Ealing Local Primary Care Specifications 2024-25

Contents

~~Respiratory~~ (Replaced by NWL Specification)

Standard 1: Musculoskeletal Health

Rationale	"Life expectancy in England has risen by more than five years in the past two decades, yet for many people, a longer life will involve more years spent in ill-health. Musculoskeletal conditions are disorders of the bones, joints, muscles and spine. They can cause pain, stiffness or a loss of mobility and dexterity that can make it difficult to carry out everyday activities. Low back and neck pain are now the leading cause of disability in England for both men and women combined. Falls, which are often a result of poor musculoskeletal health, also remain in the top ten causes of disability adjusted life years – a combination of the number of years of life lost to disease and the number of years lived with disability as a result of disease.

The wider effects

Each year 20% of people in the UK see a doctor about a musculoskeletal problem, and the NHS in England spends £5billion each year treating these conditions. As well as causing pain and disability, musculoskeletal conditions can affect people's physical health more generally. For example, people with osteoarthritis have an increased risk of cardiovascular disease, and falls among older adults increase the likelihood of early mortality. Although many musculoskeletal conditions become more common as we age, they are not limited to older adults. A report published by Arthritis Research UK in 2014 highlighted that, in the past year, one in six adults aged over 25 had reported back pain lasting more than three months. Obesity, physical inactivity and injury are all major risk factors for back pain. Mental health conditions can also increase the likelihood of developing some musculoskeletal disorders. For example, people with depression are at greater risk of developing back pain. Here lies a vicious cycle, as musculoskeletal conditions can also have a significant impact on mental health. Living with a painful condition can lead to anxiety and depression, and depression is four times more common among people in persistent pain compared with those without pain. People with musculoskeletal conditions are also less likely to be employed than people in good health, and are more likely to retire early.

Musculoskeletal health: Making a difference

Steps can be taken to improve musculoskeletal health at every stage of life, and tackling a number of risk factors could result in the dramatic improvement in the musculoskeletal health of the public. Bones, joints and muscles begin to develop before birth, and continue to develop throughout childhood. Women who have a good diet and are physically active have babies that go on to have stronger bones throughout life. Conversely, childhood obesity can put pressure on vulnerable joints, increasing the risk of MSK conditions. Regular physical activity and exercise at every stage of life can reduce the risk of many musculoskeletal conditions, including arthritis, back pain, neck pain, falls and fractures. Indeed, many of the NICE guidelines on physical activity to prevent disease or improve health are directly relevant to musculoskeletal health. A healthy balanced diet is also important for good bone health, to prevent osteoporosis and falls in later life. There is also a lot that can be done in the workplace to reduce any threats to musculoskeletal health, including adapting physical environments and work practices, as well as early interventions to identify and address problems. It's important to note that, for the three leading musculoskeletal conditions that cause the most DALYs in England, there are evidence-based interventions that work, see table below. |

Musculoskeletal Condition	Intervention
Low back and neck Pain	・Stay Physically Active and exercise regularly (For example, through a group exercise programme) ・Weight loss support (if required)
Falls	・Strength and balance training ・Home hazard approach ・Participation in falls prevention programmes such as Otago and FaME ・Activity such as tai chi, dancing or gardening
Osteoarthritis	・Activity and exercise to strength muscles and improve aerobic fitness, such as walking swimming or Pilates ・Weight loss support (if required)

The Ealing primary care perspective

Public Health England data shows that Ealing has:

- High rate of falls and emergency admissions for falls in people >65yrs.
- High rate of inactivity in adults.
- Priorities relevant to primary care, identified in the Ealing JSNA are:
- Increasing physical activity at all ages.
- Referral to falls prevention programmes.
- Secondary prevention of fragility fractures.
- Improved management of chronic pain.
- Reducing obesity and smoking in adults.
- Reducing unwarranted variations in referral rates between GP practices.
- Improved links between NHS and return to work schemes.
- Priorities from other sources:
- Increase numbers of orthopaedic referrals referred to community interface services for assessment, prehab, and diagnostics to deliver the right conservative and surgical options for patients.
- Improve advice offered in primary care to support self-management for people with musculoskeletal disorders to reduce unnecessary early referrals to physiotherapy
- Improve step-down support to reduce harm from prescribing for chronic pain: tapentadol, opioid and lignocaine patches, pregabalin
- Improve patient adherence for bone-sparing medication

Delivery

As part of this standard the provider is expected to:

General health promotion and primary prevention

1. Signpost people to activity and exercise classes appropriate for their age and health.
2. Advice regarding weight loss and healthy lifestyle programmes for people at risk of lower limb osteoarthritis and back pain.
3. Undertake a brief falls assessment in patients identified on GP systems as meeting frailty criteria, or a history of falls (e.g. FRAT).
4. Use the FRAT tool score to guide a share decision-making discussion with the patient regarding signposting to advice to reduce risk of falls (e.g. leaflet, local provision (if available)) or referral to physio-led falls service for those at medium and high risk of falls.
5. Integrate the management of physical and mental health; psychological distress makes self-management of musculoskeletal disorders more of a challenge.

Consider what psychological support is needed for people with long-term musculoskeletal conditions.

Secondary Prevention

1. Offer specific advice on activity modification and condition-specific exercises for people with musculoskeletal disorders.
2. Identify and maintain a register of people who have had a previous fragility fracture. Reduce the risk of further fractures by screening for osteoporosis and offering lifestyle interventions including diet and physical activity (e.g. using FRAT score and protocol).
3. Offer a stepped care and problem-solving approach to helping people with musculoskeletal disorders stay at work or return to work; work is a 'health outcome' that is strongly associated with better physical and mental health.

Referral Management

1. Manage patients with acute musculoskeletal conditions or acute flare- ups of chronic musculoskeletal conditions in primary care unless they meet the NW London ICB referral thresholds.
2. Use validated risk assessment tools (e.g. STarT Back) and validated decision aid tools (e.g. Cochrane surgery decision aids) to support a documented a shared decision-making discussion with patient regarding referrals.
3. Refer all non-emergency spinal, upper and lower limb conditions to the community interface service for assessment, prehab and diagnostic work-up where the GP believes surgery is the appropriate option.

Chronic Pain management in Primary care

1. Support patients to self-manage chronic musculoskeletal pain in primary care if a treatable musculoskeletal condition has been excluded, particularly those previously assessed by musculoskeletal, orthopaedic or pain services. Use an accredited system of patient information and psychological support.[1]
2. Manage concomitant depression and anxiety in patients with chronic musculoskeletal pain with appropriate psychological or pharmacological interventions.
3. Manage medication for patients with chronic musculoskeletal pain to reduce the risk of harm from ineffective interventions and choose more cost-effective options where available.

Key Performance Indicators (KPIs)	The provider is required to meet the below Key Performance Indicators: 1. 95% of people with a new fragility fracture between 1st April 2024 and 28th February 2025 at each practice are offered a falls assessment by 31st March 2025 using FRAT score and referral to falls team if deemed appropriate. 2. All patients identified as having a fragility fracture between 1st April 2024 and 28th February 2025 are screened for osteoporosis including requesting a DEXA scan if appropriate and considered for bisphosphonate if osteoporosis is confirmed.[2] Any fragility fracture after these dates should also be considered for intervention but it doesn't impact on the KPI.

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[1] **https://www.csp.org.uk/conditions/falls-fractures**

