Service Specification No.	1
Service	24hr Ambulatory Blood Pressure Monitoring (ABPM)
Commissioner Lead	Jan Giles
Provider Lead	NHS Greater Huddersfield General practices
Period	1st April 2021- 30th September 2021
Date of Review	September 2021

1. Population Needs

1.1 National/local context and evidence base

Hypertension is one of the most preventable causes of morbidity and mortality in the United Kingdom and its management is one of the most common interventions in primary care.

24 Hour ambulatory blood pressure monitoring (ABPM) permits the continuous non-invasive measurement of blood pressure over twenty four hours, whilst the patient is in their own environment, representing a true reflection of their blood pressure. Many studies have now confirmed that blood pressure measured over a 24-hour period is superior to blood pressure recorded in clinic for predicting future cardiovascular events and NICE now recommends that ambulatory blood pressure monitoring (ABPM) be offered to confirm the diagnosis of hypertension if the clinic blood pressure is 140/90 mmHg or higher.

The usage of ABPM is specialised and requires validation and quality control measures to be undertaken. Information obtained from patient diaries and drug dosage timing is expected to be used in conjunction with readings.

In the absence of easy access to ABPM there is the increased risk that patients may be inappropriately labelled as hypertensive and may be treated as such.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	√
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

Covered elsewhere in the specification

3. Scope

3.1 Aims and objectives of service

The service will have the following aims/objectives:

- To avoid inappropriate labelling of patients as hypertensive
- To identify more accurately patients at increased cardiovascular risk because of hypertension
- To initiate treatment for hypertension before the onset of target organ damage
- To progress the concept of patient self-monitoring
- To reduce unnecessary referrals to secondary care
- To remove or prevent unnecessary treatment
- Improved access to services for patients closer to home

- Better utilisation of existing expertise and capacity in General Practice
- Delivers NICE guidelines effectively

3.2 Service description/care pathway

The interpretation of the Ambulatory Blood Pressure profile will include mean daytime, mean night time at sleep and mean 24 hour measurements, as well as consideration of information from patient diaries and times of drug treatment.

The service will adhere to the following procedures:
Day One – the patient will be fitted with a 24 hour blood pressure monitoring device. Full instructions will be given to the patient on how to remove the device, and details of who to contact in case of difficultly. Patients will be encouraged to keep a diary.

Day Two – (or next working day for the practice) the patient re-attends to return the device. The device is processed and as a minimum the mean daytime, systolic and diastolic will be recorded on the practice clinical system. Within 4 weeks, the patient should book an appointment with nurse or a doctor must discuss the results of the measurements. If the readings show any signs of accelerated or malignant hypertension the patient should be contacted by the practice urgently.

When discussing the results with patients clinicians should be cautious if the term 'white coat hypertension' is used. Anecdotally some patients and clinicians seem to interpret this as equivalent to normal blood pressure. The literature around this is uncertain and debate continues. It may be that white coat hypertension could be a precursor to established hypertension and/or a cardiovascular risk factor in itself.

The service shall:
- Record monitoring in the patient's lifelong records;
- Ensure monitoring equipment is checked and regularly calibrated in accordance with the manufacturer's guidance;
- Examine and analyse the results;
- Make any relevant referrals as indicated by the results of the monitoring.

For guidance on the diagnosis of hypertension using 24 hr ABPM clinicians should refer to NICE Clinical Guideline 127 – Hypertension in adults: diagnosis and management (updated November 2016).
https://www.nice.org.uk/guidance/cg127

3.3 Population covered

Patients registered with a NHS Greater Huddersfield CCG practice

3.4 Any acceptance and exclusion criteria and thresholds

- Children and young people

3.5 Interdependence with other services/providers

The service will make links with the following:
- Secondary care services
- Community nursing service
- Appropriate lifestyle interventions

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The service will be provided in accordance with NICE Guideline CG127 – Hypertension in adults: diagnosis and management.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Not applicable

4.3 Applicable local standards

The local standards are set out at Appendix 1.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

The Quality and Performance Indicators for the service are set out in Appendix 2.

In addition, the following requirements relating to patient/carer experience data apply:

- The Provider will actively gather patient/carer experience data
- The Provider will review patient/carer experience data on a quarterly basis, make recommendations where appropriate and act on them
- The Provider will make available to the CCG patient/care experience intelligence when requested

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Not appropriate at this time. The application of any future CQUIN scheme will be funded from within the set rate/tariff for the service i.e. within the financial envelope identified and not in addition to.

6. Location of Provider Premises

The Provider's Premises are located at:

The General Practice and/or branch surgery of the Provider as named in the NHS Standard Contract.

7. Individual Service User Placement

Not applicable

APPLICABLE LOCAL STANDARDS

Training protocol

- The Provider will adhere to the required clinical guidelines and governance
- Staff applying the 24 hour BP device must be trained, assessed as competent and supervised by appropriately qualified personnel.
- Continuing Professional Development will be available for staff supporting this service (e.g. accessed from the British Hypertension Society website).
- Staff providing the service will declare themselves competent.

Equipment

- Cuffs of different sizes and non-latex material will be used to reduce allergy risk.
- Cleaning of the cuffs between patients will follow infection control policy (which incorporates adherence to manufacturers' instructions)
- Replacements and service maintenance arrangements will be managed and paid by the Provider, and these costs have been accounted for within the fee.
- When applying 24 hr ABPM machines to patient and processing the data clinicians will follow the manufacturer's instructions.

Risk management/contingency

The Provider will confirm that it has sufficient risk management procedures and contingency plans in place in relation to adverse reactions or incidents which could relate to this service.

Other standards

The patients using this service will benefit from:

- all the relevant information in a form appropriate to their need
- information about the NHS complaints system
- prompt & appropriate response to their queries
- adequate facilities including premises and equipment

Monitoring/evaluation

The Provider will be required to code activity within the clinical IT system. Appropriate codes will be advised and where practicable will cover:

- Number of Patients who have completed a period of 24 hour ABPM monitoring
- Number referred onto secondary care following the diagnostic
- Number requiring no ongoing treatment
- Number started or increased anti-hypertensive medication following the diagnostic
- Number of patients whose antihypertensive medication is stopped following the diagnostic
- Number of failed measurements of the monitoring equipment

Analysis of this information will be used to improve the service, and inform future commissioning decisions.

All adverse incidents must be dealt with and recorded by the Provider through the CCG's incident reporting.

Service Specification No.	2
Service	Anticoagulation Prescribing and Monitoring – Level 1 only
Commissioner Lead	Jan Giles
Provider Lead	
Period	1 April 2021 to 30 September 2021
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

An anticoagulant prevents coagulation (clotting) of blood and is used to treat patients with atrial fibrillation (those at risk of stroke), as well as those with or susceptible to deep-vein thrombosis or pulmonary embolism. **Warfarin is the main oral anticoagulant used in the UK and has been in existence for over 60 years. The main adverse effect associated with it is bleeding and its major drawback is that dosage requirements vary between individuals and that it** interacts with other medicines and a person's dietary intake meaning that it needs regular monitoring.

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital, therefore managing the risk associated with anticoagulants can reduce the chance of patients being harmed in the future.

In 2013, NICE produced a commissioning guide on anticoagulation therapy[1]. This sets out the evidence base and relevant guidance.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The service contributes to the following Domains of the NHS Outcomes Framework

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	√
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

Covered elsewhere in the specification.

[1] NICE **Support for Commissioning: Anticoagulation Therapy** 2013

3. Scope

3.1 Aims and objectives of service

The service is designed to be one in which:

(i) Therapy is usually initiated in secondary care or anticoagulation service but may be initiated in primary care, for recognised indications for specified lengths of time.

(i) Maintenance of patients first established in the secondary care setting should be properly controlled

(ii) Prescribing of anticoagulant therapy is in line with recommendations of the anticoagulation service for warfarin and derivatives or relevant national guidelines and summary of product characteristics for NOACs.

(iii) The service to the patient is convenient

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

(v) The therapy is discontinued when appropriate

3.2 Service description/care pathway

This service should incorporate the relevant areas of guidance from the NPSA Patient Safety Alert 'Actions that can make Anticoagulant therapy safer' March 2007

The provider will:

- Have records of patients on anti-coagulation therapy
- Receive communication from external body regarding the patients current therapy
- provide information to patients as necessary, for example an issue with a type of medication
- prescribe as required ensuring a patient's INR is being monitored and is in range before issuing a prescription. Other blood tests (e.g. renal and liver function) should be carried out as relevant.
- Make arrangements for additional INR blood tests when co-prescribing significantly interacting medicines.
- Audit of GP practice elements of this service against the NPSA standards.

Patients have phlebotomy, laboratory testing and dosing external to the provider.

3.3 Population covered

The service will be available to the practice's own population.

3.4 Any acceptance and exclusion criteria and thresholds

Not applicable

3.5 Interdependence with other services/providers

The service will have links with the following:

- Anticoagulation service
- Secondary care services
- Community nursing service

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Health Care Standards for Better Health.

Other national standards mentioned elsewhere in this specification.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

As above

4.3 Applicable local standards

These are set out under the service description/care pathway.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Competency

Staff providing the service will have the appropriate clinical qualification for the role. They will need to have current membership of their relevant bodies, evidence of annual appraisal and indemnity cover. Other requirements will be covered by statutory and mandatory training.

Staff will be qualified and registered (where appropriate) in accordance with their anticipated scope of professional responsibility.

The provider should ensure that for any registered healthcare professional who is:

(a) Performing clinical services under this agreement; or is

(b) Employed or engaged to assist in the performance of such services;

there are in place arrangements for the purpose of maintaining and updating her/his skills and knowledge in relation to the services which s/he is performing or assisting in performing.

Any nurse prescribers involved in the service should have a GP sponsor who oversees their work within it.

Untoward events

It is a condition of participation in this service that the provider will give notification to the CCG of all incidents occurring in patients covered under this service. This should be done using the CCG incident reporting system.

For serious incidents where admission or death may be due to usage of drugs covered in this service or attributable to the relevant underlying medical condition, this must be reported to the CCG's Quality & Safety Manager within 72 hours of the information becoming known to the practitioner. This is in addition to a practitioner's statutory obligations.

Patient/carer experience

The following requirements relating to patient/carer experience data apply:

- The provider will actively gather patient/carer experience data
- The provider will review patient/carer experience data on a quarterly basis, make recommendations where appropriate and act on them
- The provider will make available to the CCG patient/care experience intelligence when requested

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Not appropriate at this time. The application of any future CQUIN scheme will be funded from within the set rate/tariff for the service i.e. within the financial envelope identified and not in addition to.

6. Location of Provider Premises

The Provider's Premises are located at:

The General Practice and/or branch surgery of the Provider as named in the NHS Standard Contract.

The provider should ensure that the premises in which services are to be provided are suitable for delivery of those services and sufficient to meet the reasonable needs of patients. The premises must also meet current premises related Regulations.

7. Individual Service User Placement

Not applicable

Anticoagulation Monitoring: Warfarin prescribing guidelines - General guidance

1. This protocol sets out details for the care of patients taking warfarin. The patient should also have received advice and written information on anticoagulant therapy, normally in the form of an anticoagulant booklet.

Background

2. Warfarin use is increasing as new indications for its efficacy have been recently identified. Nevertheless, its use is associated with adverse effects, particularly bleeding, and optimum management can be achieved by shared care between hospital and general practitioner. The present indications for warfarin, together with the presently agreed degree of anticoagulation for that indication are shown in the attached Tables 1 and 2.

