The Ealing Standard

Quality Framework for Primary Care
2017/18 – 2020/21
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1 Context

1.1 Introduction

Primary care services deliver high-quality care for the population of Ealing. These services, and general practice in particular, are at the centre of the local health and social care system for every resident. GPs are not only the first point of contact for the majority of residents, they also play a co-ordinating role throughout each patient's journey through a range of clinical pathways and provider organisations.

However, we face a number of significant challenges. These include:

- Dramatic projected increases in the number of older people presenting with multiple and complex conditions and requiring a greater co-ordinating function within primary care – the number of people aged over 85 by 2020 is expected to increase by 48%;
- An increase in demand for appointments of 13% nationally over the last five years; note about access to primary care in Ealing compared to national average.
- Historic underinvestment in primary care in Ealing compared to other parts of North West London which is putting primary care under unprecedented strain.

The GP Forward View was published in April 2016 to address key challenges in general practice nationally. These are:

- Investment: accelerate funding of primary care
- Workforce: expand and support GPs and wider primary care staffing
- Workload: reduce practice burdens and help release time
- Practice infrastructure: develop the primary care estate and invest in better technology
- Care redesign: a major programme of improvement support to practices

The Ealing Standard provides an opportunity to support primary care with the investment necessary to drive improvements in the health and wellbeing of Ealing’s population, improve quality of care for patients and sustain general practice for the future. The Standards have been coproduced with the Council of Members before approval by the Governing Body.

The Ealing Standard closely links with other strategies including:

- The 2017/18 Ealing CCG Business Plan
- The Joint Strategic Needs Assessment
- The Health and Wellbeing Strategy
- The Sustainability and Transformation Plans for NWL
- Out of Hospital Delivery Strategy
- Primary Care Delivery Strategy
- North West London’s Shaping a Healthier Future Transformation Programme
- North West London’s Mental Health Transformation Programme
- Better Care Fund.

1.2 Desired outcomes of the Ealing Standard
As a result of the implementation of the standard practices and patients can expect:

More resilient general practice
- Increased investment into General Practice to strengthen staffing capacity and enable practices to be more resilient in order to meet rising demand
- Equality of opportunity to all GP practices to provide services, provided they are able to satisfy locally determined requirements
- Support for fairer distribution of funding at a locality level.

Improved access for patients
- By 2020, all practices will be open from 8am – 6.30 pm from Monday to Friday
- A minimum number of consultations available relative to the practice list size
- Responsive access for housebound patients
- Access to male and female clinicians

Improved health outcomes
- Early identification through screening and health checks
- Improved care co-ordination for patients with complex health needs

Reduction in variability
- Minimum standards across a range of therapy areas, including respiratory conditions, musculoskeletal conditions, cardiovascular disease and diabetes.
- Key performance indicators across all services

Long term sustainability
- More proactive care for patients to manage their own conditions
- Improved medicines optimisation
- Reduction in use of more expensive urgent and secondary care resources
2 Standard Principles

2.1 Introduction

Ealing CCG serves a GP registered population of more than 430,000 patients, with 76 GMS/PMS/APMS Contracts. Practices receive the majority of core contractual funding from NHS England.

NHS England is increasing the funding allocation on a yearly basis from 2017/18 up to 2020/21 after a decade of underfunding. This additional investment provides some headroom to increase the total investment in primary care across Ealing to £11.8m from March 2017 to 2021 (Figure 1).

There is also some inequity between PMS and GMS contracts. NHS England has asked CCGs to review all contracts to give equality of opportunity to all GP practices to support fairer distribution of funding at a locality level and provide equality of opportunity to all practices to provide the same range of services. The level of “PMS premium” funding currently invested in contracts with Ealing practices is £650,000 which will be re-invested fairly across all practices over a 4 year timeframe.

The CCG also commissions a number of services from practices directly outside the core contract that are best delivered from primary care for a registered population. With effect from the 1st April 2017, Ealing CCG took on responsibility for the commissioning of core general practice contracts and the overall management of the primary care allocation. This enables us to accelerate and localize primary care transformation, with increased autonomy to shape future primary care services and a stronger voice for General Practice to influence decision making.

Ealing CCG intend to use this investment to change from commissioning multiple services from practices to taking a single commissioning approach, with a single wraparound contract for all non-core CCG commissioned services. The ‘Ealing Standard’ will be holistic, improve outcomes and provide better value for money, providing vital investment to ensure primary care in Ealing is both sustained and transformed. It will also help to address equity.
of funding across practices and public and patient concerns regarding equality of access across the patch.

The new Ealing Standard will incorporate:

- Available NHS England investment, that has not been otherwise allocated, to fund changes in the core contract, changes in rents and rates reimbursements and demographic changes.
- All existing discretionary CCG funding for services, including winter resilience, LIS schemes and the Out of Hospital services.
- Reinvestment of the PMS premium.
- Funding made available from practices opting out of out of hours services, which will be separately procured for all patients.

NHS England funding for essential and additional services, estates, Directed Enhanced Services (DES) and Quality and Outcomes Framework (QOF) will remain outside the Ealing Standard.

The total value of the contract in 2017/18 will be £1.7m for a 6 months period and £11.4m in 2018/19 for the full year. Funding in future years will be dependent on the amount of discretionary headroom available following the outcome of annual negotiations on the core contract, increases in the cost of rents and rates, and increases in the patient population of Ealing.

To implement the Standard, NHS Ealing CCG is applying the following core principles:

- All additional investment should reflect CCG strategic plans for primary care, the strategic commissioning framework for London and the STP for NWL;
- Funding for practices should remain stable for the length of the contract (2017/18 to 2020/21);
- Funding from PMS transition will be reinvested back across General Practice;
- Nothing in the Ealing Standard replaces the core GMS / PMS / APMS contract.
- Give equality of opportunity to all GP practices,
- Support a fair distribution of funding at a locality level.

2.2 Basis of Standard

Since 1 April 2017, Ealing CCG has taken on delegated responsibility for commissioning Primary Care medical services and will in addition commission the contract with practices to deliver the Ealing standard in practices.

This Standard will be mutually dependent upon the core GMS/PMS/APMS Contract. This means that only a provider currently offering essential primary medical services to a list of patients under either a General Medical Services Contract (GMS), Personal Medical Services Contract (PMS) or Alternative Provider Medical Services Contract (APMS) will be capable of providing the services required under the Ealing Standard to that same list of patients or arrange for certain services to be delivered at a primary care service close by. This mutual dependency means that the Ealing Standard may be legitimately commissioned exclusively from local General Practice, as they are the most capable provider. An Independent Review Panel confirmed this procurement approach for each of the services within the Standard is appropriate.
The route used to commission this service will be via the NHS Standard Contract covering 3 and a half years, from 2017/18 to 2020/21, with recurrent increases in the allocation over the term of the contract.

2.3 Phasing of standards

The Standard will be rolled out in a phased manner, with the first phase to go live in October 2017.

This approach will enable the CCG to invest growth funding in year into general practice. Practices will be expected to deliver the majority of the standards within the contract or agree an action plan with the CCG for delivery of the standards. A small number of the standards that require specific skills and training will not be mandatory.

The phasing of standards is set out in table 1. The CCG reserves the right to vary the contract on an annual basis where necessary to reflect quality improvement, changes to clinical practice and the financial envelope.

Table 1: phasing of standards

<table>
<thead>
<tr>
<th>From October 2017:</th>
<th>From April 2018:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthcare and long term condition management</strong></td>
<td>Mental health</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
</tr>
<tr>
<td></td>
<td>Respiratory</td>
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<tr>
<td></td>
<td>Cardiovascular</td>
</tr>
<tr>
<td></td>
<td>Ring pessary</td>
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<tr>
<td></td>
<td>Care planning and coordination</td>
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<tr>
<td></td>
<td>End of life care</td>
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<tr>
<td></td>
<td>Wound care</td>
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<tr>
<td></td>
<td>Phlebotomy</td>
</tr>
<tr>
<td></td>
<td>Dementia</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td><strong>Healthcare improvement</strong></td>
<td>Cancer screening (Bowel)</td>
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<tr>
<td></td>
<td>Prevention</td>
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<td></td>
<td>Self-Care</td>
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<td></td>
<td>Carers</td>
</tr>
<tr>
<td></td>
<td>Learning Disability</td>
</tr>
<tr>
<td></td>
<td>Cancer screening (Breast)</td>
</tr>
<tr>
<td><strong>Access, safety and experience</strong></td>
<td>Homeless</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>Drug Monitoring</td>
</tr>
<tr>
<td></td>
<td>Medicines optimisation and medicines safety</td>
</tr>
<tr>
<td></td>
<td>Patient experience</td>
</tr>
<tr>
<td></td>
<td>Demand management</td>
</tr>
<tr>
<td></td>
<td>Business management (Pre-Qualifer)</td>
</tr>
</tbody>
</table>
2.4 Signing up to the standards

Practices that sign up to the Ealing Standard are required to complete the Ealing Standard Implementation Plan and submit this electronically to the CCG by 30 September 2017 together with the signed NHS Standard Contract. The implementation plan covers:

- a commitment to deliver the service including plans for mobilisation where appropriate
- confirmation of which activity based standards the practice intends to deliver and on behalf of which practices
- a commitment to attend relevant training and to provide information as required to the CCG.

The CCG will work with practices to ensure all patients registered in Ealing can receive the same standards of care in primary care for services not delivered by their registered practice.

Practices will be expected to sign up to the full contract term of 3.5 years.

To ensure that activity is being carried under this contract and not being sent inappropriately to the hospital setting, hospital activity will also be monitored.

2.5 Payment Mechanism

Services are split between capitation-based services, activity-based and prevalence-based services.

Subject to KPI performance, in 2017/18, practices will receive maximum £8.37pwp for delivery of the standards over the 6 month period from October 2017.

Subject to KPI performance, in 2018/19, practices will receive maximum £18.76pwp for delivery of the capitation-based standards. The CCG will agree individual finance and activity plans with practices for the activity-based services.

**Table 2: Payment mechanism for standards**

<table>
<thead>
<tr>
<th>Capitation-based</th>
<th>Activity-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory (except diagnostic spirometry)</td>
<td>Cardiovascular (Warfarin Monitoring, Warfarin Initiation, ECG)*</td>
</tr>
<tr>
<td>Cardiovascular (AF, HTN/ABPM, HF)</td>
<td>Diabetes (initiation)*</td>
</tr>
<tr>
<td>Musculoskeletal health</td>
<td>Respiratory (Diagnostic Spirometry)*</td>
</tr>
<tr>
<td>Care Planning and co-ordination</td>
<td>Phlebotomy*</td>
</tr>
<tr>
<td>End of Life care</td>
<td>Ring Pessary*</td>
</tr>
<tr>
<td>Wound Care</td>
<td>Homeless*</td>
</tr>
<tr>
<td>Dementia</td>
<td>ABPI*</td>
</tr>
<tr>
<td>Cancer screening</td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
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<tr>
<td>Self care</td>
<td></td>
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<tr>
<td>Learning Disabilities</td>
<td></td>
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<tr>
<td>Carers</td>
<td></td>
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<tr>
<td>Access</td>
<td></td>
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<tr>
<td>Medicines optimisation and medicines safety</td>
<td></td>
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<tr>
<td>Drug Monitoring (NPT)</td>
<td></td>
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<tr>
<td>Patient Experience</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence-based</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>


The value of services for the following mandatory elements of the Ealing standard is as follows:

<table>
<thead>
<tr>
<th>Service area</th>
<th>Contract value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phlebotomy</td>
<td>£3.12 per bleed</td>
</tr>
<tr>
<td>Care for homeless</td>
<td>£16.25 for 10 minutes of consultation</td>
</tr>
</tbody>
</table>

All services which may be delivered by one practice on behalf of another will be paid on an activity basis. Payment for these services will be paid directly to the providing practices, as follows:

<table>
<thead>
<tr>
<th>Service area</th>
<th>Contract value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular (Warfarin Monitoring)</td>
<td>£252.78 per monitored patient per year</td>
</tr>
<tr>
<td>Cardiovascular (Warfarin initiation)</td>
<td>£161.34 per initiated patient</td>
</tr>
<tr>
<td>Cardiovascular (ECGs)</td>
<td>£40.38 per test</td>
</tr>
<tr>
<td>Diabetes (insulin initiation)</td>
<td>£204.79 per initiated patient</td>
</tr>
<tr>
<td>Respiratory (Diagnostic Spirometry)</td>
<td>£41.58 per diagnostic test</td>
</tr>
<tr>
<td>Ankle-Brachial pressure index (ABPI)*</td>
<td>£17.23 per diagnostic test</td>
</tr>
</tbody>
</table>

*A separate equipment budget will include purchase of ABPI for providing practices (3 expected)

Due to the significant variation in Ealing of patients with diabetes and mental health, payment for management of patients with diabetes, high risk of diabetes and Mental Health will be adjusted for prevalence.

As the contract is developed over time, the CCG will assess which of the activity based work, if any, can move to a capitation based model.

2.6 Key performance indicators

Each of the services has a number of KPIs, which will be used to measure performance in meeting the specifications. Each of the KPIs within the capitation element of the Standard are weighted according to the criteria below:

- Effective care
- Difficulty to implement
- Patient experience
- Clinical impact elsewhere
- Financial impact elsewhere
- Collaborative working

Standards paid or part paid on a capitation basis and the number of KPIs

Table 3: KPI
The CCG is also developing and testing a goals framework for our communities contract (table 4), which incentivises disease prevention, supports planned care and timely response in time of crisis. Primary care will have a role in achieving these goals.

25% of capitated activity is subject to a KPI payment. Over time, provided the increase in allocations allow funding above core contractual primary medical services, additional future payments will be linked to primary care input into the goals framework.

**Table 4: Ealing CCG goals framework**

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Goals</th>
</tr>
</thead>
</table>
| Domain 1: health status achieved/retained | • I want to live a life that's normal for me  
• Important clinical outcomes are improving  
• Everyone has access to the care that helps them live normal lives  
• I am encouraged to have access to social activities |
| Domain 2: Process of care | • I need to trust the people looking after me  
• I am listened to  
• As a staff member, I am supported to do a good job  
• As a staff member, I feel I can trust the other partners in the system |
- Care is safe, delivered to the correct clinical standard
- My care was timely

**Domain 3: Sustainability of health**
- I feel I'm in control
- I am able to live at home
- As a carer, I feel involved, supported and have time for myself
- The resources available are used in the most effective way to provide 24/7 care
- Different organisations work well together

**Enablers**
- Technology is used to innovate and support
- Premises and infrastructure in general practice are appropriate and high quality
- Staff have the right skills for working together
- There is investment in building community resilience

### Distribution of payment for 2017/18 and 2018/19

<table>
<thead>
<tr>
<th>Contract part</th>
<th>Upfront payment</th>
<th>Service KPIs</th>
<th>Outcomes framework (2018/19 only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Element 1: Capitation-based payment</strong></td>
<td>75% payment for signing up to the contract, production of a Practice Action Plan that meets CCG requirements and implementation of the delivery aspects of the standards</td>
<td>Standards are weighted according to CCG priority and work for the practice to deliver (set out in table 3). 25% of the contract payment is made according to a sliding scale for achievement across the totality of the KPIs. E.g. achievement of 75% of the indicators will achieve 75% of the payment.</td>
<td>An additional 1% payment is made against delivery of the specified goal. For 2018/19 this will be a reduction in unwarranted variation in NEL admissions and planned care.</td>
</tr>
<tr>
<td><strong>Element 2: Activity-based payment</strong></td>
<td>100% payment for delivery of services in line with the practice activity plan in line with OOH Services as present.</td>
<td>KPIs will be monitored but there will be no separate payment for achievement against the KPIs.</td>
<td></td>
</tr>
<tr>
<td><strong>Element 3: Prevalence based payment</strong></td>
<td>40% - Diabetes payment based on number of patients on the QOF register 75% - Mental Health payments based on number of patients on the register</td>
<td>60% (Diabetes) payment based on network achievement against the key process indicators set out in the dashboard. 25% (Mental Health) payment based on network achievement against the key process indicators set out in the dashboard.</td>
<td></td>
</tr>
</tbody>
</table>

### 2.7 Payment Schedule
Payments will be made on a monthly basis as follows:

75% of capitation payment

80% of activity-based payment as set out in the F&A plan

40% of the prevalence payment as set out in the F&A plan for Diabetes and 75% for Mental Health

Payments will be adjusted for list-size changes on a quarterly basis, based on the same principle as current GMS contractual payments.

Quarterly and Annual reconciliations will be agreed as the contract develops.

2.8 Monitoring

Practices will be asked to use the templates on SystmOne (or EMIS Web) so that the CCG can monitor activity. The CCG will provide dashboards that summarise the data at practice level, Network level and CCG level. Practices should be able to run their own searches on the system to monitor performance against the contract.

2.9 Disputes

Wherever possible, disputes relating to KPIs will be resolved locally. NHS Ealing CCG has an Appeals and Escalation Process in place (currently known as the Challenge Process under the OOH contract). The appeals process will be managed by the CCG and overseen by the Primary Care Commissioning Committee. Appeals from practices will be considered on an individual basis. Practices will be expected to provide comprehensive evidence to back up their reason for appeal. This evidence will be subject to further analysis by the CCG.
3 The Ealing Standards

Standard 1  
**Adult mental health: serious long term mental illness & complex common mental illness**

This specification combines the 2 previous Out of Hospital Specifications for Serious Mental Illness and Complex Common Mental Illness. Although both groups have slightly different needs, it is recognised that increased clinical time and resource is required to provide for their mental health needs, as well as the importance of physical health care. The templates already overlap significantly. Using the same set as a guide for clinicians reduces the complexity around the requirements for delivery.

**Aims**

**Serious Long Term Mental Illness**
To:
- provide a structure, process and supporting tools for GPs to provide enhanced case management, care planning and review with SMI patients throughout the year.
- improve the bio-psycho-social health of patients, whilst supporting sustained recovery and reducing crisis escalations and reliance on secondary mental health services.
- streamline and improve the coordination of the transfer process from Secondary Care mental health services to primary care ensuring that patients are transferred safely
- support GPs in assuming clinical responsibility for patients being stepped down from Secondary Care services into primary care
- improve partnership working and improve the co-ordination of care for eligible patients
- enhance the skill of primary care teams in managing serious mental illness
- ensure that GPs and other professionals involved in care of this patient group have adequate time for engagement, follow up, liaison and DNA management inherently required for successful enhanced case management
- improve the management of physical health to prevent and/or manage long term physical health conditions.