[2] **SNOMED code Screening for Osteoporosis Xa704 / 300004007**

Borough Team Support	The local borough team will provide: · Business rules for SNOMED codes and extraction to support KPIs and local dashboard development. · Work with Local Authority and voluntary sector to provide signposting information for primary care clinicians, including a list of voluntary sector and directly commissioned exercise classes and health lifestyle services to support self-management, including digital integration. · Commission access via the MSk interface service to a community- based combined physical and psychological programme for people with chronic musculoskeletal pain. (Community single contract 2019). · Work with ICS Musculoskeletal Network to provide signposting to support self-management, ensuring digital integration.
References	· https://cks.nice.org.uk/topics/osteoporosis-prevention-of-fragility-fractures · https://www.nogg.org.uk/full-guideline/summary-main-recommendations · https://www.csp.org.uk/conditions/falls-fractures
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Standard 2: Last Phase of Life	
Rationale	Approximately 500,000 people die in England each year. People with advanced life threatening illnesses and their families should expect good end of life care, whatever the cause of their condition. In addition to physical symptoms such as pain, breathlessness, nausea and increasing fatigue, people who are approaching the end of life may also experience anxiety, depression, social and spiritual difficulties. The proper management of these issues requires effective and collaborative, multidisciplinary working within and between generalist and specialist teams, whether the person is at home, in hospital or elsewhere. Information about people approaching the end of life, and about their needs and preferences, is not always captured or shared effectively between different services involved in their care, including out of hours and ambulance services. Families, including children, close friends and informal carers, also experience a range of problems at this time. They play a crucial role and have needs of their own before, during and after the person's death: these too must be addressed. Many people receive high-quality care in hospitals, hospices, care homes and in their own homes but a considerable number do not. Up to 74% of people say they would prefer to die at home, but currently 58% of people die in hospital. There is considerable geographical variation. In Ealing 49.1% of people die in hospital, 27.3% at home, 14.0% in care home and 6.1% in a hospice[3]. The last phase of life agenda is a priority of the NWL ICS. Key areas are training, identification and advance care planning and lead provider delivery.
Delivery	**<u>Identifying Patients in the Last Phase of Life</u>** About 1% of practice populations will die each year in England, with most deaths occurring due to old age. London, however does not have the same mortality rate and in Ealing it equates to approximately 0.5%. GPs are increasingly playing a role in identifying and managing patients in the Last Phase of Life. Cancer only accounts for about 25% of all deaths - hence the importance of GP identification of patients including adding appropriate patients onto the palliative register who have progressive long term conditions like heart failure, COPD and dementia. Many of these patients can be managed in the community by the GP practice, with advice/guidance sought from the Palliative care teams as required. Some of your deaths will be genuinely 'unexpected': around 16% each year are in under 65-year-olds, but in over 65-year-olds only 0.25% is from 'external causes'. You should ask yourself "Would I be surprised if this person were to die in the next 12 months?" This simple question is accurate seven times out of ten. If you are not surprised, you should consider adding them to the palliative care register. General clinical indicators of deterioration and frailty include: - Limited self-care and interest in life: in bed or a chair more than 50% of their time. - Breathless at rest or on minimal exertion (MRC scale 4/5). - Progressive weight loss (>10% over last six months). - History of recurring or persistent infections and/or pressure ulcers.

	The GSF Prognostic Indicator Guidance has details of clinical indicators by condition. Metastatic disease should always trigger consideration of supportive care; WHO states that in cancer patients >50% of time in bed or lying down gives a prognosis of fewer than three months' survival. The Rockwood Frailty Scale and eFI give a good indication of severely frail patients who may be approaching the Last Phase of Life.

For Ealing practices there is significant variation in the percentage population on the palliative care register (currently 0.2 %).

Delivery

The provider is expected to:

1. Identify Last Phase of Life Lead at each practice.
2. Ensure palliative care register on SystmOne is regularly updated so that the appropriate practice population is correctly identified. Benchmark is 0.3% of the population.
3. Use the Universal Care Plan for appropriate patients
4. Confirm next of kin details for patients on register
5. Record Preferred Place of Care/Preferred Place of death for patients where advance care planning has taken place |
| **Key Performance Indicators (KPIs)** | The provider is required to meet the below Key Performance Indicators at a Primary Care Network Level

1. Every patient on end of life pathway to have a Universal Care Plan record which is regularly reviewed and updated. (Target: **80%**)
2. All patients with Universal Care Plan should have Preferred Place of Care/Preferred Place of Death recorded within the plan (this should write back to clinical system if Valida used) and clinical system. (Target: **75%**)
3. The Primary Care Network palliative care register should be **0.3 %** |
| **Borough Team Support** | The local borough team will provide:

‧ Dashboard of palliative care register for each network
‧ Annual self-declaration form |
| **References** | ‧ NICE Quality Standard 13: End of Life care for adults[4]
‧ Dying Matters[5]
‧ Gold Standards Framework[6]
‧ Ealing Joint Strategic Needs Assessment[7]
‧ Macmillan Palliative and End of Life Care Toolkit[8]
‧ Rockwood Clinical Frailty Scale[9] |
| **Ealing contact** | Dr. Anna Down

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[4] www.nice.org.uk/guidance/qs13

[5] www.hospiceuk.org/our-campaigns/dying-matters

[6] www.goldstandardsframework.org.uk

[7] www.ealing.gov.uk/downloads/file/13876/end_of_life_care_-_jsna_2018

[8] www.rcgp.org.uk/clinical-and-research/resources/toolkits/palliative-and-end-of-life-care-toolkit.aspx

[9] www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale_.pdf

Standard 3: Dementia	
Rationale	Over the last few years Ealing has performed well in achieving high diagnostic rates, above the target. However, diagnostic rates in Asian and Black communities have been significantly lower than in other groups. The diagnosis, management, and post diagnostic support of people with Dementia and their carers continues to be an important priority, not least due to our ageing population. The principles of the previous Ealing Standard for Dementia continue to hold, however we would like to highlight areas for particular attention. The first as mentioned above is to improve diagnostic rates in the BAME community as there may be significant numbers who without a diagnosis, are not receiving adequate management. Medication, care and support. Secondly, in light of Covid-19, health and social care services have had to review ways of working. This has highlighted the need to have better communications including up to date care plans and using Urgent Care Planning when appropriate Dementia Link Workers continue to be part of the community services to support Primary care.
Delivery	**Aims** · To maintain diagnostic rates above the National Target of 66.7%, with a particular emphasis on increasing awareness and diagnosis in Black, Asian and Minority Ethnic populations. · To continue to manage stable patients in primary care, including up to date care plans, medication reviews and use of Urgent Care Planning where appropriate. **Delivery** Providers will be expected to: 1. Provide prescriptions of cholinesterase inhibitors, and other medications that may be used in the treatment of dementia, once a maintenance dose has been achieved, monitor compliance and side effects. 2. Accept transfer of care of stable patients from CIDS. If the practice does not formally accept the transfer the patient will not be discharged by CIDS. 3. Monitor progression of dementia using general history taking of activities of daily living and support required during opportunistic or schedule consultations. 4. Work with the Dementia Link workers when appropriate. 5. Be aware of drug interactions when changing medications. 6. Refer back to secondary care if there is deterioration in mental state after ruling out other causes for this deterioration. 7. Ensure that family carer gets support, advice and health checks from GP. 8. Ensure care plans are up to date; use Urgent Care Planning when appropriate. Discuss advanced care plans/directives and resuscitation wishes with patient when appropriate 9. Run the Dementia case finding reports at least every 6 months and code appropriately 10. Make efforts to ensure the practice is dementia friendly/ dementia aware
Key Performance Indicators (KPIs)	The provider is required to meet the below Key Performance Indicators at a Primary Care Network Level 1. End of year self-declaration of case finding searches 2. End of year self-declaration to include a couple of examples[10] of practice

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[10] **https://www.alzheimers.org.uk/sites/default/files/2019-04/2017_dementia_friendly_general_practice_toolkit_guide_notts_derbys_project.pdf**

	approach to becoming dementia aware/dementia friendly
Borough Team Support	The local borough team will provide: · Annual self-declaration form
References	· Ealing Joint Strategic Needs Assessment for Dementia[11] · Guidelines for Treatment of Dementia with Acetylcholinesterase Inhibitors and Memantine · London Dementia Clinical Network Prescribing guidelines
Ealing contact	Dr. Anna Down nhsnwl.ealingprimarycare@nhs.net

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[11] www.ealing.gov.uk/downloads/download/5070/dementia

Standard 4: Healthy Child		
Rationale		**Babies and Children: 20% of Our Population, 100% of Our future**

Ealing's babies, children, and young people have the right to be happy, healthy and well. This standard has four parts aiming to support this,

The PCN Child Health Champion: A named PCN GP[12] with a passion to improve child health, to lead on implementation of the Healthy Child standard across Primary Care Network. In addition, act as a conduit between PCN and Integrated Care Partnership to support development/ implementation of:

· Family Hubs for Early Years
· Child Health Hubs to support Primary Care
· Single Point of Access for children's services (Children's Community Health, Social Care and CAMHS)

The Child Health Champion will cascade relevant information across practices, collate feedback from patients/ colleagues, and communicate with ICP professionals when required. The named Champion will also support PCN Social Prescribers to design and roll out the targeted healthy child offer.

Healthy Child Leaflets: Designed to signpost children, their parents/ carers and professionals to supportive local services to help children lead healthy lives and feel well. Childhood is a critical time to develop healthy habits and learn how to access services appropriately. 'It takes a village to raise a child' - health services (including GP surgeries) alone cannot solve many of the causes of ill health affecting children. These include poverty, housing/homelessness and racism/discrimination.

Targeted Healthy Child Offer: No two childhoods are equal. Inequality exists between and within PCN populations. Disadvantaged children/ parents or carers require targeted support to successfully access services. Supported by the PCN Child Health Champion the PCN Social Prescribers are asked to identify a disadvantaged/ vulnerable cohort of children and design and run sessions (group or individual) to increase awareness of services on healthy child leaflet and if relevant support referral. This is likely to be in conjunction with the faith, community and voluntary sector in the local area.