Table 1

Therapeutic recommended uses and International Normalised Ratios (INRs) for those uses (British Society of Haematology)

Prophylaxis of postoperative deep vein thrombosis (general surgery}	2.0-2.5
Prophylaxis of postoperative deep vein thrombosis in hip surgery and fractures	2.0-3.0
Myocardial infarction: prevention of venous thromboembolism	2.0-3.0
Treatment of venous thrombosis (DVT)	2.0-3.0
Treatment of pulmonary embolism (PE)	2.0-3.0
Transient ischaemic attacks	2.0-3.0
Tissue heart valves	2.0-3.0
Atrial fibrillation	2.0-3.0
Valvular heart disease	2.0-3.0
Recurrent deep vein thrombosis and pulmonary embolism	3.0-4.5
Arterial disease including myocardial infarction	3.0-4.5
Mechanical prosthetic valves	(see table 2)
Recurrent systemic embolism	3.0-4.5
Intravascular stent	2.5-3.5

Table 2

Recommended INR for prosthetic valves

	Sinus rhythm normal left atrial size (i.e. most aortic valve replacement patients)	**Atrial fibrillation enlarged left atrium (i.e. most mitral valve replacement patients)**
Low thrombogenicity prosthesis	2.0 - 3.0	2.5 - 3.5
Other prostheses	3.5 - 4.5	3.5 - 4.5

Dosage regimens

3. The average dose of warfarin required daily is around 5 mg (range 1-9 mg) but may vary markedly because of several factors. Warfarin should be given once daily (5-6 pm is an ideal time) and is given as a tablet for oral administration. [Tablet strengths are 1 mg (brown), 3 mg (blue), 5 mg (pink).

Duration of therapy

4. After a single episode of venous thromboembolism, it is likely that three months' therapy is necessary. The duration of therapy needed after a second episode of DVT or PE is uncertain but 6-12 months' therapy is normally advocated. Patients with repeated episodes or in whom risk factors persist may require long-term (even life-long) therapy. In other indications long-term therapy may be necessary.

5. For patients in whom no new factor has arisen, the frequency of monitoring can be determined by the criteria shown in Table 3.

Table 3

Warfarin therapy: maximum recall periods during maintenance therapy*

*(not initiation)

One INR high:	recall in 7-14 days (stop treatment for 1-3 days) (maximum 1 week in prosthetic valve patients)
One INR low:	recall in 7-14 days
One INR therapeutic:	recall in 4 weeks
Two INRs therapeutic:	recall in 6 weeks (maximum for prosthetic valve patients)
Three INRs therapeutic:	recall in 8 weeks, apart from prosthetic valve patients
Four INRs therapeutic:	recall in 10 weeks, apart from prosthetic valve patients
Five INRs therapeutic:	recall in 12 weeks, apart from prosthetic valve patients

N.B. Patients seen after discharge from hospital with prosthetic valves may need more frequent INRs in the first few weeks.

(Based on data from Ryan et al (1989) British Medical Journal 299, 1207-1209)

6. When a condition known to cause alteration in the dose requirement of warfarin occurs (eg a potentially interacting drug), or the patient has an acute intercurrent illness, frequency of monitoring should be increased.

7. The following conditions cause warfarin sensitivity (i.e. need for reduced dose):

(i) liver dysfunction
(ii) heart failure
(iii) hyperthyroidism
(iv) some drugs
(v) acute pyrexial episode.

8. Some conditions cause warfarin requirements to be increased (ie need for greater than normal dose):

(i) hypothyroidism
(ii) vitamin K containing remedies, eg some herbal remedies and enteral feeds
(iii) some drugs.

Service Specification 3

Good Practice Bundle – Part 2

Standard

All of the following non-core GMS services to be routinely available in general practice for all of a practice's registered population:

- Phlebotomy;
- ECGs;
- Ear Irrigation;
- Ambulatory Blood Pressure Monitoring;
- Spirometry.

Overview

This scheme seeks to reduce variation between practices and improve consistency of access for all Greater Huddersfield registered patients to non-GMS-core services in general practice.

The requirement is that if a patient has a non-urgent need for the any of the (part 2) bundle services, they would normally expect to be able to have that carried out in general practice.

Each practice is required to ensure that the services are available to its patients within general practice. If a practice operates from two locations (e.g. has a branch surgery) the services do not need to be provided at both locations but they do need to be available to all patients. If a practice wishes to provide a service from both its locations and the bundle payment includes a contribution to equipment costs, the practice may claim that contribution for each location.

Monitoring of scheme compliance recognises the high trust relationship between CCG and practices, on which core GMS/PMS contracts are based. There are no specific targets for "units of activity" for each service area – the principle is that the services will normally be available to patients in general practice according to patient need and choice. Practices are expected to comply with the spirit of the requirement, recognising that the sustainability of this "high trust" approach is dependent on its ability to fairly recompense effort across all Greater Huddersfield practices.

Actual activity delivered in practice will be reviewed based on 6 months' activity across all practices. The payment for the bundle will be adjusted (increased or decreased; from April 2019) to reflect the overall activity across all participating practices.

Practices must have a mechanism to make patients aware that the full range of Part 2 bundle services are routinely available in general practice.

Service-specific notes

Phlebotomy:

There are no linked changes to other parts of phlebotomy service arising from the inclusion of phlebotomy in the best practice bundle. Specifically:

- There are no changes to the sample collection service and practices will need to take account of collection times in their arrangements for offering routine phlebotomy.
- There is no change to the current CHFT outreach phlebotomy service. Practices should note that this service is not restricted to the patients of practices where outreach clinics are physically held.

ECGs:

12 lead ECG testing specification v1_9.do

Ear Irrigation:

Bundle payment includes cost of equipment. Where a practice offers Ear Irrigation at two locations the cost of equipment element can be claimed for each location.

Ambulatory Blood Pressure Monitoring:

ABPM specification v3_1.docx

Spirometry:

Bundle payment includes cost of equipment. Where a practice offers Spirometry at two locations the cost of equipment element can be claimed for each location.

It is recognised that national requirements are changing and that by April 2021 there will be mandatory requirements for inclusion in the National Register of Spirometry Accredited Practitioners. Impact on the inclusion of Spirometry within the Good Practice Bundle will be kept under review.

Payment

Payment is on a bundle basis, not a cost-per-case basis.

Scenario	Payment	Measure/Reporting
Practice confirms that all of the services in the bundle are routinely available, in	Bundle payment.	Practice declaration.

general practice, to its registered population.		
Not all of the services in the bundle are routinely available and the practice has no plans to make them all available within 6 months.	No payment	N/A
Not all of the services in the bundle are routinely available in general practice but the practice intends to make them all available to its registered population by 30 September 2018.	1 April to 30 September 2018: CCG to advise bundle payment that can be claimed – based on elements of the bundle that are being provided.	• Practice declaration of the services that are available. • Practice plan setting out how remaining services will be made available by 30 September - to be developed and agreed with CCG (by 30 April 2018). • Re-declaration (by 30 September 2018) of whether all services are available.
	From 1 October 2018 (or any time from 1 May): If practice declares that all bundle services are now available, bundle payment can be paid.	
	From 1 October 2018: If practice does not declare that all bundle services are available – No payment	

Service Specification No.	4
Service	Near Patient Testing
Commissioner Lead	Jan Giles
Provider Lead	
Period	1 April 2021 to 30 September 2021
Date of Review	

1. Population Needs

1.2 National/local context and evidence base

The treatment of a number of diseases within the fields of medicine, particularly in rheumatology, 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. It has been shown that the incidence of side-effects can be reduced significantly if this monitoring is carried out in a well-organised way, close to the patient's home.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The service contributes to the following Domains of the NHS Outcomes Framework

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	√
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

Covered elsewhere in the specification.

3. Scope

3.1 Aims and objectives of service

This service is designed to be one in which:

(vi) Therapy should normally be initiated in secondary care, for recognised indications for specified lengths of time
(vii) Maintenance of patients first established in the secondary care setting should be properly controlled
(viii) The service to the patient is convenient
(ix) The need for continuation of therapy is reviewed regularly
(x) The therapy is discontinued when appropriate

3.2 Service description/care pathway

The service can be delivered at three levels:

Level 1 – Prescribing in primary care. All monitoring organised and carried out in secondary care. The Provider should ensure that patients are being monitored according to the correct schedule before prescribing.

Level 2 – Prescribing in primary care. The Provider has responsibility for organising monitoring according to the correct schedule using CCG funded phlebotomy services. Dose adjustments may be made by specialist or GP depending on the individual shared-care guidelines and/or clinical experience.

Level 3 – Prescribing in primary care. The Provider has responsibility for organising monitoring according to the correct schedule using practice funded phlebotomy service. Dose adjustments may be made by specialist or GP depending on the individual shared-care guidelines and/or clinical experience.

The Provider is required to comply with criteria relating to these areas:

(i) A shared drug monitoring service
(ii) A register
(iii) Call and recall systems
(iv) Education for newly diagnosed patients
(v) Continuing information for patients
(vi) Professional links
(vii) Referral policies
(viii) Record keeping
(ix) Training
(x) Annual review

The details relating to these criteria are set out in Appendix 1.

3.3 Population covered

The service will be available to the practice's own population.

3.4 Any acceptance and exclusion criteria and thresholds

Not applicable

3.5 Interdependence with other services/providers

The service will have links with the following:

- Secondary care services
- Community nursing service

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Health Care Standards for Better Health.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Not applicable

4.3 Applicable local standards

These are set out under the service description/care pathway.

5. Applicable quality requirements and CQUIN goals

5.3 Applicable quality requirements (See Schedule 4 Parts A-D)

Competency

Staff providing the service will have the appropriate clinical qualification for the role. They will need to have current membership of their relevant bodies, evidence of annual appraisal and indemnity cover. Other requirements will be covered by statutory and mandatory training.

Staff will be qualified and registered (where appropriate) in accordance with their anticipated scope of professional responsibility.

The Provider should ensure that for any registered healthcare professional who is:

(c) Performing clinical services under this agreement; or is

(d) Employed or engaged to assist in the performance of such services;

there are in place arrangements for the purpose of maintaining and updating her/his skills and knowledge in relation to the services which s/he is performing or assisting in performing.

Untoward events

It is a condition of participation in this service that the Provider will give notification to the CCG of all incidents occurring in patients covered under this service. This should be done using the CCG incident reporting system.

For serious incidents where admission or death may be due to usage of drugs covered in this service or attributable to the relevant underlying medical condition, this must be reported to the CCG's Quality & Safety Manager within 72 hours of the information becoming known to the practitioner. This is in addition to a practitioner's statutory obligations.

Patient/carer experience

- The Provider will actively gather patient/carer experience data
- The Provider will review patient/carer experience data on a quarterly basis, make recommendations where appropriate and act on them
- The Provider will make available to the CCG patient/care experience intelligence when requested

5.4 Applicable CQUIN goals (See Schedule 4 Part E)

Not appropriate at this time. The application of any future CQUIN scheme will be funded from within the set rate/tariff for the service i.e. within the financial envelope identified and not in addition to.

6. Location of Provider Premises

The Provider's Premises are located at:

The General Practice and/or branch surgery of the Provider as named in the NHS Standard Contract.

The Provider should ensure that the premises in which services are to be provided are suitable for delivery of those services and sufficient to meet the reasonable needs of patients. The premises must also meet current premises related Regulations.

