Service Specification No.	**NK1**
Service	The management of Adult patients with diabetes on insulin/GLP-1 therapy in primary care (enhanced service)
Commissioner Lead	Joanne Davis
Provider Lead	
Period	1st April 2021 – 30th September 2021
Date of Review	September 2021

1. Population Needs

1.1 National/local context and evidence base

Diabetes Mellitus is a complex condition that has a profound impact on the quality of life of patients living with it and on the health economy as a whole. Risk factors are multifaceted with wide-ranging complications which make diabetes care complex and time-consuming, meaning many areas of healthcare services must be involved for optimal management. This long term condition is one of the greatest medical challenges of the 21st century for the NHS and numbers of patients continue to increase year on year.

In 2011 it was identified that nationally 80% of the NHS spending on diabetes goes into managing of preventing potentially preventable complications (State of the Nation 2012 England). In 2013, over 3.2 million adults were diagnosed with diabetes, with prevalence rates of 6% and 6.7% in England and Wales respectively (NICE 2015). North Kirklees prevalence currently is 8.1% and 90% will have Type 2 diabetes.

Effective proactive prevention and management through consistent high quality care delivered by qualified professionals with the right skills and knowledge can improve the patient outcomes and quality of life for our patients. The nine care processes are recognised in primary care as pillars for diabetes care (derived from NSF and NICE guidance).

The nine care processes are:

- Blood glucose level measurement (including HBA1c measured and managed according to NICE Guidelines)
- Blood pressure measurement
- Cholesterol level measurement
- Retinal screening
- Foot and leg check (should include a first level diabetic foot screen)
- Kidney function testing (urine)
- Kidney function testing (blood: e.g. creatinine and Micro-albuminuria)
- Weight check (including body mass index and waist circumference recorded)
- Smoking status check and recorded

The overall aim of this AQP is to set new standards for the quality of diabetes care in North Kirklees providing guidance and support to deliver high quality patient centred care which is

proactive in management and prevention of complications. This AQP will support closer collaborative working arrangements with the Diabetic Specialist Nurses, enhancing knowledge and skills of nurses working in General Practice. This AQP will sit within the overall vision and model of diabetes care in North Kirklees.

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

- Ensure all services achieve the high quality care as described in Diabetes NICE Guidelines and quality standards and where possible aim for a good compliance with QOF.
- Self – management, based in personalised care planning and the effective delivery of structured education and person empowerment are central to optimising outcomes for patients with diabetes.
- For patients to report a positive experience and feel supported and encouraged to self-care.
- To improve patient outcomes through reducing ill health and complications this will reduce avoidable admissions to hospital.
- That practices feel supported to optimise their care to patients and develop workforce skills and knowledge to deliver diabetes care closer to home rather than in a hospital setting.
- Reduced variation of care delivered in primary care through training and support and encouragement to build on core and QOF provision and work towards an enhanced service through the AQP.
- Adults with diabetes should be proactively stabilised, optimised, monitored and supported on injectable therapies.
- Care is co-ordinated and seamless with the patient at every step to ensure self-care is promoted.

3. Scope

3.1 Aims and objectives of service

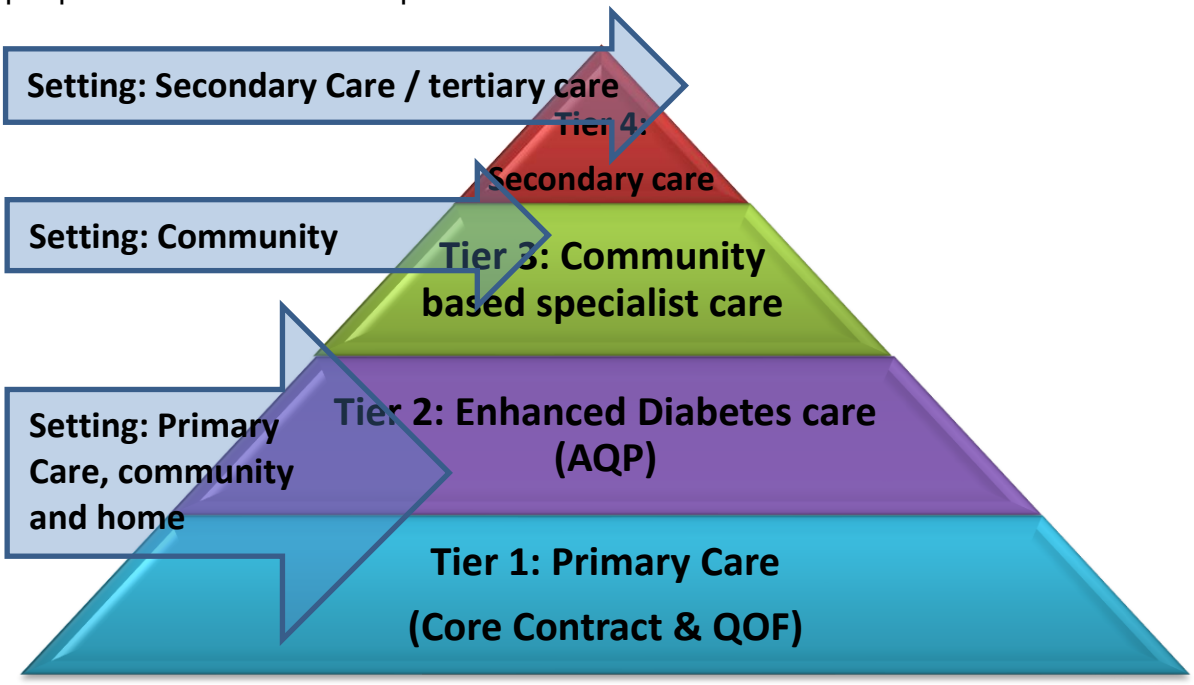
- To ensure that patients receive high quality evidence-based care and support with a proactive message of self-care closer to their home.

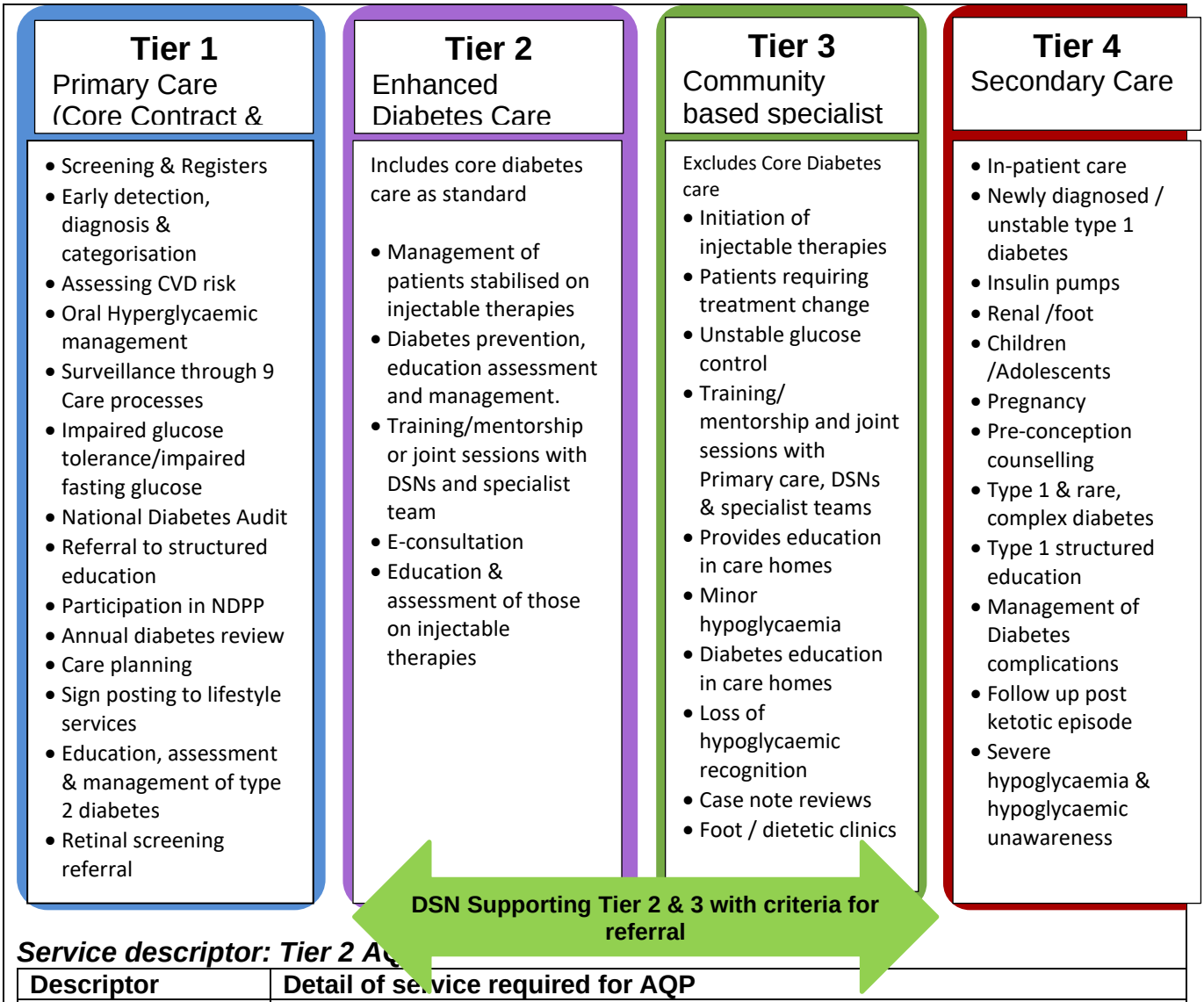
- To improve patient care and outcomes through collaborative working practices across primary care, through Diabetic Specialist Nurses and secondary care clinicians.
- To reduce the number of unplanned interventions through improvement of prevention and planned care.
- To ensure that support via specialist diabetes services are available in a timely manner, closer to patients' homes and through different routes such as E-consultation.
- Work side by side with patients aiding in optimising self-care and independence to enable them to live better quality lives for longer.
- Care for those adults stabilised on injectable therapies currently receiving their routine care from hospital-based services will transfer back to the AQP provider.
- This service will support the up-skilling of GP's, Practice Nurses and allied health professionals through collaborative working and learning as part of the joint sessions with the DSNs.