Asthma: The asthma element of the standard aims to increase diagnosis, coding and management in line with BTS/SIGN guidance. Runs alongside QoF requirements, using PCN Pharmacists, GPs or equivalent staff. Asthma is the most common long term condition among children and young people. Asthma continues to be among the top 10 causes of emergency hospital admission for children and young people in the UK.

The UK has among the highest mortality rates in Europe for children and young people with the underlying cause of asthma. Emergency admissions, and deaths, related to asthma are largely preventable with improved management and early intervention. Improving the diagnosis and management of asthma will save lives. |
| **Delivery** | | **Aims**
Child Health Champion: Child advocate for PCN - Raising profile of children and their health needs. Support roll out of standard. Main PCN contact point for teams working to develop Family Health Hubs and Child Health Hubs. Gives each PCN a 'voice at the table'. Helps with information cascades. |

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[12] **In discussion with the borough team there is some flexibility over this role however the individual is required to have the necessary influence and impact in their network in order to achieve the aims of the specification and in the large majority of situations this would be a GP.**

Healthy Child Leaflets aim to signpost all families and children (and professionals) to age relevant services for children within the borough to enable them to lead healthier, happier lives. The 'targeted offer' aims to support disadvantaged/ vulnerable children/ families access support and increase trust in services. In line with Core20PLUS5 (a national NHS England approach to support the reduction of health inequalities). The PCN will choose the cohort of patients they wish to target dependant on the needs of their population. PCNs are encouraged to access existing quantitative data to identify communities with inequalities (i.e. using WISC)

Example cohorts for consideration include:

- Child/ child of a parent/ carer coded as refugee/ asylum seeker/ homeless
- Child of parent/ carer requiring independent translator
- Child of parent/ carer with significant mental illness
- Young Carer
- Particularly underserved ethnic minority communities who may face multiple disadvantages (e.g. Gypsy/Roma/Traveller communities)

PCN to consider working with third sector organisations (i.e. faith, community and voluntary sector) running group or individual sessions (for example, engagement with local religious centre, a hotel housing refugee patients, young carers centre or mental health charity). Ealing ICB team will run training to Social Prescribers/ other staff to support this work.

Asthma standard aim is to prevent avoidable asthma deaths, improve diagnosis and support clinical practice in line with BTS/SIGN Guidance 2021. PCN Clinical Pharmacists are expected to take the lead.

The standard recognises the importance of allied health care professionals working in Primary Care Network teams.

Delivery
The provider will at PCN Level:

- Provide Ealing ICB with name of Primary Care Network Child Health Champion
- Provide PCN Child Health Champion with protected time (2 hours per month) to promote standard and work with ICP professionals as and when needed to support development/ work related to child health services in borough. This could include supporting development or workings of PCN Child Health Hub, representing PCN in discussions to development of Family Health Hubs and cascade information to PCN professionals regarding borough level service developments relating to children. The Ealing ICB GP Clinical Lead for Children will work to support the Child Health Champions develop into their role.
- Provide evidence of time spent if requested
- Provide a written report detailing name and designation of professionals attending education session, cohort chosen for targeted offer – and rationale, search and numbers identified, work within PCN or with third sector organisation to design intervention. Documentation of support given and outcomes.

The provider will at Practice Level:

- All PCN practices send out (electronically) age relevant healthy child leaflet to all children (0-17 years)/parent registered. Paper copies should be made available and shared at registration and during consultations.
- Social Prescribers/equivalent to attend Ealing ICB education session

	• Run search to identify children (0-17) who received 6 or more SABA inhalers in last 12 months. Ensure these children are also prescribed an inhaled corticosteroid (or another preventer drug) • Ensure all children prescribed an inhaled corticosteroid (or another preventer drug) are Read coded as 'asthma' or 'suspected asthma'[13] and are reviewed in a Face-to-Face clinical appointment as outlined in QOF.
Key Performance Indicators (KPIs)	The provider is required to meet the below Key Performance Indicators at a Primary Care Network Level 1. Name of PCN Child Health Champion to be shared with local borough team 2. All children (0-17) receive age relevant healthy child leaflet 3. PCN level report detailing/ evidencing 'targeted healthy child' offer 4. All Children & young People prescribed more than six short acting bronchodilator reliever inhalers (SABAs) in the previous year prescribed inhaled corticosteroids (or another preventer drug) clinically coded with asthma/ 'suspected asthma' and reviewed as per QOF requirement
Borough Team Support	The local borough team will provide: • Relevant health child leaflet and material • Supportive training sessions for SP/ equivalent to be run by Ealing ICB/ Public Health to support targeted healthy child offer • Supportive training/ upskilling session for Child Health Champions • Appropriate clinical searches for asthma • Annual self-declaration form
References	• State of Child Health: Asthma[14] • BTS/SIGN Asthma guidelines 2021[15] • Core20+5[16]
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[13] **It should be noted this work may lead to a clinical intervention, which should be completed under QoF**

[14] **https://stateofchildhealth.rcpch.ac.uk/evidence/long-term-conditions/asthma**

[15] **www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma**

[16] **www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/**

Standard 5: Carers	
Rationale	It is widely acknowledged that carers have an important part to play in an effective health care system. There has been a growing emphasis in recent years on the need to provide more comprehensive support to carers, since they often face greater social deprivation, isolation and ill health. Those caring for 50 hours a week or more are twice as likely to experience poor health, particularly mental health problems (Carers UK, 2014). Nationally, there are 6.5 million unpaid carers, accounting for 1 in 8 adults (Carers UK, 2015). The 2011 census suggests there are around 28,773 unpaid carers in Ealing, with 50-64 year olds making up the largest proportion. (Ealing JSNA, 2016). Of these, only a small proportion is known to the Council and/or their GP. Studies show that 70% of carers come into contact with the NHS, yet only 10% of these are identified as a carer (Schonegevel, L. 2013). Healthcare staff are not always proactive in signposting carers to relevant support or information, and when information is given, it comes from charities and support groups. (NHS England, 2014). In addition, patients do not always self-identify themselves with the term 'carer' and feel that they are simply carrying out ordinary responsibilities as part of a family. Therefore, proactive interaction is required in order to identify those who would benefit from carers' support. Ealing Council and Ealing Clinical Commissioning Group Joint Carers' Strategy 2018-23[17] highlighted a number of areas of development needed in order to better support carers, which included better identification of carers through primary care and enabling carers to have a life outside of their caring responsibilities. It is acknowledged that GPs are developing and improving their services for carers. However, the Royal College of General Practitioners (RCGP), (2014) highlights an urgent need to further embed the identification and support of carers within General Practice. This will ensure carers are supported at an earlier stage, enabling real benefits for both carers and patients alike.

Delivery	**Aims**
	This carers standard aims to deliver the following:
	
	    · To improve the number of carers identified within GP practices in Ealing.
	    · To ensure that carers who are identified have access to the health care they need including access to health checks.
	    · To ensure that all carers identified are referred effectively for the provision of on-going advice, information and support.
	
	Delivery
	The provider will:
	
	    · Identify a Carers Lead within each practice;
	    · Ensure that all staff, including receptionists, are 'carer aware', and have a basic understanding of support available;
	    · Display information in the waiting room and via other communication methods (e.g. website, newsletters), to help carers identify themselves and to highlight available support and information;
	    · Maintain links with local carer organisations, social services and the voluntary sector;

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[17] https://www.carersuk.org/media/gjid2e1i/uk4067-state-of-caring-2014.pdf

	• Have a carers register (for carers registered at each practice) which is maintained and updated; suggest that the question "do you look after someone?" is asked at point of registration • Record carer status in patient notes; and link to patient cared for if patient cared for is also registered at the practice and has given consent • Offer carers an annual health assessment where carer is registered at the practice; • Offer carers an annual flu vaccination where carer is registered at the practice; • Offer access to IAPT, social prescribers, the voluntary sector and other sources of support as appropriate
Key Performance Indicators (KPIs)	The provider is required to meet the below Key Performance Indicators: 1. Review carers register and ask carers if they would like an 'In Case of Emergency' (ICE) card, which logs the details of the person they care for with Local Authority and London Ambulance Services in case something happens to them then the person they care for can be looked after 2. Offered all carers a health check and flu jab, and complete a health check for at least 50% of carers on the carers register in order to review their physical and mental health and refer for further support as needed 3. Practice to keep a carers register which should be clinically reviewed and updated on an annual basis. 4. Practices to give priority to carers for appointments and offer double appointments so carer and patient can be seen if needed as carer may not be able to attend if no one to look after their cared for person
Borough Team Support	The local borough team will provide: • Provide regular information to practices on Carers developments; • Provide data and information on practice achievement of this standard; • Annual self-declaration form
References	• Carers UK, (2014) The State of Caring 2014[18] • Ealing JSNA 2016 Carers[19] • Schonegevel, L. (2013) Macmillan briefing on carers issues[20] • NHS England (NHSE), (2014) Commitment to Carers[21] • Ealing Carers Strategy 2018-23
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[18] www.bl.uk/collection-items/state-of-caring-2014

[19] www.ealing.gov.uk/downloads/download/5068/carers

[20] www.macmillan.org.uk/documents/getinvolved/campaigns/mps/commons2ndreadingbriefing.pdf

[21] www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf

Standard 6: Green Initiative	
Rationale	The NHS England Long Term Plan published in January 2019, outlined the national targets of reducing the carbon footprint of health and social care in line with the Climate Change Act targets of 51% by 2025. Primary Care is a large part of this carbon footprint with its many varied estates and multiple types of patient contact.

