Minor Injury Enhanced Services or who are receiving treatment for the wound as a complex dressing**	Simple dressings that do not require assessment or intervention.
Suture Removals *** excludes patients who have received treatment under the Minor Surgery and/or Minor Injury Enhanced Services**	Removal of sutures/staples following surgery
General ECG's	For Urgent and Non-Urgent (12 lead) ECG's clinically indicated for assessment, diagnosis and monitoring of patient care
Irrigation of Auditory Canal for the removal of ear wax	First line treatment, when clinically appropriate should be to self-care with otc sodium bicarbonate ear drops. Where ear wax has not cleared **refer to the C&P CCG Clinical Policies in respect of Ear Wax removal to ensure the patient meets the clinical threshold for this procedure**, and please offer irrigation by trained personnel https://www.cambridgeshireandpeterboroughccg.nhs.uk/health-professionals/clinical-policies-and-thresholds/clinical-policies/
Management of Catheters changes (excludes new insertions)	Undertaken by clinically trained staff at the Practice and using a catheter passport care plan.

Ring Pessary Insertion and Changes	Where clinically indicated and undertaken by clinically trained staff at the practice.

4. PRICING

Practices will receive **£1.56 per patient per annum** based on the Practice actual list size as of **1st April 2020** for the delivery of services that fall under the remit of this agreement.

The funding will cover service delivery, appropriate coding and monitoring processes of the services

The CCG reserves the right to review and amend this agreement at 6 months to assess affordability by reviewing the activity received to date.

5. REPORTING

The number of patients who have accessed the services listed within this service level agreement within the specified timeframe.

APPENDIX 2 – ANTI COAGULATION MONITORING

1. BACKGROUND

Warfarin is being used in the management of increasing numbers of patients and conditions including patients' post-myocardial infarction, atrial fibrillation, DVTs and other disorders. While it is a very effective drug in these conditions, it can also have serious side effects, e.g. severe haemorrhage. These side effects are related to the International Normalised Ratio (INR) level, which measures the delay in the clotting of the blood caused by the warfarin. While the "normal" INR is 1, the specific range of INR values depends on the disease and the clinical conditions. Warfarin monitoring aims to stabilise the INR within set limits to help prevent serious side effects while maximising effective treatment. See CCG guidance on prescribing and monitoring of warfarin.

2. AIM OF SERVICE

An anti-coagulation monitoring service is designed to be one that should be available to all registered patients including those that are housebound and require domiciliary visits. Practices are required to liaise with community services to ensure there is no gap in service provision for all patients.

a) therapy should normally be initiated in secondary care, for recognised indications for specified lengths of time
b) maintenance of patients should be properly controlled
c) the service to the patient is convenient
d) the need for continuation of therapy is reviewed regularly
e) the therapy is discontinued when appropriate

3. SERVICE DELIVERY

Level	Practice Responsibility	Summary	Tariff per patient per year (excl. Level 2)
1	Prescribing Only	- Hospital Sample - Hospital Testing - Hospital Dosing - Practice Prescribing	NIL
1 (a)	Sampling and Prescribing	- Patient Administration - Practice Sample - Hospital Testing - Hospital Dosing - Practice Prescribing	£10.50 per patient per year (Patient Administration) plus £2.10 per venous sample
2	Dosing and Prescribing	- Patient Administration - Hospital Sample - Hospital Testing - Practice Dosing - Practice Prescribing	£64.12
3	Sampling, Dosing and Prescribing	- Patient Administration - Practice Sample - Hospital Testing - Practice Dosing - Practice Prescribing	£91.98
4 (a)	Sampling, Testing and Prescribing	- Patient Administration - Practice Capillary Sample - Practice Testing - Hospital Dosing - Practice Prescribing	£147.06
4 (b)	Sampling, Testing, Dosing and Prescribing	- Patient Administration - Practice Capillary Sample - Practice Testing - Practice Dosing - Practice Prescribing	£189.07

Practices can be commissioned to provide one of the levels as outlined above. The level of service should be clearly indicated on the application form.

** Practices wishing to provide levels 4 (a) or (b) will need to provide capillary sampling to also provide the practice testing element of the service and therefore will incur the costs associated with Capillary Sampling including; Test Strips, NEQAS testing, Lancets and Control Solution. **Note** FP10's are not to be issued for test strips.*

Service Definitions

Patient Administration- The organisation of patient's appointments, including call and recalls etc

Hospital Sample - The process of obtaining a sample of blood to obtain an INR result through either venous or capillary methods undertaken by the hospital.

Practice Sample - The process of obtaining a sample of blood to obtain an INR result through either venous or capillary methods undertaken by Practice Employed Staff at the Practice

Hospital Testing – Obtaining an INR result through the testing of blood sample undertaken by the hospital.

Practice Testing – Obtaining the INR result through the testing of blood sample undertaken at the Practice.

Dosing - 'Doser' means any person who is suitably trained and qualified who, upon receipt of relevant information from laboratories or near patient testing equipment or otherwise, determines the appropriate anti-coagulant dosage and makes recommendations for the timing of the next INR test. If the relevant information from the laboratory does not include the dosing information then this must be determined by computer assisted decision-making equipment.

Practice Prescribing – Issuing Patient's prescription for Anti Coag therapy

4. SERVICE OUTLINE

1. **Professional Links.** To work together with other professionals when appropriate. Any health professionals involved in the care of patients in the programme should be appropriately trained.

2. **Referral Policies.** When appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist

3. **Patient Education.** To provide education to patients (and their carers and support staff when appropriate) in the management of their condition

4. **Call and Recall.** To ensure that a systemic call and recall of patients on this register is taking place either in a hospital or general practice setting.

5. **Clinical Procedures.** To ensure that all clinical information related to the service is recorded in the patient's own GP held lifelong record, including the completion of the "significant event" record that the patient is on warfarin

6. **Governance**. The governance for each step of the process sits with the organisation who undertakes the task. For instance, in level 4 (a) even though the majority of the activity will take place within the practice the hospital provide governance as they're dosing the test result.

7. **Individual management plans**. To prepare with the patient an individual management plan which gives the diagnosis planned duration and therapeutic range to be obtained (e.g. the yellow book and alert card)

   All new patients prescribed warfarin must have a counselling checklist completed to ensure the patient has received all the appropriate information required. At the first appointment following transfer from secondary care, education should be reinforced. The counselling should be comprehensive to ensure that patients are fully aware of their treatment and should include:-

   (i) The name of the drug and current dose,

   (ii) The reason they are taking the drug,

   (iii) Therapeutic goal,

   (iv) The anticipated length of treatment,

(v) What to do in the event of a missed dose,

(vi) Symptoms of under/over anticoagulation and action to take if these occur,

(vii) Drug/food interactions,

(viii) Clinic arrangements and how to obtain further medicine supplies,

(ix) What to do if dental treatment/surgery is required,

(x) What to do if a surgical procedure is required/indicated,

(xi) Who to contact regarding any worries or concerns relating to their anticoagulation management.

(xii) All new patients should have a yellow anticoagulation pack, including yellow record booklet.

(xiii) All relevant information will be transferred from GP Clinical system to the relevant INR software database at first appointment. All future input of data will enable both clinical system and INR software to be updated.

8. **Record-Keeping.** To maintain adequate records of the service provided. This may include the number of bleeding episodes requiring hospital admission and deaths caused by anti-coagulants

- Patient Name
- Patient Date of Birth
- NHS number
- Indication for treatment
- Length of treatment
- Target INR
- Named medical practitioner initiating treatment
- Discontinuation date
- INR results, dosage instructions and review dates
- Missed days (i.e. a record of days when the patient has not taken their anticoagulant therapy in accordance with dosing instructions)
- Concurrent medication
- Medical conditions, hospital admissions likely to affect anticoagulation such as an increased risk of haemorrhage (BCSH Guidelines 1998)
- Bleeding episodes
- Any actions taken, as well as dosing and retest dates e.g. education, advice, whether the INR result is from near patient testing or central lab testing
- Occasions when the patient failed to attend an agreed clinic appointment
- Contact details for patient or for carers responsible for the administration of Warfarin

9. **Training.** Each practice must ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so

10. **Review.** Providers must perform an annual review and make available to the Commissioner on request:

i. Local processes for compliance with CCG warfarin management guidelines - in addition to information on the number of patients being monitored

ii. information on the number of patients being monitored, the indications of anticoagulation, i.e. DVT etc, and the duration of treatment

iii. brief details as to arrangements for each of the aspects highlighted above

iv. details of any computer-assisted decision-making equipment used and arrangements for internal and external quality assurance

v. details of any near-patient testing equipment used and arrangements for internal and external quality assurance

vi. details of any training and education relevant to the anti-coagulation monitoring service received by practitioners and staff

vii. details of the standards used for the control of anti-coagulation

Annual Clinical Audit Criteria (Statement) – based on safety indicators identified by the NPSA	**Clinical Audit standard (target standard)**
Patients established on oral anticoagulation should be within INR target more than 65% of the time (via INR Software as at commencement of repatriation of patients)	100%
The practice should be able to demonstrate appropriate action has taken place for INR 5.0-8, e.g. review of patient within 1 week	95%
Practices should be able to demonstrate consideration of administration of vitamin k and/or admission for INR >8 and repeated INR the next day.	100%
Patients established on oral anticoagulation should be given written dosage instructions at each clinic visit	100%
Annual Service Return Criteria (Statement) – based on safety indicators identified by the NPSA	
Providers must ensure that all staff involved in providing any aspect of care under the scheme has the necessary training and skills	
Providers must have an up to date Standard Operating Procedure (SOP) for Anticoagulation	
All staff involved in providing the anticoagulation service must follow the SOP for Anticoagulation	
Patients should not be accepted on the SLA scheme without completed transfer documentation from secondary care	
Practices should have a call/recall system which captures any patient who fails to attend for follow up	
Patients established on oral anticoagulation should have their diagnosis recorded	
Patients established on oral anticoagulation should have their target INR recorded	
Patients established on oral anticoagulation should have their stop date recorded	
Patients established on oral anticoagulation should not go past their stop date	
Patients established on oral anticoagulation should be given written dosage instructions at each clinic visit	
Newly diagnosed patients should have a patient held record	
All new patients transferring in to the scheme should have the agreed documentation completed	
Providers must be able to evidence monthly calibration of all machines used to deliver the service. (A minimum of x4 NEQAS reports are to be submitted along with details on the steps taken to address any anomalies.)	
Information on the number of patients being monitored, the indications of anticoagulation, i.e. DVT/AF etc., and the duration of treatment	
Details of any training and education relevant to the anti-coagulation monitoring service received by practitioners and staff	
Details of any near-patient testing equipment used and arrangements for internal and external quality assurance	