3.2 Service description/care pathway

Levels of care

In North Kirklees there are 4 Tiers of Care described referring to different levels of care for people with diabetes. This specification relates to the service at Tier 2.





Service descriptor: Tier 2 AQ

Descriptor	**Detail of service required for AQP**
Management of patients stabilised on injectable therapies	• Manage patients on injectable therapies including minor titration and management of the injectable in Type 2 patients. • This must comply with NICE guidelines, quality standards and any locally approved guidelines with providers or commissioners. • Evidence of this will be required to receive AQP payment
Diabetes assessment and management of care.	• Provide dedicated protected diabetes clinic time for annual reviews/care planning consultation using a formal structured care planning approach • Evidence of high quality structured individualised care planning with agreed goals and action plans with patient, carers and health care professionals. This should form the basis of their management and self-management. Three care plans per year must be reviewed by the DSN for learning and development, this is to quality assure the standard of care planning. ○ Formal care planning and reviews must be conducted by the lead clinician on an annual basis. This may lead to further follow up appointments during the year following the review, which will be undertaken as part of this service. ○ This should ensure that the Nine Care Processes are thoroughly assessed, managed and documented effectively (new template to be used when available on SystmOne)

	○ Management of cardiovascular risk and long term complications. ○ Robust and comprehensive foot assessment must be conducted and recorded. Three examples of assessment as part of care planning should be reviewed by the DSN for quality assurance and maintenance of standards. • Provide proactive care for all patients including patients with multiple co-morbidities who are at high risk of an acute hospital admission. This could include the use of risk assessment and stratification tools (e.g. frailty and falls). • Timely management and documented evidence to support how complex patents including those with poorly controlled HbA1c and those with co-morbidities to reduce the likelihood of unplanned hospital admission are assessed and managed to maintain their condition. • Formal review of patients post discharge from secondary care Specialist services will be required where clinically appropriate. • Support house-bound patients living at home or in residential/nursing care by offering the same standard of care as those who attend clinic, including annual reviews/care planning consultations. ○ Maintain a current housebound register for diabetic patients which flags when reviews are due. ○ Provide the same quality of assessment and care for housebound diabetic patients. ○ Able to demonstrate compliance with annual review, care planning, patient education for all housebound patients. • Evidence education, support and assessment will be required to receive AQP payment.
Education of patients	• Structured patient education and support in line with NICE Guidelines to promote and enhance self-management as part of the care planning process. This should include: ○ Smoking cessation ○ Exercise & weight management programs ○ Dietary advice ○ Psychological assessment and support of mental health conditions and impact on quality of life. ○ Foot care (see appendix 4 for competency assessment) ○ Eye care (see new NICE guidelines in 2016) ○ If on injectable therapies for yearly education and training of the patient on how to correctly assembly, manage and dispose of a sharps bin. This must be evidenced and recorded in the patient record and care plan. ○ If on injectable therapies Nurses should provide evidence in the care planning of reviewing injection sites and discussion regarding risk of hypoglycemia management and triggers including sick day rules. ○ Review the patients' ability to self-monitor and review the equipment they are using. ○ Identification of complications and prompt referral to level 4 (e.g. Gastroparesis, Painful diabetic neuropathy, autonomic neuropathy, foot problems, chronic kidney disease, erectile dysfunction, eye disease). • Offer diabetes patients who would benefit from a flexible-dosing regimen are offered, monitored in attending and adhering to a formal education MY DICE programme (MYHT) • Ensure Type 2 diabetes patients are offered, monitored in attending and adhering to a formal education DESMOND programme (LOCALA)

	• *Diagnosed less than 6 months= DESMOND Newly diagnosed* • *Diagnosed more than 6 months ago= DESMOND foundation* • *Diagnosed less or more than 6 months speaking Urdu / Guajarati (culturally specific) = DESMOND BME.*
Core requirements QOF and the National Diabetes Audit.	• It is expected that all AQP providers will meet core requirements and QOF standards to ensure a high standard and quality of care prior to applying for AQP status. • In relation to the achievement of the combined **three NICE treatment targets** reported in the National Diabetes Audit 2016-17 practices are required to try to achieve the following improvement: o Practices achieving under 40% to achieve 40% or increase by 2%, whichever is greater o Practices achieving 40.1% to 48.0% to increase by at least 2% o Practices achieving 48.1% or more to increase by at least 0.5% • In relation to the achievement of the combined **nine NICE care treatment process targets** reported in the National Diabetes Audit 2016-17 practices are required to try to achieve the following improvement: o Practices achieving under 40% to achieve 40% or increase by 2%, whichever is greater o Practices achieving 40.1% to 48.0% to increase by at least 2% o Practices achieving 48.1% or more to increase by at least 0.5% • Evidence of achievement of the above requirements will need to be demonstrated to receive AQP payment.
Training/mentorship or joint sessions with DSNs and specialist team	• Practice nurses and or GPs should actively attend regular meetings and joint clinics with the specialist team to build knowledge and expertise within the primary care workforce whilst ensuring that best practice standards are met. This forms part of assessment of the AQP and must be achieved and demonstrated to show learning and development. • Evidence of this will be required to receive AQP payment.
Use of E-consultation	• Make optimal use of the e-consultation diabetes service (SystmOne practices) for advice and support. • Use OSCAR and RSS for advice and support and referral into Tier 3&4.

3.3 Population covered

The service will be available to the GP practice's own population. This service will be provided to adults with stable diabetes aged 18 years or older, including housebound patients and those on ambulatory care pathways.

For the purposes of the AQP:

A definition of who 'stabilised on injectable therapies' relates to regarding this AQP is:

- Injectable therapy has been initiated and dosing stabilised
- Stable blood glucose levels
- Confidence in managing injectable therapy
- No need for routine contact with a specialist service.
- For patients currently under specialised care or secondary care only appropriate patients will be discharged to the Tier 2 service. The process should be followed to ensure discharged patients receive a review within three months of discharge.