There has been a massive push to decrease the negative impact our behaviours have on the environment and we can make many adjustments to how we work and interact with patients by making changes over the next few years. Some may be small and incremental changes, whilst others may take preparation and additional support.

This standard aims to embrace the climate movement and encourage as many practices as possible to start making changes that will improve the health and wellbeing for generations to come. |
| **Delivery** | The Standard will be broken down into 'Essential Components' and 'Bucket List' items. There are 8 Bucket List items to choose from. Each Bucket List item has several activities. For example, Bucket List item 2 (Raising awareness: education and training of primary care team) has 4 activities (a, b, c & d). (This will be evidenced via completion of a practice based survey)

Each practice needs to fulfil the **Essential Components**:

- Designate a Green Champion Lead (clinical and/or non-clinical) within each practice as well as a PCN Green Champion who will have oversight and steer the practices to achieve targets.
- Ensure quarterly attendance at educational events and/or review resources, followed by documenting the dissemination of information within the practice.

Bucket List items completion:

- a) Complete a minimum of 2 activities per Bucket List item, from 5 of the 8 Bucket List items specified in the Delivery section, totalling 10 activities
  or
- b) i) Alternatively, select a minimum of 2 activities from the Bucket List items and
  ii) provide evidence showcasing a decrease in carbon emissions compared to the initial baseline. This evidence can be demonstrated through a carbon footprint assessment and/or improved wellness metrics.

Practices will need to audit at the beginning of the year to evidence their change in practice.

Bucket List items:

1. Calculate your practice's carbon footprint
To achieve a reduction in carbon emission, calculate the carbon footprint of your practice to act as a baseline from which changes to achieve net zero can be measured. Utilise the free online carbon footprint calculator (non-clinical); work out a plan to target and reduce at least one hotspot identified (e.g. using electronic systems instead of printing; cleaning products; changing lightbulbs to LED; installing smart meters; tuning off monitors when not in use)

2. Raising awareness: education and training of primary care team
The team need to view clinical and non-clinical care through the sustainability lens and be role models to patients. |

a. Have 'Green Agenda' as a recurring item in practice/staff and clinical meetings to raise awareness and discuss practical tips on how to mitigate climate change

b. Trainers/supervisors (GPs, nurses, clinical pharmacists) to educate trainees/students about 'greener sustainable primary care' and encourage involvement in quality improvement projects on environmental sustainability; feedback on findings, challenges and progress to the wider team

c. Practice to hold multidisciplinary team meetings (at least 1-2 meetings/year) which could include ARRS team, social care, community services and external speakers to discuss green agenda and take forward any recommendations

d. Embed sustainability in practice culture - implement policies such as staff health and well-being and/or initiate projects that are sustainable

3. Raise awareness: engage and empower patients

According to a nationally representative survey of adults conducted by MORI 2021, the public considered climate change to be a huge threat to their own health as accidents and mental health problems but majority failed to identify NHS's role as a major contributor of emissions.

a. Display and communicate public awareness material such as active travel posters, inhaler disposal and medicine wastage via laminated posters in the waiting room, surgery website, social media.

b. Discuss climate crisis with PPG and get them involved in practice action(s) as identified through discussion and carbon foot printing

c. Engage with the Social Prescriber on green community schemes (e.g. community gardens, tree planting, gardening, caring for wildflower areas); share case studies (at least one) to the wider practice team

d. Promote climate and health initiatives with your patient population (e.g. via posters, newsletter, website, group consultations, SMS)

    i. Encourage balanced plant-based diets; increase their consumption of whole grains, nuts, seeds, plant-based protein, fruits and vegetables, whilst reducing red meat and processed food consumption *and/or*

    ii. Promote physical activity for maintaining a healthy weight and improved physical and mental health *and/or*

    iii. Promote self-care practices and self-management

4. Promote Green Travel for both staff and patients

a. Sign up to the government supported 'cycle to work scheme' for staff

b. Conduct staff travel survey - analyse travel data and identify perceived barriers to active travel; identify which actions would be most effective to implement to encourage a shift to active travel at the level of general practice (e.g. safe storage for bicycles, changing facilities)

c. Take time to encourage staff to walk, cycle to work or car share where possible

d. Take time to encourage patients to attend appointments using active transport as opposed to driving

e. Encourage patients to adopt active transport into daily life (e.g. Ramblers Walking for Health have many local routes and social groups for patients and staff of all mobility levels; Green health routes)

f. Encourage accountability of travel (e.g. use of a GPS watch to track steps, miles etc.)

g. Sign up to the RCGP Active Practice Charter and become one of the national networks of practices making positive changes in staff and patient welfare

5. Reduce unnecessary visits to practice

a. Provide staff training around reduction in the number of appointments each patient attends thereby reducing the appointment attendance per patient

b. Encourage patients to reduce the number of appointments they attend in person and to be efficient with booking review appointments (e.g. patient with learning disability needing diabetes and asthma check can be invited for review in addition to the annual health check in one practice visit)
c. Introduce chronic disease 'one stop' clinics
d. Encourage remote consultation/use of digital tools to reduce the number of visits to GP practices e.g. use of digital documentation such as consenting forms, extension of sick note, prescriptions, etc.

6. Embed the '5 Rs' into Practice culture
Incorporate the '5 Rs' (refuse, reduce, reuse, repurpose, recycle) into your practice's waste reduction and recycling efforts, to minimise landfill waste and reduce carbon emissions with added financial benefits.

Reduce
a. Reduce the amount of printing done and if it is, then encourage double sided printing. Put up signs saying, "Think before you print", "Please print only if necessary"
b. Educate staff - save pathology/microbiology forms electronically and only print when patient attends for their tests as appropriate - saves time/wastage
c. Conduct a case study or audit to review pathology and microbiology tests, aiming to implement a strategy that reduces over-investigation and/or duplication
d. Optimise existing stock-taking practices with the aim of ordering only what is used, ensuring equipment and other resources are used before their expiration date, and preventing over-ordering
e. Provide staff training to reduce waste from over diagnosis and over-investigation (e.g. use Choosing Wisely)
f. Implement a SusQI approach to identify low-value interventions and embed change at a practice level

Reuse
g. Reuse as many items as possible instead of buying new ones; put up signs in the practice to encourage staff to think about what they are using and how to reduce waste (conscience prodder)
h. Use scrap paper and paper clips instead of post it notes

Repurpose
i. Prioritise refurbished, repaired, and reused items over new, where appropriate, e.g. furniture, blood pressure or ECG machines etc.

Recycle
j. Increase paper recycling in practice by ensuring each room has a box to put paper in (ensuring appropriate disposal of confidential paper) and that staff use this paper for use rather than new paper
k. Recycle whatever you can – paper, plastic, metal and glass; 'hard-to-recycle' items (lotion tubes/pumps, medicine blister packets, printer toners)
l. Encourage safe disposal of inhaler devices by returning to the pharmacy

7. Inhaler Changes
Metered Dose Inhalers (MDIs) use hydrofluorocarbons which are used in the propellant of the inhaler, so reduction in their use is encouraged either through switching to dry powder inhalers (DPIs), reducing the amount that is used or switching to lower carbon inhalers. About 70% of inhalers prescribed in the UK are MDIs which account for 4% of the entire NHS carbon footprint.