**Common Complex Mental Health**
1. Improve the diagnosis and management of Complex Common Mental illnesses, which includes (but not necessarily limited to) Moderate to Severe Depression, Anxiety, Eating Disorders, Post-traumatic Stress disorder, Perinatal mental health issues, ADHD. In this way we can prevent these conditions from worsening, and avoid the wider impact such conditions can have, such as employment and housing.
2. In addition it is important to recognise the impact that a long term illness can have on mental health, and to be more proactive at identifying and managing difficulties as soon as they arise.
**Standard 1**  
**Adult mental health: serious long term mental illness & complex common mental illness**

### Serious Long Term Mental Illness

There are national and regional drivers to transform the model of care for those with a Serious Long Term Medical illness. This involves providing care closer to home, integrating the mental and physical health aspects, and using primary care as the base, so that secondary care services can focus on the more complex cases. These patients also continue to have poor physical health and poor access to physical health care.

This is supported by the Mental Health 5 Year Forward view:

> “Physical and mental health are closely linked – *people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people* – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.” (Mental health 5 Year Forward View)

NWL has a specific Mental Health & Well-Being Strategy: Like-Minded. This has been coproduced with service users and other community stakeholders. Central to this strategy is the development of an improved wrap-round offer in primary care for patients who have long-term or complex mental health needs, supporting General Practice with enhanced primary-care based, bio-psycho-social support from Primary Care Teams. GPs are central to coordinating this care.

This service is aimed at all adults with serious and long term mental health needs on your SMI QOF register and may include all those who are:

- Stable enough to be cared for by their registered GP alone
- Have recently been discharged from Secondary Care
- Under shared care prescribing with Secondary Care

(There will no longer be separate tiers of service).

### Complex Common Mental Illness

As community mental health teams are using resources to focus more on SMI, more people with complex common mental illness are being managed in Primary Care.

The service recognizes the extra work this places on General practice and aims to support that work.

There are also national priorities linked to this around increasing access to IAPT and focusing on Long Term Conditions, and hard to reach groups
Standard 1

Adult mental health: serious long term mental illness & complex common mental illness

such as minority ethnic communities and the elderly.

**NHSE IAPT:** “The priorities for service development are:

- **Expanding services so that at least 1.5m adults access care each year by 2020/21. This means that IAPT services nationally will move from seeing around 15% of all people with anxiety and depression each year to 25%, and all areas will have more IAPT services.**

- **Focusing on people with long term conditions. Two thirds of people with a common mental health problem also have a long term physical health problem, greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services the NHS can provide better support to this group of people and achieve better outcomes.**

- **Supporting people to find or stay in work. Good work contributes to good mental health, and IAPT services can better contribute to improved employment outcomes.**

- **Improving quality and people’s experience of services. Improving the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups are all important aspects of the development of IAPT services.**

“…people with long term physical illnesses suffer more complications if they also develop mental health problems, ..” (Mental health 5 year Forward View)

**Delivery**

For Patients with **serious long term mental illness** providers will be expected to:

1. Accept appropriate transfers of care from Secondary care teams.
2. Work with the Primary care mental health teams, as well as other community providers, to support service users to recover, remain well and avoid referrals into secondary care.
3. Offer Enhanced GP access - longer booked appointments and Proactive follow up of patients by their registered GPs
4. Offer a comprehensive annual, bio-psycho-social mental health review, resulting in a ‘Recovery and Staying Well Plan’. In particular focus on annual physical health checks for prevention, early identification and management to improve outcomes, eg blood pressure control, weight loss, smoking cessation.
   - The physical health check should include as a minimum:
     - BMI, BP, lipids, HBA1c, smoking, alcohol use, substance misuse.
     - Discussion around key social issues should also take place, ie finances, accommodation needs, employment issues.
5. Assess the problem(s) and corresponding illness complexity and severity using as a minimum, a Wellbeing Questionnaire (i.e. Short Warwick Edinburgh Wellbeing Scale)
6. Prescribe, monitor, including use of appropriate blood tests, and administer medication, including depot injections.
7. Include and support carers when appropriate.
8. Use the OOH templates provided to record relevant data so that they may be captured into the dashboards (see below).
**Standard 1**

**Adult mental health: serious long term mental illness & complex common mental illness**

The target population would be patients included in the Serious Mental Illness QoF register.

For patients with *common but complex mental illness* the service provider will be expected to provide Points 1-8 above but also:

9. Proactively identify, from their registered list, patients with Complex Common Mental Illness, who are most likely to benefit from a proactive case management approach.

10. This should include:
   a) those with a Long Term Condition, eg COPD, Diabetes, Chronic Pain/Musculoskeletal Disorder, Heart Failure
   b) hard to reach groups such as minority ethnic groups, and the elderly.

These patients should be referred or signposted to IAPT as appropriate.

The target population are adult patients (aged 18 years and over) with the following common mental illnesses whose condition is complex; recurrent; chronic; severe; treatment resistant with moderate functional impairment:

- Anxiety and/or depression
- Co-morbidities with e.g. substance related disorders, ADHD
- Eating disorders
- Sleep disorders
- Obsessive compulsive disorder
- Post-traumatic stress disorder
- Personality disorders
- Perinatal mental health problems
- Sexual and gender identity disorders
- Somatization, somatoform or conversion disorders (Somatic Symptom Disorders)

**Key performance indicators**

**Providers will be expected to:**

1. Review the Mental health dashboard each month. Discuss in their network meetings to identify any ways in which clinicians within their networks can support each other to improve care.

2. Ensure that at least 75% of patients on the SMI register have had an annual physical health check per financial year.

3. Ensure that 75% of patients in the service have had at least 2 comprehensive mental health reviews per financial year

4. All patients registered with depression or anxiety and in the following groups have either been offered a referral to IAPT (or self-referral) or recorded as declined or seen or inappropriate
   - COPD
   - Diabetes
   - Heart Failure
   - Chronic Pain/Musculoskeletal Disorder

**CCG support**

Collect data and provide monthly dashboard.

The CCG will update the current templates to reflect this new specification.

**References**


NICE Guidelines: Depression and Anxiety.
<table>
<thead>
<tr>
<th>Standard 1</th>
<th><strong>Adult mental health: serious long term mental illness &amp; complex common mental illness</strong></th>
</tr>
</thead>
</table>
| CCG contact | Dr Serena Foo  
serena.foo@nhs.net |
Standard 2 | **Diabetes – high risk**
---|---
**Rationale** | The CCG wishes to commission a service for patients at high risk of diabetes that supports its strategic commissioning intentions to ensure that high quality care is delivered as close to the patient’s home as is appropriate. The service is intended to support and enable primary care clinicians to provide patient care in a seamless and integrated way.

The service provider will do this by:
- Up-skilling and increasing resourcing to the primary care workforce through supported diabetes education
- Improving the proactive care of patients at high risk of diabetes
- It will improve the overall care of patients at high risk of diabetes by:
  - Delivering measurable improvements in clinical quality
  - Enhancing patient satisfaction with the care and support they receive
  - Supporting the implementation of a clear clinical management pathway for patients at high risk of diabetes

**Delivery** | The service provider will:
- Use the Leicester Diabetes Risk Score or Diabetes UK risk assessment tool to identify patients at increased risk of diabetes
- Maintain a register of patients at high risk of diabetes (using the read codes Non-diabetic hyperglycaemia (XaaeP) or previous Gestational diabetes mellitus (L1808)) identified:
  - de novo through risk assessment tools (or other means) 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
  - through past history of gestational diabetes
- Invite patients to participate in the NHS Diabetes Prevention Programme (NDPP) by referral following ad hoc face-to-face contact or telephone consultations
- Refer patients for other intensive lifestyle management / structured education where commissioned by the CCG
- Annual follow up of HbA1c, blood pressure, BMI, smoking status, activity and provision of lifestyle advice
- Biennial follow up of lipids
- Practices sign up to managing patients in line with the agreed pathway
- Practices have information available for patients that enables them to understand the pathway.

---

Standard 2 | **Diabetes – level 1**
---|---
**Rationale** | The CCG wishes to commission a diabetes service that supports its strategic commissioning intentions to ensure that high quality care is delivered as close to the patients home as is appropriate

The service provider will do this by:
Standard 2  |  Diabetes – level 1

- Up-skilling and increasing resourcing to the primary care workforce through supported diabetes education
- Reducing variations in diabetes care and outcomes across network populations
- Enabling better self-management of diabetes through care planning
- Improving cost effective prescribing for blood glucose test strips
- Improving the overall care of patients with diabetes by:
  - Delivering measurable improvements in clinical quality
  - Enhancing patient satisfaction with the care and support they receive
  - Supporting the implementation of a clear clinical management pathway for diabetes care
  - Reducing the number of patients having routine follow up appointments in secondary care

Delivery

The service provider will:

**Newly diagnosed patients**
- Refer to CCG-commissioned structured education programme
- Provide with information about diabetes including Diabetes UK information pack

**On-going diabetes management**
- Conduct checks in line with nine key care processes at least annually: BMI, HbA1c, blood pressure, lipids, urine ACR, eGFR, record of retinal screening, foot check (including testing for neuropathy and circulation), smoking status
- Review patients at least annually and more frequently (3-6 monthly) if control inadequate
- Provide patients with information on diabetes
- Arrange dietician and podiatry reviews where necessary, according to clinical guidelines
- Provide glucometers and blood glucose strips, in line with CCG guidance
- Follow CCG guidance for insulin, needle and lancet prescribing
- Discuss service structure with patients requiring additional advice or referral and provide patients with information on the service
- Conduct patient satisfaction survey in at least 10% patients
- Offer innovative methods of follow-up consultation/support to patients that are interested, such as teleconferencing, email, texts or YouTube videos.
- Support and encourage engagement with services provided by diabetes mentors, lay educators and champions where these exist.

**Care planning**
- 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 to allow time for adequate care planning
Standard 2  Diabetes – level 1

- 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.

Referral

- Where requesting advice or referral to the community team, or level 2 service, 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 (other than injectable initiation provided by the Diabetes level 2 service) with the community service

Standard 2  Diabetes – level 2

Rationale

The CCG wishes to commission a diabetes service that supports its strategic commissioning intentions to ensure that high quality care is delivered as close to the patients home as is appropriate

This service will support and enable healthcare professionals in Primary Care to provide high quality, safe initiation and optimization of injectable therapy to patients in a seamless and integrated way.

The service will do this by:
- Delivering measurable improvements in clinical quality
- Enhancing patient satisfaction with the care and support they receive
- Supporting the implementation of a clear clinical management pathway for diabetes care
- Supporting high quality care delivery resulting in a potential reduction of Community/Secondary Care referrals
- Reducing the number of patients having routine follow up appointments in Secondary Care

Delivery

The service provider will:
- Ensure that patient consent has been obtained to access their record
- Review the referral, where appropriate
- Offer those services described in the Diabetes Level 1 specification
- Ensure injectable initiation/optimisation will be provided by an appropriately qualified and accredited registered healthcare professional(s). Staff delivering the service must provide regular and frequent injectable initiations throughout the year to maintain standards and competencies
- Ensure dietetic support is provided by a healthcare professional with Diabetes Specialist Dietician competencies (see Appendix 3). Normally this would be a Diabetes Specialist Dietician from the Community Provider
- Ensure that the initiation follows the schedule detailed in Appendix
| A | Ensure that in most instances where insulin is initiated, human insulin would be used rather than analogues, in line with CWHHE Diabetes Guidelines (under development) |
| Determin the frequency of follow-up based on the registered healthcare professional’s assessment of a patient’s progress and any complications associated with injectable initiation. |
| o In the first 12 weeks, a patient may require weekly follow-up appointments or only two follow-up appointments following initiation. |
| o During this period, the registered healthcare professional can ascertain the patient’s ability to use injectables appropriately, and identify any safety concerns and suitability to continue insulin. The requirements detailed in Appendix A are the minimum requirements for follow up |
| Prescribe the first week/month’s supply of insulin/GLP-1 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 (or equivalent clinical system) |
| Refer to other diabetes services where necessary, e.g. Foot Protection Team, Community diabetes service and Secondary Care |
| 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 |
| When insulin initiation is completed, the patient must be discharged from the service to the care of their registered GP. On discharge, the service provider will provide the patients with the following: |
| o A personal care plan agreed with the patient (a hard electronic copy to be provided to the patient and their registered GP, as appropriate) |
| o A patient management plan for the GP on SystmOne and an electronic copy emailed to the referrer, if the practice does not operate on interoperable clinical system. |
| On discharge, the following information will be collected and where appropriate, entered onto SystmOne (or equivalent clinical system): |
| o Latest measure of patient’s HbA1c and when next HbA1c test is required |
| o Patient satisfaction questionnaire completed |

The service provider will also:

- 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
- Offer innovative methods of follow-up consultation/support to patients that are interested, such as teleconferencing, VitruCare, email, texts or YouTube videos
- Ensure that an appropriately qualified and accredited healthcare professional is available to offer same day telephone advice on
<table>
<thead>
<tr>
<th>Standard 2</th>
<th><strong>Diabetes – level 2</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Injectable therapy between the hours of 08:00 to 18:30, Monday to Friday excluding Bank Holidays.</td>
</tr>
<tr>
<td></td>
<td>• Support and encourage engagement with services provided by diabetes mentors, lay educators and champions where these exist</td>
</tr>
<tr>
<td>Key performance indicators</td>
<td>1. Based on the current OOH service Diabetes Dashboard</td>
</tr>
<tr>
<td></td>
<td>2. Stretch targets will be developed in Q3 and Q4 of the financial year for the following year</td>
</tr>
<tr>
<td>CCG support</td>
<td>• Will provide the Diabetes Dashboard on a monthly basis and tailored reports on the WSIC dashboard to support practices</td>
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<tr>
<td></td>
<td>• Will provide training opportunities and updates to continuously upskill staff</td>
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<td></td>
<td>• Will align community and acute contracts to ensure the wider system work with practices</td>
</tr>
<tr>
<td></td>
<td>• Will commission support services, such as (but limited to) NDPP and Diabetic retinopathy for patients</td>
</tr>
<tr>
<td>References</td>
<td></td>
</tr>
<tr>
<td>CCG contact</td>
<td>Dr Raj Chandok</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:rajchandok@nhs.net">rajchandok@nhs.net</a></td>
</tr>
<tr>
<td><strong>Standard 3</strong></td>
<td><strong>Respiratory disease</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Aims</strong></td>
<td>To:</td>
</tr>
<tr>
<td></td>
<td>- Increase the prevalence of COPD closer to the expected and reduce variation between practices</td>
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<tr>
<td></td>
<td>- Ensure that all patients with COPD and Asthma have an annual review in line with National Guidelines.</td>
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<tr>
<td></td>
<td>- provide appropriate and timely education to enable patients to manage their respiratory disease with confidence</td>
</tr>
<tr>
<td></td>
<td>- Contribute towards the reduction in Emergency attendances and admissions for respiratory disease</td>
</tr>
<tr>
<td></td>
<td>- Achieve compliance with the London Asthma Standards for Children and Young People</td>
</tr>
<tr>
<td><strong>Rationale</strong></td>
<td>Hospital admissions for COPD In Ealing are higher than both the London and England averages. This high rate of admissions does not correlate with General Practice prevalence and therefore the variation that exists between practices must be explained by other factors, variation in care being the most obvious. This can be seen in the achievement of certain QOF indicators such as a record of FEV1 in the last 15 months varies from 100% to 17%.</td>
</tr>
<tr>
<td></td>
<td>Ealing (0.89%) has a lower recorded prevalence of COPD than London (1.14%) and England (1.85%). It is therefore estimated that 65% of people living with COPD remain undiagnosed in Ealing.</td>
</tr>
<tr>
<td></td>
<td>Ealing has equally high rates of admission for Asthma compared to London and England and Ealing’s Asthma mortality rate remains high.</td>
</tr>
<tr>
<td></td>
<td>Prevalence for Asthma in Ealing is similar to the London and England averages but large variations in care exist between practices. For example, the number of patients who have had an asthma review in the last 15 months ranges from 39% to 95%.</td>
</tr>
<tr>
<td></td>
<td>Key recommendations from the National Review of Asthma Deaths (2014) aim to address these variations. This report suggests that 90% of the deaths reviewed could have been prevented and implementation of their recommendations would significantly reduce both mortality. For example, Personal Asthma Action Plans reduce attendance at emergency settings fourfold.</td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
<td>Practices will be expected to:</td>
</tr>
<tr>
<td></td>
<td>Identify a Lead within the practice who will have oversight and will steer the practice to achieve the following:</td>
</tr>
<tr>
<td></td>
<td><strong>COPD</strong></td>
</tr>
<tr>
<td></td>
<td>- Identify ‘at risk’ patients (&gt;40, ex/current smokers, PMH frequent URTI) and screen for COPD. Anyone found to be at high risk should be formally assessed and have Quality Assured Spirometry.</td>
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<tr>
<td></td>
<td>- Patients newly diagnosed should be offered advice and support to improve exercise capacity and self-manage their condition, including using inhalers correctly.</td>
</tr>
<tr>
<td></td>
<td>- Patients with stable COPD or who have recently had an exacerbation and exercise limitation due to breathlessness should</td>
</tr>
</tbody>
</table>
be referred to a pulmonary rehabilitation programme.

- Patients with a history of frequent exacerbations should be offered a rescue pack with written instructions.
- Patients with significant breathlessness that causes anxiety should be referred to IAPT for support
- Patients with very severe COPD should be placed on the palliative care register and advanced care planning instigated.

ASTHMA - ADULTS

- Patients should be diagnosed in accordance with BTS/SIGN Guidance (2016).
- Patients should be reviewed annually, provided with a written personalised action plan and trained in correct inhaler technique.
- All patients who attend UCC, A&E or who are admitted will be reviewed within 4 days after attendance / discharge.

ASTHMA – CHILDREN AND YOUNG PEOPLE

- Children and Young People should be diagnosed in accordance with BTS / SIGN Guidance 2016
- Every child should have an assessment of the triggers for their wheeze and should be screened for other atopic comorbidities
- Consultations with children and their carers should be long enough to allow time for promotion of healthy lifestyles for the whole family and smoking cessation advice and referral made for carers who smoke.
- Children and carers should receive specific training and assessment in inhaler technique
- All children who attend UCC, A&E or who are admitted will be reviewed within 2 working days or less after attendance / discharge.
- All children on treatment for their asthma should be reviewed at least every 6 months (or 3 monthly if severe) and should include assessment of adherence, inhaler technique and Asthma Control Test for children aged over 4 years.
- Children with difficult asthma or with multiple atopic conditions may be referred to the specialist paediatric asthma nursing service.

Key performance indicators

COPD

1. Improving COPD prevalence

**Measure:** Patients who currently smoke or who have smoked in the last 5 years to have their risk of COPD assessed. This will be measured using a risk assessment tool (suggested questions to be used to be extracted from here: [https://www.copdfoundation.org/Screener.aspx](https://www.copdfoundation.org/Screener.aspx))

**Monitoring:** Quarterly Clinical Dashboard. [Numerator – Total number of patients >40 who smoke or who have smoked in the last 5 years. Denominator – Number of patients who have been screened]

**Threshold:** ≥ 75%

2. Ensuring an accurate diagnosis

**Measure:** All patients identified as being at risk, or who present with suspected COPD, to have Quality Assured Diagnostic Spirometry.