3.4 Service provision:

Provide adequate appointment times: Suggested minimum appointment times are:

Annual preparation for care planning review (including foot examination) (HCA/PN)	20 – 30 minutes
Annual GP/PN care planning consultation	20 minutes
Additional Practice nurse routine review as appropriate	20 minutes

Annual Care Planning Review to include:

1. Initial appointment to undertake annual review tests including foot examination
2. Opportunity for patient to see/receive blood test results (via letter, text, phone call or online) prior to review with practice nurse.
3. Annual Care Planning Review with Practice Nurse / GP to include a holistic conversation with the patient discussing the individual's ideas, concerns and expectations of their condition / treatment. Discussion of concerns from the healthcare professionals point of view in relation to learning about diabetes, managing diabetes, living with diabetes and other health and social issues.
4. Goal setting / action plan to be developed and agreed jointly with the patient and health care professional including for example setting a target HbA1c level.

For Care Planning Approach in Diabetes see Appendix 4.

Clinic Non-attenders suggested process

Non-attenders to be sent a total of three invitations to attend. Invitations can be sent via letter or text message.

- Patients who fail to attend the initial appointment are sent a standardised letter or text message including a further appointment.
- Upon failure to attend the second appointment, a further attempt is made to contact the patient by either letter, telephone, follow DNA ICP.
- Reasons for failure to attend are established.
- Unwillingness to attend is addressed by appropriate patient education.
- Persistent unwillingness to comply is clearly documented in the clinical record, and coded as being exempt from QOF requirements
- Patient notes to be updated to show diabetic review required to allow other health professionals to be aware

3.5 Equity of access and participation to services.

The provider should ensure that its service is accessible to all patients who meet the eligibility criteria regardless of race, age, gender identity, disability, sexual orientation, religion or belief and that it deals sensitively with all patients and potential patients and their families/carers and advocates.

The provider should take into account any disabilities, including visual impairment, when planning and delivering care for patients with diabetes as this may impact on the effectiveness of patient participation and involvement in their care.

3.6 Patient Consent

The provider should ensure that appropriate consent is taken for all patients prior to assessment and treatment, in line with their regulatory body's code of conduct and the Practice policy on consent. If English is not their first language, the patient should be offered the support of a translator.

3.7 Read Codes relating to this service

66AP - Diabetes - practice programme
66AQ - Diabetes - shared care programme
Xalle – Diabetes Care by Hospital only
XaQjs – Unsuitable for diabetes year of care programme

Read codes will be replaced with SNOMED codes from 1 April 2018. The equivalent SNOMED codes are:

512561000000108 Unsuitable for diabetes year of care programme (finding)
170774007 Diabetes practice programme (finding)
170775008 Diabetes: shared care programme (finding)
1024551000000109 Under care of hospital-based diabetes specialist nurse (finding)

The Data Quality Team will run the report on a quarterly basis.

The CCG reserves the right to undertake an annual quality check.

3.8 Education and Training Requirements

Requirements for this AQP	**Tier 1** **Core & QOF**	**Tier 2** **AQP** **(Must have Tier 1 compliance before applying for AQP status)**	**Tier 3** **Enhanced services outside of AQP** **Must have Tier 1&2 compliance before working at Tier 3**
Education & Training (see attached document on available courses)	1. At least one GP and or practice nurse within each participating practice who will be providing the majority of the diabetes care	5. Recognised Diploma /qualification in Diabetes Care 6. Evidence of competence in all 9 Care Processes needs to be verified yearly by a DSN.	11. In addition to Tier 1 & 2 requirements the practice must demonstrate: 12. Further formal competency

Template to complete and submit in Appendix 2 on a yearly basis for compliance with AQP standard and payment criteria.	2. Have a named contact for Diabetes within each practice. 3. Recognised Diploma /qualification in Diabetes Care 4. Evidence of yearly update on the management of diabetic patients to meet Core and QOF requirements to maintain a high quality of care delivery.	7. Evidence of involvement in joint diabetology session with a DSN or consultant to support learning and development on a yearly basis. 8. Evidence of attending a Diabetes injectable therapy / insulin course (e.g. MERIT) or study day in the last 3 years with yearly evidence to support continued learning and knowledge of up to date practice. 9. Yearly evidence of 3 reflective learning cases and care planning which should include all care planning for; prevention, education, assessment and management. This must be reviewed jointly with the DSN for learning and development. 10. Attended a diabetic foot care course provided by Locala or a recognised body in the last 3 years, with competencies signed off annually by a GP, Practice Nurse, podiatrist or DSN with relevant foot care qualification.	assessment must be achieved and signed off by the DSN to ensure quality and standards of initiation of injectable therapy are achieved, sustained and guidelines are complied with. 13. Mentorship with the DSN until deemed competent.

3.9 Audit requirements for monitoring and review

This service will be monitored and reviewed on a quarterly basis for audits and an annual basis for educational and training requirements. Audits will be undertaken by the CCG data quality team. Practices are required to submit their data (template in Appendix 3) via secured email by the deadline date to ensure that this can be reviewed and authorised for payment.

For the contract period all practices must keep accurate and comprehensive records of all patients who have been managed under the AQP service.

Requirements for this AQP	**Tier 1** **Core & QOF**	**Tier 2** **AQP** **(Must have Tier 1 compliance before applying for AQP status)**	**Tier 3** **Enhanced services outside of AQP** **Must have Tier 1&2 compliance before working at Tier 3**
Quarterly Audit requirements to support	• Maintain an electronic diabetes register for audit and patient recall purposes.	• Must demonstrate compliance of Tier 1 on an annual basis through a submission • Participate in the annual National Diabetes Audit. This should	

submission for payment. **Appendix 3 contains the form to complete and submit.** **This should include confirmation of Tier compliance for audit purposes.**	• Comply with Core elements of the Contract • Compliance with QOF requirements for diabetes. • Participate in the annual National Diabetes Audit. This should include reviewing performance, creating and acting upon an action plan to address any concerns. • Evidence that the practice and staff are compliant with current NSF, NICE guidance and quality standards. • Compliance with all locally agreed guidelines by the NHS North Kirklees CCG.	include reviewing performance, creating and acting upon an action plan to address any concerns. This action plan must be submitted as part of the yearly submission • Provide evidence of at least two joint sessions yearly with the DSN to demonstrate collaborative working as well as education and development at the GP practice. (Appendix 2) • Provide evidence that at least 3 care plans per year have been jointly reviewed with a DSN to maintain quality of care planning and best practice (Appendix 2) • Provide dedicated diabetes clinic time at least twice a year, of which one visit is to be for the annual diabetes care planning, consultation and development of the agreed goals and action plans with the lead diabetes GP/PN • Provide a portfolio of evidence to demonstrate PN compliance with education and training requirements listed in the above section. Any concerns with accessing courses must be escalated to the CCG to review in a timely manner (Appendix 2 &4) • Data collection/submission (to inform service planning). This should be done on a quarterly basis. This report will be run by the CCG data quality team. (see Appendix 3) • Provide evidence that you have sought patient feedback on your diabetic service and have implemented changes to enhance the quality and care of your patients.	

3.10 Any acceptance and exclusion criteria and thresholds

The service will be available to patients who meet the criteria for Tier 2, set out in section 3.2. Any patients who are transitioning between child and adult services will remain with the specialist team until their care is discharged from the specialist clinic and suitability to handover the patient to provider care is discussed and agreed.

3.11 Financial implications:

This AQP will be provided at a rate of: £6.80 per patient per month.