	a. Switch over 50% MDIs to DPIs b. Switch current MDIs to lower carbon inhalers (50%) **8. Medicine Usage** In primary care, medications account for the largest carbon emission 'hotspot', and there is a growing acknowledgment of the risks of pharmaceuticals. Prevention of illness is the best way to reduce carbon emissions from medicines. Overprescribing and pharmaceutical wastage has a considerable impact on the NHS expenditure and patient well-being, in addition to the negative environmental impact. a. Discuss with patients before starting a medication whether they can incorporate dietary/lifestyles changes in the first instance (case study) b. Use social prescribing to reduce medication usage (case study) c. Encourage patient-led ordering using the NHS App; Stop unnecessary third party ordering; Avoid unnecessary waste for care home residents and people living independently (e.g. SMS, right hand prescription message etc.) d. Encourage patients to check their prescription is correct before they leave the pharmacy. Medication returned before the patients leave the pharmacy can be reused. If medicines are taken home, they have to be destroyed e. Review repeat prescriptions for any patients on 7 or more medications to see whether they are still needed or can be reduced f. Bulk message (SMS) to patients to remind of safe disposal, both inhalers and blister packs g. Clinicians to consider lower carbon alternative to certain prescribing options, depending on how the medication is packaged (e.g. Vagifem has multiple applicators in the pack, whereas Vagirux has a reusable applicator and is no more expensive) If you are feeling adventurous, your practice may want to sign up to complete the Toolkit for green accreditation[22]
Key Performance Indicators (KPIs)	The provider is required to meet the below Key Performance Indicators (this will be evidenced via completion of a practice based survey): **Team Engagement and Training**: 1. Designate a Green Champion Lead within each practice and a PCN Green Champion. 2. Ensure quarterly attendance at educational events and/or review resources, followed by dissemination within the practice (documentation). 3. **Bucket List Activity Completion**: a) Complete a minimum of 2 activities per Bucket List item, from 5 of the 8 Bucket List items specified in the Delivery section, totalling 10 activities **or** b) i) Alternatively, select a minimum of 2 activities from the Bucket List items and ii) provide evidence showcasing a decrease in carbon emissions compared to the initial baseline. This evidence can be demonstrated through a carbon footprint assessment and/or improved wellness metrics.
Borough Team Support	The local borough team will provide: · Annual self-declaration form · Conduct random audit at practice level

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[2] **www.greenerpractice.co.uk/gifh-audit**

References	· Delivering a 'Net Zero' National Health Service report – NHS England[4] · North West London ICS developed a three-year Green Plan[5]
Ealing contact	Dr. Vasu Siva nhsnwl.ealingprimarycare@nhs.net

~~Chronic Kidney Disease~~ (Replaced by NWL Specification)	

Standard 7: Domestic Abuse	
Rationale	Domestic Abuse (DA) is a violation of human rights and a public health concern. It continues to be an issue among families, impacting both the mental and physical health and wellbeing of all who are exposed including perpetrators, victims and children who witness abuse.[23] The Domestic Abuse Act 2021[24] creates a statutory definition of Domestic Abuse based on the existing cross-government definition. 'Abusive behaviour' is defined in the act as any of the following: • Physical or sexual abuse • Violent or threatening behaviour • Controlling or coercive behaviour • Economic abuse • Psychological, emotional or other abuse For the definition to apply, both parties must be aged 16 or over and 'personally connected' (who are or have been intimate partners or family members, regardless of gender or sexuality). The Act recognises children aged under 18 years who see, hear, or experience the effects of the abuse, as a victim of Domestic Abuse, if they are related or have a parental relationship to the adult victim or perpetrator of the abuse. Crime Survey for England and Wales (CSEW)[25] estimated that 5.0% of adults, 1 in 20 adults (6.9% women and 3.0% men) aged 16 years and over experienced Domestic Abuse in the year ending March 2022; this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men). Approximately 1 in 5 adults aged 16 years had experienced Domestic Abuse since the age of 16 years. Domestic Abuse can affect anyone, regardless of age, ethnicity, gender, sexuality, class, lifestyle or geographic location[26]. Often people suffering from Domestic Abuse have unnecessary investigations and medications to address a variety of physical and/or mental health symptoms, including chronic pain, and are frequent attenders to the healthcare service[27]. Clinicians should be aware of the 'toxic trio' - DA associated with substance abuse and mental illness. Domestic Abuse is complex and often a hidden crime. Data published by SafeLives show that victims of Domestic Abuse experience abuse for an average of 3 years before getting help and visit their GP an average of 4.3 times during this time. Some victims of DA, including older individuals, Black, Asian, and minority ethnic people, and/or people with a disability, are likely to endure abuse for much longer before disclosure[28].

[23] **Pingley T: The Impact of Witnessing Domestic Violence on Children: A Systematic Review. Master of Social Work Clinic Research Papers 2017.**

[24] **www.legislation.gov.uk/ukpga/2021/17/contents**

[25] **Office for National Statistics. Domestic abuse prevalence and trends, England and Wales: year ending March 2022. www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2022**

[26] **Keynejad R, Baker N, Lindenberg U, Pitt K, Boyle A, Hawcroft C: Identifying and responding to domestic violence and abuse in healthcare settings. BMJ 2021, 373: n1047. https://www.bmj.com/content/373/bmj.n1047.abstract**

[27] **Campbell JC: Health consequences of intimate partner violence. Lancet 2002, 359(9314):1331-1336.**

[28] **Department of Health, SafeLives. Pathfinder profile: general practitioners. Guidance for general practitioners responding to domestic abuse. London: DH, SafeLives 2019. Available at: safelives.org.uk/health-pathfinder**

	Primary care team are in a unique position to help victims of abuse as they are often the victim's first or only contact and represent a lifeline to safety. Often they are able to develop a good relationship with a patient over time, increasing the chance of the patient disclosing abuse and seeking advice. Once identified, victims need to be referred to Social Care, DA support services where necessary. The team has a duty to do everything they can to support victims, and by doing so could potentially save lives.
Delivery	**Aims** ・ To improve identification of people experiencing Domestic Abuse within GP practices in Ealing. ・ To ensure safety of the victims identified (including their dependents - children and elderly) ・ To ensure victims identified are referred effectively for the provision of on-going advice, information and support. ・ Respect the wishes of patients who do not want to take further action at the time of disclosure and ensure confidentiality; however, initiate child protection and adult safeguarding procedures and offer support where necessary. ・ To increase public awareness and help break down any stigma. **Delivery** The provider will meet the following requirements: *Case Management* 1. Identification: Anyone can be a victim of Domestic Abuse, regardless of sex, gender reassignment, age, ethnicity, socio-economic status, sexuality, or background. Often people suffering DA have unnecessary investigations and medications for nonspecific or mental health symptoms. Consider asking about DA in patients with health markers of abuse (e.g. chronic pain, sexually transmitted infections, genital injuries, recurrent UTIs, TOP, mental health problems, self-harm, drug and alcohol abuse, high frequent attenders etc.) and those with high risk factors[29] for Domestic Abuse (e.g. female, young age, pregnancy, substance abuse, chronic illness or disability, previous abuse, language barriers etc.). Ask open, non-judgemental questions and validate their experience. 2. Be extra vigilant with remote consultations as the perpetrator may be in the house. 3. Assess the patient's and dependents' (children and vulnerable adults) safety and refer to child protection/adult safeguarding procedures where necessary, following discussion with the safeguarding lead. 4. Offer referral or signpost to local Domestic Abuse support services or police. Children and Adult at risk will need to be referred to Social Care[30]. Have a conversation with patient around consent to share information (or not) and ensure information is shared appropriately. 5. Risk assessment: Assess level of risk in adult and dependents; use SPECS (adults) and Barnardos Risk Identification Matrix (children). If high risk, consider multi-agency risk assessment conference (MARAC) referral and discuss with safeguarding team. 6. Undertake Mental Capacity Act assessment if concerns about mental capacity. Care Act 2014 legislation sets out responsibilities for safeguarding adults. Adults have a legal right to make decisions where they have the capacity to do so, even

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[29] **DHSC. Responding to domestic abuse: a resource for health professionals. London: DHSC, 2017. Available at:**
www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

[30] **Use appropriate code to record 'Referral to domestic abuse support services' or 'Referral declined'. If the patient is unwilling to**
engage with services, signpost to Domestic Abuse resources and provide a basic safety plan.

if their choices seem unwise (Mental Capacity Act, 2005). Safeguarding concerns should be made with the consent of the adult at risk and in line with Article 8 of the Human Rights Act 1998 which gives us a right to respect for private and family life. However, there may be justification to override consent, for example, protection of health, prevention of crime, protection of the rights and freedoms of others. Where the person lacks capacity to consent, a decision will need to be made in the person's best interests.[31]

7. Follow up at subsequent appointments to assess whether the situation has changed and to judge whether further action is needed.

8. Documentation: Keep an accurate record of all events/information disclosed.

9. Code (adult and child) as 'history of domestic abuse' in line with RCGP guidance[32] and hide the consultation from online view; it is crucial that you redact this information from the patient's record to avoid any visualisation of the content during access to records.

Education and Training of Practice Staff

1. Identify named service lead (clinical) within each practice - 'Domestic Abuse Champion(s)' act as an access point for Domestic Abuse support into and out of the organisation – but not to take on all Domestic Abuse cases; liaise with the whole team about training, referral pathways/services etc.

