NHS
North West London

North West London Single Offer Enhanced Services 24-25

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If you have any questions regarding the specifications of the North West London Single Offer, please contact us at nhsnwl.enhancedservices@nhs.net

Service	Respiratory Diagnostic Hubs (RDH) - Spirometry and FeNO Service

1. National context and evidence base

The implementation of Out of Hospital (OOH) Strategies changed the way both acute and community services are delivered with a focus on delivering care as close to patients' homes as possible and ensuring that patients are at the centre of care delivered by quality services in Primary Care. Most of the 8 NWL boroughs had established Spirometry services that were suspended at the beginning of the COVID-19 pandemic.

The NHS Long Term Plan published in 2019 increases the focus of the provision of services based on population health through Primary Care networks (PCNs) and NWL has developed Enhanced Services that are outcome focused and population based.

The aim of the service is to provide timely, quality assured diagnosis for patients with breathlessness and/or cough and/or other respiratory symptoms by improving access to quality assured diagnostic tests at a population level and usually within a community setting. When establishing diagnostic pathways, we encourage collaborative work between commissioners and providers to ensure that access is promoted to reduce health inequities in diagnosis and in turn, respiratory outcomes.

2. Aims and objectives of service

This service is intended to commission the service provider to deliver quality assured diagnostic spirometry and FeNO testing (as appropriate) to enable the accurate diagnosis of COPD and asthma. Spirometry is an essential investigation for diagnosis and assessment of severity in people with COPD and other respiratory conditions. Failure to diagnose matters because decline in lung function is faster in the earlier stages of COPD and undiagnosed patients do not receive the treatment that we know makes a big difference to outcomes.

This service must be delivered to all patients registered with practices across a borough ensuring equitable access and quality of service to the entire population group. The location(s) for delivery of the service (number of delivery points) needs to be agreed with NWL ICB. The intent is that most boroughs should have one or two hubs per borough depending on size of borough, appropriate estate and workforce capacity – however larger boroughs may need additional site(s). All sites must ensure that they can meet the operational and workforce requirements including need for sufficient training and provision of consultant oversight.

3. Service Description/Care Pathway

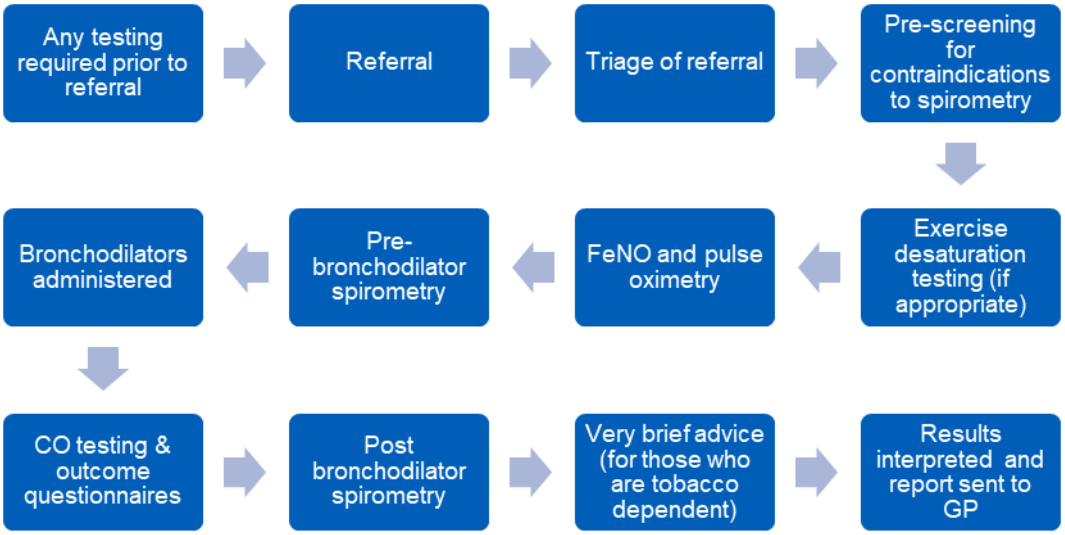
The service will be available to all patients registered with GP practices within the primary care network. The service will be delivered by a lead provider for all patients/PCNs and will offer:

- Diagnostic quality assured spirometry and FeNO in breathless patients, for example those with suspected COPD / asthma
- Diagnostic quality assured spirometry in patients whose previous diagnosis of COPD has been made without post-bronchodilator spirometry or where the patient has a diagnosis of COPD with a FEV1/FVC ratio of greater than 0.70
- Diagnostic quality assured spirometry in those patients discharged from hospital with "Suspected COPD"
- Diagnostic spirometry and FeNO to clarify diagnosis in patients with dual COPD and asthma diagnosis in primary care
- Diagnostic reports to general practice with actions / suggestions for action
- The service should ensure non-English speaking patients are included by using interpreters

Lead providers responsible for delivering the services will ensure the following, including preparing for the test:

- Identifying the type of spirometry required (post bronchodilator OR pre and post bronchodilator to test reversibility)
- Suitability for FeNO testing

- Providing patients with all information required ahead of the test
- Ensuring that the patient's registered GP has prescribed a Salbutamol inhaler and Spacer
- Administering the prescribed drug as per local policy (this can be self-administered by the patient or by a registered healthcare professional).
- Patient appointment should be of sufficient duration to offer all appropriate tests within an appointment
- Record the outcome of spirometry using SNOMED code' COPD' 13645005 OR 'Spirometry reversibility positive' 314981002 OR 'Spirometry reversibility negative' 314980001 and consider referral (where clinically appropriate as not all COPD patients require Pulmonary Rehab) to community Pulmonary Rehab service using SNOMED code 'Referral to Pulmonary Rehab' 24461000000105, where not automated through agreed templates.
- Record the outcome of FeNO testing and consider onward referral using appropriate SNOMED code, where not automated through agreed templates.



Provider will ensure that adequate consultant led supervision is in place via contracting. The consultant support is to provide oversight and regular MDT by as well as regular checks of testing and reporting accuracy (e.g. checking a proportion of reports for accuracy), supporting virtual reviews and providing specialist input in MDT for patients needing review e.g. uncertain diagnosis. This has been costed into the model to allow providers to contract 0.05 WTE/2 hours a week of consultant oversight and providers should ensure an MOU/SLA is signed with local trust to provide this service.

Where local agreement in place additional delivery will support:

- Empowering self-care and motivation: Recall patients following admission for AECOPD and provide a COPD rescue pack. Also, as part of a patient's annual review, check for the number of exacerbations over the year and issue COPD rescue pack where clinically appropriate. In both clinical scenarios, instruct patient when to use it, i.e., when early signs of exacerbation are present (increased breathlessness and sputum, or discoloured sputum). See NICE guidelines. Code 'Issue of COPD Rescue Pack' 718241000000107

In addition, if reversibility testing is required, the GP Practice(s) will ensure:

- Salbutamol to be administered via spacer
- Wait 15-20 minutes before performing of post-bronchodilator spirometry
- Recording of post-bronchodilator spirometry results and record the degree of reversibility.

Provider will also ensure that infection control and equipment standards are complied with and will follow procedures in line with required infection control policies:

- Mouthpieces for spirometry must be single use with one-way valve and disposed of after each use in line with

infection control policy.

- Mouthpieces for FeNO testing must be single use and disposed of after each use in line with infection control policy.
- Manufacturer's instructions must be followed for regular cleaning and disinfection of the spirometry transducer.
- Cleaning and disinfection of the transducer is also carried out before use on immuno-suppressed patients and after use on any patients with open sores, bleeding gums or known infection.
- There are systems in place for the regular replacement of spirometer components, such as filters, in accordance with manufacturer's instructions.
- The external surfaces of the equipment are wiped over between patients with hot water and detergent or detergent wipes

Please note that a SOP for the hubs is available upon request and goes into full detail on operational requirements – this is subject to change as guidance on acceptance criteria, IPC and so on changes.

4. Any Acceptance and exclusion criteria and thresholds

Acceptance

- Patients aged 18 and above:
- Breathlessness query cause and/or cough query cause (to confirm or support a differential diagnosis)
- CXR within the last 6 months or one booked along with this referral

Exclusions at time of spirometry/FeNO appointment:

- Spirometry to monitor the disease progression of patients with a known diagnosis of COPD, including as part of their annual review.
- FeNO to monitor/manage previously established asthma diagnosis
- < 18 years old*
- A chest infection or exacerbation (within last 6 weeks)
- Had a recent eye surgery (12 weeks standard, 6 weeks laser), chest or abdominal surgery (in the last 12 weeks)
- Uncontrolled high or low blood pressure
- Coughed up blood
- Experienced chest pain, had a heart attack or stroke in the last 12 weeks
- Condition which may be aggravated by prolonged expiration i.e. history of panic attacks
- Recent mouth/dental procedures or infection, which may make placement of the mouthpiece distressing or painful
- Symptoms of COVID or tested positive for COVID within the last 10 days

Patients not suitable for Diagnostic Hub:

- Patients requiring specialist review in the chest clinic
- TB or patients with suspected cancer (2 week wait referrals) or any other respiratory "red flags"
- Routine follow up spirometry as part of annual review
- Patients for whom FeNO readings are needed to assess treatment response
- Bed-bound patients or patients who are unable to sit upright
- Patients with cognitive impairment or dementia to a degree that they will not be able to follow instructions

5. Training, Skills and Experience

The Provider is responsible for ensuring all clinical staff have the necessary license to practice and qualifications and continuing professional development required to maintain their qualification. As a minimum this should include:

- Staff performing and interpreting spirometry and/or FeNO to be trained and assessed to ARTP or equivalent standards by recognised training bodies in the performance and interpretation of spirometry/FeNO, and that they receive regular updating (e.g., every three years).
- Minimum of 5 diagnostic spirometry tests performed per week (Healthcare Professional responsible for keeping a record of number of tests performed).
- Staff performing and interpreting spirometry and/or FeNO to have adequate regular formal supervision and an agreed number of tests/interpretations reviewed per annum.
- The service will have Specialist clinician oversight of patients results and interpretation of test results

- Clinical oversight, support and audit for the hub is required from a respiratory consultant or from an expert adult/paediatric respiratory specialist clinician, ideally one that is fully engaged and knowledgeable about primary care issues such as an Integrated Respiratory Care specialist and team if available locally, and who has access to a commissioned consultant through a regular MDT. Clinics are to be supported by allocated Consultant supervision and MDT time to enable optimal clinical governance, optimal staff training and support for clinicians in general practice & ongoing staff development, and consultant review of difficult diagnoses or cases with multiple related comorbidities (avoiding need for referral to CDC or secondary care).
- Staff should be trained in level 1 tobacco dependence support and be able to signpost or refer to local specialist smoking cessation services where they exist. They should be able to assess MRC dyspnoea score, CAT and ACT as required, understand and be able to explain the principles of pulmonary rehabilitation and signpost referring GPs to refer patients to their local PR service where appropriate

6. Equipment

Estates

The estates and IPC requirements for the hubs are outlined in the London specification. The NWL estates team supported by the IPC lead have provided the following checklist:

- An ideal room size of approximately 12-16 square meters, with an absolute minimum size being 10 square meters.
- Mechanical ventilation provision offering a minimum of 6 air changes per hour (in accordance with HTM03-01).
- Natural ventilation maybe used in conjunction with mechanical to dilute viruses or singularly if allowing sufficient air into the room where mechanical is not available
- The room is free of soft furnishing to include window dressings to allow for ease of cleaning.
- A wash-hand basin fitted with a thermostatic mixing valve (set to between 39oC and 43oC – in accordance with HTM 04-01)
- Soap dispenser
- Paper towel dispenser
- Apron and glove dispenser
- Pedal-operated sack holder for both clinical and non-clinical waste.
- Supplies trolley
- Workstation
- Operator's chair - upholstered with a wipeable material
- Consulting chairs - upholstered with a wipeable material
- All wall units will require sloped tops.
- Wash-hand basins to be fitted with level taps and display hand hygiene posters.
- Floors to be hard, sealed and impervious to moisture with upstands.
- Spirometry is not classified as an aerosol generating procedure (AGP). A fluid repellent surgical mask, apron and gloves should be worn for each patient.
- The patients should be offered a fluid repellent face mask to wear when not completing tests if tolerated and used to contain a cough then disposed of during testing.
- Patients should be advised to decontaminate hands prior and post procedure.
- Staff should be fully vaccinated against COVID-19 and undertake required testing in line with current policy.
- Patients should be screened for COVID-19 using the screening tool and must not attend if they do not qualify.
- All surfaces and equipment that is not disposable should be cleaned with a detergent and disinfectant between patients. This should include high contact surfaces such as door handles.
- Staff should not consume food and drink in these areas.
- Clinical areas must be clutter free and any display posters must be able to be cleaned.

Should any of these elements not be in place a risk-based decision should be made supported by the IPC team – for example consideration whilst Mechanical ventilation that allows for 6 air changes per hour is recommended. If this is not possible then natural ventilation will be considered e.g., how far can the window open, will they remain open in colder months, will patients be in a cold draft.

APPENDIX I - CONTRACTUAL REQUIREMENTS

SPIROMETRY		
Unit Price	**£82.27** per patient appointment	
Business Rule	**All recorded activity is payable**	
Service Type	Episodic	Pop-Up used to Record 'Enhanced services administration (**166221000000105**)
Referral Criteria	Patients aged 18 years and above are Mandatory under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
SP01	Spirometry Screening	Spirometry Screening (**171255006**) **AND** Enhanced Service Administration (**166221000000105**)

PAYMENT/KPI RULES
To Achieve Payment for Spirometry Screening SP01 • Has SNOMED code of Spirometry Screening (**171255006**) **AND** • Has SNOMED code of Enhanced Services Administration (**166221000000105**) recorded by the provider at the same time as the Spirometry test • Patient appointment should be of sufficient duration to offer all appropriate tests within an appointment

Service	Medicines Optimisation

1. National context and evidence base

The National Health Service (NHS) is experiencing a significant financial challenge so whilst all health professionals must provide the best service possible there is a need to take account of the resources available and to allocate these resources with consideration of the individual patient's needs but also the needs of the wider population.

Prescribing is the most common patient-level intervention in the NHS and is the second highest area of spending in the NHS, after staffing costs. The NHS drugs bill is growing faster than other areas of the NHS budget because of the continued growth of patients with multi-morbidities and the impact of newer medicines replacing older categories of treatment. The NHS Long Term Plan recognises that there are also opportunities for efficiencies, so NHS North West London will continue to develop plans and strategies to ensure prescribing is patient centered, safe, best value and identifies areas of prescribing that are of low clinical value. It addresses unwarranted variation, reduces waste and supports people to manage their own health. Whilst the Long Term Plan expects the NHS to reduce prescribing of low clinical value medicines and items which are readily available over the counter; support has been pledged where pharmacists can help to relieve pressure on GPs by reviewing medicines and to encourage the use of prescribing systems that support patients to get the best from their medicines and to reduce errors. Primary Care Network (PCN) clinicians are ideally placed to deliver this at the network level working with support from teams at place and ICB level.

In line with the Primary Care Strategy, supported by The NHS Long Term Plan, NHS North West London is working with PCNs to work collaboratively and deliver health services at scale; thus ensuring 100% population coverage in their geographically based areas. This will enable more patients to benefit from services commissioned, and enable the development and sharing of best practice, through collaboration and peer support.

In line with this, the Medicines Optimisation Service will be commissioned at a network level. The delivery of the service will be by individual GP practices within a PCN and must ensure 100% population coverage.

North West London Context

There are significant opportunities to improve patient outcomes in North West London (NW London) through improved working with GP practices and primary care networks. Investment has continued in a NW London Medicines Optimisation Service with the aim of supporting efficiency savings and improving quality outcomes in prescribing. This enhanced service specification has been developed to support our demanding demographics and improve the quality of prescribing by reducing unwarranted variation within NW London.

2. Aims and objectives of service

Implementing this scheme will improve patient care as medicines are systematically reviewed and ensure prescribing is safe and effective. Additionally, the service should support NW London achieve financial balance and value for money.

The principles of the scheme are:

- The Medicines Optimisation Service will reward improvements in patient care such as at individual patient and population level, as well as promoting the efficient use of resources.
- The scheme is designed to support financial stability without compromising patient care.
- The scheme will encourage primary care networks to consider how patients can be supported to get the best from their medicines, promote self-care and how they can benefit from both clinical and cost-effective prescribing.
- The scheme will run from 1st April 2024 to 31st March 2025
- 100% achievement of the Medicines Optimisation Service for 2024/25 will be paid at £1.00 per weighted patient

3. Service Description

1. Engagement Pledge (5% reward)
PCN based achievement - All practices to achieve the targets

The engagement pledge will be measured by completion of **all** of the following:

a) Every practice in the PCN to have a named GP prescribing lead to facilitate medicines optimisation
b) Attendance of at least, one practice prescribing meeting with the NW London ICB Pharmacist, unless agreed otherwise with your ICB Borough Medicines Optimisation Team, to discuss prescribing data and agree implementation of a set of actions (preferably held between April-Sept 2024)
c) PCN/practice pharmacists and ICB pharmacists to collaborate a minimum of twice in the financial year to review prescribing data and unwarranted variation, share local and national initiatives in order to discuss and implement a PCN/borough approach

Suggested topic areas for 24/25 are as follows but not limited to:
a) Oral Nutritional Supplements (ONS)
b) Stoma
c) Prescriber codes
d) Specials and High Cost Drugs (HCDs)

2. Quality Initiatives (45% reward)
PCN based achievement – All practices to achieve the targets

2.1a. Promotion of antimicrobial stewardship (AMS) in all practices in the PCN (Total 15% reward)[1]

Based on NHS Oversight Framework (5% reward for achievement of both i and ii)
i) Reduction in the number of antibiotics prescribed in primary care to be ≤ 0.871 items per STAR-PU (prescribing adjusted for patient's age, sex and specific therapeutic group).
and
ii) Proportion of broad-spectrum antibiotic prescribing in primary care
Number of broad-spectrum antibiotic (antibacterial) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care to be ≤ 10%.

2.1.b Optimising amoxicillin treatment course length in General Practice for Respiratory Tract Infections (RTIs) (5% reward)

To increase the proportion of amoxicillin 500mg capsules prescribed as a 5-day course to ≥ 55%.

2.1.c Optimising doxycycline treatment course length in General Practice for Respiratory Tract Infections (RTIs) (5% reward)

To increase the proportion of doxycycline 200mg first day then 100mg once a day, prescribed as a 5-day course to ≥ 18%.

2.2. Optimising DOAC prescribing in patients with Atrial Fibrillation (Total 10 % reward)
The following to be undertaken by each practice in the PCN:
a) Review all patients prescribed a DOAC for Atrial Fibrillation and ensure dose is reviewed and optimised in line with a recent renal function (7.5% reward).
b) Prescribe a 'best value' DOAC in patients prescribed a DOAC for Atrial Fibrillation, in line with the National Medicines Optimisation Opportunities 2023/24 (2.5% reward).

By reviewing treatment for these cohorts of patients, the aim is to increase the percentage of patients with a creatinine clearance coded in the previous 12 months and subsequent specified SNOMED codes to reflect the DOAC dose has been reviewed (target ≥50%) and increase the percentage of patients prescribed a 'best value' DOAC for Atrial Fibrillation (target ≥60%).

[1] **Achievement of 2.1 will be verified using March 2025 ePACT2 data and PrescQIPP (12-month rolling basis), as appropriate.**

2.3. Review and increase the percentage of patients with a QRISK ≥10% recorded (after 1st April 2023) either on statin or have been offered statin therapy, declined or contraindication recorded (Total 10% reward)

The following to be undertaken by each practice in the PCN:

a) Review and increase the percentage of patients with a QRISK ≥10% recorded since April 2023, either on a statin or have been offered statin therapy, declined or contraindication recorded

By reviewing treatment for these cohorts of patients, the aim is to increase the percentage of patients with a QRISK ≥10% either on a statin or coded using the specified SNOMED codes provided, outlining why the patient is not on statin therapy. The target is ≥75%.

2.4. Reviewing and optimising antihypertensive treatment (Total 10% reward)

The following to be undertaken by each practice in the PCN:

a) Review/optimise treatment of patients (identified on the clinical search) ≥ 40 to < 80 years on a single antihypertensive agent, with the last recorded clinic BP ≥ 140/90mmHg and code using the specified SNOMED codes provided.

By reviewing/optimising treatment the aim is to improve blood pressure control in this cohorts of patients. The target is ≥50%.

3. Achievement Network Prescribing Budget (20% reward)
PCN based achievement

Each PCN and practice will be allocated their practice and overall network prescribing budget. Setting the budget at practice and PCN level aims to support integration and encourage practices in a PCN to work together in managing prescribing expenditure. Setting budgets for larger populations also reduces the chance of expenditure varying significantly from the annual budget as variation arising from patient characteristics and clinical practice in smaller populations become less diversified when budgets are set for larger populations.

Network practices should work collaboratively to ensure prescribing is safe and cost-effective; identify areas of prescribing that are of low clinical value; address unwarranted variation; and help people to manage their own health.

Achievement of this target will be measured using monthly ePACT2 data and payment will be based on achievement of the PCN indicative budget. This recognises that with ongoing changes in prescribing guidance and the use of new medicines there is a need for all prescribers to continually review and adjust their prescribing so that their indicative network budget is achieved and maintained.

Achievement in this area will not be finalised until the end of the financial year but this work should be initiated as early as possible in the year in order to give practices the best chance of delivering. Achievement will be verified using ePACT2 data (March 2025 data) which will be available May 2025.

Target

- PCN expenditure to be under budget to achieve the full award (20% award)
- We recognise external factors such as updates in evidence-based guidance and fluctuations in drug prices affect the ability to manage the allocation. If your PCN is over budget, a reduced award of 10% will be made if PCNs can demonstrate that they have attempted to manage their prescribing budget by meeting the following two conditions:
  - PCN expenditure is below or equal to specified percentage*
  - PCNs have evidenced that they have completed work outlined in Appendix 1

* The percentage will be confirmed once the 24/25 prescribing budgets have been agreed

4. Efficiency Initiatives (30% reward)
PCN based achievement

See supplementary information for the review process for each initiative.

Practices/PCNs to implement efficiency saving initiatives to support achievement of the PCN prescribing budget. These initiatives require prescribers to review prescribing of particular medicines/products for individual patients with a view to switching to a more cost-effective product or deprescribing as appropriate.

Summary of efficiency savings initiative	Levels of achievement	Award
Review of Blood-Glucose and Ketone Test Strip (BGTS) and lancet prescribing and implementation of NHSE Commissioning Recommendations	Minimum 80% of prescribing (Quantities x Items) should be for products from the NHSE list of preferred strips and lancets and within the NW London formulary where appropriate.	15% if ≥ 80% 10% if 60% achieved with a sliding scale for achievement > 60 to < 80% Measurement period July 2024 to March 2025.
Review of prescribing of the following combination inhalers: • Fostair® 100/6 and 200/6 pMDI (and generic equivalents) review and change to Fostair NEXThaler® (DPI) or Bibecfo® pMDI if DPI not suitable **and** • Seretide 250 and 500 Accuhaler® (and generic equivalents) review and change to Sereflo Ciphaler®	Minimum 70% of prescribing (Quantities x Items) to be of the preferred products. Fostair NEXThaler® or Bibecfo® Sereflo Ciphaler ®* *This is a combined target	15% if ≥ 70% 10% if 60% achieved, with a sliding scale for achievement > 60 to < 70% Measurement period October 2024 to March 2025.

It is anticipated that implementation of these initiatives will generate in excess of £2m of savings across NW London GP practices.

Measurement of achievement will be calculated from ePACT2 data.

Baseline ePACT2 spend data per practice (and accumulated per PCN) will be provided.
If unforeseen issues with stock or pricing occur, alternative initiatives will be substituted as necessary

4. Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- Registered as a general practice in a North West London Primary Care Network. Please review specific indicator where relevant for criteria

Exclusion criteria

- Please review specific indicator where relevant for any exclusion criteria

5. Training, Skills and Experience

The Service will be provided by a GP, Clinical Pharmacist, Pharmacy Technician, Nurse or suitably trained staff member who is clinically competent in undertaking the medicines and pharmacy initaitive/s.

CONTRACTUAL REQUIREMENTS

MEDICINES OPTIMISATION		
Unit Price	**£1.00** per head of weighted population for full achievement. Payments will be based on weighted population as of the 1st April 2024 Dates for achievement and submission are specified below and additional information will be included in a supplementary information section provided via the NW London ICB Medicines Optimisation Team Further detail on payment structure can be found below	
Service Type	Capitation	No Pop-up
Referral Criteria	All patients registered within practices in the Primary Care Network.	

		Target description	Measured by and period	Achievement & Thresholds	Value
Engagement Pledge	1.0	**Engagement** a) Every practice to have a named GP prescribing lead to facilitate medicines optimisation b) Attendance of at least one practice prescribing meeting with the ICB Pharmacist, unless agreed otherwise, to discuss prescribing data and agree implementation of a set of actions a) PCN/practice pharmacists & ICB pharmacists to collaborate a minimum of twice in the financial year to review prescribing data & unwarranted variation, share local & national initiatives in order to discuss & implement a PCN/borough approach	Named GP Prescribing Lead Annual prescribing meeting by 30th September 2024 2 x PCN/practice pharmacist & ICB Medicines Optimisation Team meetings by 31st March 2025	**Achievement**: All practices in the PCN meet the criteria: • Named GP Prescribing Lead • Evidence of a prescribing meeting • Evidence of meetings on unwarranted variation and prescribing	5%
Quality	2.1a	**Promotion of antimicrobial stewardship** i) Reduction in the number of antibiotics prescribed in primary care per STAR PU **and** ii) Number of co-amoxiclav, cephalosporin class and fluoroquinolone items as a percentage of the total number of antibacterial items prescribed in primary care	NW London ICB Medicines Optimisation Enhanced Service 24/25 dashboard (on a 12-month rolling basis) Achievement will be verified using 12 months to March 2025 ePACT2 data	**Achievement:** All practices in the PCN meet the criteria for both i) and ii): i) ≤0.871 items per STAR-PU **and** ii) ≤ 10%	5%
	2.1b	**Optimising amoxicillin treatment course length in General Practice for Respiratory Tract Infections (RTIs)** To increase the proportion of amoxicillin 500mg capsules prescribed as a 5-day course	NW London ICB Medicines Optimisation Enhanced Service 24/25 dashboard (on a 12-month rolling basis) Achievement will be verified using 12 months to March 2025 ePACT2 data	**Achievement:** All practices in the PCN meet the criteria: ≥ 55%	5%
	2.1bc	**Optimising doxycycline treatment course length in General Practice for Respiratory Tract Infections (RTIs)** To increase the proportion of doxycycline 200mg first day then 100mg once a day prescribed as 5-day course	NW London ICB Medicines Optimisation Enhanced Service 24/25 dashboard (on a 12-month rolling basis) Achievement will be verified using 12 months to March 2025 ePACT2 data	**Achievement:** All practices in the PCN meet the criteria: ≥ 18%	5%
	2.2a	**Optimising DOAC prescribing in patients with Atrial Fibrillation** Review patients prescribed a DOAC for Atrial Fibrillation and ensure the dose is reviewed/optimised in line with a recent renal function	Practices to record Creatinine Clearance in last 12 months (see EMIS/SystmOne search) and use specified SNOMED code (see supplementary information) to record DOAC dose checked and correct. Achievement will be verified using SystmOne/EMIS searches run on the 1st April 2025.	**Achievement:** All practices in the PCN meet the criteria: ≥ 50% reviewed with specified SNOMED coding provided	7.5%
	2.2b	**Prescribing "Best Value" DOAC in patients with Atrial Fibrillation** Use a 'best value' DOAC in patients prescribed a DOAC for Atrial Fibrillation, in line with the National Medicines Optimisation Opportunities 2023/24	No. of patients prescribed generic apixaban for atrial fibrillation as a % of total no. of patients prescribed a DOAC for atrial fibrillation. Achievement will be verified using SystmOne/EMIS searches run on the 1st April 2025	**Achievement:** All practices in the PCN meet the criteria: ≥ 60% prescribed generic apixaban for atrial fibrillation	2.5%

	2.3	**Optimising Lipid Management** Review and increase the percentage of patients with a QRISK ≥10% recorded since 1st April 2023 either on statin or have been offered statin therapy, declined or contraindication recorded	Practices to review (see EMIS/SystmOne search) and either initiate statin therapy (if indicated) or use specified SNOMED codes (see supplementary information). Achievement will be verified using SystmOne/EMIS searches run on the 1st April 2025	**Achievement:** All practices in the PCN meet the criteria: ≥ 75% patients to be on statin therapy or reviewed with specified SNOMED code provided	10%
	2.4	**Optimising Antihypertensive Management** Review/optimise treatment of patients ≥ 40 to < 80 years on a single antihypertensive agent, with the last recorded clinic BP ≥ 140/90mmHg	Practices to review/optimise and code patients (see EMIS/SystmOne search) using specified SNOMED code (see supplementary information). Achievement will be verified using SystmOne/EMIS searches on the 1st April 2025	**Achievement:** All practices in the PCN meet the criteria: ≥ 50% patients reviewed with specified SNOMED codes provided	10%
Budget	**3.0**	**Achievement of Network Prescribing Budget**	ePACT2 spend against indicative budgets Apr 24-Mar 25	**Achievement:** PCN based • Within budget **or** • Overspend is ≤ to specified percentage[1] **and** PCNs have evidenced that they have completed work outlined in Appendix 1 [1] The percentage will be confirmed once the 24/25 prescribing budgets have been agreed.	20% **or** 10%
Efficiency Savings	**4.1**	**Achievement of Efficiency Savings – Blood Glucose Testing Strips (BGTS) and lancets** Review of Blood Glucose and Ketone Test Strip (BGTS) and lancet prescribing and implementation of NHSE Commissioning Recommendations	ePACT2 (Quantities x Items) Jul 24 – Mar 25	**Achievement:** PCN based • ≥ 80% of prescribing (Quantities x Items) should be for products from the NHSE list of preferred strips and lancets and within the NW London formulary where appropriate • ≥ 60% to < 80% (for partial award)	15% if ≥80% 10% if 60% achieved with a sliding scale for achievement between > 60 to <80%
	4.2	**Achievement of Efficiency Savings - Inhalers** Review of prescribing of the following combination inhalers: i) Fostair® 100/6 and 200/6 pMDI (and generic equivalents) review and change to Fostair NEXThaler® (DPI) or Bibecfo® pMDI if DPI not suitable **and** ii) Seretide 250 and 500 Accuhaler® (and generic equivalents) review and change to Sereflo Ciphaler®	ePACT2 (Quantities x Items) Oct 24 – Mar 25	**Achievement:** PCN based • ≥70% of prescribing (Quantities x Items) to be on the preferred products. Fostair NEXThaler® or Bibecfo® Sereflo Ciphaler ®* *This is a combined target • ≥ 60% to < 70% (for partial award)	15% if ≥70% 10% if 60% achieved, with a sliding scale for achievement between > 60 to < 70%

Appendix 1

Review of patients prescribed the following products which have been designated by NHSE to be for low priority prescribing – deprescribing where appropriate
Link: https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/

Summary of efficiency savings initiative	Levels of achievement
Lidocaine plasters Review all patients and deprescribe where not being prescribed according to guidance	Complete and submit a review using the template provided by 31st March 2025 **and** Reduce spend by ≥ 10% Measurement period full year 23/24 vs full year 24/25
Omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®]) Review all patients and deprescribe where not being prescribed according to guidance	Complete and submit a review using the template provided by 31st March 2025
Bath and shower preparations for dry and pruritic skin conditions Review all patients and deprescribe where not being prescribed according to NHSE guidance	Reduce spend by ≥ 40% Measurement period full year 22/23 vs full year 24/25
Needles for pre-filled and reusable insulin pens ≤£5.00 per 100 needles	≥ 80% of prescribing (Quantity x Items) to be on pen needles costing ≤£5.00 per 100 needles Measurement period full year 24/25
Review and deprescribe the following products which NHSE categorises as items where no prescribing is appropriate (no exceptions apply). NHSE says: Do not initiate in primary care. Deprescribe in patients currently prescribed this medicine. • co-proxamol • glucosamine and chondroitin • herbal treatments and other natural products • homeopathy • minocycline for acne • silk garments	Complete and submit a review using the template provided by 31st March 2025

Review templates can be found here:

NW London MOES
24-25 Appendix 1 Re

Service	Management of serious mental illness (SMI) and complex common mental health needs (CCMI).

1. National context and evidence base

North West London ICB is focused on decreasing inequality across the eight constituent boroughs to ensure that patients are at the centre of care, with the Primary Care Network (PCN), managing and coordinating the care received as part of the wider Integrated Care Partnership (ICP). A key part of this approach will be to support the continued development of high quality primary care at both a practice level and network level.

A key approach for decreasing inequality and variation, is the extension of an improved wrap-round offer in primary care for patients who have long term or complex mental health needs. GPs are central to coordinating this care and as such this Enhanced Mental Health Service specification has been developed to provide GPs with appropriate remuneration to deliver care to patients who have complex needs through proactive engagement and support.

This service will support the delivery of an enhanced biopsychosocial care approach which encompasses an extended annual mental health review (hereafter also described as "Annual Review" or "annual review"). This includes a Recovery and Stay Well plan and a patient reported wellbeing measure (e.g. Short Warwick-Edinburgh Wellbeing Scale (SWEMWBS)) and a follow up appointment during the year, to better engage with patients with serious mental illness and complex common mental health needs with primary care services.

2. Aims and objectives of service

The ICB is commissioning a service for the Enhanced Case Management of patients on the SMI QOF register and patients with complex mental health needs. This includes patients who are under Secondary Care and those under the sole care of their GP, in order to:

- Provide proactive case management for these patients, supported by a holistic Annual Biopsychosocial 'Recovery & Staying Well Plan' and patient contact throughout the year to review progress.
- Ensure that the patient benefits from high quality care, delivered as close to their home as appropriate.
- Prevent or reduce unnecessary referrals and admissions to specialist services and Secondary Care.
- Enable more integrated care of these patients between primary and secondary care so that their care can be provided in the most appropriate setting.
- Promote physical health and wellbeing for these patients including engagement with primary care and community based services.

This service is in addition to those services that GMS, PMS and APMS providers are contracted to provide to their registered patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services within the GMS, PMS and APMS contract.

3. Service Description/Care Pathway

Case Finding

The service provider will:

- Update their SMI QOF list and proactively invite the patients on the reviewed list for an Annual Mental Health review.
- Proactively identify, patients with Complex Common Mental Illness, from their registered list, on a case by case basis who are more likely to benefit from a proactive case management approach.
- The completion of targeted searches is not a mandatory requirement for case finding. However, guidance is provided to support the service provider to identify patients who may be likely to benefit from this enhanced service. The criteria are broad to enable GPs to include any patient with common mental illness they feel would benefit from this approach.

Proactive Case Management

The service provider will:

- Carry out an **Annual Mental Health Review** (recommended at a duration of 30 minutes for each patient) comprising of a biopsychosocial assessment and resulting in a care plan that is given to the patient that includes relevant physical

health interventions and applicable screening information.

- Offer a minimum of **one follow up appointment** (recommended at a duration of 10-20 minutes for each patient), during the financial year (1st April - 31st March), to review progress and make adjustments against the plan where necessary.
- Undertake all required **prescribing, monitoring, administration and annual review of medication**, particularly for patients taking Lithium. This will include provision of depot antipsychotics in primary care to those patients who are stable on these medications[2]

Appointment Guidance

- All consultations should be recorded on the primary care clinical system using the appropriate Mental Health Enhanced Service template (EMIS or SystmOne).
- Where appropriate and with the consent of the patient, carers may be involved in any appointments in primary care. If carers are involved, they will have the opportunity to have an individual appointment with the patient's GP to discuss any issues they may have. If the carer has legal responsibility for the patient, they must be involved in all review appointments.
- It is expected that a majority of the Minimum Data Set (MDS) information will be available when carrying out the Annual Review and that the GP will carry out either the annual review or at least one follow-up appointment. The other one of these appointments may be carried out by a suitably trained clinician (such as a clinical pharmacist, a physician's assistant or an advanced nurse practitioner). This is **NOT** the role of the mental health ARRS practitioners in NW London as it is not an effective use of their specialist mental health skills. Oversight of the final care plan should always be given by the GP.

The service provider will also:

- Ensure each patient has a named case manager. This should be a registered GP.
- Ensure adequate follow up and engagement of all patients who Did Not Attend (DNA), particularly those on the SMI register. Practices must have a protocol for the follow up and engagement with patients who DNA.
- It is expected that practices will make multiple attempts to contact patients via different methods, including using voluntary sector or Link Worker staff as peer support to promote the importance of this check to patients who struggle with motivation. [3]
- Assess whether patients with CCMI require ongoing proactive case management after 12 months of entry to the service; this can be discussed with the patient as part of the annual review. The expectation is that patients with ongoing SMI will remain with the service long term, unless they meet the 'in remission' criteria of five years without antipsychotic medication, secondary care or inpatient treatment.

The Annual Mental Health Review and Minimum Data Set (MDS) Requirements

1. Requirements

In one financial year the service provider is required to complete the Annual Mental Health Review described below, and a minimum of one follow up appointment, with the Minimum Dataset having been recorded. Note, however that it is not mandated that these follow up appointments must necessarily sequentially follow an annual review, as we recognise that patient specific circumstances will dictate the most appropriate type of consultation to take place at any one time. There is also no time limit on when these should occur during the year to allow this flexibility. First and follow up appointments must not occur on the same day.

This is a GP delivered service so the GP must carry out either the Annual Review consultation or the follow-up appointment. The other appointment may be carried out by a suitably trained clinician (such as a clinical pharmacist, a physician's assistant or an advanced nurse practitioner) with the care plan reviewed by the GP. These consultations must include completing the Recovery and Stay Well Plan (RSWP) with the patient as an agreed Care Plan. This should be given to the patient on the same day, or posted where the consultation is undertaken virtually. Other clinicians in the practice team *may* support the GP in providing lifestyle and physical health information as part of the MDS. It is expected that a majority of the MDS information

[2] **Guidance for Transferring stable patients on depot antipsychotics to primary care, North West London 2021**

[3] **Equally Well UK – Reducing physical health inequalities for people with mental health problems**

will be available when carrying out the Annual Review.

GP and practice non face-to-face time for liaison with Psychiatry, PCLNs, CPNs and other staff involved in a patient's care, telephone calls, DNA follow up and depot injections as appropriate, is included in the tariff price paid for each patient. The ongoing work around transformation of mental health services in NW London requires an integrated approach to ensure that where appropriate, patients can benefit from transfer to primary care so that their recovery journey can be based in their local community. Access to VCSE and social supports can be as important to their recovery as more traditional psychiatric treatments and are a part of their ongoing care needs. This also frees up capacity within secondary care services to enable them to be more responsive to the needs of those patients who are more acutely or severely unwell.

Equally, depot antipsychotic injections can be given in primary care to patients who are stable and who accept the need for them. This reduces the stigma around their treatment and helps to promote their engagement with primary care and community based services. Please see the NW London Transfer of Prescribing of Antipsychotics Guidance (August 2021)[4] for more details. Good communication between primary and secondary care is key to this ease of transfer of patients in and out of secondary care. Rapid access for GPs to secondary care advice can avoid unnecessary and prolonged relapses that are damaging to a patient's recovery. The new PCN mental health practitioner roles will be a key enabler to this. Read only access between mental health trust and GP records further enables this communication and is now possible between CNWL and GP S1 modules and CNWL S1 and EMIS. Consent is required from each practice to allow this and providers of this Enhanced Service should provide consent for this sharing.

2. The Annual Mental Health Review

The Annual Mental Health Review is a comprehensive biopsychosocial consultation that considers the MDS detailed below and results in an agreed, documented, and printed Care Plan that the patient takes away. This will include physical health interventions appropriate to the MDS data collected and applicable screening information. The Annual Review should include all aspects of the MDS within that financial year, and be reviewed by the GP. The Recovery and Stay Well Plan must be completed by the GP **OR** another suitably trained clinician (such as a clinical pharmacist, a physicians assistant or an advanced nurse practitioner). They must also generate a Care Plan and give this to the patient. Other clinicians in the practice team may support the GP in providing lifestyle and physical health information which informs the MDS.

3. The Minimum Data Set (MDS)

For every patient registered, the mandatory **15 MDS** items (which include the Recovery and Stay Well Plan (RSWP) should be completed by financial year end.

The mandatory items are shown in the table below and must be completed as these are specified and monitored by NHSE or are essential elements of the check including the RSWP, 2 appointments and the medication review. Failure to complete the 15 mandatory items will result in that patient's check not counting towards the MDS target.

Ref.	What is required?	Number per year	Mandatory	Carried out by
1.	BMI	1	✓	GP *or* HCA[5] *or* Nurse
2.	BP	1	✓	GP *or* HCA *or* Nurse
3.	Diet assessment	1	✓	GP or HCA or Nurse
4.	Exercise assessment	1	✓	GP or HCA or Nurse
5.	Smoking status	1	✓	GP *or* HCA *or* Nurse
6.	Alcohol intake	1	✓	GP *or* HCA *or* Nurse
7.	Substance misuse	1	✓	GP *or* Nurse
8.	Cancer screening prompts (breast	1	✓	GP *or* Nurse

[4] For the latest version please email nhsnwl.mhlda@nhs.net
[5] Health Care Assistant.

	bowel, cervical)			
9.	RSWP[6]	1	✓	*GP or Clinical Pharmacist or* Physicians' Assistants *or* Advanced Nurse Practitioners *or ARRS MH Practitioners****
10.	Medication review	1	✓	GP *or* Clinical Pharmacist *or* Physicians' Assistants *or* Advanced Nurse Practitioners
11.	HbA1C *or* fasting glucose	1	✓	GP or HCA or Nurse
12.	Lipids or cholesterol	1	✓	GP or HCA or Nurse
13.	Lithium monitoring	2	✓	GP or HCA or nurse
14.	First Appointment	1	✓	GP*/clinical pharmacist/ physician's assistant/ advanced nurse practitioner AND HCA or nurse
15.	Follow up Appointment (must not occur on the same day as First Appointment)	1	✓	GP*/clinical pharmacist/ physician's assistant/ advanced nurse practitioner AND HCA or nurse

HbA1C or fasting glucose and lipids or cholesterol will NOT be mandatory for SMI and CCMI patients who are NOT on antipsychotic medication AND are under 35 years OR have had these blood tests done within the last 3 years. For all patients, HbA1C is usually offered as this does not require a fasting test. Where this is not suitable, a fasting glucose test may be used instead.

MH13 Lithium monitoring is **ONLY** required for patients taking Lithium. They must have a 6 monthly check of Lithium levels, renal function and thyroid function. For patients at higher risk this should be done 3 monthly. Please use the Lithium page of the mental health template to document this.

*Either the First Appointment **OR** the Follow up appointment must be completed by the GP.
** RSWP must be supervised by the GP where is it not undertaken by the GP
***The aim is to involve the ARRS MH practitioners in this annual physical health check work as part of the primary care team where patients are most in need or are particularly difficult to engage in primary care.

4. **Overall outcome: Enhanced case management of patients with Serious Mental Illness and Complex Common Mental Illness.**

Additional indicators are included in the clinical template as best practice, and while they are not monitored for payment purposes, they are monitored by NHSE, so PCNs should aim to include these areas in delivering the physical health checks to ensure it is recorded and that action is taken on abnormal metrics. Where patients have been referred for interventions previously, or have declined further intervention this does not have to be repeated in subsequent years. Providers should monitor at practice and network level as quality indicators and part of their regular audit cycle.

Interdependence with Other Services/Providers

This service is part of a wider integrated care pathway. The provider will support an integrated approach between services and providers, ensuring that patient records are transferred appropriately to support a seamless patient transfer and service provision.

The service provider will be expected to work in close partnership with a range of health and social care providers, including:

- Local mental health services, which increasingly bring together psychiatric support, case management, health and social care navigators and peer support services.

[6] Recovery and Stay Well Plan – consisting of four items: 1) Patients Goals and Priorities; 2) Signs of becoming unwell; 3) Anticipatory Care Plan; 4) Health Action Plan.

- Integrated community and primary care mental health teams across North West London (Mental Health Integrated Network Teams (MINT) for West London NHS Trust and Community Mental Health Hubs for CNWL NHS Foundation Trust).
- Local employment, housing, benefits and other community/ voluntary sector based services, which are increasingly accessible to each PCN area.
- Secondary mental health services in the case of crisis/acute exacerbation and for shared care liaison.
- Providers of primary care or secondary care based psychological therapies.
- Local Authority commissioned services supporting wellbeing.
- Other acute providers delivering physical health care.

4. Any Acceptance and exclusion criteria and thresholds

Acceptance

- Adult patients (aged 18 years and over) who are on the QOF SMI register.
- The most complex 5% of Adult patients (aged 18 years and over) with the following common mental illnesses whose condition is any of those listed below with **recurrent, chronic, severe or treatment resistant conditions** and with **moderate functional impairment**. Diagnoses in this category may include the following diagnoses to ensure patients who would benefit from this service are not excluded on diagnostic grounds:
- ADHD (Attention deficit hyperactivity disorder) or ASD (Autism spectrum disorder) with significant mental health comorbidities.
- Anxiety and/or depression.
- Eating disorders.
- Obsessive compulsive disorder.
- Perinatal mental health needs.
- Personality disorders.
- Post-traumatic stress disorder.
- Sexual and gender identity disorders.
- Sleep disorders.
- Somatization, somatoform or conversion disorders (Somatic Symptom Disorders).
- Substance related disorders with comorbidities.
- Patients prescribed an antipsychotic but not on SMI register.

These would include patients who:

- Are under primary care but have needs above those that would ordinarily be provided for under the GMS core contract, or the Quality Outcomes Framework, and require the additional proactive support.
- Are under secondary mental health care for more than 12 months, are stable and are not inpatients.

To add a CCMI patient to the CCMI register so their check is paid please tick the 'Add CCMI register' box on the NWL template, to add the payment code Mental health administration (713491000000106). If the patient does not need the check the following year, then please tick the 'Remove patient from CCMI register' box to remove this code.

It is key that there is coordination between secondary and primary care to ensure that all eligible patients, especially those with SMI, are enabled to access this service. If a patient is having difficulty attending for a check in a primary care setting, then support to do this may be sought from a VCSE organisation to assist them. Alternatively, they can be offered a check at a community based venue via secondary care if this is preferable for them by coordinating with the relevant Community Mental Health Service if they are under their care.

If patients have comorbid substance misuse needs, ADHD or ASD they will be assessed for their suitability and can be included in this service only if they have dual diagnosis with a mental health comorbidity. With substance misuse, they must be either stable or being actively managed by substance misuse services and again have dual diagnosis with a mental health comorbidity.

It is not expected that GPs will provide specialised management or therapy for specific mental health conditions (For example OCD, eating disorders). This will continue to be provided by secondary care. The focus of this work is the

physical health and more general mental and social wellbeing aspects of care.

Exclusions

- Patients with mild to moderate CMI whose conditions respond well to first line treatment specified in NICE guidance.
- Patients under 18 years of age.
- Patients with a severe learning disability.
- Patients with organic illness.

5. Training, Skills and Experience

- The service provider must ensure that the staff delivering the service meet appropriate training and competency standards.
- The practice GP service lead must attend a local or online education session on the delivery of the service when commencing the service.
- The GP may deliver the comprehensive biopsychosocial consultation that is part of the Annual Review by any appropriate means (face to face, online or by phone). This is a GP delivered service so the GP must carry out either the Annual Review consultation or the follow-up appointment. The other appointment may be carried out by a suitably trained clinician (such as a clinical pharmacist, a physician's assistant or an advanced nurse practitioner) with the care plan reviewed by the GP.
- These consultations must include completing the Recovery and Stay Well Plan (RSWP) with the patient as an agreed Care Plan.
- Other clinicians may support the GP in collating lifestyle and physical health data which informs the Annual Review and providing patient follow up information in these areas, as set out in the Minimum Data Set (MDS)

APPENDIX I - CONTRACTUAL REQUIREMENTS

<table>
<tr><th colspan="3">MENTAL HEALTH</th></tr>
<tr><td>Unit Price</td><td colspan="2">
The funding for this service is based on disease prevalence. PCN maximum achievement is derived from 70% of the SMI Register excluding patients in remission (of current registered patients) recognising that not all patients on the register will engage with the service and 5% of Depression Prevalence as a proxy measure for the level of complex common mental illness need. This is multiplied by a unit price of £218.29 to give the maximum financial achievement available.

Total budget achievement is subject to meeting Key Performance indicators as listed below.

The tariff will be split as follows based on PCN performance, incorporating:

<table>
<tr><th>KPI</th><th>Target Thresholds</th><th>Financial Achievement</th></tr>
<tr><td rowspan="9">% of QOF SMI Register patients with Mandatory MDS completed</td><td><20%</td><td>0%</td></tr>
<tr><td>20-29%</td><td>30%</td></tr>
<tr><td>30-39%</td><td>40%</td></tr>
<tr><td>40-49%</td><td>50%</td></tr>
<tr><td>50-59%</td><td>60%</td></tr>
<tr><td>60-64%</td><td>70%</td></tr>
<tr><td>65-69%</td><td>80%</td></tr>
<tr><td>70-74%</td><td>90%</td></tr>
<tr><td>75%+</td><td>100%</td></tr>
<tr><td rowspan="9">% of Depression QOF Register (denominator is 5% of the QOF register) Patients with Mandatory MDS completed</td><td><20%</td><td>0%</td></tr>
<tr><td>20-29%</td><td>30%</td></tr>
<tr><td>40-39%</td><td>40%</td></tr>
<tr><td>40-49%</td><td>50%</td></tr>
<tr><td>50-59%</td><td>60%</td></tr>
<tr><td>60-64%</td><td>70%</td></tr>
<tr><td>65-69%</td><td>80%</td></tr>
<tr><td>70-74%</td><td>90%</td></tr>
<tr><td>75%+</td><td>100%</td></tr>
</table>

The SMI and CCMI patient groups are separate in terms of clinical diagnosis, with separate denominators as above and will be monitored and paid separately. However, the CCMI checks will ONLY be paid if 60% of the SMI checks are completed as this group is the priority.

Refer to ‘The Annual Mental Health Review and Minimum Data Set (MDS) Requirements’ under ‘Service Description/Care Pathway’ for details on the Minimum Data Set (MDS) requirements.
</td></tr>
<tr><td>Service Type</td><td>Package</td><td>No Pop-Up</td></tr>
<tr><td>Referral Criteria</td><td colspan="2">Patients aged 18 years and above are Mandatory under this contract</td></tr>
</table>

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
	See Appendix II	

TARGET POPULATION		
Ref.	**Description**	**SNOMED Code**
SMI00	Register of patients on Serious Mental Illness (SMI) register (not in remission)	QoF Mental Health Register
CC00	Register of patients on Complex Common Mental Illness (CCMI) register	Mental health administration (**713491000000106**)

TARGET POPULATION RULE

Target Population for Mental Health SMI Register SMI00

- Patient must be Aged 18 and Over **AND**
- Is on QoF Mental Health Register **WITHOUT** a more recent QoF cluster **MHREM** remission SNOMED code

Target Population for Mental Health CCMI Register CC00

- Patient must be Aged 18 and Over **WITHOUT** in Target Population **SMI00 AND**
- Has SNOMED code Mental health administration (**713491000000106**) **WITHOUT** a more recent Improvement of status (**390771008**) recorded by provider in Financial Year

PAYMENT/KPI RULES

To Achieve Payment for Mental Health

- Patient must be Aged 18 and Over **AND**
- Is in Target Population **SMI00** OR **CC00** AND
- Has achieved coding for the mandatory Minimum Data Set Items recorded by the Provider: **MH01-15**
- First Appointment (**MH14**) and Follow Up (**MH15**) **MUST NOT OCCUR** on the same day.

MH16 – MH22 are part of the Clinical Template and are considered best practice. Providers should aim to offer the full review to all patients. This data set will inform your annual audit of the service.

CCMI checks payments will be made independent of SMI checks achieved but ONLY if the minimum of 60% of the SMI checks are completed as this group is the priority

APPENDIX II – MINIMUM DATA SET

CONTRACTUAL REQUIREMENTS 1.0

NW LONDON ENHANCED SERVICES: MENTAL HEALTH

Ref.	Description	Number required per year (1 April -31 March)	SNOMED CT
MH01	**BMI**	1	Body mass index – observation (60621009)
MH02	**BP**	1	Any of: • Systolic arterial pressure (72313002) • Average systolic blood pressure (314440001) • Average night interval systolic blood pressure (314445006) • Average day interval systolic blood pressure (314446007) • Average 24 hour systolic blood pressure (314449000) • Average home systolic blood pressure (413606001) • Ambulatory systolic blood pressure (198081000000101) • Self reported systolic blood pressure (1162737008) • AND • Diastolic arterial pressure (1091811000000102) • Average diastolic blood pressure (314453003) • Average night interval diastolic blood pressure (314460009) • Average day interval diastolic blood pressure (314461008) • Average 24 hour diastolic blood pressure (314462001) • Average home diastolic blood pressure (413605002) • Ambulatory diastolic blood pressure (198091000000104) • Self reported diastolic blood pressure (1162735000)
MH03	**Diet assessment**	1	Diet good ((310500000); Diet average (310503003); Diet poor (310502008)
MH04	**Exercise assessment**	1	Enjoys heavy exercise (160633003) Enjoys moderate exercise (160632008) Enjoys light exercise (160631001) Gets no exercise (228445002) Exercise physically impossible (160629005)
MH05	**Smoking status**	1	Smoking status QOF Cluster
MH06	**Alcohol intake**	1	Alcohol units consumed per week (1082641000000106) *Alcohol intake (160573003)** **note: this code is no longer recommended for use*
MH07	**Substance misuse**	1	Misuse of prescription only drugs (191939002) Injecting drug user (226034001) Has never misused drugs (228368007)

			Misused drugs in past (44870007) Misuses drugs (361055000)
MH08	**Cancer screening prompts (breast bowel, cervical)**	1	Provision of information about cervical screening programme (851141000000101) Advice given about breast screening programme (710871000000104) Advice given about bowel cancer screening programme (382161000000102)
MH09	**RSWP**	1	Mental health personal health plan (736058004) **AND** complete the 4 fields from the Stay Well template section: • Signs that patient is becoming unwell 274652004) **AND** • Anticipatory care plan if patient unwell 792871000000101) **AND** • Agreeing on mental health care plan (867851000000109) **AND** • Review of patient goals (775501000000108)
MH10	**Medication review**	1	Mental health medication review (413143000)
MH11	**Serum lipids or cholesterol**	1	Plasma total cholesterol level (1017161000000104) Serum cholesterol level (1005671000000105) Serum cholesterol normal (166828006) Serum cholesterol raised (166830008) Serum cholesterol very high (166831007) Serum fasting total cholesterol level (1083761000000106) Serum total cholesterol level (994351000000103) Total cholesterol measurement (121868005)
MH12	**Serum HbA1c or fasting glucose level**	1	HBA QOF cluster (16 codes) **OR** GLUC QOF cluster (35 codes)
MH13	**Lithium monitoring**	2	Which must include the following twice per year for all patients on Lithium: 1. Serum lithium level (1006681000000100) 2. eGFR: either ▪ eGFR (estimated glomerular filtration rate) using creatinine Chronic Kidney Disease Epidemiology Collaboration equation per 1.73 square metres (1011481000000105) **OR** ▪ GFR - glomerular filtration rate (80274001) **OR** ▪ GFR (glomerular filtration rate) calculated by abbreviated Modification of Diet in Renal Disease Study Group calculation (1020291000000106) **OR** ▪ GFR (glomerular filtration rate) calculated by abbreviated Modification of Diet in Renal Disease Study Group calculation adjusted for African American origin (996231000000108) 3. Serum TSH (thyroid stimulating hormone) level (1022791000000101)
MH14	**Annual mental health review complete**	1	Mental health review (401061005)
MH15	**Follow-up consultation**	1	Mental health review follow up (248691000000104)

Please note:

1) A follow up appointment must be carried out in the same financial year as the Annual Review. However, it is not mandated that these follow up appointments must necessarily sequentially follow an annual review.