**Monitoring:** Quarterly Clinical Dashboard. [Numerator – Total number of
### Standard 3: Respiratory Disease

<table>
<thead>
<tr>
<th>Patients screened (in 1.). Denominator – total number of patients who have had QA spirometry</th>
<th>Threshold: 75%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Ensuring staff are competent to undertake spirometry and train patients to use inhalers correctly</strong></td>
<td></td>
</tr>
<tr>
<td>Measure: All staff performing and interpreting spirometry to be on the National Spirometry Register. All staff to attend annual inhaler technique training.</td>
<td></td>
</tr>
<tr>
<td>Monitoring: Annual declaration of attendance at relevant courses and evidence of staff entered on the Spirometry Register.</td>
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</tr>
<tr>
<td>Threshold: 100%</td>
<td></td>
</tr>
<tr>
<td><strong>4. Preventing unwarranted hospital Admissions and A&amp;E attendances</strong></td>
<td></td>
</tr>
<tr>
<td>Measure: Patients who have had more than 3 exacerbations in the previous 12 months should have a rescue pack with written instructions.</td>
<td></td>
</tr>
<tr>
<td>Monitoring: Quarterly Clinical Dashboard. [Numerator – Total number of patients with a recorded exacerbation of COPD on 3 separate occasions over previous 12 months. Denominator – number of patients coded as having received a rescue pack].</td>
<td></td>
</tr>
<tr>
<td>Threshold: 75%</td>
<td></td>
</tr>
</tbody>
</table>

### Asthma

| **1. Preventing unwarranted attendance at emergency settings:** |
| Measure: All patients who are on regular preventative inhalers to have a written Personal Asthma Action Plan |
| Monitoring: Quarterly Clinical Dashboard [Numerator – Number of patients with asthma on a preventer inhaler; Denominator – number of these patients with a PAAP]. |
| Threshold: 75% |
| **2. Improving Medication Concordance:** |
| Measure: All patients have their inhaler technique checked as part of their annual review |
| Monitoring: Quarterly Clinical Dashboard [Numerator – number of patients with asthma on any inhaler; Denominator – number of these patients coded as having their inhaler technique checked]. |
| Threshold: 75% |
| **3. Preventing further asthma attacks – Adults and CYP:** |
| Measure: Any patient who is admitted to hospital or who attends UCC or A&E due to an asthma attack is to be reviewed within 4 days (2 days for children) of being discharged |
| Monitoring: Quarterly Clinical Dashboard [numerator – number of patient with asthma attending A&E, UCC or admitted to hospital for an asthma attack; Denominator – number of these patients seen within 4 days of discharge]. |
| Threshold: 75% |

**Reporting:**

Confirm the name and role of the respiratory lead for the practice.
### Standard 3: Respiratory disease

| CCG support | • Develop business rules for Read codes and extraction to support KPIs and local dashboard development.  
• Provide inhaler technique and other applicable training for primary care clinicians  
• Continue to commission a pulmonary rehabilitation service  
• Develop a template for patients who are at risk of COPD |

| References | • Ealing JSNA  
• BTS / SIGN Asthma guidelines 2016  
• Improving the quality of diagnostic spirometry in adults: the National Register of certified professionals and operators  
• Salford quality standards for primary care  
• NICE COPD Quality Standards  
• London Asthma Standards for Children and Young People |

| CCG contact | Sally Armstrong  
sally.armstrong@nhs.net |
### Standard 4: Cardiovascular Disease

#### Rationale
Cardiovascular disease (CVD) is an overarching term that describes a family of diseases including coronary heart disease, stroke, and kidney disease sharing a common set of risk factors.
- 4.9 million people aged 16 or over in England have CVD, which is 11.7% of the population.
- CVD is responsible for 200,000 deaths per year - 1 in 3 deaths in UK.
- The combined cost of cardiovascular disease to the NHS and UK economy is estimated at £30 billion.

In Ealing the percentage of cardiovascular deaths as a proportion of all deaths was 25.6% for people aged under 75 years and 35.0% for people aged 75 and above. This is higher than England for under 75s (23.8%)

Ealing CCG GP registered population is 417,000. This is significantly higher than the Borough population which is recorded at 342,494. Over 40% of the local population is from the BME population who are known to have higher incidence of Cardiovascular disease (CVD).

Population breakdown:
- White 49% includes large Polish population - long established and new groups
- Asian 29.7% primarily Indian in origin
- Black 10.9%
- Mixed 4.4%
- Other 6%

The Ealing Primary Care Perspective

Public Health England data shows that Ealing has:
- a higher CVD Emergency admission rate (3.8/1,000) than the England average (3.3/1,000).
- the highest CVD elective admission rate (7/1,000) in London

Priorities relevant to primary care, identified in the Ealing JSNA are:

1. Address the primary prevention of CVD through the NHS health checks programmes
2. Improve AF care pathway to promote proactive case finding, identify and appropriately manage high risk patients to improve prescribing of anticoagulants adhering to NICE guidance.
3. Continue to designate smoking as a priority in reducing prevalence of CVD
4. Maintain and develop the self-care programme to enable those with CVD to effectively manage and live with their condition.
5. Promote lifestyle interventions such as physical activity, healthy eating, sensible drinking, smoking cessation and weight management; and consider the creation of integrated community lifestyle service model.
6. Active case management of patients with CVD within community should be considered to reduce the rate of emergency admissions and complications. The implementation of community based cardiology service may result in lower admission rates.
Standard 4  |  Cardiovascular disease

7. Commissioning cardiac rehabilitation

Over the last 1.5 years, we have achieved many of these standards by:
- Working closely with public health to drive up performance of NHS health checks by practices
- Commissioned a Community Cardiology Service which streamlines pathways of care for common cardiological problems as well as setting clear thresholds for referral to specialist care
- Commissioned a Cardiac Rehab Service as part of the Community Cardiology Service
- Delivered a Specialist Cardiology Upskilling Course to primary care clinicians in order to enable them to manage patients with common cardiological problems better in primary care

**Delivery** Practices will be expected to:

**Manage patients with Atrial Fibrillation**
- Utilise CHA2DS2-VASc scoring system (NICE 180) and discuss bleeding risk with patients prior to commencing appropriate anticoagulation with DOACs or warfarin
- All patients identified with an irregular pulse with no diagnosis of AF to have a 12 lead ECG and Holter/24-48hr ECG where clinically appropriate

**Identify patients with Hypertension**
- Perform ABPMs or Home Blood pressure monitors in order to formally diagnose patients with hypertension

**Manage patients with Heart Failure**
- Refer patients appropriately to the Community Heart Failure Service as per agreed Cardiology Guidelines

**Manage patients with high Cardiovascular Risk Scores – Primary Prevention**
- Ensure patients with Qrisk/CVD scores > 20% are reviewed and commenced on appropriate cardiovascular risk reduction therapy as appropriate

**Abide by the published, commonly agreed Cardiology Guidelines/Community Referral Standards developed jointly by specialists and primary care clinicians**

It is expected that practices will continue to refer to the service description/care pathway component of the OOHs specs, namely:
- Warfarin Monitoring v22
- Advanced Warfarin Monitoring v22
- ECG v22
- ABPM v22

<table>
<thead>
<tr>
<th>Key performance</th>
<th>QoF Stretch KPI/target:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. AF 006 CHA2DS2-VASC score in patients diagnosed with AF –</td>
</tr>
<tr>
<td>Standard 4</td>
<td><strong>Cardiovascular disease</strong></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
| **indicators** | QoF max target 90% - Wraparound target 95%  
2. AF 007 – Those with AF and CHA2DS2-VASC =>2 currently treated with anticoagulation therapy – QoF max target 70% - Wraparound target 100% (as per LIS 17/18). Exceptions include:  
  a. HAS BLED score>3  
  b. Anticoagulation declined  
  c. Anticoagulation not indicated |
| **Wraparound standalone KPIs** | 3. Patients anticoagulated on warfarin – practice target for TTR >70% on average for all patients on warfarin being monitored |
| **CCG support** |  
- Develop business rules for Read codes and extraction to support KPIs and local dashboard development.  
- Continue to provide annual Cardiology Upskilling courses for primary care clinicians. These will serve as refreshers and update sessions and will enable clinicians to continue to work collaboratively with our Community Cardiologist colleagues. |
https://www.nice.org.uk/guidance/cg180  
Public Health Outcomes Framework  
http://www.phoutcomes.info/public-health-outcomes-framework  
https://www.ealing.gov.uk/info/201072/strategies_plans_and_policies/1963/ealings_joint_strategic_needs_assessment |
| **CCG contact** | Dr Alex Fragoyannis  
amalexfragoyannis@nhs.net |
"Life expectancy in England has risen by more than five years in the past two decades, yet for many people, a longer life will involve more years spent in ill-health. Musculoskeletal conditions are disorders of the bones, joints, muscles and spine. They can cause pain, stiffness or a loss of mobility and dexterity that can make it difficult to carry out everyday activities. Low back and neck pain is now the leading cause of disability in England for both men and women combined. Falls, which are often a result of poor musculoskeletal health, also remain in the top ten causes of disability adjusted life years – a combination of the number of years of life lost to disease and the number of years lived with disability as a result of disease.

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

Musculoskeletal health: making a difference
Steps can be taken to improve musculoskeletal health at every stage of life, and tackling a number of risk factors could result in the dramatic improvement in the musculoskeletal health of the public. Bones, joints and muscles begin to develop before birth, and continue to develop throughout childhood. Women who have a good diet and are physically active have babies that go on to have stronger bones throughout life. Conversely, childhood obesity can put pressure on vulnerable joints, increasing the risk of MSK conditions. Regular physical activity and exercise at every stage of life can reduce the risk of many musculoskeletal conditions, including arthritis, back pain, neck pain, falls and fractures. Indeed, many of the NICE guidelines on physical activity to prevent disease or improve health are directly relevant to musculoskeletal health. A healthy balanced diet is also important for good bone health, to prevent osteoporosis and falls in later life. There is also a lot that can be done in the workplace to reduce any threats to musculoskeletal health, including adapting physical environments and work practices, as well as early interventions to identify and address problems. It’s important to note that, for the three leading...
Standard 5

Musculoskeletal health

Musculoskeletal conditions that cause the most DALYs in England, there are evidence-based interventions that work (see table).

Evidence-based interventions for the musculoskeletal conditions that cause the most DALYs

<table>
<thead>
<tr>
<th>Musculoskeletal condition</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low back and neck pain</td>
<td>Stay physically active and exercise regularly, e.g. through a group exercise programme. Weight loss support (if required).</td>
</tr>
<tr>
<td>Falls</td>
<td>Strength and balance training. Home hazard assessment. Participation in falls prevention programmes such as Otago and FaME. Activities such as tai chi, dancing or gardening.</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>Activity and exercise to strengthen muscles and improve aerobic fitness, such as walking, swimming or Pilates. Weight loss support (if required).</td>
</tr>
</tbody>
</table>


The Ealing primary care perspective

Public Health England data shows that Ealing has:
- High rate of falls and emergency admissions for falls in people >65yrs.
- High rate of hip fractures.
- High rate of inactivity in adults.

Priorities relevant to primary care, identified in the Ealing JSNA are:
- Increasing physical activity at all ages.
- Referral to falls prevention programmes.
- Secondary prevention of fragility fractures.
- Improved management of chronic pain.
- Reducing obesity and smoking in adults.
- Reducing unwarranted variations in referral rates between GP practices.
- Improved links between NHS and return to work schemes.

Priorities from other sources:
- Increase numbers of orthopaedic referrals referred to community interface services for assessment, prehab, and diagnostics to deliver the right conservative and surgical options for patients. (Source: PPwT office).
- Improve advice offered in primary care to support self-management for people with musculoskeletal disorders to reduce unnecessary early referrals to physiotherapy (Source: MSk Core Strategy...
Musculoskeletal health

- Improve referrer adherence to referral thresholds and stream selection (Source: MSk Core Strategy Group).
- Improve step-down support to reduce harm from prescribing for chronic pain: tapentadol, opioid and lignocaine patches, pregabalin (Source: Medicines Management Team).

Delivery Practices will be expected to:

General health promotion and primary prevention
1. Signpost people to activity and exercise classes appropriate for their age and health.
2. Refer to weight loss and healthy lifestyle programmes for people at risk of lower limb osteoarthritis and back pain.
3. Undertake a brief falls assessment in patients identified on GP systems as meeting frailty criteria.
4. Refer patients with a history of falls, or at medium and high risk of falls, for a falls assessment, according to local referral pathway (under development).

Secondary prevention
5. Offer specific advice on activity modification and condition-specific exercises for people with musculoskeletal disorders.
6. Refer people off work for a musculoskeletal condition for more than four weeks, when clinically appropriate, to the ‘Fit for Work’ scheme or an equivalent occupation health review.

Referral management
7. Manage patients with acute musculoskeletal conditions or acute flare-ups of chronic musculoskeletal conditions in primary care unless they meet referral thresholds agreed between provider and CCG, including where a validated risk assessment tool (e.g. STarT Back) suggests the person is at high risk of poor outcome.
8. Refer all non-emergency hip, knee, shoulder and spinal conditions to the community interface service for assessment, prehab and diagnostic work-up where the GP believes surgery is the appropriate option.

Chronic pain management in primary care
9. Manage patients with chronic musculoskeletal pain in primary care if a treatable musculoskeletal condition has been excluded, particularly those previously assessed by musculoskeletal, orthopaedic or pain services.
10. Manage concomitant depression and anxiety in patients with chronic musculoskeletal pain with psychological or pharmacological interventions.
11. Manage medication for patients with chronic musculoskeletal pain to reduce the risk of harm from ineffective interventions and choose more cost-effective options where available.

Training
<table>
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<tr>
<th>Standard 5</th>
<th><strong>Musculoskeletal health</strong></th>
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<tbody>
<tr>
<td>12. Undertake training for clinical and non-clinical staff to support the delivery of musculoskeletal care specified above. See CCG and CEPN support para 2, below.</td>
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</tbody>
</table>

### Key performance indicators

Note: There are two KPIs: a fixed KPI to support bone health, and a yearly changing KPI to support best practice use of clinical pathways.

#### 1. 90% of people with a new fragility fracture after 1 April 2018 are offered a falls assessment.
(Numerator: people with Read codes for a new fragility fracture after 1 April 2018 and falls assessment within 3 months of the fracture, Denominator: people with Read codes for a new fragility fracture after 1 April 2018.) Note, the falls assessment could be coded if completed by third party e.g. fracture liaison service.

Additional Year 1 KPI (1 year only)
2. The practice refers at least 75% of potential referrals to orthopaedics, neurosurgery (including PPwT) to the community MSk interface service.

If a practice does not achieve indicator 2, as a minimum the practice would be required to achieve indicator 2b below as an alternative:

2b. The practice refers at least 90% of potential referrals to orthopaedics, neurosurgery (including PPwT) to the community MSk interface or physiotherapy services.
(Numerator: physio + interface clinic referrals. Denominator: physio + interface clinic referrals + GP orthopaedic referrals + GP neurosurgery referrals + GP orthopaedic PPwT referrals). (Source: provider data, e-referral data, S1 referral data) Note: this option allows for referrers to refer a potential orthopaedic referral to physiotherapy rather than the interface service if clinically appropriate (and meeting referral guidance).

Additional Year 2 KPI (1 year only)
3. Reduce orthopaedic PPwT GP referrals by practice to less than 5% of total PPwT referrals by practice (including hospital generated PPwT) for hip and knee surgery. (Currently 10%) (Source: PPwT Office Audit)
(Numerator: GP hip and knee surgery PPwT referrals by practice. Denominator: Total hip and knee surgery PPwT referrals by practice)

Additional Year 3 KPI (1 year only)
4. 90% of musculoskeletal referrals have been made following use of the Referral Action Line, Local Referral Management Guidelines (in development) or a validated risk assessment tool (e.g. STarT Back).
(Numerator: referrals made with a Read code indicating use of local guidelines or risk assessment tools. Denominator: total number of referrals made).

### MSK Dashboard

5. Referrals rates (per 1,000 pop) to exercise, health lifestyle and falls programmes.
### Standard 5: Musculoskeletal health

| 6. Percentage of patients on frailty register with a falls assessment. |
| 7. Percentage of patients with a new diagnosis of osteoarthritis or back and neck pain offered advice and condition-specific exercises (year 1). A preferred list of Read codes will be published. These diagnoses can be made on clinical grounds, in primary care, without imaging, as per NICE guidelines. The expected prevalence at CCG level is available from [http://www.arthritisresearchuk.org/arthritis-information/data-and-statistics/musculoskeletal-calculator.aspx](http://www.arthritisresearchuk.org/arthritis-information/data-and-statistics/musculoskeletal-calculator.aspx) |
| 8. Percentage of people off work for more than four weeks with a musculoskeletal problem referred for an occupational health or Fit for Work assessment (year 1) |
| 9. Percentage of people re-referred to community musculoskeletal services for the same condition within 12 months. (provider data, year 1) |
| 10. Percentage of patients consulting regularly with back pain, osteoarthritis or rheumatoid arthritis who have a new diagnosis of anxiety or depression are referred or signposted to IAPT or referred to a physical and psychological pain management programme. |

The following are not KPIs but will be monitored in the longer term (5-10yrs) to ensure this enhanced contract is contributing to the Public Health Outcomes Framework National Indicators (available at borough or CCG level only) (for monitoring only)

- PHE 2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Persons)
- PHE 2.13ii - Percentage of physically active and inactive adults - inactive adults
- PHE 1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate

### CCG support

- Develop business rules for Read codes and extraction to support KPIs and local dashboard development.
- Provide training for primary care clinicians (CEPN upskilling courses)
  - Use of falls assessment tools, local referral criteria and validated MSK assessment tools
  - Fit for Work referrals
  - Local referral pathways for falls prevention
  - Core treatments for MSk conditions in primary care, including demonstrating exercises to patients to improve adherence
  - Management of chronic pain in primary care, including management of patients that GPs find challenging
- Work with Local Authority and voluntary sector to provide signposting information for primary care clinicians, including a list of voluntary sector and directly commissioned exercise classes and health lifestyle services to support self-management.
- Commission access to a community-based combined physical and psychological programme for people with chronic musculoskeletal pain.
- Work with MSk provider and Local Authority to produce leaflets,
### Standard 5

**Musculoskeletal health**

- Exercise videos and signposting to support self-management

### References


- Public Health Outcomes Framework [Link](http://www.phoutcomes.info/public-health-outcomes-framework)

- Health and Work: Spotlight on musculoskeletal conditions (MSK), Public Health England and The Work Foundation 2016 [Link](https://app.box.com/s/1qm34sx148rx6nyywnjow131xaplp3zl)


### CCG contact

- Dr Ian Bernstein
  - [ian.bernstein@nhs.net](mailto:ian.bernstein@nhs.net)
Standard 6  

**Ring pessary**

**Rationale**

Pelvic organs, such as the uterus, bladder or bowel, may protrude into the vagina because of weakness in the tissues that normally support them. The symptoms that they cause vary, depending on the type of prolapse. Pessaries (mechanical devices such as latex or silicone pessaries) can be used to try to restore the prolapsed organs to their normal position and hence to relieve symptoms. They are commonly used when conservative treatment, like physiotherapy, and surgery have either failed or are not suitable, for example in women who have other serious chronic health problems, such as heart or lung disease, that make a surgical procedure more dangerous, when the symptoms of pelvic organ prolapse are mild or when childbearing is not complete.