The Provider should also ensure it has appropriate arrangements for infection control and decontamination

7. Individual Service User Placement

Not applicable

APPENDIX 1

DETAILS OF THE SERVICE CRITERIA FOR NEAR PATIENT TESTING

Criterion One - A shared care drug monitoring service

The service is to be delivered in respect of Shared Care (Amber) Drugs listed on the South West Yorkshire Area Prescribing Committee website requiring additional monitoring. The list is updated periodically. The CCG will advise the Provider of any relevant changes.

When a patient's need for shared care has been identified, secondary care will send the shared care guideline to the provider. The Provider should ensure that the arrangements within the guideline are acceptable before commencing care.

Criterion Two – Register

To produce and maintain an up to date register of all shared drug monitoring service patients indicating patient name, date of birth and the indication and duration of treatment where appropriate and last hospital appointment.

Criterion Three – Call and Recall

To ensure systematic call and recall of patients on this register is taking place either in a hospital or general practice setting.

Criterion Four – Education of newly diagnosed patients

To ensure that all newly diagnosed/treated patients (and/or their carers when appropriate) receive appropriate education and advice on management of and prevention of secondary complications of their condition. This should include written information where appropriate.

Criterion Five – Continuing information for patients

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

Criterion Six – Professional Links

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

Criterion Seven – Referral policies

Where appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist.

Levels 2 & 3 are offered with the expectation that if there are abnormal results and the dose needs changing radically or the drug stopped, the Provider will discuss the patient with secondary care before adjusting treatment.

Criterion Eight – Record keeping

At all levels of this service, practitioners should ensure that monitoring is being carried out according to the schedule laid out in a shared care guideline. Where no shared-care guideline is in place, monitoring should occur as agreed with specialist on agreement to shared care and include recommendations in the products SPC. The details of monitoring required should be clearly stated within the patient's medical record and be available to any prescriber required to issue a prescription.

To maintain adequate records of the service provided, incorporating all known information relating to any significant events, e.g. blood tests or counts necessitating cessation of treatment, hospital admissions and death of which the Provider has been notified.

Criterion Nine – Training

To ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so.

Criterion Ten – Annual Review

To perform an annual review of patients accessing the near patient testing service. This should be done through:

i) Annual audit of patients prescribed lithium in accordance with the NPSA Patient Safety Alert 5 'Safer Lithium therapy' 1 December 2009
ii) Audit of 10% of patients on list for other near patient testing drugs (or 10 patients – whichever is greater)

To fulfil these requirements The Provider should:

(a) Send an anonymised copy of the practice register to the CCG by 15th January 2015
(b) Audit the first 10% of patients on list (in numerical order) or 10 patients, whichever is the greater (excluding those on lithium). The data collection form at Appendix 5 should be used for this purpose and sent electronically to the CCG by the due date.
(c) Audit all patients on lithium therapy. The lithium data collection form at Appendix 6 should be used for this purpose and sent electronically to the CCG by the due date.

APPENDIX 2

AUDIT FOR PROVISION OF NEAR-PATIENT TESTING FOR AMBER DRUGS REQUIRING REGULAR MONITORING

Provider Name | Audit date

Instructions for use: Please audit first 10% of patients or first 10 patients (whichever is greater) on Shared Care Register, excluding patients on lithium therapy.

Please complete the details on this form for each of these patients and return electronically to Zebbi Hussain Zebbi.hussain@greaterhuddersfieldccg.nhs.uk

Patient ID No.	Shared-care drug	Level or levels of monitoring claimed i.e. 1, 2, 3	Type of Blood Test	Dates of Blood Test	Was this patient referred back to secondary care due to problems with the shared-care drug

APPENDIX 3

LITHIUM AUDIT FORM

Practice code | | Date audit completed | |

Patient ID	Brand Name	Dose	Target Lithium range	Date	Lithium level 3 monthly	Date	Thyroid function# 6 monthly	Date	Renal function* 6 monthly	Interacting Drugs?

*Every 6 months; more often if there is evidence of deterioration or the patient starts taking drugs such as ACE inhibitors, diuretics or NSAIDS

more often if evidence of deterioration

http://www.nice.org.uk/nicemedia/pdg/CG38niceguidline.pdf

Service Specification No.	5
Service	Primary Care Ring Pessary Fitting and Replacement
Commissioner Lead	Jan Giles
Provider Lead	GHCCG GP practices
Period	1st April 2021 – 30th September 2021
Date of Review	September 2021

1. Population Needs

1.3 National/local context and evidence base

A mixed economy of ring pessary insertion/change currently operates for women registered in Greater Huddersfield GP practices, with some provision by the practices themselves and other provision by secondary care (mainly by Calderdale and Huddersfield NHS Foundation Trust).

It has been recognised that ring pessary insertion and change can be delivered in primary care with appropriate training. The CCG has therefore made the decision to commission ring pessary insertions and changes directly from GP practices.

This specification sets out the requirements for the provision of this service.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The service will contribute to the following outcomes:

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	√
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	√

2.2 Local defined outcomes

- Upskilling of general practice clinicians in gynaecology procedures
- Delivery of specific gynaecological procedures in primary care
- Care closer to home in a familiar environment

3. Scope

3.1 Aims and objectives of service

The aim of the service is the delivery of high quality, safe, evidence-based primary care gynaecology services for patients registered with the Provider.

3.2 Service description/care pathway

Service principles
The service will operate according to the following principles:

- The Provider will offer a caring, friendly and responsive service which will complement existing services and be outcome-driven.

- At all times, patients will be given the privacy and confidentiality required to ensure respect and dignity throughout the patient experience

- If patients require onward referral to secondary care, the Provider will ensure that this is undertaken within 2 working days, with full details provided in the referral.

- Information relating to each patient intervention will be recorded in line with national guidance.

- Staff providing the service will be expected to undertake initial training, where applicable, and regular updating, and the Provider will be able to evidence this.

- Waiting times will operate within a maximum of four weeks although patient choice may extend this timescale.

- A range of dates/times for appointments will be offered

- Self-care information will be given to patients to support the management of their condition

Service coverage

The Provider will deliver the service listed below and associated support:

- Insertion/change of ring pessary for the treatment of vaginal prolapse

The service descriptions/care pathway is set out below.

Service descriptions/care pathways

Ring pessary insertion/change

A ring pessary is a removable device that fits into the vagina to help support a pelvic organ prolapse. It does this by adding support to the walls of the vagina.

The service covers the following:

- First fitting of a ring pessary following the diagnosis of pelvic organ prolapse
- Follow up and change of ring pessary as deemed necessary by the practitioner fitting the ring pessary
- Follow up assessment and refitting of a ring pessary following a complication such as ulceration of the cervix

The process will be as follows:

- Use sterile equipment and vinyl or nitrite gloves (not latex)
- Assess size by vaginal examination if new or where previous concerns about fit (e.g. pessary fell out, discomfort, ulceration, etc.)
- Remove old pessary (unless a new fit)
- Speculum examination to ensure no ulceration of vaginal walls
- Use a PVC-type ring pessary
- Insert pessary: consider using a ring pessary inserter
- If ulcerated, and the patient is happy to omit the pessary for 4 weeks, then use estriol cream (one applicator full at night for two weeks and then twice a week). Review at 4 weeks and refit the ring pessary if the ulceration has settled. If not settled at 4 weeks consider referral to gynaecology.
- If patient cannot manage without the pessary, fit a new one and consider two weeks of estriol cream. Review and change pessary every 4 months.
- Offer general advice regarding pelvic floor exercises
- Review every 4 – 6 months

If a patient does not wish to have a ring pessary fitted, the practitioner should consider a referral to the local continence service prior to any referral to gynaecology

3.3 Population covered

The service will be available for women registered with the Provider.

3.4 Any acceptance and exclusion criteria and thresholds

The service should not be provided to:

- patients who are under 16 year of age - who should be referred to paediatrics
- patients who have suspected cancer conditions – a fast-track referral should be made

The following additional exclusion criteria apply to individual procedures:

Ring pessary insertion/change

- Women who may be suitable for surgery and/or pelvic floor exercises (usually younger women). These patients should be referred to the continence service and/or secondary care
- Where it has not been previously possible to fit and maintain a ring pessary please consider referral to secondary care

3.5 Interdependence with other services/providers

The service has links with Calderdale and Huddersfield NHS Foundation Trust gynaecology team and with the gynaecology services of other local providers

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NICE Guidance NG12 **Suspected Cancer: Recognition and Referral** (2015)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Royal College of Obstetricians and Gynaecologists and British Society of Urogynaecology: Post Hysterectomy Vaginal Vault Prolapse (2015).

4.3 Applicable local standards

The Provider will be responsible for ensuring that all staff involved in providing these services are appropriately qualified and that their provision of these services forms part of their appraisal/revalidation process. Staff should have appropriate professional indemnity and current Disclosure and Barring Checks. The Provider will be expected to provide assurance on all the above requirements to the CCG. Continuous Professional Development will be the responsibility of the individual with overall accountability lying with the Provider.

The specific competencies required for undertaking procedures are as follows:

- Ring pessary fitting – a GP or practice nurse with experience of fitting ring pessaries.
- Ring pessary change – a GP or any practice nurse with the ability to undertake smears and PV examinations

The Provider will ensure that corporate and clinical governance policies are in place and adhered to.

The following will be monitored and the Provider will arrange to submit quarterly data to support the indicators below:

- Number of each type of procedure carried out
- Number of referrals on to secondary care

5. Applicable quality requirements and CQUIN goals

5.5 Applicable Quality Requirements (See Schedule 4A-D)

Patient/carer experience

- The Provider will actively gather patient/carer experience data
- The Provider will review patient/carer experience data on a quarterly basis, make recommendations where appropriate and act on them
- The Provider will make available to the CCG patient/care experience intelligence when requested

5.6 Applicable CQUIN goals (See Schedule 4E)

Not appropriate at this time. The application of any future CQUIN scheme will be funded from within the set rate/tariff for the service i.e. within the financial envelope identified and not in addition to.

6. Location of Provider Premises

The General Practice and/or branch surgery of the Provider as named in the NHS Standard Contract

7. Individual Service User Placement

Not applicable.

Service Specification No.	6
Service	Treatment Room Services
Commissioner Lead	Melissa Fletcher
Provider Lead	
Period	1st April 2021- 30th September 2021
Date of Review	September 2021

1. Population Needs

1.4 National/local context and evidence base

This service covers the provision of the following treatment room procedures in primary care:

- Suture/staple removal
- Prescription/provision and application of dressings
- Administration of pre-operative or post operative low molecular weight injections (e.g. dalteparin)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The service contributes to the following Domains of the NHS Outcomes Framework

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	√
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

Covered elsewhere in the specification.

3. Scope

3.1 Aims and objectives of service

The aim of this element of the service is to provide post-operative wound care and pre-operative preventative care in general practice for those for whom attendance in a hospital setting is not necessary.

3.2 Service description/care pathway

The service will cover:

- Treatment of wounds following hospital treatment or for patients presenting at surgery with minor injuries and superficial wounds where it is expected that the healing process will be predictable and uneventful, and scarring and long-term damage minimal, and where it is unnecessary for the patient to attend hospital. The two types of activity involved will be:
  - Suture/staple removal

- Prescription/provision and application of simple dressings. This activity is to be carried out in accordance with the Joint Wound Management Formulary[2]

- Pre and post-operative low molecular weight heparin injections
- Other treatment room injections as necessary e.g. erythropoietin (EPO), testosterone etc.