NPSA Alert. The National Patient Safety Agency has issued guidance that must be used in conjunction with this specification.
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59814&q=0%c2%acwarfarin%c2%ac

5. REPORTING ARRANGEMENTS

- The number of patients who have received Anti Coag monitoring in the relevant 6 month period.
- *For Practices undertaking the Level 4 (a) or (b) service*, Practices will be required to download statistics from INR Software 6 monthly, retain at practice and make available to the Commissioner on request.

APPENDIX 3 – 24 HOUR AMBULATORY BLOOD PRESSURE MONITORING (ABPM)

1. BACKGROUND

Nice guideline (NG 136) 'Hypertension in adults: diagnosis and management' supports the use of Ambulatory Blood Pressure Monitoring (ABPM) and Home Blood Pressure Monitoring (HBPM) in the diagnosis and management of hypertension in adults.

Local clinicians in both primary and secondary care believe it is readily feasible to transfer a proportion of 24 hour BP monitoring which are currently taking place in acute hospitals to community settings. The proposal is focused on transferring direct GP referrals currently made to secondary care to primary care services. The expectation is that the majority of direct GP referred BP monitoring can take place in a more convenient locations for patients. This service shift will achieve substantial benefits for patients offering improved access, coupled with enhanced continuity of care.

2. AIM OF SERVICE

Both ABPM and HBPM permits the non-invasive measurement of blood pressure over a prolonged period (usually 24 hours) and have been in NICE guidelines for hypertension for many years. HBPM is increasingly popular and convenient for patients and its use should be supported and encouraged to confirm diagnosis and in self-monitoring.

This service is intended for:

1. Confirming the diagnosis of hypertension in patients with a clinic blood pressure measurement between 140/90 and 180/120
2. In addition to clinic measurements, to monitor patients with white coat effect or masked hypertension

The service is not intended for patients with severe hypertension, with a clinic reading > 180/120, who should either be referred for same day assessment if they are symptomatic or have investigations to assess target organ damage, which if positive should start treatment without the need for ABPM/HBPM.

3. SERVICE OUTLINE

Day 1 – the patient will be fitted with a 24-hour blood pressure monitoring device. Full instructions will be given to the patient, and details of who to contact in case of difficulty (Mobile Telephone No.). Patient will be encouraged to keep a diary.

Day 2 – the patient reattends for removal of the device. The results are checked to ensure that at least 2 measurements per hour are taken during the person's usual waking hours (for example, between 08:00 and 22:00). Use the average value of at least 14 measurements taken during the person's usual waking hours to confirm a diagnosis of hypertension. Within 1 week, a nurse or doctor must discuss the results of the measurements with the patient.

4. PRICING

Practices will be paid **£31.51** per 24-hour ambulatory BP monitoring procedure as defined in the service outline above.

5. REPORTING

The number of procedures undertaken in the relevant 6-month period.

APPENDIX 4 – 24 HOUR ECG

1. BACKGROUND

This enhanced service will deliver care and early reassurance to patients in GP Practices, provide early identification of rhythm abnormalities and avoid unnecessary referrals to secondary care. This approach is in line with the current Sustainability and Transformation Programme which aims to provide better access to services, earlier diagnosis, avoidance of unnecessary hospital attendance and integrated care.

Local clinicians in both primary and secondary care believe it is readily feasible to transfer a proportion of 24-hour ECGs which are currently taking place in acute hospitals to community settings. The proposal is focused on transferring direct GP referrals currently made to secondary care to primary care services. The expectation is that the majority of direct GP referred outpatient ECGs can take place in a more convenient location for patients. This service shift will achieve substantial benefits for patients offering improved access, coupled with enhanced continuity of care.

2. AIM OF SERVICE

ECG recordings and interpreting can be done by suitably qualified GPs in the community, thereby reducing the need to refer patients to Secondary or Acute units. This enables patients to have care closer to home and ensures that the time delay for request to investigation is minimal. This service aims to:

1. To provide a 24-hour ECG recording and interpretation service from primary care.
2. To deliver care and early reassurance to patients in a local setting, provide early identification of rhythm abnormalities and avoid unnecessary referrals to secondary care
3. Provide better access to services, earlier diagnosis, avoidance of unnecessary hospital attendance and integrated care

3. SERVICE OUTLINE

Each patient will be over the age of 16 and offered a 30-minute appointment.

3.1 Clinical criteria for undertaking procedure:

1. Patients with unexplained fainting attached or dizzy spells, either more than once a day or infrequently but severe
2. Patients with palpitations
3. Patients with atypical chest pain thought to be angina, in whom an exercise ECG is not practical
4. To follow up after commencing mediation where appropriate

Contra indications – none.

3.2 Follow up procedure:

1. Patient referred back to own GP for further management
2. If isolated SVTs only, then drug treatment should be commenced

3.3 Criteria for referring on:

1. If symptoms and ECG results correlate, except if isolated SVTs when treatment will initially be commenced in primary care.

4. PRICING

Practices will be paid **£31.51** per 24-hour ambulatory ECG procedure as defined in the service outline above.

5. REPORTING

The number of procedures undertaken in the relevant 6-month period.

APPENDIX 5 – COMPLEX DRESSINGS AND DOPPLER MANAGEMENT

1. BACKGROUND

There is currently an increasing workload demand on General Practice, particularly from a growing population with complex health needs. Government policy continues to move services into the community placing yet more pressure on overstretched GP services.

NHS England announced their intention to equalise practice core funding levels resulting in a gradual, but for some practices, quite a significant reduction in baseline funding which has forced practices to review non contractual service provision (non – core unfunded services).

Cambridgeshire and Peterborough CCG remain committed to supporting Primary Care to deliver the continuation of existing service provision to its population by delivering high quality, safe and effective value for money services.

Complex Dressings require assessments and longer appointments for treatment. These types of dressings are considered over and above the services provided under the Treatment Room 'Bundle' service and also falls into the category of 'non core' unfunded services. Feedback from patients and primary care providers suggests a preference for these services to remain as a list base service delivered within Primary Care setting. The CCG has been working with the LMC to put in place alternative arrangements so that all patients can continue to have access to these services to ensure continuity of valuable primary care list based services.

2. AIM OF SERVICE

This service specification has been developed in recognition of the work currently undertaken in General Practice.

- outlines the requirement for undertaking a holistic wound care assessment, treatment / dressings, prevention of reoccurrence and provide educational advice to support patients in primary care.
- covers only enhanced aspects of wound care (see definition of wound below)
- seeks to ensure complex wound care services are delivered by competent staff, will work jointly or refer onto specialist tissue viability or vascular clinics where appropriate.
- to deliver improved care to patients and the population
- provide equitable services to patients across Cambridgeshire and Peterborough

It is intended that this service shall have the following outcomes

- improved clinical outcomes for patients and fewer complications and reoccurrences
- reduced need for patients to utilise other services
- reduce antimicrobial use in line with CCG and National guidance
- improved patient experience and satisfaction
- reduced health inequalities by improved access to the services
- Improved healing times of wounds by seeking holistic wound assessments early in the patient journey and ensuring appropriate referrals are made.

3. SERVICE OUTLINE

The purpose of this agreement is to prevent a gap in service provision to patients, therefore Practices that sign up to this agreement are required to ensure that the service is available to all of their registered patients that need it.

This local commissioned service will fund the following service provided by **practice employed staff**:

Complex Dressings -

- A complex wound is one which usually has one or more complicating factors e.g. exudate, infection, comorbidity or polypharmacy. They are usually slow to heal and require regular holistic assessment and appropriate interventions to promote effective wound healing.

- The type of wounds considered complex are fungating lesions, leg ulcers, diabetic foot ulcers, wound fistulae and wounds that fail to heal. The time required to manage these wounds will vary but are likely to require longer nurse appointments.

Doppler Management –

- For Wounds that require the use of a Doppler for assessment, practices should undertake this procedure where appropriate.

Guidance on Wound Care Formulary – click Here

4. PRICING

Practices will receive **£15.76 per consultation** for delivery of a complex wound dressing that that falls within the remit of this agreement.

For Practices who provide a Doppler service, practices will receive **£10.40 for use of a Doppler, plus the consultation fee of £15.76, equating to a total of £26.16**

The Tariff price has been based on a half an hour appointment of a Band 7 (mid-point) plus on costs.

5. REPORTING

The **number of complex dressing's consultations and number of Doppler assessments** that have been undertaken in the relevant 6-month period.