Pelvic organ prolapse is common, with some degree of prolapse seen in up to 50% of parous women in a Gynaecological clinic setting, although many are asymptomatic. The use of pessaries (a passive mechanical device designed to support the vagina) to treat prolapse is very common, and up to 77% of clinicians use pessaries for the first line management of prolapse.

Below is activity data for Ealing Practices in the last 2 years

<table>
<thead>
<tr>
<th>Period</th>
<th>Duration</th>
<th>Pessaries</th>
<th>Practices Delivering</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>09 Months</td>
<td>213</td>
<td>37</td>
</tr>
<tr>
<td>2016/17</td>
<td>12 Months</td>
<td>508</td>
<td>44</td>
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</table>

The CCG is commissioning a ring pessary service to ensure that women can experience a high quality service delivered as close to the patient’s home as possible. It is a service that can be offered safely, conveniently and appropriately in a community setting.

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 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.

**Delivery**

The Consultant / GPwSI will refer the patient to the OOH Ring Pessary service, via their registered GP, with a detailed discharge letter specifying the pessary details and timeframe for review appointment.

N.B. The assessment and initial fitting may be carried out in Primary Care under this service specification if the Service Provider feels competent to assess suitability as outlined above.
First Consultation (post review by Consultant/GPwSI)
The service provider will:
- Ensure that patient consent has been obtained to access their record
- Review the referral/discharge letter from Secondary/Community Service and arrange an initial consultation in Primary Care
- Ensure that the patient has a prescription for a pessary from their registered GP prior to their initial appointment (if required). Thereafter the service provider will issue a prescription for a new ring pessary.
- Agree a follow up appointment time with the patient and provide safety netting advice regarding ring pessary care

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.
  - Review symptom control, and return the patient to their registered GP for consideration of referral back 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.
- 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.
- Refer patients with complications back to the specialist team, via the patient’s GP, if necessary;

Patients should be able to return to the 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.

Acceptance
Female patients aged 18 and above

Exclusions
The service is for ring pessaries only. Therefore the service does not include:
- Estring[Pharmacia] ring pessary used for atrophic vaginitis
- Insertion of Prostaglandin pessary
Standard 6 Ring pessary

- Insertion of abortifacient pessary
- Insertion of pessary for Incontinence without prolapse

Workforce Requirements
- The service provider must ensure that staff delivering the service meet the training and competency requirements outlined in the OOHS Training and Clinical Competencies Guidance document.
- The service can be provided a GP or suitably qualified registered nurse.
- Nurses providing this service must be competent in bi-manual examination in line with the competencies set out in Genital Examination in Women (RCN,2013)
- 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 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 GP provider grouping.
- The service provider should ensure that all delivery points meet CQC requirements for the delivery of medical services which as a minimum should be those required for the delivery of general medical services.
- The service provider should ensure that all standards of communication should adhere to Caldicott and Data Protection guidelines.
- Data generated in the course of delivering the service should be available to the commissioner on request. The commissioner will give due regard to data protection and confidentiality requirements.
- If required to ensure that the service is operating effectively, the commissioner can interview the service provider’s staff.
- The service provider should comply with commissioner requests for clinical audit.

Key performance indicators

- 1. 95% of patients have a pessary inserted within 9 months of previous fitting

CCG support

- Training to upskill appropriate numbers of GPs and Nurses to deliver the service
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<tbody>
<tr>
<td><strong>References</strong></td>
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<td><a href="#">RCN (2013) Genital examination in women</a></td>
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<tr>
<th>CCG contact</th>
<th>Dr Maria Waters</th>
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<td><a href="mailto:maria.waters@nhs.net">maria.waters@nhs.net</a></td>
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</table>
Standard 7 | Care planning and co-ordination

Rationale

The CCG wishes to commission a case finding, care planning and case management service for individuals with complex health and social care needs to ensure they have a care plan in place, supported by proactive case management as appropriate. This in turn supports the aim to ensure we are commissioning proactive care with the patient at the centre, coordinated by the GP. This will support patients to have consistent planned care which is joined up and will reduce the risk of patient needing unwarranted unplanned care.

This service has the following underlying principles:

- Shifting from unplanned to planned care: assessment of patient’s objectives to set appropriate goals and path going forward.
- Empowering individuals, carers and families: provision of a copy of the plan as well as relevant supporting information (e.g., patient conditions, emergency procedures, support groups)
- Improving coordination of different areas of health and social care: review and update the care plan in multi-disciplinary meetings, internal and external to practice, articulating contact with health and social care services, secondary care, mental health and others.
- Establishing exemplary governance systems: clear action planning – what are we doing, who is responsible and when will it be reviewed
- 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.
- That practices work with the rest of the system to manage patients with complex needs delivering proactive and coordinated care

Delivery | Identification of Patients:

It is expected that service providers will deliver the requirements as laid out in the core contract, of Identification and Management of Patients with Frailty;

- Use of the Electronic Frailty Index (eFI) to identify all patients who are living with moderate and severe frailty.
- Create a register for patients living with moderate and severe frailty.
- For patients with moderate or severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions.
- A practice, through experience of their patients, will know of patients who would benefit form a Care Plan who have complex medical needs who may not be identified using the eFI tool. We would therefore like these patients to be Care Planned.
- In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this, seeking informed patient consent to activate the enriched SCR.
- The practice will use tools such as the WSIC Dashboard to understand flows of patients through the system to provide targeted support
Care Planning:

- Care planning should take place during a face to face consultation with the patient (and carer as appropriate) to develop a personalized care plan.
- The care plan should be a collaborative process between the patient (and carer/family); an accountable GP or other appropriate and competent registered healthcare professionals. The care planning consultation should seek to address how their care will be managed to:
  - Enable effective management of their long term condition/s
  - Enable optimum supported self-management
  - Provide clear contact points for times of crisis / exacerbation
  - Understand the patient’s interactions with other agencies providing support to them
  - Consider the needs of the patient’s carers
  - Review medications being taken by the patient and support improved compliance, where appropriate
  - Agree the case management approach with the patient, i.e. frequency of review of care plan, review arrangements in the event of an unexpected admission to hospital etc
  - Reduce their risk of avoidable admission to hospital

- Care planning appointments should be flexible to meet the patient’s needs and the objectives of the appointment. It is expected that appointments will usually require at least 30 minutes.
- The care plan should be completed using the commissioners’ approved letter template which is available on the clinical systems.
- The care planning process should look to establish the patient’s consent for their medical record to be shared with other health and social care professionals as needed and for the service provider to be able to receive information relating to the patient’s care in other health and social care setting electronically. The service provider is expected to provide the patient with clear information as to the benefits of sharing their patient record with other providers.
- The service provider will assess for Fraser guidelines, where appropriate
- The service provider is expected to review via face to face/telephone consultation any patient identified as living with moderate and severe frailty on the eFI register who have had an unplanned admission into hospital within five working days of notification of discharge. The service provider will update the patient’s care plan as required. This contact can be by GP, pharmacist, practice nurse or nurse practitioner.
- Non elective hospital admissions should be read coded.
- The service provider will also undertake a review of the patient’s care plan following a stay in an intermediate care service commissioned by a CCG
- The service provider will carry out regular care plan reviews via a face-to-face or telephone consultation, the frequency of review will depend on risk and should be agreed between the registered healthcare professional and patient; but is recommended to be
## Care planning and co-ordination

undertaken every four to six months.

- Copies of care plans must be given to patients (and carers as appropriate)
- The creation of a care plan with the patient (and carer) is an annual process.
- When creating a care plan with the patient the following areas of the template must be populated at the same time as the assessment;
  - Admission avoidance care plan agreed
  - Summary of needs
  - Anticipatory Care Plan
  - Review of patient goals
- The practice will utilise support services such as the Intermediate care service (Homeward), Community Cardiology and Care Coordination to support their patients.
- The Care Coordination team will arrange MDTs with the relevant stakeholders as required to meet the needs of the patient and provide targeted interventions under the supervision of the clinical lead in the practice.

### Case Management: MDG

The provider is expected to support the approach to case management that is well established across North West London. This will involve:

- An appropriate member from the provider will attend Multidisciplinary Group meeting (MDG) discussions on a regular basis at a network level. The frequency and duration of the MDGs is determined by the MDGs themselves. *[Currently each MDG Chair is requesting feedback from their Practices as to whether that Network wants a bi-monthly or quarterly MDT. We should await this feedback and allow each MDG Network to review frequency of meetings annually.]*
- The CCG will perform a six monthly review of the MDG attendances to assess the return on investment and impact on improving patient care.
- Cases must be submitted a week in advance of the MDG meeting.
- The outcomes of the MDG meeting should be followed up and care plans amended as required.
- Outputs of the MDG should be shared with the wider practice team

### Case Management: MDT

- The service provider should hold a practice *monthly* Multidisciplinary Team Meeting (MDT) which could include social care, community services and specialist input, such as *practice based clinical pharmacists*, as required.
- The membership of the MDTs is dependent on the size of the service provider, however a minimum would be at least one GP/Nurse Practitioner, Practice Nurse and Senior non clinical member of the practice.
- The service provider is *expected* to bring appropriate cases for discussion and it is the responsibility of the attending clinician to play a proactive role in the MDT discussions.
- A meeting record should be available for the wider practice team to
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<th>Standard 7</th>
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<td>remain informed of actions/decisions and patient records updated if appropriate. The outcomes from the MDT meeting should be followed up and care plans amended with the patient as required.</td>
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<td>• Learning points from the discussion should be shared at provider level discussions.</td>
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<td>• The service provider will need to determine the most appropriate case management approach for each patient on their caseload.</td>
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| Key performance indicators | 2. Number of patients with a completed care plan minimum 2% (registered population) |
|                          | 3. 80% of patients who had an unplanned admission and have been reviewed within 5 working days |
|                          | 4. 90% of patients given a copy of their care plan each FY |

| CCG support | • Administrative support to coordinate MDG Meeting |
|            | • Support to MDG chairs to manage MDG Meetings |
|            | • Provision of WSIC Dashboard and tailored dashboards to meet the requirements identified by practices |
|            | • Align contractual requirements of providers to work with networks of practices |
|            | • Encourage providers to bring cases they are concerned about to MDG /MDT meetings |

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<th>References</th>
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<tr>
<th>CCG contact</th>
<th>Dr Raj Chandok</th>
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<td><a href="mailto:rajchandok@nhs.net">rajchandok@nhs.net</a></td>
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### End of life care

#### Rationale

Approximately 500,000 people die in England each year. People with advanced life threatening illnesses and their families should expect good end of life care, whatever the cause of their condition.

In addition to physical symptoms such as pain, breathlessness, nausea and increasing fatigue, people who are approaching the end of life may also experience anxiety, depression, social and spiritual difficulties. The proper management of these issues requires effective and collaborative, multidisciplinary working within and between generalist and specialist teams, whether the person is at home, in hospital or elsewhere. Information about people approaching the end of life, and about their needs and preferences, is not always captured or shared effectively between different services involved in their care, including out of hours and ambulance services.

Families, including children, close friends and informal carers, also experience a range of problems at this time. They play a crucial role and have needs of their own before, during and after the person's death: these too must be addressed.

Many people receive high-quality care in hospitals, hospices, care homes and in their own homes but a considerable number do not. Up to 74% of people say they would prefer to die at home, but currently 58% of people die in hospital.

There is considerable geographical variation. In Ealing 59% of people die in hospital, 20% at home, 14% in care home and 5% in a hospice.

The last phase of life agenda is a priority of the NWL STP. Key areas are training, identification and advance care planning and lead provider delivery.

#### Delivery

**Identifying end of life patients**

About 1% of practice populations will die each year, with most deaths occurring due to old age. Cancer only accounts for about 25% of all deaths - hence the importance of adding patients onto the palliative register who have progressive long term conditions like heart failure, COPD and dementia.

Some of your deaths will be genuinely 'unexpected': around 16% each year are in under 65-year-olds, but in over 65-year-olds only 0.25% are from 'external causes'.

You should ask yourself “Would I be surprised if this person were to die in the next 12 months?” This simple question is accurate seven times out of ten. If you are not surprised you should consider adding them to the palliative care register.

General clinical indicators of deterioration and frailty include:

- Limited self-care and interest in life: in bed or a chair more than 50% of their time.
- Breathless at rest or on minimal exertion (MRC scale 4/5).
Standard 8 | **End of life care**
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- Progressive weight loss (>10% over last six months).
- History of recurring or persistent infections and/or pressure ulcers.

The GSF Prognostic Indicator Guidance has details of clinical indicators by condition. Metastatic disease should always trigger consideration of supportive care; WHO states that in cancer patients >50% of time in bed or lying down gives a prognosis of fewer than three months survival.

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

**Delivery**
1. Identify EOL Care Lead at each practice.
2. Ensure palliative care register on S1 is regularly updated so that the practice population are correctly identified. Benchmark is 1% of the population.
3. Quarterly reviews of all patients on the palliative care register as a minimum standard. Review should include advance directive, DNACPR, current symptom review and management, medication review, care needs and social support and review the need of other health professional involvement.
4. After death analysis/case review on one death which did not occur as planned with particular reference to unplanned admission and place of death per annum
5. Continue the OOHS specification for CMC (subject to S1 interoperability)
6. Confirm next of kin details for patients on register

**Key performance indicators**
1. Named EOLC lead for each practice to attend training/educational event. Annual declaration. Threshold 100%
2. Increase current palliative care register upto 1% of practice population. Threshold for achievement 0.3%
3. Quarterly reviews of all palliative care register patients 90% threshold.
4. Following after death analysis share lessons learnt at network level and complete peer review template. Threshold 100%

**CCG support**
- Development of a palliative care peer review template.
- Dashboard of palliative care register for each network
- Arrange training and education, which includes how to have difficult conversations

**References**
- NICE Quality Standard 13 – End of Life care for adults
- www.nice.org.uk/guidance/qs13
- www.dyingmatters.org
- www.goldstandardsframework.org.uk
- Ealing JSNA
- NWL STP

**CCG contact**
Dr Vijay Tailor
Vijay.t@nhs.net
<table>
<thead>
<tr>
<th>Standard 9</th>
<th>Wound care</th>
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</table>
| **Aims**  | - To deliver a timely, effective and personalised wound management service in a safe environment  
- To prevent infection rates in wounds and treat any infections swiftly  
- To encourage adherence to the local wound care formulary  
- To undertake ABPI measurement to assess for vascular insufficiency in patients with poor wound healing or who are at risk of peripheral vascular disease  
- To reduce attendance at A&E / UCC for the purpose of wound care |
| **Rationale** | The CCG is commissioning a wound care service that supports its strategic commissioning intentions to ensure that high quality care is delivered as close to the patients’ home as is appropriate. The aim of the service is 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. |
| **Delivery** | Practices will be expected to:  
- Identify a Lead within the practice who will have oversight and will steer the practice to achieve the following:  
- Ensure the practice has an adequate number of appointments that are available to be booked on a ‘next day’ basis  
- Manage 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  
- Detect and treat any infection to prevent deterioration of the wound and systemic involvement  
- Provide appropriate patient education so that patients may make informed choices and fully participate in their care and improve concordance  
- Make the local wound care formulary accessible and encourage use of this for all wound care products  
- Refer patients to appropriate services as needed within a timely manner (e.g. Tissue Viability Specialist Nurse, Vascular Specialist, etc).  
- Undertake ABPI measurement in all patients with poor lower leg wound healing or who are at risk of having peripheral vascular disease – to be provided at Network / Locality Level. |
| **Key performance indicators** | 1. Compliance with CWHHE Wound Care Formulary  
2. 95% of patient cases with wound type recorded  
3. 95% of patient cases with procedures recorded (e.g. removal of sutures as per OOH spec v22) |
| **CCG support** | - To provide and update wound care formulary  
- To provide initial training for HCAs and update training for HCAs and Nurses  
- To commission support services such as Tissue viability |
| **References** | NICE guidelines (73) Prevention and treatment of surgical site infection  
NICE guidelines (ESMPB2) Chronic wounds: advanced wound dressings and antimicrobial dressings  
Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges) |
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<tr>
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<th><strong>Wound care</strong></th>
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<tr>
<td>Procedures carried out to NMC nursing standards</td>
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<td><strong>Applicable local standards</strong></td>
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<td>The service provider must comply with the local/CWHHE Wound Care Formulary, when available</td>
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<tr>
<td><strong>CCG contact</strong></td>
<td>Sally Armstrong</td>
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<tr>
<td></td>
<td><a href="mailto:sally.armstrong@nhs.net">sally.armstrong@nhs.net</a></td>
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</table>
**Standard 10**  
**Phlebotomy**

**Rationale**

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 (NHS Improvement, 2011). 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 (Royal College of Nursing (RCN), (2012).

The CCG is commissioning services that ensures equitable access and quality of service to the population of Ealing.

The CCG wishes to commission a timely and safe paediatric and adult 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 practices patients should be able to access Phlebotomy from a local setting and if a practice is not delivering phlebotomy from their own premises, they must be clear about the setting from which the service will be delivered for their patients, by working in collaboration with other surgeries locally.

**Delivery**

**The referring Practice:**

- Will provide patients, 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 the reason of the blood tests and clearly communicate any specific instructions such as when the patient is required to fast for the blood test.
- The referrer is expected to state the reason for testing on any referral form. Where this is not happening the provider should log the omission and contact the referring clinician.
- For Paediatric Phlebotomy the referring GP will ensure prescriptions of EMLA or equivalent (where appropriate) and instructions are provided to patients, 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. All returned referrals must be reported in monthly returns.

**The service provider:**

Can choose to deliver:
- Paediatric phlebotomy (2-<14 years)
- Adult Phlebotomy (14 years and over)
- Both Paediatric and Adult

The provider will confirm with the commissioner the service offering and the sites from which the service will be offered.