Activity delivered under this element of the service should be recorded using the Read codes set out in Appendix 1. Reporting requirements for the service are set out in Appendix 2.

3.3 Population covered

The service will be available to the practice's own population.

3.4 Any acceptance and exclusion criteria and thresholds

The Treatment service excludes housebound patients and those patients who have leg ulcers or complex wounds who will receive their care from the Community Nursing Service.

3.5 Interdependence with other services/providers

The service will have links with the following:

- Secondary care services
- Community nursing service

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Health Care Standards for Better Health.

Other national standards mentioned elsewhere in this specification.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

As above

4.3 Applicable local standards

These are set out under the service description/care pathway.

5. Applicable quality requirements and CQUIN goals

5.7 Applicable quality requirements (See Schedule 4 Parts A-D)

Competency

Staff providing the service will have the appropriate clinical qualification for the role. They will need to have current membership of their relevant bodies, evidence of annual appraisal and indemnity cover. Other requirements will be covered by statutory and mandatory training.

Staff will be qualified and registered (where appropriate) in accordance with their anticipated scope of professional responsibility.

The Provider should ensure that for any registered healthcare professional who is:

(e) Performing clinical services under this agreement; or is

[2] The Joint Wound Management Formulary (JWMF) 2010 addition produced by The Joint Wound Management Formulary Group, Original date: March 2008; First review date: March 2010 http://www.formulary.cht.nhs.uk/Guidelines/APC/Wound%20Management%20Guidelines.htm

(f) Employed or engaged to assist in the performance of such services;

there are in place arrangements for the purpose of maintaining and updating her/his skills and knowledge in relation to the services which s/he is performing or assisting in performing.

Staff administering injections under this service should be appropriately trained in the administration technique for the specific product.

Untoward events

It is a condition of participation in this service that the Provider will give notification to the CCG of all incidents occurring in patients covered under this service. This should be done using the CCG incident reporting system.

For serious incidents where admission or death may be due to usage of drugs covered in this service or attributable to the relevant underlying medical condition, this must be reported to the CCG's Quality & Safety Manager within 72 hours of the information becoming known to the practitioner. This is in addition to a practitioner's statutory obligations.

5.8 Applicable CQUIN goals (See Schedule 4 Part E)

Not appropriate at this time. The application of any future CQUIN scheme will be funded from within the set rate/tariff for the service i.e. within the financial envelope identified and not in addition to.

6. Location of Provider Premises

The Provider's Premises are located at:

The General Practice and/or branch surgery of the Provider as named in the NHS Standard Contract

The Provider should ensure that the premises in which services are to be provided are suitable for delivery of those services and sufficient to meet the reasonable needs of patients. The premises must also meet current premises related Regulations.

The Provider should also ensure it has appropriate arrangements for infection control and decontamination.

7. Individual Service User Placement

Not applicable

APPENDIX 1

RECORDING OF ACTIVITY FOR TREATMENT ROOM SERVICES

Any activity carried out under this service should be recorded in the Patient Record, coded as follows:

- All activity should be coded under Code 9N6K Referred by Secondary Care (works for both CTV3 and 5 Byte)

And

- Suture/staple removal should be coded under Code 8P0 – Removal of skin sutures/clips (works for both CTV3 and 5 Byte)
- Wound dressing should be coded under Code 81H – Dressing of wounds (works for both CTV3 and 5 Byte)
- Preoperative injections (e.g. Subcutaneous injection of heparin) should be coded as shown in the table below.

SystmOne	
Code	Term
81H..	Dressing of wound
81H1.	Dressing of ulcer
Xa97M	Dressing of burnt skin
Xa8Qp	Attention to dressing of skin
Ua1Ci	Checking dressing of skin
X70cl	Change of dressing
81HZ.	Wound dressing NOS
81Hy.	Other wound dressing
Xa8QS	Removal of suture from skin
7G220	Removal of clip from skin of head or neck
7G221	Removal of clip from skin NEC
7G222	Removal of suture from skin of head or neck
7G223	Removal of suture from skin NEC
7G22y	Removal of other specified repair material from skin
7G22z	Removal of repair material from skin NEC
8PO..	Removal of skin suture/clips
XaI8m	Removal of eye suture
XaLIF	Removal of suture from lip
721A4	Removal of protective suture from eyelid
XaLOW	Removal of suture from mouth NEC
XaDyn	Subcutaneous injection of heparin
XaKdl	Suture removal generated from secondary care activity done by practice

All other systems (e.g. EMIS LV & PCS, Isoft, etc)	
Code	Term
81H..	Dressing of wound
81H1.	Dressing of ulcer
81H2.	Dressing of burn
81H3	Attention to dressing of skin
81H4.	Checking dressing of skin
81H5.	Change of dressing
81HZ.	Wound dressing NOS
81Hy.	Other wound dressing
7G22.	Removal of suture from skin
7G220	Removal of clip from skin of head or neck
7G221	Removal of clip from skin NEC
7G222	Removal of suture from skin of head or neck
7G223	Removal of suture from skin NEC
7G22y	Removal of other specified repair material from skin
7G22z	Removal of repair material from skin NEC
8PO..	Removal of skin suture/clips
8P1..	Removal of eye suture
75043	Removal of suture from lip
721A4	Removal of protective suture from eyelid
75344	Removal of suture from mouth NEC
7L19B	Subcutaneous injection of heparin
9N7H.	Suture removal generated from secondary care activity done by practice

Adverse events relating to this activity should be coded accordingly.

Monitoring

All adverse events in relation to activity undertaken under this service should be notified using the CCG's incident reporting process.

When a non-formulary product is used for dressing a wound, an exception report (Appendix 1 of the Joint Wound Management Formulary[3]) should be completed and returned to the Tissue Viability Nurse at the local hospital, with a copy to the Medicines Management Team at the CCG. This will help monitor the appropriateness of the present formulary and influence future decision-making.

In October 2015, the Provider must run a query identifying the amount and type of activity undertaken under the service, along with the incidence and type of adverse events. The CCG will use this information for monitoring the service and for future planning.

The report at Appendix 2 should be completed for each quarter within two weeks of the end of that quarter and submitted to the Primary Care Team at the CCG. Failure to do so may result in payment being delayed.

APPENDIX 2

TREATMENT ROOM SERVICE – QUARTERLY MONITORING REPORT

Provider_____

Month	Type of Activity			Amount of activity	Any adverse events
(Example) (Q1)	Suture removal	Dressing of wound	Pre-operative clexane injections		
April	*6*	*45*		*51*	*None*
May	*5*	*10*		*15*	*None*
June	*3*	*15*	*1*	*20*	*None*

[3] The Joint Wound Management Formulary (JWMF) 2010 addition produced by The Joint Wound Management Formulary Group, Original date: March 2008; First review date: March 2010 http://www.formulary.cht.nhs.uk/Guidelines/APC/Wound%20Management%20Guidelines.html

Service Specification No.	7
Service	GH-NK Interim Level 2 Wound Care service
Commissioner Lead	Julie Oldroyd
Provider Lead	
Period	1st April 2021- 30th September 2021
Date of Review	September 2021

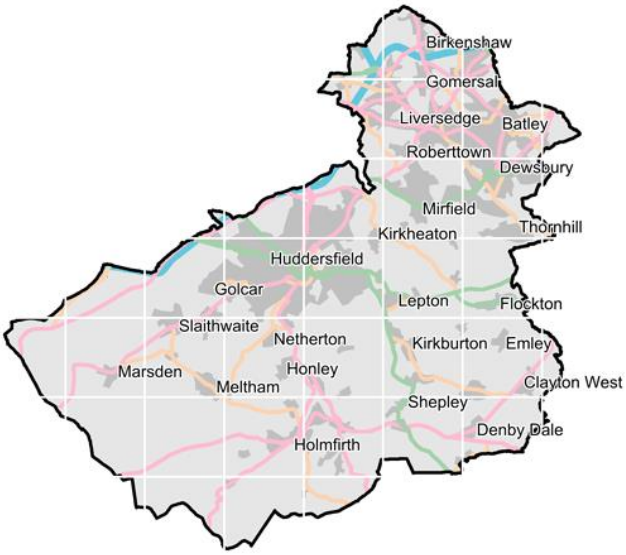
1. Population Needs

This service specification remains 'interim' as the intention is to eventually move to a shared workforce alliance approach to meet the needs of the Kirklees population via a community 'hub' model when primary care networks are fully established.

1.1 National/local context and evidence base

Geographic/Demographic Detail

Kirklees is a local government district of West Yorkshire, England. It is governed by Kirklees Council with the status of a Metropolitan Borough. The largest town and administrative centre in Kirklees is Huddersfield, and the district also includes Batley, Birstall, Cleckheaton, Denby Dale, Dewsbury, Heckmondwike, Holmfirth, Kirkburton, Marsden, Meltham, Mirfield and Slaithwaite. Kirklees has a population of approximately 440,000 and is therefore the most populated borough in England that is not a city.



The area is served by two NHS Clinical Commissioning Groups (CCGs), North Kirklees (CCGs) and Greater Huddersfield (CCGs). Primary care services are provided by 64 GP practices. Hospital services are provided by Mid Yorkshire NHS Hospital Trust (Dewsbury District Hospital and Pinderfields General Hospital) within the North of the district and Calderdale & Huddersfield NHS Foundation Trust (Huddersfield General Infirmary and Calderdale Royal Hospital) within the South. This service specification covers all people registered with a GP practice in Kirklees.

Kirklees contains areas of high and low deprivation. Regions of highest deprivation are found in some of the more densely populated urban areas to the north and east (including parts of Huddersfield, Dewsbury and Batley). Lower levels of deprivation are found in the more sparsely populated rural areas to the south and west (including the Colne and Holme Valleys, Denby Dale and Kirkburton).

Kirklees has a diverse population of around 440,000 people, and the population of those aged 65-84 is predicted to increase by 30% by 2030. Kirklees is one of the larger local authority districts in England and Wales ranking 11th out of 348.

Kirklees contains areas of high and low deprivation, with regions of highest deprivation found in some of the more densely populated urban areas to the north and east (including parts of Huddersfield, Dewsbury and Batley).

Kirklees is ethnically diverse - many ethnicities are represented, speaking a range of languages bringing a cultural diversity to the borough/area.

This enhanced service specification is to support General Practice throughout Kirklees to offer a Level 2 wound care service via a Local Enhanced Service for their registered practice population for care which is considered to be beyond the scope of essential or additional General Practice services.

Since the inception of Clinical Commissioning Groups, Greater Huddersfield and North Kirklees CCGs have progressed with service transformation in line with the NHS Five Year Forward View to deliver Care Closer to Home, thereby reducing the reliance on hospital based services.
Over the past few years, there has been an increase in post-operative patients becoming ambulatory much sooner which has impacted on the work load of General Practice, particularly Practice Nurses. This specification has been developed to meet the growing demand on wound care services making use of current primary care wound care capabilities.

The Level 2 Wound Care Enhanced Service will cover level 2 of wound care model. The service excludes housebound patients who receive their care from the Community Services Provider.