APPENDIX 6 – DENOSUMAB INJECTIONS

THIS APPENDIX HAS BEEN UPDATED – SEE UPDATED APPENDIX 6 DATED FEBRUARY 2022 AT THE FOLLOWING LINK BELOW

https://www.cambridgeshireandpeterboroughccg.nhs.uk/health-professionals/patient-pathways/local-commissioning-agreements/

APPENDIX 7 – DIABETES

THIS APPENDIX HAS BEEN UPDATED – SEE UPDATED APPENDIX 7 DATED NOVEMBER 2020 AT THE FOLLOWING LINK BELOW

https://www.cambridgeshireandpeterboroughccg.nhs.uk/health-professionals/patient-pathways/local-commissioning-agreements/

APPENDIX 8 – DEPOT ANTIPSYCHOTIC INJECTIONS

1. BACKGROUND

Long-acting antipsychotic depot injections are used for maintenance therapy for schizophrenia and other psychoses especially when compliance with oral treatment is unreliable.

Depot antipsychotics are categorised by the Cambridgeshire and Peterborough Joint Prescribing Group as 'Recommended - Specialist initiation'. Therefore, once treatment has been initiated by the hospital specialist, the depot antipsychotic injection can be continued in primary care.

The administration of the depot injections and associated physical monitoring of the patient can be undertaken in primary care.

Administration
Depot antipsychotics injections are administered by deep intramuscular injection at intervals of 1 to 4 weeks. This is dependent on the choice of depot antipsychotic injection and also on patient response.

In general, not more than 2–3 mL of oily injection should be administered at any one site; correct injection technique (including the use of z-track technique) and rotation of injection sites are essential.

Physical monitoring
Prescribing support guidance can be accessed via the Cambridgeshire and Peterborough Joint Prescribing Group website

2. AIM OF SERVICE

This locally commissioned service will fund:

- The administration of depot antipsychotic injections (as recommended in the CCG formulary) for maintenance therapy of schizophrenia and other psychoses.

3. SERVICE DELIVERY

It is a requirement of this local commissioned service that the contractor:

3.1 Create a register -
Practices will need to produce and maintain a valid up-to-date register of patients being treated as part of this enhanced service. Patients should be added to the register in a timely fashion using the relevant Read Codes.

3.2 Operate a call and recall system -
Practices will need to ensure that they operate a systematic call and recall of patients on the register and have in place the means to identify and follow up patients who default. It is the responsibility of the practice to pursue further contact with any Patient who DNAs. Any 'informed dissent' must be fully recorded.

3.3 Agree a joint clinical management programme –
Patients should be managed on the basis of individual treatment plans and on a patient by patient basis, which will normally be drawn up by local consultants, but need to be agreed in advance of transfer of care by the GP. Practices will be expected to follow these treatment plans when shared care has been agreed unless there has been discussion and agreement with local consultants to modify them, or the GP indicates they can no longer accept this patient for shared care.

3.4 Provide an outline individual management plan –

Wherever possible to ensure that the patient has an outline individual management plan, which gives the reason for treatment, agreed treatment programme and the planned duration.

3.5 Maintain Adequate Records

Each practice is required to maintain adequate records of the service provided, incorporating all known information relating to any significant events e.g. adverse reactions, hospital admissions, and relevant deaths of which the practice has been notified. Any telephone advice should be recorded as a consultation as part of patient record

3.6 Training & Development of Primary Care Staff

Each practice must ensure that all staff involved in providing any aspect of care under this scheme has the necessary training and skills to do so. Practices should be able to demonstrate that they have in place a policy to cover staff training and maintenance of skills for administration of injections.

3.7 Provide safe and suitable facilities for undertaking invasive procedures –

Practices providing this service must ensure that they have adequate and appropriate facilities and equipment comparable to those required for the safe provision of any invasive procedure

3.8 For patients still under CPFT care

1. The patient continues to receive regular support from a community psychiatric care worker.
2. The intervals for review by the psychiatric team are set out in the care plan.

3.9 For stable patients discharged by CPFT

1. If the patient's condition deteriorates, or if the care plan is not adhered to, or appears to be inadequate, the conditions for referral back to the team are clearly set out in the discharge plan, including agreement for rapid* reaccessing of CPFT services. It is recommended that in the first instance the GP contact the relevant consultant (specified in discharge plan) to agree best course of action and next steps.
2. In all cases of people covered by this LES: in an emergency, these patients may be re-referred immediately back to CPFT for rapid* re assessment. Again, it is recommended that the GP contact the relevant consultant in the first instance.

   ** Rapid - When appropriate GP contacts relevant locality consultant to discuss case and agree plan*

Where re-referral is needed:

- GP contacts their Adult Locality Team (ALT) for urgent re-referral
- GP references discharge plan to ALT
- ALT confirm discharge plan on Rio and organise urgent assessment/plan with patient and GP
- Contact your Primary Care Mental Health Service (PCMHS) team if there are any difficulties/issues with the process above.

For crisis out of hours:

- GP or patient/carer to contact First Response Service who will then liaise with ALT as required.

4. PRICING

Practices will receive **£315 per patient per annum (pro-rata)** for the administration and physical monitoring of depot antipsychotic injections to patients in line with the patients individual treatment plan ***(this payment is per patient per annum and not per injection)***

5. ACTIVITY REPORTING

The number of patients being monitored (as described above) in the relevant 6-month period.

APPENDIX 9 – GONADORELIN INJECTIONS

1. BACKGROUND

Gonadorelin analogues are used primarily, though not exclusively, in the treatment of carcinoma of the prostate. There are a number of treatment regimes, which vary in the detail of their programme of administration and main purpose. Broadly they can be divided on the basis of the progress of the disease into advanced local disease and metastatic disease. The central usage, however, remains the treatment of metastatic cancer of the prostate.

Virtually all the prescriptions issued for injectable gonadorelin analogues are written by GPs and most of these are also administered by GPs. In some practices an appropriately trained practice nurse will site the depot implants.

There are varying treatment models for administering gonadorelin analogues to patients with carcinoma of the prostate dependent on the clinical management programme agreed for that patient. Cambridgeshire & Peterborough CCG formulary recommendations are available here

Degarelix (Firmagon) has recently been reviewed by C&P Joint Prescribing Committee and it was agreed to be included in the CCG formulary in line with NICE TA404 'Treatment of hormone-dependent prostate cancer in patients with spinal metastasis' https://www.nice.org.uk/guidance/ta404. Maintenance treatment is by monthly injection as recommended in the manufacturers 'Summary of Product Characteristics' https://www.medicines.org.uk/emc/medicine/21686 .

We understand Secondary Care clinicians expect very few patients will use this in replace of alternative options.

2. AIM OF SERVICE

This locally commissioned service will fund:

- The administration of Gonadorelin analogue injections for the treatment of carcinoma of the prostate and other licensed indications as recommended in the CCG formulary
- The administration of Degarelix (Firmagon) for treating advanced hormone-dependent prostate cancer

3. SERVICE DELIVERY

It is a requirement of this local commissioned service that the contractor;

3.1 Create a register -
Practices will need to produce and maintain a valid up-to-date register of patients being treated as part of this enhanced service. Patients should be added to the register in a timely fashion using the relevant Read Codes.

3.2 Operate a call and recall system -
Practices will need to ensure that they operate a systematic call and recall of patients on the register and have in place the means to identify and follow up patients who default. It is the responsibility of the practice to pursue further contact with any Patient who DNAs. Any 'informed dissent' must be fully recorded.

3.3 Agree a joint clinical management programme –
Patients should be managed on the basis of individual treatment plans, which will normally be drawn up by local consultants. Practices will be expected to follow these treatment plans unless there has been discussion and agreement with local consultants to modify them.

3.4 Provide an outline individual management plan –

Wherever possible to ensure that the patient has an outline individual management plan, which gives the reason for treatment, agreed treatment programme and the planned duration.

3.5 Maintain Adequate Records

Each practice is required to maintain adequate records of the service provided, incorporating all known information relating to any significant events e.g. adverse reactions, hospital admissions, and relevant deaths of which the practice has been notified. Any telephone advice should be recorded as a consultation as part of patient record

3.6 Training & Development of Primary Care Staff

Each practice must ensure that all staff involved in providing any aspect of care under this scheme has the necessary training and skills to do so. Practices should be able to demonstrate that they have in place a policy to cover staff training and maintenance of skills

3.7 Provide safe and suitable facilities for undertaking invasive procedures –

Practices providing this service must ensure that they have adequate and appropriate facilities and equipment comparable to those required for the safe provision of any invasive procedure

4. PRICING

Practices will receive **£26.26** per patient, per quarter for administering gonadorelin analogue injections or Degarelix (Firmagon) to either male/female patients in line with the patients individual treatment plan (this payment is per patient per quarter and not per injection)

5. REPORTING

The number of patients receiving gonadorelin analogue injections or Degarelix (Firmagon) by the Practice in the relevant 6-month period.

APPENDIX 10 – MINOR INJURY

1. BACKGROUND

This service recognises the need for a consistent approach to rewarding GPs equitably for providing minor injury services within their own practice.

This service will be commissioned in the context of reforming emergency care services and reducing pressure on Emergency Departments. The Local Enhanced Service recognises the need for a consistent approach, rewarding GP's equitably for providing minor injury services within their own practice population. It supports those practices where the population has to travel many miles to reach their nearest MIU.

2. AIM OF SERVICE

Professional consensus indicates that 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.