We recognise that patient specific circumstances will dictate the most appropriate type of consultation to take place at any one time. There are also no time limits on when these should occur during the year to allow this flexibility

APPENDIX III - Guidance to Practices in targeting the 'Top 5% of Common Mental Illness Patients'

Background

The previous SMI (Serious Mental Illness) and CCMI (Complex Common Mental Illness) Mental Health Specifications have been extensively reviewed following feedback from practices and commissioners. Greater clarity, specificity and simplicity have been brought to this revised, joint specification with an aim to simplify delivery of the service.

One particular area that greater clarity and guidance was sought was on how practices can target the right patients from all those with common mental illness. Unlike SMI, for which there is a QOF Register, equivalent to 'known prevalence', there is no such register for Complex Common Mental Illness. The depression QOF register covers only patients with depression and anxiety, the vast majority of who would not meet the 'complexity' test. Common Mental Illness includes a range of conditions including eating disorders, personality disorders, PTSD as well as anxiety and depression. Within these conditions, many patients are often well functioning, or responsive to treatment (talking therapies and medications). Some however are particularly hard to engage with, may not function well, and may be poor responders to treatment. It is for this group that the previous CCMI specification (and this current, joint Mental Health specification) was intended: the top 5% of CMI patients in your practice that are the most complex, that would benefit from the extra time and structure that the Mental Health Enhanced Service specification brings in terms of detailed review, care planning, and follow up throughout the year to improve or maintain their physical, mental health and social wellbeing.

How were the population estimates arrived at?

In the absence of a QOF register, the Clinical Review Group undertook a literature review of the target conditions, to establish evidence based estimates of common mental illness per area. This review determined that across conditions, prevalence of *common* mental health needs was on average 5.5% of the adult registered population. As described above however, this will include a majority of patients whose level of health and functioning would not merit receipt of the enhanced services. The 'Top 5%' of these patients would be the most complex, and this equates therefore to 0.275% of the adult practice population.

This was modelled at borough level using the 18+ population and the target number of CCMI patients is determined as a proxy by the depression prevalence in each borough at the start of each financial year.**:**

Example: PCN depression prevalence = 1000 patients
CCMI target will be 5% = 50 patients
Minimum expected achievement is 60% = 30 patients to have the check

Each borough will individually determine the number of SMI and CCMI patients eligible for the service and will advise practices on the level of expected associated in-year activity.

How can practices systematically target the most complex 5% of CMI?

GP Mental Health Clinical Leads have collaborated to produce some guidance on 'markers' of complexity that GPs and practices can use to systematically search for patients from their lists that may benefit. It should be stressed that this is not an exhaustive or 'water tight' search strategy. The value of the Mental Health specification is that it strongly encourages individual clinical decision making. GPs' knowledge and clinical judgement of their own patients and whether they would benefit from the proactive case management approach of the CCMI specification may be a far more reliable predictor than a list of 'markers' or search strategies. The markers set out below may act as a prompt for new ways of considering risk and complexity amongst this group.

The following are raised as potential 'ways in' for practices to establish their 'Top 5%' of patients with Complex Common Mental Illness for referral in:

(a) Diagnoses: The 'in scope' conditions for the specification are:

- ADHD or ASD with significant mental health comorbidities as discussed above
- Anxiety and/or depression.
- Eating disorders.
- Obsessive compulsive disorder.
- Perinatal mental health needs.
- Personality disorders.
- Post-traumatic stress disorder.
- Sexual and gender identity disorders.
- Sleep disorders.
- Somatization, somatoform or conversion disorders (Somatic Symptom Disorders).
- Substance related disorders with comorbidities.

The availability of reliable information on this on the primary care system will depend on the quality and consistency of coding and existence of a pre-existing diagnosis (which for some conditions will be less likely and less accurate than for others that have been included in QOF). In addition, of course, the specification is not intended for universal registration of all patients with such conditions, but only the top 5% most complex (e.g. recurrent and or, chronic, and/or severe, and/or treatment resistant, with poor levels of functioning, poor engagement in mental health and physical health treatments, multiple long term conditions, repeated DNAs).

Nonetheless, we would recommend such 'global' searches are carried out as it will foster a better understanding at practice level of the scale and scope of CMI in their population, and use that as a basis for exploring a targeted approach, considering the factors set out in the rest of this section.

(b) Patients being prescribed antipsychotic medication who are not on the SMI QOF

Antipsychotic medication may well have been initiated for some patients who do not have an SMI, but who have a personality disorder or severe depression and anxiety with psychotic symptoms, to control those symptoms, and often at low doses. Whilst patients who experience psychosis related to schizophrenia and bipolar disorder should be registered on then SMI QOF, those outside of those conditions from the list in (a) might well be receiving antipsychotic medication and would benefit from the enhanced biopsychosocial review and care planning involved in the CCMI specification.

Practices could cross match all antipsychotic prescribing against their SMI QOF list and consider whether any of these patients might benefit from the CCMI Enhanced Service specification.

(c) Frequently changing depression/anxiety prescribing

A search could be conducted looking at any patients on the depression QOF who have had frequent changes to the drugs they have been prescribed, which might be an indicator of treatment resistance, risk and hence complexity.

(d) CMI with comorbidities e.g. drug and alcohol, ADHD, ASD Long Term Conditions (LTCs), chronic pain and other mental illnesses

The presence of one or more comorbidity will be a key marker for escalated risk and lower functioning, indicating the need for an enhanced level of care. A search for patients with these illnesses, or individual GP insight into their patients, could quickly identify patients who may benefit from the service.

(e) CMI in patients who are pregnant

Pregnancy greatly escalates the risk factors for those with mental illnesses. Searching for patients with

known pregnancy and who have one (or more) of the conditions set out under (a) would identify another at risk group who could be considered for the specification.

(f) Frequency of ED/UCC attendance

Amongst the patients identified under (a), have any attended ED/UCCs at elevated levels and for reasons that would not otherwise necessitate ED/UCC attendance. This might include physical reasons such as self harm, or excess presentation due to their mental ill health. Either could be markers of complexity that would benefit from enhanced support under the specification.

(g) Frequent DNAs

Those who DNA multiple GP or outpatient appointments may be at excess risk, notably if they have LTCs or other comorbidities. Such poor engagement in health care and support is likely a marker of poor levels of functioning and ability to self care. This specification is designed to give practices the extra resource to support them in the additional work that will be required to engage with those patients who are inherently difficult to engage.

(h) Safeguarding Children and/or Adults

Those patients with SNOMED codes related to safeguarding including domestic abuse and with one or more of the conditions under (a) may be a marker for referral in to the specification.

(i) History of childhood or familial mental health difficulties

Whilst this may not be coded, any patients who are known to have had a childhood mental health issue, or have a family history, may be at elevated risk. Consider in children who are reaching age 18 who had had a mental health issue. Consider cross checking notes of parents of children who have a mental health issue.

Please note, CCMI patients may not need the annual physical health check each year if their condition improves in year. Their inclusion the following year is therefore at clinician discretion.

APPENDIX IV - The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of each over the last 2 weeks

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

Exemption is permitted where completion of SWEMWBS is not applicable, such as in cases when:

- No suitable translation or translation services are available.
- Patient has a Learning Disability or Autistic Spectrum Disorder.
- Severe lack of insight into their condition.
- Where completion of the tool would cause significant distress.

In these circumstances, please enter N/A on SystmOne/EMIS. No more than 5% of payment claims per practice can have this code.

Service	Phlebotomy

1. National context and evidence base

The main strategic aims for the service are as follows.

- Patients have access to a local, primary care based phlebotomy service away from hospital sites.
- Reduction in secondary care phlebotomy activity;
- Reduced risk of covid19 infection.
- Reduce anxiety to patients.
- Reduced health inequalities by improved access to the service.
- Patients care is informed by prompt diagnostic test results.
- Develop and embed team based and flexible working across primary community and specialist care
- Develop high quality Primary Care services at practice level and within PCNs.

2. Aims and objectives of service

- Delivering a timely and safe phlebotomy service
- Provide phlebotomy to patients registered at practices in the PCN who are aged 14+
- Provide a universal, equitable, clinically safe and high quality community phlebotomy service away from acute hospitals to reduce patient risk of covid infection.
- Ensure fast and local access for patients either in their own practice or a practice in the PCN which will offer appointments within 2 days for urgent. For routine tests this can be 7 days or longer according to the clinical indication of the test. Make phlebotomy service available closer to patients' homes and reduce inequalities.
- Offer continuity of care for patients in familiar surroundings

3. Service Description/Care Pathway

Care pathway

- GP/healthcare professional (HCP) will ensure the patient does not fall within the exclusion criteria for the service (excluded patients will be advised of alternative provider locations.)
- HCP will complete the appropriate requisition/blood form on ICE
- Phlebotomists to have access to ICE and clinical systems to ensure digital transfer of patient information and tests requested.
- Patient attends appointment Phlebotomist checks patient details and runs through covid check list questions then draws blood from patient as indicated by the referring HCP.
- Advise the patient regarding the test result follow-up process.
- Sample bottles are clearly and appropriately labelled
- Samples are sealed in appropriate bags and are stored in a safe and appropriate clinical environment prior to transportation to the Pathology Department, in accordance with the specimen handling section of Infection Prevention and Control Guidance for Primary Care
- The phlebotomist logs details of patient contact on appropriate system using codes specified.
- Collection of specimens and transport to secondary care pathology department
- Appointment waiting times should not exceed 7 days for routine bloods (unless clinically appropriate) and 2 days for urgent bloods. Appointments should be flexible for patients with additional needs such as disability /learning difficulties where best practice should be followed.

4. Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- Patients 14 years of age and above.
- Provided to housebound patients where clinically appropriate.
- Registered at a practice in a NWL Primary Care Network.
- Patients from whom venepuncture is difficult.

Exclusion criteria

- Infants and children up to 14 years.
- Glucose Tolerance tests, finger prick tests for glucose monitoring or general health screening.
- Patients on a secondary care 2WW/urgent pathway where a blood test is deemed clinically appropriate on the same day
- Secondary care outpatient clinic generated blood test requests
- Patients under the care of Accident & Emergency
- Inpatients

5. Training, Skills and Experience

The Service may be provided by a Phlebotomist, GP, nurse, healthcare assistant or staff trained in accordance with the standards of the World Health Organisation's guidelines on drawing blood: Best practices in phlebotomy (2010). In additon:

- Non-clinical staff such as receptionists or health care support workers should undergo basic training in an appropriate training and competency programme prior to commencing supervised practice;
- All healthcare assistants involved in the provision of the service must be working under the supervision of a qualified RGN or GP
- Staff are trained to treat any vasovagal fainting episodes.
- Staff renew competencies and certification as appropriate.

6. Equipment

- The Provider is responsible for ensuring sufficient levels of consumables is maintained to deliver the service including the provision of specimen bottles and holders which will be of the type specified by the receiving laboratory.
- Consumables such as specimen bottles for blood samples (vacutainer), syringes, needles, the specimen bag and forms can be obtained in line with the agreement with your local pahtology provider
- The provider will need to supply the remainder of the equipment.
- All equipment used for taking blood is single use and must be disposed of immediately after use into either a UN-approved sharps container or orange clinical waste bag, in compliance with hazardous waste procedures.

APPENDIX I - CONTRACTUAL REQUIREMENTS

PHLEBOTOMY		
Unit Price	**£3.80** per blood test **Home visit -** £10.06 (capped at one visit per day per patient)	
Business rule	Blood test	All recorded activity is payable
	Home Visit	1 visit per patient per day across all services
Service Type	Episodic	Pop-up not required
Referral Criteria	· Patients aged 14 years and above are **Mandatory** under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
PHL01	Number of consultations (payment per sitting)	Blood sample taken **(313334002)**
PHL02	Blood sample home visits	Home Visit (**439708006**)

PAYMENT/KPI RULES

To Achieve Payment for Phlebotomy PHL01

- Has SNOMED code of Blood sample taken **(313334002)** recorded by the provider

To Achieve Payment for Phlebotomy Home Visits PHL02

- Achieved coding for PHL01 **AND**
- Has SNOMED code Home Visit (**439708006**) recorded at the same time as Phlebotomy

Service	Paediatric Phlebotomy

1. National context and evidence base

Effective and efficient phlebotomy services are crucial to the delivery of 70% of all clinical interventions since they affect diagnosis, treatment and long term monitoring of care. Phlebotomy services can be provided by a range of healthcare professionals in a wide variety of settings. Wherever an NHS service is provided, it is recommended that patient needs are considered to ensure samples are taken as local to the patient as possible, with ease of access and in a timely manner that allows early decision making

North West London ICB wishes to commission a timely and safe paediatric phlebotomy service that supports its strategic commissioning intentions to ensure that high quality care is delivered as close to the patients home as is appropriate.

All children registered with North West London practices should be able to access Phlebotomy from a local setting.

2. Aims and objectives of service

Main strategic aims for the service are as follows.

- Patients under the age of 14 have access to a local, primary care based phlebotomy service away from hospital sites.
- Reduction in secondary care phlebotomy activity;
- Reduce anxiety to patients.
- Reduced health inequalities by improved access to the service.
- Patients care is informed by prompt diagnostic test results.
- Develop and embed team based and flexible working across primary community and specialist care
- Develop high quality Primary Care services at practice level and within PCNs.
- Delivering a timely and safe phlebotomy service
- Provide phlebotomy to patients registered at practices in the PCN who are aged 2-13.
- Provide a universal, equitable, clinically safe and high quality community phlebotomy service away from acute hospitals to reduce patient risk of covid infection.
- Routine tests should be conducted within 7 days or longer according to the clinical indication of the test. Make phlebotomy service available closer to patients' homes and reduce inequalities.
- Offer continuity of care for patients in familiar surroundings

3. Service Description/Care Pathway

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, the service offering and the sites from which the service will be offered. 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

Referring Practice

As part of the delivery the referring practice:

- Will provide the patients and/or family, on request, with written information about their blood tests, when to expect the results, and who to contact with any queries
- Order tests via the order comms system.
- Will explain to the patient and the family the reason for the blood tests and clearly communicate any specific instructions such as when the patient is required to fast for the blood test
- The referring GP will ensure prescriptions of EMLA or equivalent (where appropriate) and instructions are provided to the patient and the family, where required. If this is not undertaken the provider may at their discretion return the referral however the interest of the child should be considered paramount. This specification covers children aged between 2 and 13 years old. If a referring clinician is considering blood testing in an under 2-year-old then paediatric advice and guidance must be a requested in the first instance.

The Hub Provider

As part of the delivery the provider will:

- Provide a variety of clinics so patients can have bloods taken at a time convenient to them.
- Offer routine appointments.
- ensure Health Care Professionals and Health Care Assistants maintain their clinical competence for this Standard and:
  - Ensure that staff comply with the infection prevention and control procedures and consider any additional measures as a result of COVID i.e. use of PPE, cleaning surfaces after each patient, social distancing in waiting room and triage before patient enters building. Draw blood from patients as indicated by the referring healthcare professional;
  - Routine blood tests must be completed within ten working days from receipt of referral
  - Ensure that all sample labels are electronically printed, where the service provider has the correct printing equipment to do so;
  - Ensure samples are clearly and appropriately labelled i.e. samples should be marked urgent (where undertaken) or routine;
  - Ensure that all samples taken are sealed in appropriate bags and are stored in a safe and appropriate clinical environment prior to transportation to the Pathology Department, in accordance with the specimen handling section of Infection Prevention and Control Guidance for Primary Care
  - Ensure blood samples are stored in a separate bag from urine samples

4. Any Acceptance and exclusion criteria and thresholds

Acceptance criteria

- Patients 13 years of age and younger (Excluding under 2s)
- Provided to housebound patients where clinically appropriate.
- Registered at a practice in a NWL Primary Care Network.
- Patients from whom venepuncture is difficult.

Service is split into three cohorts

- Patients 2-4 years of age
- Patients 5-13 years of age
- Patients 2-13 years of age with a Learning Disability

Exclusion criteria

- Children 14 years of age and older should be seen under the adult pleobotmy specifiaton
- Glucose Tolerance tests, finger prick tests for glucose monitoring or general health screening.
- Patients on a secondary care 2WW/urgent pathway where a blood test is deemed clinically appropriate on the same day
- Secondary care outpatient clinic generated blood test requests
- Patients under the care of Accident & Emergency
- Inpatients

5. Training, Skills and Experience

The Service may be provided by a Phlebotomist, GP, nurse, healthcare assistant or staff trained in accordance with the standards of the World Health Organisation's guidelines on drawing blood: Best practices in phlebotomy (2010). In additon:

- Ensure that the Health Care Professional and Healthcare Assistant undertake appropriate training to be able to deliver Paediatric Phlebotomy
- The Health Care Professional should have 2 years' experience of taking adult bloods before taking children's bloods.
- Non-clinical staff such as receptionists or health care support workers should undergo basic training in an appropriate training and competency programme prior to commencing supervised practice;
- All healthcare assistants involved in the provision of the service must be working under the supervision of a qualified RGN or GP

- Staff are trained to treat any vasovagal fainting episodes.
- Staff renew competencies and certification as appropriate.

6. Equipment

- The Provider is responsible for ensuring sufficient levels of consumables is maintained to deliver the service including the provision of specimen bottles and holders which will be of the type specified by the receiving laboratory.
- Consumables such as specimen bottles for blood samples (vacutainer), syringes, needles, the specimen bag and forms can be obtained in line with the agreement with your local pahtology provider
- The provider will need to supply the remainder of the equipment.
- All equipment used for taking blood is single use and must be disposed of immediately after use into either a UN-approved sharps container or orange clinical waste bag, in compliance with hazardous waste procedures.

APPENDIX I - CONTRACTUAL REQUIREMENTS

PAEDIATRIC PHLEBOTOMY		
Unit Price	Paediatric Phlebotomy (2-4 years) - £30.79 per blood test Paediatric Phlebotomy (5-13 years) - £15.40 per blood test Paediatric Phlebotomy (Learning Disability) - £30.79 per blood test **Home visit -** £10.06 (capped at one visit per day per patient)	
Business Rule	Blood test	All recorded activity is payable
	Home Visit	1 visit per patient per day across all services
Service Type	Episodic	Pop-up not required
Referral Criteria	▪ Patient over 14 years of age and older should be see under the adult phlebotomy contract ▪ Patients aged under 14 years are **Mandatory** under this contract ▪ Patients aged under 2 years are Excluded under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
PPHL01	Number of consultations (payment per sitting)	Blood sample taken (**313334002**)
PPHL02	Blood sample home visits	Home Visit (**439708006**)

PAYMENT/KPI RULES

To Achieve Payment for Paediatric Phlebotomy PPHL01

- Patient must be aged between 2 and 13 years **AND**
- Has NO SNOMED code in **Learning Disability QOF cluster (LD) AND**
- Has SNOMED code of Blood sample taken **(313334002)** recorded by the provider

To Achieve Payment for Paediatric Phlebotomy Home Visits PPHL02

- Achieved coding for PPHL01 **AND**
- Has SNOMED code Home Visit (**439708006**) recorded at the same time as Phlebotomy

To Achieve Payment for Paediatric Phlebotomy (Learning Disability) PPHL03

- Patient must be aged between 2 and 13 years **AND**
- Has SNOMED code in **Learning Disability QOF cluster (LD)**
- Has SNOMED code of Blood sample taken **(313334002)** recorded by the provider

Service	Wound Care

1. National context and evidence base

Since 2019 NWL CCG has been implementing The NHS Long Term Plan which increases the focus of the provision of services based on population health through Primary Care networks (PCNs) which has lead towards the development of Enhanced Services that are outcome focused and population based.

2. Aims and objectives of service

- To improve the quality of life for people requiring management of their wounds, through the delivery of clinically effective care and advice which reduces the risk of recurrent infection and promotes independence.
- To ensure that high quality care is delivered as close to the patients' home as is appropriate
- Delivering a timely, effective and personalised wound management and healing service in a safe environment.
- Reducing attendance at A&E/UCCs for wound dressings that should be carried out under this service specification.
- Improving local symptoms such as pain, exudate and odour and healing rate through the use of appropriate treatment in accordance with best practice, published guidance and clinical evidence and reducing unnecessary or inappropriate use of dressings and wound care products.
- Detecting, and where appropriate treating, any infection to prevent deterioration of the wound and systemic involvement.
- Providing appropriate patient education so that patients may make informed choices and fully participate in their care and improve concordance.
- Promoting the use of individualised care management plans for all patients with communication at the point of discharge to patients, carers and healthcare professionals that promotes long term leg care and reduces the risk of recurrence.
- Preventing unnecessary referrals and admissions to specialist services, hospital or nursing homes. But where onward referrals are necessary completing these in clinically appropriate timeframes.

3. Service Description/Care Pathway

Process:

- Ensure that patient consent has been obtained to access their record and review the referral, where appropriate.
- Assess the wound, ensuring that it is swabbed where clinical signs and symptoms of infection are indicated and treat as appropriate;
- Ensure that swab results are followed up (by the registered GP or as otherwise agreed by the PCN) and an assessment is made to whether antibiotics are required or need to be changed (antibiotics must be prescribed in line with existing prescribing guidance for primary care).
- The service provider will issue acute necessary prescriptions; the prescribing of repeat medicine as part of ongoing management remains the responsibility of the patient's registered GP
- Develop a mutually agreed appropriate management and treatment plan to heal the wound and improve the patient's quality of life
- Record details of the appropriate management and treatment plan in the patient's record
- Provide clinically appropriate wound care management.
- Accommodate patients for urgent appointments, as clinically required. The maximum patient waiting time for an urgent appointment is one working day. GP Enhanced Access Hubs should be utilised.
- Reassess the wound and the management and treatment plan at appropriate intervals; any changes to the treatment plan should be updated on the patient's record using the relevant clinical template, where appropriate.
- Update the patient's registered GP of the management and treatment plan following the first consultation; where possible on the day of the consultation or otherwise within five working days of the first consultation.
- Inform the patient's registered Practice when the patient is discharged from the service provider.
- Inform the patient's registered Practice if the patient requires a referral for Compression bandaging or Doppler assessment, to enable an onward referral to be made under locally commissioned arrangements e.g. Community Tissue Viability Services (TVS)
- Inform patient's registered practice if a patient's wound has failed to improve after a maximum of six weeks of

evidence based management, so that an onward referral to the TVS for expert assessment and advice on management can be made.
- Precribing dressings in line with the NWL Primary Care Wound Care Formulary[7]

4. Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- Mandatory for patients aged 16 years of age and above
- Optional for patients under 16 years of age
- Post-operative wound check following surgery, where necessary
- Dressing change/reduction post-surgery
- Re-dressing
- Suture/clip removal
- Wound reviews, including pressure sores
- Minor wound infections
- Simple dressings for wounds from trauma or burns
- Packing for pilonidal sinus and abscesses following incision and drainage
- Wound care management pending review by and post discharge from specialist services, e.g. Diabetic podiatry, Tissue Viability Services, Doppler assessment and Compression bandaging (Venous leg ulcers).

Exclusion criteria

- Patients requiring home visits (including care/nursing home residents)
- Significant wound breakdown where re-suturing is necessary
- Reduction and removal of plaster type orthopaedic dressings after orthopaedic operations/fractures.
- On-going management of wounds under the care of specialist services, including Diabetic podiatry, Tissue Viability Services, Doppler assessment and Compression bandaging (Venous leg ulcers).

5. Training, Skills and Experience

- The service provider must ensure all staff delivering the service meet the training and competency requirements outlined in the OOHS Training and Clinical Competencies Guidance document.
- All staff delivering the service should be trained and updated in aseptic technique (ANTT).
- Attendance at wound care training course. Registered nurses who are experienced and competent in the management of wound care need only attend re-fresher training.
- Staff should maintain clinical competencies by attending regular re-fresher update training. It is anticipated this should be every 2-3 years or sooner if changes to clinical guidelines occurs or if competency gaps are identified.
- Healthcare Support Workers, Healthcare Assistants and Nursing Associates with the appropriate training and competency can deliver the service if supervised by a registered nurse.

6. Equipment

Dressings

- Dressing packs, gloves, stitch removers and normal saline are included in the price of the service per attendance.
- The service provider must keep a small supply of dressings in stock for the first assessment.
- The provider will be expected to use the FP10 for prescribing dressings in line with the NWL Primary Care Wound Care Formulary.

[7] **The NWL Primary Care Wound Care Formulary aligns with the formularies used by the TVS across NWL. Therefore, we expect continuity of dressings being prescribed and used across both General Practice and Community Services. However, there may be occasions where specialist dressings outside the Formulary are clinically recommended by the TVS. In such cases, the prescribing clinician should use their clinical judgment and seek advice from the service.**

APPENDIX I - CONTRACTUAL REQUIREMENT

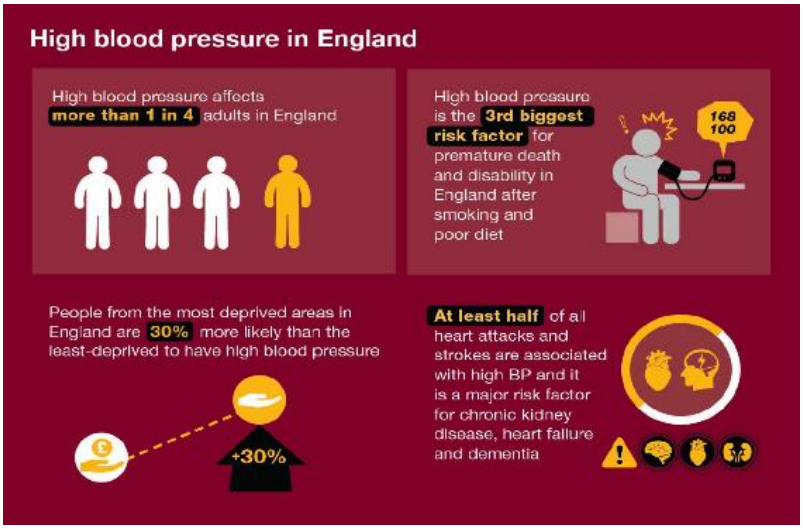
WOUND CARE		
Unit Price	**£15.76** per appointment	
Business rule	Paid per activity	
Service Type	Episodic	Pop-Up used to Record 'Enhanced services administration (**166221000000105**)
Referral Criteria	▪ Patients aged 16 years and above are **Mandatory** under this contract ▪ Patients under 16 years are **Optional** under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
W01	Consultations utilised for Wound Care	Wound Care (**225358003**) **AND** Enhanced Services Administration (**166221000000105**)

PAYMENT/KPI RULES
To Achieve Payment for Wound Care W01 ▪ Has SNOMED code of Wound care (**225358003**) recorded by the provider **AND** ▪ Has SNOMED code of Enhanced services administration (**166221000000105**) recorded at the same time as the Wound Care

Service	Ambulatory Blood Pressure Monitoring

1. National context and evidence base



High blood pressure (hypertension) is described by NICE1[8] as 'one of the most important treatable causes of premature morbidity and mortality in the world. It is a major risk factor for stroke, myocardial infarction, heart failure, chronic kidney disease, cognitive decline and premature death. Untreated hypertension is associated with a progressive rise in blood pressure'.

Hypertension continues to affect more than 1 in 4 adults in England and is the second largest single risk factor for premature death and disability in the country. A recent Public Health England (PHE)[9] analysis suggests that there is now an opportunity to prevent more than 9,000 heart attacks and at least 14,000 strokes over the next 3 years if we work towards better detection and management of high blood pressure.

Ambulatory blood pressure monitoring (APBM) correlates well with invasive blood pressure measurement and can identify both white-coat and masked hypertension. ABPM remains the gold standard for the accurate measurement of blood pressure in primary care. ABPM has therefore been retained as the preferred method for the diagnosis of hypertension. It is indicated for diagnosing hypertension in patients with a clinic BP reading between 140/90 to 180/120 mmHg. If ABPM is unsuitable or the person is unable to tolerate it, offer home blood pressure monitoring (HBPM).

The plan sets out the requirement to focus on improving hypertensions case finding and diagnosis, where the largest undiagnosed prevalence gap remains and where the greatest reductions in premature mortality can be made.

There are 305,852 people in NWL diagnosed with hypertension; prevalence 10.7%. However, expected prevalence is 26% (745,140) so there are 439,288 people who are undiagnosed [WSIC Hypertension Dashboard; Accessed Jan 2023].

This service should be used alongside the BPM@Home service offered across NWL which aims to improve the BP control of at-risk patients, reduce the time pressures on general practice and prevent avoidable heart attacks and strokes. Blood pressure monitors are being allocated nationally. It is a national programme that emerged as a priority throughout the pandemic. There is now a national recommendation to implement home blood pressure monitoring for patients with a diagnosis of hypertension which is poorly controlled, to allow treatment to be optimised, where it would be of benefit.

In addition, from November 2021, the Community Pharmacy Hypertension Case Finding Advanced Service[3] supports PCNs in improving access to blood pressure testing. The service has two stages; the first is identifying people at risk of hypertension, and offering them blood pressure monitoring (a clinic check). The second stage, where clinically indicated, is offering ambulatory blood pressure monitoring (ABPM). Blood pressure test results are shared with the patient's GP to inform a potential diagnosis of hypertension. PCNs are required to work collaboratively with community pharmacies delivering this service, the work of which will contribute towards the relevant QOF and IIF indicators

2. Aims and objectives of service

[8] **NICE Guideline [NG136], Hypertension in Adults: Diagnosis and Management, August 2019**

[9] **Public Health England, Tackling High Blood Pressure: An Update, January 2018**

[3] **NHS Community Pharmacy Hypertension Case-Finding Advanced Service, version 1, November 2021**

- To improve access for adult patients (aged 18 and over) requiring 24 hours Ambulatory Blood Pressure Monitoring (ABPM) for diagnosis and management of hypertension.
- To initiate treatment for hypertension before the onset of target organ damage.
- To enable patients with raised blood pressure between 140/90 to 180/120 mmHg in the locality to receive 24hr ABPM via primary care, hence reducing health inequalities.
- To consider 24hr ABPM where the clinician believes clinically appropriate to diagnose or rule out hypertension
- To consider 24hr ABPM, in addition to clinic blood pressure measurements, for people with hypertension identified as having a white-coat effect or masked hypertension

3. Service Description/Care Pathway

A primary care-based service that is able to offer ABPM to patients with BP readings between 140/90 to 180/120 mmHg only. Patients with BP at or greater than 180/110 should be considered as having severe hypertension and managed accordingly. Patients with a reading at or below 140/90 should have their BP routinely monitored every 5 years. Patients should be managed in line with NICE Guidance1, using the QRISK tool as appropriate.

Process

- Contact patients to arrange an appointment to fit the device, explain what the patient must and must not do and to answer any questions.
- Provide information to the patient on the service offered
- Ensure the patient returns the equipment the next day.
- Promptly and securely report back the results of the test to the appropriately qualified clinican.
- Record the results of the test into the electronic patient record.
- All patients must be provided with an annual review of care for adults with hypertension to monitor blood pressure, provide people with support, and discuss their lifestyle, symptoms and medication.

Follow-up after 24hr ABPM

- The referring GP or delegated deputy is responsible for ensuring that the results of the test are communicated to the patient, and that further tests and appropriate management is offered to the patient.

4. Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- Patients 18 years of age and above.
- Option for patients under 18 years of age where clinically appropriate
- Registered at a practice in a NWL Primary Care Network.
- If clinically appropriate, ABPM monitoring will be made available to housebound patients.
- Diagnosis: Patients who do not have an existing diagnosis of hypertension but are identified as having clinic blood pressure of between 140/90 to 180/120 mmHg.
- Monitoring: In patients who have been identified as having “white coat” effect at diagnosis of hypertension, ABPM can be used as an adjunct to usual blood pressure monitoring to assess response to treatment.
- Monitoring: Patients who have not been identified as having “white coat” syndrome at diagnosis but whose clinic blood pressure is not to target. In this scenario, GP must review lifestyle and check medication compliance with the patient, addressing any modifiable changes which may be contributing to an elevated blood pressure, before 24hrABPM may be offered. If the 24hr ABPM indicates the patient does not have white coat syndrome then the patient can be monitored with clinic blood pressure readings in future and is not eligible for further 24hr ABPMs.

Exclusion criteria

- Patients with BP at or greater than 180/110mmHg should be considered as having severe hypertension and managed accordingly.
- Patients with a reading at or below 140/90mmHg should have their BP routinely monitored every 5 years[1].

5. Training, Skills and Experience

The Service will be provided by a GP, Clinical Pharmacist, Nurse or suitably trained staff member who has received training

and be confident in the use of the specific device used by the provider, this includes:

- The principles of traditional blood pressure measurement
- Undertaking patient consultations
- Cuff fitting
- Monitoring function and analysis
- Interpreting results
- Reporting results on electronic patient record;

6. Equipment

- The Provider must use a device which has been tested according to the revised BHS protocol (1993).
- It is the Providers responsibility to purchase all equipment and consumables (such as replacement cuffs and batteries)
- It is the Providers responsibility to clean, calibrate and arrange for servicing of the device in line with the manufacturer's guidance, but not less than annually
- It is the Providers responsibility to ensure the ABPM machine is cleaned between uses
- It is the Providers responsibility to monitor the life span of the device and to purchase a new device as required. Again, this cost will be borne by the Provider as a tariff has been set for maintenance/ depreciation etc.
- It is the Provider's responsibility to replace any lost/ stolen equipment.

APPENDIX I - CONTRACTUAL REQUIREMENTS

AMBULATORY BLOOD PRESSURE MONITORING		
Unit Price	**£20.30** per completed test **Home visit -** £10.06 (capped at one visit per day per patient)	
Business rule	ABPM	Per activity
	Home Visit	1 visit per patient per day across all services
Service Type	Episodic	Pop-Up used to Record 'Enhanced services administration' (**166221000000105**)
Referral Criteria	Patients aged 18 years and above are **Mandatory** under this contract Patients under 18 years are **Optional** under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
ABPM01	Consultation utilised for 24 hour blood pressure monitoring	Application of ambulatory blood pressure monitor (**448678005**) **AND** Enhanced Services Administration (**166221000000105**)
ABPM02	Home visit undertaken for ABPM	Home Visit (**439708006**)

PAYMENT/KPI RULES

To Achieve Payment for ABPM Consultations ABPM01

- Has SNOMED code of Application of ambulatory blood pressure monitor **(448678005)** recorded by the provider **AND**
- Has SNOMED code of Enhanced Services Administration (**166221000000105**) recorded at the same time as the application of the blood pressure monitor

To Achieve Payment for ABPM Home Visits ABPM02

- Achieved coding required for **ABPM01 AND**
- Has SNOMED code of Home Visit (**439708006**) recorded at the same time as the application of the blood pressure monitor

Service	Electrocardiogram

1. National context and evidence base

This service will provide improved access to electrocardiogram (ECG) recording and interpretation of results for timely diagnosis and management.

2. Aims and objectives of service

The aim of the service is to deliver an EGG recording and interpretation service to detect common cardiology conditions such as, but not limited to, arrhythmias and heart block. By delivering this service, commissioners expect to see reduced referrals for ECGs into secondary care and where onward referrals are necessary, completing these in clinically appropriate timeframes.

3. Service Description/Care Pathway

The Provider will deliver this service specification in line with the following standards and requirements:

- Review the referral (please refer to Exclusion Criteria)
- Ensure that consent has been obtained and, where appropriate, assess using Fraser guidelines
- Ensure the ECG test is conducted within ten working days of receipt of referral
- Carry out the test by correctly placing 12 adhesive electrode leads on the patient's chest and limbs and print out the recording for interpretation
- Ensure that an appropriately competent and qualified registered Healthcare Professional carries out a preliminary review of results before the patient leaves the premises to ensure that no urgent action is required and to mitigate any clinical risk
- Ensure that the interpretation of the ECG is completed within three working days of the test;
- Record the results and interpretation of the ECG in the patient's record
- Inform the patient's GP of ECG results within one working day of interpretation
- Provide the ECG service to housebound patinets.

The patient's registered GP is responsible for acting upon test results and recommendations.

The service provider should ensure that they are able to access consultant cardiologist advice as clinically required.

4. Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- Patients 16 years of age and above.
- Option for patients under 16 years of age where clinically appropriate
- Registered at a practice in a NWL Primary Care Network.
- If clinically appropriate, ECG monitoring will be made available to housebound patients.

Exclusion criteria

- Patients with suspected acute coronary syndrome (Myocardial infarction or unstable angina)
- Acutely unwell patients; and
- Urgent referrals, patients who are symptomatic should be referred urgently to their hospital to avoid any delay to specialist intervention.

5. Training, Skills and Experience

Workforce Requirements

- A minimum number of patients are required to ensure professional competency is maintained. Each GP interpreting results must be able to interpret a minimum number of 100 ECG readings per year. There should be randomised reviews of interpretations to enure a high quality service.
- GPs cannot interpret ECGs on behalf of the service provider until they have attended a cardiology course agreed with

the commissioner, unless they can demonstrate that they have been interpreting at least 100 ECGs per year within the last 2 years.

Training Requirements

- All GPs who intend to provide interpretation must attend a cardiology course within a year of commencing with the service provider regardless of previous training and attend an update every 2 years.
- All healthcare professionals should attend appropriate courses either face to face or online
- It is for both the service provider, and contract holder if different, to ensure that staff delivering the service meet the training and competency requirements.

6. Equipment

- The Provider must use a device which has been tested and calibrated in line with manufacturer guidelines and this should take place at least annually.
- It is the Providers responsibility to purchase all equipment and consumables
- It is the Providers responsibility to clean, calibrate and arrange for servicing of the device in line with the manufacturer's guidance, but not less than annually
- It is the Providers responsibility to ensure the ECG machine is cleaned between uses
- It is the Providers responsibility to monitor the life span of the device and to purchase a new device as required. Again, this cost will be borne by the Provider as a tariff has been set for maintenance and depreciation.
- It is the Provider's responsibility to replace any lost/stolen equipment.

APPENDIX I - CONTRACTUAL REQUIREMENTS

Electrocardiogram		
Unit Price	**£47.28** per test and interpretation, both are required for payment (Split is recommended as follows Application £22.55/Interpretation £24.73) **Home visit -** £10.06 (capped at one visit per day per patient)	
Business Rule	ECG conducted and interpreted	Per activity
	Home Visit	1 visit per patient per day across all services
Service Type	Episodic	Pop-Up used to Record Enhanced services administration (**166221000000105**)
Referral Criteria	Patients aged 16 years and above are **Mandatory** under this contract Patients under 16 years are **Optional** under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
E01a	ECG tests conducted	Electrocardiographic monitoring (**46825001**) **AND** Enhanced Services Administration (**166221000000105**)
E01	ECG interpretation	ECG normal (**164854000**) **OR** ECG equivocal (**370359005**) **OR** ECG abnormal (**102594003**)
E02	Home visits undertaken for ECG tests	Home Visit (**439708006**)

PAYMENT/KPI RULES

To Achieve Payment for ECG Test Completed E01

- Has SNOMED code of Electrocardiographic monitoring (**46825001**) recorded by the provider **AND**
- Has SNOMED code of Enhanced services administration (**166221000000105**) recorded at the same time as the ECG **AND**
- Has SNOMED code of ECG normal (**164854000**) OR ECG equivocal (**370359005**) **OR** ECG abnormal (**102594003**) recorded by the provider within 7 days of the ECG conducted

To Achieve Payment for Each ECG Home Visits E02

- Has SNOMED code of Electrocardiographic monitoring (**46825001**) recorded by the provider **AND**
- Has SNOMED code of Enhanced services administration (**166221000000105**) recorded at the same time as the ECG **AND**
- Has SNOMED code for Home Visit (**439708006**) recorded at the same time as the ECG

Service	Diabetes (Level 1)

1. National context and evidence base

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality-of-care provision varies throughout the country. The number of people in the UK with diabetes is increasing and is projected to rise to 5.3 million by 2023. As of December 2022 in North West London, over 168,000 people have been diagnosed with diabetes with about 40,000 as yet undiagnosed. The total number of people living with diabetes in North West London is expected to be at least 224,000 by 2030. In North West London, there are approximately 25,000 people living with blood glucose levels above relaxed target values (HbA1c > 64mmol/mol), with over half being younger than 60 years of age.

Diabetes, particularly when blood sugars are persistently above target, can lead to serious life-threatening and life-limiting complications for people with diabetes, as well as higher costs for health and social care services. These include;

- blindness;
- foot disease leading to amputations;
- kidney disease leading to dialysis;
- heart disease;
- stroke;
- dementia.

In North West London, at least £350m (around 10% of health spend) is spent on diabetes care with an additional, as yet unquantified, amount in lost productivity and social care costs. 80% of costs are related to treating diabetes complications - with foot disease being the largest contributor - and approximately 40% of all emergency admissions and acute bed days are for diabetes-related complications. An individual may, along with diabetes, have other long-term conditions, e.g. hypertension, chronic obstructive pulmonary disease (COPD). Those living with Type 1 Diabetes Mellitus may also have other auto-immune conditions including coeliac disease and/or thyroid abnormalities.

Up to 60% of people with diabetes state that they are living with mental health or emotional difficulties. There is clear evidence that these often go undetected and untreated, leading to impaired ability to effectively self-care and resulting in poorer diabetes outcomes. The mental health difficulties people experience are broad and range from diabetes distress, depression and anxiety; to eating disorder, psychosis and dementia and yet there is a lack of a clear whole pathway integrated provision for people with specific needs in this area locally and nationally. There is good local and national evidence that, if mental health and emotional difficulties are addressed, this can lead to improved diabetes outcomes.

There is a strong evidence base for the effectiveness of lifestyle change programmes creating reductions in Type 2 diabetes incidence, and for the importance of including lifestyle interventions into any obesity intervention for it to be effective. Similarly, there is evidence for the cost saving and cost effectiveness of risk assessment and screening in pre-diabetes populations and those at high risk of developing diabetes.

A prevention and population approach will be vital for the size of the task, and will require the addressing of social determinants of health, collaboration with local government and use of social prescribing to address these issues. This represents a clear opportunity for joint commissioning between ICBs, public health, patient and support groups and the third sector, with or without additional social finance investment.

2. Aims and objectives of service

The aim of the Level 1 diabetes service is to improve quality of care and outcomes, reducing morbidity, dependency and mortality, with seamless navigation and better patient experiences across all diabetes services within North West London. This will be achieved through shared goals and objectives, shared and proactive workforce planning that aligns with the care pathway and improved communication systems between different parts of the health /social care systems. The provider/service will embed new ways of working, including the use of technology, apps, virtual contacts, remote consultations (including group consultations) in clinics to drive efficiency and avoid duplication and wastage. Providers are required to work alongside partners such as Health Education England - North West London, Public Health, Social Care, Housing, and the Voluntary Sector to meet our shared goals and objectives.

The key elements of the integrated care model are:

- Population health-based approach from wellbeing and prevention through to end of life.
- Population based health outcomes to shift activity towards prevention.
- Holistic approach including lifestyle interventions and mental health integration.
- Using data and digital technology to identify those at most risk.
- A 3-year contract with a view to extend to 10 years' dependent on achievement of agreed outcomes.
- Shared governance and accountability via the NWL Integrated Care System, performance measurement and financial framework to underpin integration.

Objectives

Objectives of the service are:

- Maximise National Diabetes Audit (NDA) participation. The legal basis for data to be collected for the NDA[10] means that GP practices and specialist services are not legally required to supply the data for their practice or diabetes clinic.
- Ensure that people living with type 1 diabetes have access to specialist support and technology to optimise their self-management
- Reduce adverse pregnancy-related outcomes for those with pre-existing or gestational diabetes
- Reduce variation in quality of care, offer, access and treatment targets for all North West London residents, irrespective of their age, gender and where they live.
- Reduce health inequalities
- Increase attendance at structured education to improve self-care
- Reduce unwarranted variation in achievement of the NICE recommended treatment targets for blood pressure, HbA1c and cholesterol
- Reduce amputation and emergency admission rates for foot complications through improvements in foot care pathways
- Improve in-patient care and reduce length of stay in acute hospitals
- Use technology as an enabler to support delivery of objectives
- Embed a mental health pathway (for all levels of mental health and emotional needs) through every aspect of the diabetes pathway to support self-care optimisation and improve people's experiences. A menu of options must be available at all stages of their journey, depending on their level of need, availability of services commissioned and patient choice.

3. Service Description/Care Pathway

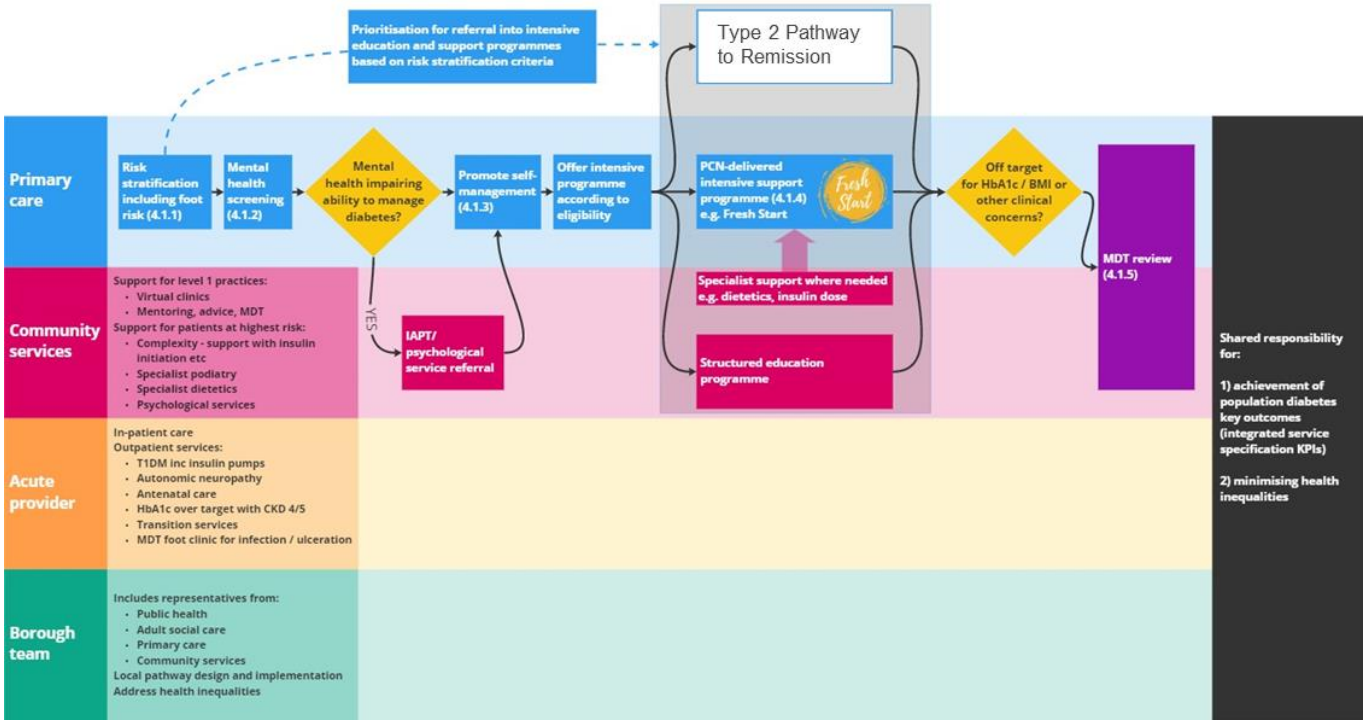
This Level 1 service fits within a wider pathway for people living with diabetes, which operates to allow people to move between levels seamlessly and as their needs dictate and where more experienced clinicians are required to manage their care.

- **Non Diabetic Hyperglycaemia (NDH):** This largely primary care service will be responsible for proactive identification of NDH and referral into nationally commissioned NHS Diabetes Prevention Programme to support the prevention of Type 2 Diabetes.
- **Diabetes (Level 1):** The primary care service at Level 1 will have primary responsibility for the person with Type 2 Diabetes
- **Diabetes (Level 2):** The level 2 service provides primary care expertise which includes primary care based experts in insulin initiation and management who also start other diabetes injectables.[11]
- **Diabetes (Level 3):** The consultant-led community-based diabetes team acts as the link between generalist clinicians and specialists. Specialists who provide the Level 3 diabetes service should spend a proportion of their time leading, advising and facilitating the work of the primary care based Level 1 and Level 2 diabetes teams. Staff will fast-track people with diabetes safely back to primary care or to Level 4 (where clinically appropriate) and allow the Level 3, 2 and 1 teams to provide care closer to the patient's home.
- **Diabetes (Level 4):** Specialist diabetes services have primary responsibility for those with Type 1 and rarer forms of

[10] **Direction under section 254 of the Health and Social Care Act 2012**

[11] **Not all boroughs across North West London commission an Insulin Initiation service from primary care, NWL aims to have a consistent offer for Insulin Initiation across Primary Care in 2023/24**

diabetes. All people with Type 1 Diabetes and other forms of diabetes, such as monogenic diabetes e.g. maturity-onset diabetes of the young (MODY), mitochondrial diabetes, diabetes due to chronic pancreatitis or total pancreatectomy, should have access to specialist diabetes services including those commissioned by NHS England. Provision needs to be made in the community for people with Type 1 Diabetes who refuse to be seen in secondary care or on end of life pathways.

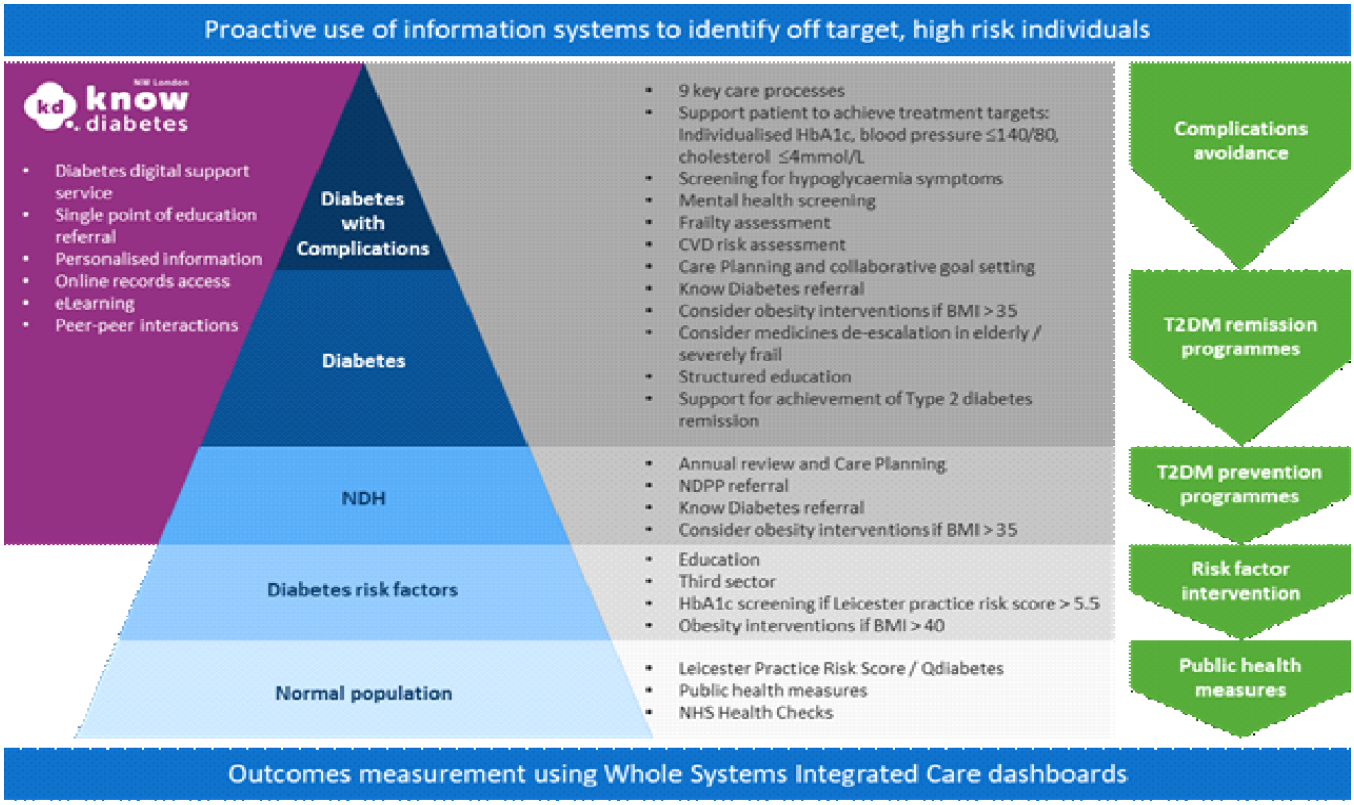


All patients with Type 2 diabetes should be offered, where appropriate, the opportunity to participate in a diabetes remission or intensive support programme, whether through a low calorie total diet replacement (TDR) programme, through other dietary options such as low carbohydrate, Mediterranean or intermittent fasting, or through bariatric surgery.

People with diabetes (seen at any level) should have access to structured education, social prescribing and emotional and mental health support according to need, commissioned services available and choice.

Accountability for the incidence of onset of complications and incidence of hard clinical endpoints such as amputation and blindness lies across the health economy, and responsibility will be shared by all providers of diabetes care, therefore both generalist and specialist services will be jointly accountable for clinical outcomes.

Care planning, care delivery, plan review and adjustment and operational improvement should underpin the approach to all service delivery.



12

The Level 1 (Primary Care Network) Diabetes Service

A Level 1 diabetes service is delivered by a group of competent (as denoted by evidence of the TREND competencies to Level 2[13] and eligible primary care providers to all patients registered with general practices ensuring equitable access and quality of service to the entire population group.

The level 1 service will:

- Deliver high quality proactive diabetes care as required by NICE and as evidenced by achievement of completion of the 9 key care processes.
- Support the prevention of the complications of diabetes by supporting people with diabetes to achieve their personalised goal for the three NICE treatment targets (glucose, blood pressure and cholesterol).
- Where patients are on target for personalised goals (dependent on duration of diagnosis and frailty), frequency of monitoring may be 6 monthly to annually. Where patients are off target, they should be reviewed 3 monthly at a minimum.