2. Create a register for 'history of domestic abuse' which is maintained and updated.

3. Ensure all clinical and non-clinical staff have appropriate levels of ongoing training that includes recognising Domestic Abuse (victims, perpetrators, children) referral pathways and available support. Each staff member should know how to safely ask, respond, refer, record and follow-up when a patient discloses experiencing abuse. The importance of reassurance, the confidential nature of conversations including the limits of confidentiality when children or vulnerable adult safety is involved should be stressed.

4. Be aware of employee experiencing Domestic Abuse. Employers have a duty of care to their employees and a legal responsibility to provide a safe and effective work environment. Where children are involved and at risk, there is a need to refer to Social Care. Establish clear policies and procedures for staff who have been affected by Domestic Abuse, and address issues relating to their own personal experiences as well as those that may arise after contact with patients.

5. Have 'Safeguarding' as a recurring item on practice and clinical meetings, to discuss any concerns raised by the team.

6. Promote your practice as a 'domestic abuse awareness practice' by displaying information in waiting areas (and other suitable places) and via other communication methods (e.g. website, newsletters) to raise awareness, help victims and perpetrators to recognise abuse and the support on offer

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[31] **Any action taken or decision made on behalf of a young person (aged 16 and 17) must be made in the young person's best interests. Staff should involve the young person in decisions as much as possible. Like with adults, consent can be overridden where there are safeguarding children issues (includes Domestic Abuse), or where a crime has been committed or likely to. All safeguarding children issues should be referred to Children Social Care.**

[32] **https://elearning.rcgp.org.uk/pluginfile.php/170658/mod_book/chapter/349/Guidance-on-recording-of-domestic-violence-June-2017.pdf**

Key Performance Indicators (KPIs)	The provider is required to meet the below Key Performance Indicators:
	
	1. **Completion of survey questions evaluating the impact of 2023/2024 domestic abuse specification implementation (by latest 30th June 2024)**
	2. **Team Engagement and Training:**
	  a) Assign 1 or 2 clinical 'Domestic Abuse Leads/Champion(s)' within each practice and a PCN Domestic Abuse Champion.
	  b) DA PCN Champions should encourage their PCN staff to take up the offer of DA training that will be rolled out by the NW London Safeguarding team during 2024-25
	  c) PCNs should ensure that their staff receive safeguarding training (Adult [33]and Children) in line with the Intercollegiate Document for Adults and Children [34]
	3. **Maintain Updated DA Register:**
	  · Create and maintain a domestic abuse register for adults and children.
	  · Conduct annual clinical reviews to update and ensure accuracy of the register.
	4. **Establish Collaborative Partnerships:**
	  · Provide evidence of collaboration with at least one local domestic abuse advocacy/support service

Borough Team Support	The local borough team will provide: · Domestic Abuse Services Directory · Educational material/e-Learning/webinars/links to resources · Annual self-declaration form
References	· Ealing Council information[35]
Ealing contact	Dr. Vasu Siva nhsnwl.ealingprimarycare@nhs.net

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[33] https://www.rcn.org.uk/Professional-Development/publications/adult-safeguarding-roles-and-competencies-for-health-care-staff-uk-pub-007-069

[34] https://www.rcn.org.uk/Professional-Development/publications/pub-007366

[35] www.ealing.gov.uk/info/201085/domestic_violence_and_abuse

Standard 8: Proactive Care Planning (Including High Intensity Users)	
Rationale	The purpose of this local specification is to build upon the existing practice based care planning service, which has been in place for patients who are living with moderate and severe frailty, to identify those patients with multiple complex health and social care needs, who may require more intensive support from the wider Integrated Neighbourhood Team (INT). These patients will usually be very frequent users of health and social care services, who will require a holistic approach to assessing their needs, to focus on their overall health, including their physical, psychological and social wellbeing. **Integrated Neighbourhood Teams (INTs)** The development and implementation of Integrated Neighbourhood Teams (INTs) in the borough is one of six key priorities for Ealing Borough Based Partnership (BBP). The overarching goal of the INT programme in Ealing is to integrate care across Primary, Secondary, Community and Social Care, joining up physical and mental health and social care provision at a neighbourhood level, utilising a population health management approach. To deliver this, the eight Primary Care Networks (PCN) in Ealing are grouped into three localities. - Southall Locality covering North and South Southall PCNs - Ealing and Acton Locality covering South Central Ealing, Acton and The Ealing Network PCNs - North Ealing covering Northolt, NGP and Greenwell PCNs. Each locality has an INT Leadership Team, which is mandated to establish and develop the infrastructure to support place-based care through the INT Operational Teams (working on a PCN footprint). Each Leadership Team is composed of members of the community services, social care, primary care and ICB borough teams as well as relevant acute teams and voluntary & community sector organisations. INTs are expected to; · Provide holistic, proactive, fully integrated and timely place-based care to the registered or resident population in the PCN area. · Function as a single team by breaking down historical barriers between services and teams · Mobilise and maintain effective and targeted multi-disciplinary team (MDT) meetings/forums, organised around specific long-term conditions, social care needs, frequent use of emergency services. · Continue building and strengthening relationships within the INT **High Intensity Users** As part the development of the INT Leadership Teams, each area has started to focus on priorities for their neighbourhoods. One of the areas of increasing activity and cost is those patients deemed High Intensity Users (HIUs). This is a small number of patients who use primary, community and secondary care services and possibly social care disproportionality more than the rest of the population. Research has shown a clear link between high intensity use of health services and wider inequalities[36]. High intensity use of health and social care services is associated with non-

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[36] **British Red Cross Nowhere else to turn: www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/exploring-the-high-intensity-use-of-accident-and-emergency-services**

	medical factors including age, housing instability, social isolation, loneliness, deprivation, as well as poor physical and mental health.

This local specification aims to bring together some of the local working around this to have a structured approach to better support these patients. In doing this we hope to:

- Reduce health inequalities by adopting a holistic approach to assessing and addressing patient's needs.
- Reduce avoidable attendances in primary, community and secondary care whilst improving the experience of care these patients are receiving,
- Establish, utilise and coordinate multi-agency and existing professional services to better support these patients.
- Safely manage and coordinate the case load through the use of multi-agency support and the voluntary sector.
- Coordinate a replicable service which can be integrated and managed over the longer term across other areas in North West London |
| **Delivery** | Primary Care Networks and their constituent practices, in conjunction with their wider system partners and other PCNs in INTs, will engage in the following:

1. Identification of Patients
- Practices will utilise data from across the system (WSIC, Systm1, EMIS, Acute, London Ambulance Service, local authority) as well as the Electronic Frailty Index (eFI), to create a register of patients who are high intensity users, and/or are vulnerable or frail, covering at least 2% of their population. This list will not include patients in their last phase of life (LPOL) as there are existing care planning arrangements for this cohort.
- Using practice's own knowledge of their patients, identify those with complex needs, who may not be highlighted through data sources but would equally benefit from a care plan or need multi-agency support.

2. Practice Care Planning
- Practices will be expected to provide care planning for the majority of the patients identified above.
- A personalised care plan should be developed between clinician, patient and carer in the most appropriate setting (either face to face or virtually). The care plan should be a collaborative process between the patient (and carer) and an accountable GP or other appropriate healthcare professional. The care planning consultation should seek to address how their care will be managed to:
  - Enable effective management of their long term condition/s
  - Enable optimum supported self- management
  - Provide clear contact points for times of crisis / exacerbation
  - Understand the patient's interactions with other agencies providing support to them
  - Consider the needs of the patient's carers
  - Review medications being taken by the patient and support improved compliance, where appropriate
  - Agree the case management approach with the patient, i.e. frequency of review of care plan, review arrangements in the event of an unexpected admission to hospital etc.
  - Reduce their risk of avoidable admission to hospital

- The care plan should be completed using the commissioners' approved letter template which is available on clinical systems.
- The health care professional will carry out regular care plan reviews with the patients (this can be virtual, via telephone, or face to face), the frequency of |

review will depend on risk and should be agreed between the registered healthcare professional and patient; but is recommended to be undertaken every four to six months.
- Copies of care plans must be given to patients (and carers as appropriate)
- The creation of a care plan with the patient (and carer) is an annual process.

3. Referral to locality HIU MDT
- For the highest intensity users in this cohort, where there are significant health and social care needs, the practice should consider referring to the Locality HIU MDT for multi-disciplinary input and direction. It is expected that this will be between 1 and 5 patients per practice per year.
    - Using the data, and knowledge of the patient, the practice should pull an initial summary of attendance and reasons for attendance to identify root cause to present to the INT.
    - Each patient should have a baseline of data and activity that demonstrates what their needs are, why they are included and provides a basis to measure outcomes.
    - This register should be agreed by the multi-agency INT Leadership Team and should have input from all partners.