This local commissioned service will fund minor injury consultations provided by the practice. In order to be eligible to provide the service, practices will be required to:

a) Actively promote and advertise the Minor Injury Service via the surgery waiting room and website

b) To appear on the NHS 111 Directory of services "DOS" to accept patients registered with your practice with minor injuries during core hours, making reasonable effort to accommodate these patients and offer a clinically appropriate minor injury/illness appointment.

c) Provide adequate facilities including premises and equipment, as are necessary to enable the proper provision of minor injury services including facilities for cardiopulmonary resuscitation and regular staff training

d) Provide appropriate care and support to patients undergoing minor injury services, ensuring they have appropriate explicit follow up care and when to seek further advice.

e) Maintain infection control standards as agreed locally

3. SERVICE DELIVERY

A **"minor injury consultation"** is defined, for the purpose of this agreement, as

a consultation, arranged at request of a patient/carer after an injury, completed within 48 hours of that injury, face to face with the appropriate practice clinician. It would include the usual clinical pattern of history taking, examination, assessment, diagnosis, treatment or referral as necessary, record keeping and follow up arrangements.

The following list outlines the minor injuries that will be commissioned from the practices:

- ✓ Lacerations requiring suturing, gluing, steri-stips
- ✓ Foreign Bodies in the skin, ear and nose (including local anaesthetic as needed) and non-penetrating foreign bodies in the eye.
- ✓ Minor Head Injury (head injuries that do not meet NICE 2007 (updated 2012) guidelines for referral to ED
- ✓ Superficial Burns and Scalds (Under 9% - excluding palms of hands and soles of feet)
- ✓ Minor Trauma to Body including hands/limbs/feet/back
- ✓ Whiplash / Road Traffic Incident – low impact
- ✓ Falls under 1m (as per Emergency Department guidance)
- ✓ Minor assaults
- ✓ Animal Bites that have punctured the skin requiring cleaning and dressing, only consider oral antibiotics as per formulary guidelines.

Restrictions and exclusions – injuries not covered by this service

- Injuries sustained outside of the 48hr window. Professional consensus indicates that injuries and wounds over 48 hours old should be dealt with through normal primary care services as should any lesion of non-traumatic origin.
- Any injury or condition for which the patient is subsequently referred to ED or MIU by the provider
- Follow ups to Minor Injury consultations initiated elsewhere (i.e. ED/MIU)
- Any minor injury that is covered under the self-care policy and should be deemed appropriate for pharmacist management
- Telephone Consultations
- Repetitive strain injuries
- Sunburn
- Insect Bites
- Bruises in isolation to any other injury
- Minor Dislocations *(patients require referral for x-ray)*
- Overdose and poisoning *(as patients need to be assessed in A&E)*
- Head injury associated with loss of consciousness or patients on anticoagulants (follow NICE guidance and discuss with secondary care) need to be assessed in A&E
- Penetrating eye injury *(as patients need to be assessed in A&E)*
- Partial and full thickness burns *(as patients need to be assessed in A&E)*
- Fractures *(patients require referral for x-ray)*
- Tendon and artery injuries *(as patients need to be assessed in A&E)*
- Suture removal *(as included under Treatment Room Service)*
- Sexual assaults *(referral to Sexual Assault Referral Centre (SARC) required)*

4. ACREDITATION

It is for the General Practice to ensure that practice staff are trained and competent to deliver Minor Injury and Wound Care services. The provider is to ensure that all registered and non-registered staff undertaking minor injury and wound closure have the necessary competencies.

Healthcare professionals providing minor injury services would be expected to:

(i) have either current experience of provision of minor injury work, or
(ii) have current minor surgery experience, or
(iii) have had Emergency Department / Minor Injury Unit experience, or
(iv) have equivalent training, which satisfies relevant appraisal and revalidation procedures.

5. PRICING

Practices will be commissioned based on previous year's activity and will be paid **£21.01** per eligible patient consultation as defined in the service outline above.

6. REPORTING

The number of minor injury consultations undertaken in the relevant 6-month period.

Practices will need to record each minor injury consultation by the agreed read code.

The presence of a minor injury diagnosis is not synonymous with a minor injury consultation (as it may have been made outside the agreed definition); occasionally, where examination excludes a suspected injury, a minor injury consultation will have properly happened without a clinical diagnosis of injury being made.

Electronic Patient Record
Practices must clearly record the events of the injury and specifically when the injury was sustained.

APPENDIX 10 – NEAR PATIENT DRUG MONITORING

1. BACKGROUND

This agreement outlines the expectations and obligations in Primary Care to undertake the prescribing and monitoring of specific medicines which have been agreed by the Cambridgeshire and Peterborough Joint Prescribing Group (C&PCCGJPG) as suitable for prescribing under Shared Care Guidance (SCG).

Practices that agree to this Local Commissioned Service do so for all shared care agreements included on the CCG Prescribing Website

***The agreement may be updated periodically with recommendations made by the Cambridgeshire and Peterborough Joint Prescribing Group concerning the list of drugs included in this agreement*.**

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This local commissioned service specification outlines a more specialised service to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient all of which are beyond the scope of essential services. The CCG believes that all currently prescribed drugs requiring shared care have been identified and SCG's are in place. This is a small number of patients, covering drugs not commonly used, and therefore all prescribing information, cautions on use and monitoring details are in a standard format in each SCG document for easy GP reference. Both drug and its indication for use form the basis of the SCG. The C&PCCG JPG includes GP representatives from each locality who have agreed that the SCGs are appropriate to management in Primary Care.

Shared Care Guidance is available for specific drugs and indications. These drugs are initiated, and the patient stabilised where necessary in the specialist setting and are continued in primary care under a formal SCG agreement under this agreement.

If a GP is uncertain about their competence to take responsibility for the patient's continuing care, they should seek further information or advice from the clinician with whom the patient's care is shared or from another experienced colleague.

If the GP is still not satisfied, they should explain this to the other clinician and to the patient, and make appropriate arrangements for their continuing care however in signing up to this agreement the practice must provide all services for all Shared Care Guidance agreements.

2. AIM OF SERVICE

The Near Patient Drug Monitoring service is designed to be one in which:

(i) therapy should only be initiated for recognised indications (as per Shared Care Guidelines clinically ratified by the Cambridgeshire and Peterborough Joint Prescribing Group) This initiation includes the **Education of Newly Diagnosed and treated Patients** which ensures that all newly diagnosed / treated patients (and / or their carers when appropriate) receive appropriate education and advice on management of and prevention of secondary complications of their condition. This should include written information where appropriate.

(ii) where applicable, maintenance of patients first stabilised in the secondary care setting should be properly controlled

(iii) the service to the patient is convenient

(iv) the need for continuation of therapy is reviewed regularly

(v) the therapy is discontinued when appropriate

(vi) the use of resources by the National Health Service is efficient.

3. SERVICE DELIVERY

This local commissioned service will fund the additional work involved in locally agreed shared care indications where monitoring is required by the relevant SCG. The monitoring required varies from SCG to SCG and is specific for that drug/indication only.

The payment for agreed monitoring reflects the practice's workload to complete all aspects of monitoring and is outlined in 2 levels – Level, 2 and 3. All drugs are outlined in Appendix A.

There are **two levels** of monitoring intensity levels being proposed within the proposed contract:

Level Two – medium/low intensity blood monitoring. Monitoring including blood testing.

Level Three – high intensity blood monitoring required. A shared care drug monitoring service including frequent blood testing

The tariff pricing for each level includes blood sampling. Blood samples undertaken within this agreement are excluded from the Phlebotomy LES.

All drugs covered by SCG are likely to be repeat medications and the medication review on repeat. The reference to the Shared Care Guideline is accepted as the evidence that the following are in place:

(i) **A Register of all patients under SCG.** Practices should be able to produce and maintain an up-to-date register of all shared care drug monitoring service patients, indicating:
- patient name
- date of birth
- indication and duration of treatment
- date practice accepted responsibility for monitoring
- last hospital appointment

(ii) **A system of Call and Recall.** To ensure that systematic call and recall of patients on this register is taking place.

(iii) **Continuing information for patients.** To ensure that all patients, (and/or their carers and support staff when appropriate), are informed of how to access appropriate and relevant information.

(v) **Professional links.** To work together with other professionals when appropriate. Any health care professionals involved in the care of patients in the programme should be appropriately trained.

(vi) **Referral policies.** Where appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist.

(vii) **Record keeping.** To maintain adequate records of the service provided, incorporating all known information relating to any significant events e.g. hospital admissions, death of which the practice has been notified.

(viii) **Training.** Each practice must ensure that all staff involved in providing any aspect of care under this scheme has the necessary training and skills to do so. Staff are expected to keep up to date with current evidence and guidance.

In addition, as good governance, practices should perform Annual Review of its shared care including

(a) brief details as to arrangements for each of the aspects highlighted in the service
(b) details as to any computer-assisted decision-making equipment used and arrangements for internal and external quality assurance
(c) details as to any near patient testing equipment used and arrangements for internal and external quality assurance
(d) details of training and education relevant to the drug monitoring service
(e) details of the standards used for the control of the relevant condition
(f) assurance that any staff member responsible for prescribing must have developed the necessary skills to prescribe safely.

4. PRICING

Practices will receive the following payments:

- **£41.60 per patient per annum for Level Two**
- **£93.60 per patient per annum for Level Three**

If a patient is taking more than one medicine under a shared care agreement, the practice may only claim for the patient once. This will be paid at the level that attracts the highest payment.

5. REPORTING

The **number of patients** (not number of tests) in the relevant 6 month period who are receiving practice-based monitoring of the drugs listed under **Appendix A** below.