3.12 Interdependence with other services and providers & referral criteria for DSN and Secondary care.

The service will link with:

- Mid Yorkshire Community Diabetes Specialist Nurse team
- Mid Yorkshire specialist services
- Locala
- Diabetes Multidisciplinary Team
- Community Nursing Service

3.13 Referral criteria for Community DSN and Tier 4 Secondary Care

Referral Criteria to DSN Tier 3

For Tier 1 Primary Care Practices only:

- **Type 2 patients on max tolerated oral hypoglycaemic agents with HbA1c persistently above 57mmol/mol**
- **Types 1&2 insulin - treated patens for glucose management**
- **Type 2 GLP-1 treated patients for glucose management**
- **Insulin - treated patients requiring the following:**
- **Holiday advice, exercise advice, shift work advice**
- **Treatment changes for terminal patients.**

For Tier 2 Enhanced Diabetes Care Practices only:

- **Patients requiring insulin/ GLP-1 initiation**
- **Patient management on insulin/ GLP-1 who are not maintaining their individual HbA1c Target**
- **Patients requiring insulin regime review**
- **Patients experiencing regular hypoglycaemic episodes**

For Tier 3 Community based specialist care:

- **Patient management on insulin/ GLP-1 who are not maintaining their HbA1c target**
- **Patients requiring insulin regime review**
- **Patients experiencing regular hypoglycaemic episodes**

Referral Criteria to Tier 4 from Tier 1,2 or 3

- **Insulin initiation for new Type 1**
- **Follow up post ketotic episode**
- **Pregnancy: Preconceptual care and management during pregnancy**
- **Early glycaemic management of unstable diabetes**
- **Initiation of insulin / GLP -1**
- **Assessment, change and stabilisation of insulin regimen**
- **Glycaemic management of patients with complications.**
- **Hypoglycaemic unawareness**
- **Complex Glycaemic management due to shift work**
- **Complex regimes**
- **Pump assessment/therapy**
- **Transitional clinic patients**
- **Management of diabetes complications**
- **In patient care**
- **Continuos blood glucose monitoring**
- **Rare / complex diabetes**
- **Pregnancy**

Please refer to OSCAR (Online Support and Clinical Advice Resource) for the current care pathways:

Self- Management Care Pathway - https://my-oscar.nhs.uk/care-pathways/self-management/self-management-kirklees-care-pathway
Diabetes (suspected) Care Pathway - https://my-oscar.nhs.uk/care-pathways/endocrinology/diabetes-suspected-in-adults-care-pathway-draft
Diabetes Type 2 Care Pathway - https://my-oscar.nhs.uk/care-pathways/endocrinology/type-2-diabetes-crg
Diabetes Hypoglycaemia Care Pathway - https://my-oscar.nhs.uk/care-pathways/endocrinology/diabetes-hypoglycaemia-care-pathway
Diabetes Foot Care Pathway - https://my-oscar.nhs.uk/care-pathways/endocrinology/diabetes-foot-care-pathway

Diabetes – Lipid Management Care Pathway - https://my-oscar.nhs.uk/care-pathways/endocrinology/diabetes-lipid-management-care-pathway
Diabetes Type 2 - Anti-hypertensive Treatment Guidance - https://my-oscar.nhs.uk/care-pathways/endocrinology/antihypertensive-treatment-guideline

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NICE Guidelines relating to diabetes:

National Institute for Health and Care Excellence (2015 updated 2017). **Type 2 Diabetes in Adults: Management** (NG28) https://www.nice.org.uk/guidance/ng28

National Institute for Health and Care Excellence (2015 updated July 2016) **Type 1 Diabetes in adults: diagnosis and management** (NG17) https://www.nice.org.uk/guidance/ng17

National Institute for Health and Care Excellence (2015 updated in 2016). **Diabetic foot problems: prevention and management** (NG19) https://www.nice.org.uk/guidance/ng19

National Institute for Health and Care Excellence (2015). **Diabetes (type 1 and type 2) in children and young people: diagnosis and management** (NG18) https://www.nice.org.uk/guidance/ng18

National Institute for Health and care Excellence (2015). Diabetes in pregnancy: management from pre-conception to the post-natal period (NG3) https://www.nice.org.uk/guidance/ng3

National Institute for Health and Care Excellence (2009) **Type 2 diabetes: the management of type 2 diabetes** (NG87) http://guidance.nice.org.uk/CG87

National Institute for Health and Care Excellence (2009). **Type 2 diabetes: newer agents for blood glucose control in type 2 diabetes** (Short NG87) http://guidance.nice.org.uk/CG87

National Institute for Health and Care Excellence (2011). **Quality Standard Diabetes in Adults** (QS6) http://guidance.nice.org.uk/QS6

Technology appraisals:

National Institute for Health and Care Excellence (2015). **Empaglifozin in combination therapy for treating type 2 diabetes** (TA336) https://www.nice.org.uk/guidance/ta336

National Institute for Health and Care Excellence (2002). **Guidance on the use of long-acting insulin analogues for the treatment of diabetes** (TA53) http://guidance.nice.org.uk/TA53

National Institute for Health and Care Excellence (2003). **Guidance on the use of patient-education models for diabetes** (TA 60) http://guidance.nice.org.uk/TA60

National Institute for Health and Care Excellence (2011). **Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus** (TA151) http://guidance.nice.org.uk/TA151

National Institute for Health and Care Excellence (2012). **Exenatide prolonged-release suspension for injection in combination with oral antidiabetic therapy for the treatment of type 2 diabetes** (TA 248) http://guidance.nice.org.uk/TA248

Quality standards:

National Institute for Health and Care Excellence (2016). **Diabetes in Pregnancy** (QS109) https://www.nice.org.uk/guidance/qs109

National Institute for Health and Care Excellence (2016). **Diabetes in children and young people** (QS125) https://www.nice.org.uk/guidance/qs125
National Institute for Health and Care Excellence (2011). **Diabetes in Adults.** (QS06) http://guidance.nice.org.uk/QS6

Public Health England:

Public Health England (2012): **Type 2 Diabetes: Prevention in people at high risk**. (PH38) https://www.nice.org.uk/guidance/ph38

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

Royal College of Physicians (2004) **Type 1 Diabetes – National Clinical Guideline for Diagnosis and Management in Primary and Secondary Care**
http://www.rcplondon.ac.uk/sites/default/files/documents/type-1-diabetes-guideline.pdf

Royal College of Physicians (2009) **Type 2 Diabetes – National Clinical Guideline for Management in Primary and Secondary Care**
http://www.rcplondon.ac.uk/sites/default/files/documents/type-2-diabetes-revised-guideline.pdf

Royal College of Nursing (2012) **Starting injectable treatment in adults with Type 2 Diabetes**
https://www2.rcn.org.uk/__data/assets/pdf_file/0009/78606/002254.pdf

4.3. Applicable local standards

Covered elsewhere in this specification.

4.4 Additional resources

Diabetes UK**:** https://www.diabetes.org.uk

Care planning guidance from NHS England: (2015): https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf

Care planning guidance from NHS England (2015): https://www.england.nhs.uk/wp-content/uploads/2016/04/practcl-del-care-support-planning.pdf

Foot care pathway:
https://shop.diabetes.org.uk/usr/downloads/0997C_PFF%20Pathway%20resource%20update_A2%20v2_amended_PRINT.pdf

Trend UK**:** http://trend-uk.org/

Year of care (care planning):
https://www.yearofcare.co.uk/sites/default/files/pdfs/dh_care%20planning%20in%20diabetes.pdf

Fit4diabetes: Guidance on Injectable therapy:
http://www.fit4diabetes.com/files/4514/7946/3482/FIT_UK_Recommendations_4th_Edition.pdf

5. Applicable quality and safety requirements and CQUIN goals

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

National requirements

- Diabetes QOF indicators (where relevant).
- NICE Diabetes Quality Standards.
- Compliance with the Quality & Safety and Registration & Regulation Standards set by the Care Quality Commission.

Medicines management

The service will be required to have compliance on relevant local and national medicines and prescribing guidance, and the CCG medicines management action plans.

Safeguarding

It is the responsibility of the provider to ensure all staff providing the service undertake regular safeguarding training and follow local safeguarding procedures.