Risk Stratification

- Stratify patients by risk of complications and/or exacerbation in order to prioritise referrals into more intensive pathways of care
- Risk stratify patients in relation to diabetes foot complications.
- Identify potential complications including: cardiovascular disease (coronary heart disease, arrhythmia, TIA/stroke, peripheral vascular disease), foot ulceration, non-alcoholic fatty liver disease, renal disease and ophthalmological disease and intervene/seek advice/refer as per guidance.

[12] **A small number of specialised services are commissioned nationally by NHS England directly as part of NHS England's specialised commissioning role. These services include islet cell transplantation, pancreas transplantation, insulin-resistant diabetes, congenital hyperinsulinism, Alstrom Syndrome, Bardet-Biedl Syndromes and Wolfram Syndrome, and are delivered by tertiary centres that specialise in these specific conditions. Service specifications for these specialised services will not be covered here, but are included in the work streams of the Diabetes Specialised Commissioning Clinical Reference Group at NHS England.**

[13] www.diabetes.org.uk/professionals/training--competencies/competencies

Mental Health and Well-being

- The service will ensure that clinicians and support-staff will screen patients with diabetes for mental health and emotional difficulties (and in community setting people with non-diabetic hyperglycaemia) on their caseload as follows:
- All people with off target diabetes control who are over the age of 60 using 6 item Cognitive Impairment Test or another validated tool and follow the local pathway for referrals and management.
- Screen for emotional or mental difficulties annually using either the Diabetes Distress Scale (DDS2) or the combination of two questionnaires[14] and refer or intervene as per guidance
- The screening will facilitate further conversation and a menu of choices which must be discussed with the person with diabetes. Depending on risk and severity as well as local availability and person choice, these will include:
  - Conservative approach (watchful waiting) with 3/12 review
  - Refer to mental health supportive information on the Know Diabetes website
  - Antidepressant medication
  - Peer support
  - Mindfulness training
  - Physical activities
  - Therapy options like cognitive behaviour therapy (CBT) via IAPT, specialist psychology
  - Drug and alcohol services
  - If high risk of harm to self, the service will make a referral to the mental health provider (CNWL or WLT as appropriate for geographical area) or via the adult single point of access telephone numbers in the respective organisations as available.
  - If Complex Common Mental Health Needs (CCMHN) are identified, this should trigger the CCMHN pathway as per the Like-Minded strategy[15]
- Ensure that there are clear pathways for referral into low intensity and high intensity psychological services like IAPT, eating disorders services and weight management and bariatric surgery services.
- If mild cognitive impairment, this should lead to watchful waiting
- Following communication from secondary care about moderate to severe cognitive impairment, the GP must review the person and consider further assessment and investigations as per the new NICE June 2018 Dementia guideline
- For all severities of cognitive impairment, any service working with the person must ensure assessment and optimisation of eyesight, hearing, mobility, independence, support network where commissioned to do so.
- For all severities of cognitive impairment, any service working with the person must ensure assessment and optimisation of mental capacity for all decisions as per the Mental Capacity Act 2015
- The service provider will measure performance by reporting to commissioners: The number and percentage of people with diabetes and non-diabetic hyperglycaemia on caseload/register with one of the recommended assessment tool/s competed as set out under DL105 of Appendix 1 below. This includes DDS2 or PHQ4 (i.e. PHQ2 and GAD2) annually with an analysis and evaluation of the data collection (in primary care and community settings). Extended DDS-17, PHQ2 AND GAD2, PHQ 2 AND GAD7, PHQ9 AND GAD2, PHQ9 AND GAD7, PAM or PAM level scores also permitted.

Promoting Self-Management

- Promote and facilitate self-care through signposting patients to information in the Know Diabetes Service and supporting increased uptake of accredited structured education and behaviour change interventions for people with Type 2 Diabetes.
- Promote and facilitate referral of eligible patients into the NWL QISMET approved structured education programmes[16]
- For T2DR (NHSE Type 2 Diabetes Remission programme) and other remission and weight management programmes where locally available. Patients being referred should be made aware of the intensive nature of the programme and

[14] **This combination could be the Patient Health Questionnaire4 (PHQ4), which has two basic questions for depression, PHQ2 - and two for anxiety, GAD2 or a combination set out in DL105 in Appendix V**

[15] www.healthiernorthwestlondon.nhs.uk/news/2016/05/03/bringing-minded-strategy-life

[16] www.knowdiabetes.org.uk/for-you/programmes/type-2

commitment required.

- Updated results to be made available to patients at least a week before their care planning review, in order to allow time for patients to formulate questions and consider any changes they may wish to make
- At least one appointment per year of 30 minutes or more (which would ideally be performed as part of a group consultation) to allow time for collaborative goal setting and action planning in order to engage patients in self-management
- Agree diabetes care plan based on the patient and registered healthcare professional's shared goals and individualized targets for HbA1c, cholesterol and blood pressure where possible
- Offer a copy of the care plan to the patient
- Register of housebound and care home diabetes patients with care plans.
- PCNs may also decide to deliver group consultation[17]

PCN-based Multidisciplinary Team (MDT)

- One of the aims of this service is to ensure that PCNs are enabled to work as a collective of practices and specialists from acute, community, mental health, and voluntary sector organisations. This is especially important for people with diabetes, whose needs are often best met by using an MDT approach.
- Within each borough, providers of diabetes services as well as the borough-based team will need to agree local implementation of MDT pathways including but not limited to:
  - Specialist support to individual practices and the PCN MDT
  - Escalation and referral pathways
  - Approaches to minimising health inequalities
- As the formation of PCN MDTs is in its infancy, especially for this cohort of patients, the borough team will work with the PCNs to develop and agree robust commissioning and contracting arrangements.
- For this cohort of patients, the MDT can consist of the following traditionally practice-based professionals, as required:
  - GP with competency
  - Practice nurse / clinician with competency
  - Practice-based Pharmacist
  - Healthcare Assistant
  - Health coach
  - Administrator
  - Management staff
  - Diabetes lay mentor
- In addition[18], the following specialists/experts, as required:
  - Care navigator
  - Social prescribing link worker
  - Diabetes specialist nurse
  - Diabetes specialist dietician
  - Psychiatric nurse or doctor
  - Clinical psychologist/Improving Access to Psychological Therapies
  - Podiatrist
  - Diabetes consultant
- Practices should ensure that the following patients are discussed with a wider MDT team in order to agree an appropriate management plan:
  - Patients remaining off target for HbA1c, BP, lipids or BMI despite engagement in intensive support programmes
  - Patients who do not engage or do not attend
  - Patients with complex mental health issues
  - Patients who have severe frailty or complex multi-morbidity

[17] www.knowdiabetes.org.uk/professional/group-consultations

[18] **These lists are not intended to be exhaustive**

- Where requesting advice or referral to a PCN-based service including MDT discussions, community/mental health team or other service provider, agree to provide up to date information on all nine key care processes and current medication
- Practices are encouraged to discuss all referrals for further diabetes care with the PCN MDT except:
  - Children/adolescents
  - Type 1 diabetes patients, unless referral to specialist care has been refused
  - Patients who are acutely unwell (including sudden deterioration in renal function)
  - Pregnancy
  - Acute foot complications (ulceration, infection or swelling)
  - Practices sign up to managing patients in line with the agreed pathway
  - Practices have systems and processes in place for discharging from secondary care all suitable patients identified in the pathway
  - Practices have information available for patients that enables them to understand the pathway.

Outcomes

The level 1 service will demonstrate performance by:

- Engaging in the National Diabetes Audit for Care processes and treatment targets
- Allowing automated data extraction from primary care systems via the Discovery Data Service into WSIC to support quality improvement and key outcomes monitoring
- Engaging with service-related outcomes and patient reported outcomes via the NWL KPI monitoring dashboard
- Achievement of key performance indicators as noted in this specification
- Links with other diabetes services within the ICB including the T2DR service, the community diabetes service, foot protection team and patient education.

The level 1 service will ensure that:

- The service uses digital systems and tools to support detection and monitoring (For example, risk scoring, risk stratification, and proactive recall systems)
- The service Clinical staff in the primary care team have an up-to-date understanding of diabetes and its complications, at least second line oral medication options, and an overview of the impact of weight loss, Total Diet Replacement and low-carbohydrate diets on Type 2 Diabetes.

4. Any Acceptance and exclusion criteria and thresholds

Exclusions:

- Pregnancy
- Patients aged under 17

5. Training, Skills and Experience

The service provider must:

- Ensure that the staff delivering the service meet the requirements the Training Research and Education for Nurses in Diabetes (TREND) competencies for level 1 and that this is compliant with the Cambridge Diabetes Education Programme including peer reviews.
- The named service lead should be a GP who has overall responsibility for ensuring the service is delivered in accordance with the specification.
- ensure staff delivering the service have access to on-going diabetes education programmes and updates.
- Registered nurses must meet the relevant minimum competencies for “competent nurse”, as recommended by TREND and working towards “experienced or proficient nurse”.[19]
- Complete the Cambridge Diabetes Education Programme[20] as part of staff’s continuing professional development.

[19] https://trenddiabetes.online/wp-content/uploads/2020/04/Framework_6th_EDN_TREND_FINAL.pdf

[20] www.cdep.org.uk

6. Equipment

There is no specialist equipment required for the delivery of this service.

APPENDIX I - CONTRACTUAL REQUIREMENTS

DIABETES LEVEL 1

Unit Price

A maximum total of **£45.75** per patient on QOF Diabetes Register (Diabetes diagnosis without a more recent diabetes resolved diagnosis) subject to meeting Key Performance indicators as listed below.

The tariff will be split as follows:

1. **15%** for complete of 9 key care processes (Appendix II)
2. **30%** when a PCN reaches full achievement for the three Treatment Targets (Appendix III)
3. **20%** when a PCN reaches full achievement for HbA1c in newly diagnosed patients (Appendix IV)
4. **10%** when a PCN reaches full achievement for mental health screening (Appendix V)
5. **25%** for complete diabetes care plan (Appendix VI)

Achievements are banded as follows:

KPI	Target Thresholds	Financial Achievement
% 9 Key Care Process in last 15m (Appendix II)	<55%	0%
	55-65%	7.5%
	>65%	15%
% HbA1c ≤58 (≤75 in mod/sev frailty), BP ≤140/80 (≤ 150/90 in mod/sev frailty), Non HDL Cholesterol ≤ 3.0 in last 15m (Appendix III)	<29	0%
	29-35%	15%
	>35%	30%
% Newly Diagnosed HbA1c <= 53 in last 15m (Appendix IV)	<50%	0%
	50-60%	10%
	>60%	20%
% Mental Health Screening in last 15m (Appendix V)	<45%	0%
	45-55%	5%
	>55%	10%
% with diabetes care plan in last 15m (Appendix VI)	<70%	0%
	70-75%	12.5%
	>75%	25%

Service Type	Package	No Pop-Up
Referral Criteria	Patients aged 17 years and above are Mandatory under this contract	

CODING NECESSARY FOR PAYMENT

Ref.	Description	SNOMED Code
DL101	Number of patients on the PCN QOF Diabetes Register	QoF Cluster for Diabetes mellitus

PAYMENT/KPI RULES

To Achieve Payment for Diabetes Level 1 DL101

- Patient must be Aged 17 and Over **AND**
- Has a SNOMED code of QoF Diabetes cluster without being resolved

APPENDIX II - 9 KEY CARE PROCESSES

Ref.	Description	SNOMED Code[21]		Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL102	% of patients on PCN diabetes register receiving 9 key care processes (HbA1c; BP; Cholesterol; serum creatinine/eGFR; urine albumin; foot surveillance; BMI; smoking in last 15m and retinal screening in the last 27m)	BMI	Body Mass Index - observation **(60621009)**	**Numerator:** Number of patients within the PCN receiving all 9 key care processes within last 15m (27m for retinal screening)	**Denominator:** Number of patients on the PCN QoF diabetes register	<55% 55-65% >65%	0% 7.5% 15%	Monthly – via the Diabetes Dashboard
		HbA1c	HbA1c level - IFCC standardised **(999791000000106)** HbA1c level (monitoring range) - IFCC standardised (**1049321000000109**) HbA1c level (diagnostic range) - IFCC standardised (**1049301000000100**)					
		Blood Pressure	**ONE OF:** O/E - Systolic BP reading **(72313002)** Average systolic blood pressure (**314440001**) Average night interval systolic blood pressure (**314445006**) Average day interval systolic blood pressure (**314446007**) Average 24 hour systolic blood pressure (**314449000**) Average home systolic blood pressure (**413606001**) Ambulatory systolic blood pressure (**198081000000101**) Self reported systolic blood pressure (**1162737008**) **AND ONE OF:** O/E - Diastolic BP reading **(1091811000000102)** Average diastolic blood pressure (**314453003**) Average night interval diastolic blood pressure (**314460009**) Average day interval diastolic blood pressure (**314461008**) Average 24 hour diastolic blood pressure (**314462001**) Average home diastolic blood pressure (**413605002**) Ambulatory diastolic blood pressure (**198091000000104**)					

[21] **At present, a number of codes are in use by different pathology services across North West London. There is ongoing work on unification of coding**

			Self reported diastolic blood pressure (**1162735000**)					
		Lipids	Serum cholesterol level **(1005671000000105)** Serum fasting total cholesterol **(1083761000000106)** Serum total cholesterol level **(994351000000103)** Total cholesterol measurement **(121868005)** Fasting Cholesterol level (**1083761000000106**) Cholesterol: HDL ratio *Serum non high density lipoprotein cholesterol level (**1006191000000106**) *Non high density lipoprotein cholesterol level **(1030411000000101)** Serum cholesterol/high density lipoprotein ratio (**1015681000000109**)					
		Urine ACR	Urine albumin/creatinine ratio **(1023491000000104)** Urine protein/creatinine ratio **(1028731000000100)** Urine Microalbumin level **(1010251000000109)** Urine Microalbumin Profile (**994621000000103**) Urine protein/creatinine index **(1030991000000102)** Random Urine protein/creatinine ratio **(1006631000000104)**					
		eGFR	*Glomerular filtration rate **(80274001)** *GFR calculated abbreviated MDRD (**1020291000000106**) *eGFR using creatinine (CKD-EPI) per 1.73 square metres **(1011481000000105)** GFR (glomerular filtration rate) calculated by abbreviated Modification of Diet in Renal Disease Study Group calculation adjusted for African American origin (**996231000000108**)					
		Record of Retinal Screening[22]	Digital retinal screening (**390852004**) Retinal screening (**390735007**) Seen by ophthalmologist (**305721007**) Seen in ophthalmology clinic (**185222001**) Diabetic retinopathy screening (**134395001**) Slit lamp fundus examination (**410455004**) O/E - no left diabetic retinopathy (**390853009**)					

[22] **Clinical coding currently being reviewed and additional codes may be added at a later date**

			O/E - left eye background diabetic retinopathy (**408410002**) O/E - left eye preproliferative diabetic retinopathy (**408412005**) O/E - left eye proliferative diabetic retinopathy (**408414006**) O/E - left eye stable treated proliferative diabetic retinopathy (**414894003**) O/E - no right diabetic retinopathy (**390850007**) O/E - right eye background diabetic retinopathy (**408409007**) O/E - right eye preproliferative diabetic retinopathy (**408411003**) O/E - right eye proliferative diabetic retinopathy (**408413000**) O/E - right eye stable treated proliferative diabetic retinopathy (**414910007**) O/E - left eye no maculopathy (**414893009**) O/E - left eye diabetic maculopathy (**408416008**) O/E - right eye no maculopathy (**414909002**) O/E - right eye diabetic maculopathy (**408415007**)					
		Foot check (including testing for neuropathy and circulation)	Any of: O/E - Left diabetic foot at low risk (**394675000**) O/E - Left diabetic foot at moderate risk (**394681008**) O/E - Left diabetic foot at high risk (**394676004**) O/E - left diabetic foot ulcerated (**394674001**) O/E - Amputated left leg (**308094003**) O/E - Amputated left above knee (**308096001**) O/E - Amputated left below knee (**308098000**) **AND** Any of: O/E - Right diabetic foot at low risk (**394671009**) O/E - Right diabetic foot at moderate risk (**394682001**) O/E - Right diabetic foot at high risk (**394672002**) O/E - Right diabetic foot - ulcerated (**394673007**) O/E - Amputated right leg (**308093009**) O/E - Amputated right above knee (**308095002**) O/E - Amputated right below knee (**308097005**)					
		Smoking	Smoking Status QOF cluster					

		status						

PAYMENT/KPI RULES:
To Achieve Payment for Diabetes Level 1 DL102 · Patient must be Aged 17 and Over **AND** · Has a SNOMED code of QoF Diabetes cluster without being resolved **AND** · Has all of the **9 Key care processes** (**DL102**) recorded within the previous 15 months

APPENDIX III - HbA1c, BLOOD PRESSURE, CHOLESTEROL TREATMENT TARGET

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL103	% patients on PCN diabetes register with latest 3 Treatment Targets values in range: HbA1c ≤58 (≤75 in moderate/severe frailty), BP ≤140/80 (≤150/90 in moderate/severe frailty), non-HDL cholesterol ≤3.0 in last 15m	HbA1c level - IFCC standardised (**999791000000106**) HbA1c level (monitoring range) - IFCC standardised (**1049321000000109**) HbA1c level (diagnostic range) - IFCC standardised (**1049301000000100**) O/E - Systolic BP reading **(72313002)** Average systolic blood pressure (**314440001**) Average night interval systolic blood pressure (**314445006**) Average day interval systolic blood pressure (**314446007**) Average 24 hour systolic blood pressure (**314449000**) Average home systolic blood pressure (**413606001**) Ambulatory systolic blood pressure (**198081000000101**) Self reported systolic blood pressure (**1162737008**) O/E - Diastolic BP reading **(1091811000000102)** Average diastolic blood pressure (**314453003**) Average night interval diastolic blood pressure (**314460009**) Average day interval diastolic blood pressure (**314461008**) Average 24 hour diastolic blood pressure (**314462001**) Average home diastolic blood pressure (**413605002**) Ambulatory diastolic blood pressure (**198091000000104**) Self reported diastolic blood pressure (**1162735000**) Non high density lipoprotein cholesterol level (**1030411000000101**) Serum non high density lipoprotein cholesterol level (**1006191000000106**)	**Numerator A:** Number of patients on the diabetes register who have latest HbA1c ≤ 58 AND Blood Pressure ≤ 140/80 AND non-HDL cholesterol ≤3.0) AND recorded within the previous 15 months and NO code for moderate or severe frailty **Numerator B:** Number of patients on the diabetes register who have latest HbA1c ≤ 75 AND Blood Pressure ≤ 150/90 AND non-HDL cholesterol ≤3.0) AND recorded within the previous 15 months and code for moderate or severe frailty	**Denominator A:** Number of patients on the PCN QoF diabetes register with NO code for moderate or severe frailty **Denominator B:** Number of patients on the PCN QoF diabetes register WITH code for moderate or severe frailty	<29% 29-35% >35%	0% 15% 30%	Monthly – via the Diabetes Dashboard

PAYMENT/KPI RULES:
To Achieve Payment for Diabetes Level 1 DL103 • Patient must be Aged 17 and Over **AND** • Has a SNOMED code of QoF Diabetes cluster without being resolved • **AND EITHER:** • Has latest HbA1c ≤ 58 **AND** Blood Pressure ≤ 140/80 **AND** non-HDL cholesterol ≤3.0) **AND** recorded within the previous 15 months and **NO** code for moderate frailty (**925831000000107**) or severe frailty (**925861000000102**) **OR** • Has latest HbA1c ≤ 75 **AND** Blood Pressure ≤ 150/90 **AND** non-HDL cholesterol ≤3.0) **AND** recorded within the previous 15 months and code for moderate frailty (**925831000000107**) or severe frailty (**925861000000102**)

APPENDIX IV - HbA1c TREATMENT TARGET

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL104	% of patients on the PCN diabetes register diagnosed within last 6 years who have latest HbA1c ≤ 53 completed within last 15m	Haemoglobin A1c level – IFCC standardized (**999791000000106**) HbA1c level (monitoring range) - IFCC standardised (**1049321000000109**) HbA1c level (diagnostic range) - IFCC standardised (**1049301000000100**)	**Numerator:** Number of patients who have latest HbA1c ≤ 53 (completed within last 15m)	**Denominator:** Number of patients on the PCN QoF diabetes register diagnosed within the last 6 years	<52.5% 52.5-57.5% >57.5%	0% 10% 20%	Monthly – via the Diabetes Dashboard

PAYMENT/KPI RULES:

To Achieve Payment for Diabetes Level 1 DL104

- Patient must be Aged 17 and Over **AND**
- Has a SNOMED code of QoF Diabetes cluster without being resolved **AND**
- Diabetes Diagnosis within the last 6 years **AND**
- Has latest HbA1c ≤ 53 **AND** recorded within the previous 15 months

APPENDIX V - MENTAL HEALTH SCREENING TREATMENT TARGET

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL105	% patients on PCN diabetes register with mental health screening or PAM score in last 15m	One of: · DDS - (DDS- 2 (**909421000000102**) or DDS-17 (**910931000000101**) · PHQ-4 (**1104961000000104**) · PHQ AND GAD together - · PHQ- 2 (**836541000000100**) **AND** GAD-2 (**836571000000106**) · PHQ- 2 (**836541000000100**) **AND** GAD-7 (**445455005**) · PHQ-9 (**720433000**) **AND** GAD-2 (**836571000000106**) · PHQ-9 (**720433000**) **AND** GAD-7 (**445455005**)	**Numerator:** Number of patients on the PCN diabetes register with a record of PHQ4, DDS-2, (GAD AND PHQ) score in the last 15 months	**Denominator:** Number of patients on the PCN QoF diabetes register	<60% 60-70% >70%	0% 5% 10%	Monthly – via the Diabetes Dashboard

PAYMENT/KPI RULES:

To Achieve Payment for Diabetes Level 1 DL105

- Patient must be Aged 17 and Over **AND**
- Has a SNOMED code of QoF Diabetes cluster without being resolved **AND**
- Has a SNOMED code of either i) DDS-2 or DDS-17 ii) PHQ-4 iii) PHQ-2 or PHQ-9 **AND** GAD-2 or GAD-7

APPENDIX VI - DIABETES CARE PLAN

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL108	% of patients on the PCN diabetes register who have documentation of care planning consultation (including offer of referral in previous 15months (results prior to consultation, documentation of agreed goals and plan, care plan offered to patient)	Review of patient goals (**775501000000108**) **AND** Diabetes care plan agreed (**703040004**) With **ONE OF:** Attended diabetes structured education programme (**413597006**) Attended DESMOND (diabetes education and self-management for ongoing and newly diagnosed) structured programme (**276651000000107**) Attended dose adjustment for normal eating diabetes structured education programme (**306441000000109**) Attended expert patient education versus routine treatment diabetes structured education programme (**306401000000106**) Remote diabetes structured education and support programme commenced (**1097131000000105**) Diabetes structured education programme completed (**755491000000100**) Diabetes education and self-management for ongoing and newly diagnosed structured programme completed (**306501000000105**) Dose adjustment for normal eating diabetes structured education programme completed (**306471000000103**) Expert patient education versus routine treatment diabetes structured education programme completed (**306531000000104**) X-PERT (expert patient education versus routine	**Numerator:** Number of patients on the PCN diabetes register who have documentation of care planning consultation in previous 15 months	**Denominator:** Number of patients on the PCN QoF diabetes register	<70% 70-75% >75%	0% 12.5% 25%	Monthly – via the Diabetes Dashboard

		treatment) First Steps diabetes self-management programme completed (**1033281000000100**) Remote diabetes structured education and support programme completed (**1097141000000101**) Referral to diabetes structured education programme (**415270003**) Referral to online diabetes structured education programme (**1108731000000100**) Referral to type I diabetes structured education programme (**754461000000105**) Referral to dose adjustment for normal eating diabetes structured education programme (**306701000000102**) Referral to expert patient education versus routine treatment diabetes structured education programme (**306771000000105**) Referral to diabetes education and self management for ongoing and newly diagnosed structured programme declined (**781161000000107**) Referral to total diet replacement programme (**1239571000000105**) Referral to National Health Service Digital Weight Management Programme (**1402911000000108**) Diabetes structured education programme declined (**306591000000103**) Referral to dose adjustment for normal eating diabetes structured education programme declined (**860981000000106**) Referral to diabetes education and self management for ongoing and newly diagnosed structured programme declined (**781161000000107**) Total diet replacement programme declined (**1239581000000107**) Group consultation (**1149511000000104)** Group consultation via video conference (**1323941000000101**)					

PAYMENT/KPI RULES:

To Achieve Payment for Diabetes Level 1 DL108

- Patient must be Aged 17 and Over **AND**
- Has a SNOMED code of QoF Diabetes cluster without being resolved **AND**
- Has a SNOMED code of Review of patient goals (**775501000000108**) **AND** Diabetes care plan agreed (**703040004**) **AND**
- Has a SNOMED code of Attended diabetes structured education programme (**413597006**) **OR** Attended DESMOND (diabetes education and self-management for ongoing and newly diagnosed) structured programme (**276651000000107**) **OR** Attended dose adjustment for normal eating diabetes structured education programme (**306441000000109**) **OR** Attended expert patient education versus routine treatment diabetes structured education programme (**306401000000106**) or Remote diabetes structured education and support programme commenced (**1097131000000105**) **OR** Diabetes structured education programme completed (**755491000000100**) **OR** Diabetes education and self-management for ongoing and newly diagnosed structured programme completed (**306501000000105**) **OR** Dose adjustment for normal eating diabetes structured education programme completed (**306471000000103**) **OR** Expert patient education versus routine treatment diabetes structured education programme completed (**306531000000104**) **OR** X-PERT (expert patient education versus routine treatment) First Steps diabetes self-management programme completed (**1033281000000100**) **OR** Remote diabetes structured education and support programme completed (**1097141000000101**) **OR** Referral to diabetes structured education programme (**415270003**) **OR** Referral to online diabetes structured education programme (**1108731000000100**) **OR** Referral to type I diabetes structured education programme (**754461000000105**) **OR** Referral to dose adjustment for normal eating diabetes structured education programme (**306701000000102**) **OR** Referral to expert patient education versus routine treatment diabetes structured education programme (**306771000000105**) **OR** Referral to diabetes education and self management for ongoing and newly diagnosed structured programme declined (**781161000000107**) **OR** Referral to total diet replacement programme (**1239571000000105**) **OR** Referral to National Health Service Digital Weight Management Programme (**1402911000000108**) **OR** Diabetes structured education programme declined (**306591000000103**) **OR** Referral to dose adjustment for normal eating diabetes structured education programme declined (**860981000000106**) **OR** Referral to diabetes education and self management for ongoing and newly diagnosed structured programme declined (**781161000000107**) **OR** Total diet replacement programme declined (**1239581000000107**)

APPENDIX VII - QUALITY METRICS

QUALITY METRICS							
Ref.	**Description**	**SNOMED Code**	**Measurement**		**Target achievement**	**% of total payable for achieving target**	**Frequency of Monitoring**
DL106 (a)	% patients on PCN diabetes register starting a group consultation programme (minimum 1 * one hour session,) ***within the last 27 months OR:***	Group consultation (**1149511000000104)** **OR** Group consultation via video conference (**1323941000000101**) **OR** Diabetes monitoring invitation (**310425007**) **AND** Did not attend diabetic clinic (**390922008**)	**Numerator:** Number of patients on the PCN diabetes register with a record of a group consultation in the past 27 months	**Denominator:** Number of patients on the PCN QoF diabetes register	<7.5% 7.5-15% >15%	NA	Monthly – via the Diabetes Dashboard
DL106 (b)	% patients on PCN diabetes register starting a group consultation programme (minimum 1 * one hour session,) **within the last 15 months**	Group consultation (**1149511000000104)** **OR** Group consultation via video conference (**1323941000000101**) **OR** Diabetes monitoring invitation (**310425007**) **AND** Did not attend diabetic clinic (**390922008**)	**Numerator:** Number of patients on the PCN diabetes register with a record of a group consultation in the past 15 months	**Denominator:** Number of patients on the PCN QoF diabetes register	<3.75% 3.75 - 7.5% >7.5%	NA	Monthly – via the Diabetes Dashboard months
DL107	% of patients on the PCN diabetes register eligible for T2DR who have started the T2DR programme	Total diet replacement programme commenced (**1239591000000109**)	**Numerator:** Number of patients eligible for the T2DR programme who have a record of starting the T2DR programme	**Denominator:** Number of patients on the PCN QoF diabetes register eligible for T2DR	<0.5% 0.5-1% >1%	NA	Monthly – via the Diabetes Dashboard

DL109	% of patients on the PCN diabetes register on insulin or sulphonylureas who have a record of hypoglycaemia frequency	Frequency of hypoglycaemia attack (**712656006**)	**Numerator:** Number of patients on the PCN diabetes register with record on hypoglycaemia frequency in previous 15 months	**Denominator:** Number of patients on the PCN QoF diabetes register on insulin or sulphonylureas in last 6 months	80%	NA	Monthly – via the Diabetes Dashboard
DL110	% of patients on PCN diabetes register who have attended structured education within 12months of diagnosis	Attended diabetes structured education programme (**413597006**) Attended DESMOND (diabetes education and self management for ongoing and newly diagnosed) structured programme (**276651000000107**) Attended dose adjustment for normal eating diabetes structured education programme (**306441000000109**) Attended expert patient education versus routine treatment diabetes structured education programme (**306401000000106**) Remote diabetes structured education and support programme commenced (**1097131000000105**) Diabetes structured education programme completed (**755491000000100**) Diabetes education and self management for ongoing and newly diagnosed structured programme completed (**306501000000105**) Dose adjustment for normal eating diabetes structured education programme completed (**306471000000103**) Expert patient education versus routine treatment diabetes structured education programme completed (**306531000000104**) X-PERT (expert patient education versus routine treatment) First Steps diabetes self-management programme completed (**1033281000000100**) Remote diabetes structured education and support programme completed (**1097141000000101**)	**Numerator:** Number of patients on the PCN diabetes register who have attended or completed structured education within 12 months of diagnosis	**Denominator:** Number of patients on the PCN QoF diabetes register	50%	NA	Monthly – via the Diabetes Dashboard

DL111	% patients on PCN diabetes register starting a group consultation programme who have attended 2 sessions	Group consultation (**1149511000000104**) **OR** Group consultation via video conference (**1323941000000101**)	**Numerator:** Number of patients on the PCN diabetes register with a record of 2 group consultations at least 3 weeks apart in the past 15 months	**Denominator:** Number of patients on the PCN QoF diabetes register with at least one group consultation code	75%	NA	Monthly – via the Diabetes Dashboard
DL112	% patients on PCN diabetes register starting a group consultation programme who have attended 3 sessions	Group consultation (**1149511000000104**) **OR** Group consultation via video conference (**1323941000000101**)	**Numerator:** Number of patients on the PCN diabetes register with a record of 3 group consultations at least 3 weeks apart in the past 15 months	**Denominator:** Number of patients on the PCN QoF diabetes register with at least one group consultation code	60%	NA	Monthly – via the Diabetes Dashboard
DL113	% of patients on the PCN diabetes register with recorded email address	Clinical system report	**Numerator:** Number of patients on the PCN diabetes register with a record of email address	**Denominator:** Number of patients on the PCN QoF diabetes register	70%	NA	Monthly – via the Diabetes Dashboard

DL114	% patients on PCN diabetes register who have attended a QISMET approved education programme within the past 5 years	One of: · Attended diabetes structured education programme (**413597006**) · Attended DESMOND (diabetes education and self-management for ongoing and newly diagnosed) structured programme (**276651000000107**) · Attended dose adjustment for normal eating diabetes structured education programme (**306441000000109**) · Attended expert patient education versus routine treatment diabetes structured education programme (**306401000000106**) · Remote diabetes structured education and support programme commenced (**1097131000000105**) · Diabetes structured education programme completed (**755491000000100**) · Diabetes education and self-management for ongoing and newly diagnosed structured programme completed (**306501000000105**) · Dose adjustment for normal eating diabetes structured education programme completed (**306471000000103**) · Expert patient education versus routine treatment diabetes structured education programme completed (**306531000000104**) · X-PERT (expert patient education versus routine treatment) First Steps diabetes self-management programme completed (**1033281000000100**) · Remote diabetes structured education and support programme completed (**1097141000000101**)	**Numerator:** Number of patients on the PCN diabetes register with a record of attending a QISMET approved education programme in the last 5 years	**Denominator:** Number of patients on the PCN QoF diabetes register	<5% 5-15% >15%	NA	Monthly – via the Diabetes Dashboard

Service	Diabetes (Non-Diabetic Hypoglycemia)

1. National context and evidence base

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality-of-care provision varies throughout the country. The number of people in the UK with diabetes is increasing and is projected to rise to 5.3 million by 2023. As of December 2022 in North West London, over 168,000 people have been diagnosed with diabetes with about 40,000 as yet undiagnosed. The total number of people living with diabetes in North West London is expected to be at least 224,000 by 2030. In North West London, there are approximately 25,000 people living with blood glucose levels above relaxed target values (HbA1c > 64mmol/mol), with over half being younger than 60 years of age.

Diabetes, particularly when blood sugars are persistently above target, can lead to serious life-threatening and life-limiting complications for people with diabetes, as well as higher costs for health and social care services. These include;

- blindness;
- foot disease leading to amputations;
- kidney disease leading to dialysis;
- heart disease;
- stroke;
- dementia.

In North West London, at least £350m (around 10% of health spend) is spent on diabetes care with an additional, as yet unquantified, amount in lost productivity and social care costs. 80% of costs are related to treating diabetes complications - with foot disease being the largest contributor - and approximately 40% of all emergency admissions and acute bed days are for diabetes-related complications. An individual may, along with diabetes, have other long-term conditions, e.g. hypertension, chronic obstructive pulmonary disease (COPD). Those living with Type 1 Diabetes Mellitus may also have other auto-immune conditions including coeliac disease and/or thyroid abnormalities.

Up to 60% of people with diabetes state that they are living with mental health or emotional difficulties. There is clear evidence that these often go undetected and untreated, leading to impaired ability to effectively self-care and resulting in poorer diabetes outcomes. The mental health difficulties people experience are broad and range from diabetes distress, depression and anxiety; to eating disorder, psychosis and dementia and yet there is a lack of a clear whole pathway integrated provision for people with specific needs in this area locally and nationally. There is good local and national evidence that, if mental health and emotional difficulties are addressed, this can lead to improved diabetes outcomes.

There is a strong evidence base for the effectiveness of lifestyle change programmes creating reductions in Type 2 diabetes incidence, and for the importance of including lifestyle interventions into any obesity intervention for it to be effective. Similarly, there is evidence for the cost saving and cost effectiveness of risk assessment and screening in pre-diabetes populations and those at high risk of developing diabetes.

A prevention and population approach will be vital for the size of the task, and will require the addressing of social determinants of health, collaboration with local government and use of social prescribing to address these issues. This represents a clear opportunity for joint commissioning between ICBs, public health, patient and support groups and the third sector, with or without additional social finance investment.

2. Aims and objectives of service

The aim of the NDH service is to prevent or delay onset of Type 2 diabetes, increase early detection of all types of diabetes and provide seamless navigation and better patient experiences across all diabetes services within North West London. This will be achieved through shared goals and objectives, shared and proactive workforce planning that aligns with the care pathway and improved communication systems between different parts of the health /social care systems.

The provider/service will embed new ways of working, including the use of technology, apps, virtual contacts, remote consultations (including group consultations) in clinics to drive efficiency and avoid duplication and wastage. Providers are required to work alongside partners such as community and acute providers, local government (particularly the public health team) and borough teams, Health Education England - North West London, Public Health, Social Care, Housing, and the

Voluntary Sector to meet our shared goals and objectives.

Objectives

Objectives of the service are to:

- Maximise National Diabetes Audit (NDA) participation.
- Maximise Type 2 diabetes prevention by encouraging patient participation in the NHS Diabetes Prevention programme (NDPP).
- At every opportunity, pro-actively raise awareness, signpost to services and empower residents to maintain a healthy weight, stop smoking, be active and eat healthily to reduce the risk of Type 2 Diabetes Mellitus and its complications
- Improve the early detection of non-diabetic hyperglycaemia (NDH) through risk scoring in primary care and the community and by raising awareness of signs and symptoms of Type 2 Diabetes Mellitus via available services (e.g. Local Authority and third sector)
- Prioritise interventions in order to reduce numbers progressing from NDH to type 2 diabetes and maximise remission of type 2 diabetes
- Reduce variation in quality of care, offer, access and treatment targets for all North West London residents, irrespective of their age, gender and where they live.
- Reduce health inequalities
- Use technology as an enabler to support delivery of objectives
- Embed a mental health pathway (for all levels of mental health and emotional needs) through every aspect of the diabetes pathway to support self-care optimisation and improve people's experiences. A menu of options must be available at all stages of their journey, depending on their level of need, availability of services commissioned and patient choice.

3. Service Description/Care Pathway

This NDH service fits within a wider pathway for people at risk of or living with diabetes, which operates to allow people to move between levels seamlessly and as their needs dictate and where more experienced clinicians are required to manage their care. This wider pathway is detailed with the specification for Diabetes (Level 1) and should be delivered in conjunction with the pathway for diabetes care in North West London.

The Non-Diabetic Hyperglycaemia Service

The primary aim of the NHS Diabetes Prevention Programme is to work with individuals at high risk of type 2 diabetes (all of whom will have non-diabetic hyperglycaemia) and reduce their incidence of getting a Type 2 diabetes diagnosis.

The secondary aims are:

- To reduce blood glucose parameters (HbA1c or Fasting Plasma Glucose (FPG)) in Service Users at 12 months and beyond
- To reduce weight of Service Users at 12 months and beyond
- To maximise completion rates of Service Users in the programme.

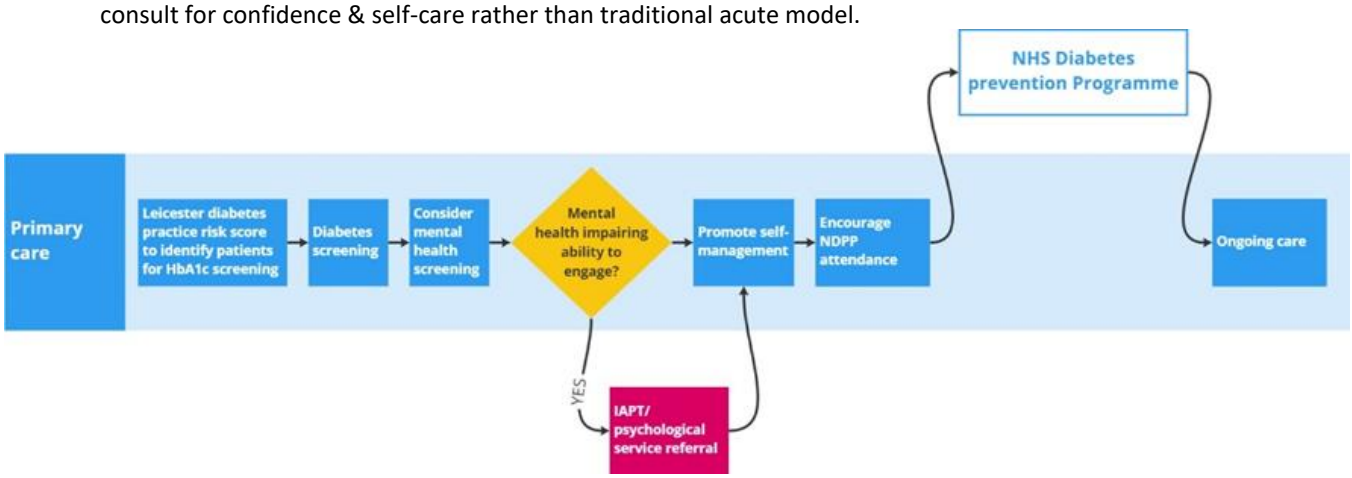
The Non-Diabetic Hyperglycaemia service will:

- Use the Leicester Practice Diabetes Risk Score[23] (available through the Whole Systems Integrated Care platform), to identify all patients at increased risk of diabetes within the practice and invite those with an elevated risk score for screening using HbA1c. This will help identify younger patients from at risk groups who would not normally be invited for an NHS Health Check.
- Identify patients through other approaches such as using QDiabetes or the NHS Health Check Programme.
- Ensure that information about any new diagnosis of gestational diabetes is coded into primary care systems following receipt of information about any new diagnosis of gestational diabetes from other services.
- Maintain a register of patients with Non-Diabetic Hyperglycaemia or previous gestational diabetes identified:
  - de novo through risk assessment tools and subsequent HbA1c in the range 42-47mmol/mol
  - previously through fasting blood glucose, oral glucose tolerance testing or HbA1c in the range 42-47 mmol/mol

[23] **This is currently available through the Whole Systems Integrated Care platform**

- through past history of gestational diabetes

- Refer newly diagnosed NDH patients for intensive lifestyle management / structured education
- Conduct annual follow up of HbA1c, blood pressure, lipids, BMI, smoking status and provision of lifestyle advice depending on need (for example alcohol, smoking, diet, other relevant need)
- Be aware of mental health issues including CMHD (common mental health disorder) and refer or intervene as per guidance.
- NHSE/Digital data inter-operability via local and centralised information systems (For example, Whole System Integrated care) for better coordinated work.
- Ensure family, friends and carer's input in the person's care plans where appropriate.
- Enablers for the NDPP - provide training for health & care frontline staff using available resources including how to consult for confidence & self-care rather than traditional acute model.



Mental Health and Well-being[24]

The service will ensure that clinicians and support-staff consider screening for mental health and emotional difficulties in people with NDH as follows:

- In people who are over the age of 60 using 6 item Cognitive Impairment Test or another validated tool and follow the local pathway for referrals and management.
- In people with NDH on their caseload, using the DDS2 or a combination of two questionnaires in the PHQ4 (Patient Health Questionnaire, which has two basic questions for depression - PHQ2 - and two for anxiety - GAD2 - and can lead to a treatment pathway).

The screening will facilitate further conversation and a menu of choices which must be discussed with the person with non-diabetic hyperglycaemia (NDH). Depending on risk and severity as well as local availability and person choice, these will include:

- Conservative approach (watchful waiting) with quarterly review
- North West London digital platform
- Antidepressant medication
- Peer support
- Mindfulness training
- Physical activities
- Therapy options like Cognitive Behaviour Therapy (CBT) via Improving Access to Psychological Therapies, specialist psychology
- Drug and alcohol services
- If high risk of harm to self, the service will make a referral to the mental health provider[25] or via the adult single point

[24] **See Integrated Service Specification section about Special Populations for people with severe mental illness and for people with eating disorders**

[25] Central and North West London NHS Foundation Trust (CNWL) or West London NHS Trust (WLT) as appropriate

of access telephone numbers in the respective organisations as available.

- If Complex Common Mental Health Needs (CCMHN) are identified, this should trigger the CCMHN pathway as per the Like-Minded strategy[26]
- Ensure that there are clear pathways for referral into low intensity and high intensity psychological services like IAPT, eating disorders services and weight management and bariatric surgery services.
- If mild cognitive impairment, this should lead to watchful waiting
- Following communication from secondary care about moderate to severe cognitive impairment, the GP must review the person and consider further assessment and investigations as per the new NICE June 2018 Dementia guideline
- For all severities of cognitive impairment, any service working with the person must ensure assessment and optimisation of eyesight, hearing, mobility, independence, support network where commissioned to do so.
- For all severities of cognitive impairment, any service working with the person must ensure assessment and optimisation of mental capacity for all decisions as per the Mental Capacity Act 2015

The service provider will measure performance by reporting to commissioners:

- The number and percentage of people with diabetes and non-diabetic hyperglycaemia on caseload/register with completed DDS2 or PHQ4 (i.e. PHQ2 and GAD2) annually with an analysis and evaluation of the data collection (in primary care and community settings)

Care Planning

- Use time within the annual review (which ideally would be conducted within a group consultation setting) to engage patients in collaborative goal setting and action planning in order to increase confidence in self-management
- Offer a copy of the care plan to the patient

Referral

- Practices sign up to managing patients in line with the agreed pathway
- Practices have systems and processes in place for discharging from secondary care all suitable patients identified in the pathway
- Practices have information available for patients that enables them to understand the pathway

Outcomes

- The Provider delivering NDH service will demonstrate performance by:
- Engaging in the National Diabetes Audit (which includes data for patients with NDH)
- Allowing automated data extraction from primary care systems via the Discovery Data Service to support quality improvement and key outcomes monitoring
- Engaging with service-related outcomes and patient reported outcomes via the NWL KPI monitoring dashboard
- Demonstrating achievement of key performance indicators as noted within this specification
- Linking with other diabetes services within the ICB including the REWIND service, the community diabetes service, foot protection team and patient education.

The NDH service will ensure that:

- The service uses digital systems and tools to support detection and monitoring (e.g. risk scoring, risk stratification, and proactive recall systems)
- The service supports patients remotely through providing services such as remote monitoring, virtual group consultations (ideally running at a PCN level), telephone/video consultations and email/SMS messaging. Clinical staff in the primary care team have an up to date understanding of NDH and an understanding of the importance of weight management in diabetes prevention.

4. Any Acceptance and exclusion criteria and thresholds

Exclusions:

- Pregnancy

[26] www.healthiernorthwestlondon.nhs.uk/news/2016/05/03/bringing-minded-strategy-life

- Patients aged under 17

5. Training, Skills and Experience

The service provider must:

- Ensure that the staff delivering the service meet the requirements the Training Research and Education for Nurses in Diabetes (TREND) competencies for level 1 and that this is compliant with the Cambridge Diabetes Education Programme including peer reviews.
- The named service lead should be a GP who has overall responsibility for ensuring the service is delivered in accordance with the specification.
- ensure staff delivering the service have access to on-going diabetes education programmes and updates.
- Registered nurses must meet the relevant minimum competencies for "competent nurse", as recommended by TREND and working towards "experienced or proficient nurse".[27]
- Complete the Cambridge Diabetes Education Programme[28] as part of staff's continuing professional development.

6. Equipment

There is no specialist equipment required for the delivery of this service.

[27] https://trenddiabetes.online/wp-content/uploads/2020/04/Framework_6th_EDN_TREND_FINAL.pdf

[28] www.cdep.org.uk

APPENDIX I - CONTRACTUAL REQUIREMENTS

DIABETES (NDH)

Unit Price

A maximum total of **£22.93** per patient on register of patients with agreed high risk of diabetes) subject to meeting Key Performance indicators as listed below.

The tariff will be split as follows based on PCN performance:

KPI	Target Thresholds	Financial Achievement
NDH : Diabetes Ratio (Appendix II)	<0.9-1.15 (deprivation dependent)	0%
	Between 0.9-1.15 and 1.1-1.35 (deprivation dependent)	20%
	>1.1-1.35 (deprivation dependent)	40%
% Starting NHS Diabetes Prevention Programme (Appendix III)	< 5%	0%
	5-7.5%	15%
	>7.5%	30%
% Annual Review in last 15m (Appendix IV)	<50%	0%
	50-60%	15%
	>60%	30%

Service Type	Package	No Pop-Up
Referral Criteria	Patients aged 17 years and above are Mandatory under this contract	

CODING NECESSARY FOR PAYMENT

Ref.	Description	SNOMED Code[29]
DH01	Register of patients with agreed high risk of diabetes	Non-diabetic hyperglycaemia (**700449008**) **OR** previous Gestational diabetes mellitus (**11687002**)

PAYMENT/KPI RULES

To Achieve Payment for

- Patient must be Aged 17 and Over **WITHOUT SNOMED** code of Unresolved QoF Diabetes cluster **AND**
- Has SNOMED code of Non-diabetic hyperglycaemia (**700449008**) OR Gestational diabetes mellitus (**11687002**) recorded by the practice ever

[29] **The existing SNOMED codes for High Risk of Diabetes (837491000000107), Pre-diabetes (858301000000107), Impaired glucose tolerance (9414007), Impaired fasting glycaemia (390951007), Impaired glucose regulation (849171000000106) are being superseded by the above SNOMED codes and will no longer be used under this contract from the 31st March 2023**

APPENDIX II - PATIENT RATIO TREATMENT TARGET

Ref.	Description	SNOMED Code	Measurement		Target achievement	Percentage of total payable for achieving target	Frequency of Monitoring
DH02	Ratio of patients on the PCN NDH register to the number on the PCN diabetes register	Non-diabetic hyperglycaemia (**700449008) OR** previous Gestational diabetes mellitus **(11687002)** QOF Diabetes Cluster	**Numerator:** Number of patients on the PCN NDH register	**Denominator:** Number of patients on the PCN QOF Diabetes register	<0.9-1.15 (deprivation dependent) Between 0.9-1.15 and 1.1-1.35 (deprivation dependent) >1.1-1.35 (deprivation dependent)	0% 20% 40%	Monthly – via the Diabetes Dashboard

PAYMENT/PERFORMANCE RELATED KPI RULES:
To Achieve Payment for High Risk of Diabetes DH02 · Patient must be Aged 17 and Over **WITHOUT** SNOMED code of Unresolved QoF Diabetes cluster **AND** · Has SNOMED code of Non-diabetic hyperglycaemia **(700449008) OR** Gestational diabetes mellitus **(11687002)** recorded ever

APPENDIX III – DIABETES PREVENTION PROGRAMME TREATMENT TARGET

Ref.	Description	SNOMED Code	Measurement		Target achievement	Percentage of total payable for achieving target	Frequency of Monitoring
DH03	% of patients on PCN NDH register starting NHS Diabetes Prevention Programme n last 15 months	NHS Diabetes Prevention Programme started **(1025271000000103)**	**Numerator:** Number of Patients on PCN NDH register **aged under 80 years** starting NHS Diabetes Prevention Programme	**Denominator:** Number of patients **aged under 80 years** on the PCN NDH register.	<5% 5-7.5% >7.5%	0% 15% 30%	Monthly – via the Diabetes Dashboard

PAYMENT/PERFORMANCE RELATED KPI RULES:

To Achieve Payment for Non-Diabetic Hyperglycaemia DH03

- Patient must be Aged 17 and Over **WITHOUT** SNOMED code of Unresolved QoF Diabetes cluster **AND**
- Has SNOMED code of (Non-diabetic hyperglycaemia **(700449008) OR** Gestational diabetes mellitus **(11687002)**) recorded ever **AND**
- Has SNOMED code of NHS Diabetes Prevention Programme started (**1025271000000103**) recorded within the previous 15 months

APPENDIX IV - CARE PROCESSES TREATMENT TARGET

Ref.	Description	SNOMED Code		Measurement		Target achievement	Percentage of total payable for achieving target	Frequency of Monitoring
DH04	% of PCN NDH register with annual review (including HbA1c, BP, biennial lipids, BMI, smoking status, lifestyle advice)	**HbA1c**	HbA1c level - IFCC standardized (**999791000000106**) HbA1c level (monitoring range) - IFCC standardised (**1049321000000109**) HbA1c level (diagnostic range) - IFCC standardised (**1049301000000100**)	**Numerator:** Number of patients on PCN diabetes register aged under 80 years with annual review	**Denominator:** Number of patients on the PCN NDH register aged under 80 years.	<50% 55-60% >60%	0% 15% 30%	Monthly – via the Diabetes Dashboard
		Blood Pressure	O/E - Systolic BP reading **(72313002)** Average systolic blood pressure (**314440001**) Average night interval systolic blood pressure (**314445006**) Average day interval systolic blood pressure (**314446007**) Average 24 hour systolic blood pressure (**314449000**) Average home systolic blood pressure (**413606001**) Ambulatory systolic blood pressure (**198081000000101**) Self reported systolic blood pressure (**1162737008**) O/E - Diastolic BP reading **(1091811000000102)** Average diastolic blood pressure (**314453003**) Average night interval diastolic blood pressure (**314460009**) Average day interval diastolic blood pressure (**314461008**) Average 24 hour diastolic blood pressure (**314462001**) Average home diastolic blood pressure					

			(**413605002**) Ambulatory diastolic blood pressure (**198091000000104**) Self reported diastolic blood pressure (**1162735000**)					
		BMI	Body Mass Index – observation **(60621009)**					
		Exercise	*Child codes of* Activity exercise pattern (**106020009**)					
		Lifestyle advice	Lifestyle advice regarding diet **(443288003)** **AND** Lifestyle advice regarding exercise **(304507003)**					
		Lipids Biennial	Serum cholesterol level **(1005671000000105)** Serum fasting total cholesterol **(1083761000000106)** Serum total cholesterol level **(994351000000103)** Total cholesterol measurement **(121868005)** Fasting Cholesterol level (**1083761000000106**) Serum non high density lipoprotein cholesterol level (**1006191000000106**) Non high density lipoprotein cholesterol level **(1030411000000101)** Serum cholesterol/high density lipoprotein ratio (**1015681000000109**)					
		Smoking status	Smoking Status QOF cluster					

PAYMENT/KPI RULES:
To Achieve Payment for High Risk of Diabetes DH04 · Patient must be Aged 17 and Over **WITHOUT** SNOMED code of Unresolved QoF Diabetes cluster **AND** · Has SNOMED code of (Non-diabetic hyperglycaemia **(700449008) OR** Gestational diabetes mellitus **(11687002)**) recorded ever **AND** · Has all of the **7 Minimum Data Set codes** (**DH04**) recorded within the previous 15 months (27 months for cholesterol)

APPENDIX V – RECORDED EMAIL ADDRESS

Ref.	Description	SNOMED Code	Measurement		Target achievement	Percentage of total payable for achieving target	Frequency of Monitoring
DH05	% of patients on the PCN NDH register with recorded email address	Email (clinical system search)	**Numerator:** Number of patients on PCN diabetes register with recorded email address	**Denominator:** Number of patients on the PCN NDH register.	50%	NA	Monthly – via the Diabetes Dashboard

Service	Multi-Disciplinary Diabetes Team Service Specification (Level 2)
Delivery Point	Primary Care Networks or Integrated Neighborhood Teams

1. National context and evidence base

There are currently over 3.6 million people diagnosed with diabetes in England, with over 171,000 in North West London. There are clear correlations between achievement of key treatment targets and risk of complications, with clear evidence that improving these risk factors can substantially reduce the incidence of adverse outcomes including cardiovascular disease (CVD), renal disease, amputation and death.

Type 2 diabetes in particular is a disease of health inequalities, with substantially more prevalence (and lower achievement of treatment targets) in areas of higher deprivation, BAME ethnicity and amongst those with serious mental health problems. Furthermore, there is an inverse correlation both locally and nationally between age and achievement of targets and thus young people are exposed to very significant lifetime complications risks.

2. Aims and objectives of service

The aim of the MDT (Level 2) diabetes service is to improve quality of care and outcomes, reducing morbidity, dependency and mortality, with seamless navigation and better patient experiences across all diabetes services within North West London. This will be achieved through increased integration of services for patients, with shared goals and objectives, shared and proactive workforce planning that aligns with the care pathway and improved communication systems between different parts of the health /social care systems.

The provider/service will embed new ways of working (e.g. new technologies, apps, virtual contacts, remote consultations, remote monitoring or group consultations) in clinics to drive efficiency and avoid duplication and wastage. Providers are required to work alongside partners such as Health Education England - North West London, Public Health, Social Care, Housing, and the Voluntary Sector to meet our shared goals and objectives.