APPENDIX A - LIST OF SHARED CARE DRUGS UNDER THIS AGREEMENT

Drug	Indication	Monitoring Intensity Level	Payment
Alemtuzumab	Multiple Sclerosis	Level 3	£93.60 per patient per annum
Aliskiren	Resistant hypertension	Level 2	£41.60 per patient per annum
Atomoxetine, Dexamfetamine, Methylphenidate, Lisdexamfetamine	ADHD (Adults and Children)	Level 3	£93.60 per patient per annum
Azathioprine	Immunosuppression	Level 2	£41.60 per patient per annum
Ciclosporin	Immunosuppression	Level 2	£41.60 per patient per annum
Cinacalcet	Secondary hyperparathyr-oidism in chronic renal failure (Adults)	Level 2	£41.60 per patient per annum
Colistin	Pseudomonas aeruginosa lung infections	Level 2	£41.60 per patient per annum
Enoxaparin injection	Patients undergoing invasive procedures to establish a diagnosis of pulmonary hypertension, assess treatment response or in preparation for surgery (Adults)	Level 2	£41.60 per patient per annum
Gentamicin (nebulised)	Long term prophylaxis of chronic lung infections in non-CF bronchiectasis (Adults)	Level 2	£41.60 per patient per annum
Gold (Myocrisin, Sodium Aurothiomalate) intramuscular injection	Rheumatoid arthritis	Level 3	£93.60 per patient per annum
Hydroxycarbamide	Myeloproliferative neoplasms treatment in adults	Level 3	£93.60 per patient per annum
Leflunomide	Rheumatic diseases	Level 3	£93.60 per patient per annum
Lithium		Level 3	£93.60 per patient per annum
Melatonin	Sleep disturbances (children and adolescents)	Level 2	£40.00 per patient per annum
6-mercaptopurine	Immunosuppression	Level 3	£93.60 per patient per annum
Methotrexate (sub-cutaneous and low dose)	Immunosuppression	Level 3	£93.60 per patient per annum
Midodrine	Idiopathic orthostatic hypotension	Level 2	£41.60 per patient per annum
Modafinil	Narcolepsy with or without cataplexy (Adults)	Level 2	£41.60 per patient per annum
Mycophenolate	Immunosuppression	Level 2	£41.60 per patient per annum
Nintedanib	Idiopathic pulmonary fibrosis	Level 3	£93.60 per patient per annum
Penicilliamine	Immunosuppression	Level 3	£93.60 per patient per annum
Pirfenidone	Idiopathic pulmonary fibrosis	Level 2	£41.60 per patient per annum
Riluzole	Amyotrophic lateral sclerosis form of motor neurone disease	Level 2	£41.60 per patient per annum
Sirolimus	Transplant patients	Level 2	£41.60 per patient per annum
Sodium oxybate	Cataplexy in adults patients with narcolepsy (Adults)	Level 2	£41.60 per patient per annum
Stiripentol	Seizures (Paediatrics)	Level 2	£41.60 per patient per annum
Sulfasalazine	Rheumatic diseases	Level 2	£41.60 per patient per annum
Tacrolimus	Transplant (Adults)	Level 2	£41.60 per patient per annum
Tobramycin (nebulised)	Chronic *Pseudomonas aeruginosa* infections (Paediatrics)	Level 2	£41.60 per patient per annum
Tolvaptan	Tolvaptan (Jinarc) for autosomal dominant polycystic kidney disease	Level 3	£93.60 per patient per annum

APPENDIX 11 – NURSING HOMES

1. BACKGROUND

The term 'enhanced care' encompasses those activities, relating to patients in nursing homes that have been identified as being activities over and above those that General Practitioners would normally provide under General Medical Services (GMS). This local service is designed to compliment the GPs responsibility for the long term health care needs and chronic disease management for patients nursing homes. It further relates to the coordinating role of the General Practitioner in supporting enhanced liaison between health professionals and other organisations in the management of such conditions.

2. AIM OF SERVICE

The aim of this Local Commissioned Service is to improve through good working relationships the quality and continuity of care provided to residents in nursing homes across Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). This local service also seeks to promote alignment of GP Practices to these nursing homes.

The intention of this local commissioned service is to improve input, communication and care planning between GP practices and nursing homes and to ensure admissions to hospital are appropriate.

3. SERVICE DELIVERY

GP practices will be required to adopt a systematic, pro-active and preventive approach to the assessment of the needs of older people who are residents in a Nursing Home.

Exclusions
This service does not apply to 'extra-care' facilities which include designated intermediate care beds and interim beds under the Winter Pressures fund where GPs are employed directly to provide cover by alternative arrangements.

In order to achieve compliance with this agreement Practices who are commissioned under this Local Commissioned Service will be required to meet the following criteria:

1. Ceilings of Care	Practices are encouraged to work towards achieving 'ceilings of care' to avoid admissions where appropriate.
2. Nominate a Lead GP	The Practice is required to nominate a Lead GP responsible for each allocated Nursing Home. This GP (or nominated deputy in his/her absence) will be required to deliver general medical care to permanent residents and respite patients in the specified Nursing Home. He/she will also act as the interface between the Commissioner, Primary/Secondary Care, Community Services and relatives, to ensure that decisions are made in the individual patients' best interests.
3. Assessment of new admissions and those recently discharged from Hospital	An initial assessment which must include a medication review should be completed for ALL patients within a reasonable timescale (ideally within 2 weeks) and a copy retained in the medical records**.** The GP should work pro-actively with the mental health services to ensure assessment of patients needs and follow up in a timely manner. **Required Target 100%** **(A sample assessment template is provided as Appendix A but this does not preclude Practitioners from adopting their own template to meet the needs of the Patient and the individual completing the assessment. Assessment tools should be viewed as a working document given that some information may not be known at the point of the initial assessment. If the Practice is unable to complete within the initial 2 week time period then the reason for this must be documented in the patient's medical records)**
4. Regular Visits	The nominated GP or deputy will commit to undertake a fortnightly visit to the assigned nursing home to undertake a "ward round" and to meet with the Care Manager or deputy to offer general support and advice to nursing home staff on clinical issues and ongoing care which should also include a review of hospital admissions and discharges. The focus of the "ward round" element of these

	visits should be on new patients and those in need of clinical review. Notes from these meetings will need to be retained as evidence. In addition the nominated GP or deputy is also required to respond to any contacts from the nursing home that fall outside of the fortnightly visit.
5. Maintain Clinical Records	The nominated GP or deputy is responsible to ensure clinical records for all patients are maintained and kept up to date on the Practice clinical system using approved read codes. All key clinical decisions and medication changes should be communicated and recorded by Nursing Home Staff. All Clinical records must remain accessible to visiting clinicians and where appropriate shared with others i.e. OOH
6. Medication Reviews	The nominated GP or deputy will be responsible for prescribing in the allocated nursing home and will be required to liaise with the local medicines management team and care home staff. A full review of medication for each patient in the Nursing Home must be carried out within a 2 weeks of admission to the home and every 6 months thereafter. The reviews should be documented and retained at the Practice and Nursing Home. **Required Target 100%** ***This can be demonstrated and evidenced by Practices using the suggested Read Code for each relevant patient***
7. End of Life Care Plans	Individuals should be supported to die in their place of choice. This can be reinforced through advance care planning, personalised care plans and treatment escalation plans. The GP is required to work collaboratively with MDT Co-ordinators, nursing home staff, families, Out of Hours, NHS 111 and Older Peoples Specialist Team colleagues to ensure appropriate palliative and terminal care is provided at the end of life for their patient in their preferred place of care/death. This should be achieved through the implementation and maintenance of End of Life Care Plans for all patients considered appropriate. End of Life Care Plans should meet relevant guidelines i.e. Gold Standards Framework and should be updated every 3 months. **Required Target 100%** ***This can be demonstrated and evidenced by Practices using the suggested Read Code for each relevant patient***
8. Dementia Care	a) A timely diagnosis of Dementia is important as is the support required following a diagnosis. Practices to consider if an assessment is required and whether after an assessment, a confirmed Dementia Diagnosis should be recorded for the patient. b) Shared care planning is important in delivering high quality personalised care planning and life planning, and for ensuring timely access to secondary care and to specialised mental health services c) Education, training and professional development help ensure that carers, families and staff employed by social care feel supported. d) Medication reviews are particularly important for people with Dementia and should focus on reducing polypharmacy and optimising antipsychotic medication

NURSING HOME RESPONSIBILITES

Practices are required to share this service specification with the relevant nursing homes so that they are aware of the service and the responsibilities of all parties involved.

The unit manager has the responsibility to Care Quality Commission (CQC) to ensure that they meet the needs of individual patients before admission or readmission after hospital stay.

4. PRICING

Practices will receive **£156.00 per Nursing Home bed per annum.**

Practices will be commissioned against commissioned levels of activity based on the number of Nursing Home beds that the practice provides GP/cover support to in each Nursing Home and an indicative budget will be set for the provision of this service.

5. REPORTING

Practices are required to submit the number of registered patients in Nursing Homes for monitoring purposes only in the relevant 6 month period.

In addition, Practices must ensure that they are able to provide evidence that they have met the criteria of this commissioned service by undertaking a 6-monthly review (see separate Appendix C) and make the information available to the commissioner on request.

APPENDIX 12 – PHLEBOTOMY

excluding routine sampling for warfarin monitoring and routine drug monitoring covered within the Near Patient Drug Monitoring LES, plus blood sampling undertaken for NHS Health Checks

1. BACKGROUND

Cambridgeshire & Peterborough CCG remain committed to the delivery of high quality, safe and effective value for money services.