The provider must provide a variety of clinics both morning and afternoon so patients can have bloods taken at a time convenient to them.
Standard 10  |  **Phlebotomy**
--- | ---
There should be both routine and urgent appointments available
The provider should ensure Clinicians maintain their clinical competence for this Standard and:

- Ensure that staff comply with the infection prevention and control procedures i.e. hands Ensure are decontaminated, clean gloves used for every procedure and that the puncture site is prepped as appropriate
- Draw blood from patients as indicated by the referring healthcare professional;
- Urgent blood tests where requested must be completed within two working days
- Routine blood tests must be completed within ten working days
- 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 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

If the Service Provider is offering a walk in service, the Provider must ensure that there is sufficient waiting space for patients and an appropriate check in system (i.e. the use of a ticketing machine), to enable patients to be seen in the order which they arrive. Patients referred to the Phlebotomy walk-in clinics can be registered as temporary residents or immediate and necessary.

| Key performance indicators | 1. Audit activity to demonstrate the waiting times, feedback from users of the service, any complaints or incidents | 2. Provide the CCG with a signed declaration to verify that the provider has a written protocol for the provision of a phlebotomy service, in line with CQC requirements, for premises, infection control and needle stick injuries | 3. Provide the CCG with a signed declaration to verify that all staff delivering this service are adequately trained, competent to deliver, have Hepatitis B protection, have phlebotomy included as a duty within their job description and the provider has suitable indemnity. |
| CCG support |  | *Update practices on any relevant changes to national guidance* | *Liaise with Hillingdon laboratory to arrange morning and afternoon and weekend sample collections* |
| References | Freeman, G., Hughes, J., (2010) Continuity of care and the patient experience London: The King’s Fund Available at:
<table>
<thead>
<tr>
<th>Standard 10</th>
<th><strong>Phlebotomy</strong></th>
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<tr>
<th>CCG contact</th>
<th>Fionnuala O'Donnell</th>
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<tr>
<td><a href="Fionnuala.odonnell@nhs.net">Text</a></td>
<td><a href="Fionnuala.odonnell@nhs.net">Fionnuala.odonnell@nhs.net</a></td>
</tr>
<tr>
<td>Standard 11</td>
<td><strong>Dementia</strong></td>
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</table>
| **Aim**     | - To maintain diagnostic rates at >80%.
- To manage stable patients in primary care |
| **Rationale** | Over the last years Ealing has performed well in achieving high diagnostic rates, above the target. It is important to maintain the levels of diagnosis but at the same time provide good post diagnostic care. In order to be able to focus on assessing and diagnosing new patients in a timely manner, as well as managing those with complex behavioural problems, the Cognitive Impairment and Dementia Service (CIDS) has transferred the care of their stable patients to Primary care with the support of Dementia Link workers. |
| **Delivery** | Providers will be expected to:
1. Provide prescriptions of cholinesterase inhibitors once a maintenance dose has been achieved, monitor compliance and side effects.
2. Accept transfer of care of stable patients from CIDS.
3. Monitor progression of dementia using general history taking of activities of daily living and support required during opportunistic or schedule consultations. Tests such as the Montreal Cognitive Assessment can be used as a measure of cognition.
4. Work with the Dementia Link workers when appropriate.
5. Be aware of drug interactions when changing medications.
6. Refer back to secondary care if there is deterioration in mental state after ruling out other causes for this deterioration.
7. Ensure that family carer gets support advice and health checks from GP |
| **Key performance indicators** | 1. 90% of patients with Dementia offered an annual review (which includes medication and care plan) using the templates provided. (S1 templates still need developing)
2. Or recorded as DNA/declined/Not appropriate |
| **CCG support** | - The CCG has commissioned Dementia Link workers to support networks.
- The CCG will facilitate meetings between the providers. |
| **References** | |
| **CCG contact** | Dr Serena Foo
serena.foo@nhs.net |
**Bowel Cancer Screening**

The National Bowel Cancer Screening Programme saves lives. Bowel cancer causes almost 1,400 deaths a year in London, 72% of which are in people over the age of 65. Yet many of these deaths could be avoided by prevention or earlier detection through the national bowel screening programme. In Ealing the one year survival rate from colorectal cancer is 75.3% (London 76.4%) and the five year survival is 49.5% (London 54.7%).

Screening reduces mortality from bowel cancer by 16% at population level, and in people who participate, by 25%. Although uptake has increased across the capital since the programme was introduced, achieving the 60% national target is challenging. Participation rates amongst Londoners lag behind the rest of the country. The programme coverage rate in London was 49% in March 2016, compared to the England rate of 58.5%, with wide variation in London CCG rates from 40.4% to 57.4% and between practices within CCGs.

The Good Practice Guide for Cancer Screening in London recommends interventions to increase bowel screening through primary care. Endorsement by people’s own GP is a strong factor in participation. Ealing CCG has been a forerunner with respect to this intervention being one of the first CCG’s in the country to implement this before any formal guidance.

Improving bowel cancer screening uptake has been a component of Ealing CCG’s Local Improvement Screen since 2013. The success of this has been demonstrated by the increase in uptake from 41.2% in 2014 to 44.3% in 2016. There are 3 practices in Ealing who have reached the 60% target. Most practices are between 30-45%.

An additional challenge for Ealing practices is the ethnic mix across the borough with certain ethnic groups less likely to participate in bowel screening and the pockets of economic deprivation across the borough having a negative impact on uptake.

**Breast Cancer Screening**

Breast cancer screening is an important intervention for early detection of breast cancers. Screening saves about one life from breast cancer for every 200 women who are screened. This adds up to about 1,300 lives saved from breast cancer by screening each year in the UK. Ealing CCG’s uptake is 67%, the national target is 70%, the England average is 73.5% and Harrow CCG’s uptake is 71%.

One of the challenges for Ealing is the ethnic diversity of the population since BME groups and Muslim women are less likely to attend for screening. Like with bowel screening evidence shows positive endorsement from a healthcare professional can increase screening uptake. Following up women who did not attend or declined screening can have a positive impact on uptake.

**Bowel cancer screening**

Personal intervention by GP practices for practice population who have not responded to the bowel screening invitation. The practice will be notified via
Cancer screening

Path links of all non-responders throughout the year. This should be done by personal letter from the Practice GP or a phone call conversation from a suitably trained member of the practice team.

Breast cancer screening

Ealing Practice’s cohorts of the population are given an appointment on a 6 monthly cycle. Hence half of Ealing practice’s population will receive an appointment in the first 6 months of the year and the 2nd half the remaining 6 months. Once the practice has received notification of a DNA or declined screening invitation, the practice is required to send a personal letter to the patient highlighting the importance of breast screening or a phone call conversation from a suitably trained member of the practice team. Texting patients will NOT be considered as appropriate intervention.

Key performance indicators

1. Bowel cancer screening – % of patients who have been sent a personal letter or received a phone call from practice where practice has been notified that the patient has not responded to bowel screening invitation - threshold 90%
2. Breast cancer screening – % of patients who have been sent a personal letter or received a phone call from practice where practice has been notified that patient has DNA’d or declined screening invitation – threshold 90%

Monitoring of activity by specific read code entry.

CCG support

- CRUK Primary Care Facilitator with support from the CCG will provide training resources to individual practices.
- List of women to be invited for breast screening in the coming 6 months will be provided to the practice beforehand.

References

Good Practice Guide for Bowel, Breast and Cervical Cancer Screening In Primary Care 2016


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<thead>
<tr>
<th>Standard 12</th>
<th><strong>Cancer screening</strong></th>
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<td><a href="https://fingertips.phe.org.uk/profile/cancerservices">https://fingertips.phe.org.uk/profile/cancerservices</a></td>
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<tr>
<td>CCG contact</td>
<td>Dr Vijay Tailor</td>
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<tr>
<td></td>
<td><a href="mailto:vijay.t@nhs.net">vijay.t@nhs.net</a></td>
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<tr>
<td>Standard 12</td>
<td>Prevention Immunisation and Vaccination</td>
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**Rationale**

The *Public Health Outcomes Framework* highlights health protection as one of 3 main pillars for improving and protecting the nation's health (PHE, 2014). Immunisation is also the most important way of protecting people from vaccine preventable diseases (DH, 2014).

**Influenza**

The best way to improve the prevention and management of ‘flu is to increase the uptake of vaccination, especially amongst those in clinical risk groups.

**Pneumonia**

Pneumococcal disease is caused by the bacterium *Streptococcus Pneumoniae* (pneumococcus). It is a major cause of disease and death globally, and in the UK. It particularly affects the elderly, people with no spleen or a non-functioning spleen, and people with other causes of impaired immunity and certain chronic medical conditions.

**Delivery**

**Practices will be expected to:**

- Provide access to flu vaccination for people aged 65 years and over;
- Provide access to flu vaccination for people less than 65 years old who are in an at risk group, namely:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease at stage three, four or five
  - chronic liver disease
  - chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability
  - diabetes
  - splenic dysfunction
  - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment);
  - All pregnant women (including those women who become pregnant during the flu season)
  - All those aged two, three, and four years (but not five years or older) on 31 August
  - Registered carers
- Provide access to pneumococcal vaccination for people aged 65 years and over;
- Provide childhood immunisations;
- Have a system in place to follow up DNA’s;
- Ensure data of those immunised is reported promptly on IMMform.
- Practices to have established the systems and processes to call and recall children and adults that require Imms and Vacs under this spec.
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<tr>
<th>Standard 12</th>
<th><strong>Prevention Immunisation and Vaccination</strong></th>
</tr>
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</table>
| **Key performance indicators** | The Thresholds for each of these are set by NHSE and practices are incentivized under this specification to establish proper call/recall systems through:  
- Self declaration of development of a practice protocol for the call / recall of children and adults for the above immunisations  
- Production, if appropriate, of an action plan if practices are not meeting the lowest national targets. |
| **CCG support** | **The CCG will:**  
- Support Practices with education and training re: vaccination processes;  
- Provide Practices with relevant data and information on uptake. |
| **CCG contact** | Name: Sally Armstrong  
Email: sally.armstrong@nhs.net |
<table>
<thead>
<tr>
<th>Standard 12</th>
<th>Prevention Health Improvement in Children</th>
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<tr>
<td><strong>Rationale</strong></td>
<td>Childhood obesity in Ealing is a significant problem. The numbers of overweight and obese children in Ealing at reception age are similar to the England and London averages, but are noticeably elevated when children reach Year 6: 37.5% children overweight in Ealing at year 6 compared to an average of 33.2% in England and 37.2% across the whole of London. Whilst Primary Care cannot solve this problem alone, it can have a significant role to play in identifying and helping to prevent obesity at key touch points in a child’s life. For example, key messages can be conveyed to parents and guardians at visits for immunisations and other health interventions as well as opportunistically when an ill child presents.</td>
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<tr>
<td><strong>Delivery</strong></td>
<td>Tooth decay in Ealing is the highest in London in the under 5-year age group. It is the TOP cause of hospital admissions in children aged 1-18 and accounts for more admissions than viral infections and abdominal pain. As with childhood obesity, primary care can have a significant role to play in reversing this trend and trying to prevent tooth decay in children. Conveying key messages about oral health at touch points in a child’s encounter with primary care could have a huge impact and could considerably help to decrease the numbers of children in Ealing with tooth decay. The aim of the delivery of this part of the specification is to contribute to the improvement in awareness of the benefits of preventing childhood obesity and tooth decay. Therefore, practices will be expected to:</td>
</tr>
<tr>
<td><strong>Key performance indicators</strong></td>
<td>1. Ensure practice nurses attend training on delivering key messages in relation to childhood obesity and tooth decay. <em>Monitoring:</em> Declaration of attendance at training. <em>Threshold:</em> 100%</td>
</tr>
<tr>
<td><strong>CCG support</strong></td>
<td>1. Provide relevant training to practice nurses in delivering the defined key messages 2. Ensure the IT system enables recording of confirmation of delivery of key messages</td>
</tr>
<tr>
<td><strong>References</strong></td>
<td>Ealing JSNA – CYP chapter 2016</td>
</tr>
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</table>
| **CCG contact** | Name: Sally Armstrong  
*Email:* sally.armstrong@nhs.net |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Prevention Requirement in Children</th>
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<tr>
<td>12</td>
<td>Rationale</td>
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**NHS Health Checks (risk identification/early diagnosis of Stroke, Diabetes, Kidney Disease, Cardiovascular Disease)**

In England, over 4 million people are estimated to have cardiovascular disease (CVD). This is recognised as the largest single cause of long-term ill health, disability and death (DH, 2013). A steep rise in unhealthy behaviours – smoking, physical inactivity, eating a poor diet and alcohol misuse - has led to increasing levels of ill health across all sections of the population. This is magnifying the burden of vascular conditions (Murray et al, 2013).

In 2012, 80,000 deaths were due to coronary heart disease (CHD). It is estimated that 46,000 of these were premature, and could possibly have been avoided (British Heart Foundation (BHF), 2014).

Over the last 20 years, the number of people diagnosed with diabetes has increased from 1.4 million to 2.9 million. By 2025, it is estimated that 5 million people will have type 2 diabetes in England (Diabetes UK, 2012).

Over 10.5 million people are drinking at levels which increase their risk of ill-health. Liver disease, linked to alcohol misuse, is fast becoming one of the UK’s biggest killers (British Society of Gastroenterology (BSG), 2010).

**Pulse Checks (aged 65 years and over)**

Atrial Fibrillation (AF) is the most common sustained dysrhythmia, affecting at least 600,000 people in England. It is a major cause of stroke. Every year there are approximately 152,000 strokes in the UK. Most people affected are over 65 and identifying AF early could prevent 4,500 strokes and 3,000 deaths per year in the UK (Stroke Association, 2014). Estimates suggest that one stroke would be prevented for every 37 people screened.

**Alcohol – AUDIT C, AUDIT 10 & Brief Intervention**

Alcohol misuse creates a huge burden on health, in terms of treating alcohol related disease and premature mortality. About 26% of all adults in England, equating to 10.5 million people, are drinking at hazardous and harmful levels (British Society of Gastroenterology (BSG), 2010).

Ealing is well above the national average for the prevalence of problem drinking.

Connor et al. (2015) recommended in the Lancet that: "Screening and brief interventions could encourage people with alcohol use disorders to receive treatment early. Patients scoring 0–7 in the AUDIT in primary care (100) should be given basic alcohol education, those scoring 8–15 given straightforward advice on reduction of hazardous drinking, those scoring 16–19 given straightforward advice in addition to brief counselling and continued monitoring, and those scoring 20–40 referred for specialist assessment."
**Proactive Screening**

General Practice already performs a lot of opportunistic screening of elements of NHS Health Check, without formally considering it part of the NHS Health Check programme.

In Ealing, there are around 110,000 patients aged 40-75 yrs without a readcode of diabetes or hypertension: (as per 12/06/2017):

- 68.9% (75861) do not have a QRISK2 coded within past 5yrs
- 36.6% (40259) do not have a Cholesterol coded within past 5yrs
- 36.1% (39724) do not have a GFR coded within past 5yrs
- 34.9% (38376) do not have a HBA1c/glucose coded within past 5yrs
- 33.6% (37005) do not have a weight/BMI coded within past 5yrs
- 21.4% (23527) do not have a BP coded within past 5yrs
- 65.6% (72261) do not have an Alcohol consumption/screening code within past 5yrs
  
(Smoking covered by existing QOF indicator)

The aim of this Proactive domain is to provide reports/alerts on SystmOne to encourage GPs/Nurses to take a more systematic approach (i.e. more inclusive of all datasets to considering measuring) when performing opportunistic screening of patients – beyond just the formal NHS Health Check programme. It may include some disease registers (excluded by the formal NHS Health Checks programme) as a fail-safe to ensure these patients are being reviewed.

Public Health (LBE) funds NHS Health Checks for a certain number of patients for each practice. This proactive domain will provide reports to highlight patients with the greatest number of missing datasets, which practices might find helpful when determining who to target for inviting for NHS Health Checks – for example, there are 17835 (3.9%) patients missing 7 or more of the datasets above.

This Proactive screening indicators do not attract any additional funding via the NHS. It is provides a set of reports/dashboards that the practices might find helpful. This will include comparison on performance on these indicators with other practices in Ealing. The main funding source for the practice will be derived by using the reports to target inviting patients to attend for NHS Health Checks, which is funded by Public Health (LBE).

**Proactive Management**

Other reports will be provided that can act as “fail-safes” for patients to review – e.g.

- HBA1c >=48 without readcode of diabetes
- BP >=150/90* without readcode of hypertension
  
*may drop (e.g. to 140/90) in future in accordance with NICE guidance
- Last GFR <60 without readcode of CKD
- Last QRISK>=10% without statin offered/prescribed/readcode to indicate why statin not prescribed
Pulse Checks (aged 65 years and over)
Offer opportunistic pulse checks (including rhythm) to patients aged 65 years and over e.g. when patients are attending for another reason such as the flu jab.

Alcohol
- Ongoing minimum Audit-C screening of new Adult patient registrations (cohort targeted by previously Alcohol DES and now part of core GMS)
- Practices to move towards standardising New Patient Registration Forms across Ealing, which incorporates minimum Audit-C questionnaire with brief images explaining units:
  a) There are two example Registration Forms (Ealing & CWHHE versions) which are already accessible on SystmOne
  b) Practices may wish to adopt either of these forms in entirety or simply adopt elements into their own current forms, particularly around alcohol screening with images.

Key performance indicators

Proactive Screening
Practices will be provided with regular Peer-to-Peer comparisons (with other Ealing practices) on achievement of these indicators:
- %Pts (40-75yrs) without QRISK2 coded within past 5yrs
- %Pts (40-75yrs) without Cholesterol coded within past 5yrs
- %Pts (40-75yrs) without GFR coded within past 5yrs
- %Pts (40-75yrs) without HBA1c/glucose coded within past 5yrs
- %Pts (40-75yrs) without Weight/BMI coded within past 5yrs
- %Pts (40-75yrs) without BP coded within past 5yrs
- %Pts (40-75yrs) without Alcohol consumption coded within past 5yrs
- QOF Smoking indicator

Proactive Management
For the indicators below, peer-to-peer comparisons will be provided across Ealing practices which may be linked to payment according to ranking/achievement:
1) HBA1c >=48 without readcode of diabetes
2) BP >=150/90* without readcode of hypertension
   *may drop (e.g. to 140/90) in future in accordance with NICE guidance
3) Last GFR <60 without readcode of CKD
4) Last QRISK>=10% without statin offered/prescribed/readcode to indicate why statin not prescribed
For indicators 1-3, these follow on from the Ealing LIS 2017/2018 and the aim would be to maintain having no outstanding patients showing on these reports as an ongoing process.

For indicator 4, it is recognised there is much debate about the NICE guidance including the medicalisation of this potential cohort of patients (vs risk reduction) and workload impact. The initial approach to indicator 4 would be focus on peer-to-peer comparison without absolute thresholds to reach.

**Pulse Checks (aged 65 years and over)**

For the indicators below, peer-to-peer comparisons will be provided across Ealing practices which may be linked to payment according to ranking/achievement:

- % patients over 65 years with a pulse check (with coded rhythm) within past year

**Alcohol**

- Practice to confirm integration of Alcohol Screening (with images) into New Adult Patient registration form
- Peer to Peer practice ranked comparison of coding of Alcohol Audit-C (adjusted for number of new registrations)
- See also Proactive Screening indicators above for Alcohol screening in 40-75 year olds.

| CCG / Public Health support | - Network Relationship Managers
|                           | - Public Health (LBE) |

**References**

- British Society of Gastroenterology (BSG), (2010) Alcohol related disease: Meeting the challenge of improved quality of care and better use of resources London.
- Public Health England (PHE), (2015a) Local Alcohol Profiles Available at: www.lape.org.uk/
- Public Health England (PHE), (2015b) Local Tobacco Control Profiles Available at: www.tobaccoprofiles.info
### Standard 14

**Self-care and use of Patient Activation Measures**

#### Rationale

The Five Year Forward view states we will do more to support people to manage their own health—staying healthy, making informed choices of treatment, managing conditions and avoiding complications.