5.2 Safety

The provider shall have a framework that assures patient and staff safety and is supported by a range of policies and strategies including as a minimum:

- Consent policy
- Chaperone policy
- Safeguarding policy / Multi agency policies for children and adults
- Complaints process/policy
- Emergency and contingency procedure policies
- Incident and serious incident reporting (including duty of candour);
- Risk management;
- Clinical (or quality) governance strategy;
- Health and safety policy;
- Infection Control
- Medicine Management
- Whistleblowing

- Equality and Diversity policy

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Not applicable

Appendix 1

Training course	Location	Duration	Cost	Additional information
Diabetes Management in Primary Care (RN)		300 hours (accredited) or 250 hours (CPD) Over 6 months	From £648.00	http://www.primarycaretraining.co.uk/product/diabetes-management-in-primary-care/
Diabetes update - GPs	PPT	Full Afternoon session	Provided by DSN / Consultant Diabetologist	This will be timetabled as part of PPT
Foot care update	PPT / Nurses Forum	Afternoon 2 hour session	Provided via Locala podiatry team	This will be timetabled as part of PPT
Diabetic Foot Screening all primary and secondary health care staff (annual refresher training only)	Health education Yorkshire & Humber have a e-hub e-learning club	1 hour session	NIL	http://www.nwyhelearning.nhs.uk/elearning/yorksandhumber/shared/Catalogue_of_Regional_Courses.pdf Page 33 of the catalogue contains a link to the e-learning module.
Diabetes update – Practice Nurses & HCAs	PPT / Nurses Forum	Afternoon 2 hour session	Provided by DSN & Dietician	This will be timetabled as part of PPT
Care Planning	Nurses Forum	Afternoon 2 hour session		This will be timetabled as part of PPT
Insulin Conversion in People with Type 2 Diabetes in Primary Care (RN)	Primary care training Centre	100 hours (accredited) or 75 hours (CPD) Over 4 months		http://www.primarycaretraining.co.uk/product/insulin-conversion-in-people-with-type-2-diabetes-in-primary-care/
See Diabetes UK for further locations to source training				https://www.diabetes.org.uk
Future training may be available from Wakefield Academy and Huddersfield University				CCG will provide updates as and when this is available.

Appendix 2: Please print off and complete on a yearly basis and send an electronic version through to_____

Name: _____ Job Title: _____

Practice: _____

Core & QOF AQP	Education and Training Criteria for Core, QOF and AQP	Course details/date/location	Date complete or occurred	Name, Signature, date of Practice Manager authorising this document. DSN to sign in designated criteria's.
Core &QOF	Recognised diploma qualification in diabetes			
Core & QOF	Attended a yearly update for diabetes management to meet Core and QOF requirements.			
AQP	Evidence of maintaining competencies by attending a Diabetes course / Diabetes injectable/insulin course or study day in the last 3 years			
AQP	Evidence of attending a Diabetes foot care course or study day in the last 3 years.			
AQP	Evidence of attending an update session on a yearly basis through PPT			
AQP	Annual action plan agreed for Practice Nurse development			

Core & QOF AQP	Education and Training Criteria for Core, QOF and AQP	Course details/date/location	Date complete or occurred	Name, Signature, date of Practice Manager authorising this document. DSN to sign in designated criteria's.
AQP	Evidence of 9 care processes within the care planning (3 care plans have to be reviewed for this AQP) needs to be verified yearly by Practice Manager	**1** **2** **3**		**1** **2** **3**
AQP	Submission of bi-annual data collection information	**1** **2**		**1** **2**
AQP	Signature of DSN to verify on a yearly basis that the Injectable knowledge is current and the Practice Nurse shows continuing development in Injectable management.	**1**		**DSN to Sign** **1**
AQP	Signature of DSN to confirm that the Diabetes Practice Nurse has complied with the minimum of 2 joint sessions with the DSN or consultant on a yearly basis.	**1.** **2.**		**DSN to Sign** **1.** **2.**
AQP	Signature of DSN to confirm that the Diabetes Practice Nurse has complied with joint review of the minimum of 3 patient cases and their care plans for reflective learning and development. To ensure all criteria as mentioned in 3.8 and in the service descriptor 3.2 (is complied with on a yearly basis).	**1** **2** **3**		**DSN to Sign** **1** **2** **3**

On behalf of the above named Practice, I am applying to participate in the service for Managing Diabetes Injectable Therapies

I certify that the above named people have undergone the appropriate training, a record of which is maintained in the Practice for inspection by the CCG and that all aspects of the specification and contract for this service will be adhered to.

Name_____ Signed _____ Date_____

Appendix 3

Audit tool DATA SUBMISSION (6th monthly: End of Q1 & Q3)

Please print off and complete on a 6th monthly basis and send an electronic version through to_____

Practice Name_____ Practice contact_____

Named Contact for Diabetes within the practice: _____

Identify the GP or Nurse who provides the majority of diabetes care_____

Confirmation of what Tier this practice is working to_____

Date of submission: _____Email securely to_____

Time Frame:	Q1 Data	Q3 Data	Q3 additional data required By Age 18-45	46-64	65-74	75+
Total practice population						
Adult Diabetic population (18 years+)						
Number of newly diagnosed in the last 6 months.						
Number of adult patients with Type 1 diabetes						
Number of adult patients with Type 2 diabetes						
Number of adult patients using Insulin						

Time Frame:	**Q1 Data**	**Q3 Data**	**Q3 additional data required** **By Age** **18-45**	**46-64**	**65-74**	**75+**
Number of adult patients using GLP-1						
Number of adult patients under secondary care for diabetes						
Number of adult patients under secondary care (Tier 4)						
Number of referrals to Tier 4 in the last 6 months.	**Urgent** **Routine**	**Urgent** **Routine**				
Number of patients under DSN Care (Tier 3)						
Number of referrals to Tier 3 in the last 6 months.	**Urgent** **Routine**	**Urgent** **Routine**				
Number of referrals returned to primary care in the last 6 months.						
Evidence of collating and reviewing (action plan submitted if required) patient experience information on their service.						
Number of patients who are housebound						
% compliance of annual diabetes review for housebound patients						
Ethnicity by group where this is recorded on their clinical record			**White**	**Asian**	**e.g.**	**e.g.**

Appendix 4

FOOT ASSESSMENT - EVIDENCE TOOL

Aim: To demonstrate competency at performing a diabetic foot assessment for newly diagnosed patients and those at low current risk

Objectives	Objective demonstrated √	Signed – Practice mentor
1. Communicate with individuals and carers throughout the discussion and examination in a manner which is appropriate to them and which encourages an open exchange of views and information		
2. Confirm that the individual understands the purpose and nature of any examinations which need to be carried out, and gives consent		
3. Identify I. gross foot deformities II. evidence of trauma		
4. Assess for peripheral sensory neuropathy using appropriate tools		
5. Assess for peripheral vascular disease by palpating pedal pulses		
6. Examine the individual's footwear and assess its suitability for foot type and risk status		
7. Gather information on subjective symptoms through discussion with the individual		
8. Give basic advice on the care of the feet to prevent injury		
9. Identify the main factors that are likely to limit the individual's ability to care for their feet		

Objectives	Objective demonstrated √	Signed – Practice mentor
10. Take all the relevant information you have gathered into account in assessing risk status		
11. Consult with colleagues, or seek advice from others who are able to assist, where the information you have gathered is difficult to interpret		
12. Discuss the results of the examination with the individual and carer in an appropriate manner, and at a suitable level and pace		
13. Explain any indications of specific problems revealed by the examination		
14. Assess through discussion the individual's understanding of the risks to their feet		
15. Offer written information on foot care in a suitable form for the individual and carer		
16. Arrange further assessment and make appropriate referral when required		
17. Make a record of the examination and any actions to be taken which can be followed by other members of the care team, the individual and carer		

Declaration **I agree that I have met the specified objectives.**		**I agree that the named individual has met the specified objectives**	
Name: (Printed)		**Name: (Printed)**	
Signed: (Individual)		**Signed: (Podiatry/GP Mentor)**	
Date:		**Date:**	
Designation:		**Designation:**	
Practice:		**Organisation:**	

Service Specification No.	**NK2**
Service	Bundle of services
Commissioner Lead	Joanne Davis, Senior Primary Care Support Manager
Provider Lead	N/A
Period	1 April 2021 – 30th September 2021
Date of Review	September 2021

Overview

This specification sets out the requirements for the delivery in primary care of a bundle of services which consists of the following elements:

- Anticoagulation prescribing and monitoring
- Treatment Room Services
- Near Patient Testing
- Provision of Gonadorelin Analogue Treatments under Shared Care Guidelines (Zoladex & Prostap)

1. Population Needs

1.2 National/local context and evidence base

Definitions used in this service specification:
Anticoagulation prescribing and monitoring
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 2016, NICE updated their commissioning guide on anticoagulation therapy[1]. This sets out the evidence base and relevant guidance.