NHS England announced their intention to equalise practice core funding levels resulting in a gradual but for some Practices quite significant reduction in baseline funding. As a result Practices have had little option but to review all services that are not contractually required and/or are unfunded to deliver

Phlebotomy falls into the category of non-core, unfunded services and feedback from patients and primary care providers suggests a preference for phlebotomy to remain as a service that is delivered within Primary Care. Therefore, the CCG has been working with the LMC to put in place alternative arrangements to ensure continuity of this valuable primary care list based service.

By commissioning a primary care-based phlebotomy service, it is anticipated that the following outcomes will be achieved:

- Improve clinical outcomes for patients
- Improve patients' experience of phlebotomy services
- Deliver a local service that is cost effective
- Give patients a choice to attend a local service and give all patients the same choice of locations and providers

2. AIM OF SERVICE

This service model is designed to cover the enhanced service aspects of phlebotomy care which are beyond the scope of mainstream primary care services. It outlines the requirement for the provision of a primary care phlebotomy service being provided over and above the essential and additional services that General Medical Service (GMS) and Personal Medical Service (PMS) are contracted to provide.

Cambridgeshire & Peterborough Clinical Commissioning Group recognises that the provision of a phlebotomy service in primary care has significant benefits. Alternative Personal Medical Service (APMS) practices will be already provided as part of the contract. The key aims of the service are:

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

3. SERVICE DELIVERY

3.1 Non Registered Patients
The Practice will need to be clear how to manage phlebotomy for non-registered patients. For example advise them to contact either their own practice for the results and signpost another delegated provider.

3.2 Domiciliary Patients – Housebound Patients are excluded from this Service Level Agreement however, if a blood test is required during a routine home visit – the

GP/Nurse is able to action this where appropriate and in line with required competencies and service standards.

3.3 Exclusions

In addition to the exclusion above, this agreement does not cover sampling undertaken as part of any Enhanced Service Agreement commissioned by or on behalf of NHS England. Local Authority or the CCG. Examples of these include Near Patient Drug Monitoring, Anti-Coag Monitoring, NHS Health Checks etc.

3.4 Referrals

Blood tests are requested via the local pathology services (TPP). Patients should be given the opportunity of booking an appointment directly with their own GP practice if they offer a phlebotomy service, alternatively patients will be signposted to where they can attend for a phlebotomy appointment.

3.5 Assessment

The service provider should ensure that all patients are assessed on arrival by a suitably qualified healthcare professional qualified to take blood. This assessment should be used to identify the suitability of any patient attending the service for a phlebotomy appointment. Assessment for phlebotomy appointments should be conducted with the patient and as a minimum include:

- Patient name and date of birth
- Patients general condition on arrival including baseline observations and abnormalities
- Ensuring the patient understands the reason for the phlebotomy appointment
- Any contraindications
- Preparation (ie, patient has followed all pre blood-test requirements)

3.6 Referral to other services

The provider shall be expected to work and liaise with secondary care providers for referral into their services where required. The service should develop close links with secondary care and community providers.

The provider shall have in place mechanisms for the transfer of patients suffering complications of the procedure.

3.7 Satisfactory Facilities – (excluding opportunistic domiciliary phlebotomy)

The provider will ensure that the services are carried out in approved premises. Providers should have such facilities as are necessary to enable them to provide the phlebotomy service properly.

3.8 Self Competence

The provider is to ensure that any healthcare professional who is involved in performing or assisting in any procedure has the evidence of necessary experience, skills and training with regards to said procedure.

Healthcare professionals who have previously provided services similar to the proposed service and who satisfy at appraisal that they have such continuing medical experience, training and competencies as is necessary to enable them to contract for the service shall be deemed professionally qualified to do so.

3.9 Sterilization & Infection Control

It is the responsibility of the provider to ensure that appropriate arrangements are in place for infection control and decontamination in premises where these procedures are undertaken. The provider must have infection control policies that are compliant with national guidelines.

3.10 Pathology

The service shall be supported by the “Local” Hospital pathology services at CUHFT, NWAFT. Test results may be given to patients by an appropriate staff member over the telephone or as part of face to face consultation as deemed clinically appropriate and

dependent on the nature of the result. Serious Pathology will be addressed by the pathology lab and reported back to the patients registered GP and the patient where necessary.

3.11 Review and Audit

Practices are encouraged to undertake regular audits in order to review and evaluate whether the service remains safe and effective, delivering quality and meeting the needs of patients. Practices could consider including the following when undertaking an audit:

- Number of patients attending for blood tests (clinic based & domiciliary where requested)
- Number of patients who DNA
- Waiting times for appointments from time of request
- Number of adverse events /serious untoward incidents (SI's)

4. PRICING

Practices will receive **£2.10 per bleed** for providing a Phlebotomy service to patients as outlined in the specification.

N.B Two tests at the same time, one fee. Two tests on the same patient on different days, 2 fees. Whoever takes the blood in the practice, same fee.

The funding will cover service delivery, appropriate coding and monitoring processes of the services.

5. REPORTING

The number of blood samples undertaken in the relevant 6-month period.

APPENDIX 13- RESIDENTIAL HOMES

1. BACKGROUND

The term 'enhanced care' encompasses those activities, relating to patients in residential homes that have been identified as being activities over and above those that General Practitioners would normally provide under General Medical Services (GMS). This local service is designed to compliment the GPs responsibility for the long term health care needs and chronic disease management for patients' residential homes. It further relates to the coordinating role of the General Practitioner in supporting enhanced liaison between health professionals and other organisations in the management of such conditions.

2. AIM OF SERVICE

The aim of this Local Commissioned Service is to improve through good working relationships the quality and continuity of care provided to residents in residential homes across Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). This local service also seeks to promote alignment of GP Practices to these residential homes.

The intention of this local commissioned service is to improve input, communication and care planning between GP practices and residential homes and to ensure admissions to hospital are appropriate.

3. SERVICE DELIVERY

GP practices will be required to adopt a systematic, pro-active and preventive approach to the assessment of the needs of older people who are residents in a Residential Home.

Exclusions
This service does not apply to 'extra-care' facilities which include designated intermediate care beds and interim beds under the Winter Pressures fund where GPs are employed directly to provide cover by alternative arrangements.

In order to achieve compliance with this agreement Practices who are commissioned under this Local Commissioned Service will be required to meet the following criteria:

1. Ceilings of Care	Practices are encouraged to work towards achieving 'ceilings of care' to avoid admissions where appropriate.
2. Nominate a Lead GP	The Practice is required to nominate a Lead GP responsible for each allocated Residential Home. This GP (or nominated deputy in his/her absence) will be required to deliver general medical care to permanent residents and respite patients in the specified Residential Home. He/she will also act as the interface between the Commissioner, Primary/Secondary Care, Community Services and relatives, to ensure that decisions are made in the individual patients' best interests.
3. Assessment of new admissions and those recently discharged from Hospital	An initial assessment which must include a medication review should be completed for ALL patients within a reasonable timescale (ideally within 2 weeks) and a copy retained in the medical records**.** The GP should work pro-actively with the mental health services to ensure assessment of patients needs and follow up in a timely manner. **Required Target 100%** **(A sample assessment template is provided as Appendix A but this does not preclude Practitioners from adopting their own template to meet the needs of the Patient and the individual completing the assessment. Assessment tools should be viewed as a working document given that some information may not be known at the point of the initial assessment. If the Practice is unable to complete within the initial 2 week time period then the reason for this must be documented in the patient's medical records)**
4. Regular Visits	The nominated GP or deputy will commit to undertake a fortnightly visit to the assigned residential home to undertake a "ward round" and to meet with the Care Manager or deputy to offer general support and advice to residential home staff on clinical issues and ongoing care which should also include a review of hospital admissions and discharges. The focus of the "ward round" element of these visits

	should be on new patients and those in need of clinical review. Notes from these meetings will need to be retained as evidence. In addition the nominated GP or deputy is also required to respond to any contacts from the residential home that fall outside of the fortnightly visit.
5. Maintain Clinical Records	The nominated GP or deputy is responsible to ensure clinical records for all patients are maintained and kept up to date on the Practice clinical system using approved read codes. All key clinical decisions and medication changes should be communicated and recorded by Residential Home Staff. All Clinical records must remain accessible to visiting clinicians and where appropriate shared with others i.e. OOH
6. Medication Reviews	The nominated GP or deputy will be responsible for prescribing in the allocated residential home and will be required to liaise with the local medicines management team and care home staff. A full review of medication for each patient in the Residential Home must be carried out within a 2 weeks of admission to the home and every 6 months thereafter. The reviews should be documented and retained at the Practice and Residential Home. **Required Target 100%** ***This can be demonstrated and evidenced by Practices using the suggested Read Code for each relevant patient***
7. End of Life Care Plans	Individuals should be supported to die in their place of choice. This can be reinforced through advance care planning, personalised care plans and treatment escalation plans. The GP is required to work collaboratively with MDT Co-ordinators, residential home staff, families, Out of Hours, NHS 111 and Older Peoples Specialist Team colleagues to ensure appropriate palliative and terminal care is provided at the end of life for their patient in their preferred place of care/death. This should be achieved through the implementation and maintenance of End of Life Care Plans for all patients considered appropriate. End of Life Care Plans should meet relevant guidelines i.e. Gold Standards Framework and should be updated every 3 months. **Required Target 100%** ***This can be demonstrated and evidenced by Practices using the suggested Read Code for each relevant patient***
8. Dementia Care	a) A timely diagnosis of Dementia is important as is the support required following a diagnosis. Practices to consider if an assessment is required and whether after an assessment, a confirmed Dementia Diagnosis should be recorded for the patient. b) Shared care planning is important in delivering high quality personalised care planning and life planning, and for ensuring timely access to secondary care and to specialised mental health services c) Education, training and professional development help ensure that carers, families and staff employed by social care feel supported. d) Medication reviews are particularly important for people with Dementia and should focus on reducing polypharmacy and optimising antipsychotic medication

RESIDENTIAL HOMES RESPONSIBILITIES

Practices are required to share this service specification with the relevant residential homes so that they are aware of the service and the responsibilities of all parties involved.