Self-care support means moving people away from being passive recipients of care to a collaborative relationship where people are active partners in their own health. To do this, people need to develop their knowledge, skills and confidence to make informed decisions and adapt their health related behaviours. They need to be supported by health professionals with the skills, expertise and confidence to support them in making informed decisions, achieving their goals and overcoming barriers.

PAM provides a simple, evidence-based mechanism for establishing the capacity of individuals to manage their health and then using that information to optimise the delivery of care.

Ealing CCG, as part of the NHS England PAM Programme, has agreed a phased approach to embed PAM across 76 General Practices to support tailored care planning with an overall target of 6,000 patients receiving the PAM licence within 2017-18.

In Ealing, people with long-term conditions are the most frequent users of health care services accounting for 50% of all GP appointments and 70% of all inpatient bed days. PAM is a key enabler to support people diagnosed with long term conditions to develop the skills required to be able to effectively self-manage their care and take more control of their health and wellbeing.

#### Delivery

**Practices will be expected to:**

- Engage in training to understand how to use the Patient Activation Status to support self-management of long term conditions.
- Attend training sessions and/or access the online training to understand the administration of the PAM assessment
- Input PAM data within the GP primary care IT system care planning templates to support data collection and evaluation;
- Review Patient Activation Status when reviewing patients care plan.

#### Key performance indicators

1. A minimum of 2 staff in each practice attend training sessions (measured by training sign in sheet);
2. Documented Peer Review within the practice of 3 cases where the patient activation status has informed a discussion to support a patient’s self-management

#### CCG support

The CCG will:

- Provide and/or publicise training sessions on PAM;
- Provide monthly reporting on PAM licence use from S1;
- Communicate with GPs regarding best practice arising across the NW London-wide PAM project.
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<tr>
<th><strong>Standard 14</strong></th>
<th><strong>Self-care and use of Patient Activation Measures</strong></th>
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<tr>
<td><strong>CCG contact</strong></td>
<td>Shanker Vijayadeva <a href="mailto:svijayadeva@nhs.net">svijayadeva@nhs.net</a></td>
</tr>
<tr>
<td>Standard 15</td>
<td><strong>Learning disability</strong></td>
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<tr>
<td><strong>Aim</strong></td>
<td>To ensure patients with Learning Disabilities &gt;14 years old have an annual physical health check.</td>
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| **Rationale** | People with learning disabilities (LD) have complex health needs. Mental ill health, cardiovascular disease, diabetes, and epilepsy, are amongst many conditions which are more common in people with LD. Yet, this group are less likely to receive regular health checks and access routine screening e.g. cervical, breast and bowel (Royal College of General Practitioners (RCGP), date unknown), (Houghton, 2010). People with LD have a shorter life expectancy, compared to the general population (Emerson and Baines, 2010). Avoidable deaths, from causes amenable to change by quality health care, were more common in people with LD (37%), than in the general population of England and Wales (13%) (Heslop et al, 2014). These health inequalities have also been highlighted in a number of documents (Disability Rights Commission (DRC), 2006; Mencap, 2007; Emerson et al, 2011). The interaction of physical, behavioural and mental health issues can be difficult to interpret, causing illness to be over-looked. This diagnostic overshadowing may lead to some GPs not investigating early enough, as they rationalise new symptoms as part of the learning disability, rather than the needs of the whole person (Mason, 2004, cited in Houghton, 2010). In 2008, annual health checks for adults with LD were introduced by the Government. However, recent research has shown that less than half of those entitled to a health check get one, and there are concerns around quality and consistency (Heslop et al, 2014)."
| **Delivery** | **Practices will be expected to:**  
|             | • Review their registered lists of patients with Learning Disabilities in conjunction with the Learning Disability team to ensure that there is concordance of diagnosis. This will also ensure that patients have not been overlooked and that those who need support are identified. There may also be patients who do not actually have a Learning Disability and are inappropriately classified.  
<p>|             | • Ensure that those &gt;14 years old have an annual physical health check. |
| <strong>Key performance indicators</strong> | 1. &gt;70% of those &gt;14yo have an annual health check. |
| <strong>CCG support</strong> | • The CCG will facilitate meetings between the Learning Disabilities team and providers. |</p>
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<th>Standard 15</th>
<th>Learning disability</th>
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<td>References</td>
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<tr>
<td>CCG contact</td>
<td>Dr Serena Foo</td>
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<td><a href="mailto:serena.foo@nhs.net">serena.foo@nhs.net</a></td>
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<tr>
<td>Standard 16</td>
<td><strong>Carers</strong></td>
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| **Aim**    | - To improve the number of carers identified within GP practices in Ealing.  
             - To ensure that carers who are identified have access to the health care they need including access to health checks.  
             - To ensure that all carers identified are referred effectively for the provision of ongoing advice, information and support. |
| **Rationale** | It is widely acknowledged that carers have an important part to play in an effective health care system. There has been a growing emphasis in recent years on the need to provide more comprehensive support to carers, since they often face greater social deprivation, isolation and ill health. Those caring for 50 hours a week or more are twice as likely to experience poor health, particularly mental health problems (Carers UK, 2014).  
Nationally, there are 6.5 million unpaid carers, accounting for 1 in 8 adults (Carers UK, 2015). The 2011 census suggests there are around 28,773 unpaid carers in Ealing, with 50-64 year olds making up the largest proportion. (Ealing JSNA, 2016). Of these, only a small proportion is known to the Council and/or their GP.  
Findings from a recent study highlighted that 70% of carers come into contact with the NHS, yet only 10% of these are identified as a carer (Schonegevel, L. 2013). Healthcare staff are not always proactive in signposting carers to relevant support or information, and when information is given, it comes from charities and support groups. (NHS England, 2014). In addition, patients do not always self-identify themselves with the term ‘carer’ and feel that they are simply carrying out ordinary responsibilities as part of a family. Therefore, proactive interaction is required in order to identify those who would benefit from carers’ support.  
Ealing Council and Ealing Clinical Commissioning Group (CCG) Joint Carers’ Strategy 2012-18 highlighted a number of areas of development needed in order to better support carers, which included better identification of carers through primary care and continued improvement and access to information.  
It is acknowledged that GPs are developing and improving their services for carers. However, the Royal College of General Practitioners (RCGP), (2014) highlights an urgent need to further embed the identification and support of carers within General Practice. This will ensure carers are supported at an earlier stage, enabling real benefits for both carers and patients alike. |
| **Delivery** | **Practices will be expected to:**  
- Identify a Carers Lead (link) within the practice;  
- Ensure that all staff, including receptionists, are ‘carer aware’, and have a basic understanding of support available;  
- Display information in the waiting room and via other communication methods (e.g. website, newsletters), to help carers... |
**Standard 16  Carers**

- Identify themselves and to highlight available support and information;
  - Maintain links with local carer organisations, social services and the voluntary sector;
  - Have a carers register (for carers registered at the practice) which is maintained and updated; suggest that the question “do you look after someone?” be added to registration form.
  - Record carer status in patient notes;
  - Have a conversation with patient and carer around consent to record sharing and ensure agreements to share information are logged on clinical system so that this information is available for clinicians outside the practice as needed, the practice should have a clear policy on proxy access to medical records and enable this where necessary in line with patient wishes.
  - Offer carers an annual health assessment;
  - Offer carers an annual flu vaccination;
  - Have available an electronic referral form on the practice or other system to refer to Ealing Carers Centre;
  - Offer access to IAPT, care coordinators, the voluntary sector and other sources of support as appropriate.

**Key performance indicators**

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<th>Year 1: 2018/19</th>
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<tr>
<td>1. Practices to run baseline search audit of carers register and perform a data cleansing exercise to ensure carers register is up to date.</td>
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<td>2. Increase numbers of carers registered within practices – achieve 2% of list size</td>
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**Year 2: 2019/20**

| 3. Offer annual health assessment to at least 70% carers on register and record on S1 |
| 4. Offer annual flu vaccination to at least 70% carers on register and record on S1 |
| 5. Record as offered referral to appropriate support services (or declined) |

**CCG support**

- The CCG will:
  - Provide regular information to practices on Carers developments;
  - Provide data and information on practice achievement of this standard;
  - Maintain/update electronic forms for practice systems for referral for Carers support (or use of universal referral template);
  - Provide a carers page for Practice websites with links to local resources

**References**

- Ealing JSNA 2016 Carers
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<tr>
<td><strong>Ealing Council and Ealing Clinical Commissioning Group (CCG) Joint Carers' Strategy 2012-18</strong></td>
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<td><strong>CCG contact</strong></td>
<td>Fionnuala O'Donnell</td>
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<td><a href="mailto:fionnuala.odonnell@nhs.net">fionnuala.odonnell@nhs.net</a></td>
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Results from the GP Patient Survey consistently report a poorer experience of making an appointment and lower levels of satisfaction with practice opening time than other CCGs in London. This is also in line with feedback from Healthwatch surveys. A patient’s ease of access to their Practice, and preferred GP, can affect their quality of care and health outcomes (The King’s Fund, 2012).

The Strategic-commissioning framework (SCF) for London was co-developed by NHS England (London region) with 1,500+ stakeholders, including the LMC, clinicians, commissioners, patients and other partners across London. It comprises a set of 3 specifications (proactive, accessible and coordinated care) made up of descriptors that articulate a vision of quality primary care that providers will need to adopt consistently by 2020.

The SCF confirms that good access to primary care should consist of:

- Patient choice: both continuity of care and rapid access
- Only one call, click or contact to make an appointment
- Routine opening hours of pre-bookable appointments for the population from 8am – 6.30pm
- Extended opening hours: 8am – 8pm to access a GP or healthcare professional in local area, which is being met through extended access.
- Same day access: consultation with GP or appropriately skilled nurse on same day within routine surgery hours if clinically indicated.
- Rapid assessment of patients with emergency care needs
- Continuity of care: All patients should have named GP for care coordination.

High levels of patient satisfaction with access to Primary Care correlates with higher QOF scores, and also with lower rates of emergency hospital admission (Kontopantelis et al, 2010). Poor access to a GP has been linked to a higher proportion of patients with a first diagnosis of cancer being admitted to hospital as an emergency (Bottle et al., 2012). It can also cause stress and frustration for patients at a time when they may already be worried and may prolong discomfort or pain.

Good access to general practice also has an impact on the health system overall. Inadequate capacity in General Practice can lead to an increase in demand for Accident & Emergency (A&E), and other hospital services (Rosen 2014). On average, there were 22 more A&E attendances per 1,000 registered patients (8%) at practices open for 45 core hours or less per week, after adjusting for differences in patients’ age and sex. (National Audit Office 2015 and 2017).

Different people value different dimensions of access differently, depending on their need, age and working circumstances. For some patients, continuity of care is most important – it contributes towards reductions in secondary care activity and whole system costs and the rate of emergency admissions (NHSE 2014).

There are complexities in transferring work from hospital to primary care.
<table>
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<td>successfully (Nuffield Trust 2017). Successful transfer can only happen with additional and appropriately trained workforce, by resolving some of the prevailing social care problems and by understanding the demand for primary care. Practices aiming to increase demand should analyse the specific needs of their population and consider a suitable workforce skill mix for their locality population.</td>
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Ealing CCG is using this specification as an opportunity to:
- Embed and sustain the changes achieved through the prime ministers challenge fund
- Meet the requirements of the strategic commissioning framework for the population of Ealing by 2020.

<table>
<thead>
<tr>
<th>Delivery</th>
<th>The access policy improves access to primary care during core hours</th>
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<td>The evidence suggests that continuity from the doctor or practice who knows the patient, is an important factor in improving patient outcomes</td>
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**Opening Hours**

By April 2020, registered patients should be able to access primary medical services between 08:00 and 18:30 Monday to Friday. Practices should be able to demonstrate that they are able to meet the access requirements providing consultation capacity to meet the appropriate needs of their practice population. It does not imply every practice needs to be open but it does mean that the practice population has equity of access.

- By 1st April 2020 at the latest all registered patients in Ealing must be able to access services as defined under opening hours between 08:00 and 18:30 Monday to Friday.
- Practices already delivering the minimum of 52.5 hours, will be expected to maintain this.
- Practices that are not already achieving this will be required to determine how they will achieve this standard for their practice population by 2020.

**Expected access during opening Hours**

- A staffed reception during the length of core hours (8am – 6.30pm Monday to Friday) for patients to freely access the premises without the need to be physically admitted, book appointments, respond to patient queries and manage repeat prescriptions.
- Ensure a clinician assesses children under 12 with perceived urgent needs on the same day.
- Access to a registered healthcare professional on the same day if clinically urgent.
- Have a flexible appointment system that meets the needs of patients so patients with complex problems can book longer appointments if needed.
- Telephone consultations and online booking of appointments available up to 4 weeks (as referenced in the SCF) in advance
- Ability to book a routine appointment with a clinician of the patient’s choosing through any route
Standard 17 | Access

- Earliest consultation not later than 8.30am; consultations to run until at least 6pm Monday – Friday
- Practices may wish to consider collaborating with neighbouring practices where this makes delivery easier
- Practices working together will need to ensure access to patient records to allow the specifications to be delivered.
- Collaborative arrangements, where implemented under this access policy, must be formally documented, and should include clear clinical leadership and governance arrangements.

Home Visits

- Home Visits for all housebound patients and other patients who require a home visit during core hours of 8am and 6.30pm, including:
  - Triage by clinician within 30 minutes to 1 hour
  - Confirmation with the patient when the visit (if appropriate) will happen

Capacity - October 2017- 31 March 2018

- A minimum of 100¹ consultations with a registered health care professional (via any medium, face to face, telephone or video) per 1000 registered patients per week (excluding additional hours during winter surge and extended hours). The number of telephone and video consultations counted for the purposes of this measurement should not exceed 33% of the total reported, unless otherwise agreed.
- To provide additional capacity at times of surge during winter consistent with previous winter schemes. Between 1 December and 31 March this equates to an additional 5 face-to-face consultations with a registered health care professional per 1000 registered patients per week.
- Accept UCC re-directions. Practices will work with local UCCs to reduce inappropriate attendances – this may involve working with the CCG on a recovery plan.
- Practices to undertake a demand and capacity analysis on an annual basis to ensure that appointments meet the demands of the patients – tool will be provided by the CCG. CCG will support practices to determine the trajectory to meet the full specification in line with the practice’s current baseline and evidence from the capacity analysis.

Capacity – April 2018 onwards

From April 2018 CCG will work with practices to ensure continuous improvements in access based on outputs of the demand and capacity analysis.

¹ In line with national guidance – 75 per GP, 25 per nurse
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| **Key performance indicators** | 1. Clinical consultations available for 100/1000 registered patients per week – measured through S1  
2. During winter months – Clinical consultations of an additional 5 face to face consultations per 1000 registered patients per week – measured through S1  
3. 20% of patients given online access to book appointments – measured through S1  
4. Increase in appointments made available online evidenced in practice declaration  
5. Over time to see a reduction in inappropriate UCC attendances/re-attendances – thresholds to be agreed  
6. Results of Demand and Capacity to be shared with PPG group |

**In addition the CCG:**
- Will audit a proportion of practices opening hours by telephoning practices to ensure open or sending in a “mystery shopper”
- Will work with UCC to ensure that any suitable patients are diverted from UCC to general practice

| CCG support | Support around signposting patients for self-care if patient is requesting appointment for self-limiting conditions  
Website support to provide up to date information for patients  
To provide active signposting training for receptionists  
Provide a Diagnostic tool for Demand and Capacity for practices to utilise |

| References | GP Patient Survey, Ipsos MORI  
UCC Data  
The King’s Fund, (2012) exploring the association between quality of care and the experience of patients London.  
Bottle, A; Tsang, C; Parsons, C; Majeed, A; Soljak, M; Aylin, P (2012), Association between patient and general practice characteristics and unplanned first time admissions for cancer, observational study. British Journal of cancer, 107 (8),  
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<th>Standard 17</th>
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<td>NHSE (2014) Emergency Admissions Technical Paper</td>
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<tr>
<td>CCG contact</td>
<td>Dr Mohini Parmar</td>
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<td><a href="mailto:Mohini.parmar@nhs.net">Mohini.parmar@nhs.net</a></td>
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</table>
| Standard 18 | Homeless  
(People who sleep rough, live in hostels, ‘surf’ on sofas, or who are chronically insecurely housed) |
|------------|-------------------------------------------------------------|
| Rationale  | There is a large bank of evidence and research that shows poor housing conditions can lead to poor physical, mental and emotional health. Life expectancy for the homeless population is almost half that for the general population. This standards aims to provide a more accessible and responsive service to:  
- People who are homeless, whether registered with a GP or not  
- People who sleep on the streets (rough sleepers)  
- People who live in hostels, refuge and night shelter residents  
- Squatters  
- People of no fixed abode who are staying temporarily with friends and relatives  

Ealing falls within inner and outer London and as a result it contains areas of affluence and pockets of deprivation. Within the borough, there has been an increase in the number of homeless people between 2011/2012 to 2014/15, although the number of recorded rough sleepers has decreased. Types of homelessness such as ‘sofa surfing’ are difficult to measure so the true level of need in the average practice population may be higher than is officially recorded.

Health issues for homeless people and rough sleepers include drug and alcohol abuse, mental health issues, respiratory problems, arthritis and cardiovascular disease. Homeless people are two and a half times more likely to have asthma and six times more likely to have heart disease. Rates of TB are 34 times higher in the homeless population and Hepatitis C 50 times higher.

Homeless people also attend Accident and Emergency departments five times as often as the general population. When they are admitted to hospital, they stay three times as long and when they are ready to leave they are often discharged without their underlying issues being addressed.

People who are homeless may experience difficulties in accessing primary care, due to inappropriate registration policies, perceived discrimination and staff attitudes, lack of flexibility in services provided and communication barriers. They may have a number of complex health problems, and may also require proactive support to manage their health needs, for example, targeted support, regular and/or longer appointments.

<table>
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<tr>
<th>Delivery</th>
<th>Practices will be expected to:</th>
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|          | General  
- Assign a named service lead for this standard, who should be a GP with overall responsibility for ensuring the service is delivered in accordance with the specification; |
### Standard 18

**Homeless**

(People who sleep rough, live in hostels, ‘surf’ on sofas, or who are chronically insecurely housed)

- Ensure at least one registered healthcare professional per practice attends a homeless awareness training session, which should include, but is not limited to the named lead;
- Record patient’s homeless status in their notes.