Treatment Room Services (Inc Level One Woundcare)

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

- Level One Woundcare
- Prescription/provision and application of dressings where required
- Administration of pre-operative or post-operative low molecular weight injections (e.g. dalteparin)

Level One Woundcare to include:

- 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).

[1] NICE **Support for Commissioning: Anticoagulation Therapy - Oral** 2016

Near Patient Testing
The treatment of several 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.

Prescribing and Administration of Gonadorelin Analogue Treatments under Shared Care Guidelines (Zoladex and Prostap)
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 (Decapeptyl®)

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.

Triptorelin – This is used in the treatment of cancer of the prostate gland in men and in the management of endometriosis 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.

Monitoring Associated with Amber Drugs
This activity will be monitoring associated with Amber Drugs as defined by the South West Yorkshire Area Prescribing Committee inclusive of Apomorphine and Denusomab.

https://www.swyapc.org/shared-care-guidelines/).

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

Anticoagulation Monitoring and Near Patient Testing
These elements of the service are designed to be those in which:

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

Treatment Room Services (Inc Level 1 Woundcare)
The aim of this element of the service is to provide post-operative wound care and pre-operative preventative care in primary care for those with simple wound or for whom attendance in a hospital setting is not necessary.

Zoladex/Prostap
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 to aim of moving care closer to home.

3.2 Service description/care pathway

Anticoagulation monitoring

This element of the service relates to Level 1 – laboratory outreach sampling, test and dose.

It consists of:

(i) **The development and maintenance of a register.** The Provider should be able to produce an up to-date register of all anti-coagulation monitoring service patients, indicating patient name, date of birth, the indication for, and length of, treatment, including the target INR
(ii) **Call and recall** To ensure that systematic call and recall of patients on this register is taking place either in a hospital or general practice setting
(iii) **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
(iv) **Referral policies** When appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist
(v) **Clinical procedures** To ensure that at initial diagnosis and at least annually an appropriate review of the patient's health is carried out including checks for potential complications and, as necessary, a review of the patient's own monitoring records. To ensure that all clinical information related to the service is recorded in the patient's own GP held lifelong record, including the completion of the "significant event" record that the patient is on warfarin.
(vi) **Record-keeping** To maintain adequate records of the performance and result of the service provided, incorporating appropriate known information, as appropriate. This may include the number of bleeding episodes requiring hospital admission and deaths caused by anti-coagulants
(vii) **Training** The Provider must ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so

Treatment Room Services (Inc. Level 1 Wound Care)
The service will cover:

Level One Wound Care to include:

- 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
- Lower leg wounds (not requiring compression dressings or input from TVN.
- Prescription/provision and application of simple dressings where needed.
- 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 also set out in Appendix 1.

Near Patient Testing

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 2.

Monitoring Associated with Amber Drugs
Monitoring associated with Amber Drugs as defined by the South West Yorkshire Area Prescribing Committee inclusive of Apomorphine and Denusomab.

https://www.swyapc.org/shared-care-guidelines/

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

Practices will be required to provide read coded entries to determine activity in relation to the administration of Prostap/Zoladex.

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

Practices will be required to carry out a blood test prior to the appointment which includes PSA monitoring. The practice will be required to use the Patient Monitoring and Recording template prior to administration of the injection.

The provider will be required to produce a register of all patients currently prescribed Zoladex or Prostap under current shared care guidelines (https://www.swyapc.org/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.

3.3 Population covered

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

3.4 Coding, templates and clinical searches

Practices are requested to make a record of activity using recommended codes, SNOMED codes, templates and searches by the Data quality team. The CCG data quality team will provide practices with the relevant information in relation to coding, templates and clinical searches.

3.5 Any acceptance and exclusion criteria and thresholds

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

3.6 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 relevant 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.

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 (Quality Issue Log).

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 Manager within 72 hours of the information becoming known to the practitioner. This is in addition to a practitioner's statutory obligations.

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 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

NKCCG 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)
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	XaLIF	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****					

RECORDING OF ACTIVITY FOR TREATMENT ROOM SERVICES

Any activity carried out under this service should be recorded in the Patient Record, coded as follows:
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[2]) should be completed and returned to the Tissue Viability Nurse, 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

[2] The Joint Wound Management Formulary (JWMF) 2016 addition produced by The Joint Wound Management Formulary Group, Original date: March 2008; Fourth review date: May 2016 https://www.swyapc.org/wp-content/uploads/2017/09/Wound-Formulary-4th-Edition-v2-20-9-2017.pdf

APPENDIX 2

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

The Provider should

a) send an anonymised copy of the practice register through to the CCG by 15th January each year.

b) undertake an annual audit of patients prescribed lithium in accordance with the NPSA Patient Safety Alert 5 'Safer Lithium therapy' 1 December 2009.

APPENDIX 3

Lithium Audit Form

Practice code		Date audit completed	

Service Specification No.	**NK3**
Service	24hr Ambulatory Blood Pressure Monitoring (ABPM)
Commissioner Lead	Joanne Davis
Provider Lead	
Period	1st April 2021 to 30th September 2021
Date of Review	September 2021

1. Population Needs

1.3 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 a diagnosis of hypertension should be made using 24-hour ambulatory blood pressure monitoring (ABPM). This should be offered to patients 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.

The implementation of NICE guidance will increase level of ABPM required and there is a need to improve access and equality of access to ABPM across North Kirklees.

In the absence of easy access to ABPM there is the increased risk that patients may be unnecessarily 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 unnecessarily labelling of patients as hypertensive
- To identify patients at increased cardiovascular risk because of hypertension more accurately
- To initiate treatment for hypertension before the onset of target organ damage
- To introduce the concept of patient self-monitoring
- To reduce unnecessary referrals to secondary care
- To remove or prevent unnecessary treatment

- Equity across North Kirklees
- Improved access to services for patients closer to home
- Better utilisation of existing expertise and capacity in primary care/the community
- Delivers NICE guidelines effectively

3.2 Service description/care pathway

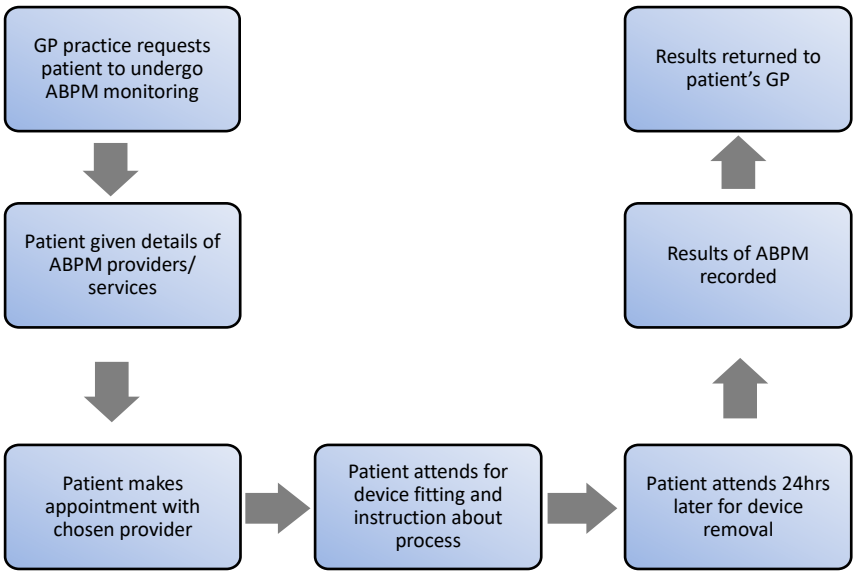
This service relates to the provision of 24hr Ambulatory Blood Pressure Monitoring as a planned diagnostic test.

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, and details of who to contact in case of difficultly. Patients will be encouraged to keep a diary.

Day Two – the patient re-attends for removal of the device. The device is processed and as a minimum the mean daytime, systolic and diastolic will be recorded on the Provider's system.