The key elements of the integrated care model are:

- Population health-based approach from wellbeing and prevention through to end of life.
- Population based health outcomes to shift activity towards prevention.
- Holistic approach including lifestyle interventions and mental health integration.
- Using data and digital technology alongside clinician expertise to identify those individuals at most risk.
- Using data and digital technology to identify populations most at risk e.g. WSIC (and target resources where possible)
- A 3-year contract with a view to extend to 10 years' dependent on achievement of agreed outcomes.
- Evolving criteria and methodologies according to evaluation, new concepts in care and best practice
- Shared governance and accountability via the NWL Integrated Care System, performance measurement and financial framework to underpin integration.

Objectives

Objectives of the service is to provide more intensive and integrated support for high risk groups of patients:

- Young people (18-39) with Early Onset Type 2 DM (note that HbA1c targets should be tighter - ideally 48 or less - for this group)
- Off target and on 3+ (or maximum tolerated) oral medications (e.g. 3 HbA1c > 58 or individualised target – some of these patients will need intensification with insulin or GLP-1 / tirzepatide therapy)
- 2 or more HbA1c values over 75
- Patients with mental health / social factors interfering with ability to self-manage effectively (e.g. SMI, needle phobia, social complexity)
- Frail elderly at risk of hypoglycaemia for de-intensification
- Others nominated by the patient's GP practice, particularly where there would otherwise be a secondary care referral – e.g. patients with CKD or Heart failure where a specialist opinion about medication would be helpful

- People with Type 1 Diabetes who refuse referral to secondary care or tier 3 services (if a Consultant Diabetologist is providing clinical oversight)

Throughout the service, the team should aim to identify and address wider health needs - including support and referral for weight management, mental health and social issues.

The key objectives of the service will be achieved by:

- **Establishing and developing a diabetes multi-disciplinary team (MDT) in each PCN** or Integrated Neighbourhood Team (INT) with the following aims:
    - Proactive, systematic identification of people living with diabetes who have significant reversible risk factors for adverse outcomes for MDT review
    - Proactive, systematic identification of people living with diabetes who would benefit from optimisation and where this is seen as potentially feasible but where it has proven difficult to achieve this
    - Conducting of regular MDT meetings (in person or virtual) resulting in a clear management plan for each patient which is communicated back to the patient's own practice team
    - Ensuring that clinicians involved in injectable initiation and optimization are part of a broader MDT and are maintaining their competency
- **Providing additional support to people with Early Onset Type 2 Diabetes (EOT2D)** through:
    - MDT review of people with EOT2D (an EOT2D enhanced service for a 30 minute face to face review, ideally performed prior to an MDT, is funded separately by NHSE, but the aim is to ensure that the two enhanced services work as a seamless pathway)
- **Insulin / GLP-1 / tirzepatide initiation and optimization** where needed in order to achieve glycaemic targets and reduce complications rates.

It is expected that the service will increase the pool of clinicians and support staff who are skilled in supporting people living with complex diabetes-related issues.

3. Service Description/Care Pathway

This Level 2 service fits within a wider pathway for people living with diabetes, which operates to allow people to move between levels seamlessly and as their needs dictate and where more experienced clinicians are required to manage their care.

All people with Type 2 diabetes (particularly those with EOT2D) should be offered, where appropriate, the opportunity to participate in a diabetes remission or intensive weight management support programme, whether through a low calorie total diet replacement (TDR) programme, the NHS digital weight management programme, through other education programmes such as X-PERT, or through bariatric surgery.

People with diabetes (seen at any level) should have access to the Know Diabetes Service, structured education, social prescribing and emotional and mental health support according to need, commissioned services available and choice.

Accountability for the incidence of onset of complications and incidence of hard clinical endpoints such as amputation and blindness lies across the health economy, and responsibility will be shared by all providers of diabetes care, therefore both generalist and specialist services will be jointly accountable for clinical outcomes.

Care planning, care delivery, plan review and adjustment and operational improvement should underpin the approach to all service delivery.[30]

[30] **A small number of specialised services are commissioned nationally by NHS England directly as part of NHS England's specialised commissioning role. These services include islet cell transplantation, pancreas transplantation, insulin-resistant diabetes, congenital hyperinsulinism, Alstrom Syndrome, Bardet-Biedl Syndromes and Wolfram Syndrome, and are delivered by tertiary centres that specialise in these specific conditions. Service specifications for these specialised services will not be covered here, but are included in the work streams of the Diabetes Specialised Commissioning Clinical Reference Group at NHS England.**

The Level 2 (Primary Care Network) Diabetes Service

This service consists of 2 main components. For the initial period from October 23 to end of March 24, these components can be delivered independently of each other.

1. Multi-Disciplinary Team (MDT) meetings
    - Formation of a Primary Care Network (PCN) or Integrated Neighbourhood Team (INT)-level Diabetes MDT
    - Identification of patients suitable for review by a Diabetes Multidisciplinary Team (MDT)
    - Preparation, Delivery, and Follow-up of Diabetes Virtual Clinic / MDT sessions
2. Initiation and Optimisation of insulin or GLP-1 / tirzepatide therapy for suitable patients

Whilst the expectation is that the MDT Level 2 service will deliver all the components of the service specification, it is understood that insulin and GLP-1 / tirzepatide expertise may take time to develop. PCNs may therefore start with the MDT components of the service whilst training is underway for the insulin/GLP-1/tirzepatide component.

There should be closely integrated with the Level 1 and Early Onset Type 2 Diabetes services as well as with community specialist diabetes services.

See Appendix 1 for examples of patient pathways.

In order to ensure that the NHSE funded service for Early Onset Type 2 Diabetes (EOT2D) launches in October 2023, this has been separated from the MDT Level 2 Specification, but these should be seen as a single pathway from the perspective of patient care, where the MDT Level 2 Specification is also running. Therefore people with EOT2D should receive the 30 minute review specified within the EOT2D specification but many will also benefit from MDT discussion and/or injectable initiation.

Additionally it should be noted that the direction of travel is towards greater integration of other long term conditions such as CVD and renal. Further work will be undertaken in 2024 to bring some of these pathways together more closely.

3.1. Primary Care Network (PCN) Diabetes MDTs

3.1.1. Formation of the MDT

One of the aims of this service is to ensure that PCNs or INTs are enabled to work as a collective of practices and specialists from acute, community, mental health, and voluntary sector organisations. This is especially important for people with diabetes, whose needs are often best met by using an MDT approach.

Within each borough, providers of diabetes services as well as the borough-based team will need to agree local implementation of MDT pathways including but not limited to:

- Specialist support to individual practices and the PCN / INT MDT
- Escalation and referral pathways
- Approaches to minimising health inequalities
- Approaches to minimise the number of professional contacts to deliver very high quality patient care

As the formation of PCN / INT MDTs is in its infancy, especially for this cohort of patients, the borough team will work with the PCNs / INTs to develop and agree local pathways.

The MDT should be jointly led by a lead GP and a diabetes consultant / nurse consultant

Recommended MDT membership includes*:

- DSN with Diabetes Consultant support
- Practice Nurse
- Social Prescriber / Link Worker
- Health and Wellbeing Coach

- District Nurse (where housebound / residential home patients are being discussed)
- Clinical Psychologist / Mental Health Support Worker / Psychiatric Nurse
- Clinical Pharmacist
- Dietitian
- Podiatrist

* This list is not intended to be exhaustive. Not all of these team members will need to be present at every MDT meeting

A Consultant Diabetologist has 3 main roles within the MDT:
1. Quality assurance - having an involvement at the early stages to ensure correct decision making and overseeing audit
2. Regular involvement in complex clinical care - at least quarterly MDTs with consultant and ability to see most complex patients whether in consultant clinics separately at Tier 3 or even better within the Tier 2 MDT
3. Training and importantly research. PCN level hubs should be encouraged to take on clinical trial work as this will deliver T2DM clinical research

Each MDT will need to ensure that the following are agreed and configured:

- Member contact details are shared
- All members have necessary IT configuration and permissions e.g. MS Teams access, access to WSIC
- Clinical Systems (EMIS/SystmOne) are configured to support either a referral in to the PCN team or that MDT appointments are set up and patients are registered on the PCN system
- Smart card configuration
- Staff are trained on use of clinical system templates and tasking

3.1.2. Identification of patients suitable for review by a Diabetes Multidisciplinary Team (MDT)

The MDT should adopt a proactive approach to identifying patients for review. Patients will include:

a) those identified by their own GP practice who would benefit from MDT input
b) patients from high-risk groups identified through systematic, data-driven approaches – these high-risk groups will include:
    - Patients with mental health / social factors interfering with ability to self-manage effectively (e.g. SMI, needle phobia, social complexity)
    - Young people with T2DM (note that HbA1c targets should be tighter - ideally 48 or less - for this group). This may include exclusion of other diagnoses, signposting and support to engage with dietary interventions and / or initiation of insulin or GLP-1 / tirzepatide therapies
    - Off target and on 3+ oral medications (e.g. 3 HbA1c > 58 – some of these patients will need intensification with insulin or GLP-1 / tirzepatide therapy)
    - 2 or more HbA1c values over 75
    - Frail elderly at risk of hypoglycaemia for de-intensification
    - Others nominated by the patient's GP practice, particularly where there would otherwise be a secondary care referral – e.g. patients with CKD or Heart failure where a specialist opinion about medication would be helpful
    - People with Type 1 Diabetes who refuse referral to secondary care or tier 3 services (if a Consultant Diabetologist is present)

Suitable tools for systematic patient cohort identification include:

a) **Whole Systems Integrated Care (WSIC) Diabetes Radar** – WSIC pulls data from GP practices on a daily basis. The WSIC diabetes radar dashboard was developed for proactive identification of diabetes patients with significant risk factors. A number of preset search filters have been developed including:
    - Patients aged 18-40 with Type 2 Diabetes
    - Latest 2 HbA1c values over 75 (or more than 20 above target)
    - 3 diabetes meds and HbA1c >58 – some of these patients will need intensification with insulin or GLP-1 / tirzepatide therapies

- Hypo risk – people over 65 on insulin or sulphonylureas with HbA1c < 48 – need deintensification

Furthermore patients can be ranked by UKPDS risk score (takes into account various factors including ethnicity, duration of diabetes, latest HbA1c, BP, cholesterol/HDL ratio, smoking status, age) or other factors.

In order to gain access to WSIC, each user will need login details. Once logged in, the following link can be used to access the diabetes Radar: Diabetes Radar: Diabetes Radar - Tableau Server (london.nhs.uk)

b) **Clinical System searches** – further detail to be provided - these will be made available on SystmOne and EMIS

It may be helpful to group patients for discussion in a thematic manner in order to maximise the time efficiency of specialist input e.g. discuss all young T2DM patients one week, all housebound patients another week (with district nurse attendance). A thematic approach could be rotated on a monthly basis.

Exclusions:

- Children/adolescents
- Type 1 diabetes patients, unless referral to specialist care or tier 3 services has been refused and a Consultant Diabetologist is present
- Patients who are acutely unwell (including sudden deterioration in renal function)
- Pregnancy
- Acute foot complications (ulceration, infection or swelling)

3.1.3. Preparation, Delivery, and Follow-up of Diabetes Virtual Clinic / MDT sessions

It is likely that MDTs will need to run either weekly or fortnightly dependent on the PCN/INT diabetes population.

Preparation

Some preparatory work is required prior to the MDT to ensure that where possible all the information required for the MDT discussion is reviewed and up to date. These tasks will include:

a) Carried out by e.g. Clinical Pharmacist or Nurse

- Check 9 key care processes complete where possible
- Mental health screening score
- Medication review
- Check patient adherence
- Check health beliefs e.g. anti-injections
- Check previous interventions:
    - Lifestyle factors including diet and activity
    - Structured education
    - Engagement with REWIND / other weight management programmes
- ***Ensure that all patients with T2DM (unless unsuitable due to e.g. age or frailty) are encouraged to take up weight management interventions and create a Know Diabetes account***
- Factors affecting self-management e.g. shift working, dependencies
- Offer Health and Wellbeing Coach / Psychology support where appropriate

b) Administrator

Review all relevant data entries completed and that individuals attending know the time and location/Teams link of the meeting

Delivery

Main elements of the MDT meeting are as follows:

- Screenshare clinical record or patient spreadsheet where needed

- Clinician from patient's own practice attends for discussion and to action outcomes
- Mental health worker to attend if patient is known to a mental health service
- Enter the outcome of the MDT discussion in the clinical record using Diabetes MDT template (this will require a PCN instance of EMIS/SystmOne and either a referral in or an MDT appointment)

Post MDT activity
Outcomes from the MDT should be communicated back to the patient's practice either by email or as a clinical system task (agreed between the participating practices)

3.2. Initiation and Optimisation of insulin / GLP-1 / tirzepatide therapy for suitable patients

Patients may be identified through systematic review processes or referred from their own GP practice to the MDT Level 2 service for insulin/GLP-1 initiation or optimisation. Where a patient is identified by systematic review, the expectation is that the patient's own clinical team would be consulted as part of the decision making process.
Level 2 teams with sufficient experience in starting insulin/GLP-1 therapies may choose not to review these patients in the MDT prior to initiating therapies.

However, level 2 teams with less experience of insulin/GLP-1 therapies should discuss patients within the MDT prior to initiating therapy.

Service delivery plan for insulin or GLP-1 / tirzepatide therapies
The Provider will ensure that this service specification is delivered by the PCN Tier 2 team in line with the following standards and requirements:

- Ensure that the patient has been offered those services described in the Diabetes Level 1 specification
- Ensure the patient has been reviewed by the PCN/INT diabetes MDT (see. section 3.3) where appropriate. For some PCNs/INTs where there is less experience in initiating injectable therapies, the MDT may need to be more directly involved in reviewing patients at the start of the process while clinicians are upskilling.
- Ensure injectable initiation/optimisation will be provided by accredited clinician(s). These clinicians must be providing regular and frequent injectable initiations throughout the year to maintain standards and competencies
- **All patients starting insulin or GLP-1 therapies should receive dietetic support provided by a clinician with Diabetes Specialist Dietician competencies** (see Appendix C to this specification). Normally this would be a Diabetes Specialist Dietician from the community provider
- Ensure that the initiation follows the schedule detailed in Appendix A to this specification.
- Ensure that injectables are initiated in line with NWL Diabetes guidelines
- Determine the frequency of follow-up based upon the clinician's assessment of a patient's progress and any complications associated with injectable initiation. In the first 12 weeks, a patient may require weekly follow-up appointments or only two follow-up appointments following initiation. During this period, the clinician can ascertain the patient's ability to use insulin or GLP-1 therapies appropriately, and identify any safety concerns and suitability to continue insulin or GLP-1 therapy. (The requirements detailed in Appendix A to this specification are the minimum requirements for follow up)

Before discharging the patient to their GP, ensure the patient or carer is deemed capable of safely managing their insulin, including being able to undertake home blood glucose monitoring, inject insulin and adjusting their own dose
The provider will also:

- Prescribe the first week/month's supply of insulin/GLP-1/ tirzepatide in line with the NWL prescribing policy, if this will reduce delay in treatment
- Provide patients on insulin with an insulin passport and code in SystmOne/ EMIS

When insulin/GLP-1/ tirzepatide initiation is completed, return to GP care with:

- A personal care plan agreed with the patient (hard copy or email for the patient, electronic copy to the GP)
- A patient management plan for the GP on SystmOne/ EMIS and an electronic copy emailed to the referring practice if it is not on SystmOne/ EMIS.

- Contact details for the practice and patient for further support if required

On discharge, the following information will be collected and where appropriate, entered into the SystmOne/ EMIS clinical system:

- Latest measure of patient's HbA1c and when next HbA1c test is required
- Patient satisfaction questionnaire completed
- 100% patients should have a self-management care plan on discharge

Other requirements for the GP practice:

- Sign up to managing patients in line with the agreed pathway
- Have systems and processes in place for discharging from secondary care all suitable patients identified in the pathway
- Discuss, as appropriate, referrals to secondary care with the community service (except type 1, acutely unwell including urgent foot complications, gestational diabetes or children)
- Have information available for patients that enables them to understand the care that they will be given
- The practice maintains the list of staff who will be involved in the service, including identified lead clinician
- Offer innovative methods of follow-up consultation/ support to patients that are interested, such as teleconferencing, Know Diabetes, email, texts or YouTube videos
- For insulin or GLP-1/tirzepatide therapy, an accredited clinician(s) will be available to offer same day telephone advice between the hours of 08:00 -18:30, Monday-Friday excluding Bank Holidays.
- Support and encourage engagement with services provided by diabetes mentors, lay educators and champions where these exist.
- The service must be offered between 08:00 and 18:30 Monday to Friday, excluding Bank Holidays, as a minimum requirement.

The service will be delivered at scale to all patients registered with the Practice/Network ensuring equitable access and quality of service to the entire population group. For Network based delivery, the location(s) for delivery of the service (number of delivery points) will need to be agreed with the NWL team.

Outcomes

The level 2 service will demonstrate performance by:

- Engaging in the review of quality metrics (including activity and improvement in key care processes)

4. Any Acceptance and exclusion criteria and thresholds

Inclusions:

- Patients on three (or maximum tolerated) oral medications with HbA1c above 58 or above their individualised target[31] (or two oral agents if referral is for insulin initiation)
- Injectable therapy: GLP-1/tirzepatide or insulin initiation
- Optimisation of insulin therapy
- Younger patients with Type 2 diabetes (30-40 years) requiring more aggressive management of their diabetes / earlier initiation of injectable therapy or for
- People with diabetes and complex mental health problems
- Recurrent hypoglycaemia
- Frailty (including nursing home and housebound)
- Type 1 diabetes needing community management (e.g. care home, housebound patients, learning disabilities)
- Community -based flash glucose monitoring and CBG devices

Exclusions:

- Type 1 Diabetes able to be seen in secondary care

[31] Individualised HbA1c target may be as low as 48 for people with EOT2D

- Patients under 18 years of age
- Pregnant or planning to conceive within 12 months – these patients should be referred to acute services for antenatal care or preconception advice
- CKD Stage 5 or CKD Stage 4 requiring nephrology input
- Pancreatic diabetes
- Suspected genetic diabetes e.g. MODY unless for MDT discussion about differential diagnosis

5. Training, Skills and Experience

Diabetes Clinician:

- Minimum Grade:
  - Agenda for Change Band 7 or equivalent.
- Education, Qualifications &Training
  - Minimum competencies in line with Training Research and Education for Nurses in Diabetes (TREND) recommendations www.trend-uk.org/documents/TREND_3rd.pdf for "competent nurse" and working towards competencies for "experienced or proficient nurse".
  - PITSTOP or similar training for insulin and GLP-1 / tirzepatide initiation / optimisation

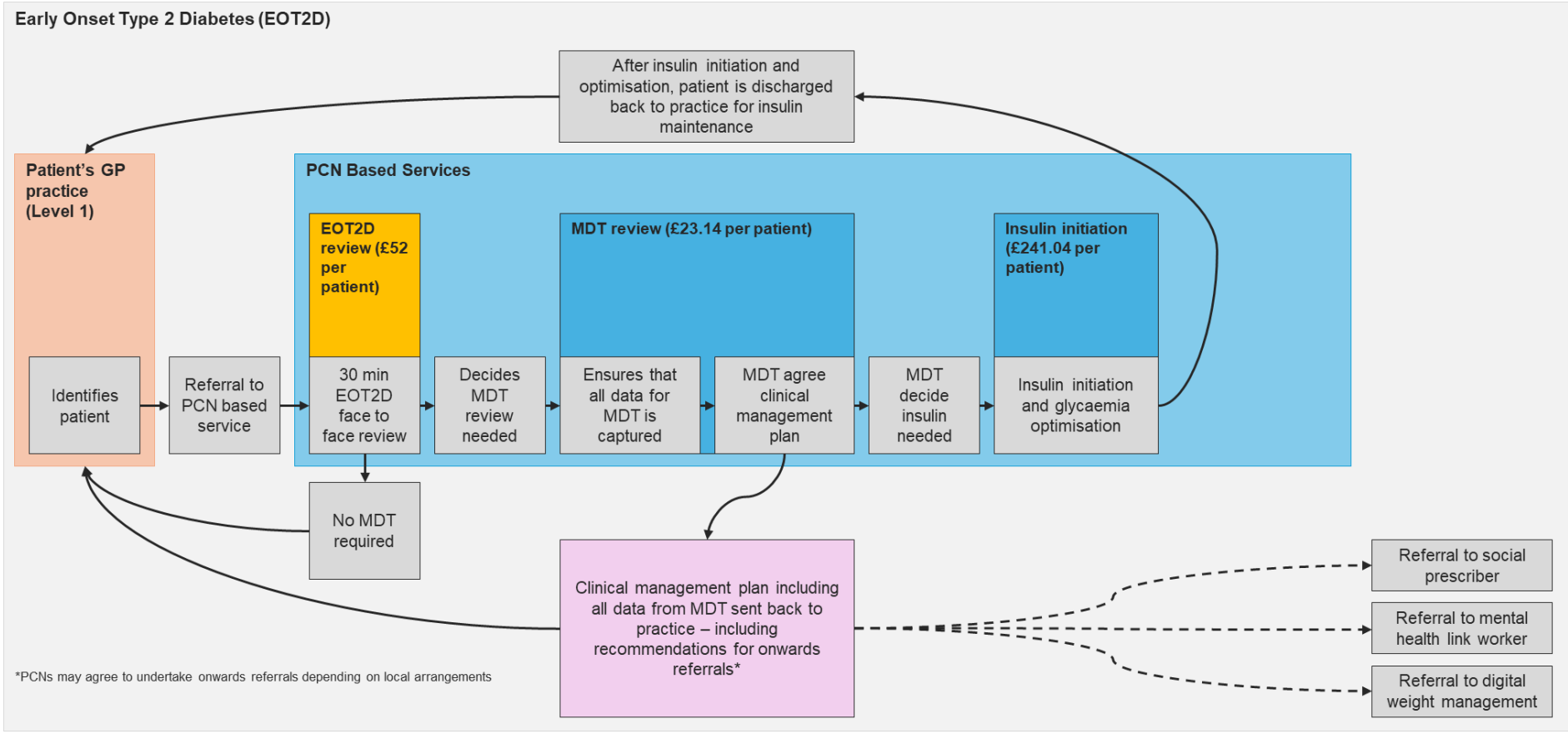
Dietetics Competencies:

- Minimum Grade:
  - Agenda for Change Band 7 or equivalent.
- Education, Qualifications &Training
  - Minimum competencies for Diabetes Specialist Dietician as indicated in An Integrated Career and Competency Framework for Dieticians and Frontline Staff produced by the Diabetes UK Professional Education Working Group (2011) http://www.dmeg.org.uk/Doccuments/Dietetic%20Competency%20Framework%202011.pdf
  - PITSTOP training

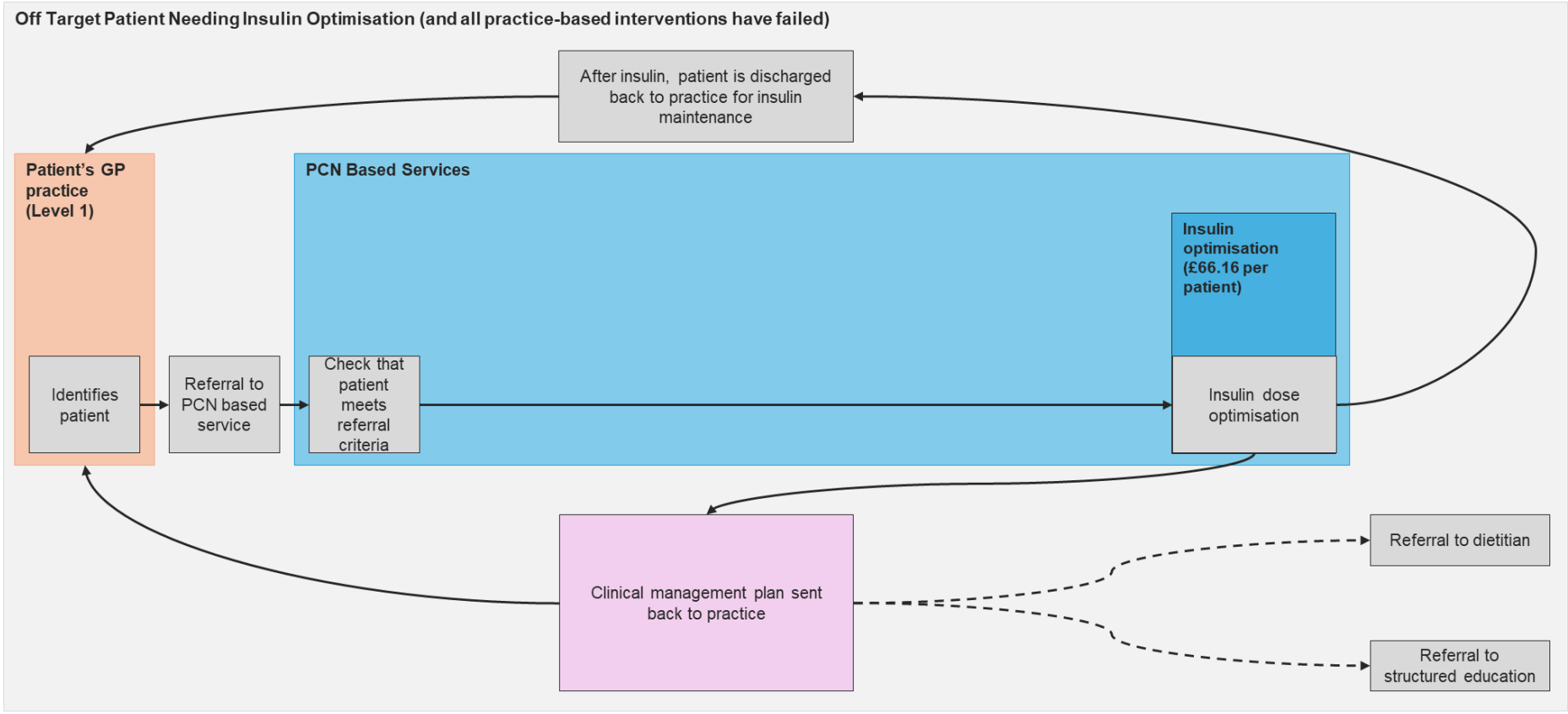
6. Equipment

There is no specialist equipment required for the delivery of this service.

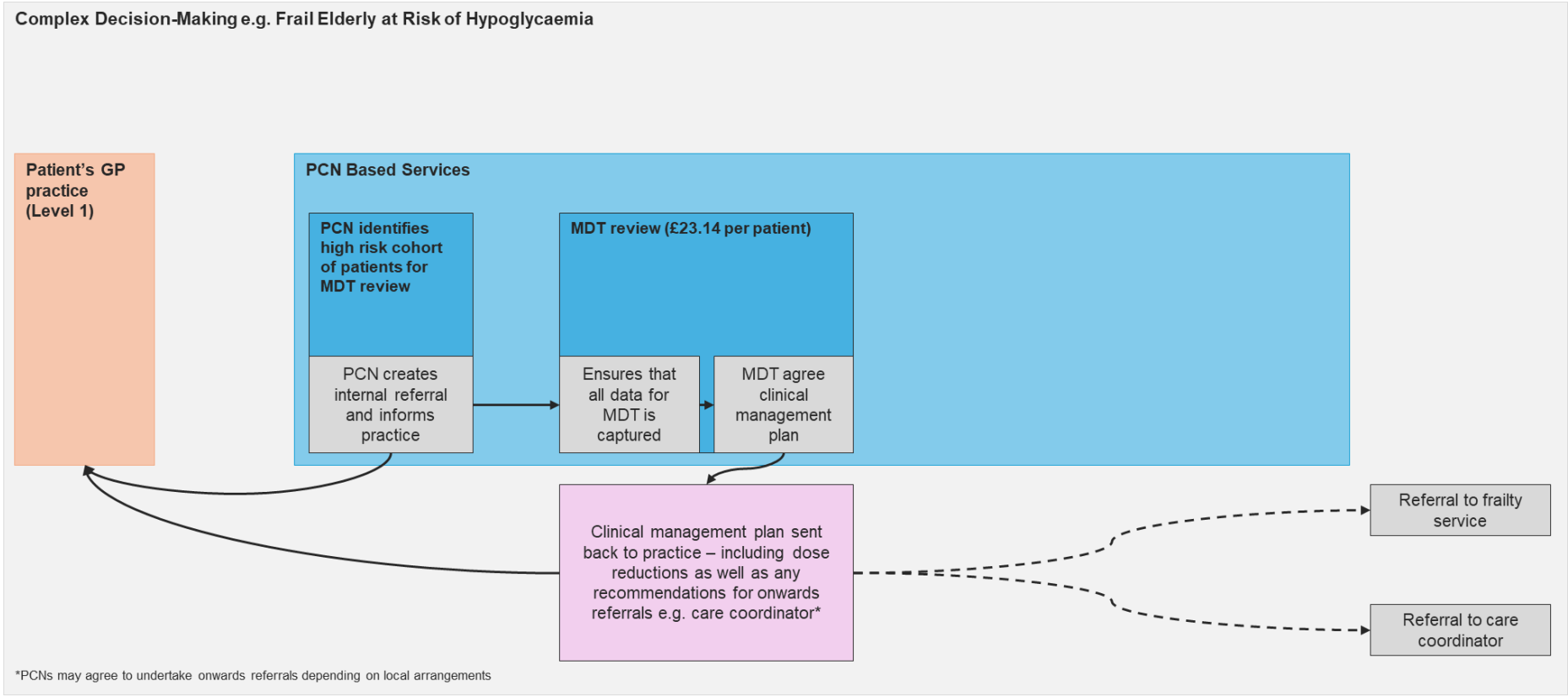
APPENDIX 1: EXAMPLE PATHWAYS



Example pathway for a patient with Early Onset Type 2 Diabetes – illustrating that one patient may attract payments for more than one service. Note that the EOT2D review is a separate but linked service specification. All onwards referrals are examples only, but are illustrative of the kind of support which may be required.



Example pathway for a patient referred by their GP practice requiring insulin optimisation but not MDT review. All onwards referrals are examples only, but are illustrative of the kind of support which may be required.



Example pathway for a patient identified through PCN-based clinical system or WSIC searches. In this case the MDT recommendation back to the patient's practice is for de-intensification of diabetes medication and onwards referral to a frailty service and care coordinator.

APPENDIX 2: STEPS IN THE MDT PROCESS

MDT PROCESS

Establish MDT	Cohort Identification	Pre MDT Activities	MDT	Post MDT Activities
Leadership / membership MDT should be jointly led by • Lead GP • Diabetes Consultant / Nurse Consultant Recommended MDT membership includes: • DSN with Diabetes Consultant support • Practice Nurse • Social Prescriber / Link Worker • Health and Wellbeing Coach • District Nurse (where housebound / residential home patients are being discussed) • Psychologist / Mental Health Support Worker • Clinical Pharmacist • Dietitian • Podiatrist **Purpose** • Support injectable initiation / optimisation where local skill mix requires this • Support complex decision making **Baseline activities** Agree dates Ensure that members have invitations Ensure that all members have necessary IT configuration e.g. MS Teams access, access to WSIC Clinical Systems configuration to support referral in to the PCN team, smart card configuration, training on use of clinical system templates and tasking	*Suggested approach is a proactive systematic, thematic review of PCN/INT patients as well as taking ad hoc referrals from practices in the PCN/Integrated Neighbourhood Team* High risk groups include: • Mental health / social factors interfering with ability to self-manage effectively (e.g. SMI, needle phobia, social complexity) • Young T2DM (note that HbA1c targets should be tighter - ideally 48 or less - for this group). This may include exclusion of other diagnoses, signposting and support to engage with dietary interventions and / or initiation of injectable therapies) • Off target and on 3+ oral medications, needing intensification or other risk factors present) • Off target and on 3+ oral medications (e.g. 2 HbA1c > 75) • Patients with established CKD / CVD complications • Frail elderly at risk of hypoglycaemia for de-intensification • Others nominated by the patient's GP practice, particularly where there would otherwise be a secondary care referral – e.g. patients with CKD or Heart failure where a specialist opinion about medication would be helpful Approaches to systematic cohort identification will include: • Whole Systems Integrated Care (WSIC) diabetes RADAR (most of these cohorts are established) • Clinical system searches	**Clinical Pharmacist / Nurse** Check 9 key care processes complete where possible Mental health screening score Medication review Check patient adherence Check health beliefs e.g. anti-injections Check previous interventions: • Lifestyle factors including diet and activity • Structured education • Engagement with REWIND / other weight management programmes ***Ensure that all suitable patients with T2DM are encouraged to take up weight management interventions and create a Know Diabetes account*** Offer Health and Wellbeing Coach / Psychology support where appropriate **Clinical Pharmacist / Nurse + GP** Identify key questions to resolve **Administrator** Review all relevant data entries completed	Screenshare clinical record or spreadsheet where needed Ideally, a clinician from patient's own practice attends for discussion and to action outcomes Mental health worker to attend if patient is known to mental health service Scribe actions – ideally using Diabetes MDT template in shared clinical record (this will require a PCN instance of EMIS/SystmOne and either a referral in or an MDT appointment)	Agree communication back to referring practices (via tasking or email)
IT Tools Referrals in configuration WSIC accounts Smart cards	**IT Tools** Clinical system searches WSIC radar	**IT Tools** Pre-MDT template Tasking / email for communication with patient's normal GP	**IT Tools** MDT template	**IT Tools** Tasking / emails

APPENDIX 3 - CONTRACTUAL REQUIREMENTS

<table>
<tr><th colspan="4">DIABETES LEVEL 2</th></tr>
<tr><td>Unit Price</td><td colspan="3">Each of the level 2 activities carries a separate tariff. These are as follows:

<table>
<tr><th>Activity</th><th>Target Thresholds</th><th>Price per patient</th></tr>
<tr><td>DL201: Review in MDT Diabetes Clinic</td><td>10 % of Diabetes Population (capped)</td><td>£23.14</td></tr>
<tr><td>DL203: Insulin treatment initiated (or GLP-1 initiation in patients already on insulin)</td><td>N/A</td><td>£241.04</td></tr>
<tr><td>DL204: GLP-1 / tirzepatide therapy initiated</td><td>N/A</td><td>£174.88</td></tr>
<tr><td>DL205: Insulin optimisation</td><td>N/A</td><td>£66.16</td></tr>
</table></td></tr>
<tr><td rowspan="3">Business Rule</td><td>MDT Review</td><td colspan="2">1 review per patient per financial year</td></tr>
<tr><td>Insulin Initiation</td><td colspan="2">Paid per activity</td></tr>
<tr><td>Insulin Optimisation</td><td colspan="2">Paid per activity</td></tr>
<tr><td>Service Type</td><td>Package</td><td colspan="2">Pop-Up used to Record Enhanced services administration (166221000000105)</td></tr>
<tr><td>Referral Criteria</td><td colspan="3">Patients aged 18 years and above are Mandatory under this contract</td></tr>
</table>

APPENDIX 4 – MDT REVIEW

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL201	Number of patients discussed at MDT	Seen in multidisciplinary diabetic clinic (**198841000000104**) AND Enhanced services administration (**166221000000105**)					Monthly via dashboard

PAYMENT/KPI RULES:

To Achieve Payment for Diabetes Level 2 DL201

- Patient must be Aged 18 and Over **AND**
- Has a SNOMED code of QoF Diabetes cluster without being resolved **AND**
- Seen in multidisciplinary diabetic clinic (**198841000000104**) **AND** Enhanced services administration (**166221000000105**) with both of these codes entered on the same day

APPENDIX 5 – INSULIN INITIATION

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL203	Number of patients initiating insulin	Insulin treatment initiated (**345041000000101**)					Monthly via dashboard

PAYMENT/KPI RULES:
To Achieve Payment for Diabetes Level 2 DL202 • Patient must be Aged 18 and Over **AND** • Has a SNOMED code of QoF Diabetes cluster without being resolved **AND** • Has a SNOMED code of Insulin treatment initiated (**345041000000101**)

APPENDIX 6 – GLP-1 INITIATION

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL204	Number of patients initiating GLP-1 / tirzepatide therapy	Incretin mimetic therapy started (**702542006**)					Monthly via dashboard

PAYMENT/KPI RULES:
To Achieve Payment for Diabetes Level 2 DL203 • Patient must be Aged 18 and Over **AND** • Has a SNOMED code of QoF Diabetes cluster without being resolved **AND** • Has a SNOMED code of Incretin mimetic therapy started (**702542006**)

APPENDIX 7 – INSULIN OPTIMISATION

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL205	Number of patients requiring insulin optimisation or intensification	Insulin dose changed (**703972004**)					

PAYMENT/KPI RULES:
To Achieve Payment for Diabetes Level 2 DL204 ▪ Patient must be Aged 18 and Over **AND** ▪ Has a SNOMED code of QoF Diabetes cluster without being resolved **AND** ▪ Has a SNOMED code of Insulin dose changed (**703972004**)

APPENDIX 8 - QUALITY METRICS – MDT REVIEW

QUALITY METRICS							
Ref.	**Description**	**SNOMED Code**	**Measurement**		**Target achievement**	**% of total payable for achieving target**	**Frequency of Monitoring**
DL206a	Average change in HbA1c 3m, 6m, 12m following MDT review	Haemoglobin A1c level – IFCC standardized (**999791000000106**) **OR** Haemoglobin A1c level (monitoring ranges) - International Federation of Clinical Chemistry and Laboratory Medicine standardised (**1049321000000109**)	**Numerator:**	**Denominator:**		NA	Monthly – via the WSIC Tier 2 Dashboard
DL206b	Average change in BP 3m, 6m, 12m following MDT review	O/E - Systolic BP reading **(72313002)** O/E - Diastolic BP reading **(1091811000000102)**					Monthly – via the WSIC Tier 2 Dashboard
DL206c	Average change in lipids 3m, 6m, 12m following MDT review	Non high density lipoprotein cholesterol level (**1030411000000101**)					Monthly – via the WSIC Tier 2 Dashboard
DL206d	Average change in weight 3m, 6m, 12m following MDT review	On examination - weight (**162763007**)					Monthly – via the WSIC Tier 2 Dashboard
DL206e	Average change in BMI 3m, 6m, 12m following MDT review	Body Mass Index - observation **(60621009)**					Monthly – via the WSIC Tier 2 Dashboard
DL206f	% of patients referred to weight management programmes	Any of the following: • Referral to NHS Digital Weight Management Programme (**1402911000000108**) • Referral to weight management service (**1326201000000101**) • Referral to National Health Service Tier 3 specialist weight management service (**1403011000000103**)					Monthly – via the WSIC Tier 2 Dashboard

		• Referral to NHS Tier 4 specialist weight management service (**1402991000000104**) • Referral to total diet replacement programme (**1239571000000105**) • Referral to bariatric surgeon (**698563003**) • Referral for pre-bariatric surgery assessment (**907731000000102**)					
DL206g	% of patients referred to ARRS team	Any of the following: • Referral to social prescribing service (**871731000000106**) • Referred for health coaching (**276221000000100**) • Referral to mental health link worker (**1362951000000104**) Referral to pharmacist (**306362008**) • Referral to community-based dietitian (**306353006**)					

APPENDIX 9 - QUALITY METRICS – Insulin initiation or optimisation

QUALITY METRICS							
Ref.	**Description**	**SNOMED Code**	**Measurement**		**Target achievement**	**% of total payable for achieving target**	**Frequency of Monitoring**
DL208a	Average change in HbA1c 3m, 6m, 12m following insulin initiation	Haemoglobin A1c level – IFCC standardized (**999791000000106**) **OR** Haemoglobin A1c level (monitoring ranges) - International Federation of Clinical Chemistry and Laboratory Medicine standardised (**1049321000000109**)	**Numerator:**	**Denominator:**		NA	Monthly – via the WSIC Tier 2 Dashboard
DL208b	Average change in BP 3m, 6m, 12m following insulin initiation	O/E - Systolic BP reading **(72313002)** O/E - Diastolic BP reading **(1091811000000102)**					Monthly – via the WSIC Tier 2 Dashboard
DL208c	Average change in lipids 3m, 6m, following insulin initiation	Non high density lipoprotein cholesterol level (**1030411000000101**)					Monthly – via the WSIC Tier 2 Dashboard
DL208d	Average change in weight 3m, 6m, following insulin initiation	On examination - weight (**162763007**)					Monthly – via the WSIC Tier 2 Dashboard
DL208e	Average change in BMI 3m, 6m, following insulin initiation	Body Mass Index - observation **(60621009)**					Monthly – via the WSIC Tier 2 Dashboard
DL208f	% of patients referred to weight management programmes	Any of the following: • Referral to NHS Digital Weight Management Programme (**1402911000000108**) • Referral to weight management service (**1326201000000101**) • Referral to National Health Service Tier 3 specialist weight management service (**1403011000000103**)					Monthly – via the WSIC Tier 2 Dashboard

		• Referral to NHS Tier 4 specialist weight management service (**1402991000000104**) • Referral to bariatric surgeon (**698563003**) • Referral for pre-bariatric surgery assessment (**907731000000102**)Referral to bariatric surgeon (**698563003**)					
DL208g	% of patients referred to ARRS team	Any of the following: • Referral to social prescribing service (**871731000000106**) • Referred for health coaching (**276221000000100**) • Referral to mental health link worker (**1362951000000104**) • Referral to pharmacist (**306362008**) • Referral to community-based dietitian (**306353006**)					

APPENDIX 10 - QUALITY METRICS – GLP-1 / tirzepatide initiation

QUALITY METRICS							
Ref.	**Description**	**SNOMED Code**	**Measurement**		**Target achievement**	**% of total payable for achieving target**	**Frequency of Monitoring**
DL209a	Average change in HbA1c 3m, 6m, 12m following GLP-1 / tirzepatide initiation	Haemoglobin A1c level – IFCC standardized (**999791000000106**) **OR** Haemoglobin A1c level (monitoring ranges) - International Federation of Clinical Chemistry and Laboratory Medicine standardised (**1049321000000109**)	**Numerator:**	**Denominator:**		NA	Monthly – via the WSIC Tier 2 Dashboard
DL209b	Average change in BP 3m, 6m, 12m following GLP-1 / tirzepatide initiation	O/E - Systolic BP reading **(72313002)** O/E - Diastolic BP reading **(1091811000000102)**					Monthly – via the WSIC Tier 2 Dashboard
DL209c	Average change in lipids 3m, 6m, following GLP-1 / tirzepatide initiation	Non high density lipoprotein cholesterol level (**1030411000000101**)					Monthly – via the WSIC Tier 2 Dashboard
DL209d	Average change in weight 3m, 6m, following GLP-1 / tirzepatide initiation	On examination - weight (**162763007**)					Monthly – via the WSIC Tier 2 Dashboard
DL209e	Average change in BMI 3m, 6m, following GLP-1 / tirzepatide initiation	Body Mass Index - observation **(60621009)**					Monthly – via the WSIC Tier 2 Dashboard
DL209f	% of patients referred to weight management programmes	Any of the following: • Referral to NHS Digital Weight Management Programme (**1402911000000108**) • Referral to weight management service (**1326201000000101**) • Referral to National Health Service Tier 3 specialist weight management service (**1403011000000103**)					Monthly – via the WSIC Tier 2 Dashboard

		• Referral to NHS Tier 4 specialist weight management service (**1402991000000104**) • Referral to total diet replacement programme (**1239571000000105**) • Referral to bariatric surgeon (**698563003**) • Referral for pre-bariatric surgery assessment (**907731000000102**)					

APPENDIX 11 - context

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality-of-care provision varies throughout the country. The number of people in the UK with diabetes is increasing and is projected to rise to 5.3 million by 2023. As of July 2023 in North West London, over 171,000 people have been diagnosed with diabetes with about 40,000 as yet undiagnosed. The total number of people living with diabetes in North West London is expected to be at least 224,000 by 2030. In North West London, there are approximately 25,000 people living with blood glucose levels above relaxed target values (HbA1c > 64mmol/mol), with over half being younger than 60 years of age.

Diabetes, particularly when blood sugars are persistently above target, can lead to serious life-threatening and life-limiting complications for people with diabetes, as well as higher costs for health and social care services. These include;

- blindness;
- foot disease leading to amputations;
- kidney disease leading to dialysis;
- heart disease;
- stroke;
- dementia.

In North West London, at least £350m (around 10% of health spend) is spent on diabetes care with an additional, as yet unquantified, amount in lost productivity and social care costs. 80% of costs are related to treating diabetes complications - with foot disease being the largest contributor - and approximately 40% of all emergency admissions and acute bed days are for diabetes-related complications. An individual may, along with diabetes, have other long-term conditions, e.g. hypertension, chronic obstructive pulmonary disease (COPD). Those living with Type 1 Diabetes Mellitus may also have other auto-immune conditions including coeliac disease and/or thyroid abnormalities.

Up to 60% of people with diabetes state that they are living with mental health or emotional difficulties. There is clear evidence that these often go undetected and untreated, leading to impaired ability to effectively self-care and resulting in poorer diabetes outcomes. The mental health difficulties people experience are broad and range from diabetes distress, depression and anxiety; to eating disorder, psychosis and dementia and yet there is a lack of a clear whole pathway integrated provision for people with specific needs in this area locally and nationally. There is good local and national evidence that, if mental health and emotional difficulties are addressed, this can lead to improved diabetes outcomes.

There is a strong evidence base for the effectiveness of lifestyle change programmes creating reductions in Type 2 diabetes incidence, and for the importance of including lifestyle interventions into any obesity intervention for it to be effective. Similarly, there is evidence for the cost saving and cost effectiveness of risk assessment and screening in pre-diabetes populations and those at high risk of developing diabetes.

Additionally, there is good evidence that multidisciplinary team (MDT) working in diabetes improves outcomes, but this needs to be supported by good team leadership, good communication and a system that supports this type of working.

A prevention and population approach will be vital for the size of the task and will require the addressing of social determinants of health, collaboration with local government and use of social prescribing to address these issues. This represents a clear opportunity for joint commissioning between ICBs, public health, patient and support groups and the third sector, with or without additional social finance investment.

Service	Early Onset Type 2 Diabetes Service
Delivery Point	Primary Care Networks or Integrated Neighborhood Teams

1. National context and evidence base

Early onset Type 2 diabetes (EOT2D) is defined as the development of Type 2 diabetes below the age of 40 years. It is more common in people from ethnic minorities (particularity in people with South Asian ethnicity) and people living in the most socio-economically deprived areas. A high proportion of people with EOT2D are living with obesity and may also have concurrent unmet psychological and social needs.

The National Diabetes Audit (NDA) shows that prevalence is increasing yearly, with 137,260 people with Type 2 diabetes aged 18-39 in England in the latest report (21/22). In North West London specifically, there are approximately 8235 people with EOT2D, the majority of whom are cared for exclusively in General Practice, with an average of ~180 adults with EOT2D per Primary Care Network (PCN).

EOT2D is associated with a more aggressive diabetes phenotype than older-onset Type 2 diabetes, including more rapid progression of glycaemia and early development of complications with significant reduction in life expectancy. Despite this, people with EOT2D are less likely to receive all NICE-recommended care processes and tend to have higher HbA1c than older people with Type 2 diabetes1[32].

54% of pregnancies in people with diabetes in 2020 related to those affected by Type 2 diabetes, representing a doubling in proportion since 2002. Attaining HbA1c < 48 mmol/mol is associated with better neonatal outcomes; however, in 2020 only 11% of women with Type 2 diabetes who became pregnant had evidence of adequate preparation for pregnancy[33], reducing to only 6% of those living in the most deprived areas[34].

National funding is being made available to all ICBs for the T2Day: Type 2 Diabetes in the Young Programme, a 2-year initiative (for 23/24 and 24/25) aiming to improve care for people with EOT2D.

In North West London, the aim is to integrate the Early Onset Type 2 Service within the MDT Level 2 Service Specification in April 2024, once the MDT Level 2 Service is rolled out universally to all PCNs.

2. Aims and objectives of service

1.) to work with people with EOT2D to provide high quality care and optimise glycaemia, cardiovascular risk and weight, aiming to reduce long-term complications and morbidity
2.) to support better preparation for pregnancy in women[35] with Type 2 diabetes, including supporting access to contraception for those not trying for pregnancy
3.) to help address unmet psychological and social needs and support overall wellbeing

[32] For completion of all 8 care processes - 22.8% of 19-25 year olds and 33.6% of 26-39 year olds compared to 46.6% and 58.5% of 40-59 and 60-79 year olds respectively; for HbA1c ≤ 58 mmol/mol - 51.6% of 19-25 year olds and 54.5% of 26-39 year olds compared to 57.1% and 68.4% of 40-59 and 60-79 year olds respectively - National Diabetes Audit, Young People with Type 2 Diabetes, 2019-20

[33] Defined as achieving HbA1c target of < 48 mmol/mol, taking 5mg folic acid and avoiding potentially teratogenic medications.

[34] National Pregnancy in Diabetes Audit Report 2020 - NDRS (digital.nhs.uk)

[35] The specification and other supporting material uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant.

3. Service Description/Care Pathway

This Early Onset Type 2 Diabetes service specification fits within a wider pathway for people living with diabetes, which operates to allow people to move between levels seamlessly and as their needs dictate and where more experienced clinicians are required to manage their care.

- **Non Diabetic Hyperglycaemia (NDH):** This largely primary care service will be responsible for proactive identification of NDH and referral into nationally commissioned NHS Diabetes Prevention Programme to support the prevention of Type 2 Diabetes.
- **Diabetes (Level 1):** The primary care service at Level 1 will have primary responsibility for the person with Type 2 Diabetes
- **Diabetes (MDT Level 2):** The MDT level 2 service is a PCN/INT-based service which integrates level 1 primary care services and specialist support and uses methodologies including an MDT approach to optimise patient care. The objectives of the MDT include to integrate complex decision making inter-professionally and bring levels 2,3 and 4 together rapidly, improving patient outcomes and reducing the need for direct F2F Level 4 contact as well as to initiate insulin and GLP-1 agents. The MDT will also integrate mental health and social prescribing input in order to help direct the clinical team towards the most appropriate support pathways for patients with more complex mental health and social care needs. Lastly, the MDT Level 2 service will provide more intensive support for people with EOT2D.
- **Diabetes (Level 3):** The consultant-led community-based diabetes team acts as the link between generalist clinicians and specialists. Specialists who provide the Level 3 diabetes service should spend a proportion of their time leading, advising and facilitating the work of the primary care based Level 1 and Level 2 diabetes teams. Staff will fast-track people with diabetes safely back to primary care or to Level 4 (where clinically appropriate) and allow the Level 3, 2 and 1 teams to provide care closer to the patient's home.
- **Diabetes (Level 4):** Specialist diabetes services have primary responsibility for those with Type 1 and rarer forms of diabetes. All people with Type 1 Diabetes and other forms of diabetes, such as monogenic diabetes e.g. maturity-onset diabetes of the young (MODY), mitochondrial diabetes, diabetes due to chronic pancreatitis or total pancreatectomy, should have access to specialist diabetes services including those commissioned by NHS England. Provision needs to be made in the community for people with Type 1 Diabetes who refuse to be seen in secondary care or on end of life pathways.

The ultimate aim is to integrate pathways and funding further, particularly for level 2 and 3 services, in order to provide a more seamless experience for patients.

All people with Type 2 diabetes (particularly those with EOT2D) should be offered, where appropriate, the opportunity to participate in a diabetes remission or intensive weight management support programme, whether through a low calorie total diet replacement (TDR) programme, through other education programmes such as X-PERT, or through bariatric surgery.

People with diabetes (seen at any level) should have access to the Know Diabetes Service, structured education, social prescribing and emotional and mental health support according to need, commissioned services available and choice.

Accountability for the incidence of onset of complications and incidence of hard clinical endpoints such as amputation and blindness lies across the health economy, and responsibility will be shared by all providers of diabetes care as well as by the wider integrated care system.

Care planning, care delivery, plan review and adjustment and operational improvement should underpin the approach to all service delivery.[36]

<u>Additional Support for Early Onset Type 2 Diabetes</u>

All people with EOT2D should be encouraged to attend an extended (at least 30 minute) face to face review and where appropriate, discussed at an MDT meeting.

a) Data gathering to support reviews / opportunistic care process delivery

[36] A small number of specialised services are commissioned nationally by NHS England directly as part of NHS England's specialised commissioning role. These services include islet cell transplantation, pancreas transplantation, insulin-resistant diabetes, congenital hyperinsulinism, Alstrom Syndrome, Bardet-Biedl Syndromes and Wolfram Syndrome, and are delivered by tertiary centres that specialise in these specific conditions. Service specifications for these specialised services will not be covered here, but are included in the work streams of the Diabetes Specialised Commissioning Clinical Reference Group at NHS England.

- For clarity, it is expected that completion of all 9 NICE recommended annual care processes should occur in all people with diabetes, independent of this intervention
- Prior to a review, appropriately up-to-date values of relevant clinical markers should be obtained to guide shared decision-making and therapeutic approach (e.g., re-checking HbA1c prior to review, particularly if there has been an intervening change to glucose-lowering medication or last HbA1c was recorded more than 6 months ago)
- The additional contact / review(s) funded by this intervention also present an opportunity to ensure completion of any care processes that were previously missed

b) Consideration of potential misclassification of diabetes type

- During reviews, consideration should be given to any features suggesting that diabetes type may be other than Type 2 diabetes, taking into account any prior correspondence from specialist services
- If there is suspicion that misclassification may have occurred, local pathways for further assessment should be followed (this is likely to include a referral to specialist services)

c) Contraception and planning for possibility of pregnancy

For all women with EOT2D and potential to become pregnant, discuss contraception, the importance of pre-pregnancy planning and what to do if they have a positive pregnancy test.

For women with potential to become pregnant, who are not trying for pregnancy, encourage use of contraception:

- Offer initiation of contraception or signpost/refer as appropriate

For women with potential to become pregnant who are trying for pregnancy / likely to become pregnant (including those who are sexually active and not using contraception):

- Prescribe folic acid supplementation of 5mg daily
- Avoid use of medications which are not suitable in pregnancy. This includes many glucose-lowering medications (except metformin and insulin) as well as other medications which are not used for glucose-lowering (e.g., statins, ACE-i etc)
- Emphasise the importance of intensive glycaemic control in reducing the risk of adverse maternal and foetal outcomes in pregnancy. Referral to specialist services for insulin initiation may be indicated

Women with EOT2D should be informed that they should urgently notify their GP practice (or diabetes team if applicable) if they have a positive pregnancy test so that they can be urgently referred to the Diabetes in Pregnancy team (for antenatal clinic review within a week to reduce pregnancy risks).

d) Optimisation of glycaemia and cardiovascular risk and weight

It is recommended that clinicians follow NICE guidance on management of glucose, cardiometabolic risk factors and weight, with the avoidance of therapeutic inertia and undue delay in intensification.

This includes use of non-pharmacological treatments, with particular consideration of suitability for the NHS Type 2 Diabetes Path to Remission Programme (which is currently available in most of England and will be available nationwide by the end of 23/24).