### GP Patient Registration and Appointment Booking

- Comply with Patient Registration: Standard Operating Principles for Primary Medical Care (General Practice);
- Provide registration with a general practice to the homeless regardless of their length of stay within the catchment area;
- Provide care to homeless patients who have a registered GP but are temporarily registered with the service provider as well as homeless patients who require immediate and necessary care;
- Ensure that homeless patients are seen by a registered healthcare professional within 24 hours of registration;
- Provide more accessible service to patients through flexible appointment systems including walk in appointments, and longer appointment times for people with multiple needs – especially as homeless patients may have less access to phoneline/online systems to book appointments. Practices may also need to tailor review processes (e.g. patient told to come back physically to practice after tests done) if homeless patients has less reliable contact details (e.g. postal address/phone line).
- Ensure that homeless patients offered an appointment 24 hours from contacting the practice.

### Case Management

- The service provider is encouraged to provide additional out of hospital services (i.e. Wound Care, Serious Mental Illness and Phlebotomy) to better meet the needs of homeless patients in conjunction with this specification;
- Provide a comprehensive assessment and appropriate screening for the following:
  - Mental Illness
  - Substance misuse
  - Alcohol misuse
  - Blood borne virus (e.g. Hepatitis B and C and HIV),
  - Tuberculosis (TB)
  - Cervical smear test (for women 25 years and over)
  - Sexually transmittable infections
- Offer Flu, Pneumococcal and Hepatitis B vaccinations, where clinically indicated;
- Administer Vitamin B (Pabrinex) IM injections, where clinically indicated
- Review case at 6 months for each patient following a health check, where applicable;
- Use relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity.
Referrals

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

### Key performance

1. 90% patients seen offered screening for Hepatitis B, C and HIV
2. 90% patients with a completed full Alcohol Use Disorder
**Standard 18**

**Homeless**
(People who sleep rough, live in hostels, ‘surf’ on sofas, or who are chronically insecurely housed)

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<th>indicators</th>
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<tr>
<td>Identification Test (AUDIT) questionnaire</td>
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<td>3. % of registered homeless patients with multiple appointments per financial/QOF year</td>
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<td>4. 100% of homeless patients seen with substance use recorded and offered referral to appropriate services</td>
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<td>5. 100% of homeless patients seen with smoking status recorded</td>
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<td>• Provide access to appropriate training, including e-learning, on homeless and inclusion health for practices to access</td>
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<th>References</th>
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<tr>
<td>Helping Improve Care for People who are Homeless – e-learning for Practice Managers and Receptionists, available here: <a href="https://www.healthylondon.org/homeless/e-learning">https://www.healthylondon.org/homeless/e-learning</a></td>
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<td>Homelessness and General Practice, Pathway, available here: <a href="http://www.pathway.org.uk/home/learning/gp/">http://www.pathway.org.uk/home/learning/gp/</a></td>
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<tr>
<td>Shanker Vijayadeva</td>
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<td><a href="mailto:svijayadeva@nhs.net">svijayadeva@nhs.net</a></td>
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### Rationale

The NICE medicines optimisation Guidance (2015) highlights that getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medications. Data suggests (HSCIC) that between 2003 and 2013 the average number of prescription items per year for any one person in England increased from 13 (2003) to 19 (2013). As the population ages and life expectancy increases, more people are living with several long-term conditions that are being managed with an increasing number of medicines.

Medication safety is an important consideration. A Department of Health report, ‘Exploring the cost of unsafe care in the NHS’, found that 5% to 8% of unplanned hospital admissions are due to medication issues. Effective systems and processes can minimise the risk of preventable medicines-related problems such as side effects, adverse effects or interactions with other medicines or comorbidities.

A number of medication safety priorities have been identified including:
- STOPP & RCGP indicators
- Problematic Polypharmacy
- MHRA alerts
- NICE guidance
- Other national guidance

These are reviewed and if appropriate for Ealing CCG’s population are included in the Prescribing incentive scheme where one of the components is a patient safety audit. They are also included in the Ealing CCG’s Prescribing Updates.

### Delivery

Practices will be expected to:

**Undertake a patient safety audit as part of the Medicines Safety and Optimisation Scheme**
- Utilise resources and searches provided by the medicines management team to undertake the required audit to the standards set. GP practices will have access to their pharmaceutical Advisor for support and guidance.

**Identify and review patients with unsafe prescriptions in line with MHRA alerts**
- All MHRA alerts are cascaded to the GP practices via the Prescribing Update. The practice will be expected to review their patients and action appropriately. GP practices will have access to their pharmaceutical Advisor for support and guidance.

**Abide by the North West London Integrated Formulary, NICE guidance and other nationally agreed guidance**
- Practices are expected to keep up to date with the current available resources and prescribe in line with them as appropriate.

This specification is in line with the Prescribing Incentive Scheme in 17/18.
### Medicines safety and optimisation

The clinical focus areas for the audits will be defined in Q4 of the FY.

#### Key performance indicators

**QoF Stretch KPI/target:**
1. Engagement with the PIS and QIPP plan.

**Wraparound standalone KPIs**
2. Keep within the practices prescribing budget.

#### CCG support

- Pharmaceutical advisors will outline what is required to each practice and work with the practice to support their reviews. If required and submitted when requested the Pharmaceutical advisor will provide peer review for the audit and give feedback if the audit is not meeting the standards set.
- Continue to provide medicines safety information during the year and support the practices to review all the appropriate patients.
- To provide SystmOne Searches to help support GPs identifying the correct cohorts of patients where possible.

#### References

- Royal Collage of GPs Prescribing Safety Indicators. 2014. [http://bjgp.org/content/bjgp/64/621/e181.full.pdf](http://bjgp.org/content/bjgp/64/621/e181.full.pdf)
- National Institute for Health and Care Excellence. NICE guidance’s. [https://www.nice.org.uk/guidance/conditions-and-diseases](https://www.nice.org.uk/guidance/conditions-and-diseases)
- Prescribing Updates Ealing CCG extranet (log in required) [https://extranet.cwhheecgs.nhs.uk/ealingccg/Prescribing/Pages/Prescribing%20Updates.aspx](https://extranet.cwhheecgs.nhs.uk/ealingccg/Prescribing/Pages/Prescribing%20Updates.aspx)
- First Databank. OptimizeRx. [http://www.fdbhealth.co.uk/solutions/optimiserx/](http://www.fdbhealth.co.uk/solutions/optimiserx/)

#### CCG contact

Beryl Bevan
beryl.bevan@nhs.net
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<th>Standard 20</th>
<th><strong>Drug monitoring – near patient monitoring</strong></th>
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| **Rationale** | This service is intended to enable Primary Care to provide a near patient monitoring service for patients who are on:  
  a) Denosumab for Osteoporosis  
  b) High risk disease modifying drugs (DMARDs) for the below indicators.  
  • Arthritis  
  • Inflammatory bowel disease  
  • Psoriatic arthritis  
  • Severe psoriasis  
  • Peripheral spondyloarthritis  
  • Severe Refractory Eczema  
  • Rheumatoid Arthritis  

The treatment of these diseases is increasingly reliant on drugs that while clinically effective need regular blood monitoring. This is due to the potentially serious side effects that these drugs can occasionally cause. Side effects can be reduced significantly if monitoring is carried out in a well-organised structured way following agreed National Guidelines, close to the patient’s home. Service providers will need to work in partnership with the patient, the patients registered GP and secondary care specialists. |

**Individual Empowerment and Self Care**  
The standard requires 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 standard requires the provider to deliver the service as close to a patient’s home as possible.  

**Care Planning and Multidisciplinary Care Delivery**  
The standard requires the service to be provided in a setting where the patient is also receiving other aspects of care at the same time. 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 SystmOne. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.  

**Population- and Prevention-oriented**  
The standard sets out the requirement for the provider to proactively engage with the patient, as appropriate, to support uptake for screening, medical review, attendance at forthcoming appointments and prevent complications.  
The CCG expects the service provider to ensure that the service is accessible to all patients registered with GP providers within the CCG.  

**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. |
| **Delivery** | The CCG 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. The GP provider grouping and location(s) for delivery of the service (number of delivery points) needs to be agreed with the commissioning CCG. |
Standard 20 | **Drug monitoring – near patient monitoring**

The CCG is commissioning a near patient monitoring service that means the service provider will:
- Provide the service for patients on their register.
- 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 standard will do this by:
- Delivering a timely, effective and personalised near patient monitoring service within their registered practice, 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 standard 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.

It is expected that practices will continue to refer to the service description/shared care arrangements/Drug Monitoring Guides sections of the OOHs spec:
- Near Patient Monitoring v22

**Monitoring**
Quarterly Audits, with action plans (if appropriate) to implement any changes as a result of the audit outcomes.

<table>
<thead>
<tr>
<th>Key performance indicators</th>
<th>QoF Stretch KPI/target:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Drugs to be monitored in line with the shared care arrangements outlined in the OOH Near Patient Monitoring spec v22.</td>
</tr>
</tbody>
</table>

**CCG support**
- It is the responsibility of the GPs to deliver this standard. Appropriate support will be provided by the Medicines Management Team.

**References**
<table>
<thead>
<tr>
<th>Standard 20</th>
<th>Drug monitoring – near patient monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Dermatologists. 2008.</td>
</tr>
<tr>
<td></td>
<td>BSG Guidelines for the management of inflammatory bowel disease in adults. 2011</td>
</tr>
<tr>
<td></td>
<td>British Association of Dermatologists’ guidelines for the safe and effective prescribing of azathioprine. 2011.</td>
</tr>
<tr>
<td>CCG contact</td>
<td>Beryl Bevan</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:beryl.bevan@nhs.net">beryl.bevan@nhs.net</a></td>
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</tbody>
</table>
### Standard 21: Patient experience

| Rationale | Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. However, experiences of care can vary by different patient groups, with the poorest care often received by those least likely to make complaints, exercise choice or have family to speak up for them. In 2013, Don Berwick presented his report on patient safety at The King’s Fund. He suggested the NHS should be engaging, empowering and hearing the views of patients, and their carers, all the time. The Government Care Act (2014) strongly advocates that patients are involved in decisions about their care, and services that may affect them. The learning from patient surveys, or patient forums, can be used to stimulate local improvement. It can also empower NHS staff to carry out the sorts of changes that make a real difference to patients and their care (NHS England, 2014). Since 1 April 2015, Patient Participation Groups have been a mandatory part of the GP contract, and practices are expected to have an effective group within the practice which meets at regular intervals, empowers patients; assists and supports GP’s; and informs and enhances the work of the CCG. |
| Delivery | **Practices will be expected to:**  
- Establish and organise effective patient participation group within the practice.  
- The PPG shall meet regularly at times determined by its members but as a minimum two times a year, once in each six-month period increasing to three times a year in 2019/20 and then four times a year in 2020/21. Areas for discussion shall be determined by the members and should include, but not be limited to:  
  - Access, including opening hours, telephone access, availability of appointments  
  - Clinical services  
  - Reception services  
  - How patient feedback is being used to improve clinical standards  
  - How patient feedback is being used to improve patient experience  
  - Use of IT – uptake of online appointments, prescriptions and access to medical records, health apps etc  
- Have a system in place to take feedback from all patients and provide information about what has happened as a result of the feedback (e.g. ‘you said, we did’ noticeboard; Including feedback from NHS choices, Google reviews, I Want Great Care, Patient Opinion etc.  
- Review NHS Choices content annually for accuracy  
- Patient satisfaction will be measured by, but not be limited to:  
  - An annual locally-administered survey of patients using a... |
Standard 21

**Patient experience**

- **Survey approved by the Commissioner**
  - The NHS GP Friends and Family Test
- Develop improvement action plans relating to patient experience, using the themes arising from local intelligence and patient feedback from Family & Friends test, PPG feedback, and other patient feedback sources. Use these plans to demonstrate how patient feedback has been acted upon and used to make improvements.

**Key performance indicators**

The following KPIs will be measured annually from the GP Patient Survey:

1. Percentage of patients responding within the ‘good’ range to the question “Overall, how would you recommend your experience of your GP Surgery?”;
2. Percentage of patients who would definitely or probably recommend their GP Surgery;
3. Percentage of patients responding within the ‘helpful’ range to the question “How helpful do you find the receptionists at your GP Surgery?”;
4. Percentage of patients responding within the ‘easy’ range to the question “Generally, how easy is it to get through to someone at your GP Surgery on the phone?”;
5. Percentage of patients that “don’t have to wait too long” to be seen for their appointment.

This is in line with the Standard Alternative Provider Medical Services Contract 2016/17.

In year 1, the outcomes of the KPIs will be used to establish a baseline. An appropriate stretch will be applied in year 2 onwards.

**CCG support**

- The CCG Patient and Public Engagement Manager will provide advice and support for the set up and running of PPG’s, and attend meetings on an ad-hoc basis;
- The CCG will provide support around self care and signposting to local services that can help patients manage their health;
- The CCG will share examples of best practice and share learning from successful PPGs;
- The CCG will help link Public Health with Practices to help communicate public health priorities and will provide information for GP practice websites on local services and public health campaigns.

**References**

- National Association for Patient Participation (NAPP), (2014) Available at:
<table>
<thead>
<tr>
<th>Standard 21</th>
<th>Patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://www.napp.org.uk/overview.html">www.napp.org.uk/overview.html</a></td>
</tr>
<tr>
<td>CCG contact</td>
<td>Shanker Vijayadeva</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:svijayadeva@nhs.net">svijayadeva@nhs.net</a></td>
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### Standard 22

**Demand management**

<table>
<thead>
<tr>
<th><strong>Aims</strong></th>
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| To ensure Effective Utilisation of Resources  
| To help deliver the Government 'referral to treatment’ target of 18 weeks, by ensuring demand is clinically appropriate  |

<table>
<thead>
<tr>
<th><strong>Rationale</strong></th>
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</table>
| The NHS is not obliged to provide every treatment that a patient, or group of patients, may demand. It does, however, have a statutory duty to take into account the resources available to it and the competing demands on those resources. The process for prioritising resource allocation is a matter of judgement. To ensure local resources are used effectively, Ealing CCG has developed pathways, clinical guidelines and quality referral standards on a number of specialities. These provide referral guidance for Primary Care. GPs are expected to follow these pathways when considering a referral.  
In addition to clinical guidelines and quality referral standards, we utilise a Referral Facilitation Service (RFS) which supports primary care in terms of processing referrals which are subsequently sent to providers. The RFS also provides clinical assessment (by GPs) of referrals based on a variety of specialities. This provides educational feedback to referrers and assists in adherence with agreed guidelines.  
In NWL, there is an agreed list of surgical procedures that should only be performed by secondary care following agreed criteria having been met. The list is available and kept up to date via the Hounslow CCG website - [http://www.hounslowccg.nhs.uk/news,-publications-and-policies/publications.aspx?n=2003](http://www.hounslowccg.nhs.uk/news,-publications-and-policies/publications.aspx?n=2003)  
In addition to PPwT procedures, a number of procedures and treatments are only able to be funded following scrutiny by an NWL Individual Funding Request (IFR) panel. Details of the types of procedures and treatments which can be applied for via the IFR route is available here - [http://www.hounslowccg.nhs.uk/news,-publications-and-policies/publications.aspx?n=2137](http://www.hounslowccg.nhs.uk/news,-publications-and-policies/publications.aspx?n=2137)  
|  

| **Delivery** | **Practices will be expected to:**  
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| Refer all referrals through RFS unless the referral is on the specific RFS exclusion list (e.g. direct access referrals). The RFS will utilise the NHS e-Referrals system when sending to providers and abide by the pre-defined patient choice.  
| Ensure appropriate practice staff are aware of PPwT Policies.  
| Ensure PPwT policies and referral criteria are easily accessible for all referrers within practices.  
| Comply with the PPwT Policies; examples include:  
| - Benign skin lesions  
| - Tonsillectomy  
| Comply with IFR Policies; examples include:  
| - Cosmetic procedures  
| Review referral data provided by the CCG and engage in practice referral discussions for a range of specialities  
| Conduct internal practice peer reviews and/or establish processes to review referrals from all referrers within the practice – especially referrals generated by sessional staff or locums  
|  

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## Standard 22: Demand management

- Ensure that practice locum packs include appropriate links to Ealing Speciality Referral Guidelines and Quality Referral Standards
- Actively participate in Peer reviews in network based sessions as arranged by the CCG

### Key performance indicators

1. Submit a declaration of compliance with the following:
   - Use of the Referral Facilitation Service (RFS) for all appropriate referrals.
   - Discussion and awareness of PPwT policies with appropriate practice staff.
   - Ensuring that PPwT policies are easily accessible for all referrers within Practices.

2. Reflect on referral behaviour within the practice or network upon referral data reports being provided by the CCG on a number of clinical specialities (as per “delivery” section above)

### CCG support

The CCG will:
- Ensure it participates in the NWL PPwT policy updates as required
- Provide Practices with referral data and information as required for peer review
- Develop and facilitate a peer review event to enable Practices to take part in

### References

Ealing RFS Referral Guidelines – Ealing CCG Extranet: [https://extranet.cwhheccgs.nhs.uk/ealingccg/GP/RFS2/Pages/default.aspx](https://extranet.cwhheccgs.nhs.uk/ealingccg/GP/RFS2/Pages/default.aspx)


### CCG contact

Dr Alex Fragoyannis
alexfragoyannis@nhs.net
<table>
<thead>
<tr>
<th>Standard 23</th>
<th>Pre-Qualifier Business management: information governance</th>
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<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>This standard aims to ensure that high quality systems of business management and information governance are standardised across primary care in Ealing. It includes additional provisions for membership engagement, use of local information systems and managing conflicts of interest. NHS Ealing CCG is a membership organisation made up of all GPs from across the 76 practices in Ealing. Active engagement with members is vital in order to:</td>
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<td>- Enable shared learning and spreading of good practice;</td>
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<td>- Identify and understand local challenges;</td>
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<td>- Establish a high level of shared purpose between practices and make sure that contributes to planning care for patients;</td>
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<td>- Understand the CCG vision, purpose, strategies and plans.</td>
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<tr>
<td><strong>Delivery</strong></td>
<td>Practices will be expected to:</td>
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<tr>
<td></td>
<td>- Have appointed a GP lead and a deputy (another GP, Practice Manager, Business Manager, Senior Nurse) as the main point of contact for the CCG;</td>
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<td>- Ensure that a senior representative (GP, PM or PN) attends 80% of the Council of Members (CoM) Meetings and the Annual General Meeting (AGM);</td>
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<td>- Use local information systems and tools:</td>
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<td>Subject to data availability, review performance data at least once a month;</td>
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<td>- Be aware of and use locally commissioned pathways, proactively seeking out the information required;</td>
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<td></td>
<td>- Effectively manage conflicts of interest, and complete a Declaration of Interest Form and send to the CCG for inclusion in the register;</td>
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<td></td>
<td>- Comply with Information Governance laws as well as policies set by the NHS in Ealing and/or North West London;</td>
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<td>- Share information with commissioners to support quality improvements (subject to IG rules);</td>
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<td></td>
<td>- Participate in clinical audit cycles and peer review external to their practice;</td>
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<td>- Actively collect, analyse and act on feedback from patients and carers;</td>
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<td>- Operate an accessible complaints procedure that is consistent with the principles of the NHS complaints procedure.</td>
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<td></td>
<td>- Report annually about complaints to NHS E.</td>
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<td>- Have up to date policies on Infection Control, Information Governance, significant events and child and adult safeguarding</td>
</tr>
<tr>
<td><strong>Key performance indicators</strong></td>
<td>1. Practice has confirmed GP Lead and deputy with the Network Relationship Managers by the required date;</td>
</tr>
<tr>
<td></td>
<td>2. Practice has signed attendance sheets at 80% COM meetings and AGM (audit);</td>
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## Standard 23

### Pre-Qualifier

**Business management: information governance**

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<td></td>
<td>3. 100% staff complete conflicts of interest declaration (or nil return);</td>
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### CCG support

The CCG will:
- Provide a Network Relationship Manager to liaise with CCGs on issues of business management and information governance;
- Communicate the dates of Council of Members meetings and the AGM to practices well in advance;
- Provide training on local information systems and tools;
- Maintain a Declaration of Interest register.