The unit manager has the responsibility to Care Quality Commission (CQC) to ensure that they meet the needs of individual patients before admission or readmission after hospital stay.

4. PRICING

Practices will receive **£135.20 per Residential Home bed per annum.**

Practices will be commissioned against commissioned levels of activity based on the number of Residential Home beds that the practice provides GP/cover support to in each Residential Home and an indicative budget will be set for the provision of this service.

5. REPORTING

Practices are required to submit the number of registered patients in Residential Homes for monitoring purposes only in the relevant 6-month period.

In addition, Practices must ensure that they are able to provide evidence that they have met the criteria of this commissioned service by undertaking a 6-monthlty review (See separate Appendix C) and make the information available to the commissioner on request.

APPENDIX 14 – SMI HEALTH CHECKS

1. BACKGROUND

People living with severe mental illness face one of the greatest health inequality gaps in England. Individuals with SMI are not consistently being offered appropriate or timely physical health assessments despite their higher risk of poor physical health. The five-year forward view for mental health committed to leading work to ensure by 2020/21, SMI patients have their physical health needs met by increasing early detection and expanding physical assessment and intervention each year.

This local enhanced service aims to Improve health outcomes for SMI Patients and supports the national SMI physical health ambition and National CQUINS.

2. AIM OF SERVICE

In order to deliver the requirements of this objective the practices will need to:

- Increase the uptake of physical health checks for all patients on SMI registers (overall annual target of 60% of QOF SMI Register or pro rata)
- Adopt the use of the Bradford Toolkit for undertaking physical health checks. Data entry templates for both clinical systems are available (and updated) on the C and P dashboards/EMIS web support.
- Work closely to support PRISM teams with collaborative working and supporting access to physical health checks and interventions

3. SERVICE DELIVERY

To provide a comprehensive and systematic annual health check and cardiovascular risk assessment for those currently on the Severe and enduring Mental Illness register (SMI) to build upon the existing QOF criteria for Mental Health (MH).

a) Eligible individuals from the practice SMI registered list will be offered a health check which includes the interventions detailed at point 1a below.

1a *NICE Guidance Physical Health Checks for people on SMI Registers.

Measurements Body Mass Index Waist circumference Pulse rate (ECG if clinically indicated) Blood pressure	**Blood tests** Lipids Fasting Blood Glucose or HbA1C
Screening **Support access to all national screening programmes (cervical, breast, bowel, aortic aneurysm)** Encouraging discussion and provide advice on self-examination (breast and testicular) –well woman/well man advice	**Lifestyle advice/management** Sleep Smoking Exercise Alcohol Diet **(including request to PRISM for support to enable people to access physical health interventions)**
Medication **reconciliation and monitoring** including**:** Antipsychotics –annual Mood stabilisers –annual	

b) **Quality and Clinical Governance Standards**

The provider will ensure that patients receive a quality service whilst in their charge and will ensure the following quality standards are in place:

i) Ensure adherence to best practice and commitment to continually improving the service.

ii) Meet all clinical standards, legislative guidance and local procedures as required of the service.

iii) Meet all applicable statutory reporting requirements such as compliance against Care Quality Commission Quality and Safety regulations. The provider should provide evidence of compliance to the commissioner as and when requested to do so.

iv) Practices will be expected to adopt the Standard Operating Procedure attached herewith.

v) In addition, the service will be expected to conform to relevant national and local guidance and NICE guidelines in particular.

vi) Providers should ensure that appropriate risk management and health and safety procedures are in place.

vii) Providers should ensure appropriate systems are in place to report Serious Incidents in line with national and local policy.

4. PRICING

Practices will receive **£0.12 per patient**, based on list size as of 1st April 2020, for undertaking the requirements as outlined in this agreement for 6 months between 1st April 2020 and 30th September 2020.

5. REPORTING

Practices will not be required to submit SMI health check activity to the CCG as this will be extracted centrally on behalf of Practices, via our Primary Care Information Team on a quarterly basis.

APPENDIX 15 – VENOUS THROMBOEMBOLISM

1. BACKGROUND

The Venous Thromboembolism Service has been introduced by Cambridgeshire and Peterborough CCG. Currently this agreement is only available to practices located within the Greater Peterborough geography.

The Greater Peterborough agreement involves partnership working with either North West Anglia NHS Foundation Trust (PCH) or Excell Ultrasound Ltd

2. AIM OF SERVICE

The key aim for this local commissioned service is to provide a high-quality service to patients to access an initial assessment and diagnosis of a suspected VT. This Agreement supports primary care practitioners to manage the assessment and initiate treatment for a confirmed VT without the need for an onward referral to a hospital pathway. The expectation is that this will ensure the hospital pathway is accessed appropriately, (where the community option is not clinically indicated and/or available)

3. SERVICE DELIVERY

This specification sets out an in-hours service. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

To be eligible for Part 1 payment you must have the ability to:-

- **Assessment and completion of Wells Test**
- **Complete D-Dimer (including purchase of the equipment and ability to near test) if clinical indicated**
- **Initiate Dalteparin/Rivaroxiban if clinically indicated**

If you are unable to offer all of the above elements you will not be eligible to sign up to the LES.

5.1 Part 1 - tariff payment £52.00

All Practitioners will need to complete a full assessment and initiate immediate management of a suspected VT to become eligible to receive Part 1 payment.

I. If a patient presents with a suspected VT, the GP should undertake a Wells test. The NICE guidance Wells score template can be accessed on Systm1 (*click on Blue dot*) .

II. If a patient scores 1 or less, the GP should complete a D-Dimer test. Practices to purchase their own equipment or D-dimer test kits

III. If the D-Dimer test is positive, or the patient scores 2 or more, the GP should commence suitable treatment, either Dalteparin or Rivaroxaban and choose onward referral for an ultrasound scan to either the Community Provider, Excell Ultrasound Ltd or the hospital.

5.2 – Part 2 (A)– Community Provider Pathway - tariff payment £36.40

a. Excell Ultrasound Ltd is commissioned to provide access to a community ultrasound service and can be used by any GP Practice in the Greater Peterborough geography

b. For practices that choose to refer patients to the community provider for an ultrasound scan, practices will be responsible for the treatment plan, ensuring that patients receive the appropriate care following the scan. Depending on whether the result is positive or negative, this may include initiating treatment and organising further investigation where appropriate. An additional payment is attached to this part of the agreement – see Appendix 1.

c. A copy of the referral form is available see Appendix 2. Referral forms can also be downloaded from the Excell Ultrasound Ltd website www.excellultrasound.co.uk.

d. Referrals can be made via nhs.net to capccg.excell@nhs.net.

e. Please ensure that all the relevant information is included in the referral, including previous examinations, any mobility issues and BMI/weight and language if a non - English speaker.

f. The Community Ultrasound Provider will contact the patient to arrange an appointment. All patients are offered an appointment date and slot, usually on the same day or on the next working day. This may mean that an appointment is not at the patient's own surgery. If the patient refuses to travel to another venue, this may result in a delay in scanning and therefore we cannot guarantee the scan will be performed within the timeframe advised by NICE guidance.

g. The hours of operation of the service are attached – See separate Appendix 3.

h. When the patient is returned to the general practice with or without a positive test for a VT, the GP now has the responsibility for initiating treatment and organising further investigation where appropriate.

i. On receipt of the scan, the GP makes a decision based on the result and prescribes Warfarin as required, investigating unprovoked VTs as per pathway. This will involve 1-3 consultations.

j. Positive patients will require daily administering of Dalteparin or Rivaroxaban until INR is in the therapeutic range. This may be self-administered or administered by a practice clinician.

k. Any patient registered with a GP, who has signed up to this pathway, within the Peterborough locality can use this service.

5.3 Part 2 (B) Hospital Provider Pathway - Tariff payment £0.00

Practices can choose to refer patients to the hospital for an ultrasound scan, where the hospital will be responsible for undertaking the scan and acting on the results. Therefore **there is no additional payment for practices for onward referral via the hospital pathway.**

How to make a referral to the hospital (PSHFT)
A referral form is available on the Peterborough Hospitals extranet (a copy of this is attached at **Appendix 2**). Referrals should be made through e-RS when possible. Alternatively referrals may be made by email to peh_tr.VTService@nhs.net or via a telephone call (01733 677779). The patient will be given an appointment date and slot, usually on the same day or on the next working day

4. ACREDITATION

4.1 The contractor will ensure the provision of adequate facilities including premises and equipment as are necessary to enable the proper provision of services under this Agreement, including D-Dimer kits.

4.2 The contractor will ensure that the premises are fit for the purpose of the task with appropriate measures in place. All relevant staff should have received infection prevention and control training within the last 12 months and that policies are available to include hand hygiene, personal protective equipment, sharps and waste management including sharps injury management, decontamination and environmental cleaning. These should be in place in line with the Care Quality Commission registration requirements which come into force April 2012.

4.3 Further advice, guidance and training can be sought by directly contacting the Infection Prevention Control Team on email CAPCCG.ipc@nhs.net.