Glycaemia:

- In accordance with NICE NG28, individualised targets should be discussed and agreed. These should take into account the more aggressive nature of EOT2D and the high lifetime risk of complications
- Targets are therefore likely to be more intensive than those which may be typically used in people developing Type 2 diabetes at more advanced age
- NICE Patient Decision Aid may support discussions on HbA1c
- It is important to avoid therapeutic inertia and discuss treatment escalation promptly if individualised targets are not met
- Offer referral to Structured Education, taking into account individual needs and preferences (note the availability of nationally commissioned digital structured education)

Cardiovascular risk:

- Lipid-lowering therapies (e.g., statins) should be offered in line with NICE CG181[6]
- SGLT2 inhibitors should be offered in line with NICE NG28[6] for addressing cardiovascular risk (and renal protection in CKD)
- NICE NG1368 recommendations for the diagnosis, treatment and monitoring of hypertension should be followed[37]
- Offer support with smoking cessation including referral / signposting as appropriate

Weight:

- Weight management support is likely to be indicated in the majority of people with EOT2D. This may include pharmacological interventions (in line with NICE guidance) and/or appropriate referral to weight management services
- Given the high prevalence of obesity in people with EOT2D, a high proportion may be eligible for GLP-1 receptor agonist treatment, in line with NICE guidance. This may be as an intensification of glucose-lowering therapy in accordance with NICE NG28, or as a treatment for weight management in line with relevant NICE guidance and technology appraisals.

e) Psychological wellbeing unmet and social needs

Assess unmet psychological needs and manage accordingly
Explore unmet social needs and consider social prescribing and other support services
Consider availability and opportunities for peer support

Funding and commissioning: Funding allocations for systems have been based on the number of people with EOT2D in each system (NDA quarterly data – 2022/23 Q3). These are the minimum allocations (initially £52 per adult with EOT2D) which may increase depending on take-up of the offer across all ICBs.

All systems receiving funding in 2023/24 will receive the same level of funding in 2024/25 (subject to annual confirmation). There will be no future opportunities for expressing interest beyond August 2023.

Although systems should consider sustainability from the outset, there is no specific requirement for systems to commit to sustaining the service following the period of national funding.

Reporting: Evaluation of the service will be supported by the National Diabetes Audit as well as data from nationally commissioned services (e.g., NHS Type 2 Diabetes Path to Remission Programme). It is recommended that systems also monitor applicable metrics (such as those listed in the section above, in addition to others considered relevant) to assess performance, identify need and inform ongoing quality improvement. This may also support local service sustainability. Systems participating must confirm mobilisation but no further reporting will be required.

Equity: Service providers should make sure systems are in place to address health inequalities and ensure equity of access to the enhanced support and any treatment interventions. They should deliver the service in a culturally sensitive way to meet the needs of their local, diverse populations.

Supporting resources: The following documents are enclosed:

- **Annex B:** Example of Supporting Information for Clinical Reviews
- **Annex C:** Prevalence Data and Minimum ICB Funding Allocations
- **Annex D:** National Webinar Slide pack. A recording of the national webinar is also available at EOT2D Webinar
- **Annex E:** Memorandum of Understanding

Annex B: Example of Supporting Information for Clinical Reviews is a resource to support clinicians carrying out reviews of people with EOT2D. It should be adapted by systems according to local needs, pathways, processes, services, formulary etc., signed off by local clinical leads and 'owned' by the ICB. Systems are therefore encouraged to modify sections, add elements to suit local need and change
presentation / formatting, providing the key elements of the service remain.

<u>Outcomes</u>

[37] And any updates to the guidance during the lifetime of the service

Metrics used to evaluate impact include:
- Completion of all NICE recommended care processes
- Improvements in treatment target achievement
- Proportion with HbA1c ≤ 48 mmol/mol
- Proportion achieving > 5% weight loss
- Prescribing data relating to management of diabetes, weight, and cardiovascular risk
- Referral / uptake of NHS Type 2 Diabetes Path to Remission Programme (once available)
- Use of other services, e.g., Digital Weight Management, NHS Talking Therapies etc.
- Proportion of women with potential to become pregnant with preparation for pregnancy (preconception advice and folic acid)
- Rates of maternal and neonatal adverse outcomes at NWL or national level

- Across relevant metrics, inequality including by ethnicity and socioeconomic deprivation

4. Any Acceptance and exclusion criteria and thresholds

Inclusions:

- Patients aged 18-39 with assumed Type 2 Diabetes

Exclusions:

- People with known Type 1 Diabetes or MODY
- Patients aged under 18 or 40 or above

5. Training, Skills and Experience

Diabetes Clinician:

- Minimum Grade:
- Agenda for Change Band 7 or equivalent.
- Education, Qualifications &Training
- Minimum competencies in line with Training Research and Education for Nurses in Diabetes (TREND) recommendations www.trend-uk.org/documents/TREND_3rd.pdf for "competent nurse" and working towards competencies for "experienced or proficient nurse".
- PITSTOP or similar training for insulin and GLP-1 initiation / optimisation

Add in other qualifiers

6. Equipment

There is no specialist equipment required for the delivery of this service.

APPENDIX I - CONTRACTUAL REQUIREMENTS

<table>
<tr><th colspan="4">EARLY ONSET TYPE 2 DIABETES</th></tr>
<tr><td>Unit Price</td><td colspan="3"><table>
<tr><th>Activity</th><th>Target Thresholds</th><th>Price per patient</th></tr>
<tr><td>DL202: Review of patients with EOT2D</td><td>100% of EOTD patients</td><td>£52</td></tr>
</table></td></tr>
<tr><td>Business Rule</td><td colspan="3">1 review per patient ever</td></tr>
<tr><td>Service Type</td><td>Package</td><td colspan="2">No Pop-Up</td></tr>
<tr><td>Referral Criteria</td><td colspan="3">Patients aged 18 years and above are Mandatory under this contract</td></tr>
</table>

APPENDIX II – EOT2D REVIEW

Ref.	Description	SNOMED Code	Measurement		Target achievement	% of total payable for achieving target	Frequency of Monitoring
DL202	Number of patients receiving EOT2D review	Diabetes self-management plan review (**810961000000103**)	**Numerator:** Number of patients with EOT2D (coded as T2DM and aged 18-39) with diabetes self-management plan review	**Denominator:** Number of patients with EOT2D (coded as T2DM and aged 18-39)			Monthly via dashboard

PAYMENT/KPI RULES:
To Achieve Payment for EOT2D DL202 ▪ Patient must be Aged 18-39 **AND** ▪ Has a SNOMED code of Type 2 Diabetes Mellitus without being resolved **AND** ▪ Has a SNOMED code of Diabetes self-management plan review (**810961000000103**)

APPENDIX III - QUALITY METRICS – EOT2D REVIEW

QUALITY METRICS							
Ref.	**Description**	**SNOMED Code**	**Measurement**		**Target achievement**	**% of total payable for achieving target**	**Frequency of Monitoring**
DL207a	Average change in HbA1c 3m, 6m, 12m following EOT2D review	Haemoglobin A1c level – IFCC standardized (**999791000000106**) **OR** Haemoglobin A1c level (monitoring ranges) - International Federation of Clinical Chemistry and Laboratory Medicine standardised (**1049321000000109**)	**Numerator:**	**Denominator:**		NA	Monthly – via the WSIC Tier 2 Dashboard
DL207b	Average change in BP 3m, 6m, 12m following EOT2D review	O/E - Systolic BP reading **(72313002)** O/E - Diastolic BP reading **(1091811000000102)**					Monthly – via the WSIC Tier 2 Dashboard
DL207c	Average change in lipids 3m, 6m, 12m following EOT2D review	Non high density lipoprotein cholesterol level (**1030411000000101**)					Monthly – via the WSIC Tier 2 Dashboard
DL207d	Average change in weight 3m, 6m, 12m following EOT2D review	On examination - weight (**162763007**)					Monthly – via the WSIC Tier 2 Dashboard
DL207e	Average change in BMI 3m, 6m, 12m following EOT2D review	Body Mass Index - observation **(60621009)**					Monthly – via the WSIC Tier 2 Dashboard
DL207f	% of people with EOT2D referred to weight management programmes	Any of the following: • • Referral to NHS Digital Weight Management Programme (**1402911000000108**) • Referral to weight management service (**1326201000000101**) • Referral to National Health Service Tier 3 specialist weight management service	**Numerator:** Number of patients with EOT2D (coded as T2DM and aged 18-39) with weight management referral	**Denominator:** Number of patients with EOT2D (coded as T2DM and aged 18-39)			Monthly – via the WSIC Tier 2 Dashboard

		(**1403011000000103**) • Referral to NHS Tier 4 specialist weight management service (**1402991000000104**) • Referral to total diet replacement programme (**1239571000000105**) • Referral to bariatric surgeon (**698563003**) • Referral for pre-bariatric surgery assessment (**907731000000102**)					
DL207g	% of patients with EOT2D referred to ARRS team	Any of the following: • Referral to social prescribing service (**871731000000106**) • Referral for health coaching (**276221000000100**) • Referral to mental health link worker (**1362951000000104**)	**Numerator:** Number of patients with EOT2D (coded as T2DM and aged 18-39) with ARRS referral	**Denominator:** Number of patients with EOT2D (coded as T2DM and aged 18-39)			
DL207h	% of female patients with EOT2D with record of preconception advice	Pre-conception advice (**171012002**)	**Numerator:** Number of female patients with EOT2D (coded as T2DM and aged 18-39) with preconception counseling code	**Denominator:** Number of female patients with EOT2D (coded as T2DM and aged 18-39)			
DL208i	% of female patients with EOT2D with record of folic acid prescription	Folic acid prescribed in last 6m	**Numerator:** Number of female patients with EOT2D (coded as T2DM and aged 18-39) with folic acid prescription in last 6m	**Denominator:** Number of female patients with EOT2D (coded as T2DM and aged 18-39)			

APPENDIX: T2Day: Type 2 Diabetes in the Young –Supporting Information for Reviews

Early onset Type 2 diabetes (EOT2D) is defined as the development of Type 2 diabetes below the age of 40 years. It is more common in people from ethnic minorities (particularity in people with South Asian ethnicity) and people living in the most socio-economically deprived areas. A high proportion of people with EOT2D are living with obesity and may also have concurrent unmet psychological and social needs.
The National Diabetes Audit (NDA) shows that prevalence is increasing yearly, with 137,260 people with Type 2 diabetes aged 18-39 in England in the latest report (2021/22). It is associated with a more aggressive phenotype than older-onset Type 2 diabetes, including more rapid progression of glycaemia, and earlier complications with significant reduction in life expectancy. Despite this, people with EOT2D are less likely to receive all recommended care processes and tend to have higher HbA1c levels than people with older-onset Type 2 diabetes[38]1. Preparation for pregnancy and pregnancy outcomes are also poorer than in people with Type 1 diabetes; during 2018-2020, only 11% of women with Type 2 diabetes who became pregnant had evidence of adequate preparation for pregnancy[39] reducing to only 6% of those living in the most deprived areas3.
Please note that although this document relates to the reviews of adults with early onset Type 2 diabetes, the process for identifying this group is likely to involve system searches for all people aged under 40 years who are recorded as having Type 2 diabetes. If any people aged under 18 years are identified, they should be supported to access specialist care for management, as recommended in NICE NG18 (2023) guidance.

Before the reviews:

- NICE-recommended annual care processes should be completed, and up-to-date values of relevant measures obtained (e.g., re-checking HbA1c prior to review, particularly if there has been an intervening change to glucose-lowering medication or last HbA1c was checked > 6 months ago)
- Please note these reviews are additional to the usual routine care provided for people with EOT2D

During the reviews:
As well as opportunistically addressing any missed care processes, the four key elements of reviews are:
1) Classification of diabetes type – is this Type 2 diabetes?
2) Contraception and planning for possibility of pregnancy
3) Optimisation of glycaemia, cardiovascular risk, and weight
4) Psychological wellbeing and unmet social needs

[38] For completion of all 8 care processes - 22.8% of 19–25-year-olds and 33.6% of 26–39-year-olds compared to 46.6% and 58.5% of 40-59- and 60–79-year-olds respectively; for HbA1c ≤ 58 mmol/mol - 51.6% of 19-25 year olds and 54.5% of 26-39 year olds compared to 57.1% and 68.4% of 40-59 and 60-79 year olds respectively - National Diabetes Audit, Young People with Type 2 Diabetes, 2019-20
[39] Defined as achieving HbA1c target of < 48 mmol/mol, taking 5mg folic acid and avoiding potentially teratogenic medications.

1) Classification of diabetes type – is this Type 2 diabetes?

- Young people may have subtypes of diabetes other than Type 2 diabetes such as Type 1 diabetes or monogenic diabetes (e.g., maturity onset diabetes of the young, MODY)
- Although it can be difficult to distinguish Type 2 diabetes from other types of diabetes based on clinical features, it is worth considering 'are there features here that don't fit with early onset Type 2 diabetes?'
    - For example, they have a relatively lean BMI, they do not have any features of insulin resistance or metabolic syndrome, there is no family history of Type 2 diabetes. Note that in people of South Asian ethnicity, EOT2D may develop at lower levels of BMI than people of white ethnicity, although they would usually still have a BMI falling within the overweight or obese category
    - NICE NG17 (2022) states that people with Type 1 diabetes typically (but not always) have 1 or more of: ketosis, rapid weight loss, age of onset < 50 years, BMI < 25 kg/m2, personal and/or family history of autoimmune disease. Do not use age, BMI, or ethnicity alone to exclude Type 1 diabetes
    - MODY is usually characterised by a strong family history of which may have been identified in multiple generations at young ages (50% chance of being passed to the next generation). Bear in mind that a parent may have been misclassified as having Type 1 or Type 2 diabetes
    - The agreed national guidelines for eligibility for testing for MODY (R141 guidelines) are available at https://www.diabetesgenes.org/tests-for-diabetes-subtypes/guidelines-for-genetic-testing-in-mody/
- Although classification of diabetes type should be considered at time of diagnosis, it should also be regularly reviewed as features may develop that indicate an alternative diabetes subtype
- If there is concern that this may not be Type 2 diabetes, follow the local pathway for further assessment. In most areas, this is likely to include a referral to specialist teams. If Type 1 diabetes is strongly suspected, urgently discuss with specialist care, and do not delay starting treatment

2) Contraception and planning for possibility of pregnancy

- Women with EOT2D have an increased risk of stillbirth and neonatal morbidity. The major modifiable risk factor for this is glucose control at the start of pregnancy (this may be before the woman is aware she is pregnant). HbA1c > 48 mmol/mol is associated with poor pregnancy outcomes
    - According to NPID data (2014 to 2020), only 11% of pregnant women with Type 2 diabetes had received adequate pre-pregnancy care
- Note that many of the medicines used to manage glucose and cardiovascular risk are not advised in pregnancy. Contraception should be used if taking these drugs. If not wishing to use contraception, consider likelihood of pregnancy occurring (it may be reasonable to assume that pregnancy is likely – almost half of all pregnancies are unplanned)
- If not trying for pregnancy, contraception should be offered and initiated / arranged as appropriate
- Women trying for pregnancy or likely to become pregnant should be prescribed folic acid 5mg daily and have their medication reviewed
    - The only safe glucose-lowering drugs in pregnancy are metformin and insulin. If insulin initiation is needed, this should be commenced in line

with local pathways
    - If actively trying for pregnancy, an HbA1c target of < 43 mmol/mol may be suggested
    - Follow local pathways for pre-conception support / review
- Women with EOT2D should be informed that they should urgently notify their GP practice (or diabetes team if applicable) if they have a positive pregnancy test so that they can be urgently referred to the Diabetes in Pregnancy team (for antenatal clinic review within a week to reduce pregnancy risks)

3) Optimisation of glycaemia, cardiovascular risk, and weight

- Consider referral to the NHS Type 2 Diabetes Path to Remission Programme (T2DR; will be available nationwide by April 2024) or other intensive lifestyle change interventions
- Early outcomes from the NHS T2DR programme show mean weight loss of 11kg at 12 months. It is expected to improve glycaemia, blood pressure and cardiovascular risk (data on remission rates is awaited). See your local referral form for full eligibility requirements

a) Glycaemia:

- NICE NG28 recommends discussing and agreeing an individual HbA1c target. One factor the accompanying NICE decision aid specifies is 'thinking about my age and my health overall, my quality of life in the long term is important.' The decision aid is found at
- https://www.nice.org.uk/guidance/ng28/resources/patient-decision-aid-pdf-2187281198
- People with EOT2D are at higher risk of complications that those who develop Type 2 diabetes later in life. There is therefore rationale for agreeing more intensive glycaemic targets in people with EOT2D than typically used. Given the higher risk profile, the QOF-incentivised HbA1c target of ≤ 58 mmol/mol is unlikely to be suitable; a target of ≤ 48 mmol/mol may be more appropriate
- Note that people with EOT2D may have faster progression with increasing HbA1c than is typically seen with onset at older ages. NICE recommend rechecking HbA1c every 3-6 months until HbA1c is stable on unchanging therapy and then 6 monthly. It is important to avoid therapeutic inertia and to escalate treatment promptly if individualised targets are not met
- NICE NG28 sets out guidance on use of glucose-lowering therapies, including recommendations for each step of intensification. Note that, in addition to glucose-lowering impact, SGLT2 inhibitors and GLP-1 receptor agonists have additional benefits in supporting weight loss and reducing CV risk and may therefore be particularly appropriate for people with EOT2D at applicable steps of intensification, in line with NICE guidance (not suitable if trying for pregnancy / likely to become pregnant)
- Offer diabetes structured education, even if previously attended. Take into account individual needs and preference and discuss options available. Note that Healthy Living is a nationally commissioned, digital structured education service which can be accessed at www.healthyliving.nhs.uk

b) **Cardiovascular risk:**

- Statins and SGLT2 inhibitors may be indicated for reducing cardiovascular risk
- Anyone with EOT2D and known CVD / HF should be offered a statin as well as an SGLT2 inhibitor
- Due to particularly elevated lifetime risk of CVD, NICE recommends consideration of the use of SGLT2 inhibitors in people with EOT2D and any of hypertension, dyslipidaemia, smoking, obesity, and family history (in a first-degree relative) of premature cardiovascular disease
- While setting the threshold to offer statins for primary prevention at a 10-year QRISK3 score of ≥ 10%, NICE CG181 states 'do not rule out treatment with atorvastatin 20 mg for the primary prevention of CVD just because the person's 10-year QRISK3 score is less than 10% if they have an informed preference for taking a statin or there is concern that risk may be underestimated'
- Note that the 10-year QRISK3 score will not reflect lifetime CVD risk for people with EO2TD and therefore consideration for statin therapy, in line with the criteria set out for considering use of SGLT2 inhibitors, may be appropriate
- Statins are also recommended if there is co-existent CKD, as are SGLT2 inhibitors. Note that the guidance for each SGLT2 inhibitor varies for this indication. Follow your local pathway and formulary
- SGLT2 inhibitors and statins are not suitable if trying for pregnancy / likely to become pregnant
- Blood pressure should be managed in line with NICE NG136, with a clinic BP target of < 140/90 mmHg (or average home BP of < 135/85 mmHg) for people with EOT2D and hypertension
- NICE recommends that an ACE-inhibitor or Angiotensin Receptor Blocker (ARB) is used preferentially as the first-line medication for managing high blood pressure in people with Type 2 diabetes, with an ARB more suitable in people of Black ethnicity. Note that these medicines are not suitable in women if trying for pregnancy / likely to become pregnant
- Offer support with smoking cessation in line with local pathways

c) Weight:

- If not referring to the NHS Type 2 Diabetes Path to Remission Programme, consider other appropriate weight management support, including local service offers
- The NHS Digital Weight Management Programme is available for people with diabetes and BMI ≥ 30 (adjusted to BMI ≥ 27.5 in ethnic minorities)
- Also consider referring to specialist obesity services in line with local pathways

d) **Psychological wellbeing and unmet social needs**

- People with EOT2D may have concurrent psychological needs. These should be assessed, and appropriate support offered in accordance with relevant NICE guidance and local pathways
- Explore unmet social needs and consider if social prescribing and/or other support may be indicated
- Consider local opportunities for peer support

Service	Anticoagulation Warfarin Service

1. National context and evidence base

Since 2019 North West London (NWL) has been implementing The NHS Long Term Plan which increases the focus of the provision of services based on population health through Primary Care Networks (PCNs) which has led towards the development of Enhanced Services that are outcome focused and population based.

2. Aims and objectives of service

- An anticoagulation service which ensures high quality care is delivered as close to the patients home as is appropriate
- Improves patient access to safe and clinically effective anticoagulation initiation for patients starting warfarin therapy using near patient testing and decision support software
- Ensures all patients are treated to the same high quality standard across NWL and to prevent patient safety incidents through proper training, systems maintenance and contingency planning
- The service is intended to support and enable general practitioners to provide patient care in a seamless and integrated way
- This service is in addition to those existing contracted services that providers are providing to their registered patients.
- The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services.

3. Service Description/Care Pathway

- The scope of the service includes warfarin initiation, warfarin monitoring and cessation of therapy when and if clinically appropriate.
- This includes blood monitoring, determination of INR and dosing of warfarin provided to all patients during a single clinic attendance and at a frequency appropriate to clinical need.
- The preferred computerised decision support software (CDSS) is INRStar which integrates with EMIS/SystemOne and requires capillary blood samples. However some providers use DAWN and this is an acceptable alternative.
- This service includes domiciliary visits to housebound patients.

Initiation is the process of starting patients on warfarin for the first time or after a significant break from taking warfarin. The process of initiating a patient on warfarin is more time consuming than warfarin monitoring. For warfarin this requires more frequent monitoring and requires a greater level of clinical competency to prevent thromboembolic events.

This Anticoagulation Service[40] is for patients who:

- Require slow initiation of oral anticoagulant when this has been recommended by a Secondary Care doctor or GP in line with guidance from NICE
- Require restart of warfarin following a prolonged absence from warfarin treatment.

The service provider will:

- Counsel the patient regarding clinic procedure, and check for:
  - Bleeding or thrombotic incidences
  - Tablet compliance and change of concomitant medication (N.B. OTC medicines)
  - Acute illness, diarrhoea or vomiting
  - Lifestyle changes e.g. alcohol intake
- Obtain a capillary blood sample from the patient and undertake analysis of blood. The use of venous sampling is not recommended as the analysis method and results differ from near patient testing and can result in unnecessary dose

[40] **Monitoring of other Coumarins: Patients are occasionally prescribed coumarins other than warfarin. This is unusual and such patients should be monitored in Secondary Care.**

changes

- Use Point of Care Testing (Coaguchek XS Plus) and INRstar during a single visit, patients should be dosed, any clinical interventions that are required should be undertaken and an appointment for the next visit should be made.
- Assess condition requiring warfarin considering the risks versus benefits of warfarin treatment and checking they have a clear understanding of the referrer's intended treatment target and duration or in line with NICE guidance.
- Ensure that all patients receiving warfarin (and/or carers and support staff, when appropriate) are given appropriate education at the start of therapy and at regular intervals thereafter. This should include information on the management and prevention of secondary complications.
- Ensure that each patient is provided with an individual management plan, which gives the diagnosis, planned duration and therapeutic INR target to be obtained. Each patient must be provided with an NPSA Oral Anticoagulation Therapy (OAT) patient information booklet or equivalent which can be ordered via PCSE.
- Ensure there is a robust and systematic call and recall of patients on the register
- Have a system in place for follow-up of patients who do not attend appointments
- Have the ability to offer patients an appointment within 2 working days
- Complete and provide patient with an OAT record book with verbal and written instruction regarding dosage, recall and relevant treatment information
- Record all clinical information related to the provision of this service in patient-specific records retained by the service provider and must ensure that the patient's registered GP is provided with a summary of every monitoring visit.
- A robust mechanism for communication must be in place for any patient who is housebound and the sample is taken at home and the test/dose calculation takes place at a different venue. Calibration/QC checks on machines should be made before home visits and a QC test done before a patients sample.
- Carry out and annual review of all patients on a long-term OAT.
- Assess whether anticoagulation therapy is still appropriate.

Warfarin Prescribing

- The patient's own GP is responsible for prescribing (after latest INR reading and recommended dosage guidance).
- The provider must have adequate systems in place for clinical governance to ensure that information is transferred to the patient's registered practice in a timely manner to facilitate prescribing.

Dosing and Monitoring

The service provider will:

- Provide INR testing at necessary intervals according to results
- The frequency of monitoring is determined by the stability of the INR and should normally be determined by the (CDSS) algorithm. The maximum length of time between tests being twelve weeks (or six weeks for those with mechanical heart valves). INR should be monitored more frequently in patients at increased risk of over-coagulation (e.g. those with severe hypertension, liver or renal disease) and in those for whom adherence may be poor.
- If there is no evidence of an INR test within the last 12 weeks, prescribers must balance the risk between prescribing and not prescribing warfarin. Providers must work in cooperation with prescribers to provide reliable channels of communication to ensure patients receive safe care.
- Ensure that the decision to manually dose a patient is risk assessed and documented appropriately.
- Warfarin should be given once daily and dosing is based on individual patient requirements

The NPSA Alert issued in March 2007 recommends the following:

- Use the least number of tablets each day
- Use constant dosing and not alternate day dosing
- Avoid use of half tablets
- All strengths of warfarin tablets should be used to best meet the needs of individual patients. Not all patients will need all strengths of tablet
- Doses should always be expressed in milligrams and not tablet number

Managing sub-therapeutic INR

The clinician should follow INR-STAR[41] dosing recommendations. Sub-therapeutic INR as defined in NICE guidance, details it as two INRs above 5 or one INR above 8 in the last 6 months; or two INRs below 1.5 in the last 6 months; or a TTR<65% (calculated electronically or as a simple percentage of tests within the therapeutic range). NICE recommends that anticoagulant quality is reviewed at least annually.

In cases where the INR is significantly sub-therapeutic, such that INR-STAR does not offer dosing instructions, clinicians should consider boosting doses and/or consider referral to secondary care for bridging with low molecular weight heparin.
Referral for low molecular weight heparin should be particularly considered for high-risk patients including:

- Patients with mechanical and prosthetic mitral heart valves
- Patients with APS/Protein C and Protein S deficiency
- Recurrent VTE
- AF and recent embolic stroke (within last 6-8 weeks)
- Patients in the first 4-6 weeks of VTE treatment

Surgery

- It is the responsibility of the surgeon to advise the patient and service provider/patient's own GP when and for how long warfarin should be stopped prior to surgery and to conduct necessary additional INR checks to ensure INR is within an appropriate range prior to the surgery/procedure.
- The provider should have access to information regarding any planned surgery so that the patient can be appropriately counselled and appraised.

Stopping Warfarin

- Most adverse events reported with warfarin are as a result of over-coagulation and so it is important that the need for therapy is reviewed regularly and discontinued when no longer appropriate. The service must insert a 'date' and 'reason' for every patient discontinuing OAT.
- Patients with a history of a single thromboembolic event may be prescribed warfarin for a specific period of time. The end date of treatment should be clearly stated on the original referral form. At the end of treatment, the patient should be assessed by the provider with regard to continuing treatment, the default position being to stop warfarin
- For all other patients: To discontinue warfarin it is advised to obtain written confirmation from the clinician who commenced warfarin therapy or the patient's usual GP. Treatment cessation should be Read coded on the GP clinical computer system and the patient's GP advised that warfarin should be removed from repeat prescriptions. The patient should be deactivated from INRstar or DAWN if they are not to be restarted
- When stopping warfarin therapy, the service provider must formally inform the patient's GP.

Patient Information

- At the start of therapy, all patients must be educated on the impact and implications of OAT, potential drug interactions, symptoms for which they should seek medical attention and how to deal with bleeding episodes. The service provider must ensure that all new patients are given an OAT pack (yellow patient information booklets) on initiation of OAT and on completion of a previous book
- On-going education should be provided throughout the duration of therapy and a check made of patients understanding of their therapy at the first appointment and on an on-going basis throughout their treatment
- All INR results and dosing instructions should be communicated to patients and their GP at the OAT clinic appointment and documented in the OAT book. Colour copies from INRstar/DAWN should be given to patients to advise them of their current dose
- The service provider must ensure that each patient under their care has received the revised OAT patient information booklet – 'Oral Anticoagulant Therapy: Important Information for patients'
- Patients should be encouraged to carry their yellow OAT book with them at all times and show it to any health professional whenever they seek treatment or advice and when requesting and collecting prescriptions

Minimum reporting and data collection requirements

[41] **INR Star does also have a bridging component where clinically necessary and required for patient care.**

- The service provider must undertake an annual review of each patient with the purpose of establishing whether continuation on warfarin remains clinically indicated
- On a quarterly basis, providers must submit the patient count and contact count
- The service provider must input information obtained following testing on to the Clinical Decision Support Software (CDSS), INRstar or DAWN to determine the appropriate warfarin dosage

The service provider must be able to produce an up-to-date register of OAT patients for clinical management and audit purposes, this will include:

- Patient's name, address and date of birth
- Indication for OAT
- Duration of therapy – including stop date (where appropriate)
- Details of concomitant medication and any changes
- Target INR
- Dosing information
- Current INR and dosage in milligrams
- Date of next appointment
- Relevant notes supporting dose decision, counselling and self-management
- Bleeding episodes and adverse events associated with the use of OAT
- Information on adherence to treatment, changes in diet, changes in smoking or alcohol or planned surgery
- Name of referring consultant or GP
- Name of hospital consultant recommending warfarin (if known)
- OAT dates of missed appointments
- Education material and advice given
- Any additional actions taken to be recorded in the patient's record
- Therapeutic Time in Range (TTR) – must be ≥ 65%[42]

The service must provide annual report, to include as a minimum

- service user experience, with an action plan to address any issues identified through responses.
- An audit of waiting times, with a minimum standard to 95% of patients to be offered an appointment within 2 working days from referral
- Service time in therapeutic range
- Proportion of patients with high INR
- Proportion of patients with low INR
- Minimum number of test per year
- Number of patients referred onto secondary care and why
- Any reported Serious Incidents or near misses

Equipment

An equipment tariff will be provided by the commissioner, which will provide funding towards for the Point of Care Testing POCT (Coagucheck XS Plus) machine and the licences for the clinical decision support software (INRstar/DAWN) to Practices contracted to deliver Anticoagulation Services.

The service provider will provide:

- All other necessary equipment and consumables (including gloves and single use lancets)
- Point of care testing test strips (these must not be prescribed on FP10 prescription forms; the only exception is if the patient is self-monitoring) – the cost for these is included within the tariff for the service itself.
- Computer and colour printer

[42] **It is important that TTR for each patient should be known because if <65% and there is no obvious reason for it then there an alternative anticoagulant should be used or dose adjustment. This is backed up by this 2018 audit that states if patient has TTR <65% should be classed as a 'never' event https://thrombosisuk.org/downloads/2018%20Anticoagulation%20UK%20-%20Audit%20of%20Anticoagulation%20management%20in%20secondary%20care%20in%20England.pdf)**

- Internal QA samples / solution
- External QA via NEQAS
- The equipment must be properly maintained and calibrated and serviced annually in accordance with the manufacturer's' instructions.
- Tests of blood coagulation must also be quality assessed externally by U.K. National External Quality Assessment Scheme (NEQAS) for Blood Coagulation. It is the responsibility of the Service provider to register and pay external auditing materials from NEQAS http://www.ukneqas.org.uk/) and undertake testing, as required
- Internal quality assurance (IQA) procedures must be in place to test the consistency of the results and must be reviewed weekly by the clinical lead. IQA is essential to perform and must be documented using the form available on INRstar
- Internal testing must involve control samples with known INRs in the coagulometers to ensure the equipment is calibrated correctly and working accurately. Control test samples are stored in a clinical fridge at 2-8OC or according to manufacturer's instructions.
- If there is >1 operator of the machine, operator lists should be set up and each operator should undertake an internal QC monthly- this can be organized as detailed in manual set-up.
- Internal quality assurance should routinely be performed:
  - Weekly after cleaning the Coaguchek XS Plus monitor according to manufacturer's instructions, and
  - Whenever a new batch of test strips is opened for use
  - When commencing use of newly delivered strips (even if the same lot number as before)
  - It should also be performed ad hoc:
    - If the machine is dropped, or;
    - If incorrect storage and handling of test strips is suspected, or:
    - If an unexpectedly high or low INR result is obtained on a patient
- The manufacturer's instructions for this process are to be followed – ready reference guide must be kept with machine
  - Date of test, name/ID of operator, batch (or lot) number of control sample, batch (or lot) number of test strip and the INR result must be logged in the "quality control log" along with the reason for testing i.e. routine or ad hoc. (INR star has a facility to record this)
- The provider must register with the National External Quality Assessment Scheme (NEQAS) centre in Sheffield. This involves quarterly distribution of samples, which are then tested on the Coaguchek XS Plus monitor and results returned for comparison with other centres using the same device. Records of this should include: date received, NEQAS BN, date of testing, PT BN, PT expiry, result, interpretation operator ID and procedure for equipment failure. (INRstar has a facility to record this)

4. Any acceptance and exclusion criteria and thresholds

Acceptable

The Anticoagulation service is required for patients aged 18 and above who:

- Require slow initiation of oral anticoagulant when this has been recommended by a Secondary Care doctor or GP in line with guidance from NICE
- Require restart of warfarin following a prolonged absence from warfarin treatment (slow initiation only)
- Patients who require adjustments and intensive monitoring after hospital admission

Exclusions

- Contraindications and cautions to management in primary care must be considered on an individual patient basis, taking into account his / her medical condition(s), home situation and any additional support that may be required. Patients with problems and conditions listed below should be excluded from the primary care service. Those with factors that increase the risk of bleeding should have INR monitored more frequently and consideration of shorter duration of therapy
- Known hypersensitivity to warfarin or to any of the excipients
- Haemorrhagic stroke
- Clinically significant bleeding
- Within 72 hours of major surgery with risk of severe bleeding

- Within 48 hours postpartum
- Pregnancy (first and third trimesters)
- A known hereditary or acquired bleeding disorder or thrombophilia
- Documented evidence of CNS haemorrhage in the previous six months
- Liver failure
- Gastro-intestinal bleeding in the previous six months
- On chemotherapy for cancer (to be managed by Oncologist and Haematologist)
- Intravenous (IV) drug user
- Children under 18yrs (to be managed by hospital).

Cautions

Caution should be used for patients with the following conditions / problems:

- A known alcohol problem
- Renal impairment
- Drug misuse
- Recent ischaemic stroke
- Bacterial endocarditis
- History of previous GI bleeding
- Active peptic ulceration
- Significant risk drugs interactions.

- Patients who require rapid anticoagulation
- Patients who have been rapidly initiated in secondary care and then are discharged home unstable[43] **do NOT fall under this specification.**

5. Training, Skills and Experience

Service Lead

- The service lead must be an accountable clinician (GP/Nurse/Pharmacist registered with a professional body and will take overall clinical responsibility of the service), who has attended an accredited university course on anticoagulation. Further learning is available at: https://bjcardio.co.uk/category/anticoagulation-learning/
- To maintain competence, the provider should manage a minimum of 10 patients per annum

All Staff

- Additionally, all staff delivering the service must follow:
- Anticoagulation Competency Framework.docx
- BMJ Training:
- Maintaining patients on oral anticoagulants: how to do it https://learning.bmj.com/learning/module-intro/anticoagulants-maintaining-.html?moduleId=5004429&locale=en_GB
- Starting patients on oral anticoagulants in primary care: how to do it https://learning.bmj.com/learning/module-intro/anticoagulants-primary.html?moduleId=10052760&searchTerm="anticoagulation"&page=1&locale=en_GB

[43] **Unstable in this context refers to patient having had at least 3 readings in range with none out of range before they can be taken on in primary care**

APPENDIX I - CONTRACTUAL REQUIREMENTS

ANTI-COAGULATION		
Unit Price	**Warfarin Initiation** - **£50.96** Per Quarter when the patient is seen (Maximum of £203.84 per patient per annum) **Warfarin Monitoring - £35.38** Per Quarter when the patient is seen (Maximum of £141.52 per patient per annum) **Home visit -** £10.06 (capped at one visit per day per patient) Provider can only receive one per annum payment either for initiation or monitoring in a 12 month Period	
Business rule	Warfarin Monitoring	1 activity per patient per quarter
	Warfarin Initiation	1 activity per patient per quarter
	Home Visit	1 visit per patient per day across all services
Service Type	Quarterly payment on activity	Pop-Up used to Record 'Enhanced services administration (**166221000000105**)
Referral Criteria	▪ Patients aged 18 years and above are **Mandatory** under this contract ▪ Housebound patients	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
AC01	Number of patients initiated	Warfarin Therapy Started (**170920007)** **AND** International normalised ratio **(165581004)**
AC02	Number of Home Visits undertaken for warfarin initiation	Home Visit (**439708006**)
AC03	Number of patients warfarin monitored	Warfarin Monitoring **(268526009)** **AND** International normalised ratio (**165581004**)
AC04	Number of Home Visits undertaken for Warfarin monitoring	Home Visit (**439708006**)

PAYMENT/KPI RULES

To Achieve Quarterly Payment for Warfarin Initiation AC01

- Registered patient must be Aged 18 and Over **AND**
- Has SNOMED code of Warfarin Therapy Started **(170920007)** recorded by the provider in the payment Quarter
- Has SNOMED code of International normalised ratio **(165581004)** recorded by the provider in the payment Quarter
- Has SNOMED code of Enhanced Services Administration (**166221000000105**) recorded at the same time as the International normalised ratio

To Achieve Quarterly Payment for Warfarin Initiation Home Visit AC02

- Has achieved coding for AC01 **AND**
- Has SNOMED code of Home Visit (**439708006**) recorded at the same time as International normalised ratio

To Achieve Quarterly Payment for Warfarin Monitoring AC03

- Registered patient must be Aged 18 and Over **WITHOUT** being initiated by the provider on **Warfarin Initiation** in last 12 months **AND**
- Has SNOMED code of Warfarin Monitoring **(268526009)** recorded by the provider
- Has SNOMED code of International normalised ratio (**165581004**) recorded by the provider in the payment Quarter
- Has SNOMED code of Enhanced Services Administration (**166221000000105**) recorded at the same time as the International normalised ratio

To Achieve Quarterly Payment for Warfarin Monitoring Home Visit AC04

- Has achieved coding for AC03 AND
- Has SNOMED code of Home Visit (**439708006**) recorded at the same time as International normalised ratio

Service	Latent Tuberculosis Testing

1. National context and evidence base

The national Latent Tuberculosis Infection (LTBI) testing and treatment programme is 1 of 10 key activities in the NHS England/PHE Collaborative Tuberculosis (TB) Strategy for England, that aims to reduce TB in England.

The number of people with TB in England has fallen from a peak of 8,280 in 2011 to 4,655 in 2018 – a reduction of approximately 44%. The incidence of TB in 2018 (8.3 per 100,000 population) was the lowest TB rate ever recorded in England. 86% of TB cases are notified more than 2 years after entry to the UK and are likely due to reactivation of Latent TB Infection. TB rates in England remain high and are associated with significant morbidity, mortality and costs. This is attributed to delayed diagnosis resulting in poor outcomes for the individual, and in the case of pulmonary TB, a transmission risk to the public. There are also significant inequalities in the rate of TB; the most deprived 10% of the population have a rate more than 7 times higher than the least deprived 10%, and people born outside the UK have a rate 13 times higher than people born in the UK. Nearly 13% of people notified with TB have a social risk factor.

Since 2015 NHS England has funded a LTBI testing and treatment programme and funding has been secured until 2024/25. The programme has delivered

- A total of 45,121 LTBI tests have been reported from programme commencement to 31st March 2019
- 17% of all LTBI tests were positive for LTBI
- 64% of people with a positive LTBI test commenced treatment
- 69% of people with a positive LTBI test who commenced treatment completed treatment

North West London has a TB incidence rate of 36 per 100,000 population. The majority (82%) of people with TB in London were born outside the UK, most of whom had been in the UK a long time prior to TB notification.

2. Aims and objectives of service

The aim of this service is to support the national LTBI testing and treatment programme which sets to identify eligible migrant populations to reduce the prevalence of TB in North West London by:

- Early detection, diagnosis and treatment of LTBI
- Increased awareness of Active and LTBI within Primary Care
- Increased awareness within local Communities of the importance for LTBI screening
- Improved quality of care and cost effectiveness of treating TB
- Cost savings after 3-5 years resulting from reduced treatment for Active TB

3. Service Description/Care Pathway

Based on evidence of cost effectiveness, LTBI testing and treatment will be limited to persons who are from countries with a WHO estimated incidence of over 150 per 100,000 or from Sub-Saharan Africa and who have arrived in England within the last five years.

Step One: Offer TB Screening to Eligible Patients

- The LTBI testing and screening template (SystmOne and EMIS) is to be used to capture the required variables and populate the data fields for the programme.
- GP staff to explain why the LTBI test is being offered and patients given a copy of the national LTBI patient information sheet.
- If, a new registrant has symptoms of active TB, organise immediate referral to local TB services and follow standard national infection control guidelines.
- Screening and clinical assessment to be managed in accordance with NICE Guidelines for TB.

Step Two: IGRA (TB) Blood testing pathway of eligible patients

- The IGRA (Interferon Gamma Release Assay) TB blood testing pathway to be followed:
- Record all IGRA blood results on SystmOne / EMIS.
- GP practices may use this opportunity to test for HIV, if appropriate, in particular among people from countries where co-infection is common (e.g. Sub-Saharan Africa) or other HIV high incidence areas.
- GP practices to consider combining LTBI testing with other health checks, such as for diabetes or blood born viruses (BBVs) as appropriate.
- The test to be ordered via ICE and the sample sent to your current pathology laboratory as normal.
- LTBI testing will be performed with a single IGRA blood test at IGRA test-processing laboratory as per agreed local pathway.
- The provider will follow-up patients who are non-compliant at least 3 times. Use relevant codes each time the patient has been contacted
- If patient explicitly declines the test, GP Practice to record this using the appropriate code – appendix 2
- Providers are responsible for informing patients of their IGRA test results.
- Patients with negative test results will be informed of their results (either by telephone call or letter) and given information on the signs and symptoms of TB disease.
- If a patient has symptoms of active TB, the provider will organise immediate referral to local TB services and follow standard national infection control guidelines.
- The provider will record patients with a BCG scar using appropriate coding
- Awareness should be raised among practice staff to ensure they have an increased index of suspicion for TB in patients who present with any of the common signs or symptoms of TB or who have other, unexplained symptoms.
- Pregnant women can be tested and symptomatic TB patients need to be referred to TB services immediately. However, for pregnant patients with positive IGRA tests and who are asymptomatic, LTBI treatment should wait until after delivery. The provider will ensure that arrangements are made for treatment to be scheduled after delivery.
- If the patient is a child from high-risk countries and have not received BCG vaccination they will be offered BCG as per national guidelines.

Step Three: Referral to TB Clinic (positive IGRA)

- All positive IGRA blood tests to be referred to the TB Clinic, in accordance with local pathways, protocols and Nice Guidelines.

If a patient has a positive result to Latent TB infection, where the family/people they are living with have followed the same path into the country they should also be registered and offered screening.

Data Entry & Data Quality Assurance

Good data entry will form the basis of all remuneration and all data fields on the LTBI template on SystmOne/EMIS are required to be completed are completed

This service requires:

- GP staff to ensure data entered into the practice template is correct
- The number of outstanding data quality errors at Practice level will be monitored
- GP staff to work with Public Health England (PHE) to resolve data quality issues

All practices who participate will need to share data with the Public Health England (PHE) secure data warehouse via direct upload. Under regulation 3 of section 251 (National Health Service Act 2006) Public Health England has obtained the legal ability to collect patient identifiable data without patient consent. GPs will provide a patient information leaflet to inform patients on how their information is processed and used along with instructions for patients who would like to opt out of sharing their data. Patient identifiable data will not be provided to any other third parties.

The programme is monitored and evaluated by NHS England based on data submitted to and reported on by Public Health England to NHS England and LTBI programme partners.

Detailed Service Requirements

Service provision	Requirements of Service
Element 1: Patient invited for testing but **declined**	・ Identify patients that meet the inclusion criteria detailed above and populate mandatory data fields. ・ Patients identified at registration or from retrospective searches/ Flag 4 data ・ Offer IGRA test and record if patient declines the offer ・ If no response record at least three attempts to contact identified patient. ・ Contact can be in the form of a telephone call, letter, text message or any other communication process already established at the practice. ・ After the third attempt record as declined ・ Record all demographic data (as specified in the section below) in the NW London template.
Element 2: Patients invited and were tested	・ Invite and test patients ・ Record the outcome of the IGRA test using the codes
Element 3: Identification of patients with a positive IGRA test result.	・ Examination for suspected tuberculosis ・ Record IGRA tests in clinical system ・ A referral to a locally specified TB Clinic is made. ・ Referral to tuberculosis screening service

4. Any acceptance and exclusion criteria and thresholds

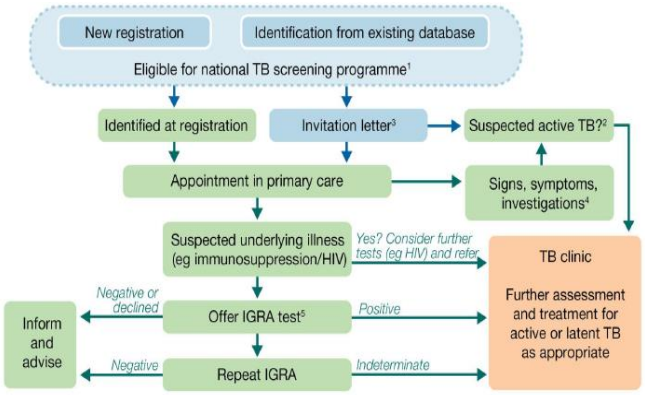
Inclusion Criteria

Practices are expected to identify patients at the point of registration or retrospectively (through searches or flag 4 data) provided the patient meets the following eligibility criteria for LTBI testing and treatment:

- Registered with a GP practice in the last 5 years
- Born or spent >6 months in a high incidence country (≥150 per 100,000 or Sub-Saharan Africa (complete list of countries found in specification)
- Entered the UK within the last 5 years
- Aged 16-35
- Not previously been tested or treated for LTBI in the UK
- Not previously screened for LTBI

Patients should still be referred for testing even if they have had;

- BCG - the vaccination is not 100% effective so they could still have latent TB.
- Chest X-ray – (usually part of the visa application process) an x-ray only detects active TB so they could still have latent TB.
- If a patient knows they have been in the presence of someone with TB then they should also be offered testing as a duty of care



5. Training, Skills and Experience

The service should be delivered by an appropriately registered clinician. There are no specifc training needs required as part of their delivery.

6. Equipment

There is no specifc equipment reqiuired in the delivery of this service.

APPENDIX I - CONTRACTUAL REQUIREMENTS

LATENT TUBERCULOSIS TESTING		
Unit Price	**Offering Testing LTBI** - £4.84 Patients identified but declined or did not respond after 3 invitations **Latent TB Testing** - £18.50 Number identified and tested **Positive IGRA Test** - £41.13 Number of patients testing positive LTBI and referred to hospital TB Clinic	
Business Rule	Offering Testing LTBI	1 activity per patient ever Patient cannot have had IGRA Testing completed
	Latent TB Testing	1 activity per patient ever Patients cannot have been invited more than 3 times or declined
	Positive IGRA Test	1 activity per patient ever
Service Type	Episodic	No Pop-Up
Referral Criteria	Patients aged 16-35 are **Mandatory** under this contract	
Target Population		
Patients included in Target population **TB00**: ▪ Patients must be aged 16-35 ▪ Registered with a GP Practice in last 5 years ▪ Entered UK within the last 5 years (**860021000000109**) ▪ Born **OR** Lived >6 months in a high incidence country ▪ No previous history of TB or LTBI ▪ Not previously screened for LTBI (**171400006**/**1087701000000104**)		

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
TB01	Invited for screening 3 times or have declined	Latent tuberculosis screening invitation (<<**925541000000101**) (3 times) **OR** Latent tuberculosis screening declined (**926261000000105**)
TB02	Patients who have been tested	Either: IGRA Positive (**440662009**) IGRA Negative (**440661002**) IGRA Indeterminate (**439996009**)

TB03	Identification of patients with a positive IGRA test result and referral to TB service	IGRA Positive (**440662009**) **AND EITHER** Referral to tuberculosis screening service (**519121000000100**) Examination for suspected tuberculosis (**171400006**)

PAYMENT/KPI RULES

To Achieve Payment for Latent TB Invitation (3 times) or Declined for TB01

- Patient is in target population **TB00 AND**
- Has SNOMED code of Latent tuberculosis screening invitation at least 3 times (<<**925541000000101**) on different days OR Latent tuberculosis screening declined (**926261000000105**) recorded by the provider

To Achieve Payment for Latent TB Testing TB02

- Patient is in target population **TB00 AND**
- Has either SNOMED code of IGRA Positive (**440662009**) OR IGRA Negative (**440661002**) OR IGRA Indeterminate (**439996009**) recorded by the provider

To Achieve Payment for Positive IGRA Result and Referral to TB Service TB03

- Patient is in target population **TB00 AND**
- Has SNOMED code of IGRA Positive (**440662009**) recorded by the provider **AND**
- Has SNOMED code of Referral to tuberculosis screening service (**519121000000100**) **OR** Examination for suspected tuberculosis (**171400006**) recorded by the provider

Service	Ring Pessary

1. National/ Local context and evidence base

This specification describes the Locally Commissioned Service for Ring Pessary to be provided within primary care. A vaginal ring pessary is an effective treatment for pelvic organ prolapse and is more appropriate for some patients than surgery. The procedure is suitable for primary care provision. This specification is intended to cover the enhanced aspects of clinical care of the patient, which are beyond the scope of GMS essential services and the quality and outcomes framework.

All practices are expected to provide essential and those additional services they are contracted to provide to all their registered patients. This Locally Commissioned Enhanced Service (LES) specification for Ring Pessary outlines the more specialised services to be provided. No part of this specification by commission, omission or implication defines or redefines essential or additional services. This service must be provided in a way that ensures it is equitable in respect of race, creed, culture, diversity, disability, sex, and age.

In 2019 all CCGs in North West London began the implementation of a five-year framework for GP Contract reform, to provide a foundation for The NHS Long Term Plan. Following the development of a PCN arrangement and the commissioning of the Network Contract DES, PCNs have begun working with system partners to meet the increasingly complex needs of local populations.

This service is aimed at women who need a ring pessary and is intended to enable the management, refitting and removal of ring pessaries to take place within Primary Care. Effective treatment and symptom relief for prolapse can be achieved by the use of an appropriately sized and fitted pessary. This route is recommended by NICE [NG123][44] where appropriate before surgical options are explored. Ring pessaries are also sometimes used as a temporary measure in the management of vaginal prolapse in women who are planning another pregnancy and sometimes used in the management of stress incontinence caused by prolapse.

2. Aims and objectives of service

- The ICB is commissioning services that must be delivered by a group of GP providers to all patients registered with these practices ensuring equitable access and quality of service to the entire population group. The GP provider grouping and location(s) for delivery of the service (number of delivery points) will need to be agreed with the Borough Primary Care team.
- The ICB is commissioning a ring pessary service that supports its strategic commissioning intentions to ensure that high quality care is delivered as close to the patient's home as appropriate.

The service will do this by:

- Delivering a timely, effective and personalised ring pessary service in a safe environment
- Providing appropriate patient education so that patients may make informed choices and fully participate in their care and improve concordance.
- Preventing unnecessary referrals and admissions to specialist services, hospital or nursing homes. But where onward referrals are necessary completing these in clinically appropriate timeframes.
- This service is in addition to those existing contracted services that GP providers are providing to their registered patients. This service specification is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services.
- This service aims to improve access to ring pessaries in primary care and reduce the need for patients to attend secondary care.

[44] **Urinary incontinence and pelvic organ prolapse in women: www.nice.org.uk/guidance/ng123**

3. Service Description/Care Pathway

The registered GP will make the necessary assessment to recommend a ring pessary in-house or refer the patient refer the patient to the local Community Gynaecology Service, or Ring Pessary clinic within their PCN or to secondary care for assessment, sizing and initial fitting. It is expected that a significant number of patients requiring a ring pessary assessment/fitting might have already been assessed in secondary care and will be referred back to GP practices for further management. It is expected that all patients referred to the Provider will have had an assessment of their suitability for other forms of management of symptoms and an informed discussion regarding the use of a ring pessary.[45]

First Consultation

The service provider will:

- The service provider will issue acute necessary prescriptions; the prescribing of repeat medicine as part of ongoing management remains the responsibility of the patient's registered GP. This means the service provider will ensure that the patient has a prescription for a pessary from their registered GP prior to their appointment (if required). If after being assessed the patient needs an acute prescription for a different size pessary or for some topical oestrogen, then that should be done by the provider.
- Ensure that patient consent has been obtained to access their record
- Assess the patient and fit the ring pessary
- Agree a follow up appointment time with the patient and provide safety netting advice regarding ring pessary care.
- The provider is expected to achieve at least a first to follow up ratio of 1:2 within a calendar year. Follow-up every 4 to 6 months

On-going Follow-up in Primary Care (for review/replacement)

The service provider will:

- Ensure patients are invited for follow-up every 4 to 6 months, depending on any specific product instructions. At each follow-up appointment:
  - The service provider will carry out an assessment to check whether the pessary gives adequate symptom relief
  - The service provider will remove the pessary and inspect the vagina for evidence of pressure necrosis, atrophic vaginitis or granulation tissue
  - Depending on the type of pessary, either a new one should be inserted or the pessary should be washed and replaced
  - Advise the patient on the timescale for their next follow up.
  - Review symptom control, and return the patient to their registered GP for consideration of referral to secondary care if symptom control by ring pessary is not possible.
  - Ensure the consultation summary is available to the patient's registered GP following each appointment.
  - Provide appropriate counselling and screening prior to insertion in accordance with NICE Guidelines[46]
  - Hold a caseload and ensure that there is systematic call and recall of patients under the service. The service provider is responsible for follow up of any patients who do not attend their scheduled ring pessary appointment in Primary Care. Patients should be discharged back to their registered GP if there is no response to two letters or phone calls.
  - Refer patients with complications back to the specialist team, via the patient's GP, if necessary
  - Patients should be able to return to the to the local Community Gynaecology Service,Ring Pessary clinic within their PCN/Federation orto secondary care service specialist team as soon as possible if there are any problems within the first 6 weeks of fitting, if the management cannot be provided in Primary Care

Population Covered

- This service will cover all patients with a registered GP in North W London either at a practice level or at PCN level. PCNs may collaborate to work at scale. The GP provider grouping and location(s) of delivery of the service (number of delivery points) must be agreed with the Borough Primary Care team.
- Where the provider is not the patient's registered practice, the provider must ensure that the patient's registered practice

[45] **The assessment and initial fitting may be carried out by the Primary Care (GP) under this service specification if the Service Provider feels competent to assess suitability as outlined above or alternatively refer the patient to the local PCN/Federation PCN Ring Pessary Clinic (Service points to be determined by each PCN in discussion with their borough team).**

[46] **Urinary incontinence and pelvic organ prolapse in women: www.nice.org.uk/guidance/ng123**

is given all appropriate clinical details for inclusion in the patient's record within a reasonable timeframe, and no longer than five days.