This service specification replaces the previous Greater Huddersfield interim wound care level 2 service specification.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely - not appropriate domain in this context	x
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Local defined outcomes

I. Patients requiring wound care access services in a timely fashion so as not to hinder healing
   a. KPI – Appointment within 48 hours
II. All wound care patients are cared for in premises that are fit for purpose
   a. KPI – meet required CQC standards
III. Wherever possible patients should be educated on self-care to reduce the number of visits

3. Scope

3.1 Aims & Objectives of the service

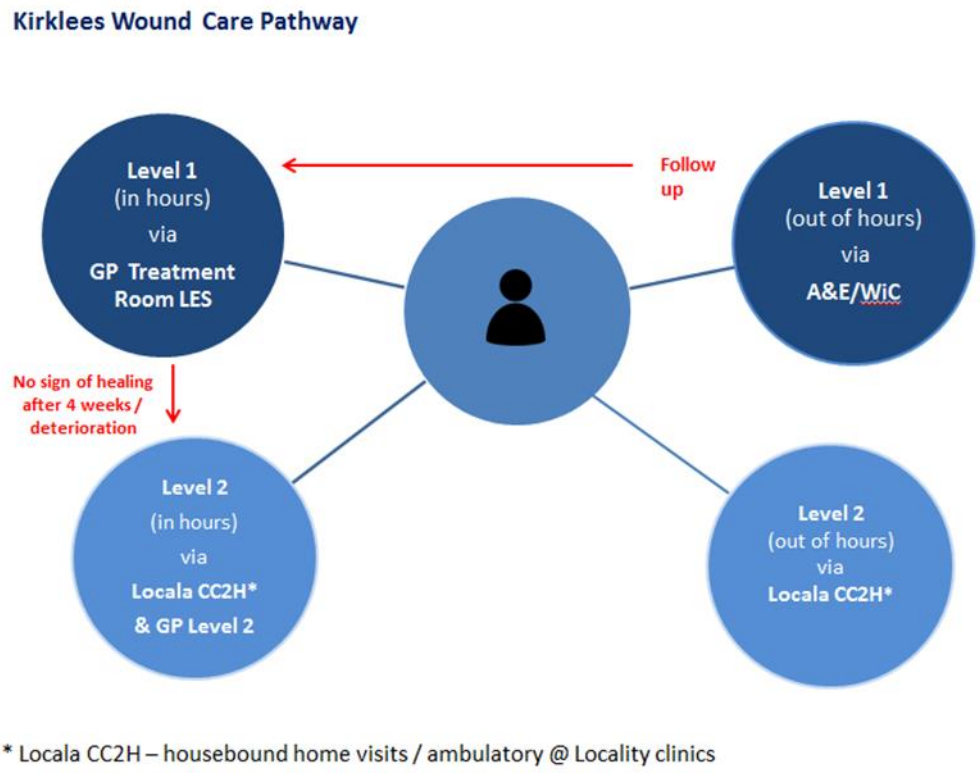
This Wound Care Service has been developed to recognise the additional nursing capacity required to meet the wound care needs of this patient group.

The overall aim and objectives of the Level 2 wound care service is to:

- Ensure a safe, effective, efficient and consistent high quality service is delivered to patients
- Patients requiring wound care access services in a timely fashion to help healing
- Ensure that patients with wounds are managed in accordance with national and local policies and as per research based guidelines
- Improve the local arrangements for patients receiving wound care and ensure that they are better educated regarding wound care, frequency of dressings, infection control within the home and their self-management responsibilities

3.2 Service description/care pathway

Figure 1: Service model



* Locala CC2H – housebound home visits / ambulatory @ Locality clinics

Level 1 Wound Care

Level one wound care interventions will be delivered by the GP practices as part of the Treatment room LES within their contracted hours.

- Completion of the clinical template (DQ Wound Assessment/Dressing/Suture Removal) is required for all level 1 wound care activity (and any follow-on updated templates).

Level 1

- **Surgical – suture / clip removal**
- **Grazes**
- **Skin tears**
- **Varicose Veins – removal of clips**
- **Pin Sites**
- **Cavity dressings - cavity wounds that could be dealt with within the competencies and training of practice nurses**
- **Lower Leg Wounds (not requiring compression dressings or input from TVN)**

For all of the above, should there be no sign of healing after 4 weeks referral should be made to a Level 2 service, the referral should be made sooner should there be obvious signs of deterioration.

Level 2 Wound Care

The Level 2 Wound Care Service incorporates any wound not deemed to be Level 1 and provides the following elements for non-housebound patients with wounds where the patient is registered with a Kirklees GP:

- Assessment & Diagnosis, with an option of including Doppler
- Treatment/Application of dressings, including compression bandaging where appropriate
- Ongoing treatment as required

Level 2 wound care has been split into 3 elements, as below:

Level 2

Level 2 wound care incorporates any wound not deemed to be Level 1, defined as:

2a	**Assessment & Diagnosis, Treatment/Application of dressings**
2b	**Compression bandaging**
2c	**Doppler**

Tissue Viability Service will support practices with any complex dressings i.e. Topical Negative Pressure (Vac), Larvae Therapy and Complex Burns. All diabetes foot issues should also be referred to podiatry as routine.

Level 2 practices are required to:

- have been signed off as competent for Level 1 wound care
- have treatment rooms in line with national standard requirements

- be signed up to the Urgo Competency Framework in conjunction with the University of Huddersfield and staff delivering wound care should have achieved the appropriate competencies http://www.urgo.co.uk/387-tvlc-competency-framework

TVLC_Competency_Framework_Urgo_Med

- to complete *the DQ Wound Assessment/Dressing/Suture Removal* / *DQ Leg Ulcer Assessment* clinical templates for Level 2 wound care (including compression bandaging and Doppler assessments) and any follow-on updated templates

Payment

Payment for Level 2 wound care services will be based on cost-per-case activity, practices can opt to provide 2a) or in addition 2b) and 2c), as competencies allow:

	Level 2 Wound Care	**Payment**	**Average appointment length**	**Competency requirements**
2a	**Assessment & Diagnosis, Treatment/Applications of dressings**	£14.70	Up to 20 minutes	Level 1 assessment completed
2b	**Compression bandaging**	£29.40	Up to 40 minutes	Training & assessment completed via Tissue Viability Nurse
2c	**Doppler**	£29.40	Up to 40 minutes	Training & assessment completed via Tissue Viability Nurse

3.3 Population covered

The service will be available to the practice's registered list population for ambulatory patients requiring Level 2a; 2b; 2c wound care.

Those practices choosing not to provide an element of Level 2 wound care will refer for the appropriate service to Locala via their Single point of contact.

3.4 Any acceptance and exclusion criteria and thresholds

The provider should be signed off by the CCG and already be providing Level 1 wound care.

This service specification offers Level 2 wound care to ambulatory patients. Housebound patients are exempt from this specification, including those residing in residential/nursing homes.

Doppler assessments apply only to those patients with an active leg wound. Doppler assessments for vascular assessment only are exempt from this specification.

3.5 Co-operation and Interdependence with other services/providers

A close working relationship is required with Locala District Nursing and Tissue Viability Teams to ensure high quality standards are maintained and any training needs are addressed promptly.

There will also be close interdependencies with:

- Hospital based services
- Total Wound Care Purchase model

3.6 Sub-contracting

Sub-contracting with other practices will not be supported for this service, however this may be incorporated into a future primary care network 'hub' model.

3.7 Equipment

The provider will ensure that Services that are properly planned and that are appropriately staffed and resourced have the right equipment and maintain quality of wound care at all times.

3.8 Referrals

Referrals will be received from:

- Within the practice
- Locala Community services
- Secondary Care

3.9 Human Resource Management – Provider Workforce Recruitment and Competence

The Provider must have a comprehensive, robust plan in place, for recruitment, selection and employment procedures, that are compliant with all applicable employment legislation and/or directives.

The principle objectives of the Provider must:

1. Reflect the local community and range of languages spoken to support access to services
2. Meet the essential day-to-day staff leadership, management and supervisory needs of the contract during its lifetime, including during mobilisation and, if appropriate, contract termination
3. Support the provision of safe, high quality clinical services
4. Ensure the appropriate skill mix
5. Ensure that every member of the staff has a job description and appropriate contracts of employment setting out their terms and conditions, and roles and obligations as well as their rights
6. Providers must specify arrangements to ensure that all mandatory pre-employment checks are implemented for all staff working in the organisation, including ensuring that all staff complete appropriate DBS checks before they start employment
7. Ensure, through appropriate audit, training and continuous professional development, that all staff involved in treating residents are and remain qualified and competent to do so
8. Support the implementation of all relevant statutory and non-statutory NHS standards, regulations, guidelines and codes of practice
9. Ensure there are systems in place to monitor that clinicians do not work excessive shifts or hours to the detriment of patient safety and their own welfare
10. Ensure annual appraisals are undertaken for all employed staff
11. Meet all mandatory training requirements
12. Undertake an annual staff survey

The Provider should provide details of the management structure and the escalation procedures for resolving problems. Also how, during periods of annual leave or sickness or an industrial dispute, the service will be delivered.

The Provider must ensure all Clinical Staff are registered with all appropriate regulatory bodies including without limitation the following:

1. For Nursing Staff, the Nursing and Midwifery Council

All Nursing Staff:

1. Are registered on the Nursing and Midwifery Council Register and, if they are to prescribe drugs and/or medicine, that the corresponding entry in the register indicates that they hold a prescribing qualification

2. Are subject to robust procedures for monitoring of re-registration annually and revalidation for nurses
3. Have declared of previous NMC suspensions and or limitations within the last five (5) years

All other health and social care professionals:

1. Are registered on the relevant professional register for example Health and Care Professions Council register or General Pharmaceutical Council register, The Professional Association for Social Work and Social Workers etc.
2. Are subject to robust procedures for monitoring of re-registration and monitoring of such
3. Have declared any previous professional suspensions and or limitations within the last five (5) years

3.10 Workforce Training and Development

The Provider must ensure arrangements are in place to ensure that all clinical and non-clinical staff are adequately trained and are competent for their roles.

The Provider must have robust staff development processes in place including opportunities which will provide development for both clinical and non-clinical staff. This might include short courses and on-the-job training. All staff employed must receive an annual appraisal and hold a personal development plan.

Training will be provided by the Locala Tissue Viability Team to support existing Level 2 practices (Greater Huddersfield practices previously providing Level 2 services via the interim service) and those practices who would like to start to provide Level 2 services.

Separate training sessions require completion for levels 2a, 2b and 2c, followed by a period of mentoring and assessment before competency is achieved.

3.11 Service Benefits

Patients: the proposed service model provides a whole system, structured approach to wound management, including where appropriate, self-management.

Referencing the extensive generic engagement feedback to support the CCGs Care Closer to Home programme, the proposed wound care model has also considered what local people told us they want to see from any service change:

- As many services as possible should be close to home in local settings such as a GP practice with improved waiting and appointment times.

- Services are coordinated and wrap around all the persons' needs involving a range of partners and agencies.

- The right staff, with the right skills that are caring and competent and treat people with dignity and respect.

- Services are properly planned and are appropriately staffed and resourced, have the right equipment and maintain quality of wound care.

- More information is available about health conditions and more communication about what is available to ensure people can make choices and have support to self-manage their health care.

- Services can be accessed by everyone and are available in clean comfortable buildings, aimed at the right target audience, appropriate information is given and the staff represents the community they serve.