### References

**CCG contact**
Fionnuala O’Donnell
fionnuala.odonnell@nhs.net

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## Standard 23

### Pre-Qualifier

**Business management: accessible information standards**

### Rationale

The standard aims to ensure that patients and service users (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss receive:

- Accessible information (information which is able to be read or received and understood by the individual or group for which it is intended);
- Communication support (support which is needed to enable effective, accurate dialogue between a professional and a service user to take place).

Such that they are not put "at a substantial disadvantage…in comparison with persons who are not disabled" when accessing NHS or adult social services. This includes accessible information and communication support to enable individuals to:

- Make decisions about their health and wellbeing, and about their care and treatment;
- Self-manage conditions;
- Access services appropriately and independently;
- Make choices about treatments and procedures including the provision or withholding of consent;
- To be able to attend appointments.

The Equality Act (2010) places a legal duty on all service providers to take steps or make “reasonable adjustments” in order to avoid putting a disabled person at a substantial disadvantage when compared to a person who is not disabled. Guidance produced by the Equality and Human Rights Commission (EHRC) states that, “Anything which is more than minor or trivial is a substantial disadvantage.” The Act is explicit in including the provision of information in “an accessible format” as a ‘reasonable step’ to be taken.

From 1st August 2016 onwards, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard says that patients, service users, carers and parents with a disability or sensory loss should:

- Be able to contact, and be contacted by, services in accessible
| Standard 23 | Pre-Qualifier  
Business management: accessible information standards |
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<tr>
<td>ways, for example via email, text message or Text Relay;</td>
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<tr>
<td>• Receive information and correspondence in formats they can read and understand, for example in audio, braille, easy read or large print;</td>
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<tr>
<td>• Be supported by a communication professional at appointments if this is needed to support conversation, for example a British Sign Language interpreter;</td>
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<tr>
<td>• Get support from health and care staff and organisations to communicate, for example to lip-read or use a hearing aid.</td>
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<thead>
<tr>
<th>Delivery</th>
<th>Practices will be expected to:</th>
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<tr>
<td>• Make reasonable adjustments for those with protected characteristics;</td>
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<tr>
<td>• Ensure that all staff are aware and can access interpretation and translation services for patients who are non-English speaking during service operation hours;</td>
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<tr>
<td>• Request information from the CCG e.g. BSL film, pictures &amp; symbols where required;</td>
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<tr>
<td>• Comply with Accessible Information Standard, including:</td>
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<tr>
<td>o Asking people if they have any information or communication needs, and finding out how to meet their needs;</td>
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<tr>
<td>o Recording those needs clearly and in a set way;</td>
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<tr>
<td>o Highlighting or flagging the person’s file or notes so it is clear that they have information or communication needs and how to meet those needs;</td>
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<tr>
<td>o Sharing information about people’s information and communication needs with other providers of NHS and adult social care, when patient consent is given to do so;</td>
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<tr>
<td>o Taking steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.</td>
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<tr>
<td>• Enable patients to provide feedback about their experience of receiving information in an appropriate format via PPGs, PALS, CCG web page, questionnaires or engagement events.</td>
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<table>
<thead>
<tr>
<th>Key performance indicators</th>
<th>Annual audit to demonstrate:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. Compliance with Accessible Information Standard (SCCI1605) by providing examples of information provided to patients in alternative formats.</td>
</tr>
<tr>
<td></td>
<td>2. All eligible patients are able to access interpreters when required.</td>
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<thead>
<tr>
<th>CCG support</th>
<th>The CCG will:</th>
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<tr>
<td></td>
<td>• Prepare and publish the communication and engagement strategy which includes information on accessible communications;</td>
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<td></td>
<td>• Ensure that their commissioning and procurement processes with providers of health and / or adult social care reflect, enable and support implementation and compliance with this standard;</td>
</tr>
<tr>
<td></td>
<td>• Seek assurance from provider organisations of their compliance with this standard, including evidence of identifying, recording, flagging, sharing and meeting of needs;</td>
</tr>
<tr>
<td></td>
<td>• Ensure the Accessible Information Standard SCCI-1605 is available on the website.</td>
</tr>
</tbody>
</table>
### Standard 23

#### Pre-Qualifier

**Business management: accessible information standards**


| CCG contact | Fionnuala O'Donnell  
|             | fionnuala.odonnell@nhs.net |

### Standard 23

#### Pre-Qualifier

**Business management: business continuity**

| Aims | To ensure GP practices have an adequate and up to date Business Continuity Plan.  
|      | To ensure GP practices Business Continuity Plans include plans to ensure they are effectively able to manage surges in activity i.e. winter periods, around bank holiday weekends. |

| Rationale | The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major incident.  
|           | Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. In addition, CCG System Resilience Groups are required to provide assurance to NHS England that robust arrangements are in place to effectively manage surges in activity at both the start and the end of the patients time in care, therefore, including primary care. |

| Delivery | **Practices will be expected to:**  
|          | • Have an adequate, up to date practice Business Continuity Plan;  
|          | • Within the Business Continuity plan practices will be expected to have outlined plans / processes to manage surges in activity;  
|          | • Examples of what these plans could include are below; plans may involve federated working with other practices:  
|          |   o Extended hours / Weekend clinics;  
|          |   o Additional capacity;  
|          |   o Emergency only clinics post bank holiday;  
|          |   o Drop-In clinics;  
|          |   o Telephone consultations / Triage systems;  
|          | • Contingency staffing plans. |

| Key performance indicators | There will be a random audit of Business Continuity Plans across practices |

<p>| References | Ealing CCG Business Continuity Plan available at |</p>
<table>
<thead>
<tr>
<th>Standard 23</th>
<th>Pre-Qualifier Business management: business continuity</th>
</tr>
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<tbody>
<tr>
<td>CCG contact</td>
<td>Fionnuala O'Donnell <a href="mailto:fionnuala.odonnell@nhs.net">fionnuala.odonnell@nhs.net</a></td>
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</table>
4 Education and Training Requirements

Introduction

This section provides information about the principles of education and training for delivery of the Ealing Standard. Ealing Community Education Provider Network (CEPN) [Funded by Health Education Northwest London and supported by Ealing CCG] will be responsible for provision, coordination and evaluation of all education and training. It aims to ensure that the Ealing Standard can be delivered by a competent and confident workforce that has access to timely and appropriate training opportunities. Ealing CEPN will endeavor to ensure that the workforce is supported to meet the needs of the local population’s health and improve clinical outcomes through a focus on career development, leadership and mentorship.

Education and Training for the Ealing standard will be part of a wider programme across primary care to continuously up skill staff and enhance workforce capability to provide an ever increasing diversity of services. As the care of patients shifts from hospital to home, the need to support a more varied workforce and to increase the workforce numbers will become more pressing. Various strategies will be employed by Ealing CEPN to drive this forward, such as pre-registration nursing students being trained in primary care, developing the clinical pharmacist role and other new roles and marketing primary care as an exciting and rewarding place to work.

What will Ealing CEPN be expected to do:

- Ealing CEPN will provide a programme of education and other training sessions to support delivery of the Ealing Standard.
- A calendar of education and training will be published on a yearly basis and updated regularly as per local training needs.
- A schedule of initial training and update requirements will be provided for each service.
- Education and Training will be provided for all staff groups and, where appropriate will run multidisciplinary events to encourage system-wide coordination.
- Ealing CEPN will aim to provide locally driven, high quality training through a system of provider feedback and evaluation.
- Ealing CEPN will provide support to practices who become training hubs e.g. via Locality Nurses and provision of mentorship training, etc.
- Ealing CEPN will provide access to validated online update training modules as appropriate.
- Education and training sessions will take place at appropriate venues and at varied times across Ealing.

What the expectations of practices are:

*With specific Reference to the Ealing Standard:*

- There are appropriately competent, qualified and trained staff to deliver the specified level of service/intervention in line with the service specifications.
- The OOH service Training and Clinical Competency Guidance will form the basis of the requirements for practices and will be updated over time.
- Staff have access to refresher training as required to maintain clinical competence in delivering the specified services.
- Staff have completed all relevant mandatory training and updates.
With Reference to Education and Training General Expectations:

- Practices to offer all staff opportunities to develop professionally and allow staff to attend training sessions where appropriate for their role.
- Nurses should be encouraged to undertake mentorship training in line with their professional code of conduct defined by the NMC.
- Practices will be encouraged to become training hubs and to take on primary care placements where possible.
- Practices will be encouraged to provide career guidance and opportunities through CPD to progress staff professional development.
- Staff attending any training will be encouraged to feedback at practice team meetings where appropriate.
- Practices with HCAs will be expected to provide appropriate supervision to HCAs and support them in their development.
- At least one representative from all staff groups from each practice will be expected to attend their relevant forum, eg HCA, Nurse, Receptionist and Practice Manager Forums.
5 Mobilisation

5.1 Signing up to the Ealing Standard

The Ealing Standard has been developed in order to significantly invest in Ealing’s primary care offer, allowing it to both sustain and transform in to the future, while also improving access, quality and service provision for the whole population.

Patients in Ealing should expect to access a consistent set of services anywhere across the borough. In commissioning these services, the CCG needs to achieve value for money and equity of funding across primary care.

Signing up to the Ealing Standard confirms the practices intention to deliver the Ealing Standard in full, as described within the specification.

The practice should compile a mobilisation plan, outlining how the funding associated with the Ealing Standard will be utilised across the duration of the contract to ensure full and ongoing delivery of the Ealing Standard by 2020.

5.2 Preparing for Mobilisation

For general practice the Ealing Standard will enable a sustainable model of patient care which is clearly defined over a longer period of time. The principles that will remain consistent through its development are:

- **Sustainable and resilient** - the new primary care offer will provide stable income and streamlined payment processes, which will reduce the administrative workload within practices and allow practices to confidently invest and attract the workforce required to improve access and continuity;
- **Investment in primary care** - to enable this sustainability, there needs to be investment in practice and workforce development. The funds will be used primarily to increase workforce (clinical and non-clinical). The impact of this increase in workforce will be improved access and continuity of care in the primary care setting. Practices will be encouraged to explore how different roles, such as clinical pharmacists, can support the work that primary care is required to deliver;
- **Networked support** – delivery of the Ealing Standard will enable practices to build on the systems and processes developed for the Out Of Hospital Services contract, allowing for services to be delivered at Practice, Network, Locality and Borough levels.

Preparation for mobilisation of the Ealing Standard will clearly need to be tailored to the needs of each individual practice to support the thinking, planning and investment at an individual practice level. However, this does not restrict practices that have innovative solutions to sustainability or would like to work at scale with other practices.

5.3 Support Available

Ealing CCG has developed a provider development plan in relation to the GP Forward View, which includes (but is not limited to):

- Access to quality improvement programmes for individual practices, including the Productive General Practice Quick Start Programme;
• Resilience funding to help practices become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients;
• The investment of £3p/h across 2017/18 and 2018/19 in provider development (from core allocation, non-recurrent), in line with GP Forward View priorities of helping free up GP time, implementing the 10 High Impact Actions, improving access, and securing the sustainability of general practice.

5.4 Investing in Provider Development

For Ealing CCG, the £3p/h investment will be profiled as £1/head in 17/18 and £2/head in 18/19 (with 1% uplift). This investment, which will go directly into practices, is a key enabler to support the wider programme of transformation and specifically to support practices to ready themselves to deliver the Ealing Standard.

Practices can choose which programmes they wish to prioritise and in what order to address the needs of their practices and practice populations. Furthermore, practices can approach the delivery of the expected outcomes either as individual practices, groups of practices, or through networks. By working collaboratively the benefits of working at scale may be more easily realised, for example reducing duplication, wider distribution of resource, sharing learning, sharing workforce skill-mix or expertise and streamlining processes.

5.5 Support for at-scale working

There are a number of emerging models of at-scale primary care across the UK, including informal partnerships, GP Federations, networks, super-surgeries, primary care homes and multispecialty community provider partnerships. These are not necessarily mutually exclusive, but whichever model(s) work best for individual providers, they need to have a number of key skills and capabilities.

A ‘GP Provider Maturity Assessment Framework’ has been developed by North West London Collaboration of CCGs, which will be available from July 2017 for providers working together at any scale. The facilitated assessment session will enable at-scale providers to explore:

• Their ability to undertake population management and manage reduction in unwarranted variation;
• Their readiness to hold future capitation budgets;
• Where they want to be as an organisation;
• How they will achieve their ambitions and the commissioner and provider roles within the system to achieve this.

This may provide another opportunity to explore the most appropriate, sustainable and innovative approaches to delivering the Ealing Standard, as part of provider’s preparation for mobilisation.

5.6 Mobilisation

Phase One: October 2017 – March 2017

Practices should be prepared to deliver the following services from 1st October 2017:

• Standard 18  Access
In addition:

- Undertake demand and capacity modelling

Phase One of the roll out of the Ealing Standard will run alongside the existing Out of Hospital Services contract, which will end on 31st March 2018.

During Phase One, practices should consider how they will prepare to move from the existing Out of Hospital contract to the new Ealing Standard from 1st April 2018.

By 30 September 2017, practices should submit the access components of the ‘Ealing Standard Implementation Plan’ which outlines how they will deliver the Ealing Standard across the duration of the contract. The complete plan should be submitted by end of January 2018. This should include:

- Which Standards the practice is already delivering, and which they are ready to provide on contract start date;
- Which Standards are not yet deliverable in full, what actions will be taken to deliver them and by when;
- If the practice intends to deliver in partnership with other providers;
- How the available funding will be allocated to in order to deliver the Ealing Standard.

**Phase Two: April 2018 – March 2019**

The full Ealing Standard contract will be in operation from 1st April 2018.

Practices mobilisation plans should outline how they are ensured they can deliver each of the Standards, and where a phased implementation is required, what the trajectory is for full delivery by 2020.
# 6 Ealing Standard Implementation Plan

<table>
<thead>
<tr>
<th>Practice Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Name</td>
<td></td>
</tr>
<tr>
<td>Name and position of person completing the form</td>
<td></td>
</tr>
<tr>
<td>Email address:</td>
<td></td>
</tr>
</tbody>
</table>

## Services delivered (activity based services) for submission by 31st January 2018

Please confirm which of the non-mandatory services you intend deliver (an F&A plan is required for each of these services)

<table>
<thead>
<tr>
<th>Service</th>
<th>✓ or x</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular (Warfarin Monitoring)</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular (Warfarin initiation)</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular (ECGs)</td>
<td></td>
</tr>
<tr>
<td>Diabetes (insulin initiation)</td>
<td></td>
</tr>
<tr>
<td>Respiratory (Diagnostic Spirometry)</td>
<td></td>
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<tr>
<td>ABPI</td>
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<tr>
<td>Phlebotomy</td>
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<tr>
<td>Homeless</td>
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<tr>
<td>Ring Pessary</td>
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</tbody>
</table>

Please confirm arrangements in place to ensure your patients can benefit from the activity based services in primary care if you are not delivering them

<table>
<thead>
<tr>
<th>Service</th>
<th>To be delivered by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular (Warfarin Monitoring)</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular (Warfarin initiation)</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular (ECGs)</td>
<td></td>
</tr>
<tr>
<td>Diabetes (Insulin initiation)</td>
<td></td>
</tr>
<tr>
<td>Services delivered (Access) for submission by 30th September 2017</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Current opening hours:</td>
<td>Core hours:</td>
</tr>
<tr>
<td>Plans for patients able to access primary medical services from 08:00-18:30 Monday to Friday by 2020 if not currently open, including working with other practices where appropriate</td>
<td></td>
</tr>
<tr>
<td>Confirm how patients are able to contact the practice to book appointments</td>
<td></td>
</tr>
<tr>
<td>What system do you have in place for reviewing telephone access to ensure patients are able to contact the surgery (eg overflow call handling, interactive voice response)?</td>
<td></td>
</tr>
<tr>
<td>How does the practice advertise online booking and online repeat prescribing requests?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Which of the following appointment types do you offer: Face-to-face, telephone, e-consultation, video consultation?</td>
<td></td>
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<tr>
<td>What arrangements do you have for different appointment lengths?</td>
<td></td>
</tr>
<tr>
<td>Current number of weekly GP appointments, by appointment type provided during core hours.</td>
<td></td>
</tr>
<tr>
<td>Please include:</td>
<td></td>
</tr>
<tr>
<td>• Face-to-face appointments AND length of appointments</td>
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<tr>
<td>• Walk in appointments</td>
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<tr>
<td>• Telephone consultations (includes GP triage leading to a future appointment)</td>
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<tr>
<td>• Email consultations</td>
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<tr>
<td>• Video consultations</td>
<td></td>
</tr>
<tr>
<td>Current number of weekly appointments with a registered nurse, by appointment type provided during core hours.</td>
<td></td>
</tr>
<tr>
<td>Current number of weekly appointments with other healthcare professional, by appointment type provided during core hours.</td>
<td></td>
</tr>
<tr>
<td>How far in advance are patients able to book a routine appointment?</td>
<td></td>
</tr>
<tr>
<td>Plans for patients to book up to 4 week in advance appointment booking, if not currently providing?</td>
<td></td>
</tr>
<tr>
<td>How will you make arrangements to meet the urgent needs of patients? (Practices should ensure a clinician assesses children with perceived urgent needs on the same day and provide access to a registered healthcare professional on the same day if clinically urgent)</td>
<td></td>
</tr>
</tbody>
</table>
### Services delivered (other new services)

Please confirm how you intend to mobilise the services that you are not currently delivering and how you intend to resource them.

### Education and training

Please confirm how you will ensure that:
- There are appropriately competent, qualified and trained staff to deliver the specified level of service/intervention in line with the service specifications.
- Staff have access to refresher training as required to maintain clinical competence in delivering the specified services.
- Staff have completed all relevant mandatory training and updates.

### Annual Self Declaration

A Self-Declaration Form will be circulated to practice to complete and submit annually.