4. Any acceptance and exclusion criteria and thresholds

Acceptance

Female patients aged 18 and above with symptomatic pelvic organ prolapse requiring vaginal ring pessaries in primary care.

Exclusions

This service is for ring pessary only. Therefore, the service does not include:

- Estring (Pharmacia) ring pessary which may be used for atrophic vaginitis
- Insertion of prostaglandin pessary
- Insertion of abortifacient pessary NEC

Referral sources

- The PCN should have appropriate agreement with practices in the PCN to provide the service on their behalf or other arrangement.
- Often GPs will fit ring pessaries and will refer up to the Urogynaecology team in secondary in secondary care for more complex prolapses and for women who haven't responded to conservative treatments who need further assessment and investigations.

Interdependencies with other services

- The service will be interdependent with any local community Gynae service where available
- The service provider should ensure that any referral pathways that are required between themselves and other interdependent services (i.e. Secondary Care/Community) are in place.

5. Training, Skills and Experience

Workforce Requirements

- The service provider must ensure that staff delivering the service meet the training and competency requirements to safely fit and change ring pessaries.
- The service can be provided by a GP or suitably qualified registered nurse.
- Nurses providing this service must be competent in bi-annual examination in line with the competencies set out in *Genital Examination in Women* (RCN,2020)[47] and good understanding of Urogynaecology as set out by the *RCN*[48]
- There should be at least two members of staff on the premises when this procedure is performed, which should be conducted in line with GMC recommendations for chaperones

Minimum clinical governance requirements

- The service provider will need to be able to deliver, manage and report on service performance in line with the contractual requirements
- Within the PCN or GP provider grouping there will need to be a mechanism for referring and receiving clinical information about patients between the referring practices and the service delivery points that will need to be supported by robust governance processes
- 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 PCN or 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

[47] **Royal College of Nursing - Genital examination in women:** www.rcn.org.uk/professional-development/publications/rcn-genital-examination-in-women-pub007961

[48] **Royal College of Nursing -** www.rcn.org.uk/clinical-topics/womens-health/urogynaecology

- 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

APPENDIX I - CONTRACTUAL REQUIREMENTS

RING PESSARY		
Unit Price	**Ring Pessary -** £29.25 per six months when the patient is seen. (Maximum of £58.50 per patient per annum)	
Business Rule	1 activity per patient per 6 months	
Service Type	Episodic	Pop-Up used to Record Enhanced services administration (**166221000000105**)
Referral Criteria	▪ Patients aged 18 and over are **Mandatory** under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
R01	Consultations completed for ring pessary	Insertion of ring pessary into vagina **(176726001) OR** Removal of ring pessary **(236865002) OR** Renewal of ring pessary in vagina **(236861006)**

PAYMENT/KPI RULES

To Achieve Payment for Ring Pessary R01

- Has SNOMED code of Insertion of ring pessary into vagina **(176726001) OR** Removal of ring pessary **(236865002**) **OR** Renewal of ring pessary in vagina **(236861006)** recorded by the provider **AND**
- Has SNOMED code of Enhanced services administration (**166221000000105**) recorded at the same time as the Ring Pessary

Activity Planning Assumptions

To achieve the full payment of tariff the provider must complete a full treatment cycle in line with the NICE guidance of 2-3 (every 4 to 6 months) consultations within a calendar year. These consultations should include a first initial appointment and one/two follow up appointments within the year. This will equate to a maximum first to follow up ratio of 1:2.

Service	Near Patient Testing for Disease-modifying anti-rheumatic drugs (DMARDs)

1. National context and evidence base

Since 2019 NWL CCG has been implementing The NHS Long Term Plan which increases the focus of the provision of services based on population health through Primary Care networks (PCNs) which has lead towards the development of Enhanced Services that are outcome focused and population based.

Disease Modifying Anti-Rheumatic drugs (DMARDs) are prescribed in the treatment of rheumatoid arthritis (RA) to suppress inflammation; they may be used as monotherapy or more commonly in combination. DMARDs are also used for the treatment of other rheumatology conditions (e.g. connective tissue disease and vasculitis) and in other specialities, including dermatology, respiratory medicine, neurology, ophthalmology and gastroenterology. Patients are initiated on these drugs by the hospital specialists and the transfer of prescribing and monitoring to primary care is after the patients have been stabilised, usually after 3 months and under shared care with the specialist hospital team.

To promote a standard approach to Shared Care Protocols (SCPs), on behalf of the national Regional Medicines Optimisation Committees (RMOCs) system, RMOC (North) led the development of Shared Care for Medicines Guidance – A Standard Approach. This guidance defines the principles for a national system of shared care for medicines. The guidance provides a framework for the seamless shared care and decision making between the patient, specialist service and primary care prescriber in relation to medicines use. It builds on the NHS England guidance Responsibility for prescribing between primary and secondary/tertiary care (2018). As part of this work, number of national SCPs for DMARDs have recently been published by NHS England in July 2022.

The SCPs are clinically focussed and provide the information required to support safe and effective shared care for the specified medicines. They include licensed indications and established off-label uses. Standardised templates will improve patient safety, reduce duplication and reduce inequity of access. There is no legal obligation nor mandatory requirement to use the SCPs however North West London ICB will be reviewing these via the NW London Integrated Formulary Panel for a decision.

The national SCDs have been developed for the following DMARDs for adults only (18 years and over)

Along with using these protocols, please ensure that summaries of product characteristics (SPCs), British National Formulary (BNF) or the Medicines and Healthcare products Regulatory Agency (MHRA) or NICE websites are reviewed for up-to-date information on any medicine.

- Azathioprine and mercaptopurine for patients within adult services (non-transplant indications) (last updated January 2022)
- Ciclosporin (oral) for patients within adult services (non-transplant indications) (last updated January 2022)
- Hydroxycarbamide for myeloproliferative disorders and sickle cell disease for patients within adult services (last updated January 2022)
- Hydroxychloroquine for patients within adult services (last updated January 2022)
- Leflunomide for patients within adult services (last updated January 2022)
- Methotrexate (oral and subcutaneous) for patients in adult services (excluding cancer care) (last updated January 2022)
- Mycophenolate mofetil and mycophenolic acid for patients within adult services (last updated January 2022)
- Sulfasalazine for patients within adult services (last updated January 2022)

Penicillamine is a DMARD that is rarely used now and a national SCD is not currently available. There is a minority of patients in NW London that continue to be on this medication thus penicillamine is included in this service. It is anticipated that there will be no new patients. Monitoring recommendations for this drug are based on Specialist Pharmacy Services in the absence of a national SCD. A local SCD will be developed.

2. Aims and objectives of service

- To enable key DMARDs to be prescribed and monitored safely in primary care by mutual agreement.
- The treatment of several diseases within the fields of medicine, particularly in rheumatology, gastroenterology and dermatology, is increasingly reliant on drugs that, while clinically effective, need regular monitoring. This is due to the potentially serious side-effects that these drugs can occasionally cause.
- The Near Patient Testing for Disease-modifying anti-rheumatic drugs (DMARDs) Service is designed to be one in which:
  - therapy should only be continued in primary care for recognised indications for specified lengths of time
  - maintenance of patients first stabilised in the secondary care setting should be properly controlled thereafter
  - the service to the patient is convenient
  - the need for continuation of therapy is reviewed regularly
  - the therapy is discontinued when appropriate
  - the use of resources by the National Health Service is efficient.

The ICB is commissioning a near patient testing service that means the service provider will:

- Provide the service for patients in their PCN
- Provide a maintenance service for patients first stabilised in Secondary Care and where the patient is well controlled
- Ensure that patients have regular blood tests, recognising that the interval and tests are different for each drug
- Conduct a robust call and recall system
- Deliver a service that is convenient to the patient and will take any necessary action in response to any DNA.
- Discontinue therapy in response to blood test results and in liaison with the patient's Consultant.

The service will do this by:

- Delivering a timely, effective and personalised service in a safe environment
- Providing appropriate patient education so that patients may make informed choices and fully participate in their care and improve concordance
- Promoting the use of individualised care management plans for all patients
- Preventing unnecessary referrals and admissions to specialist services, hospital or nursing homes. But where onward referrals are necessary completing these in clinically appropriate timeframes
- This service is in addition to those existing contracted services that providers are providing to their registered patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services
- Ensuring the contact details of the responsible specialist/clinic is made available to the service provider e.g., direct number/e-mail address with a reasonable response time of 72 hours

3. Service Description/Care Pathway

The near patient testing service is designed to be one in which:

- Initial treatment is started by the Consultant Specialist will retain the prescribing and monitoring responsibility for at least 12 weeks for most DMARDs
- The patient is stabilised
- The patient is then transferred under shared care arrangements to the service provider with clear instructions from the specialist on the duration of treatment, potential side effects, monitoring timetable, and when to transfer back if there are complications
- The service provider should be the patient's registered GP practice/PCN.
- The service must be convenient for the patient
- The therapy is discontinued when appropriate and as recommended by the Hospital Consultant.

The service shall provide a drug monitoring service in which:

- Therapy should only be started for recognised indications for specified lengths of time
- Maintenance of patients first stabilised in the secondary care setting (should be properly controlled thereafter)
- The need for continuation of therapy is reviewed regularly
- The therapy is discontinued when appropriate
- The service to the patient is convenient

- Maintain an up to date register of all patients seen within this service
- For all patients managed under the agreed protocol provides repeat prescriptions and undertakes appropriate tests to monitor patients in line with the agreed protocol
- Ensure that the appropriate Patient Held Record (Purple book for Methotrexate) and other appropriate record books for other drugs (as available) is up to date at all times
- If the patient does not have the purple book the practice/service provider will supply this to the patient
- The patient's electronic record in the practice has up to date records of monitoring blood test results. This is to support a robust system of recall and monitor patients systematically and prescribe methotrexate safely. This follows the NPSA guidance for hand held records.
- Ensure that the service has an adequate supply of the required record books to give to the patient as necessary
- Contact secondary care for advice where the patient's results are abnormal
- Refer patients back to secondary care following the agreed protocol where necessary for follow up within a reasonable time frame
- To record any changes in therapy in the clinical record on receipt of such communication from secondary care
- To monitor the patient's overall health and wellbeing including the Disease Activity and to report any adverse drug reactions or interactions, and worsening Disease Activity to secondary care
- The use of resources by the National Health Service is efficient

4. Any acceptance and exclusion criteria and thresholds

Inclusion

- All patients must be agreed to the transfer by the consultant, the patient and the GP.
- Adults 18 years and over.
- Patients will be initiated and stabilised by the specialist hospital team before transfer to primary care- at least 12 weeks after initiation.
- List of drugs included in this service:
  - Azathioprine
  - Ciclosporin
  - Hydroxycarbamide
  - Hydroxychloroquine
  - Leflunomide
  - Mercaptopurine
  - Methotrexate (oral and injectable)
  - Mycophenolate mofetil and mycophenolic acid
  - Penicillamine
  - Sulfasalazine

Exclusion

- Children under 18 years
- Where a patient, for clinical reasons is referred back to secondary care within the year the payment will cease from the first day of the following quarter, and resumed from the quarter that the patient is transferred back for monitoring. In some instances, practices may be requested to continue to monitor these patients, in which case they are applicable for reimbursement in the scheme

5. Training, Skills and Experience

The service provider must ensure all staff delivering the service meet the training and competency requirements.

6. Equipment

There is no specifc equipment required for the delivery of this service.

APPENDIX I - CONTRACTUAL REQUIREMENTS

NEAR PATIENT TESTING		
Unit Price	**£14.77** Per Quarter when the patient is seen (Maximum of **£59.08** per patient per annum) Provider can also receive an additional tariff for Phlebotomy as part of the delivery of Near Patient Testing	
Business Rule	1 activity per patient per quarter	
Service Type	Episodic	Pop-up not required
Referral Criteria	▪ Patients aged 18 years and above are **Mandatory** under this contract ▪ Patient is prescribing a medication as listed with the specification ▪ Patient has formal Shared Care Protocols (SCPs)	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
NPT01	Number of consultations for Near Patient Testing	Near Patient Testing Enhanced Service completed **(166451000000101)**

PAYMENT/KPI RULES
To Achieve Payment for Near Patient Testing ▪ Patients must be aged 18 and over **AND** ▪ Has SNOMED code of Near patient testing enhanced service completed **(166451000000101)** recorded by the provider in payment Quarter

Clinical Information for the Near Patient Testing for Disease-modifying anti-rheumatic drugs (DMARDs) and Immunosuppressant Drugs

National Shared Care Protocols

To promote a standard approach to Shared Care Protocols (SCPs), on behalf of the national Regional Medicines Optimisation Committees (RMOCs) system, RMOC (North) led the development of Shared Care for Medicines Guidance – A Standard Approach. This guidance defines the principles for a national system of shared care for medicines. The guidance provides a framework for the seamless shared care and decision making between the patient, specialist service and primary care prescriber in relation to medicines use. It builds on the NHS England guidance Responsibility for prescribing between primary and secondary/tertiary care (2018).

SCPs are clinically focussed and provide the information required to support safe and effective shared care for the specified medicines. They include licensed indications and established off-label uses. Standardised templates will improve patient safety, reduce duplication and reduce inequity of access. There is no legal obligation nor mandatory requirement to use the SCPs.

SCPs includes all information required for safe prescribing in strict accordance with current guidance.

Penicillamine is a DMARD that is rarely used now and a national SCD is not currently available. There is a minority of patients in NW London that continue to be on this medication thus penicillamine is included in this service. It is anticipated that there will be no new patients. Monitoring recommendations for this drug are based on Specialist Pharmacy Services in the absence of a national SCD. A local SCD will be developed.

Along with using these protocols, please ensure that summaries of product characteristics (SPCs), British National Formulary (BNF) or the Medicines and Healthcare products Regulatory Agency (MHRA) or NICE websites are reviewed for up-to-date information on any medicine.

Some DMARDs are used for transplant patients and the national shared care protocols exclude these patients as anti-rejection DMARD drugs prescribing and monitoring should remain with the hospital transplant team.[49]

Note that

- Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to primary care.
- Transfer of monitoring and prescribing to primary care is normally **after at least 12 weeks**, and when the patient's dose has been optimised and with satisfactory investigation results **for at least 4 weeks**.
- The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.
- All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician.
- The specialist will retain the responsibility for monitoring the patient's ongoing response to treatment and advise if a dose change or treatment cessation is appropriate. **This should usually be undertaken annually**.
- After each review, the specialist is to advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in the SCD remains appropriate.
- Primary care to provide ongoing vaccinations as appropriate for examples, Shingles, influenza, COVID-19 and pneumococcal vaccinations
- Please refer to the individual SCD for full details.

[49] **Monitoring recommendations are based on the national NHS England Shared Care Documents www.england.nhs.uk/medicines-2/regional-medicines-optimisation-committees-advice/shared-care-protocols**

Drugs included in the Near Patient Testing DMARD Service

NO	Drug	National Shared Care Protocol: NHS England » Shared Care Protocols (SCPs)	Indications included in the Service	
			Licenced Indications	Off-label indications These indications are off-label. The specialist must specify the indication for each patient when initiating shared care and clearly state when use is off-label.
1	**Azathioprine**	**Yes:** Azathioprine and mercaptopurine for patients with adult service (non-transplant indications)	Licensed indications include: ・ Auto-immune chronic active hepatitis ・ Auto-immune haemolytic anaemia ・ Chronic refractory idiopathic thrombocytopenic purpura ・ Dermatomyositis ・ Inflammatory bowel disease (IBD) ・ Pemphigus vulgaris ・ Polyarteritis nodosa ・ Polymyositis ・ Pyoderma gangrenosum ・ Rheumatoid arthritis ・ Systemic lupus erythematosus (SLE)	Including treatment of chronic inflammatory conditions where off-label use of azathioprine is appropriate, including, but not limited to the following specialities and conditions: ・ Dermatology (e.g. severe eczema) ・ Neurology (e.g. myasthenia gravis, demyelinating conditions) ・ Ophthalmology (e.g. uveitis, scleritis) ・ Oral medicine (e.g. Behçet's disease, refractory inflammatory oral disease) ・ Renal medicine (e.g. immune-mediated nephritis) ・ Respiratory disease (e.g. interstitial lung disease) ・ Rheumatology (e.g. inflammatory arthritis, connective tissue disease, vasculitis, giant cell arteritis)
2	**Ciclosporin**	**Yes:** Ciclosporin (oral) for patients within adult services (non-transplant indications**)**	Licensed indications: ・ Endogenous uveitis ・ Nephrotic syndrome ・ Rheumatoid arthritis ・ Psoriasis ・ Atopic dermatitis	Chronic inflammatory conditions where off-label use of ciclosporin is appropriate, including, but not limited to, the following specialities and conditions: ・ Rheumatology (e.g. psoriatic arthritis, systemic lupus erythematosus, connective tissue disease, vasculitis) ・ Dermatology (e.g. urticaria, inflammatory dermatoses, bullous conditions) ・ Gastroenterology (e.g. severe ulcerative colitis) ・ Renal medicine (e.g. vasculitis, lupus nephritis) ・ Neurology (e.g. myasthenia gravis)
3	**Hydroxycarbamide**	**Yes:** Hydroxycarbamide for myeloproliferative disorders and sickle cell disease for patients within adult services	Licensed indications include: ・ Chronic myeloid leukaemia ・ Essential thrombocythaemia ・ Polycythaemia vera ・ Sickle-cell disease	Other myeloproliferative disorders and inflammatory conditions where off-label use of hydroxycarbamide is appropriate, including: ・ Primary myelofibrosis‡ ・ Unclassified myeloproliferative disorders‡ ・ Psoriasis‡

4	**Hydroxychloroquine sulfate**	**Yes:** Hydroxychloroquine for patients within adult services	Licensed indications: ・ Active rheumatoid arthritis ・ Systemic and discoid lupus erythematosus ・ Dermatological conditions caused or aggravated by sunlight	Chronic inflammatory conditions where off-label use of hydroxychloroquine is appropriate, including but not limited to the following specialities and conditions: ・ Rheumatology (e.g. inflammatory arthritis, connective tissue disease, Sjögren's syndrome, myositis) ・ Dermatology (e.g. urticaria, other inflammatory skin diseases) ・ Respiratory disease (e.g. interstitial lung disease, sarcoidosis). ・ Renal medicine
5	**Leflunomide**	**Yes:** Leflunomide for patients within adult services	Licensed indications: ・ Rheumatoid arthritis ・ Psoriatic arthritis	Off-label use for other inflammatory conditions including: ・ Rheumatology conditions (e.g. systemic lupus erythematosus, axial spondyloarthopathy) ・ Interstitial lung disease ・ Vasculitis
6	**Mercaptopurine**	**Yes:** Azathioprine and mercaptopurine for patients with adult service (non-transplant indications)	**None:** licensed oncology indications remain responsibility of hospital	Including treatment of chronic inflammatory conditions where off-label use of azathioprine is appropriate, including, but not limited to the following specialities and conditions: ・ Inflammatory bowel disease ・ Autoimmune encephalitides ・ Autoimmune hepatitis
7	**Methotrexate:** Oral and sub-cut injection	**Yes:** Methotrexate (oral and subcutaneous) for patients in adult services (excluding cancer care)	The licensed indications include: ・ Active rheumatoid arthritis ・ Mild to moderate Crohn's disease in patients refractory or intolerant to thiopurines (licensed indication of subcutaneous preparations) ・ Severe psoriasis ・ Severe psoriatic arthritis Licensed indications vary with brand. See relevant summary of product characteristics for full details.	Other chronic inflammatory conditions where off-label use of methotrexate is appropriate, including, but not limited to, the following specialities and conditions: ・ Rheumatology (e.g. inflammatory arthritis, connective tissue disease, vasculitis) ・ Dermatology (e.g., severe eczema, bullous conditions) ・ Gastroenterology (e.g. severe Crohn's disease or other inflammatory bowel disease) ・ Neurology (e.g. myasthenia gravis, inflammatory neuropathies) ・ Ophthalmology (e.g. uveitis, scleritis) ・ Respiratory disease (e.g. sarcoidosis, interstitial lung disease)

8	**Mycophenolate mofetil and mycophenolic acid**	**Yes:** Mycophenolate mofetil and mycophenolic acid for patients within adult services (non-transplant indications)		Off-label use for the treatment of chronic inflammatory conditions where use of mycophenolate is appropriate, including but not limited to the following specialities and conditions: ・ Dermatology (e.g. myositis, severe psoriasis, severe atopic dermatitis/eczema, autoimmune bullous dermatoses, SLE) ・ Gastroenterology (e.g. Crohn's disease, ulcerative colitis) ・ Haematology (e.g. idiopathic thrombocytopenic purpura) ・ Hepatology (e.g. auto-immune hepatitis) ・ Neurology (e.g. inflammatory neuropathies, myasthenia gravis) ・ Ophthalmology (e.g. uveitis, scleritis) ・ Oral medicine (e.g. Behçet's disease, refractory inflammatory oral disease) ・ Renal medicine (e.g. immune-mediated nephritis) ・ Respiratory disease (e.g. interstitial lung disease) ・ Rheumatology (e.g. rheumatoid arthritis, systemic lupus erythematosus [SLE], vasculitis)
9	**Penicillamine**	**No:** Rarely used, historical patients continue to require close monitoring	The licensed indications for penicillamime include: ・ Severe, active rheumatoid arthritis, including juvenile forms ・ Wilson's disease (hepatolenticular degeneration) in adults ・ Cystinuria-dissolution and prevention of cystine stones in adults ・ Chronic active hepatitis in adult	
10	**Sulfasalazine**	**Yes:** Sulfasalazine for patients within adult services	The licensed indications for sulfasalazine are: ・ Rheumatoid arthritis (EC tablets only) ・ Ulcerative colitis ・ Active Crohn's disease	Off-label use for other chronic inflammatory disorders including: ・ Seronegative spondyloarthropathies such as psoriatic arthritis ・ Sarcoidosis

Near Patient Monitoring for DMARDs[50]

NO.	Drug	Refer to individual Shared Care Document for detailed information	
		Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist (here for information)	**Ongoing monitoring requirements to be undertaken by primary care**
1	**Azathioprine**	**Baseline investigations:** · Height and weight · Blood pressure · Full blood count (FBC) · Urea and electrolytes (U&Es) & creatinine clearance (CrCl) · Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), and albumin · Baseline thiopurine methyl transferase (TPMT) status · Screening for viral infections as per local policy, e.g. HIV, hepatitis B and C, varicella zoster, Epstein Barr virus, cytomegalovirus · Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case by case basis · Confirm cervical screening is up to date **Initial monitoring and at dose change:** To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly for 3 months: · FBC · U&Es, including creatinine and CrCl · LFTs, including AST and/or ALT, and albumin Following a dose increase repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule. More frequent monitoring is appropriate in patients at higher risk of toxicity.	Monthly for three months, unless already completed in secondary care. Thereafter at least every 12 weeks, and more frequently in patients at higher risk of toxicity, as advised by the specialist team. · FBC · U&Es including creatinine and CrCl · ALT and/or AST, and albumin · Rheumatology patients: CRP &/or ESR **The exact frequency of monitoring to be communicated by the specialist in all cases**
2	**Ciclosporin**	**Baseline investigations:** · Height and weight · Blood pressure (BP) · HbA1c · Full blood count (FBC) · Urea and electrolytes (U&Es) & creatinine clearance (CrCl), ideally on two occasions prior to starting ciclosporin	Monthly: · BP · HbA1c · FBC · U&Es including creatinine and CrCl · ALT and/or AST, albumin, and bilirubin · Rheumatology patients: CRP &/or ESR

[50] **NHS England Shared Care Protocols** www.england.nhs.uk/medicines-2/regional-medicines-optimisation-committees-advice/shared-care-protocols **- Specialist Pharmacy Services, Drug Monitoring Guidance** www.sps.nhs.uk/home/guidance/drug-monitoring

		▪ Serum magnesium ▪ Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), albumin, and bilirubin ▪ Serum lipids and uric acid ▪ Screening for HIV and hepatitis B and C ▪ Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case by case basis ▪ Consider baseline pregnancy testing, if clinically appropriate ▪ Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, shingles, influenza, COVID-19) **Initial monitoring and at dose change:** To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly. After which, the transfer of prescribing to primary care should normally only take place when the patient has received a stable dose for at least 4 weeks and their blood and physical tests results have been satisfactory. It is anticipated that this should be around 12 weeks after initiation of the medicine, but may be sooner in some indications. ▪ BP ▪ HbA1c ▪ FBC ▪ U&Es, including creatinine and CrCl ▪ AST and/or ALT, albumin, and bilirubin ▪ Rheumatology patients: C-reactive protein (CRP) &/or erythrocyte sedimentation rate (ESR) Following a dose change repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule. After one month of treatment: ▪ Serum lipids More frequent monitoring is appropriate in patients at higher risk of toxicity. Monitoring of ciclosporin drug levels, where clinically appropriate, would usually be undertaken by the specialist if indicated. Prescribing and dispensing of ciclosporin should be by brand name to avoid inadvertent switching.	Patients who have been stable for 12 months can be considered for reduced frequency monitoring on a case-by-case basis. Six monthly: ▪ Serum lipids ▪ Uric acid ▪ Serum magnesium **The exact frequency of monitoring to be communicated by the specialist team in all cases**.

		If it is necessary to switch a patient to a different brand, this should be done cautiously under specialist supervision. The patient should be monitored closely for changes in the following: · Serum creatinine · BP	
3	**Hydroxycarbamide**	**Baseline investigations:** · FBC · Urea and electrolytes (U&Es) · LFTs · Screening for viral infections as per local policy, e.g. HIV, hepatitis B and C, varicella zoster, Epstein Barr virus, cytomegalovirus · Screening for lung disease, including interstitial lung disease and tuberculosis, should be undertaken at clinician discretion on a case by case basis · Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, shingles, influenza, COVID-19) **Additional baseline investigations for patients with sickle-cell disease:** · Reticulocyte count **Initial monitoring:** To be repeated every 2 weeks until dose has been optimised and all test results are stable (minimum of 8 weeks). · FBC · U&Es · LFTs · Reticulocyte count (sickle cell disease only)	Every 8-12 weeks · FBC · U&Es · LFTs · Reticulocyte count (for sickle-cell disease patients) **The exact frequency of monitoring to be communicated by the specialist in all cases**.
4	**Hydroxychloroquine**	**Baseline investigations:** · Urea and electrolytes (U&Es) & creatinine clearance (CrCl) · Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), & albumin · Full blood count (FBC) · Weight · Height and blood pressure (if indicated) · Assess for co-morbidities which may influence DMARD choice, including risk factors for retinopathy (e.g. concomitant tamoxifen use, eGFR <60 mL/min) · Electrocardiogram (ECG), if concerns exist regarding the QT-interval, see SCD for details **Ongoing monitoring:**	Remind the specialist when the patient is approaching **5 years of treatment** (or **1 year** in patients with additional risk factors). These patients require referral from the specialist to ophthalmology (or other commissioned service as appropriate) for annual retinopathy monitoring. See RCOphth guidelines. Risk factors may change over time; primary care should discuss with specialist if new risk factors that are 'high risk' are identified before the five-year mark. · Annually after 5 years of treatment, or · After 1 year if additional risk factors are present. Risk factors include: – concomitant tamoxifen use

		· No routine ongoing laboratory monitoring is required for hydroxychloroquine. Monitoring may be required if the patient is prescribed an additional DMARD. · After the patient has been on hydroxychloroquine for five years, refer to ophthalmology (or other commissioned service as appropriate) for annual monitoring for retinopathy. · Patients who are at higher risk of retinal toxicity will need to be referred earlier.	– impaired renal function (eGFR <60mL/min/1.73m^2) – hydroxychloroquine dose (>5mg/kg/day)
5	**Leflunomide**	**Baseline investigations:** · Height and weight · Blood pressure · Full blood count (FBC) · Urea and electrolytes (U&Es) & creatinine clearance (CrCl) · Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), and albumin · Screening for viral infections as per local policy, e.g. HIV, hepatitis B and C, varicella zoster, Epstein Barr virus, cytomegalovirus · Screening for lung disease, including interstitial lung disease, should be undertaken at clinician discretion on a case by case basis. · Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, shingles, influenza, COVID-19) · Pregnancy should be excluded before starting treatment. **Initial monitoring:** To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly for 3 months. · FBC · U&Es, including creatinine and CrCl · AST and/or ALT, and albumin Following a dose change repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule. More frequent monitoring is appropriate in patients at higher risk of toxicity; e.g. concurrent use of more than one DMARD. This is particularly important for patients co-prescribed methotrexate and leflunomide. The combination is highly effective but potentially synergistically toxic to liver and bone marrow, and increase monitoring frequency is strongly advised.	Monthly for the first three months of treatment followed by: at least every 12 weeks, and more frequently in patients at higher risk of toxicity, as advised by the specialist team. · FBC · U&Es including creatinine and CrCl · ALT and/or AST and albumin · BP & weight · Rheumatology patients: CRP &/or ESR **The exact frequency of monitoring to be communicated by the specialist in all cases**.
6	**Mercaptopurine**	**Baseline investigations:** · Height and weight · Blood pressure	Monthly for three months, unless already completed in secondary care. Thereafter at least every 12 weeks, and more frequently in patients at higher risk of toxicity, as advised by the specialist team.

		• Full blood count (FBC) • Urea and electrolytes (U&Es) & creatinine clearance (CrCl) • Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), and albumin • Baseline thiopurine methyl transferase (TPMT) status • Screening for viral infections as per local policy, e.g. HIV, hepatitis B and C, varicella zoster, Epstein Barr virus, cytomegalovirus • Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case by case basis • Confirm cervical screening is up to date **Initial monitoring and at dose change:** To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly for 3 months: • FBC • U&Es, including creatinine and CrCl • LFTs, including AST and/or ALT, and albumin Following a dose increase repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule. More frequent monitoring is appropriate in patients at higher risk of toxicity.	• FBC • U&Es including creatinine and CrCl • ALT and/or AST, and albumin • Rheumatology patients: CRP &/or ESR **The exact frequency of monitoring to be communicated by the specialist in all cases**
7	**Methotrexate**	**Baseline investigations:** • Height and weight • Blood pressure • Full blood count (FBC) • Urea and electrolytes (U&Es) including creatinine and creatinine clearance (CrCl) • Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), and albumin • Screening for HIV and hepatitis B and C • Screening for lung disease, including interstitial lung disease and tuberculosis, should be undertaken at clinician discretion on a case by case basis • Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, shingles, influenza, COVID-19) • Psoriasis patients: serum procollagen 3 N-terminal peptide (PIIINP) **Initial monitoring and at dose change:** To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly for 3 months. After which, the transfer of prescribing to primary care should	At least every 12 weeks, and more frequently in patients at higher risk of toxicity, as advised by the specialist team. • FBC • U&Es including creatinine and CrCl • ALT and/or AST and albumin • Rheumatology patients: CRP &/or ESR; specialist to confirm • Psoriasis patients: serum PIIINP **The exact frequency of monitoring to be communicated by the specialist in all cases**.

		normally only take place when the patient has received a stable dose for at least 4 weeks and their blood and physical tests results have been satisfactory. ・ FBC ・ U&Es, including creatinine and CrCl ・ ALT and/or AST, and albumin ・ Rheumatology patients: CRP &/or ESR ・ Psoriasis patients: serum PIIINP Following a dose change repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule. More frequent monitoring is appropriate in patients at higher risk of toxicity.	
8	**Mycophenolate mofetil and mycophenolic acid**	**Baseline investigations:** ・ Full blood count (FBC) ・ Urea and electrolytes (U&E), including creatinine and creatinine clearance (CrCl) ・ Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), and albumin ・ Height & weight ・ Blood pressure ・ Screening for viral infections as per local policy, e.g. HIV and hepatitis B and C, varicella zoster, Epstein Barr virus, cytomegalovirus ・ Before starting mycophenolate mofetil treatment, people of childbearing potential should have a negative pregnancy test. Two serum or urine pregnancy tests with a sensitivity of at least 25 mIU/mL are recommended. A second test should be done 8-10 days after the first one and immediately before starting mycophenolate mofetil, unless exceptional circumstances exist whereby a delay in the initiation of treatment would cause harm to the patient and the prescriber is satisfied that a single test is adequate to rule out pregnancy. Pregnancy tests should be repeated as clinically required (e.g. after any gap in contraception is reported). See MHRA Drug Safety Update for more detail ・ Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case by case basis ・ Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, shingles, influenza, COVID-19) **Initial monitoring:** To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly for 3 months: ・ FBC	Monthly for three months unless already completed in secondary care, thereafter at least every 12 weeks, and more frequently in patients at higher risk of toxicity, as advised by the specialist team. ・ FBC ・ U&Es including creatinine and CrCl ・ ALT and/or AST and albumin ・ Rheumatology patients: CRP &/or ESR **The exact frequency of monitoring to be communicated by the specialist in all cases**.

		▪ U&Es, including creatinine and CrCl ▪ AST and/or ALT, and albumin **Following a dose increase** repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule.	
9	**Penicillamine**	**Baseline investigations:** ▪ Urea and electrolytes (U&Es) including creatinine and creatinine clearance (CrCl) ▪ Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), & albumin ▪ Full blood count (FBC) ▪ Urinalysis TBC: ▪ Weight ▪ Height and blood pressure ▪ Assess for co-morbidities which may influence DMARD choice ▪ Screening for HIV and hepatitis B and C ▪ Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case by case basis. ▪ Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, influenza, COVID-19) **Initial monitoring and at dose change:** To be repeated every 2 weeks for 6 weeks to 3 monthly: ▪ Creatinine and creatinine clearance (CrCl) ▪ Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), & albumin ▪ Full blood count (FBC) ▪ Urinalysis	Monthly for 12 months, then every 3 months: ▪ Creatinine and creatinine clearance (CrCl) – increase to every 2 weeks if renal impairment ▪ Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), & albumin ▪ Full blood count (FBC) ▪ Urinalysis **The exact frequency of monitoring to be communicated by the specialist in all cases**.
10	**Sulfasalazine**	**Baseline investigations:** ▪ Urea and electrolytes (U&Es) including creatinine and creatinine clearance (CrCl) ▪ Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), & albumin ▪ Full blood Count (FBC) ▪ Weight ▪ Height and blood pressure ▪ Assess for co-morbidities which may influence DMARD choice ▪ Screening for HIV and hepatitis B and C	Monthly ▪ FBC ▪ U&Es including creatinine and CrCl ▪ ALT and/or AST and albumin ▪ Rheumatology patients: CRP &/or ESR After 12 months no routine monitoring is required for the majority of patients. Annual serum creatinine or eGFR may be considered.

		▪ Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case by case basis. ▪ Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, influenza, COVID-19) **Initial monitoring and at dose change:** To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly for three months. ▪ BP ▪ FBC ▪ U&Es, including creatinine and CrCl ▪ AST and/or ALT, albumin, and bilirubin ▪ Rheumatology patients: C-reactive protein (CRP) &/or erythrocyte sedimentation rate (ESR) Following a dose change repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule.	**The decision to discontinue monitoring should be following advice from the specialist for the individual patient.**

Service	Chronic Kidney Disease

1. National context and evidence base

Chronic Kidney Disease (CKD) is defined as a reduction in kidney function or structural damage (or both) present for more than 3 months, with associated cardiovascular and renal health implications. Blood test results that demonstrate CKD are often incidental. CKD has been identified as an easily missed diagnosis. Furthermore, correct coding is commonly not carried out and patients are often unaware of a CKD diagnosis, missing the opportunity for proactive approaches to treatment optimisation. Early CKD detection and management will have a significant positive impact on patient care by reducing the progression to advanced kidney disease and its associated cardiovascular morbidity and mortality.

2. Aims and objectives of service

The service aims to

1. Test and diagnose for CKD and assign appropriate codes
2. Offer CKD management in accordance with NICE consistent NWL CKD guidance
3. Perform an annual CKD review for patients on the CKD register

3. Service Description/Care Pathway

To note this services is for patients with CKD 3a through to 5

1. <u>Test and diagnose for CKD and assign appropriate codes</u>

Identifying patients who likely have CKD but have not yet received a diagnosis and appropriately coded.
The criteria for identifying patients is

- 2*eGFR <60 or
- 2*uACR> 3
- And with no CKD code.

Consider if patient has CKD and diagnosis and assign the appropriate codes. Provider to consider repeating tests if required.

CKD diagnosis:

- CKD3a – eGFR 45-59
- CKD3b – eGFR 30-45
- CKD4 – eGFR 15–29
- CKD5 – eGFR < 15

Patients should be informed of the CKD diagnosis, its consequences and complete an annual review.

If appropriate they should be offered further resources such as being invited to online NWL “Know Your Kidneys” Seminar and linked to associated educational videos

2. <u>CKD Management</u>

This should be in keeping with NWL CKD (NICE consistent) guidance.

3. <u>Annual CKD review</u>

Patients with a with CKD 3, 4 or 5. diagnosis should have an annual CKD review. This should include:

- Test urine albumin: creatinine ratio (uACR)
- Review the need for an ACE-I or ARB as follows
    - CKD and ACR >70
    - CKD with HTN and ACR >30

- CKD with DM and ACR >3
- Check BP and achieve target range
  - 120 to 140/<90 (ACR <70)
  - 110 to 130/<80 (ACR >70)
  - 120 to 150/<90 (>/=80 years)
- Review statin and check compliance.
- Review the need for SGLT2 (CKD and T2DM with uACR>3, CKD without T2DM and uACR>22.6)

There should be an option for all medications in the CKD review to have been considered and not initiated or continued to allow for patient choice and clinical nuance.

4. Any Acceptance and exclusion criteria and thresholds

Acceptance criteria

- Registered with a NW London GP Practice
- Patients with a CKD diagnosis
- Patients who likely have CKD but not yet diagnosed/coded as defined by
  - 2*eGFR <60 or
  - 2*uACR> 3
  - And No CKD code.

5. Training, Skills and Experience

The service provider must ensure that the staff delivering the service meet appropriate training and competency standards.

APPENDIX I - CONTRACTUAL REQUIREMENTS

<table>
<tr><th colspan="3">CKD</th></tr>
<tr><td>Unit Price</td><td colspan="2">A maximum total of £0.75 per weighted patient can be achieved subject to meeting Key Performance indicators as listed below.

The tariff will be split as follows based on PCN performance:
<table>
<tr><th>KPI</th><th>Target Thresholds</th><th>Financial Achievement</th></tr>
<tr><td rowspan="2">Identifying patients with who likely have CKD, diagnose and code appropriately.</td><td><80%</td><td>0%</td></tr>
<tr><td>>80%</td><td>40%</td></tr>
<tr><td rowspan="3">Complete an annual CKD (with those CKD 3a through to 5) review for patients on the CKD register</td><td><60%</td><td>0%</td></tr>
<tr><td>60-70%</td><td>40%</td></tr>
<tr><td>>70%</td><td>60%</td></tr>
</table></td></tr>
<tr><td>Service Type</td><td>Capitation</td><td>Non Pop-up</td></tr>
<tr><td>Referral Criteria</td><td colspan="2">All patients registered within practices in the Primary Care Network.</td></tr>
</table>

TARGET POPULATION		
Ref.	**Description**	**SNOMED Code**
CKD01Da	eGFR	· eGFR using CKD-Epi (Chronic Kidney Disease Epidemiology Collaboration) formula (**857971000000104**) · eGFR using creatinine Chronic Kidney Disease Epidemiology Collaboration equation per 1.73 square metres (**1011481000000105**) · eGFR using cystatin C Chronic Kidney Disease Epidemiology Collaboration equation per 1.73 square metres (**1011491000000107**) · GFR calculated by abbreviated Modification of Diet in Renal Disease Study Group calculation (**1020291000000106**) · GFR calculated by abbreviated Modification of Diet in Renal Disease Study Group calculation adjusted for African American origin (**996231000000108**) · GFR - glomerular filtration rate (**80274001**)
CKD01Db	Urine ACR	· Urine albumin/creatinine ratio (**1023491000000104**) · Urine protein/creatinine ratio (**1028731000000100**) · Urine Microalbumin level (**1010251000000109**) · Urine protein/creatinine index (**1030991000000102**) · Random Urine protein/creatinine ratio (**1006631000000104**)
CKD01Dc	Patients on Chronic Kidney Disease (1-2) register	QOF Cluster CKD (1-2)
CKD01Dd	Patients on Chronic Kidney Disease (3a – 5) register	QOF Cluster CKD (3-5)

TARGET POPULATION RULES

Patients included in Target Population for Chronic Kidney Disease CKD01D

- Patient has latest eGFR (**CKD01Da**) <60 recorded and a previous eGFR < 60 recorded between 3 months and 2 years before **OR**
- Has Urine ACR (**CKD01Db**) > 3 recorded and a previous Urine ACR > 3 recorded between 1 week and 2 years before
- Has **NO** QOF Cluster CKD (1-2) (**CKD01Dc**) or QOF Cluster CKD (3-5) (**CKD01Dd**) before the start of the financial year

Patients included in Target Population for Chronic Kidney Disease CKD02D

- Patient has a SNOMED code QoF Cluster CKD (3-5) (**CKD01Dd**) WITHOUT a more recent Chronic Kidney disease resolved (939211000000104) OR QOF Cluster CKD (1-2) (**CKD01Dc**)

CODING NECESSARY FOR PAYMENT

Ref.	Description	SNOMED Code	Measurement	
CKD01N	% of patients who are likely to have CKD to be diagnosed and coded appropriately	CKD with GFR category G1 & albuminuria category A1 (**949401000000103**) CKD with GFR category G1 & albuminuria category A2 (**949421000000107**) CKD with GFR category G1 & albuminuria category A3 (**949481000000108**) CKD with GFR category G2 & albuminuria category A1 (**949521000000108**) CKD with GFR category G2 & albuminuria category A2 (**949561000000100**) CKD with GFR category G2 & albuminuria category A3 (**949621000000109**) CKD with GFR category G3a & albuminuria category A1 (**949881000000106**) CKD with GFR category G3a & albuminuria category A2 (**949901000000109**) CKD with GFR category G3a & albuminuria category A3 (**949921000000100**) CKD with GFR category G3b & albuminuria category A1 (**950061000000103**) CKD with GFR category G3b & albuminuria category A2 (**950081000000107**) CKD with GFR category G3b & albuminuria category A3 (**950101000000101**) CKD with GFR category G4 & albuminuria category A1 (**950181000000106**) CKD with GFR category G4 & albuminuria category A2 (**950211000000107**) CKD with GFR category G4 & albuminuria category A3 (**950231000000104**) CKD with GFR category G5 & albuminuria category A1 (**950251000000106**) CKD with GFR category G5 & albuminuria category A2 (**950291000000103**)	**Numerator**: Number of patients diagnosed and coded appropriately	**Denominator**: Number of patients who are likely to have CKD

		CKD with GFR category G5 & albuminuria category A3 (**950311000000102**)		
CKD02N	% of patients with CKD (3a-5) with CKD Annual Review recorded	Chronic kidney disease annual review (**249171000000102**)	**Numerator**: Patients with CKD Annual Review recorded	**Denominator**: Patients on CKD Register (3a-5)

CODING NECESSARY FOR PAYMENT

To Achieve Payment for Chronic Kidney Disease CKD01N

- Patient must be in **CKD01D AND**
- Has diagnosis **CKD01N** recorded in the financial year by the provider

To Achieve Payment for Chronic Kidney Disease CKD02N

- Patient must be in **CKD02D AND**
- Has CKD Annual Review **CKD02N** recorded in the financial year by the provider

Service	Hypertension

1. Context and evidence base

Cardiovascular disease (CVD) is the leading cause of death worldwide, with hypertension being the number one risk factor for heart attacks and strokes. Hypertension accounts for an estimated 54% of all strokes and 47% of all ischemic heart disease events globally. Early detection and treatment of hypertension can help people live longer and healthier lives. The NHS Long Term Plan focuses on tackling health inequalities and the prevention of ill health and aims to prevent 150,000 strokes and heart attacks as a result of CVD, over the next ten years. This also aligns with the CORE20PLUS5 approach which is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement - 'Hypertension case-finding and optimal management and lipid optimal management' is one of the 5 key clinical areas of health inequalities requiring accelerated improvement[51].

CVD is strongly associated with health inequalities with the most deprived quintile of the population being four times more likely to die from CVD than the least deprived population. Hypertension is more common in Black and Minority Ethnic (BME) groups. The Black and Black British populations have a higher risk of hypertension and subsequent stroke or renal failure[52]. Black ethnic groups exhibit a disproportionately higher prevalence and severity of hypertension compared to other racial and ethnic groups. According to **The Health of People from Ethnic Minority Groups in England[53]** which examines ethnic differences in health outcomes, *"Black groups have higher-than-average incidence of mortality from hypertension and stroke, and they have strokes at a younger age. The prevalence of hypertension, a risk factor for stroke, is high in Africa and the West Indies."*

Hypertension is a multifactorial condition, influenced by a complex interplay of genetic, environmental, and social determinants. It is pertinent to note that social and genetic factors are contributors to the heightened prevalence of hypertension among individuals of Black and Black British ethnicity. People in lower socioeconomic groups also have a higher risk of hypertension and an increased risk of cardiovascular mortality compared to more affluent groups.

There is an ambition to prevent 25% of heart attacks and strokes in NW London, whilst actively addressing health inequalities by March 2029. This will be achieved by creating a culture of care focusing on the prevention, detection, and treatment optimisation of CVD risk factors, prioritising intervention for those who are adversely affected by health inequalities in this disease area.

Evidence suggests that there are significant numbers of residents across NW London with undiagnosed hypertension. The aim is to:

- Detect 80% of the expected population with hypertension – currently around 48% (based on expected prevalence of 22% vs reported prevalence of 11%)
- Ensure 77% of patients treated to target by March 2024 – currently around 56%, although for those aged 80+, this is much closer to target.[54]

The NW London primary care inequalities metric relates to hypertension management – Aggregate goal: 60% of a PCN's hypertensive patients to have controlled blood pressure; Ethnicity goal: 60% of a PCN's Black/Black British hypertensive patients to have controlled BP.

In NW London, the number of people diagnosed with hypertension is 308,756 (11.1% prevalence) of which 57.2% have controlled blood pressure <140/90. The number of Black and Black British people diagnosed with hypertension is 37,781 (15.8% prevalence) of which 52.0% have controlled blood pressure <140/90 across all ages.[55]

[51] https://www.england.nhs.uk/wp-content/uploads/2021/11/core20plus5-infographic-v3.pdf
[52] NICE, Hypertension in adults: Diagnosis and Management (Link)
[53] Publication by University Department of Medicine, City Hospital, Birmingham UK, Ethnic differences in hypertension and blood pressure control in the UK
[54] Information presented at the NWL Core20Plus5 meeting (8th November 2023)
[55] Data Source: WSIC, 27 September 2023

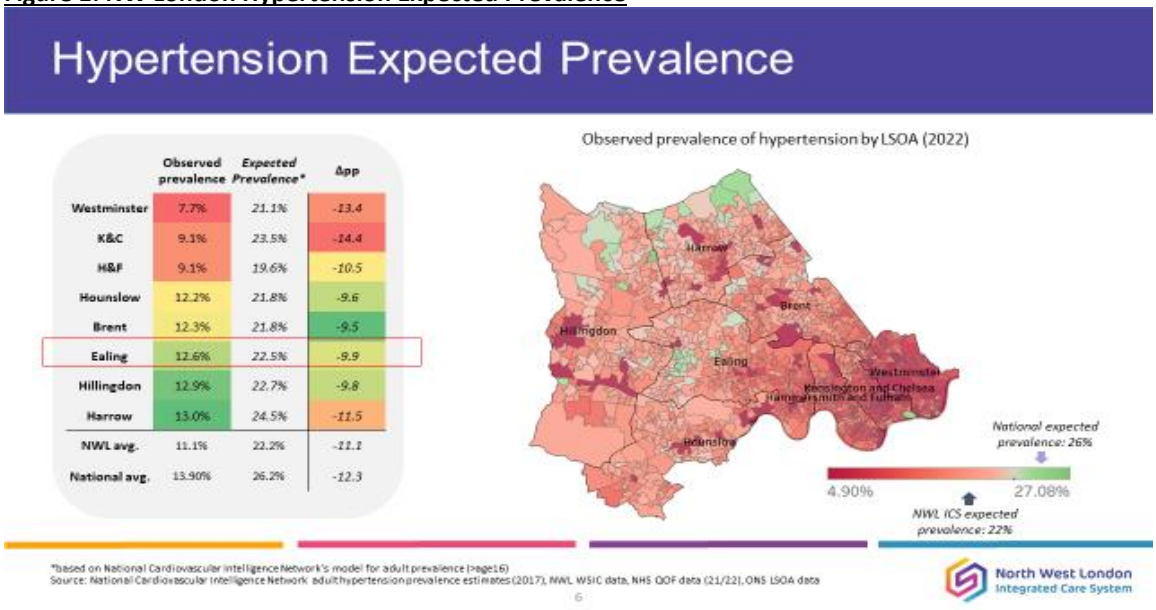
NW London Boroughs have an average prevalence of 11.0%. In 2017, Public Health England estimated the range of hypertension is between 18.8% and 31% of patients. NW London Business Intelligence estimate an expected prevalence of 26.2% for NW London (refer to Figure 1).

Based on this data, hypertension is considerably underdiagnosed and therefore case finding is a priority across the whole population. Of the 308,756 patients currently on the hypertension register 53,449 (17.3%) have not had a BP reading recorded at their practice in last 12 months. Refer to Table 1 for data broken down by borough.

Table 1: NW London Hypertension: Prevalence, Controlled Blood Pressure and No Readings (All) (WSIC September 2023)

Borough	Number of hypertensive patients	Total population	Hypertension prevalence	Number of hypertensive patients with control of BP <140/90	% of hypertensive patients with control of BP <140/90	Number of patients who have no BP reading in last 12 months	Number of patients who have no BP reading in last 12 months %
NWL	**308,756**	**2,814,157**	**11.0%**	**176,469**	**57.2%**	**53,449**	**17%**
Brent	54,245	486,318	11.2%	30,471	56.2%	9,517	18%
Central London	19,938	273,942	7.3%	11,270	56.5%	4,093	21%
Ealing	57,942	456,097	12.7%	33,868	58.5%	9,471	16%
H&F	25,432	343,319	7.4%	14,096	55.4%	5,186	20%
Harrow	39,017	292,952	13.3%	22,579	57.9%	6,321	16%
Hillingdon	43,462	334,574	13.0%	24,473	56.3%	7,357	17%
Hounslow	42,239	343,950	12.3%	24,353	57.7%	7,059	17%
West London	26,481	283,005	9.4%	15,359	58.0%	4,445	17%

Figure 1: NW London Hypertension Expected Prevalence



Across North West London, an average of 74% of Black/Black British patients aged over 45 years were recorded as having had their blood pressure checked within the last five years. By borough, the average ranges from 62% in West London and Central London to 82% in Brent. Refer to Table 2.

Table 2: Number and proportion of blood pressure checks recorded over the last 12 months and last 5 years, Black/Black British patients over the age of 45 years, North West London (WSIC)

Row Labels	Over 45's (Black/Black British)	BP Check Last 12 Months (Black/Black British)	BP Check - Last 5 Yrs (Black/Black British)	% in Last 5 Years (Black/Black British)	Target
NWL	**150,770**	**74,843**	**111,114**	**73.70%**	**90%**
Brent	32,333	18,449	26,569	82.17%	90%
Central London	17,488	7,128	10,863	62.12%	90%
Ealing	22,990	12,433	18,209	79.20%	90%
H&F	15,260	7,668	11,462	75.11%	90%
Harrow	12,859	6,654	9,923	77.17%	90%
Hillingdon	14,987	6,829	10,432	69.61%	90%
Hounslow	13,090	6,897	10,318	78.82%	90%
West London	13,078	5,399	8,054	61.58%	90%
Other	7,482	2,727	4,350	58.14%	90%
Unknown	1,203	659	934	77.64%	90%

Interdependencies

1. **NICE guidelines** cover identifying and treating primary hypertension (high blood pressure) in people aged 18 and over, including people with type 2 diabetes. It aims to reduce the risk of cardiovascular problems such as heart attacks and strokes by helping healthcare professionals to diagnose hypertension accurately and treat it effectively.

2. The **NHS Community Pharmacy Blood Pressure Check Service** supports risk identification and prevention of cardiovascular disease (CVD). This service is eligible for people over the age of 40 who have previously not been diagnosed with hypertension. People identified as likely to have high blood pressure would be referred to general practice, for ongoing care to manage their blood pressure. In addition, General practices can refer patients to a participating community pharmacy for a clinic blood pressure reading or for 24-hour ambulatory blood pressure monitoring.

3. The **Network Contract DES** includes requirements for the delivery of a cardiovascular disease (CVD) prevention and diagnosis service by primary care networks (PCNs). This best practice guidance should help inform and support implementation and delivery of the Network Contract DES requirements.

4. Under the **Quality and Outcomes Framework (QOF) guidance for 2023/24** there are a number of indicators related to hypertension and blood pressure within the GMS contract.

Furthermore, it is vital to foster awareness and education surrounding hypertension within the Black/Black British community. Addressing the unique challenges faced by this cohort in obtaining appropriate healthcare, tailored resources, and culturally sensitive advice can help empower individuals to actively participate in their own blood pressure management.

2. Aims and objectives of service

1. Identifying hypertension in at risk groups:
   - The percentage of Black & Black British patients aged 45 or over who have a record of blood pressure in the

preceding 5 years. **Target: 90%**

2. Improving control of existing patients with Hypertension:
   - Number of patients who have no BP reading in last 12 months. **Target: >10% to >5%**

*the ethnicity cohort identified as *Black and Black British* as defined as below:

Ethnic Category	**Ethnicity Description**
Black or black British	Any other Black background
Mixed	White and Black Caribbean
Black or black British	Caribbean
Black or black British	African
Mixed	White and Black African
Mixed	Any other mixed background

3. Service Description/Care Pathway

Treatment and monitoring hypertension

- Offering lifestyle advice, including advice on diet and exercise, stress management, alcohol consumption, and smoking cessation (if applicable).
- Considering the need for antihypertensive drug treatment, which is initiated in a stepwise approach.
- Considering the need for statin treatment, following cardiovascular risk assessment.
- Monitoring response to lifestyle changes and drug treatment.
- Reviewing the person annually to monitor blood pressure, review medication, provide support, and discuss lifestyle, symptoms, and treatment(s).

4. Any Acceptance and exclusion criteria and thresholds

Acceptance criteria

- Registered with a NW London GP Practice

5. Training, Skills and Experience

The service will be provided by a suitable staff member with the necessary competencies.
There is valuable CVD resources available on UCL – Partners (UCLP). CVD resources - UCLPartners e.g. risk stratification

6. Equipment

- It is the Providers responsibility to purchase all equipment and consumables
- It is the Providers responsibility to clean, calibrate and arrange for servicing of the device in line with the manufacturer's guidance
- It is the Providers responsibility to ensure equipment is cleaned between uses
- It is the Providers responsibility to monitor the life span of the device and to purchase a new device as required.
- It is the Provider's responsibility to replace any lost/ stolen equipment.