- Any barriers to parking, travel and transport are addressed with a clear plan which takes account of diversity and locality.
- Communication is improved between all agencies involved in a person's care and treatment including better communication with young people.
- Services are responsive and flexible - particularly in an urgent care situation.
- Delays in getting the care and treatment required are reduced and waiting times improved upon.
- Technology is used, as appropriate to reduce travel times and unnecessary journeys – particularly for young people.
- Support for mental health is available across all services.
- *Clinicians:* Wound care is predominantly delivered by our local nursing profession and is underpinned by:
    - the recognised competency framework developed by the University of Huddersfield
    - the local Kirklees Wound Care Formulary to ensure that the type of wound care products used are appropriate and cost effective
- Offers the opportunity for workforce development
- *Partners:* The proposed model will eliminate any ambiguity and give clarity across the local health system of which organisation should be responsible for the patient at each stage of the pathway. In the context of wound management, the service and pathway provides clarity on the definition of "House Bound".

3.13 Service monitoring

Monitoring Requirements

Read code guidance and templates to support Level 1 and Level 2 wound care have been published in both clinical systems. Providers to use these templates (including updated templates going forward) and monthly reporting to inform invoicing requirements.

Performance Reports

The provider is required to complete *the Data Quality Wound Assessment/Dressing/Suture Removal* / *DQ Leg Ulcer Assessment* clinical templates for all Level 2 wound care activity (including compression bandaging and Doppler assessments). See Appendix 1 for details of template read codes.

The intention during 2019/20 is to align the NK & GH wound care template with Locala's wound care template which has recently been updated against best practice. Practices will be expected to use this new template once it becomes available. See Appendix 2 for details of the Locala template minimum dataset.

Healing rates will be monitored via referral onto Locala for non-healing wounds. Any concerns regarding healing rates will be addressed with individual practices directly.

The provider is required to submit monthly activity reports to the CCG via the invoicing route, using data from the DQ Wound Care Assessment reports.

Quality Standards

Mandatory quality standards will be reported on a monthly basis and will form part of the monthly performance reports. Quality standards will include:

- Clinical outcomes
- Incident Reporting
- Complements & Complaints
- Service User Satisfaction / Friends and Family Test feedback

Clinical audit

The provider will have a robust process in place to carry out regular audit with the focus on continual improvement. This will include:

- Clinical Audit Annual programme and audit outcomes for financial year.
- Quarterly progress report with audit programme to ensure focus on service improvements rather than results.

Evidence of service improvements as a result of clinical audit activity to be included in quarterly audit report

Patient Carer and Staff Surveys

Measuring and Responding to Service User and Carer Experience

The provider will actively gather patient / carer experience data, including equality data, from patients using the service. The opportunity to participate in the National Friends and Family Survey will also be offered to each person using the service. The provider will review patient / carer experience data on a monthly basis, and where appropriate take action to improve patient / carer experience by identifying common themes and positively acting upon them.

The provider will promote and look into innovative methods of capturing patient / carer experience to ensure input from a proportionate sample of service users including protected groups. The providers will also have systems and procedures in place to respond to complaints and ad hoc service user and carer feedback.

Changing the way a service is currently provided

Where the Provider wishes to change the way a service is currently provided this is likely to give rise to an obligation to engage and/or consult with patients and or their representatives. This statutory obligation is that of the CCG but the CCG will expect the Provider (at its own cost) to co-operate with it in doing so. Both CCGs and the provider will work to the principles and approaches set out in the commissioners Patient Engagement and Experience strategy. The provider will work to the legislation set out in the strategy which includes the Health and Social Care Act 2012, The Equality Act 2010 and the NHS Constitution. Where these circumstances arise, the provider will be expected to propose a detailed engagement plan for approval by the CCG.

The provider will be required when requested to submit any plans for engagement and consultation to the commissioner to ensure an appropriate process is being followed. Where service user involvement has been undertaken the providers will demonstrate progress on involving all equality groups through equality monitoring.

The provider will share the findings from any engagement and/or consultation activity with the commissioner, service users/carers and the general public.

The CCG will carefully consider the outcome of any consultation exercise and reserves the right to amend the service specification. Any such amendment will be dealt with in accordance with the variation procedure contained at Clause xxx notwithstanding that the service may not have commenced'.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- National Framework and NICE guidance
- CQC registration
- DH Guidance
- Royal College Guidance
- The Care Act (2014)
- The Mental Capacity Act 2005
- The Deprivations of Liberties Safeguards 2009
- Domestic Violence, Crime and Victims Act 2004: Section 9 (Domestic Homicide Review
- Best Practice
- Audit/Reviews that exist

Mental Capacity Act

The Provider will be compliant with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards, within the Act. They will be follow the guidance and use it to judge whether they are meeting their duties and responsibilities under the Act.

The provider should evidence that all staff are up to date with MCA/DOLs training to ensure they have a thorough understanding and awareness of capacity and consent issues and raise these with the care home as appropriate

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

- All practices providing this service must have treatment rooms in line with national standard requirements.

- Practices must be signed up to the Urgo Competency Framework in conjunction with the University of Huddersfield and staff delivering wound care should have achieved the appropriate competencies http://www.urgo.co.uk/387-tvlc-competency-framework

Safeguarding

A culture must exist within the service that 'safeguarding is everybody's business'. Providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported (as per Care Quality Commission, CQC registration requirements). Effective safeguarding arrangements should be in place to safeguard children, young people and adults at risk including, safe recruitment, effective training and supervision. Robust processes should be in place to assure the service themselves, regulators and commissioners that these arrangements are working. The service should work within the guidance of their organisation's Safeguarding Policy.
The Provider shall:

Provide the services to adults at risk who are registered with the practice in accordance with the standards contained in the National Service Framework for Older People (2001), and any protocols notified to the Provider by the Commissioner, as amended from time to time

Ensure that all Adults at Risk are assessed for any risk of abuse or neglect.

Ensure that medical and frontline staff, and anyone working on behalf of the Provider (including volunteers), are familiar with, and receive regular training in line with National guidance Safeguarding for Adults: Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and Safeguarding Children and Young People: Roles and competences for health care staff, RCPCH (2014), and safeguarding policies/procedures as directed by the West and North Yorkshire and York Multi-Agency Safeguarding Adults Policies and Procedure as amended from time to time.

The Provider must ensure that they have safeguarding policies and procedures in place that which comply with and reference the NKCCG and GHCCG Safeguarding Children and Adults at Risk Policy, the Safeguarding Children Board Policies and Procedures for the Protection of Children and the West Yorkshire, North Yorkshire and York Multi-agency Policy and Procedure for Safeguarding Adults, and staff receive training in relation to these policies and procedures.

The provider should have a GP safeguarding lead and systems in place for staff to seek advice as required from that person. The safeguarding lead will been trained to the appropriate level as defined by CCGs safeguarding policies and the National guidance Safeguarding for Adults: Adult Safeguarding: Roles and Competencies
for Health Care Staff (2018) The safeguarding lead will regularly attend the GP safeguarding lead forum hosted by NK CCG. The safeguarding lead will seek advice from the designated safeguarding leads as required.

The Provider shall ensure that safeguarding concerns are reported to the relevant Local Authority directly in line with the Safeguarding children and safeguarding adults Boards' policies and procedures. Participate in any relevant strategy meetings and case conferences, work with, and accept support from the designated professional leads for safeguarding in the CCGs Area. This includes the statutory duty to share information and communicate with other health professionals and agencies where there are safeguarding concerns.

The Provider must comply with requests from the local authorities to engage in and contribute to safeguarding enquiries (as described in the Care Act, 2014 and Working Together to Safeguard Children 2018).

Safe recruitment policies will be in place which includes forbidding "compromise agreements" to prevent staff from resigning in order to avoid disciplinary proceedings in cases of abuse and neglect.

Ensure that all staff working with adults at risk have the appropriate level check as outlined by the Disclosure and Barring Service (DBS)

The Provider will be compliant with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards, within the Act. They will be follow the guidance and use it to judge whether they are meeting their duties and responsibilities under the Act.

The provider should evidence annually that all staff are up to date with MCA/DOLs training to ensure they have a thorough understanding and awareness of capacity and consent issues and raise these with the care home as appropriate.

The provider will ensure that systems are in place to report any breaches of professional code of conduct to the relevant professional body.

Staff will receive training on recognising Modern Slavery and Human Trafficking and how to support victims.

Good Clinical Practice

The Provider shall ensure that:

Services are performed in accordance with the following requirements as amended from time to time:

1. Care Quality Commission Essential Standards in force during the term of this Contract
2. any relevant MHRA guidance, NICE guidance, technical standards, and alert notices are adhered to
3. the highest level of clinical standards that can be derived from the standards and regulations referred to in this paragraph 7.1 of Part A of Schedule 2
4. for GPs, the General Medical Council guidance on Good Medical Practice (2013 or most recently published)

Clinical Governance and Quality Assurance

Show a commitment to work within local frameworks, particularly for locally commissioned services and public health standards to achieve the highest possible standard.

Comply with any commissioner Quality Standards that may be introduced during the term of the contract, subject to the agreement of additional funding should it be reasonably required.

Operate an effective, comprehensive, system of Clinical Governance with clear channels of accountability, supervision and reporting, and effective systems to reduce the risk of clinical system failure.

Have medical leadership in place with a named clinical lead for all areas including Commissioner engagement.

Nominate a person who will have responsibility for ensuring the effective operation of the system of Clinical Governance and who is accountable for any activity carried out on a patient.

Continuously monitor and report on clinical performance as detailed in the Key Performance Indictors and service monitoring requirements.

Use appropriate formal methods such as root cause analysis for serious incidents, near misses and complaints, and report via the correct channels, i.e. STEIS.

Have in place a system for collecting data on serious incidents, near misses and complaints in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements. Furthermore, the Provider shall have in place a system for adopting such changes into practice and processes.

Operate robust auditing of clinical care against clinical standards and in line with CQC essential standards.

Comply with the Commissioner's governance requirements and inspections and make available, on reasonable notice to the Commissioner, any and all Provider records (including permitting the Commissioner to take copies) relating to Provider clinical governance, to enable the Commissioner to audit and verify the clinical governance standards of the Provider.

Where appropriate, fully implement any recommendations following Commissioner clinical governance inspections within three (3) months of notification by the Commissioner of the recommendations, including the development and submission of improvement plans as required by the commissioner. Participate in all Commissioner quality and clinical governance initiatives.

Risk Management

The Provider shall:

Operate mechanisms for assessing & managing clinical and general business risk including the maintenance of a suitable risk register that is reviewed, as a minimum by the Provider on a monthly basis.

Prepare disaster recovery, contingency and business continuity plans that should be available for inspection by the Commissioner at any time ensuring named medical cover for agreed contract times.

Keep the Commissioner fully informed about any significant risks that have been identified that could impact on the performance of the contract

Notify the Commissioner of the person responsible for risk management within the Provider's organisation.

Incidents and Serious Incidents

Must be read in conjunction with:

NHS England Serious Incident Framework, Supporting Learning to Prevent Recurrence(March 2015) available at https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

i. The Provider is expected to work with commissioners to ensure implementation of all standards that are included within the above.

ii. The provider is required to share with the commissioners any report relating to a serious incident that may be required by external bodies.

Never Events

If, and each time a never event occurs, this should be reported to the commissioner as per The Serious Incident Framework 2015:

https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-revised-never-events-policy-and-framework-and-never-events-list-2018

The provider will report all never events as serious incidents to the commissioner as outlined in the Revised Never Event Policy and Framework (March 2015) available at:

https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/never-evnts-pol-framwrk-apr2.pdf

The never events list 2015/16 is available at:

https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/01/never-evnts-list-15-16-v2.pdf

The never events list occasionally changes and providers must ensure that they are using the most up to date list which can be found along with other patient safety.