4. Agree Integrated Neighbourhood Team case lead(s)
- The locality INT HIU MDT will discuss the service user, agree actions and identify and agree who from the INT will take a case management lead – depending on expertise and need. In complex cases, where multiple causes are identified, this may be a more than one lead. This will be agreed jointly between members of the INT.
- Each patient should have a named case manager (This may change as care is developed and patient need increases or decreases over time). This may or may not be the practice the patient is registered with.
- The outcomes from the MDT meeting should be followed up and care plans amended with the patient as required.

5. Co-production of care plan
- Case Management lead co-produces a care plan with patient (and carer as appropriate. This will involve a holistic approach to assessing the patients' needs to ensure that it captures the overall health of the patient, including their physical, psychological and social wellbeing. The care plan should also capture any goals important to the patient or carer.
- Copy of plan to be shared with patient (and carer where appropriate)
- Case Management lead(s) conduct regular touch points with the patient (and carer) to review plan.
- Case Management lead(s) to raise issues identified with the HIU MDT to unblock

6. Monitoring
- Continue to monitor the data (based on initial searches) to identify additional patients falling in this cohort for support.
- The INT Leadership Team will oversee the register from a high level, monitoring the baseline data for the patients and impact of interventions.

7. Evaluation
- Evaluation and learning from cases shared at INT Operational Level and Leadership team
- INT Leads will report progress and learning to the Ealing BBP INT Steering Group

Further details on the HIU MDT operations is within the Standard Operating procedures for the service.

There is an expectation that the case management and primary care inventions for these patients have a high level of intensity. The case manager may be from the wider system but it is expected that to understand the primary needs of the individual, primary care will need to take a proactive approach to supporting the individual.

Year 2 Requirements

HIU Service
In year 1 (2023/24) there was a phased approached to the implementation of locality HIU services. Each locality now has an established HIU service and all PCN member practices are able to refer their identified service users. In year 2 PCNs, in collaboration with locality partners, must ensure the locality HIU service;

1. Is operating in line with process outlined above and the HIU Standard Operating Procedures.
2. Is able to receive referrals from non-primary care partners.
3. Is able to establish baseline activity across health and social care settings for referred patients and is able to monitor this to measure success of interventions.
4. Produce a written report with quantitative and qualitative feedback on effectiveness and learning of the service by 31st March 2025.

PCN INT leadership roles.
1. Each PCN must have an INT Clinical lead and an INT Managerial lead in place throughout the year. The appointment of these leads will ensure that funding to support the PCN leadership within the INTs is sustained, at the same time as bolstering overall PCN clinical leadership and management capacity.
2. These roles will lead on the implementation of functioning INT Leadership and INT Operational teams in their localities and the development and delivery of key priority areas for their populations.
3. The total funding for the PCN INT Clinical and managerial leads equates to 85p per weighted patient.
4. Time commitment for the clinical and managerial leads should be proportionate to the funding received by the PCN.
5. How funding is allocated between the clinical and managerial lead is for the PCN to determine but the minimum time commitment from the INT Clinical Lead is 1 session per week and the minimum time commitment from the Managerial lead is 1 day per week (this is based on the funding available for a PCN with a weighted list size of circa 37,000 registered patients.)
6. The PCN will be required to confirm the name and the time commitment of each INT Clinical and Managerial Lead to the INT programme team by 30 April 2024.
7. Roles and responsibilities of INT Clinical Leads are outlined in Roles and Responsibilities document.
8. The leads, in partnership with the other members of INT-LT, should agree an annual priority programme for the locality population using a population health approach and establish key metrics to demonstrate achievements for agreed priorities.
9. All INT Leads are encouraged to collaborate closely with each other, especially with those in their locality, to share responsibilities, and integrate the INT agenda into already established work streams wherever possible.
10. If there are more than one clinical Lead or managerial lead appointed by the PCN, Leads are encouraged to develop ways to collaborate and inform the INT Programme Team about any modifications or distribution of time commitments and responsibilities.

	11. INT Programme Team will work closely with INT Clinical and Managerial Leads to support the development and implementation of the priorities agreed by the INT-LT.
Key Performance Indicators (KPIs)	The provider is required to meet the below Key Performance Indicators: 1. Number of patients with a completed practice care plan should be at least 2.5% of the PCN population (weighted). 2. A care plan in place for each patient referred to the locality HIU service (unless referral is rejected). 3. Locality end of year report on HIU service progress, outcomes and learning by 31st May 2025. 4. Confirm the name and weekly time commitment of each PCN INT Clinical lead and INT Management Lead to the INT Programme team.
Borough Team Support	The local borough team will provide: • Support from the Business Intelligence (BI) team to pull together data sources to identify HIU over multiple services. • Support from Ealing Borough INT project leads and delivery managers to progress programme.
References	None
Ealing contact	Dr. Vijay Tailor nhsnwl.ealingprimarycare@nhs.net

Access[37] (Replaced by NWL Specification)

Paediatric Phlebotomy (Replaced by NWL Specification)

Standard 9: Homelessness (People who sleep rough, live in hostels, 'surf' on sofas, or who are chronically insecurely housed)

Rationale	There is a large bank of evidence and research that shows poor housing conditions can lead to poor physical, mental and emotional health. Life expectancy for the homeless population is almost half that for the general population. This standard aims to provide a more accessible and responsive service to: · People who are homeless, whether registered with a GP or not · People who sleep on the streets (rough sleepers) · People who live in hostels, refuge and night shelter residents · Squatters · People of no fixed abode who are staying temporarily with friends and relatives Ealing falls within inner and outer London and as a result it contains areas of affluence and pockets of deprivation. Within the borough, there has been an increase in the number of homeless people between 2011/2012 to 2014/15, although the number of recorded rough sleepers has decreased. Types of homelessness such as 'sofa surfing' are difficult to measure so the true level of need in the average practice population may be higher than is officially recorded. Health issues for homeless people and rough sleepers include drug and alcohol abuse, mental health issues, respiratory problems, arthritis and cardiovascular disease. Homeless people are two and a half times more likely to have asthma and six times more likely to have heart disease. Rates of Tuberculous are thirty-four times higher in the homeless population and Hepatitis C fifty times higher. Homeless people also attend Accident and Emergency departments five times as often as the general population. When they are admitted to hospital, they stay three times as long and when they are ready to leave they are often discharged without their underlying issues being addressed. Homeless people also attend Accident and Emergency departments five times as often as the general population. When they are admitted to hospital, they stay three times as long and when they are ready to leave they are often discharged without their underlying issues being addressed. People who are homeless may experience difficulties in accessing primary care, due to inappropriate registration policies, perceived discrimination and staff attitudes, lack of flexibility in services provided and communication barriers. They may have a number of complex health problems, and may also require proactive support to manage their health needs, for example, targeted support, regular and/or longer appointments.

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[37] **In mid-March 2023 NHS England released further information on the content of the GP Contract for 2023/24 which included the introduction of performance indicators around access. To ensure there is no duplication of ask, we will revise the delivery requirements of the access specification in line with the national contract when the full detail is released**

	The provider is expected to:
Delivery	**General**
	- Assign a named service lead for this standard, who should be a GP with overall responsibility for ensuring the service is delivered in accordance with the specification;
	- Ensure at least one registered healthcare professional per practice attends a homeless awareness training session, which should include, but is not limited to the named lead;
	- Record patient's homeless status in their notes.
	- Ensure they are using the correct clinical codes for the delivery of the service as directed by the local borough team
	GP Patient Registration and Appointment Booking
	- Comply with Patient Registration: Standard Operating Principles for Primary Medical Care (General Practice); including avoiding unnecessary delay to registration by ensuring patients aware that ID/Proof of address is not required for registration
	- Provide registration with a general practice to the homeless regardless of their length of stay within the catchment area;
	- Provide care to homeless patients who have a registered GP but are temporarily registered with the service provider as well as homeless patients who require immediate and necessary care;
	- Ensure that homeless patients are seen (as required) by a registered healthcare professional within one working day of registration;
	- Provide more accessible service to patients through flexible appointment systems including walk in appointments, and longer appointment times for people with multiple needs – especially as homeless patients may have less access to phone line/online systems to book appointments. Practices may also need to tailor review processes (e.g. patient told to come back physically to practice after tests done) if homeless patients have less reliable contact details (e.g. postal address/phone line).
	- Ensure that homeless patients offered an appointment within one working day from contacting the practice.
	Case Management
	- The service provider is encouraged to provide additional NWL local enhanced services (i.e. Wound Care, Serious Mental Illness and Phlebotomy) to better meet the needs of homeless patients in conjunction with this specification;
	- Provide a comprehensive assessment and appropriate screening for the following:
	– Mental Illness
	– Substance misuse
	– Alcohol misuse
	– Blood borne virus (e.g. Hepatitis B and C and HIV),
	– Tuberculosis (TB)
	– Cervical smear test (for women 25 years and over)
	– Sexually transmittable infections
	- Offer Flu, Pneumococcal and Hepatitis B vaccinations, where clinically indicated;
	- Administer Vitamin B (Pabrinex) IM injections, where clinically indicated
	- Review case at 6 months for each patient following a health check, where applicable;

- Use relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity.