APPENDIX I - CONTRACTUAL REQUIREMENTS

<table>
<tr><th colspan="4">Hypertension</th></tr>
<tr><td>Unit Price</td><td colspan="3">A maximum total of £0.23 per weighted patient can be achieved subject to meeting Key Performance indicators as listed below.

The tariff will be split as follows based on PCN performance:

<table>
<tr><th>KPI</th><th>Target Thresholds</th><th>Financial Achievement</th></tr>
<tr><td rowspan="3">The percentage of Black & Black British patients aged 45 or over who have a record of blood pressure in the preceding 5 years.</td><td><80%</td><td>0%</td></tr>
<tr><td>80%-90%</td><td>20%</td></tr>
<tr><td>>90%</td><td>40%</td></tr>
<tr><td rowspan="3">Number of hypertension patients who have no BP reading in last 12 months.</td><td>>20%</td><td>0%</td></tr>
<tr><td>10%-20%</td><td>30%</td></tr>
<tr><td><10%</td><td>60%</td></tr>
</table></td></tr>
<tr><td>Service Type</td><td colspan="2">Capitation</td><td>No Pop-up</td></tr>
<tr><td>Referral Criteria</td><td colspan="3">All patients registered within practices in the Primary Care Network.</td></tr>
</table>

TARGET POPULATION		
Ref.	**Description**	**SNOMED Code**
HYP01D	Number of Black or Black British patients	Most recent code of the following • African - ethnic category 2001 census (**92491000000104**) • African: African, African Scottish or African British - Scotland ethnic category 2011 census (**978231000000100**) • African: any other African - Scotland ethnic category 2011 census (**978251000000107**) • Afro-Caribbean (**413465009**) • Black - ethnic group (**315240009**) • Black - other African country (**185993005**) • Black - other Asian (**185996002**) • Black - other, mixed (**185998001**) • Black African (**18167009**) • Black Arab (**275587000**) • Black British (**185990008**) • Black British - ethnic category 2001 census (**110791000000100**) • Black Caribbean (**185988007**) • Black Caribbean/W.I./Guyana (**270460000**) • Black East African Asian (**275589002**) • Black East African Asian/Indo-Caribbean (**270462008**) • Black Guyana (**309644006**) • Black Indo-Caribbean (**275590006**) • Black Iranian (**275588005**) • Black N African/Arab/Iranian (**270461001**) • Black North African (**275586009**) • Black or African or Caribbean or Black British: African - England and

		Wales ethnic category 2011 census (**976891000000104**) • Black or African or Caribbean or Black British: African - Northern Ireland ethnic category 2011 census (**977791000000109**) • Black or African or Caribbean or Black British: Caribbean - England and Wales ethnic category 2011 census (**976911000000101**) • Black or African or Caribbean or Black British: Caribbean - Northern Ireland ethnic category 2011 census (**977811000000105**) • Black or African or Caribbean or Black British: other Black or African or Caribbean background - England and Wales ethnic category 2011 census (**976931000000109**) • Black or African or Caribbean or Black British: other Black or African or Caribbean background - Northern Ireland ethnic category 2011 census (**977831000000102**) • Black, other, non-mixed origin (**185989004**) • Caribbean - ethnic category 2001 census (**107691000000105**) • Caribbean I./W.I./Guyana (NMO) (**270463003**) • Caribbean Island (NMO) (**275591005**) • Caribbean or Black: any other Black or Caribbean group - Scotland ethnic category 2011 census (**978361000000101**) • Caribbean or Black: Black, Black Scottish or Black British - Scotland ethnic category 2011 census (**978341000000102**) • Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British - Scotland ethnic category 2011 census (**978271000000103**) • Guyana (NMO) (**275593008**) • Mixed Black - ethnic category 2001 census (**92721000000106**) • Nigerian - ethnic category 2001 census (**92731000000108**) • Other African countries (NMO) (**186010002**) • Other Black background - ethnic category 2001 census (**92501000000105**) • Other black ethnic group (**315279003**) • Other Black or Black unspecified - ethnic category 2001 census (**92741000000104**) • Race: West Indian (**160531006**) • Somali - ethnic category 2001 census (**92711000000100**) • West Indian (NMO) (**275592003**) • Mixed: White and Black Caribbean - NI ethnic cat 2011 census (**977391000000108**) • Mixed: White+Black Caribbean - Eng+Wales eth cat 2011 census (**976711000000103**) • White and Black Caribbean - ethnic category 2001 census (**92421000000102**) • Black Caribbean and White (**315634007**) • Mixed: White and Black African - NI ethnic cat 2011 census (**977411000000108**) • Mixed: White+Black African - Eng+Wales eth cat 2011 census (**976731000000106**) • White and Black African - ethnic category 2001 census (**92431000000100**) • Other Black - Black/White orig (**185999009**) • Other ethnic, Black/White orig (**186020007**) • Black African and White (**315635008**) • Race: Afro-caucasian (**413466005**)

		• (**976771000000108**) • Black and Chinese - ethnic category 2001 census (**92591000000103**) • Black and White - ethnic category 2001 census (**110771000000104**) • Other Black - Black/Asian orig (**186000006**)
HYP02D	Number of patients on Hypertension register	QoF Cluster for Hypertension

TARGET POPULATION RULES

Patients included in Target Population for Hypertension HYP01D

- Patient must be Aged 45 and Over **AND**
- Has a SNOMED code of Black or Black British (**HYP01D**)

Patients included in Target Population for Hypertension HYP02D

- Patient has a SNOMED code QoF Hypertension cluster without being resolved

CODING NECESSARY FOR PAYMENT				
Ref.	**Description**	**SNOMED Code**	**Measurement**	
HYP01N	% of Black or Black British patients aged 45 and over with blood pressure reading recorded in last 5 years	Any of: • Systolic arterial pressure (**72313002**) • Average systolic blood pressure (**314440001**) • Average night interval systolic blood pressure (**314445006**) • Average day interval systolic blood pressure (**314446007**) • Average 24 hour systolic blood pressure (**314449000**) • Average home systolic blood pressure (**413606001**) • Ambulatory systolic blood pressure (**198081000000101**) • Self reported systolic blood pressure (**1162737008**) AND • Diastolic arterial pressure (**1091811000000102**) • Average diastolic blood pressure (**314453003**) • Average night interval diastolic blood pressure (**314460009**) • Average day interval diastolic blood pressure (**314461008**) • Average 24 hour diastolic blood pressure (**314462001**) • Average home diastolic blood pressure (**413605002**) • Ambulatory diastolic blood pressure (**198091000000104**) • Self reported diastolic blood pressure (**1162735000**)	**Numerator**: Number of patients with blood pressure reading recorded in last 5 years	**Denominator**: Number of Black or Black British patients aged 45 and over
HYP02N	% of hypertension patients who have no BP reading in last 12 months.	Same blood pressure codes as above	**Numerator**: Number of patients with no blood pressure reading recorded in last 12 months	**Denominator**: Number of hypertension patients

PAYMENT/KPI RULES:

To Achieve Payment for Hypertension HYP01N

- Patient must be in **HYP01D AND**
- Has blood pressure reading (**HYP01N**) recorded in last 5 years by the provider

To Achieve Payment for Hypertension HYP02N

- Patient must be in **HYP02D AND**
- Has NO blood pressure reading (**HYP02N**) recorded in last 12 months by the provider

Service	Atrial Fibrillation (AF)

1. National context and evidence base

Background

Atrial fibrillation (AF) is a heart condition that causes an irregular and often abnormally fast heart rate. In atrial fibrillation, the heart's upper chambers (atria) contract randomly and sometimes so fast that the heart muscle cannot relax properly between contractions. This reduces the heart's efficiency and performance.

Atrial fibrillation is the most common heart rhythm disturbance, affecting around 1.4 million people in the UK. It can affect adults of any age, but it's more common in older people. More men than women have atrial fibrillation. AF increases the risk and severity of stroke, heart failure and other heart-related complications. Some strokes arising from AF are avoidable with appropriate anticoagulation in patients with diagnosed AF. Earlier diagnosis of AF can lead to improved health outcomes.

Sometimes atrial fibrillation does not cause any symptoms and a person who has it is completely unaware that their heart rate is irregular.

The burden of AF is projected to rise very sharply. It has risen 13% in the last two decades[56] and is estimated to at least double in the next 50 years.[57]

Rationale

Active screening significantly increases detection. In a safe trial (*Fitzmaurice DA et al. BMJ 2007; 335: 383*) the detection rate/year of new AF cases was 1.63% (screening practices) vs 1.04% (control practices). The preferred method of screening in primary care is opportunistic pulse taking with follow-up ECG.

West-Hill Health PCN in West London has been piloting proactive opportunistic screening for the over 65s within its cohort practices with the following results:

- AF diagnosis of 2.15% for the over 65s population in 2019 during which 1,988 opportunistic screens were undertaken.
- The previous year, when screening was not taking place, the AF diagnosis rate in West Hill was 0.95%.

2. Aims and objectives of service

- To improve the diagnosis rate of patients with AF
- To improve the quality of care and health outcomes for patients with newly diagnosed AF, particularly looking to reduce instances of stroke where AF is a key cause.

3. Service Description/Care Pathway

3.1 Service requirements

The service is composed of two core elements:

[56] 1. Miyasaka Y et al. *Circulation* 2006;114:119–25.
[57] 2. Go AS et al. JAMA 2001;285:2370–5. Adapted from: Savelieva I et al. Clin Cardiol 2008;31:55–62.

- Screening to improve diagnosis of AF
- Services for patients with existing or newly diagnosed AF

3.2 AF Screening

Practices to undertake AF screening for all patients aged over 55 via hand held devices that are intended to facility mass opportunistic screening for the at risk age group. This is above and beyond manual pulse checking and research has indicated positive results from using such devices. [585960]

This screening can be undertaken in multiple ways, for instance:

- Opportunistically when patients attend practice
- Through planned invites
- In conjunction with other programs e.g. flu clinics for the over 65s.

Practices should take additional steps to identify harder to reach patients (i.e. those who live in care or nursing homes, or who have mental health conditions or learning disabilities) who may be at risk of Atrial Fibrillation by using appropriate case-finding and screening tools.

Any positive or inconclusive results from the opportunistic AF screening via a hand held device must be followed up with a 12 lead ECG screen to confirm diagnosis.

Equipment

AF screening should be undertaken quickly and efficiently using portable scanners that provide instant analysis to a smart phone. In previous pilots in NW London the AliveCor KardiaMobile has been successfully used upon the recommendation of local cardiologists. The KardiaMobile is NICE approved, details can be found at: https://www.alivecor.co.uk/

Other comparable mobile devices are available and can be sourced by PCNs providing they offer portability, quick reliable results and do not store any PID information on devices outside of the practice clinical system.

The recommendation is practices should obtain a minimum of 1 scanner for every 1,500 patient to effectively screen the population.

3.3 Services for patients newly diagnosed AF

The following points should be implemented for patients newly diagnosed with AF where deemed clinically appropriate:

- Provide newly diagnosed patients with rapid information on the choice of anticoagulant and initiate anticoagulant therapy
- Ensure patients newly diagnosed with Atrial Fibrillation who are deemed at risk of stroke are assessed using the CHA2DS2- VASc tool. Patients requiring this assessment should be identified in-line with NICE guidelines;
- Ensure patients newly diagnosed with Atrial Fibrillation who are deemed at risk of bleeding are assessed using the HAS-BLED tool or ORBIT). Patients requiring this assessment should be identified in- line with NICE guidelines (link below);
- Ensure patients diagnosed with Atrial Fibrillation are offered a personalised management plan in-line with NICE guidance (link below); that:
    - Is accessible to the patient and carer(s);
    - Is shared with other members of the patient's wider Multi- Disciplinary Team;
    - Sets out triggers and treatments; and

[58] https://heart.bmj.com/content/106/16/1261

[59] https://www.nice.org.uk/guidance/mtg13/documents/watchbp-home-a-for-diagnosing-and-monitoring-hypertension-and-detecting-atrial-fibrillation-appendix-to-sponsors-submission-de-novo-cost-analysis2

[60] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8119837/

- Provides information as to what to do in the case of exacerbation and crisis personalised to the patient's requirements.

- Ensure that patients' personalised management plans are to be reviewed annually, or following a hospital admission for bleeding or stroke. If changes need to be made to the plan these should be undertaken with the patient and/or carer (via telephone, email or face to face discussion – whichever is the most appropriate);
- Assess anticoagulation control in adults who are on long term vitamin K antagonist therapy to ensure that patients are achieving satisfactory time in treatment range;
- Provide effective support and education to patients in a way that is appropriate to their needs, in order to promote their ability to make informed decisions and manage their condition.
- Ensure patients are referred to specialist management, where clinically required.

3.4 Core service requirements

The following are requirements are essential pre-requisites to providing the services and payment eligibility.

1. All AF screens should be coded using the appropriate template to ensure the required SNOMED codes are used as this will inform payment and record:

    - The number of AF screens undertaken
    - The results of those screens, positive, negative or inconclusive

2. Code all newly diagnosed AF patients at risk of stroke or bleeding

3. 90% of newly diagnosed patients at risk of stroke to be assessed via the CHA2DS2- VASc tool.

4. 90% of patients newly diagnosed with Atrial Fibrillation who are deemed at risk of bleeding to be assessed using the HAS-BLED tool or ORBIT

5. 90% of newly diagnosed patients to be initiated on appropriate anticoagulation therapy within 3 weeks of diagnosis. The longer a patient is not anticoagulated, the higher their stroke risk until they are anticoagulated and therefore newly diagnosed patients should be placed on anticoagulation as soon as possible.

Please note under this specification only point 1 above (AF screens and results) will be monitored.

4. Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- Patients 55 years of age and above.
- Registered at a practice in a NWL Primary Care Network.

Exclusion criteria

- Patients under 55 years of age
- Patients with existing AF Atrial Fibrillation (AF) or Paroxysmal Atrial Fibrillation (PAF) diagnosis

5. Training, Skills and Experience

Any practice staff can undertake AF screening via hand held portable devices providing they are trained in how to use the device by a GP or Nurse, aware of the relevant practice procedures and protocols and responsibility to record and follow up on test results.

Services for patients newly diagnosed with AF must be provided by appropriately trained clinical staff

NICE guidance at:

Overview | Atrial fibrillation: diagnosis and management | Guidance | NICE

Atrial fibrillation | Health topics A to Z | CKS | NICE

6. Equipment

- It is the Providers responsibility to purchase all equipment and consumables
- It is the Providers responsibility to clean, calibrate and arrange for servicing of the device in line with the manufacturer's guidance
- It is the Providers responsibility to ensure equipment is cleaned between uses
- It is the Providers responsibility to monitor the life span of the device and to purchase a new device as required. Again, this cost will be borne by the Provider as a tariff has been set for maintenance/ depreciation etc.
- It is the Provider's responsibility to replace any lost/ stolen equipment.

APPENDIX I - CONTRACTUAL REQUIREMENTS

Atrial Fibrillation (AF)		
Unit Price	**£3.48** per screen and recorded interpretation	
Business Rule	Payment will be capped at a maximum of 2 per patient per year This allows for an element of repeat opportunistic screening.	
Service Type	Episodic	Pop-Up used to Record 'Enhanced services administration (**166221000000105**)
Referral Criteria	Patients aged 55 years and above	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
AF01a	Single lead ECG tests conducted	Electrocardiogram, single lead (**14431003**) **AND** Enhanced services administration (**166221000000105**)
AF01	Single lead ECG Interpretation	Atrial fibrillation detected (**1066831000000104**) **OR** Atrial fibrillation not detected (**1067061000000104**) **OR** Electrocardiogram equivocal (**370359005**)

PAYMENT/KPI RULES

To Achieve Payment for AF ECG Test Completed AF01

- Patient must be aged 55 and over **AND**
- Has no previous diagnosis of Atrial Fibrillation (QOF AFIB) OR Paroxysmal Atrial Fibrillation **(28285002) AND**
- Has SNOMED code of Electrocardiogram, single lead (**14431003**) **AND**
- Has SNOMED code of Enhanced services administration (**166221000000105**) recorded at the same time as the single lead ECG **AND**
- Has SNOMED code of Atrial fibrillation detected (**1066831000000104**) **OR** Atrial fibrillation not detected (**1067061000000104**) **OR** Electrocardiogram equivocal (**370359005**) recorded within 7 days of the single lead ECG

Service	Coil Fitting for Non-Contraception

1. National context and evidence base

The Women's Health Strategy for England was released in August 2022[61] with a number of objectives to improve women's health in response to over 100,000 responses about the services they currently receive. One of the six points of the plan is to Improve access to services – ensuring women can access services that meet their reproductive health needs across their lives, and prioritising services for women's conditions. In the call for evidence, the strategy found that it is important that women and girls are able to access services that meet all their reproductive health needs from adolescence through to menopause. They reported it can be difficult for women to access the women's health services they need in ways that are convenient to them and fragmented commissioning and delivery of sexual and reproductive health services negatively impacts women's access to services, in particular access to contraception. Some written responses highlighted barriers to women accessing contraception for non-contraceptive purposes, for example Long Acting Contraception (LARC) to treat heavy menstrual bleeding (HMB).

The provision of LARC delivered via Intrauterine methods and other methods is procured by borough level Local Authority under Public Health Local Service Agreements. These agreements specifically exclude payment for the fitting of levonorgestrel-releasing Intrauterine devices (LNG-IUDs) where these are used for the primary indications of HMB, hormone replacement therapy (HRT), or other non-contraceptive uses.

The 52mg LNG-IUD is effective for the management of HMB[62] studies vary for the majority of the reduction in menstrual blood loss appears to be achieved in the first 3 months. One well conducted randomised control trial reported reductions in bleeding from baseline of up to 90%.

One 52mg LNG-IUD, Mirena, is also licenced for use for endometrial protection as part of HRT, it can also be used in the management of other gynaecological conditions including polycystic ovary syndrome, the treatment of endometrial hyperplasia and individuals who desire menstrual suppression.
In commissioning this service for non-contraceptive uses, NHS NW London intends to provide improved access to LNG-IUDS, for HMB or as part of a HRT regime, in line with NICE recommendations.

2. Aims and objectives of service

Providing this service to all patients registered with a NW London GP would:
- Help reduce inequality of care across NW London
- Provide convenient primary care locations for all patients
- Offer choice for all patients
- Provide a cost effective alternative to secondary care supporting national and local ICB priorities and ensuring value for money
- Provide access in primary care to LNG-IUDs for non-contraceptive indications for all NW London patients.
- Reduce the number of referrals to secondary care for the insertion / removal of LNG-IUDs for non-contraceptive uses.

This service is intended to fund:
- Fitting and removal of LNG-IUDs for non-contraceptive indications where appropriate
- LNG-IUDS removal of devices not fitted by the practice

Prior to referral into the service patients must have;
- Been assessed as medically suitable for LNG-IUD[63]

[61] Women's Health Strategy for England August 2022 (publishing.service.gov.uk)
[62] Beelen P, van den Brink MJ, Herman MC, et al Levonorgestrel-releasing intrauterine system versus endometrial ablation for heavy menstrual bleeding. *Am J Obstet Gynaecol* 2021;**224**:187 e1-187.e10
[63] UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) - Faculty of Sexual and Reproductive Healthcare (fsrh.org)

- Been counselled as to the reason for the indication of LNG- IUD and effects on bleeding pattern
- Had a sexual history taken prior to insertion and screening offered to individuals at risk of sexually transmitted infections (STIs)

This service is for women with Heavy Menstrual Bleeding and progesterone opposition of HRT and **NOT** for women only requiring contraception

3. Service Description/Care Pathway

For LNG-IUD Fitting the provider will:

- Provide the appropriate LNG-IUD device via a prescription.
- Check patient's suitability for LNG-IUDs for non-contraceptive indications in line with appropriate clinical guidance and best practice.
- Check the patient's understanding of the effects of the LNG-IUD including contraception effect, duration of use, potential bleeding patterns and side effects, considering use of interpreting service as required.
- Provide advice about what they can expect during the procedure of fitting an LNG-IUD and risks including infection, perforation and pain that can be expected. Consider offering Lidocaine 10% spray.
- Assess the patient to reasonably exclude pregnancy (Box 1 Intrauterine Contraception - Faculty of Sexual and Reproductive Healthcare[64])
- Offer the patient a chaperone.
- Asses for risk of STI and offer screening at the time of the procedure. It should be made clear that no form of LARC provides protection against HIV and other sexually transmitted infections. This should include promotion and advice around use of condoms to prevent infection.
- Have an appropriately trained assistant in the room or available on site to provide additional equipment, monitor the condition of the patient and call for help if needed.
- Perform a bimanual examination.
- Provide fitting of LNG-IUDs in line with clinical guidance and best practice (Faculty of Reproductive and Sexual Health).
- Have mechanisms in place for management of a failed fitting of an LNG-IUD.
- Provide advice about after care and who to contact if they have any problems relating to their intrauterine method. Women should be given verbal and written details about the lifespan of the LNG-IUDS, side effects and effectiveness in a format appropriate to their needs.
- With the exception of PPIUC, routine post-insertion check-ups are not required. Patients should be advised to check for their threads within the first 4-6 weeks after insertion and then at regular intervals.

For LNG-IUD Removal the provider will:

- Check the patients understanding of the impact on their indication, eg. Return of HMB, need for an alternative progesterone opposition for HRT.
- Check for pregnancy risk and the potential need for Emergency contraception.
- Identify threads visually or with a retriever.
- Removal LNG-IUD
- Have mechanisms in place for management of a failed removal of an LNG- IUD.

4. Any Acceptance and exclusion criteria and thresholds

This specification relates only to the provision of LNG-IUDs where the primary indication is not for contraceptive purposes. Where the primary indication is contraception, practices should refer to their Local Authority Public Health Local Service Agreement for LARC fitting.

Complex procedures should be referred to complex coil clinic in sexual health services (were commissioned) or secondary care, for example:

• where threads are not visible or retrievable

[64] FSRH Guideline (March 2023) Intrauterine contraception | BMJ Sexual & Reproductive Health

• previous difficult fitting
• unsuccessful fitting in primary care

5. Training, Skills and Experience

It is the practice's responsibility to ensure that all clinicians and staff involved in delivery of this LCS are familiar with the requirements of the service, any relevant guidance and are appropriately trained.

All clinicians undertaking procedures under this service must

- Have an up-to-date Faculty of Sexual and Reproductive Healthcare (FSRH) letter of competence (LoC) in IUD/S insertion and removal and this to be maintained and re-certified in accordance with FSRH regulations every 5 years.
- Hold current FRSH associate membership
- Should fit a minimum of 12 Intrauterine devices per year, this can be across this and other contracts.

Clinicians must be up to date with mandatory training, basic life support and anaphylaxis training in accordance with employer's policy.

6. Equipment

The provider will:

- Be responsible for provision of adequate equipment for fitting and removal of LNG-IUDS including;
- An appropriate room fitted with a couch and with adequate space
- Equipment for resuscitation including oxygen and basic drugs e.g. adrenaline.
- A variety of vaginal specula, cervical dilators, and equipment for cervical anesthesia also need to be available.
- Disposable sterile instruments for IUD fitting.
- Have infection control policies that are compliant with national guidelines including the handling of used instruments, aseptic technique and the disposal of clinical waste.

APPENDIX I - CONTRACTUAL REQUIREMENTS

COIL FITTING FOR NON CONTRACEPTION		
Unit Price	**£112.82** per patient insertion **£32.34** per patient removal	
Business Rule	All recorded activity is payable	
Service Type	Episodic	Pop-Up used to Record 'Enhanced services administration (**166221000000105**)
Referral Criteria	Patients aged 18 years and above are Mandatory under this contract	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
COF00	Non-contraceptive indication	Menorrhagia (**386692008**) **OR** Hormone replacement therapy (**266717002**) **OR** Gynaecological disorder treatment started **(170871005) OR** Pain in female pelvis (**426702003**)
COF01	Insertion or replacement of LNG-IUD	Insertion of hormone releasing intrauterine contraceptive device (**472837007**) **OR** Replacement of intrauterine system (**844911000000104**) **OR** Unsuccessful intrauterine contraceptive device insertion (**416548008**)
COF02	Removal of LNG-IUD	Removal of hormone releasing intrauterine contraceptive device (**472838002**) **OR** Unsuccessful intrauterine contraceptive device removal (**429596008**)

PAYMENT/KPI RULES

To Achieve Payment Insertion or Replacement of LNG-IUD COF01

- Female patient must be aged 18 and over **AND**
- Has history of non-contraceptive indicator **COF00** recorded **AND**
- Has SNOMED code of Insertion of hormone releasing intrauterine contraceptive device (**472837007**) **OR**

Replacement of intrauterine system (**844911000000104**) **OR** Unsuccessful intrauterine contraceptive device insertion (**416548008**) recorded in the payment period by the provider **AND**

- Has SNOMED code of Enhanced services administration (**166221000000105**) recorded at the same time as the Insertion or replacement of LNG-IUD

To Achieve Payment Removal of LNG-IUD COF02

- Female patient must be aged 18 and over **AND**
- Has history of non-contraceptive indicator **COF00** recorded **AND**
- Has SNOMED code of Removal of hormone releasing intrauterine contraceptive device (**472838002**) **OR** Unsuccessful intrauterine contraceptive device removal (**429596008**) recorded in the payment period by the provider **AND**
- Has SNOMED code of Enhanced services administration (**166221000000105**) recorded at the same time as the Removal of LNG-IUD

Service	Asylum Seeker Service for Interim Accommodation Centres Please note that this does not include Overnight Initial Accommodation Centres (OIACs) which operate under a separate contractual arrangement.
Delivery Point	Where possible (where space is appropriate and upon agreement from the commissioner) in an outreach clinic in the hotel. Alternatively, the provider's delivery points should be from its own practice sites where GMS/PMS/APMS services are delivered.

1. Aims and objectives of service

This service has been put in place in recognition of the additional clinical and administrative pressures placed on general practice in the proximity of asylum seeker IAC hotels, given the complex care needs of asylum seekers and the volume of throughput in delivering health services for this patient population.

The aims of the service are:

- To provide an equitable, patient focussed, easily accessible and high quality service
- To reduce in patients attending Accident and Emergency/Urgent Treatment Centre for minor illnesses
- To reduce burden on Primary Care services in GMS delivery
- To improve patient access to community services
- To improve patient choice and experience
- To provide clarity regarding activity to inform on-going commissioning needs
- To provide clear pathways for the management of care for patients from this vulnerable cohort
- To provide promotion of self-care techniques and preventative measures to improve health and wellbeing of Asylum Seekers

The desired outcomes are:

- Reduce the number of SUs attending Accident and Emergency/Urgent Treatment Centre for minor illnesses
- Reduce the burden on Primary Care services in the local area of patient registrations and ongoing care needs
- Reduce Accident and Emergency follow up
- Improve Service User experience
- Provide clarity regarding activity and ongoing health needs of this specific cohort to inform on-going commissioning needs
- Provide an equitable, patient focussed and easily accessible service
- Provide clear pathways for the management of care for patients from this vulnerable cohort
- Provide promotion of self-care techniques and preventative measures to improve health and wellbeing of Asylum Seekers

2. Service Description/Care Pathway

This service replaces all other NWL Primary Care schemes for IACs.

Each Primary Care Network with hotels in their vicinity will receive a list of the hotels in its area which will require care under this LES. It is the responsibility of the Network to allocate lead practice(s) per IAC in their geographical area. The same lead practice does not have to be the same practice for all hotels in one network geography. The provider must offer both same day and routine care to its patients registered from the hotel for which they are the responsible practice. PCNs should discuss their plans with the Commissioner to ensure that there is an equitable care model across each Network. The number of hotels and the number of residents may change over the course of a year. PCNs may also collaborate across networks to cover historical arrangements where agreed with the commissioner. Where existing patients are registered across a range of different practices, these registrations should not change unless initiated by the patient.

Asylum Seekers are eligible to access all core GMS, PCN DES and LES services commissioned by NHS NW London.

Where possible, an outreach model will be operational, where staff will provide these clinics at their designated IAC on a

rota basis and will have a dedicated consultation room on the hotel site.

Where this is not possible within the confines of the hotel premises following discussions with the hotel, specific clinics should be offered at a nearby GP practice premises. This will be made upon agreement between the commissioner and the PCN and as per the process document in Appendix 2 outlines.

The provider will work with the Borough Primary Care Team in NHS North West London Integrated Care Board (NWL ICB) on setting-up the clinics and infrastructure at each of the IACs, including any medical and IT equipment.

Where a hotel has patients registered from multiple practices in the PCN under historical allocation arrangements, the responsible practice(s) in each PCN may choose to enable the asylum seeker clinics to be remotely bookable on the clinical system for the practices within their PCN who have SUs registered at their practice to utilise. This structure would work much like Enhanced Access hubs etc and allow for equitable care for patients regardless of which practice they are registered too. This can be a solution should the patients not choose to register with the Responsible Practice. This access allows the ICB to ensure equity of access and full population coverage of SUs in the IAC hotels.

The Provider will be responsible for providing a team of clinical and non-clinical staff (these roles could be outside of their existing staffing structure if desired). This team must not reduce day to day staffing within General Practice and therefore impact on delivery of core GMS services for the practice.

The Provider will be responsible for providing services to all arrivals into their designated IAC in the Borough. SUs will be registered on the practice's clinical system unit until their stay at the IAC ends. It will be the responsibility of the Provider to ensure that the health needs of the SUs registered on their clinical system are met in timely manner during this time, including referrals for necessary checks and screening, any referrals for secondary/community health care treatment, prescriptions for medication, immunisations and signposting SUs to appropriate health and wellbeing provision e.g. Social Prescribers, IAPT etc.

The Provider will be required to utilise the clinical entry templates in the clinical system to allow clinicians to document the health screening, and hereafter all clinical encounters will be required to be recorded in the patient's record as per all GMS activity, alongside any referrals made to community, mental health and secondary care services but there will be no fixed template for this. The template for screening will be iterative, based on feedback from GP users and to ensure that it is fit for purpose. The template for health screening will be in place in its initial format from the launch of the specification. Feedback from users for the template should come into the Enhanced Services inbox nhsnwl.enhancedservices@nhs.net

The Provider will be responsible for prescribing all medication indicated, including medicines usually obtained over the counter in light of the likely situation of an SU not being able to purchase these in the normal way due to not having recourse to public funds or being able to work. The NWL ICB Medicines Management Team will be advised of this in order that variation in prescribing costs are clearly understood.

1.2 Service Requirement

For all patient registration for SUs residing in the PCN IAC(s) with no GP registration:

The Provider will:

- liaise with IACs to register the SUs as a permanent registered patient on the practice clinical system within 5 working days of arrival at the hotel accommodation.
- Arrange and conduct a face-to-face healthcare assessment within 15 working days of the patient being registered with the practice:
    - This initial assessment is to be conducted by GP or Nurse Practitioner and is to be offered as part of a minimum 30-minute consultation appointment;
    - This assessment is to be offered from the SU's registered IAC premises where possible, or from the GP premises, as agreed with the commissioner;
    - This assessment is to be recorded on the practice clinical system using a suitable template and using prescribed SNOMED codes (Appendix A of service specification);

For all patients residing in the IAC:

- Provide regular outreach sessions on site in the IAC (minimum 1 session per week for hotel sites of 100 beds or more), or where not possible due to space restrictions on sites, in practice with bespoke clinics at the responsible

practice nearby. This is to be agreed with the Borough Team commissioner. The frequency and structure of the clinics must be agreed with the commissioner prior to commencement.

- In respect of hotel IAC sites with less than 100 resident beds the frequency and structure of the clinics (whether at the hotel site or at a local practice) must be agreed with the commissioner prior to commencement. In some cases, this may be less than 1 session per week or may vary dependent on patient numbers/need. However, the requirement for in person health screens within 15 days of arrival still applies.
- Provide all SUs within the designated IAC with access to routine and same day health services should they be required.
- These consultations are to be recorded on the practice clinical system using a suitable template and SNOMED codes if appropriate.
- Complete all necessary referrals to Community, Mental Health and Secondary Care providers.
- If appropriate, complete pre-dispersal documents to support the medical needs of a SU in the dispersal process or move to another IAC hotel.
- Provide remotely bookable clinics for all practices within the PCN to book SUs accommodated in the designated IAC where necessary.

1.3 Service Delivery: Healthcare Assessment and Treatment

The healthcare assessment offered should include the following:

- General physical health;
- Drug and alcohol usage;
- Mental health;
- Medications;
- Discuss future plans for any screening and vaccinations including any mandatory checks;
- Issuing of prescriptions and either dispensing of medication or electronic transfer of prescription to nominated pharmacy;
- Recording of all test results, investigations etc. on a patient's medical record, taking necessary action in relation to any abnormal results as part of the patients care plan;
- Referrals to secondary care and other services as and when necessary;
- Ensure that the specific vulnerabilities of these patient groups including COVID-19, TB, Hepatitis B and C, HIV and substance misuse are recognised and onward referral for the screening is conducted;
- Identifying and addressing any safeguarding issues as appropriate, including FGM and Modern Slavery

The above list is not exhaustive and must be relevant for the patients' needs. It may not be possible to deliver the entire assessment within a single appointment.

1.4 Responsibility

The Provider will:

- Register SUs under their practice by completing GMS1 form and undertake face to face clinics at the IACs on rota basis to provide immediate and necessary and on-going care;
- Ensure that all care and outreach clinics are delivered in line with the provider's Infection Prevention and Control policies, CQC guidelines, and safely manage the disposal of clinical waste;
- Provide outreach clinics on site where possible;
- Ensure that they register people on the principles of:
    - Do not insist on proof of address documents;
    - Do not insist on proof of identification;
    - Never ask to see a visa or proof of immigration status;
- Ensure all registrations are coded accurately including any onward referrals for screening, tests, etc.;
- Participate in Safe Surgeries Approach, which includes training and resources to support primary for this population;
- Providers should adopt a flexible approach where letters are requested for this patient cohort that recognises their unique situation. Practices are not expected to charge patients at IAC sites for letters;
- Share agreed KPI data with Commissioners on a mutually agreed basis;
- Set-up clinics on the clinical system as required at each of the IACs to host face to face clinics (as negotiated with

the Borough Team);

- Ensure clinics are remotely bookable for all practices within the PCN to book SU from the designated IAC if this arrangement is required within the PCN and agreed by practices to share workload within the PCN;
- Work in collaboration with the NWL Health Protection Team and Borough Public Health Teams in the identification, flagging and response to any communicable disease outbreak;
- Ensure appropriate interpretation and translation services through Silent Sounds are provided to SUs as and when required for ease of communication;
- Work with the Local Authority, the VCSE, wider system partners and other stakeholders for any matters requiring wellbeing support for SUs, including escalating safeguarding concerns;
- Ensure that SUs residing in hotels have full access to all Out of Hospital Services commissioned by NHS NW London;
- Work with the ICB as commissioners on service monitoring and improvement to ensure that service requirements are being fully met and appropriate levels of care are being provided to Service Users;
- Ensure that all Service Users (including adults) are offered catch up to the UK Immunisation Schedule;
- Regularly compare patient lists with lists from the Clearsprings ReadyHomes portal in order to ensure accurate list cleansing is taking place. At a minimum this should take place once per quarter.

3. Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- Resident in a Home Office-commissioned Interim Accommodation Centre

Exclusion criteria

- Resident in any other Home Office Hotel e.g. short stay
- Resident in Local Authority dispersal accommodation

4. Training, Skills and Experience

- Ensure that practice staff demonstrate understanding and sensitivity towards asylum seekers
- Ensure relevant practice staff are meeting the required children and adult safeguarding training levels
- Ensure that a patient registration policy, that includes registering asylum seekers, is in place and adhered
- Ensure practice staff and clinicians participate in the appropriate training and education to improve knowledge and understanding of the needs of asylum seekers, refugees and the homeless. Doctors Of The World, a third sector medical charity offer free 1-1.5 hour training sessions for GP practices accessible at: Safe Surgeries Peer-to-peer training - Doctors of the World
- Clinicians should ensure that they are utilising translation services accordingly
- The Responsible Provider should ensure that clinical teams are appropriately trained in order to manage this. As well as standard NHS staff training, the Provider may want to consider that all staff are fully aware of the informaiton in:

Useful Documents	
Doctors of the World Toolkit	https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/04/DOTW-Access-to-healthcare-in-initial-and-contingency-accommodation-report-April-2022.pdf https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/03/Asylum-Seeking-Children-in-IACs-Contingency-Accomodation-Final.pdf https://www.doctorsoftheworld.org.uk/wp-content/uploads/2018/11/DOTW-evidence-from-medical-assessments-in-the-barracks.pdf

	https://www.doctorsoftheworld.org.uk/translated-health-information/
Safer Surgeries	Safe Surgeries Toolkit - Doctors of the World
Migrant health	Migrant Health - Resources and Information
BMA Refugee and Asylum Seeker Patient Health Toolkit	https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit
FGM Pathway	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/542650/FGM_Flowchart.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf
NHS Entitlements: Migrant Health Guide	https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide
Homeless and Inclusion Health standards for commissioners and service providers	Homeless and Inclusion Health standards for commissioners and service providers
CQC- Registration and treatment of asylum seekers, refugees and other migrants	CQC - Registration and treatment of asylum seekers, refugees and other migrants
NHS England leaflet for asylum seekers and refugees	Follow the guidance in the NHS England leaflet for asylum seekers and refugees; How to Register with a Doctor (GP) – Gateway Reference 06277
Advisory Council on the Misuse of Drugs Report 2019	Advisory Council on the Misuse of Drugs Report 2019
Modern Slavery	Modern slavery and human trafficking - National Crime Agency Modern Slavery Helpline
Immunisation Schedule	The complete routine immunisation schedule from February 2022 (publishing.service.gov.uk)

5. Equipment

- Practices should utilise existing equipment in order to deliver services, including laptops
- Where additional equipment is required in order to facilitate outreach clinics, additional equipment may be purchased/ requested in negotiation with the ICB Borough Team, depending on what local stocks are available and what equipment may already be in the system.

APPENDIX I - CONTRACTUAL REQUIREMENTS

Asylum Seekers		
Unit Price	Tariff is £150 per head. Per head will be based on the full financial year average per head occupancy as per Home Office reports	
Service Type	Block payment	Pop-Up used to Record 'Enhanced services administration (**166221000000105**)
Referral Criteria	Resident in NW London IAC hotel	

CODING NECESSARY FOR PAYMENT			
Ref.	**Description**	**SNOMED Code**	
AS01D	Registration of Asylum Seeker	Asylum seeker (**390790000**) & Enhanced services administration (**166221000000105**)	
AS02N	Completion of Health Assessment for all new patients (100% of new patients registered from date of commencement of service)	Height	Standing Height (**248333004**)
		Weight	Body weight (**27113001**)
		BMI	Body mass index (**60621009**)
		Blood pressure	Systolic arterial pressure (**72313002**) **AND** Diastolic arterial pressure (**1091811000000102**)
		Pulse rate or rhythm	• Pulse rate (**78564009**) • Pulse regular (**271636001**) • Pulse irregular (**61086009**) • O/E pulse irregularly irregular (**163000006**) • O/E pulse regularly irregular (**163001005**)
		Smoking status	• Light cigarette smoker (**160603005**) • Moderate cigarette smoker (**160604004**) • Heavy cigarette smoker (**160605003**) • Very heavy cigarette smoker (**160606002**) • Ex-smoker (**8517006**) • Never smoked tobacco (**266919005**) • Smoking cessation education (**225323000**)
AS03N	Medication review done	Medication review done (**314530002**)	
AS04N	100% of the identified eligible patients to be offered an annual **influenza immunization** PCNs will be monitored on their flu	• Administration of first inactivated seasonal influenza vaccination (**985151000000100**) • Administration of first intranasal seasonal influenza vaccine (**884861000000100**) • Administration of second inactivated seasonal influenza	

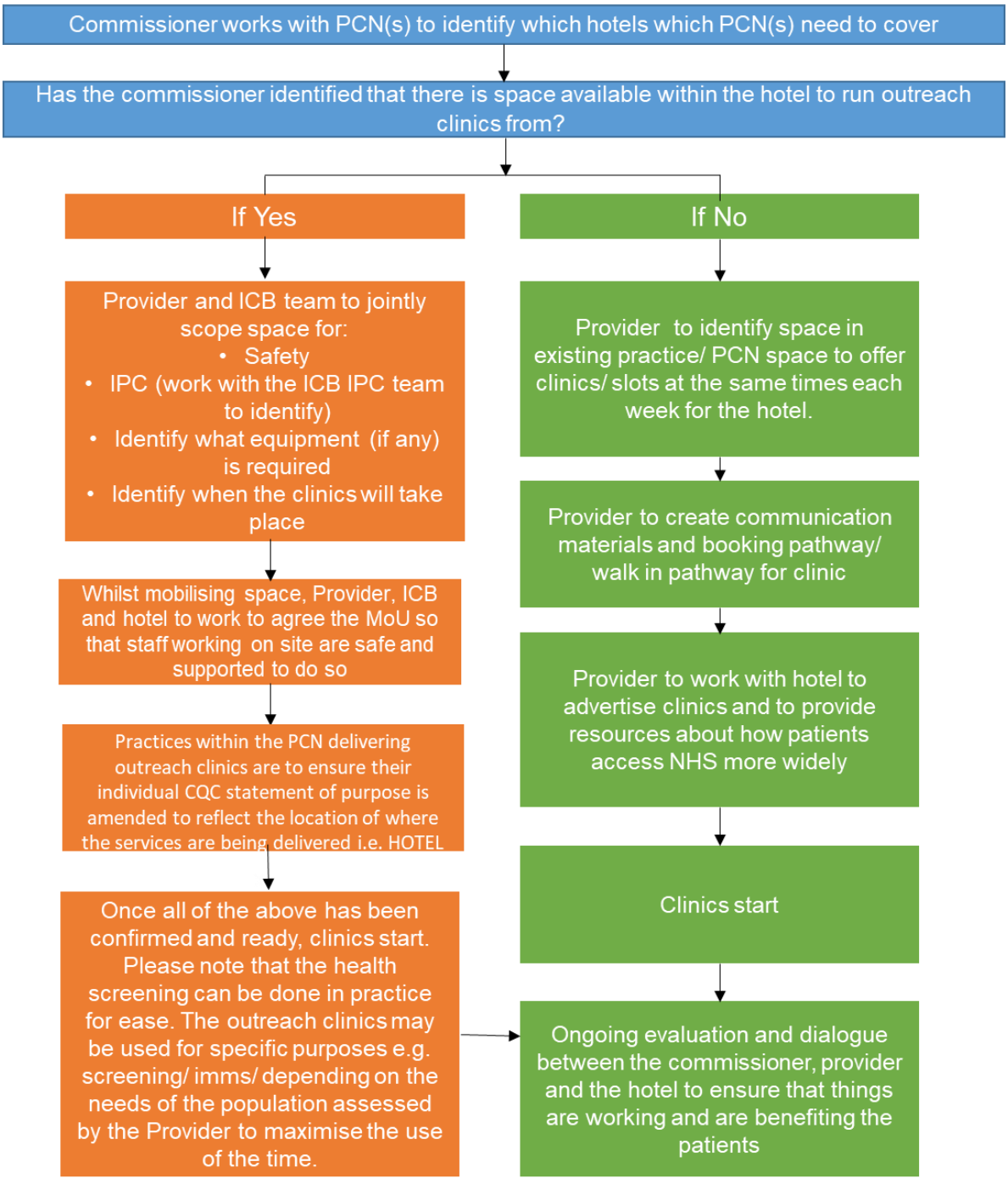
	vaccination uptake for this identified cohort and all PCNs should aim to achieve an uptake rate of at least 20%	vaccination (**985171000000109**) • Administration of second intranasal seasonal influenza vaccine (**884881000000109**) • Seasonal influenza vaccination declined (**822931000000100**) • Seasonal influenza vaccination given by other healthcare provider (**955651000000100**) • Seasonal influenza vaccination given by pharmacist (**955691000000108**) • Seasonal influenza vaccination given while hospital inpatient (**955701000000108**)
AS05N	Safeguarding record	• Adult safeguarding concern (**766561000000109**) • Adult no longer safeguarding concern (**766601000000109**) • Child is cause for safeguarding concern (**836881000000105**) • Child no longer safeguarding concern (**810771000000107**) • No safeguarding concern identified (**1010194003**)
AS06N	Mental Health Assessment	• Mental Health PHQ-9 Score (**720433000**) • Psychological review (**165981000000108**)
AS07N	Care Plan	Care Plan (**734163000**)
	All lead practices for IACs in the PCN to be accredited as a **Safe Surgery** with Doctors of the World (DOTW) or can evidence that they are working towards getting accreditation status by March 2024 (desirable: all practices in the PCN to undertak Surgeries training)	Confirmation by DOTW that the practice is accredited. This information is provided by DOTW to the Borough Primary Care Team. Practice to advertise on their practice website that they are a safe surgery and what this means for them as a patient.

PAYMENT/KPI RULES

- All PCNs must include patients from the target group unless they can demonstrate that they do not have any eligible patients.
- PCNs to provide a declaration to confirm the dedicated clinics in place as per the number of sessions and frequency agreed with borough team
- PCNs can support practices to build relationships with partner organisations through joint MDT meetings.
- Payment mechanism is as per the Enhanced Service Contract. Specific coding will need to be used for assurances. PCNs to review delivery of this service on a quarterly basis utilising Clinical System Search & Report data against the deliverables.
- All lead practices for IACs in the PCN to be accredited as a **Safe Surgery** with Doctors of the World (DOTW) or can evidence that they are working towards getting accreditation status by March 2024
- Each PCN will be allocated with a budget to conduct these health assessments within. Any PCN that exceeds this budget will not be funded further. PCN should monitor activity against the budget to manage internal finances and ensure that the most vulnerable patients are prioritised.

The block payment may be reviewed if the PCN total hotel resident population increases/decreases by more than 15% ie. If a PCN is covering 3 hotels it would be 15% increase/decrease in the total number of people living across those sites or additional hotels open within the PCN's boundary that increases the total population care for. This may be reviewed as part of the PCN's quarterly monitoring meetings or at year end reconciliation.

APPENDIX 2 - Process Map for Mobilisation of Outreach Clinics



Service	Asylum Seeker Service for Overnight Initial Accommodation Centres - OIACs (This service does not include the Initial Accommodation Centres (IACs) which operate under a separate contractual arrangement)
Delivery Point	Where possible (where space is appropriate and upon agreement from the commissioner) in an outreach clinic in the hotel. Alternatively, the provider's delivery points should be from its own practice sites where GMS/PMS/APMS services are delivered.

1. National context and evidence base

OIA's known as Overnight Initial Accommodation Centre's OIACs are used by UKVI for pre-asylum cases. Currently across NW London, there are three OIA's commissioned by the Home Office.

The period of stay is 72hr's, however some SU's have been in OIACs for 4 weeks or more due to the delays within the system caused by high numbers of asylum seekers arriving in to the UK.
The number of service users (SUs) changes frequently, more often than not decreasing rather than increasing of which SUs are relocated at short notice.

The picture changes with instruction from the Home Office with hotels standing up and standing down.

SUs are a vulnerable cohort requiring prompt access to healthcare services to address their acute health needs. In many cases, SUs will not have any documentation relating to their healthcare history, and some may not have had access to healthcare for some time. It is essential, therefore, to provide comprehensive health care including health checks as early as possible in order to detect any immediate healthcare needs and reduce any risk to individuals and the wider community especially in relation to potential communicable diseases. In order to reduce potential risks, providing timely registrations enabling easily accessible clinics for SUs is important. It is also important to ensure that access to Primary Care is provided in a consistent way in order to ensure equality of access to services, regardless of where in the ICS an OIAC is located.

It is also worth noting that whilst SUs may face many of the same health problems as the UK population, they may additionally:

- Have poor awareness of the NHS and fear barriers to accessing treatment;
- Come from countries of origin with poor/different healthcare;
- Suffer health impacts (mental and physical) after leaving their country and arriving in the UK;
- Do not have access to any public funds and are therefore not able to purchase medication over the counter;
- Have experienced war, conflict, or torture;
- Be separated from family;
- Have poor housing and be socially isolated.

As part of a pilot in 2022, a lead GP practice with a Primary Care Network (PCN) provided service provision and registration to this cohort based on the catchment area of the OIACs.

Local practices which covered the geographical location of the OIAC's were provided with a set monthly administration fee. The funding was used to deliver immediate necessary treatment to this cohort and was underpinned by a MOU between the lead GP practice and North West London ICB (NWL ICB). This has been deemed costly due to the rapid fluctuation in SU's being relocated when compared with the number of arrivals arriving. This scheme is designed to replace the previous arrangements.

2. Aims and objectives of service

This service has been put into place in recognition of the additional clinical and administrative pressures placed on general practice in the proximity of asylum seeker OIAC hotels, given the complex care needs of asylum seekers and the volume of throughput in delivering health services for this patient population.

The aims of the service are:

- To provide an equitable, patient focussed, easily accessible and high-quality service
- To provide immediate necessary service
- Reduce in patients attending Accident and Emergency/Urgent Treatment Centre for minor illnesses
- To reduce burden on Primary Care services in GMS delivery
- To improve patient access
- To provide clarity regarding activity to inform on-going commissioning needs
- To provide clear pathways for the management of care for patients from this vulnerable cohort
- To provide promotion of self-care techniques and preventative measures to improve health and wellbeing of Asylum Seekers

The desired outcomes are:

- Reduce the number of SUs attending Accident and Emergency/Urgent Treatment Centre for minor illnesses
- Reduce the burden on Primary Care services in the local area of patient registrations and ongoing care needs
- Reduce Accident and Emergency follow up's
- Improve Service User experience
- Provide clarity regarding activity and ongoing health needs of this specific cohort to inform on-going commissioning needs
- Provide an equitable, patient focussed and easily accessible service
- Provide clear pathways for the management of care for patients from this vulnerable cohort
- Provide promotion of self-care techniques and preventative measures to improve health and wellbeing

3. Service Description/Care Pathway

This service replaces all other NWL Primary Care ICB schemes for OIACs. Each Primary Care Network with hotels in their vicinity will receive a list of the OIAC hotels in its area which will require care under this LES. It is the responsibility of the Primary Care Network to allocate a lead practice(s) per OIAC within its geographical area. The same lead practice does not have to be the same practice for all OIA hotels within the primary care network geography.
The provider must offer same day acute care to its patients registered from the OIA for which they are the responsible practice.

PCNs should discuss their plans with the Commissioner to ensure there an equitable care model across each Primary Care Network. The number of hotels and the number of residents may change over the course of the year. PCNs may also collaborate across networks to cover arrangements where it is agreed with the commissioner. Where existing patients are registered across a range of different practices, these registrations should not change unless initiated by the patient.

Asylum Seekers are eligible to access immediate necessary treatment as part of acute care. Where possible, an outreach model will be operational where staff can provide these clinics at the designated OIAC on a rota basis and will have a dedicated consultation room on the hotel site. Where this is not possible within the confines of the hotel premises following discussions with the hotel, specific clinics should be offered at the GP practice premises. This will be made upon agreement between the commissioner and the PCN and as per the process document in appendix 1.

The provider will work with the Borough Primary Care Team in NHS North West London Integrated Care Board (NWL ICB) on

setting-up the clinics and infrastructure at each of the OIACs, including any medical and IT equipment.

The PCN may choose to enable the asylum seeker clinics to be remotely bookable on the clinical system for the practice within their PCN who have SUs registered at their practice to utilise. This structure would work much like Enhanced Access hubs etc and allow for equitable care for patients regardless of which practice they are registered too. This can be a solution should the patients not choose to register with the Responsible Practice. This access allows the ICB to ensure equity of access and full population coverage of SUs in the OIAC hotels.

Where a hotel has patients registered from multiple practices in the PCN under historical allocation arrangements, the responsible practice(s) in each PCN may choose to enable the asylum seeker clinics to be remotely bookable on the clinical system for the practices within their PCN who have SUs registered at their practice to utilise. This structure would work much like Enhanced Access hubs etc and allow for equitable care for patients regardless of which practice they are registered too. This can be a solution should the patients not choose to register with the Responsible Practice. This access allows the ICB to ensure equity of access and full population coverage of SUs in the OIAC hotels.

The Provider will be responsible for providing a team of clinical and non-clinical staff (these roles could be outside of their existing staffing structure if desired). This team must not reduce day to day staffing within General Practice and therefore impact on delivery of core GMS services for the practice.

The Provider will be responsible for providing services to those arrivals in the designated OIA's that require immediate care. SUs will be registered as a temporary patient on the practice's clinical system. It will be the responsibility of the Provider to ensure that the health needs of the SUs registered on their clinical system are met in timely manner during this time, including referrals for necessary checks, any referrals for secondary and community health care treatment, prescriptions for medication and signposting to appropriate health and wellbeing provision e.g. Mental Health support out of hours.

The Provider will be responsible to utilise the clinical entry template in the clinical system to allow clinicians to document referrals made to community and secondary care.

The provider will be responsible for prescribing all medication indicated, including medicines usually obtained over the counter in light of the likely situation of an SU not being able to purchase these in the normal way due to not having recourse to public funds or being able to work. The NWL ICB Medicines Management Team will be advised of this in order that variation in prescribing costs are clearly understood.

3.1 Service Requirement

For all patient registration for SUs residing in the PCN OIAC(s) with no GP registration:

The Provider will:

- Liaise with OIACs to register those SUs that require immediate necessary treatment on the practice clinical system within 24hrs of arrival at the hotel accommodation.

For all patients residing in the OIAC:

- Provide regular outreach clinic sessions on site in the OIAC (minimum 1 session per week for hotel sites of 100 residents), or where not possible due to space restrictions on sites, in practice with bespoke clinics at the responsible practice. This is to be agreed with the Borough Team commissioner. The frequency and structure of the clinics must be agreed with the commissioner prior to commencement.
- A clinic session is: 4 hrs GP time; 30 mnts nurse time - 30 minute GP apps per patient.
- Provide all SUs within the designated OIAC access same day health services should they be required.
    - Clinics will be recorded on the practice clinical system using a suitable template and SNOMED codes if appropriate
- Complete all necessary referrals to Community Mental Health and Secondary Care Providers.
- Provide remote bookable clinics for all practices within the PCN to boo SU's accommodated in the designated OIAC where necessary.