The consequence of a never event occurring will be financial penalty.

Patient Safety. External Alerts Management & Dissemination

The commissioner expects that the provider will have effective and robust risk management systems in place for reporting, investigating and learning from patients safety incidents.

All patient safety incidents will be reported to the National Patient Safety Agency (NPSA) electronically via the National Reporting and learning System (or any successor organisation or system)

NPSA and Medicine and Healthcare Products Regulatory Agency (MHRA) guidance disseminated via the Central Alert System (CAS) including patient safety alerts and other safety solutions and products developed for the NHS will be disseminated, implemented and evaluated in a timely manner. Where the guidance and/or alert have specified timeframes, the provider will work within these. If the provider chooses not to comply with this guidance a response including decision process should be provided to the commissioner.

Equity of Access

The Commissioner acknowledges that to improve equity of access for black and minority ethnic (BME) communities, it is important to collect information on ethnicity and first language due to the need to take

into account culture, religion and language in providing appropriate care packages and the need to demonstrate non-discrimination and equality of access to service provision. The Provider shall therefore be required to record the ethnic origin and first language of all registered patients.

The Provider will have systems and policies in place to ensure that it is responsive to the individual needs of its service users and will demonstrate it makes all reasonable adjustments to ensure that its services are accessible, appropriate and flexible, whether this is in terms of the location of the service or the provision of service.

The Provider will consider the specific needs of protected groups in relation to the service provided, making specific arrangements where necessary, such as interpreting or longer appointment times.

All protected characteristics will be considered and adjustments made, but particular attention will be paid to disabled people, including those with learning disabilities and to people who may have additional communication requirements. Providers will comply with the NHS Accessible Information Standard.

The Provider shall:

Not discriminate between patients on the grounds of age, sex, sexual orientation, ethnicity, disability, or any other non-medical characteristics

The service Provider must implement Royal National Institute for the Blind, Royal National Institute for the Deaf guidance and other relevant guidance to ensure residents who have disabilities and/or communication difficulties, are able to access the services. This includes ensuring arrangements are in place to enable staff to communicate fully with people that have a hearing impairment and may involve the Provider ensuring there is the correct assisted hearing system(s) available and in working order, (e.g. loop system) or a BSL interpreter available if required, or having a dedicated telephone number for text phone users who have hearing difficulties to enable them to access the Services. Frontline staff should undertake Deaf Awareness training and services should note that Reasonable Adjustments only include lip reading or written information if that is the method of communication that the patient requests

For people that have sight loss, make information available in a format suitable to them e.g. large print, Braille, audio tape or audio CD. For people that have dual sensory loss (sight and hearing impairments), an interpreter or communicator guide should be made available to enable effective communication to occur between staff and patient

Utilise available professional translation services:

1. as required for all non-English speaking residents during all consultations
2. to provide appropriate translations of materials describing procedures and clinical prognosis, where it is normal procedure to provide such materials in English, for the languages most commonly spoken by residents who are likely to use the Services

Take reasonable steps to proactively deliver health promotion and disease prevention activities to all care home residents including but not be limited to the following patient groups:

1. those who do not understand written or spoken English
2. those who have any hearing, sight or dual sensory impairment, or have other disabilities
3. those who have mental illnesses

The Provider will have systems/procedures/policies in place to equality monitor referrals and service users, and will report this as required to the commissioner. The provider will evidence actions undertaken to address any preventable inequalities of access, experience or outcomes, where these become apparent. The Provider must ensure that they are, where appropriate, providing services to the local community equitably.

The Provider will assess the impact of its services and work with service users and other stakeholders to understand whether there are any barriers to improved access, experience or outcomes. Where these are identified, reasonable steps should be taken to minimise the impact of the barriers.

The Provider must carry out an annual audit of its compliance with these obligations and must demonstrate at review meetings the extent to which service improvements have been made as a result.

Health Promotion and Disease Prevention

The Provider shall:

Provide services focusing on health promotion and disease prevention and work with the Commissioner, CCGs, Local Authority, other local GP practices and other health Providers on initiatives to promote health and prevent disease within the Commissioner's area

Ensure it has effective strategies for health promotion and disease prevention in place these shall include, but not be limited to:

- smoking
- alcohol
- obesity
- lack of exercise (if appropriate)
- dietary habits
- sexual health

Patient Dignity and Respect

The Provider shall:

Ensure that the provision of the Services protect and preserve patient dignity, privacy and confidentiality.

Allow patients to have their personal clinical details discussed with them by a person of the same gender, where required by the patient.

Provide a chaperone for intimate examinations to preserve patient dignity, and respect cultural preferences.

Ensure that the Provider's staff and anyone acting on behalf of the Provider behaves professionally and with discretion towards all residents, carers and visitors at all times

Informed Consent

The Provider shall comply with NHS requirements in relation to obtaining informed consent from each patient prior to commencing treatment including the following as amended from time to time:

- Department of Health Good Practice in Consent Implementation Guide: Consent to Examination or Treatment 2001 (or most updated version)
- Health Service Circular HSC 2001/023
- Consent: Patient and Doctors making decision together: RCGP 2008 (or most updated version)
- The Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007) and accompanying Codes of Practice
- Guidance on covert medication

Patient Records

The Provider shall at its own cost retain and maintain all the clinical records in accordance with:

Good Practice Guidelines:

https://digital.nhs.uk/information-governance-alliance

The provider will be compliant with all GDPR Regulations

The Provider shall at its own cost retain and maintain all the paper based clinical records in chronological order and in a form that is capable of audit. The Provider is responsible for complying with NHS Digital requirements in relation to 'Paper-free at the Point of Care' agenda.

Patient records should be retained in line with the records management code of practice for health and social care

https://digital.nhs.uk/article/1202/Records-Management-Code-of-Practice-for-Health-and-Social-Care-2016

Provider Records

The Provider shall during the term of this Contract and for a period of ten (10) years thereafter, maintain at its own cost such records relating to the provision of the Services, the calculation of the Charges and/or the performance by the Provider of its obligations under this Contract as the Commissioner may reasonably require in any form (the **'**Records'), including information relating to:

- Contract management reporting
- National/data set reporting

The Provider shall, subject always to the provisions of relevant legislation and Directions:

On request produce the Records for inspection by the Commissioner or, on receipt of reasonable notice, allow or procure for the Commissioner and/or its authorised representatives access to any premises where any Records are stored for the purposes of inspecting and/or taking copies of and extracts from Records free of charge and for the purposes of carrying out an audit of the Provider's compliance with this Contract, including all activities of the Provider, the Charges and the performance, and the security and integrity of the Provider in providing the Services under this Contract

Preserve the integrity of the Records in the possession or control of the Provider and Provider Staff and all data which is used in, or generated as a result of, providing the Services

Prevent any corruption or loss of the Records, including keeping a back-up copy

Provide any assistance reasonably requested by the Commissioner in order to interpret or understand any Records

The Provider shall ensure that during any Records inspection the Commissioner and/or its authorised representatives receive all reasonable assistance and access to all relevant Provider staff, premises, systems, data and other information and records relating to this Contract (whether manual or electronic)

Infection Control and Prevention

The Provider shall have in place arrangements that meet the standards outlined in the NICE guidelines - *Health care-associated infections: prevention and control in primary and community care (March 2012 or most recent)*, It offers evidence-based advice on the prevention and control of healthcare-associated infections in primary and community care. New and updated recommendations address areas in which clinical practice for preventing healthcare-associated infections in primary and community care has changed, where the risk of healthcare-associated infections is greatest, and where the evidence has changed.

To comply with NHS England Standard Operating Procedure Infection Prevention & Control Audit requirements and the The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (2016):

Use only disposable medical devices

Make arrangements for the ordering, recording, handling, safe keeping, safe administration and disposal of medicines used in relation to the Services

Make arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff (including any clinical practitioners which the Provider has asked to carry out clinical activity)

Follow appropriate guidelines to the management of hospital acquired infections

Complaints procedure

The Provider will:

Produce and publicise in the service/practice leaflet and on the website, a complaints procedure that is consistent with the latest version NHS Complaints Policy. The complaints procedure must be easy to understand, accessible and available to the homes to residents and provide for a prompt response

Respond to complaints with acknowledgement of receipt within 3 working days, and respond fully to complaint within a maximum of 28 days, or mutually agreed with the complainant depending on the severity. Difference between acknowledgement (3 working days) and response. Timescales should be mutually agreed with the complainant and are dependent on severity.

If a case has passed the 40 working day target (or the timescale agreed with the complainant if different), the complainant (and advocate if relevant) should receive an update every 10 working days thereafter the target has been surpassed. This could be by telephone, email or letter but the format should be agreed with the complainant

www.england.nhs.uk/wp-content/uploads/2016/07/nhse-complaints-policy-june-2017.pdf

Ensure all complaints are monitored, audited and appropriate action taken when required

Take reasonable steps to ensure that residents are aware of:

1. The complaints procedure
2. The role of the NHS England and other bodies in relation to complaints about services under the Contract
3. The right to assistance with any complaint from independent advocacy services provided under section 19A of the Complaints Act

Take reasonable steps to ensure that the complaints procedure is accessible to all residents; being aware of language, and communication support needs

CQC Registration

The Commissioners require the provider to share the following information:

- CQC inspection reports
- Any conditions applied to registration, from subsequent inspections or from changes to regulated activities.
- Any action plans and progress reports required by CQC
- Notification of any in-year changes

NICE guidance

The provider will comply with the recommendations contained in guidance issued by the National Institute for Health and Care Excellence (or equivalent), to include Technology Appraisals, Interventional Procedures, Clinical Guidelines and Quality Standards.

Risk Management

The provider will be able to demonstrate an appropriate system for recording, monitoring and reporting of risk issues.

The provider will adhere to the NHS Greater Huddersfield and North Kirklees CCGs risk reporting policy.

The provider is required to have sufficient professional indemnity

Pharmacy and Medicines Management

The service provider will be required to have access to specialist prescribing advice.

The service provider will ensure links with existing community pharmacist, practice pharmacist and local CCG Medicines management teams to maximize the benefits available to patients through these practitioners roles in:

- Medicines management
- Waste reduction
- Managing prescribing interface issues (especially discharge planning)
- support for patient education and self-care
- their holistic use of Medicines Use Reviews (MURs)/clinical medication review
- Level 3/10 point medication review

The service provider must ensure that GP records are accurately updated when new medications have been prescribed by the end of that working day.

Medicines/Dressings Management

Wound management products should be supplied in line with the current local wound management formulary. If a product is supplied out of formulary then a “non-formulary exemption reporting form” must be completed and sent to the Tissue Viability Service. All management of medicines must follow the same pathways to avoid confusion and also ensure patients are not compromised.

The Provider has full responsibility for initial supply of products in situations where the patient has not received a prior prescription for them due to the unplanned nature of their condition e.g. first dressings.

Any incidents related to medicines or medical devices should be reported via the National Reporting and Learning System (www.nrls.npsa.nhs.uk/report-a-patient-safety-incident) in a timely manner.

Product Provision

North Kirklees Clinical Commissioning Group is currently piloting a total purchasing route to supply wound care products across level 1 and 2 wound care with the aim of rolling the model across Greater Huddersfield Clinical Commissioning Group should the evaluation prove positive.