5. PRICING

Payment is dependent upon the level of service provided as outlined in the table below:

	Requirements	Payment Tariff
Part 1	Assessment, Wells Score **plus D – Dimer if required**	**£52.00**
Part 2 (A)	Onward referral to Community Provider	**£36.40**
	TOTAL PAYMENT	**£88.40**
Part 2 (B)	Onward referral to Hospital	**£0.00**

6. REPORTING

Practices are required to record and report the following information in the relevant 6-month period:

- The Total number of patients who have been assessed for a VT
- The Total number of patients with a positive result who have been referred for further management via the community pathway
- The Total number of patients with a positive result who have been referred for further management via the hospital pathway

APPENDIX 16 – WARFARIN INITIATION

1. BACKGROUND

Warfarin is being used in the management of increasing numbers of patients and conditions including patients' post-myocardial infarction, atrial fibrillation, DVTs and other disorders. While it is a very effective drug in these conditions, it can also have serious side effects, e.g. severe haemorrhage. These side effects are related to the International Normalised Ratio (INR) level, which measures the delay in the clotting of the blood caused by the warfarin. While the "normal" INR is 1, the specific range of INR values depends on the disease and the clinical conditions. Warfarin monitoring aims to stabilise the INR within set limits to help prevent serious side effects while maximising effective treatment.

2. AIM OF SERVICE

The overall aims of this service are to improve patient access to safe and effective Warfarin initiation through collaboration between the patients GP and the provider service.

The CCG is commissioning a community based initiation service with the following objectives:

- To make specialist clinical decisions regarding anticoagulation initiation for all new patients (the patient's GP or patient where appropriate will be involved in this decision making process).
- Ongoing monitoring of patients on warfarin using the most efficient method. It is expected that this will be done via point of care testing (POCT), unless it can be clinically justified otherwise.
- Monitoring will be performed using Clinical Decision Support Software (CDSS – INR Star) at all service delivery points.
- Undertake reviews for patients on warfarin medication
- Information flow between the service provider and patient's GP practice should be secure and electronic
- The service delivery should cover people who are housebound and disabled
- Healthcare professionals who initiate, monitor and / or review anticoagulation therapy must have the appropriate training, skills and competencies to meet the requirements of their role having undertaken an accredited online course(s).
- The service must provide value for money to the CCG
- Meet local key performance indicators (KPIs)

3. SERVICE DELIVERY

3.1 Service description/care pathway

The CCG wishes to commission a single delivery model that provides value for money to deliver the comprehensive service.

The full service is required to cover:

- Assessment of all new patient referrals, for patients not registered with the provider practice, and decision-making regarding initiation of the most appropriate anticoagulation therapy for each individual patient. This will involve considering all options which may be appropriate for each individual patient. Where required this decision making process may be done collaboratively with the patient's GP, and may include the patient/ carer.
- When a patient is referred to the provider for initiation of Warfarin they will prescribe medication and will be the initial point of contact for the patient and will determine with the patient which is the most appropriate monitoring option.
- Equivalent services will be provided in the homes of patients who are housebound.
- All clinical reviews and onward referrals will be in line with local clinical pathways.
- The provider must be able to pass on all data collected, including personal identifiable data, to the patient's GP practice electronically via secure system (NHS mail to NHS mail).

3.2 Overall service requirements

- Service risk assessment
- Staff training, skills and competency assessments
- Clinic times/appointment system and availability
- Patient register identifying patients not registered with provider practice
- Call and recall system for Warfarin patients
- Follow up patients that do not attend (DNA)
- Provision of expert clinical input to initiation/change of anticoagulation therapies
- Initiation of Warfarin for appropriate patients
- Prescription of Warfarin medication and testing strips
- Prescription of injectable anticoagulants in line with bridging plan when patient has their first clinical appointment where required.
- Monitoring, dosing and cessation of Warfarin
- Provision of equivalent service to housebound Warfarin patients
- Patient education
- Documentation and electronic sharing of clinic information with patient's GP practice
- Clinical reviews and reassessments for Warfarin patients in line with local care pathways.
- Liaison with secondary care where required
- Liaison with other health and social care professionals where necessary
- Contingency planning
- Systematic, standardised coding and reporting of adverse events
- Arrangements for disposal of sharps and clinical waste
- Clinical supervision
- Monitoring the safety and quality of service delivery
- Reporting and learning from serious incidents.
- Implementing action, where appropriate, on the results of safety and quality monitoring.

3.3 Eligibility criteria

- Ensure that all service delivery points meet Care Quality Commission (CQC) requirements for the delivery of medical services which as a minimum should be those required for the delivery of General Medical Services.
- Undertake a full service risk assessment, in line with NPSA guidance.
- Have competent individuals, who are registered health care professionals, named as the service lead and deputy lead at each service delivery site. The service lead and deputy lead will have overall responsibility for ensuring the safe and effective delivery of anticoagulation services at the service delivery site.
- Have at least one registered health care professional who is a prescriber working at all times that initiation clinics are running. This is to ensure all patients' anticoagulation therapy can be initiated and prescription can be provided, providing an efficient and consistent service for all patients.
- Ensure that all staff who are involved in service delivery are clinically competent to deliver the level of service they are required to provide and have appropriate up to date records to demonstrate this. This should involve being a registered health professional and having undertaken expert anticoagulation specific training – this will have included use of Point of Care Testing (POCT) equipment and the CDSS to aid dosing and patient education.
- Adhere to policy documents outlined in the SLA monitoring of Warfarin including annual audit review.
- Have service continuity plans in place to cover periods of absence for annual leave, study leave, sickness, equipment failure, epidemics and unforeseen events.
- Have adequate storage facilities for equipment and reagents.
- Have adequate indemnity insurance.

- Ensure that all staff involved in service provision has completed Enhanced Disclosure and Barring Service (DBS) checks.

3.4 Equipment (to be provided, maintained and insured by service provider)

The service provider will ensure that all equipment:

- Complies with current health and safety regulations
- Is properly maintained and calibrated in accordance with the manufacturer's instructions and is fit for purpose
- Complies with medical devices legislation

The service provider will be responsible for providing:

- The CCG purchased the initial near patient testing equipment to support GP practices. All subsequent near-patient testing equipment including POCT machines and testing strips for use in anticoagulation clinic or when visiting domiciliary patients must be purchased by the provider.
- Consumables (including single use lancets and personal protective equipment)
- Computer and colour printers in each service delivery site.
- Quality assurance materials
- Clinical waste disposal
- Oral anticoagulation therapy (OAT) information packs (e.g. yellow pack with book)

It is the responsibility of the service provider to ensure this equipment is kept in good working order, is serviced regularly and in line with manufacturer's instructions. It is the service provider's responsibility to ensure that all equipment is insured and to pay for the insurance if required.
The service provider must undertake internal and external quality assurance as appropriate.

3.5 Computerised Decision Support Software (CDSS)

The service provider must:

- Provide an appropriate CDSS which is compliant with the European Medical Device Directive, ISO 27001
- Use CDSS to undertake dosing
- Ensure the most up-to-date clinical version of the CDSS software is used
- Ensure that all staff using the software undertake training and are competent to do so
- Ensure all data is stored in line with NHS Information Governance requirements
- Ensure the CDSS used at all service delivery points is interoperable with GP systems

3.6 Domiciliary patients

The majority of appointments will be based in the community anticoagulation clinics but the service provider must ensure that the service is also provided for patients who are housebound or unable to leave their home environment due to physical or psychological illness.

Within this service, home visits are required for patients in the following circumstances:

- Bed bound
- Leaving home is medically contra-indicated
- They are dependent on specially adapted transportation

In the case of a home visit, the service provider must take all necessary equipment with them to provide the full service at this location.

3.7 Population covered

Patients registered with Mercheford House and Riverside Practice who require initiation of Warfarin and patients registered with Trinity Surgery and Clarkson Surgery, Wisbech who require initiation of Warfarin.

3.8 Clinic Reviews

3.8.1 Warfarin Review/ Discontinuation

- Routine clinical review of anticoagulants should be undertaken at a frequency appropriate to the indication for warfarin, and the clinical circumstances of the individual patient.
- Clinical review and reassessment of warfarin should take into account as a minimum: cognitive function, medicines adherence, illness, interacting medicines, lifestyle factor that could affect INR, renal function and adverse events relating to warfarin.
- Liaison with the patient's GP may be required to fully complete the review in complex cases.
- It is the responsibility of the provider to call warfarin patients for their review.
- All reviews should be fully documented and the patient's GP informed, providing that warfarin dose is not being changed, or discontinued.
- If discontinuing warfarin, the date of cessation and reason should be documented and the patient's GP informed by email and letter on the same working day.

3.8.2 Any acceptance and exclusion criteria and thresholds

The fee will be paid for new patients (not registered with the provider practice) who have never had Warfarin. The fee cannot be claimed for restarting after stopping treatment due to a high INR or other management issues.

3.8.3 Interdependence with other services/providers

NHS Acute Trusts, Riverside Practice, Mercheford House Surgery March, Trinity Surgery, Wisbech; Clarkson Surgery Wisbech

4. PRICING

The provider will receive the sum of **£63.02 per patient** for initiation of Warfarin for non-registered patients.

5. REPORTING

The number of non-registered patients who have received warfarin initiation in the relevant 6-month period

APPENDIX 17 – MEDICINES OPTIMISATION

THIS APPENDIX HAS BEEN UPDATED – SEE UPDATED APPENDIX 17 DATED FEBRUARY 2022 AT THE FOLLOWING LINK BELOW

https://www.cambridgeshireandpeterboroughccg.nhs.uk/health-professionals/patient-pathways/local-commissioning-agreements/