3.2 Responsibility

The Provider will:

- Register SUs under their practice as a temporary patient and undertake face to face clinics at the OIACs on rota basis to provide immediate necessary treatment
- Ensure that all care and outreach clinics are delivered in line with the provider's Infection Prevention and Control policies, CQC guidelines, and safely manage the disposal of clinical waste
- Ensure acute health needs of the SUs are met in timely manner during this time, including onward referrals were appropriate, A&E letters and prescriptions for medication
- Provide outreach clinics on site where possible
- Ensure that they register on the principles of:
    - Do not insist on proof of address documents
    - Do not insist on proof of identification
    - Never ask to see a visa or proof of immigration status
- Ensure registrations and clinics and any onward referrals are coded accurately on the practice's clinical system unit
- Participate in Safe Surgeries Approach, which includes training and resources to support primary for this population
- Share agreed KPI data with Commissioners on a mutually agreed basis
- Set-up clinics on the clinical system as required at each of the OIACs to host face to face clinics (as negotiated with the Borough Team)
- Ensure clinics are remotely bookable for all practices within the PCN to book SU from the designated OIAC if this arrangement is required within the PCN and agreed by practices to share workload within the PCN
- Work in collaboration with the NWL Health Protection Team and Borough Public Health Teams in the identification, flagging and response to any communicable disease outbreak's
- Ensure appropriate interpretation and translation services through Silent Sounds are provided to SUs as and when required for ease of communication
- Highlight interpretation and translation service issues to the Borough Team
- Work with the London Borough of Hillingdon, Hillingdon Public Health Team, Health visitors, Mental Health service and other relevant stakeholders for any matters requiring wellbeing support for SUs, including escalating safeguarding concerns
- Work with the ICB as commissioners on service monitoring and improvement to ensure that service requirements are being fully met and appropriate levels of care are being provided to Service Users
- Develop and build a working relationship with the hotel management staff
- Ensure the hotel management is made aware what services SUs residing in the hotels can access out of hours i.e. 111, Mental Health crisis team etc
- Work with the ICB as commissioners on service monitoring and improvement to ensure that service requirements are being fully met and appropriate levels of care are being provided to Service Users
- Be responsible for prescribing all medication, including medicines usually obtained over the counter in light of the likely situation of an SU not being able to purchase these in the normal way due to not having recourse to public funds or being able to work
- Regularly compare patient lists with lists from the Clearsprings Readyhomes portal in order to ensure accurate list cleansing is taking place. At a minimum this should take place once a month

4. Acceptance and exclusion criteria and thresholds

Acceptance criteria

Resident in a Home Office-commissioned Overnight Interim Accommodation Centre

Exclusion criteria

- Resident in any other Home Office Hotel e.g. Interim Accommodation Centre (IAC)
- Resident in Local Authority dispersal accommodation

5. Training, Skills and Experience

- Ensure that practice staff along with the PCN ARR's staff demonstrate understanding and sensitivity towards asylum seekers;
- Ensure relevant practice staff are meeting the required children and adult safeguarding training levels;
- Ensure that a patient registration policy, that includes registering asylum seekers temporarily is in place and adhered to;
- Ensure there is a business continuity plan in place whereby there is off site provision and that it is robust

Note: Clinicians should ensure that they are utilisng translation services accordingly.

6. Equipment

- Practices should utilise existing equipment in order to deliver services, including laptops
- Where additional equipment is required in order to facilitate outreach clinics, additional equipment may be purchased/ requested in negotiation with the ICB Borough Team, depending on what local stocks are available and what equipment may already be within the system.

7. Funding

- £442 per clinic (based NWL tariff of 4 hrs GP time; 30 minutes' nurse time and 15 minute's admin time)
- Number of weekly clinic sessions to be agreed with Borough team prior to implementation

Caveat
When Ready Homes and/or the Home Office notify the borough team of changes to the length of stay e.g. service users staying prolonged periods of time the number and frequency of clinics will
be reviewed.

APPENDIX I - CONTRACTUAL REQUIREMENTS

Asylum Seekers		
Unit Price	£442 per clinic (clinic session is 4 hrs GP time; 30 minutes' nurse time) No of clinic's to be agreed by the commissioner	
Contract Type	Block payment	
Referral Criteria	Residents residing within a NW London OIAC hotel	

PAYMENT/KPI RULES
• Formal coding is not required to recognise the service is a reactive model to needs. The Provider can use IACs asylum Seeker Template if deemed beneficial • PCNs to provide a declaration to confirm the dedicated clinics in place as per the number of sessions and frequency agreed with borough team. As part of the declaration, PCNs are required to confirm number of patients treated quarterly • PCN will be allocated with a budget to conduct clinics.

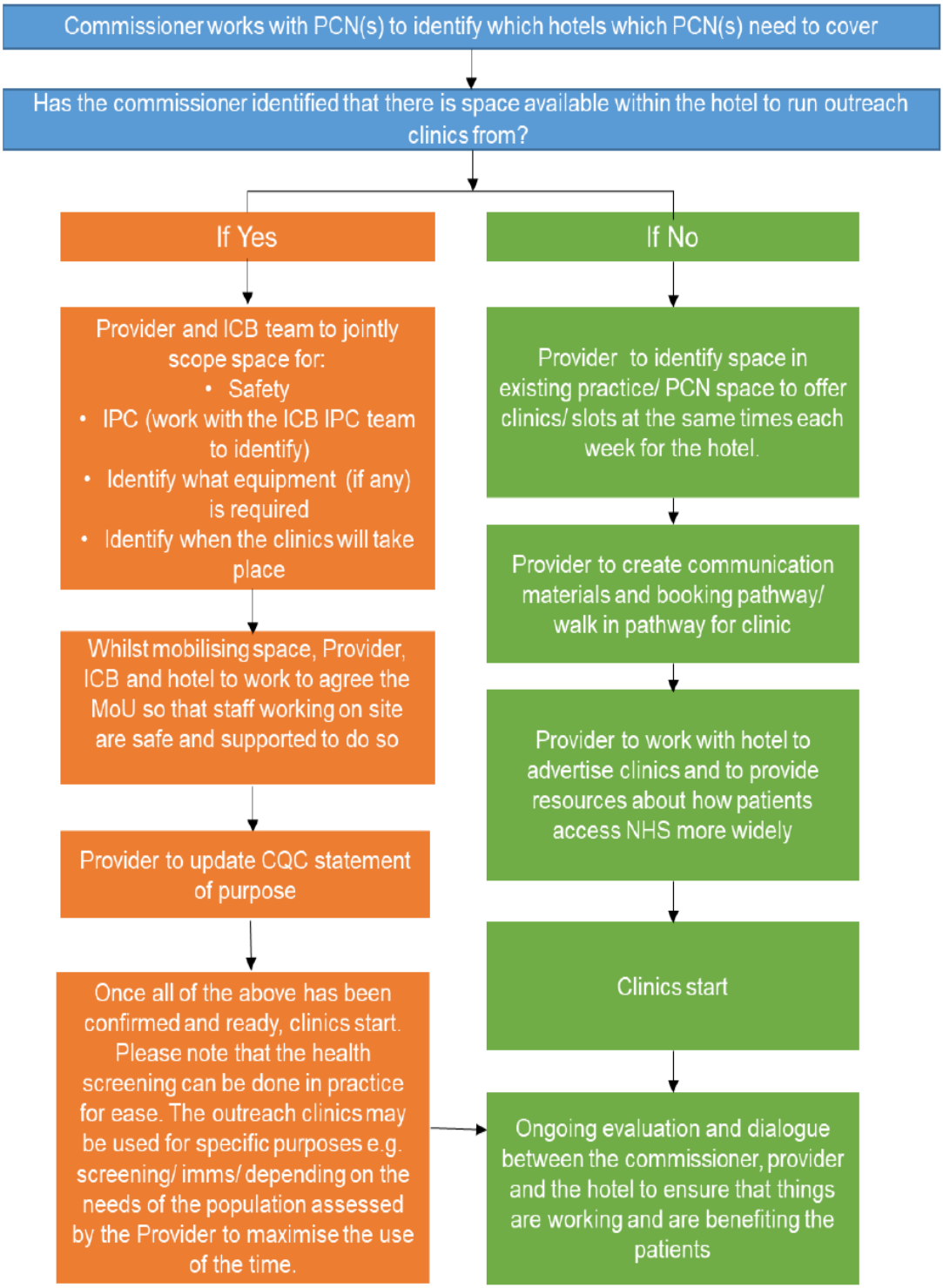
Useful Documents	
Doctors of the World Toolkit	https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/04/DOTW-Access-to-healthcare-in-initial-and-contingency-accommodation-report-April-2022.pdf https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/03/Asylum-Seeking-Children-in-IACs-Contingency-Accomodation-Final.pdf https://www.doctorsoftheworld.org.uk/wp-content/uploads/2018/11/DOTW-evidence-from-medical-assessments-in-the-barracks.pdf https://www.doctorsoftheworld.org.uk/translated-health-information/
Safer Surgeries	Safe Surgeries Toolkit - Doctors of the World
Migrant health	Migrant Health - Resources and Information
BMA Refugee and Asylum Seeker Patient Health Toolkit	https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit
NHS Entitlements: Migrant Health Guide	https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide
Advisory Council on the Misuse of Drugs Report 2019	Advisory Council on the Misuse of Drugs Report 2019

Useful Documents	
FGM Pathway	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/542650/FGM_Flowchart.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf
Homeless and Inclusion Health standards for commissioners and service providers	Homeless and Inclusion Health standards for commissioners and service providers

CQC- Registration and treatment of asylum seekers, refugees and other migrants	CQC - Registration and treatment of asylum seekers, refugees and other migrants
NHS England leaflet for asylum seekers and refugees	Follow the guidance in the NHS England leaflet for asylum seekers and refugees; How to Register with a Doctor (GP) – Gateway Reference 06277
Modern Slavery	Modern slavery and human trafficking - National Crime Agency Modern Slavery Helpline
Immunisation Schedule	The complete routine immunisation schedule from February 2022 (publishing.service.gov.uk)

Note: Refugees, asylum seekers, refused asylum seekers, and undocumented migrants, can apply to the NHS low income scheme for help with medical costs, including prescription charges, dental treatment, and sight tests. Individuals must fill in an HC1 form and will receive an HC2 certificate if eligible.

APPENDIX 1 - Process Map for Mobilisation of Outreach Clinics



Service	Safeguarding Adults and Children

1. National context and evidence base

This service is designed to provide support to GP practices to enable them to fulfil their professional obligation to assist with safeguarding investigations for both adults and children and provide reports for safeguarding conferences.

Local Authorities have overarching responsibility for the safeguarding of all children, and adults with care and support needs in their area. They have a number of statutory functions under the 1989 and 2004 Children Act, and the Care Act 2014 which include specific duties in relation to children in need and children and adults with care and support needs suffering, or likely to suffer, significant harm.

Whilst Local Authorities play a lead role, safeguarding all children, and adults with care and support needs and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play. Within the Children Act 1989 and 2004, and the Care Act 2014, the statutory duty is described for all relevant agencies who are required to co-operate with local authorities to promote the well-being of children, and adults with care and support needs in each local authority area. This service seeks to strengthen the co-operation that exist between Partner organisations.

In addition to national context, there is a London Multi-Agency Safeguarding Data Sharing Agreement for Safeguarding and Promoting the Welfare of Children and set of procedures[65]
Professionals working within agencies with these duties are responsible for ensuring that they fulfil their role and responsibilities in a manner consistent with their statutory duties. The agencies include all GP surgeries and Out of Hours providers, and the professionals include all GPs and the wider professional workforce.

No part of this ES specification by commission, omission or implication defines or redefines essential or additional services.

This specification aims to provide financial recompense for the time required to support Child Protection Case Conference and for an Adult Safeguarding Enquiries. Practices and PCNs will be encouraged to develop their safeguarding infrastructure and processes to enable the delivery of suitable high-quality reports for consideration at Child Protection Case Conference and for an Adult Safeguarding Enquiry. This Enhanced Service reflects the additional work that the Practice will need to undertake to support the case reviews.

2. Aims and objectives of service

This service aims to support the ongoing development and maintenance of more robust arrangements in General Practice to Safeguard Children in line with Working Together to Safeguard Children and GMC Good Practice guideline, and in a manner consistent with Good Practice in Adult Safeguarding as referenced in the Royal College of General Physicians Adult Safeguarding Toolkit (2017), including:

- Raising awareness of statutory and legal requirements of Child and Adult Safeguarding legislations
- Supporting PCNs and practices to meet the standards set out in the Specification.
- Provide level of assurance in respect of arrangements for safeguarding children, young people and children looked after, and adults with care and support needs in primary care general practice.
- Supporting practices to provide high quality reports to Local Authority partners for information related to safeguarding issues linked to patients registered with the Practice.

3. Service Description/Care Pathway

If a request for information is made by the Local Authority to a GP Practice to assist with a Child Protection Enquiry (s47) or

[65] https://www.londonsafeguardingchildrenprocedures.co.uk/index.html

provide a Child Protection Case Conference report or an Adult Protection Enquiry (s42) or provide a report for Conference, it is a statutory duty to share this information; this Enhanced Service is designed to support the Practice achieve this requirement.

All requests for Safeguarding information for both adults and children, including Case Conference reports must be recorded, even if no information is shared by the Practice. An explanation of why no information was shared should be recorded.

Pre-requisites to sign-up

The pre-requisites for this enhanced service are set out below, practices will be requested to confirm the requisites below are in place prior to sign up:

- Practice has an identified Named lead and Deputy safeguarding lead for adults and children. (The Child and Adult Safeguarding Leads and any deputy Leads should be GPs or other clinicians trained to level 3, as per 'Safeguarding children and young people: roles and competences for health care staff – Intercollegiate document'.
- Practices to keep a register of all patients who are on a Child Protection Plan, Child in Need Plan (where notified) or are Looked After Children, or on an Adult Safeguarding Plan or if the surgery is aware that they are experiencing domestic abuse. Practices should keep this register updated at all times, including the outcome of any Practice/multiagency/professional meetings and the date for the next meeting.[66]
- Complete audits requests (e.g. biennial section 11 audit (as and when requested by NHS North West London through an approved reporting audit)

Child Protection Conference

- A claim can be made for each case conference where
    - Child Protection Report is submitted within the requested timeframe
    - Attended the case conference if requested by the Chair
    - A minimum data set (template to be available on SystmOne and EMIS) to be completed for each case for the purpose of quality assurance, timeliness and payment.
    - There can only be one claim made for each case conference.

- A "Case Conference Report" to be completed in accordance with the following guidance:
    - The wording on the report must be in a legible form that can be understood by non-medical professionals and the parents.
    - Include information about any medical problems (including mental health concerns, alcohol/drug misuse and reported domestic abuse) or other information that is relevant for safeguarding for each parent of a child named in the conference and each adult in the household of children named at the conference who is registered at the surgery. Do not put the children's medical information on this form.
    - Please include an explanation of why these problems are relevant for safeguarding.
    - Information from the parents or adults in the household's records that is not relevant for safeguarding should not be sent as per the Data Protection Act (Principle 3).
    - The parents / adults should be informed that their medical information will be shared with the case conference, even if they do not agree or consent, as per the "Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers". If appropriate and safe, parents / adults should be given opportunity to view what information will be shared. This is reinforced by the London agreed safeguarding procedure for information sharing[67]
    - Any other information relevant to the case review.

Adult Safeguarding Enquiry

[66] NWL is not descriptive on how practices meet the pre-requisites, not to disadvantages any particular local configurations. Some guidance is available via RCGP e.g. https://elearning.rcgp.org.uk/pluginfile.php/170659/mod_book/chapter/376/RCGP-Safeguarding-Coding-Information-June-2017.pdf

[67] http://londonsafeguardingchildrenprocedures.co.uk/info_sharing.html

- A claim can be made for each adult safeguarding enquiry where
    - Adult Safeguarding Report is submitted within the requested timeframe
    - A minimum data set (template to be available on SystmOne and EMIS) must be completed for each case for the purpose of quality assurance, timeliness and payment.
- The wording on the report to be in a form that may be understood by non-medical professionals and the patient.
- The patient should be contacted where they have capacity and an offer made via letter or phone call for them to review the Report in advance of it being sent to the Adult Safeguarding Team, unless this would be felt to increase the risk to the adult or affect any possible criminal investigations.
- Provide any other information which may assist Partner organisation with the case review

Interdependence with other services/providers

- It is best Practice for the GP who has written the report to liaise with the chair and/or the allocated social care worker of the case conference or adult safeguarding enquiry to discuss the report in advance of the conference, unless they will be attending the conference, however this will not form part of the payment and may not always be possible.

It is the PCN responsibility is to submit a claim form on behalf of practices declaring number of reports completed. **Audit**

- Practices to confirm the pre-requisites requirements have been met
- Learning from case reviews to be shared with GP practices to aid training and development
- In the event where reports are not to the expected standard or meet timelines for submission, payment may be withheld for the identified reports.

4. Any Acceptance and exclusion criteria and thresholds

Acceptance criteria:

- Any request for a child protection case report by a Local Authority including follow-up clarification requests.
- Any request for an Adult Safeguarding report from the Local Authority Adult Safeguarding Team, including follow-up clarifications requests

Exclusion:

- If a duplicate request is made (same member from same family) within a reasonable timeframe (1/month 6 weeks), the Local Authority should be referred to the information they already have. Records should be reviewed and any relevant additional safeguarding information shared if applicable.

5. Training, Skills and Experience

Each Practice should have a nominated Child Safeguarding Lead and Adult Safeguarding Lead with deputy Leads as appropriate to promote this work, as referenced in 'Working Together to Safeguard Children 2018', RCGP Adult Safeguarding Toolkit and RCGP Child Safeguarding Toolkit.

The Child and Adult Safeguarding Leads and any deputy Leads should be GPs or other clinicians trained to level 3, as per 'Safeguarding children and young people: roles and competences for health care staff – Intercollegiate document. 3rd Edition and RCGP Adult Safeguarding Toolkit.

APPENDIX I - CONTRACTUAL REQUIREMENTS

SAFEGUARDING		
Unit Price	**Activity** A payment of £49.35 per "Child Protection Case Conference Report" or "Adult Safeguarding Report" as requested by the Local Authority with the MDS template completed. Please note that only one claim can be made for a child protection case conference report, regardless of the number of siblings included in the report.	
Service Type	Episodic	No Pop-Up
Referral Criteria	• Acceptance: Any request for a Child Protection Case Conference report by a Local Authority, Acceptance: Any request for an Adult Safeguarding report from the Local Authority Adult Safeguarding Team	

CODING NECESSARY FOR PAYMENT		
Ref.	**Description**	**SNOMED Code**
SG01	Safeguarding report	Safeguarding Report **(909021000000108)**

PAYMENT/KPI RULES
To Achieve Payment for Safeguarding Reporting • Has SNOMED code of Safeguarding Report **(909021000000108)** • PCN will be required to submit claim form, this is because the ICB is not able to distinguish, through the clinical system reporting, whether the template was completed for an individual child or for siblings.

Service	Respiratory

1. National context and evidence base

Respiratory disease is the third biggest killer in the UK. It affects one in 5 people, from children to older people, and places demands on primary, secondary, community and specialised care, particularly during winter. Respiratory disease also creates most disruption to the lives and wellbeing of people in the most deprived areas, with the avoidable mortality rate for respiratory disease being 6.5 times higher for men and 8.4 times higher for women in the most deprived parts of the country compared with the least deprived (see the 2nd Atlas of Variation).

Since 2019, North West London (NWL) has been implementing the NHS Long Term Plan which increases the focus of the provision of services based on population health through Primary Care networks (PCNs). This has led towards the development of Enhanced Services that are outcome focused and population based.

Aiming to increase accurate diagnosis for respiratory conditions is one of the drivers for the respiratory diagnosis enhanced service specification and the creation of PCN level diagnostic hubs, and should be considered as adjacent to this specification.

The recent update in August 2023 of the DHSC Major Conditions Strategy includes chronic respiratory disease as a key area, and includes a focus on prevention (smoking, obesity, vaccinations), management (annual reviews, a personalised action plan, appropriate inhaler optimisation and advice on smoking cessation) and living with the condition (pulmonary rehabilitation).

This service specification describes a consistent model for respiratory care across NWL with sufficient flexibility for the model to respond to the local needs of each area.

2. Aims and objectives of service

The aim of this service is to:

- Improve care for patients living with COPD and asthma for 24/ 25, and to deliver high quality integrated respiratory services to patients in the community by staff with correct skill sets and competency, which supports the Out of Hospital ambitions of NWL ICB for the development of pathways of care across health and social care, transforming care pathways by shifting care from acute to community and primary care settings where appropriate, avoiding hospital attendance and admissions and improving supported early discharge.
- improve the quality of patient care, manage the risks of hospital admissions and ensure patients are seen in the right place in a timely manner.
- Provide appropriate patient education so that patients may make informed choices and fully participate in their care and improve concordance.
- Support and align with the existing specification for early and accurate diagnosis in people with respiratory conditions including COPD and Asthma; Spirometry service provision (see spirometry specification –appendix VII)
- Ensure prompt, optimal management for all patients in line with evidence-based guidance, providing:
    - expert care close to patient's home
    - referral to other services such as community respiratory services, virtual wards and/or hospital when required
    - referral to pulmonary rehabilitation
    - referral for oxygen assessment in a timely fashion.
- Ensure effective management of co-morbidities, optimisation of therapy and smoking cessation as appropriate.
- Ensure end of life register updated for those with end stage respiratory disease
- Ensure those with severe conditions have an universal care plan accessible by the out of hours services eg 999, 111.

We will know we have been successful via the following outcomes:

- More referrals for pulmonary rehabilitation
- Increased universal care plans for those with severe disease
- More patients helped to stop smoking

- More flu vaccinations.

In addition, the service will aim to provide the following outcomes common to all health care services:

- Ensure that users of the service have a positive experience of care
- Ensure effective integrated respiratory care and communication between relevant health professionals
- Improve symptom control, function and quality of life for all patients with respiratory disease known to team
- Reduce/eliminate waste and poor quality care, and strengthen affordability and value
- Ensure staff have had the correct training and competencies to deliver their roles.

3. Service Description/Care Pathway

The primary care respiratory pathway is described at a high level

1. **Prevention**
   I. Smoking
   II. Obesity
   III. Vaccinations
2. **Diagnosis**
   I. Case finding and Virtual Reviews
   II. Referral to respiratory hub/CDC for diagnostic tests
3. **Management**
   I. Annual reviews
   II. Personalised action plan
   III. Appropriate inhaler optimisation
   IV. Advice on smoking cessation
   V. Post exacerbation
4. **Living with**
   I. Referral to Pulmonary rehabilitation
   II. Home oxygen – creating universal care plans – UCPs for these patients
   III. Palliative care using Universal care plans

Detailed service description

This service is part of a wider integrated care pathway. The provider will support an integrated approach between services and providers, by providing the appropriate clinical information required for onward referral or having information governance processes in place for record sharing, to support a seamless patient transfer and service provision.

On the operational side/outside of the care pathway, the service will lead on/participate in:

- MDT working with consultant support via community MDTs
- Identifying a PCN clinical lead for Respiratory (GP, Nurse practitioner or Clinical Pharmacist) ie. Respiratory champion (highlighted further below)
- Understanding and targeting any health inequalities via case finding in underrepresented groups or areas

The care pathway is as described below. This respiratory specification builds on existing arrangements already in place for prevention (see appendix III). The focus of the enhanced service specification is management and living with COPD and asthma.

For future years, we are looking to further integrate other services such as case finding and virtual review and diagnostic testing which is already in place via the Community diagnostic centre and respiratory hubs as detailed within those specifications (see appendix IV).

Management

I. **Annual reviews**: all patients with a diagnosis of COPD should be offered a review as per the section below and recorded using the NWL template in EMIS/S1. All patients with a diagnosis of asthma should be offered an enhanced asthma review (detailed in section below and recorded using the NWL template in EMIS/S1), over and above the routine asthma offering within the Quality and Outcomes framework. (QOF).

II. **Exacerbation & Post exacerbation/other:**
- early intervention service not limited to but may include rapid response, GPs, community respiratory service. This service is part of a wider integrated care pathway
- post exacerbation reviews as per NWL template
- referral to virtual wards in appropriate cases/post COVID19 services
- as a minimum, an expectation of one Respiratory champion in each PCN to act as a local expert and link to respiratory specialists/MDTs/ensure standards of care. The respiratory champions to work with hospital/community respiratory or equivalent teams, where available
- The respiratory champion would refer/discuss with local hospital/community respiratory or equivalent teams who would then link to the virtual wards for exacerbation management

Living with

Empower patients, carers and families by providing the information and support they need to manage their care needs including through social prescribing, care co-ordinators etc, thereby creating a culture of supported self-care; and proactive interventions

I. **Pulmonary rehabilitation:** ensure all eligible patients are offered and referred to pulmonary rehabilitation. Target of 60% of eligible patients referred. EMIS and S1 searches have been created to ensure practices can track those patients that have been referred.
II. **Home oxygen:** creation of a practice register and tracking that reviews have taken place as well as ensuring all patients have a UCP) https://www.cqc.org.uk/guidance-providers/adult-social-care/managing-oxygen-in-peoples-own-homes
III. **Palliative care using Universal care plans** that will align with new pathway and further alignment with the EOL dashboard.

Prevention

I. **Smoking:** Level 2 smoking cessation treatment and advice, with prescription of pharmacotherapy if possible, or onward referral to specialist smoking cessation service. Prescription of expert recommended treatment including tobacco dependence treatment
II. **Obesity:** on the GP practice's "Obesity Register". Patients aged 18 years or over with a BMI ≥30 in the preceding 12 months which the GP practice establishes and maintains under the Quality and Outcomes Framework
III. **Vaccinations:** Patients are offered appropriate vaccination eg. COVID19, Flu, PPV. Clinical system searches are currently available in EMIS and S1 to assist practices with a recall for unvaccinated patients aligned to their GMS contract

Condition specific detail

Asthma

Enhanced annual asthma review

- Patients with a diagnosis of asthma who are on the asthma register should be actively invited to attend for an enhanced annual asthma review as per NWL template.
- The review must include;
- *Assessment of asthma control using the Asthma Control Test (ACT) or **Children's Asthma Control Test (C-ACT).
- *Review of written personalised asthma action plans, to include;
    - An asthma care management and treatment plan which supports self-management, AND
    - An acute Asthma UK management plan detailing how and when to seek help in an emergency.
- *Check inhaler technique and record which one / if correct/& if optimised
- Ensure all patients are offered and can use a spacer when required and that mouthpiece (not mask) is prescribed if ≥ 3 years old
- *Measurement of peak flow in patients >/= to 6 years of age

- *Recording predicted peak flow in patients as per NWL template
- *Assessment and advice regarding avoidance of triggers (what are triggers-drop down)
- Number of episodes of exacerbations in last 12 months
- Record Number of courses of oral steroids in the last 12 months
- Record Number of hospital admissions in the last 12 months
- Asthma medication optimisation review (including review need to step up/down and use of SABAs)
- How many salbutamol inhalers have they collected in the last 12 months
- How many steroid inhalers have they collected in the last 12 months
- Medicines for patients are prescribed according to the North West London formulary unless specialist exemptions
- Smoking status – refer to smoking cessation service
- Lifestyle advice including weight control
- Offer Influenza, Pneumococcal and Covid Vaccination (if appropriate)
- Appropriate prescribing and appropriate disposal of inhalers

Poorly controlled asthma
The practice will provide a follow up review (at least within a week of an attack, but ideally before they run out of OCS) undertaken by a GP or suitably qualified individual (this could include a clinical pharmacist, or appropriately trained Practice Nurse, HCA) in addition to the Enhanced review by an appropriately trained nurse for patients who (i) have had an unplanned hospital admission and / or UCC/A&E attendance due to an acute exacerbation or uncontrolled asthma, or (ii) have scored positive on the enhanced review by the nurse. This is in order to maximise medication efficacy and ensure that those screening positive are having the appropriate treatment. These patients (those covered by points i and ii) should be considered for specialist review/discussed at MDT If ≥ 2 exacerbations. Anyone who has had a life threatening attack must be referred urgently to an asthma specialist.

A) Post-discharge review

The post discharge review will be carried out within 3 working days of the discharge letter being received. The review must be conducted by a GP or suitably qualified individual.
The review must include the questions within the 7 step plan which is already included in the NWL EMIS/S1 template.

B) Follow up enhanced review
Those patients identified during the enhanced review as having either daytime symptoms or night time symptoms of asthma at least weekly will receive a review by appropriately trained healthcare care professional.
The appropriately trained healthcare professional will review if the medication being prescribed is sufficient, will give a reiteration of lifestyle advice, ensure medication compliance and update the personal asthma plan given by the nurse. If the control is not sufficient the clinician should ensure that they organise follow up in order to confirm compliance with medication and improvement of symptoms. If no improvement they should be referred for a respiratory opinion.

COPD

GP Practice is required to ensure delivery of the following key standards (which should be read alongside the appropriate NICE Quality Statements and the appropriate British Thoracic Society guidance https://www.brit-thoracic.org.uk/standards-of-care/guidelines/nice-guideline-copd-in-over-16s-diagnosis-and- management/):

- As part of the existing respiratory specification, all patients aged 35 and above who present with a risk factor and one or more symptoms of COPD have quality assured Spirometry. Patients with COPD who are prescribed an inhaler have their inhaler technique assessed when starting treatment and then annually during treatment or following a COPD-related hospital admission where it has been at least 6 months since the last assessment;
- Patients diagnosed with COPD are offered a personalised management plan in-line with the relevant NICE 2011 quality standards (https://www.nice.org.uk/guidance/qs10/chapter/List-of-quality-statements) that:

- Include 8 care processes
- Is accessible to the patient and carer(s);

- Is shared with other members of the patient's wider Multi- Disciplinary Team;
- Sets out triggers and treatments;
- Provides education, self-care advice and support to improve exercise capacity; and
- Provides information as to what to do in the case of exacerbation and crisis personalised to the patient's requirements.
    - Patients with COPD are screened for anxiety and depression and then referred to IAPT services if required or managed according to NICE guidance and local pathways;
    - Patients with COPD are offered appropriate vaccination eg. COVID19, Flu, PPV vaccinations
    - Patients with COPD are offered smoking cessation treatment with a qualified smoking cessation professional;
    - Medicines for patients are prescribed according to the North West London formulary; unless specialist exemption
    - Patients with stable COPD and exercise limitation due to breathlessness, or who have had a recent hospital admission for an acute exacerbation, are referred to a pulmonary rehabilitation programme in-line with local pathways (MRC grade 3 or higher);
    - People with stable COPD and a persistent resting stable oxygen saturation level of 92% or less are referred for Oxygen assessment
    - Perform assessment of severe COPD if FEV1 < 50%, MRC >3, unresponsive to medical treatment. Ensure they have been reviewed or discussed with a specialist for suitability for intervention
    - If end stage COPD is suspected, then collaborate with the palliative care team as appropriate. Other pointers include low BMI, weight loss, heart failure (see NICE).

Partners

The service provider will be expected to identify a clinical lead/respiratory champion for each PCN and in terms of good practice work in close partnership with a range of health and social care providers, listed in appendix II.

4. Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

- Patients >/= 6 years old with asthma
- Patients > 35 year of age with suspected COPD
- The service is designed to meet the needs of patients who report respiratory symptoms or are deemed to be at risk of and display symptoms suggestive of COPD or asthma, but who have not received quality assured spirometry or FeNO testing. In addition, patients who have had confirmed or suspected COVID-19 pneumonia and continue to experience breathlessness who need assessment.

Exclusion Criteria

For COPD and Asthma:

- Patients <6 years of age for asthma and <35 for COPD;
- Patients registered with a GP outside of NWL GP practices;
- Aortic aneurysm;
- Haemoptysis of unknown origin;
- Pneumothorax;
- Heart attack or stroke in the last 12 weeks;
- Unstable cardiovascular status, recent (within 1 month) MI, uncontrolled hypertension, pulmonary embolism or chest pain or history of haemorrhagic cerebrovascular event;
- Recent thoracic, abdominal or eye surgery;
- Confusion, dementia;
- Suspected lung cancer;
- Suspected TB;
- Experienced chest pain;

5. Training, Skills and Experience

The service provider must ensure all staff delivering the service meet the training and competency requirements outlined in the specification. Staff should maintain clinical competencies by attending regular re-fresher update training. It is anticipated this should be every 2-3 years or sooner if changes to clinical guidelines occurs or if competency gaps are identified.

Healthcare Support Workers, Healthcare Assistants and Nursing Associates with the appropriate training and competency can deliver the service if supervised by a specialist respiratory nurse or GP.

Training competencies – Submission of the completed training for:

1. Adults - https://portal.e-lfh.org.uk/Asthmaadults
2. Children - Asthma (Children and young people) - elearning for healthcare (e-lfh.org.uk) Tier 3

Who - practice level and PCN level respiratory lead (which should already in place)
When - Submission of the completed training in Q1

Proposed Training for Management of Respiratory Disease in primary Care in NWL
The following is based on a 3-year programme of training for all staff working in General Practice in NWL. It ranges from staff having basic respiratory 'awareness' and the ability to signpost to specialist clinical skills coupled with leadership and teaching skills. Each level builds on the other so staff cannot do one without having done the one before.

Role / Level of Care	Proposed Training needed	Example Provider of training
Reception / Admin Signposting / Having Awareness	Tier 1 Paeds Asthma e-learning module	e-lfh
HCA / GPA Opportunistic education	Tier 1 Paeds Asthma e-learning module. Plus 1 days training on Inhaler Technique, Measuring Peak Flow and identifying red flags	e-lfh Geltech
Nurse / Pharmacist / PA Annual Reviews / managing stable patients / identifying red flags	Core Foundation Training Paeds Tier 2	Rotherham Respiratory Core Modules (Asthma, COPD) e-lfh
Nurse / Pharmacist / PA Provision of more specialist clinical interventions: Diagnostic tests / Education	Spirometry training / ARTP Paeds Tier 3	Rotherham Respiratory Spirometry Module ARTP Portfolio Registration e-lfh
Nurse / Pharmacist / PA / GP Diagnostics / Staff supervision and training / service design and evaluation	Advanced clinical training modules (Asthma / COPD etc) Time spent with clinical specialists leaders	Rotherham Respiratory Advanced Modules Time for training / support from senior clinicians / leaders

APPENDIX I – Contractual requirements

Respiratory

Unit Price

A maximum total of **£0.48** per weighted patient can be achieved subject to meeting Key Performance indicators as listed below.

The tariff and thresholds will be split as follows based on PCN performance:

Tariff	KPI	Target Thresholds	Financial Achievement
£0.31	UCLP Group 1 Asthma and COPD patients to have a UCP and an enhanced annual review	<50%	0%
		50-80%	50%
		>80%	100%

Tariff	KPI	Target Thresholds	Financial Achievement
£0.02	Patient living with home oxygen to have a UCP and an enhanced annual review	<90%	0%
		>90%	100%

Tariff	KPI	Target Thresholds	Financial Achievement
£0.15	% decrease adult asthma patients prescribed <=5 ICS containing inhalers per year		0%
		Any decrease	100%

Service Type	Capitation
Referral Criteria	Patients aged 6 years and above

TARGET POPULATION

Ref.	Description	SNOMED Code
RESP01Da	Patients with Asthma	QOF Cluster Asthma Diagnosis
RESP01Db	Patients with COPD	QOF Cluster COPD

TARGET POPULATION RULES

Patients included in Target Population for Respiratory RESP01D

- Patient must be aged 6 and over **AND**
- Has Asthma diagnosis (**RESP01Da**) WITHOUT a more recent QOF Cluster Asthma resolved recorded **AND**
- Has medication Beclometasone, Salbutamol, Terbutaline prescribed in last 12 months **AND**
- Has the following medication prescribed:

Medication	Search Period
Omalizumab, mepolizumab, reslizumab, and benralizumab	Any prescribed in last 12 months
Tiotropium	Any prescribed in last 6 months
Prednisolone	3 or more prescribed in last 12 months

Amoxicillin, doxycycline, erythromycin, clarithromycin	3 or more prescribed in last 12 months
Theophyline	Any prescribed in last 12 months
Montelukast sodium	Any prescribed in last 12 months
Erythromycin	3 or more prescribed in last 12 months
Doxycyline/hycate/monohydrate	3 or more prescribed in last 12 months
Fostair	Any prescribed in last 6 months
Beclazone and Bambuterol Hydrochloride	Both prescribed in last 6 months
Beclazone and Beclometasone	Both prescribed in last 6 months

OR

- Patient must be aged 35 and over **AND**
- Has COPD (RESP01Db) WITHOUT a more recent QOF Cluster COPDRES recorded **AND**
- Has any of the following recorded
- Home oxygen supply (**268512000**) or Oxygen therapy (**57485005**) in last 12 months
- Medical Research Council Dyspnoea scale grade 4 (**391125004**) or Medical Research Council Dyspnoea scale grade 5 (**391126003**) without a more recent Medical Research Council Dyspnoea scale grade 1 (**391120009**), Medical Research Council Dyspnoea scale grade 2 (**391123006**), Medical Research Council Dyspnoea scale grade 3 (**391124000**) recorded in last 5 years
- Chronic cor pulmonale (**79955004**) recorded in last 5 years
- Most recent Percent predicted FEV1 (**313223002**) < 50%

Patients included in Target Population for Respiratory RESP02D

- Patient must be aged 6 and over **AND**
- Has Home oxygen supply (**268512000**) or Oxygen therapy (**57485005**) in last 12 months recorded

Patients included in Target Population for Respiratory RESP05D

- Patient must be aged between 6 and 17 **AND**
- Has Asthma diagnosis (**RESP01Da**) WITHOUT a more recent QOF Cluster Asthma resolved recorded **AND**
- Has medication asthma related drug (QOF ASTTRT) recorded in last 12 months

Patients included in Target Population for Respiratory RESP06D

- Patient must be aged 18 and over **AND**
- Has Asthma diagnosis (**RESP01Da**) WITHOUT a more recent QOF Cluster Asthma resolved recorded **AND**
- Has medication asthma related drug (QOF ASTTRT) recorded in last 12 months
- Has Number of prescriptions for reliever inhaler per year (**734949005**) recorded in the financial year

CODING NECESSARY FOR PAYMENT

Ref.	Description	SNOMED Code		Measurement	
RESP01N	% of UCLP Group 1 Asthma or COPD Patients with UCP and an Enhanced annual review	UCP	Advance care planning (**713603004**)	**Numerator**: The number of patients with UCP and an enhanced annual review	**Denominator**: The number of patients on UCLP Group 1 Asthma and COPD as of 31 March 2024
		Enhanced annual review	Chronic obstructive pulmonary disease annual review (**394703002**) **OR** Asthma annual review (**394700004**) **AND** Enhanced services administration (**166221000000105**)		

RESP02N	% Patient living with home oxygen to have a UCP and an enhanced annual review	UCP	Advance care planning (**713603004**)	**Numerator**: The number of patients with UCP and an enhanced annual review	**Denominator**: The number of patients living with home oxygen
		Enhanced annual review	Chronic obstructive pulmonary disease annual review (**394703002**) **OR** Asthma annual review (**394700004**) **AND** Enhanced services administration (**166221000000105**)		
RESP03N	% decrease adult asthma patients prescribed <= 5 ICS containing inhalers per year	Data source – ePACT (respiratory dashboard)		**Numerator**: Number of patients receiving 5 or fewer steroid inhalers including ICS LABA products within a rolling 12 month period	**Denominator:** Total number of patients receiving any prescription items for steroid inhalers including ICS LABA products (see numerator for list) within a rolling 12 month period

CODING NECESSARY FOR PAYMENT

To achieve payment for Respiratory RESP01N

- Patient must be in **RESP01D AND**
- Has UCP (**713603004**) recorded in the financial year **AND**
- Has Chronic obstructive pulmonary disease annual review (**394703002**) **OR** Asthma annual review (**394700004**) recorded in the financial year **AND**
- Has Enhanced services administration (**166221000000105**) at the same time as COPD or asthma review

To achieve payment for Respiratory RESP02N

- Patient must be in **RESP02D AND**
- Has UCP (**713603004**) recorded in the financial year **AND**
- Has Chronic obstructive pulmonary disease annual review (**394703002**) **OR** Asthma annual review (**394700004**) recorded in the financial year **AND**
- Has Enhanced services administration (**166221000000105**) at the same time as COPD or asthma review

QUALITY METRICS

Ref.	Description	SNOMED Code		Measurement	
RESP04	Patients with COPD rescue pack recorded	Has supply of rescue medication (**734347001**) Issue of chronic obstructive pulmonary disease rescue pack (**718241000000107**)		Rescue pack > 4 recorded 24/25 will be a baselining year	
RESP05N	% of people on the CYP asthma register who have had ALL 8 care processes completed	Asthma control Test (aged 12+) **OR** Children asthma control test (aged 6-12)	Asthma control test score (**443117005**) Childhood Asthma Control Test score (**905301000000103**)	**Numerator:** The number of asthma patients aged between 6 and 17 with ALL 8 care processes completed	**Denominator:** The number of asthma patients aged between 6 and 17
		Personalised asthma action plans	Asthma clinical management plan (**736056000**) **AND** Patient has a written asthma personal action plan (**527171000000103**)		
		Inhaler technique	Inhaler technique – good (**170625000**) **OR** Inhaler technique – moderate (**390869002**) **OR** Inhaler technique – poor (**170626004**)		
		Measurement of peak flow	Peak expiratory flow rate (**18491006**)		
		Predicted peak flow	Predicted peak expiratory flow rate using EN 13826 standard (**178271000000100**)		

		Asthma trigger (once ever)	Any of the following: Asthma trigger (**400987003**) Asthma trigger respiratory infection (**201031000000108**) Asthma trigger – pollen (**340911000000109**) Asthma trigger – seasonal (**201041000000104**) Asthma trigger – cold air (**201191000000108**) Asthma trigger – damp (**201201000000105**) Asthma trigger - animals (**201051000000101**) Asthma trigger – exercise (**340901000000107**) Asthma trigger –airborne dust (**340891000000106**) Asthma trigger – tobacco smoke (**340921000000103**)		
		Episodes of exacerbations	Number of asthma exacerbations in past year (**366874008**)		
		Asthma medication review	Asthma medication review (**394720003**)		
RESP06N	% increase adult Asthma patients prescribed no more than 3 SABA inhalers issued per year	Number of SABA inhaler prescribed per year (**734949005**)		**Numerator**: Number of adult asthma patients prescribed no more than 3 SABA inhalers per year	**Denominator**: Number of adult asthma patients prescribed SABA inhalers per year

CODING NECESSARY FOR QUALITY METRICS

To achieve payment for Respiratory RESP04

- Patient must be aged 35 and over **AND**
- Has COPD rescue pack (**RESP04**) recorded in the financial year (24/25 baselining year)

To achieve payment for Respiratory RESP05N

- Patient must be in **RESP05D AND**
- Has all 8 Key care processes recorded in the financial year

To achieve payment for Respiratory RESP06N

- Patient must be in **RESP06D AND**
- Has no more than 3 SABA inhalers prescribed (**RESP06N**) in the financial year

APPENDIX II - PCN clinical lead/respiratory champion

The service provider will be expected to identify a clinical lead/respiratory champion for each PCN and in terms of good practice, will work in close partnership with a range of health and social care providers, including:

- Community respiratory teams (where they exist)
- Local Mental Health Services, which increasingly bring together psychiatric support, case management, health and social care navigators and peer support services.
- Integrated community and primary care Mental Health teams being planned across NWL (MINT for WLT and Community hubs for CNWL).
- Local employment, housing, benefits and other community/ voluntary sector based services, which are increasingly accessible to each PCN area.
- Secondary Mental Health Services in the case of crisis/acute exacerbation and for shared care liaison
- Providers of primary care or secondary care based psychological therapies
- Local Authority commissioned services supporting wellbeing
- Other acute providers delivering physical health care
- Other community provider services including community nursing and specialist nursing and therapy teams
- Community Champions and other community based networks
- Patient Navigators

APPENDIX III - Prevention

I. Smoking: Level 2 smoking cessation treatment and advice, with prescription of pharmacotherapy if possible, or onward referral to specialist smoking cessation service. Prescription of expert recommended treatment including tobacco dependence treatment

II. Obesity: on the GP practice's "Obesity Register". Patients aged 18 years or over with a BMI ≥30 in the preceding 12 months which the GP practice establishes and maintains under the Quality and Outcomes Framework

III. Vaccinations: Patients are offered appropriate vaccination eg. COVID19, Flu, PPV. Clinical system searches are currently available in EMIS and S1 to assist practices with a recall for unvaccinated patients aligned to their GMS contract

APPENDIX IV – Diagnosis

I. Case finding and virtual reviews of lists. Case finding searches using supportive tools eg Search Tool (EARLY), UCLP for Asthma and COPD are currently in the clinical systems of EMIS and S1 – further webinars and training will be provided for these as well use of the WSIC dashboard for Asthma and COPD and other respiratory conditions).

II. Diagnostic testing will be offered via the Community Diagnostic Centre (CDC) and respiratory diagnostic hubs as detailed within those specifications, and will ensure accurate investigations via spirometry, FeNO and other objective tests. Primary care will be responsible for referral, interpretation and coding of results as per the enhanced service specification and is not detailed here. Diagnosis using the results with examination and history will be performed in primary care with MDT support and referral to specialists as required.

APPENDIX V – Guide – Tool Kit

Guide
This aims to complement but not duplicate the QOF requirements of general practice but augment delivery and improve quality. All healthcare professionals need to ensure that patients are fully made aware when they have their annual reviews and discuss detailed personalised care plans. **Spirometry – already has a separate specification and diagnostic hub** **Pulmonary rehabilitation – already has a separate specification** **EMIS and S1 clinical templates and searches have been created to assist practices and** **primary care networks as a suite for respiratory conditions providing practice and thereby** **aggregated real time data.** **A. Training competencies – Submission of the completed training for** **1. Adults - https://portal.e-lfh.org.uk/Asthmaadults** **2.Children Asthma (Children and young people) - elearning for healthcare (e-lfh.org.uk) Tier 3** **Who – nominated practice lead and PCN respiratory lead** **When – Submission of the completed training certification to the PCN respiratory lead in Q1** **Why – As noted below** **At present a number of asthma deaths have been reported nationally with the key theme being at inquest these were preventable and the patient had a number of interactions with healthcare professional days or weeks prior to their death.** **The UK is also one of the worst-performing developed countries ranking 35 out of 37 for asthma deaths in the 5-to-34-year-age range.** **This will link to and complement the CYP Asthma core offer of the following competencies from a NWL perspective.** **All organisations have a named Asthma lead – PCNs/Practices** **All organisations have appropriately trained professionals based on the national tiered** **Capabilities framework** **There is network agreed pathway and guidance, including for severe asthma and transition to adults** **B. Risk stratification – use of UCLP searches and WISC searches – webinars will be conducted during Jan-March 2024. Supports the rising risk identification of patients and prioritising throughout the year and winter pressures and prioritisation of those that would require a UCP** **Who – PCN Respiratory champion** **When – Submission of confirmation of attendance in Q1** **Why – Supports the rising risk identification of patients and prioritising those that would require a UCP and links to the Proactive Care ES**

Practice level with oversight at PCN level – also supports the winter pressures workstream

C. Oxygen home supply – creation of a register and regular review – supports the linkage with creating UCP for this cohort of patients and keeping under regular review.

At present primary care do not have registers for this cohort of patients

D. Pulmonary rehabilitation register and follow through – supports the link with the current pulmonary rehabilitation service but further ensures utilisation and follow-through

E. Spirometry register and follow through – supports the link with the current diagnostic

Respiratory hublets and further ensures utilisation and follow-through.

(Quarterly submission of screen shots for these searches at practice level and PCN level to be submitted on 01/04/2024 – baseline, 01/07/2024, 01/10/2024, 01/02/2024 and 31/03/2024)

F. Enhanced asthma review – ensuring earlier review of patients following discharge from hospital

Component	Q1	Q2	Q3	Q4	ROI
A - Training – (Practice)	Submission of completion of training to PCN Respiratory champion	Attendance of borough level or NWL Asthma update session in the last 9 months	Submission of evidence to indicate learnings have been shared with practice members	Winter pressures – attendance of NWL webinars	NWL quality assurance and improvement at the frontline for asthma care at all ages
PCN	Certification of training	Attendance of borough level or NWL Asthma update session in the last 9 months	Submission of evidence to indicate learnings have been shared with member practices		
B - Risk stratification (Practice)	Creation and reflection on the patients in Group 1 for both asthma and COPD – commence UCP/Enhanced asthma review (F)	Ongoing creation and link to UCP. Ensuring appropriate vaccinations have been completed eg pneumococcal	80% review of the patients in Group 1 (for asthma and COPD) as noted – completed and UCPs created		Improved personalised care planning and link to UCP ES. Enables emergency health care providers to also understand the clinical care thresholds required for optimising the health of the patient.
PCN	Aggregate data for member practices to be reviewed and assist practices to prioritise and review cases. Develop standard operating procedures that complement the way the member practices currently work – ensuring ownership and understanding by all	Complete borough level or NWL training sessions for review of practice level searches and align to WSIC case finder identification – as well as feeding back on the strengths and weakness of the tools made available to the borough level clinical respiratory leads.	Assist practices in the dynamic review of patients in each group – reflecting dynamic change in the patient list		Population health understanding of the local population health care needs and informs NWL how best to meet these in a dynamic. Enables the NWL strategy to be operationalised.
C, D, E (Practice)	Create the registers and add and review patients on the respective registers Ensure review of all suspected asthma and suspected COPD patients and correct diagnostic codes	Oxygen supply register – 90% - all patients to have a UCP. Pulmonary rehabilitation and spirometry registers – complete reviews and ensure all records are up to date	Establish business as usual processes for new patients identified in each register		Improves the understanding of the health care needs of the local population, quality of the services delivered and allows for “closed loop” but continual monitoring of the services provided to ensure utilisation. Improved asthma and COPD and chronic respiratory conditions registers – at an individual

					patient level.
C, D, E (PCN)	Aggregate the data for all member practices Develop standard operating procedures that complement the way the member practices currently work – ensuring ownership and understanding by all.	Review reasons as to why patients may or may not be attending/declining the services and feedback to the borough respiratory clinical leads who will feedback to NWL Respiratory CRG.	Continue to support practices with the clinical audit cycle of ensuring all patients are reviewed in a timely manner.		

<u>APPENDIX VI</u>– NWL ICS EMIS Respiratory Conditions Template

The embedded example document includes screenshots of the North West London ICS Respiratory Conditions template referred to throughout this specification. The KPI codes are captured within the template.

NWL EMIS
Respiratory Conditic

Service	Applicable Service Standards

1. Context

The implementation of Out of Hospital (OOH) Strategies in 2015 changed the way both acute and community services are delivered with a focus on delivering care as close to patients' homes as is possible and ensuring that patients are at the centre of care delivered by quality services in Primary Care. The services contained within this contract increase the focus of the provision of services based on population health through Primary Care networks (PCNs) and NWL has developed Enhanced Services that are outcome focused and population based.

The services aim to:

- Improve prevention and tackling health inequalities in the delivery of primary care
- Support better patient outcomes in the community through proactive primary care
- Support improved patient access to primary care services
- Deliver better outcomes for patients on medication

2. NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**√**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**√**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**√**
Domain 4	**Ensuring people have a positive experience of care**	**√**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**√**

3. Local defined outcomes

Individual Empowerment and Self Care
The specifications require the provider to make available the appropriate information to patients' specific care which will help patients achieve good clinical outcomes.
Access, Convenience and Responsiveness
The specifications require the provider to deliver the services as close to a patients home as possible.
Care Planning and Multidisciplinary Care Delivery
Individuals will experience coordinated, seamless and integrated services using evidence based care pathways, case management and personalised care planning where their primary care clinician has access to their results through EMIS or SystmOne. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.
Population and Prevention
The specifications set out the requirement for the provider to proactively engage with the patient, as appropriate, to support up take for screening, medical review, attendance at forthcoming appointments and prevent infection/ complications. The ICB expects the service provider to ensure that the service is accessible to all patients registered with GP providers within NWL ICB.

Safe and High Quality
The provider should have access to the whole patient records, where clinically indicated and with patient consent, so they can contextualise patient results and advise on next steps.

4. Interdependence with other services /providers

The provider should ensure fast and local access for patients either in their own practice or in a practice or hub in the Primary Care Network. Where appropriate, and agreed with local borough teams, the Primary Care Network can arrange, through appropriate subcontracts, to provide a service borough wide.

In addition, the Primary Care Network should ensure they are:

- Preventing unnecessary referrals and admissions to secondary care services. But where onward referrals are necessary completing these in clinically appropriate timeframes
- Delivering services to adult patients[68] (people aged 18 and over) registered at practices in a NWL PCN.
- If practices are not providing this service they will be expected to have a local agreement with their PCN to ensure their patients receive this service in Primary Care.
- Adverse incidents are to be recorded along with details of staff training in managing the equipment, and type of equipment in use.

The Provider will develop relationships with other providers in order to become an integral member of the Health and Social Care Community.

- NWL Integrated Care Board (ICB) and local borough teams
- Acute trust
- Community trust
- Third sector organisations
- Borough Council
- Service users as key stakeholders
- Other Primary Care Networks in North West London
- Local and North West London Training Hubs

5. Applicable national standards

All specifications should be delivered following all applicable service standards for the service they are delivering, these may include:

- NICE Guidelines
- Public Health England Guidelines
- Applicable standards set out in Guidance and/or issued by a competent body (for example, Royal Colleges)

6. Applicable local standards

The provider must ensure that

- All specifications will be delivered as a basket of services accessible to all patients in the network and will be at 100% population coverage.
- Other than clinical and operational appropriateness, it will be for PCNs to decide the model of service delivery
- Data sharing is an obligatory requirement of this contract
- All member practices within the PCN will ensure the rates of pay for staff are appropriate to the role and responsibility, taking into account agenda for change rates and the levels set under the London Living Wage
- Subcontracting will be the responsibility of the primary care network to arrange with their member practices, evidence of subcontracting arrangement will be required by NWL ICB.
- Care is being provided to the highest standards, managing quality and training as a part of its governance of working

[68] **Unless specifically noted within the service specification**

at scale.

- As a minimum the Provider will ensure that the service is available to the population covered by this contract between 08:00 and 18.30, Mondays to Fridays, excluding Bank Holidays

All specifications should be delivered following all applicable service standards for the service they are delivering, these may include:

- NWL IPC Guidance
- Revised Incident Reporting Guidelines
- Infection control Guidelines
- Services may be reviewed in light of national changes or replaced with PCN outcome delivery requirement

7. Disability, equality and diversity

The service provider will adhere to all national and local legislation and practice guidance with reference to disability, equality and diversity. This includes reasonable adjustments for patients with learning disabilities, people with dementia or sensory impairments, including support from carers and/or easy read information as appropriate, and patients who may have autistic spectrum disorder who may require additional time to prepare for appointments. This also includes ensuring the service complies with the Public Sector Equality.

In particular the provider must ensure they have paid due regard to the Equality Act 2010 and can evidence, that they meet the needs of those covered by the requirements of the protected characteristics.[69]

8. Minimum clinical governance requirements

The PCN will need to have in place the organisational and contractual structure to be able to deliver, manage and report on service performance in line with the contractual requirements

The provider should:

- Have a clearly documented process / Standard Operating Procedure for the services provided
- Have a clearly documented delivery points and referral pathways for each service
- Ensure that there are robust governance processes in place to ensure clinical services are delivered safely in accordance with infection prevention control requirements.
- Robust governance processes must be in place to report all serious incidents associated with the delivery of the services
- Ensure that the service meets CQC requirements for the delivery of medical services which as a minimum should be those required for the delivery of general medical services
- 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 practice / PCN's staff
- Comply with commissioner requests for clinical audit where appropriate.

9. Premises

The premises where these services are delivered should be easily accessible with provision for people with disabilities including waiting areas. The provider will ensure that all premises and equipment comply with all current NHS standards, good clinical practice and good healthcare practice, legislative standards and any applicable quality standards and that they are clean, safe and sufficient

[69] **Further information can be found at www.equalityhumanrights.com**