24HR AMBULATORY BLOOD PRESSURE MONITORING PATHWAY



The Provider will accept referrals via an agreed referral process from all GP practices within North Kirklees CCG area (see Appendix 1) and will ensure that:

- Referred patients are contacted within one week of the referral being received;
- Referred patients are offered a choice of appointments within the following two weeks;
- Monitoring results are reported to the patient's GP as soon as possible but within five working days of the test;

If the Provider has an indication that a secondary care follow up is required they shall:

- Notify the referring GP by telephone or fax within 24 hours;
- The referring GP will make the appropriate secondary care referral;
- A formal communication, from the Provider, confirming monitoring results shall be sent to the referring GP and patient within 48 hours.

http://publications.nice.org.uk/hypertension-cg127

3.3 Population covered

The service is to be provided to adults registered with a GP practice in the North Kirklees area (see Appendix 1).

3.4 Any acceptance and exclusion criteria and thresholds

- Adults registered with GP practices that are not in the North Kirklees CCG area
- 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

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The service will be provided in accordance with NICE Guideline CG127 – Clinical Management of Primary Hypertension in Adults.

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 2.

5. Applicable quality requirements and CQUIN goals

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

The Quality and Performance Indicators for the service are set out in Appendix 3.

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:

7. Individual Service User Placement

Not applicable

APPENDIX 1

GP PRACTICES IN NORTH KIRKLEES CCG

Albion Mount Medical Practice
Blackburn Road Medical Centre
Brookroyd Limited
Broughton House Surgery
Cherry Tree Surgery
Cook Lane Surgery
Dr Hassan & Zia, Batley Health Centre
Dr Mahmood, Ravensthorpe Health Centre
Calder View Surgery
Dr Y Patel, Slaithwaite Road
Eightlands Surgery Limited
Greenway Medical Practice
Grove House Surgery
Healds Road Surgery
Kirkgate Surgery
Liversedge Medical Centre
Mirfield Medical Practice Limited
Mount Pleasant Medical Centre
The Sidings Healthcare Centre
North Road Suite, Ravensthorpe Health Centre
Parkview Surgery, Cleckheaton Health Centre
Savile Town Medical Centre
Cleckheaton Group Practice
The Paddock Surgery
Undercliffe Surgery
Wellington House
Windsor Medical Centre

APPENDIX 2

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 North Kirklees CCG infection control policy (which incorporates adherence to manufacturers' instructions)
- The Provider will ensure monitoring equipment is checked and regularly calibrated in accordance with the manufacturer's guidance;
- Replacements and service maintenance arrangements will be managed and paid by the Provider, direct with the approved 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 manufactures 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.

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

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 adhere to the arrangements on performance information set out in Appendix 3.

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

This information is to be provided to NKCCG. A template will be issued to the Provider, by the CCG and will be requested to return this within a two week period at the end of the reporting schedule. In order to comply with the monitoring, it will be necessary for the Provider to code the details on their system, to enable a report to be produced with the outcomes. This information is required for evaluation of the overall service by the commissioners.

APPENDIX 3

Quality/ Performance Indicators	Indicators	Threshold	Method of Measurement	Consequences of Breach
Outcomes	A) Number of Patients who have completed a period of 24 hour ABPM monitoring	N/A	• Provider will receive a standard template from the commissioner to complete. (where possible this will be embedded into the IT system for completion at the time of consultation) • The Provider will record all the outcome measures for each episode of treatment • The Provider will submit an audit including all the measures • The audit will cover one calendar month (month to be determined) • For Evaluation purposes and financial performance monitoring, all records must be completed. • The Provider will also supply an exceptions report for the audit month highlighting where the information was not recorded and why the outcomes were not met	Review between CCG and provider
	B) Percentage of those patients who were contacted within a week of the referral being received	95%		
	C) Percentage of those patients whose monitoring was undertaken within two weeks of contact being made with them	95%		
	D) Percentage of those patients whose results were provided to their GP within five working days of the completion of their monitoring	95%		
	E) Number of failed measurements of the monitoring equipment (number of incomplete reports)	N/A		
	F) Number of patients requiring a retest as a result of failed measurements/incomplete reports	N/A		

ervice Specification No.	**NK4**
Service	Community Phlebotomy Service
Commissioner Lead	Joanne Davis
Provider Lead	
Period	1st April 2021 to 30th September 2021
Date of Review	September 2021

1. Population Needs

1.4 National/local context and evidence base

There is a general increased demand for phlebotomy which is community based, due to increasing Long Term Conditions management needs and the shift of services away from secondary care.

The proposal is to maximise the facilities in the community, increase phlebotomy provision by the appropriate personnel and ensure demand is met closer to home and at more convenient times/locations for patients by making the service available more widely.

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

- Patients will have access to blood tests in a variety of settings/locations
- Minimise patient waiting time.
- Reduce patient travel time.
- Reduce anxiety to patients.
- Improve access to phlebotomy to patients attending outpatients.
- Enable staff to spend more time with patients.
- Reduce stress levels to staff, enhancing the service to patients.

3. Scope

3.1 Aims and objectives of service

Aim

To provide a phlebotomy service for GP-requested pathology for patients registered with practices in North Kirklees CCG.

Objectives

- To provide an equitable service for all users.
- To provide equality for all users.
- To redesign the Phlebotomy Pathway with added flexibility and choice of location.
- To ensure appropriate resources are available in the community to undertake Phlebotomy.
- To make phlebotomy service available closer to patients' homes.
- To provide a cost effective service.

- To offer continuity of care for the patients in familiar surroundings.

3.2 Service description/care pathway

A Phlebotomy service will be made available to all patients in a range of approved settings/locations.

The service will be provided by a trained phlebotomist.

Patients will access the phlebotomy service via a Primary Care Health Professional completing the appropriate request form. The patient will have a choice of how to have the required phlebotomy delivered, which will include:

- Patient accessing a blood test at the same time as seeing a clinician in primary care or community care
- Patient being offered a further appointment for the phlebotomy within primary or community care

The Provider will offer a phlebotomy service that will offer drop-in or bookable slots. An appointment must be available within two working days of request/referral/requirement.

The Provider is required to ensure that sufficient trained members of staff are available to meet the service demand at all times including periods of annual leave and sickness.

The Provider must deliver a phlebotomy service for 90% of patients requesting the service from that provider, within 6 months of the commencement of the scheme.

The Provider is required to ensure that all premises and equipment comply with all current NHS standards, good clinical practice and good healthcare practice, legislative standards and any applicable quality standards and that they are clean, safe and sufficient.

The Provider must have in place appropriate health and safety and risk management systems that adhere to:

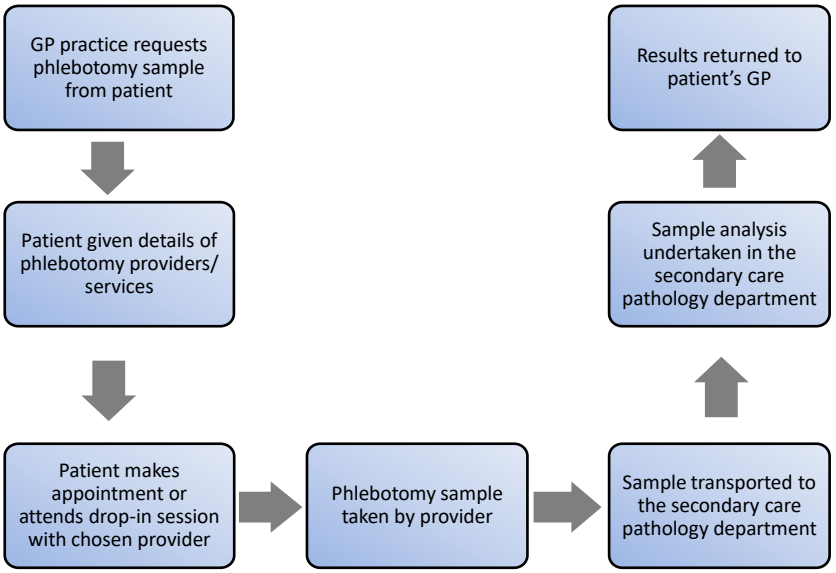
Department of Health Primary and Social Care Premises and Planning and Design Guidance (www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership) and www.dh.gov.uk/en/Publichealth/Healthprotection/Healthcareacquiredinfection,

The Waste Management Guidelines for North Kirklees CCG must be adhered to.