Referrals

- Discuss with patients whether their housing status is affecting their health. This could act as a trigger for a health intervention and/or onward referral to social prescribing – for example housing, financial, legal issues, immigration, reconnection, educational and employment support;
- Work in partnership with homeless agencies (where locally commissioned) as well as a range of health and social care services to ensure a seamless patient service provision:
    - **Peripatetic Nurse Service:** works closely with hostels to enable homeless people to have access to primary health care; provides support and training in the management of the homeless client and are a knowledge, health and social link
    - **Health Peer Advocacy Support:** The JSNA Rough Sleeper report highlights that the DNA rate for hospital and GP appointments for the homeless population is high. The service provider should access services such as Groundswell UK, which provides health peer advocacy service for the homeless patient. The service provider can book a peer advocate to accompany the homeless patient to their health appointment by contacting Groundswell on 030000 39600
    - **Drug and Alcohol specialist services:** The service provider shall also encourage self-care wherever appropriate, including provision of self-care information and encouraging support and signposting patients into relevant services, such as smoking cessation, screening programmes and the health trainer service as well as groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Groundswell and the Expert Patient Programme, health promotion and harm minimisation programme
    - **Counselling/Psychological Therapy**: MINT; Community Mental Health Nurse (CMHN), and Mental Health Support Team services
    - **Liaison with local statutory services and homelessness agencies** and, where appropriate, the development of a joint protocol, e.g. with the local Homeless Persons Unit (HPU), as well as links with local A&E departments, where appropriate
    - **Outreach Services:** Recognising that this vulnerable client group live in temporary accommodation, hostels or access day/night shelters, or clients gather at day centres, churches, etc., means that they are less likely to approach healthcare services to address their health needs. Therefore, the service is expected to work in partnership with locally commissioned outreach providers to improve access to primary care services for homeless patients, e.g. St Mungo's Broadway Ealing Outreach Team and Rough Sleeper advice surgeries as appropriate
    - Any other service that is applicable

- Patients seen offered screening for Hepatitis B, C and HIV where appropriate
- Patients offered a completed full Alcohol Use Disorder Identification Test (AUDIT) questionnaire where appropriate
- Homeless patients seen with substance use recorded and offered referral to appropriate services where appropriate
- Homeless patients asked about their smoking status and recorded

Key Performance Indicators (KPIs)	This will be a self-declaration by practices that their processes and staff training provide people who are homeless with the service delivery listed above
Borough Team Support	The local borough team will provide support and signposting to relevant resources or services.
References	· Healthcare and people who are homeless Commissioning Guidance for London, Healthy London Partnership 2016 · Ealing Homeless JSNA chapter, 2016[38] · Housing and Homelessness Strategy 2014-19 · Helping Improve Care for People who are Homeless: e-learning for Practice Managers and Receptionists[39] · Story, A. (2013) Slopes and Cliffs: comparative morbidity of housed and homeless people. The Lancet. Nov 29. Volume 382. Special issue. S1- S105. Beijer, U et al (2012) Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. The Lancet Infectious Diseases; 12:11, 859-870. · Patient Registration: Standard Operating Principles for Primary Medical Care[40] · Homelessness and General Practice Pathway[41] · Resource pack to help general practitioners and other primary health care professionals in their work with refugees and asylum seekers[42]
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[38] www.ealing.gov.uk/download/downloads/id/13877/housing_and_homelessness_-_jsna_2016.pdf

[39] www.healthylondon.org/homeless/e-learning

[40] www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf

[41] www.pathway.org.uk/home/learning/gp

[42] www.guysandstthomas.nhs.uk/resources/our-services/community/health-inclusion/refugee-resource-pack.pdf //

~~Insulin and GLP-1 Initiation~~ **(Replaced by NWL Specification)**	

Standard 10: Ankle-Brachial Pressure Index (ABPI)	
Rationale	The Ankle-Brachial Pressure Index (ABPI) is a non-invasive method for detecting or ruling out the presence of Peripheral Artery Disease (PAD). PAD is a significant risk factor for cardiovascular events and lower limb amputation. Whilst classic symptoms such as limited joint movement and intermittent claudication are present in many cases of PAD, this is not always the case and there is often diagnostic uncertainty, especially when a patient has multiple coexisting problems, such as arthritis and diabetes. The prevalence of PAD is increased among older people, people who smoke and people who have diabetes. Although the absence of a pedal pulse will indicate that PAD is highly likely, measuring ABPI is a more sensitive and replicable test. The measurement of the ABPI can provide valuable clinical information and can reduce inappropriate secondary referrals and reduce the time to successful treatment of chronic leg ulcers.
Delivery	**Aims** • To improve access to ABPI providing care more easily accessible, closer to home and at a time to suit the patient • To improve the patient pathway and ensure only those patients with significant Peripheral Arterial Disease are referred to a specialist • To speed up the diagnosis treatment and management of PAD and associated problems • As the service becomes established, to use the ABPI service to speed up the healing process for patients with chronic venous leg ulcers **Delivery** The expectation for this services is that it will be delivered at scale across the Primary Care network with practices referring in to a local hub. The Primary care network will confirm with the borough team, which site in the network the service will be offered from. The Primary Care Network must keep the local borough team updated of any changes to provision so that referring practices have an up to date list of where to refer This service provider is expected to identify a lead within the practice who will have oversight and will steer the practice to achieve the following: • Ensure the practitioner undertaking the ABPI measurements attends the training provided by Ealing CEPN initially and then follow-up support sessions as appropriate • Ensure all practices in Ealing are able to refer to their service • Review the referral (please refer to Exclusion Criteria) • Ensure that consent has been obtained and, where appropriate, assess using Fraser guidelines • Carry out the test using equipment supplied by the local borough team[43] • Undertake accurate ABPI measurements for all patients referred • Provide the results (with interpretation) to referring practices • Ensure they are using the correct clinical codes for the delivery of the service as directed by the local borough team **Who can be seen in this service?**

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[43] **This will be provided as funding to the primary Care Network for the purchase of equipment**

ABPI is recommended for the following clinical indications:

- Diagnosis of PAD in patients presenting with signs and symptoms of PAD (leg pain fitting with intermittent claudication)
- To identify PAD in 'at risk' patients e.g. diabetic patients, smokers
- An indication of the severity of disease – i.e. if an urgent referral is needed or not
- To exclude PAD in patients who are undergoing treatment that may result in vascular complications, for example patients undergoing leg or foot surgery

Population covered

- Patients who have leg pain and/or need assessment for the safe use of compression treatment for venous leg ulceration
- Acceptance: Mandatory for patients aged 16 years and over. Optional for patients under 16 years of age
- The provider can provide this service to housebound patients where clinically appropriate and at local discretion of the local borough team

The following exclusions apply:

1. Suspected DVT
2. Critical Ischaemia
3. Excruciating Pain in lower leg

Equipment

- The service provider must have ABPI equipment
- The service provider must ensure that the equipment is maintained through servicing and calibration as needed.

Workforce Requirements

The service provider must ensure that staff delivering the service have been adequately trained.

Minimum clinical governance requirements

- The service provider must ensure that there are robust governance processes in place to ensure clinical services are delivered safely in each delivery point and are coordinated across the GP provider grouping
- The service provider should ensure that all delivery points meet CQC requirements for the delivery of medical services which, as a minimum, should be those required for the delivery of general medical services
- The service provider should ensure that all standards of communication should adhere to Caldicott and Data Protection guidelines
- Data generated in the course of delivering the service should be available to the commissioner on request. The commissioner will give due regard to data protection and confidentiality requirements
- If required to ensure that the service is operating effectively, the commissioner can interview the service provider's staff
- The service provider should comply with commissioner requests for clinical audit.
- Appointments made within 2 weeks (10 working days) of receipt of referral and results sent to the referring practice within 72 hours of the ABPI measurement being done.

Key Performance Indicators (KPIs)	This will be an activity based service and will be paid per test undertaken.
Borough Team Support	The local borough team will provide: ・ Data on current activity undertaken on a monthly basis.
References	・ Atypical leg symptoms: does routine measurement of the ankle brachial pressure index (ABPI) in primary care benefit patients? Christine Oesterling, Amun Kalia, Thomas Chetcuti & Steven Walker. Published online: 28 Sep 2015 ・ Nice Quality Standards[44] ・ NICE CKS[45]
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[44] **www.nice.org.uk/guidance/qs52/chapter/quality-statement-1-identification-and-assessment-of-peripheral-arterial-disease**
[45] **https://cks.nice.org.uk/peripheral-arterial-disease#!diagnosissub:2**