The aim of this service element will be to provide an efficient and cost effective supply of dressings direct to authorised end users within the geographical areas covered by both Clinical Commissioning Groups in Kirklees.

Policies and Procedures

The service provider must have in place the following policies:

- Equality and Diversity
- Recruitment and Staff Training
- Health & Safety
- Lone Working
- Record Keeping
- Confidentiality/Data Protection/Caldicott
- Compliments & Complaints
- Incident reporting and management of Adverse Events
- Appropriate industrial relations policies, including managing sickness/absence, discipline, grievance and disputes; programme of compulsory and legislative training to comply with national requirements
- Human Resources Policies, including staff appraisal, managing stress, staff support arrangements such as occupational health support, pay protection and staff redeployment or redundancy arrangements

IM&T

The provider must be able to access relevant clinical systems, for example System One, in order that any necessary updates to patient records are made by the end of that working day.

The provider must also ensure that technology is maximised and contributes to the effective and efficient use of resources and capacity; an example of this may be around the reduced reliance on hospital based services/admission avoidance/early supported discharge.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements

In line with the wound care quality standards required for community providers, all nurses, including tissue viability nurses, should ensure the service they deliver to patients is safe, effective and that the patient has a good experience in line with the CQUIN framework.

- Practitioners should select the most appropriate wound dressing in order to promote wound healing, reduce the risk of infection, reduce pain, manage exudate and prevent readmission to hospital due to wound infection (Shorney and Ousey, 2011).
- The provider will actively gather patient/carer experience data
- The Provider will review patient/carer experience data on a quarterly basis, make recommendations where appropriate and act on them
- The Provider will make available to the CCG patient/care experience intelligence when requested

5.2 Applicable CQUIN goals (See Schedule 4D)

Not appropriate at this time. The application of any future CQUIN scheme will be funded from within the set rate/tariff for the service i.e. within the financial envelope identified and not in addition to.

6. Location of Provider Premises

The Provider's Premises are located at:

The provider should ensure that the premises in which services are to be provided are suitable for delivery of those services and sufficient to meet the reasonable needs of patients. The premises must also meet current premises related regulations.

7. Individual Service User Placement

Not applicable

8. Glossary

See section 3.2 for description of Level 1 and Level 2 wound care

Doppler – in this context Doppler refers only to patients with an active wound requiring a Doppler assessment.

Appendix 1 - GH & NK Wound Care LES Read Codes 2018/19

Wound Care Level 1 (Treatment Room)

A suture/clip removal or basic dressing.

Term	CTV3 Code	READ2 Code	Snomed Concept ID	Template on Which Code Can Be Recorded (SystmOne)	
				Name of Template	Page
Dressing of Wound	81H	81H	182531007	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Dressing of Ulcer	81H1	81H1	182532000	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Dressing of Burnt Skin	Xa97M	81H2	90660004	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Attention to Dressing of Skin	Xa8Qp	81H3	302436000	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Checking Dressing of Skin	Ua1Ci	81H4	225143001	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Change of Dressing	X70cl	81H5	18949003	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Suture Generated from Secondary Care Done by Practice	XaKdl	9N7H	185621000000100	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Skin Sutures/Clips	8P0	N/A	30549001	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)

Term	CTV3 Code	READ2 Code	Snomed Concept ID	Template on Which Code Can Be Recorded (SystmOne)	
				Name of Template	Page
Removal of Suture from Skin	Xa8QS	7G223	302415002	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Clip from Skin	Xa8QR	7G221	302414003	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Other Specified Repair Material from Skin	7G22y	7G22y	265687005	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Repair Material from Skin NOS	7G22z	7G22z	265687005	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Suture from Skin of Head or Neck	7G222	7G222	177565006	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Clip from Skin of Head or Neck	7G220	7G220	177563004	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Protective Suture from Eyelid	721A4	721A4	172269008	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Suture from Lip	XaLlF	75043	426870002	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
Removal of Suture from Mouth NEC	XaLOW	75344	234921007	DQ Wound Assessment/Dressing/Suture Removal	Wound Dressing/Suture Removal (Page 4)
****Any of the above codes should be recorded within the last financial quarter****					

Wound Care Level 2

Complex wound care.

Term	CTV3 Code	READ2 Code	Snomed Concept ID	Template on Which Code Can Be Recorded (SystmOne)	
Complex Wound Care Enhanced Services Administration	XaPfk	9kd	373681000000104	DQ Wound Assessment/Dressing/Suture Removal	Wound Assessment(Page 1) or Wound Dressing/Suture Removal (Page 4)
****To be recorded within the last financial quarter, the claim will be broken down by item count****					

Wound Care Level 2 Enhanced

Compression dressings or doppler assessment.

Term	CTV3 Code	READ2 Code	Snomed Concept ID	Template on Which Code Can Be Recorded (SystmOne)	
Multi-Layer Compression Bandaging	XaKCL	8316	414782002	DQ Wound Assessment/Dressing/Suture Removal	Wound Assessment(Page 1) or Wound Dressing/Suture Removal (Page 4)
Doppler Studies Normal	XaDt9	58580	312369005	DQ Doppler Testing	
Doppler Studies Abnormal	XaDtA	58581	312370006	DQ Doppler Testing	
****Any of the above codes to be recorded within the last financial quarter, the claim will be broken down by item count (N.B if claiming only for either compression dressing or doppler assessment please do not also tick 'complex wound care enhanced services administration' as this will count as a separate claim****					

Appendix 2 - Wound care template – Minimum data set

Domains	Core Generic Wound Assessment Minimum Data Set
General Health Information	- Risk factors for delayed healing (systemic and local blood supply to the wound, susceptibility to infection, medication affecting wound healing, skin integrity)
	- *Allergies
	- Skin sensitivities
	- * *Impact of the wound on* q*uality of life (physical, social & emotional)*
	- *Information provided to patient and carers*
Wound Baseline Information	- Number of wounds
	- Wound location
	- Wound type/classification
	- Wound duration
	- Treatment aim
	- Planned re-assessment date
Wound Assessment	- Wound size (maximum length, width and depth)
	- Undermining/tunnelling
	- Category (if pressure ulcer)
	- Wound bed tissue type
	- Wound bed tissue amount
	- Description of wound margins/edges
	- Colour and condition of surrounding skin
	- Whether the wound has healed
Wound Symptoms	- Presence of wound pain
	- Wound pain frequency
	- Wound pain severity
	- Exudate amount
	- Exudate consistency/type/colour
	- Odour occurrence
	- *Signs of systemic infection
	- Signs of local wound infection
	- Whether a wound swab has been taken

-	Specialists	-	- Investigation for lower limb (ABPI)
		-	- Referrals (TVT, Hospital Consultants)

Service Specification No.	8
Service	Administration of Gonadorelin Analogue Treatments under Shared Care Guidelines (Zoladex/Prostap)
Commissioner Lead	Melissa Fletcher
Provider Lead	
Period	1st April 2021- 30th September 2021
Date of Review	September 2021

1. Population Needs

1.5 National/local context and evidence base

This service covers the administration of Zoladex and Prostap (see below) under agreed shared care guidelines approved by the Area Prescribing Committee with treatment normally initiated in secondary care and ongoing treatment delivered in primary care.

The drugs involved are:
Goserelin (Zoladex®)
Leuprorelin (Prostap®)
Triptorelin

Zoladex – This is used in the treatment of cancer of the prostate gland in men and in treating breast cancer in women.

Prostap – DR DCS (Dual Chamber Pre-Filled Syringe) is a synthetic hormone which can be used to reduce the levels of testosterone and estrogen circulating in the body. It is used to treat prostate cancer in men and endometriosis and uterine fibroids in women.

These drugs specified above fall within the NICE clinical guideline on prostate cancer (CG58), which recommends their use for patients with specific types of prostate cancer.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The bundle of services contributes to the following Domains of the NHS Outcomes Framework

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	√
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

Covered elsewhere in the specification.

3. Scope

3.1 Aims and objectives of service

The aim of the service is for practices to administer gonadorelin analogues (gosorelin, leuprorelin and triptorelin) to registered patients in GP practices reducing the need for patients to attend clinics in secondary care. This supports the aim of moving care closer to home.

3.2 Service description/care pathway

This service is delivered under agreed shared care guidelines approved by the Area Prescribing Committee.

Treatment is normally initiated in the secondary care sector and ongoing treatment is delivered in primary care.

There is no requirement within primary care for additional monitoring to be undertaken with patients receiving this treatment.

The Provider will be required to produce a register of all patients currently prescribed Zoladex or Prostap under current shared care guidelines. The register should include the conditions for which the drug is prescribed, details of the agreed treatment regime (1 monthly or 3 monthly injections) date of next injection and date of next review if known.

The Provider will be required to work proactively with patients and facilitate co-operative management of their care.

The Provider will be required to demonstrate a robust call and recall system and evidence of internal audit of their systems.

The Provider should note those patients whose treatment is complete and discontinue the medication from their clinical record.

The Provider should have procedures in place to notify secondary care clinicians of any changes to patient status.

The CCG will agree an internal monitoring process for this service.

3.3 Population covered

The service will be available to the practice's registered population.

3.4 Any acceptance and exclusion criteria and thresholds

Not applicable

3.5 Interdependence with other services/providers

The service will have links with the following:

- Secondary care services

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Health Care Standards for Better Health.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

None applicable

4.3 Applicable local standards

These are set out under the service description/care pathway.

5. Applicable quality requirements and CQUIN goals

5.9 Applicable quality requirements (See Schedule 4 Parts A-D)

Competency

Staff providing the service will have the appropriate clinical qualification for the role. They will need to have current membership of their relevant bodies, evidence of annual appraisal and indemnity cover. Other requirements will be covered by statutory and mandatory training.

Staff will be qualified and registered (where appropriate) in accordance with their anticipated scope of professional responsibility.

The Provider should ensure that for any registered healthcare professional who is:

(g) Performing clinical services under this agreement; or is

(h) Employed or engaged to assist in the performance of such services;

there are in place arrangements for the purpose of maintaining and updating her/his skills and knowledge in relation to the services which s/he is performing or assisting in performing.

Staff administering injections under this service should be appropriately trained in the administration technique for the specific product prescribed (this is particularly important with Zoladex preparations)

Untoward events

It is a condition of participation in this service that the Provider will give notification to the CCG of all incidents occurring in patients covered under this service. This should be done using the CCG incident reporting system.

For serious incidents where admission or death may be due to usage of drugs covered in this service or attributable to the relevant underlying medical condition, this must be reported to the CCG's Quality & Safety Manager within 72 hours of the information becoming known to the practitioner. This is in addition to a practitioner's statutory obligations.

Patient/carer experience

- The Provider will actively gather patient/carer experience data
- The Provider will review patient/carer experience data on a quarterly basis, make recommendations where appropriate and act on them
- The Provider will make available to the CCG patient/care experience intelligence when requested

5.10 Applicable CQUIN goals (See Schedule 4 Part E)

Not appropriate at this time. The application of any future CQUIN scheme will be funded from within the set rate/tariff for the service i.e. within the financial envelope identified and not in addition to.

6. Location of Provider Premises

The Provider's Premises are located at:

The Provider should ensure that the premises in which services are to be provided are suitable for delivery of those services and sufficient to meet the reasonable needs of patients. The premises must also meet current premises related Regulations.

The Provider should also ensure it has appropriate arrangements for infection control and decontamination

7. Individual Service User Placement

Not applicable