Service Outline

1. GP/healthcare professional, having decided a blood sample is required, will ensure the patient does not fall within the exclusion criteria for the service and will complete the appropriate requisition slip with GP practice details.
2. Patient will be advised of potential providers and their availability/accessibility.
3. Patient makes/attends appropriate appointment and venepuncture undertaken; the Provider logs details of patient contact on appropriate system.
4. Collection of specimens - taken to secondary care pathology department through individual provider arrangements.
5. Results returned to patient's GP practice.

COMMUNITY PHLEBOTOMY PATHWAY



The service will be provided between Monday and Friday with hours of provision to meet patient demand, clinical, laboratory and transport needs.

GP/healthcare professional having decided a blood sample is required will complete the appropriate requisition slip with GP practice details.

Patient's attendance, with an appropriate and valid request form, will be taken as implied consent for blood to be taken.

Referral route
Patient identified as requiring a blood test.

Patient is given information regarding potential providers by the referring GP practice.

It is the patient's responsibility to book the appointment with the chosen provider.

Discharge planning and criteria
Providers must ensure forms are fully completed with all appropriate patient identifiable details and that the correct labelling of samples is adhered to prior to discharge and all samples requested are collected.

A record must be kept of all patients seen including dates/times of attendance and their registered GP.

Self-care and patient and carer information
Eligible patients will have been offered a choice of phlebotomy provider for service provision at the point of referral.

3.3 Population covered

Provision of a community based Phlebotomy service for routine adult patients and children over the age of five years who are registered with a GP within North Kirklees CCG listed in appendix 1. Separate services are commissioned for children less than 5 years, housebound and hard to bleed patients.

3.4 Any acceptance and exclusion criteria and thresholds

- Children up to the age of 5
- Patients who are clinically assessed as difficult to bleed patients (the CCG has commissioned separate services to meet the needs of these patient groups).

- Where bloods are taken at MYHT e.g. INR
- Where funding is available through any other community-based services commissioned by the CCG

3.5 Interdependence with other services/providers

The provider will work closely with all the North Kirklees CCG GP practices to ensure communication of service availability. The Provider will inform North Kirklees CCG of the availability of all Phlebotomy services and any changes so that an up to date list of phlebotomy services available to patients across the area can be provided to all practices.

Specimen bottles will be made available to all providers. At this stage providers should assume that these must be collected from Mid Yorkshire Hospitals Trust Pathology Department or a local delivery point already in existence.

It is the responsibility of the service provider to arrange for the timely transport of samples to the pathology laboratory commissioned by North Kirklees CCG to analyse the samples, currently Mid Yorkshire NHS Trust, for analysis. This transportation must be in accordance with the law, good clinical practice and good healthcare practice and in line with guidance provided by and as from time to time revised by the Mid Yorkshire NHS Trust Pathology Laboratory (or as advised) this includes the timely receipt of the samples at the laboratory.

Where Providers have existing transport arrangements these will continue for transportation of samples to the laboratory. The CCG will periodically review the transport arrangements to ensure these meet the demands of all providers and the laboratory.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Department of Health Public health and Health protection guidance

Department of Health Health Technical Memorandum 07-01: Safe Management of Healthcare Waste

Waste Management Guidelines for North Kirklees CCG

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

There are no relevant standards from the Royal Colleges.

4.3 Applicable local standards

Once the patient requests an appointment, this should be offered within two working days of the request of the blood test or of the clinical need, as appropriate.

Provider must deliver a phlebotomy service for 90% of patients requesting the service from that provider, within 6 months of the commencement of the scheme.

5. Applicable quality requirements and CQUIN goals

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

The Quality and Performance Indicator requirements for the service are set out at Appendix 2.

The provider shall also:

- Ensure that the service environment is clean, adequate, functional and effective and fit for the purpose of providing the service.
- Provide a chair which is vinyl and ideally has the ability to fold flat, or a clinical couch.
- Provide a Multi-height stool for phlebotomist use.
- Provide access and facilities for patients with disabilities, in accordance with the Disability Discrimination Act 1995

- Have a procedure for dealing with any vasovagal fainting episodes.
- Provide vinyl floor covering in the clinical area, or have an agreed, time bound action plan to meet this specification.
- Provide a clinical hand wash basin in the clinical area.
- Provide suitable storage for consumables
- Ensure compliance with hazardous waste procedures.
- Ensure the service environment meets the patient's requirements for dignity and privacy.
- Ensure reasonable access to appropriate translation services as required.
- Be able to demonstrate that evidence-based clinical protocols are being used. E.g. Needle stick injuries.
- Be responsible for all consumables required to deliver the service, with the exception of the provision of specimen bottles.

Accreditation requirements

- The provider is required to ensure that all personnel involved in the clinical delivery of the Phlebotomy service can demonstrate competence, as a minimum to the levels described in the National Occupational Standard HSC376 training (www.skillsforhealth.org.uk), which includes a period of mentorship.
- Evidence of staff appraisal on an annual basis and at an appropriate level is required.
- The provider is required to ensure appropriate indemnity insurance cover is available.

5.6 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

7. Individual Service User Placement

Not applicable

Service Specification No.	**NK5**
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

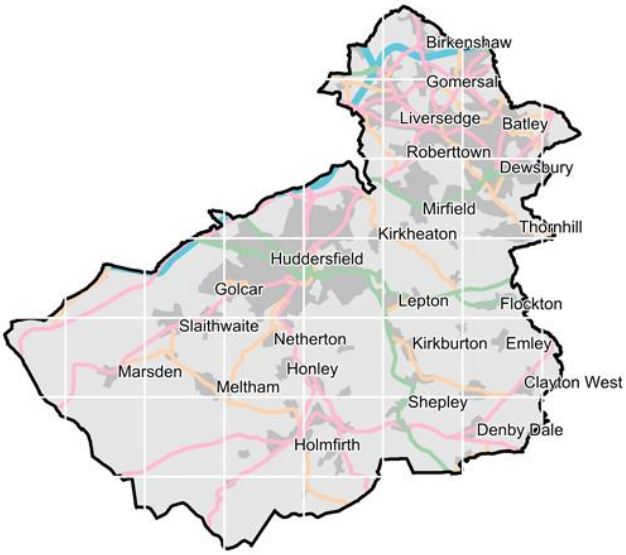
1. Population Needs

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.

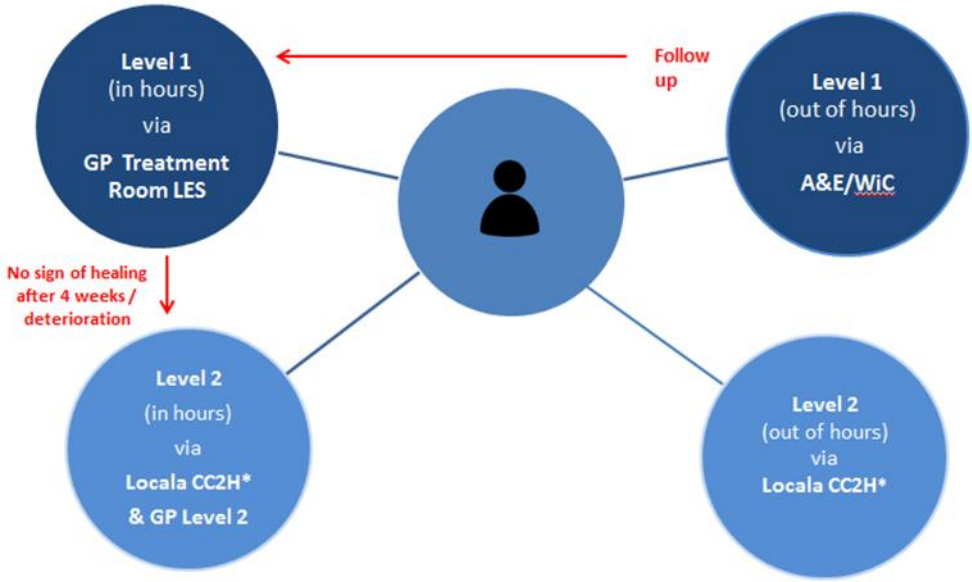
The overall aim and objectives of the Level 2 wound care service is to:

- 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

Kirklees Wound Care Pathway



* 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 quality 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)