

2021/22 UNIVERSAL OFFER SPECIFICATION

Service	GP Universal Offer Specification
Commissioner Lead	Camden CCG
Provider Lead	GP Practices
Period	1 April 2021 to 31 March 2022

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1. Introduction

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NCL CCG is commissioning services that must be delivered by local GP practices to registered patients, ensuring equitable access and quality of service to the entire registered population.

The GP Universal Offer specification covers enhanced aspects of general practice-based clinical care which are beyond the scope of core GP services and the Quality and Outcomes Framework. No part of the specification by commission, omission or implication defines or redefines core or additional services.

The provision of this service will not be prejudicial to those common principles that underpin the General Medical Services (GMS)/Personal Medical Services (PMS)/Alternative Provider Medical Services (APMS) contract to ensure minimum standards are met and encourage high-quality care.

This service specification outlines the services to be provided by Camden practices, to deliver universal access to enhanced services for Camden registered patients.

The Universal Offer is expected to improve patient outcomes and experience, access and quality, and reduce pressure in secondary care (via reducing Accident & Emergency [A&E] attendance and admissions). The Universal Offer will be funded from the Local Enhanced Service (LES) budget.

The clinical aspect of the Universal Offer has been led by Camden GPs, through stakeholder working groups, with locality committee and Local Medical Committee (LMC) involvement.

2. Aims

The specification aims to:

- Support the delivery of a consistent, equitable and high-quality Primary Care Enhanced Service offer to the registered patients in Camden.
- Improve patient access to a set of services that meet the needs of the local population, supporting the CCG's strategic objective to deliver care as close to home as possible, and the primary care mandate to deliver universal coverage of locally-commissioned services.
- Improve the health outcomes of patients, reduce inequalities and ensure the most cost-effective use of resources.

3. Scope

The Universal Offer is made up of the following 10 services:

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1. Enhanced Care Planning
2. Neighbourhood Outcomes (includes activity payments for Ambulatory Blood Pressure Monitoring)
3. End of Life Care
4. Post-Operative Wound Care
5. Asthma Service for Children and Young People
6. Childhood Immunisation
7. High Risk Drug Monitoring
8. Direct Oral Anticoagulants (DOACs) Initiation
9. Homelessness
10. Prostate Cancer

This specification is designed to cover the enhanced aspects of care, which are considered to be beyond the scope of essential services and additional services.

4. Eligibility and Exclusion Criteria

In order to provide the Universal Offer services, providers will:

- Be fully compliant with all requirements of GP core contracts (GMS, PMS or APMS) and the requirements of the additional services, as set out within this specification.
- Comply with the CCG's quality alert processes, reporting and responding to quality alert investigations where necessary. Practices undergoing remedial processes will be excluded from the offer; the CCG will establish arrangements to ensure continuity of patient care. Where the CCG believes a practice is not complying with the terms of the contract it should invoke a remedial notice according to the procedure laid out in Regulation.

5. Quality and Safety

- Practices making claims for payment will be required to complete and submit EMIS web searches and reports in accordance with the submission schedule (see Section 7 – Monitoring and Payment schedule).
- All practices delivering the Universal Offer must provide assurance that they are compliant with all stipulations outlined in Section 4 (Eligibility and Exclusion Criteria); with the eligibility criteria for each service, as well as the following:
 - The practice is registered with the Care Quality Commission (CQC)
 - The practice must have evidence of appropriate Indemnity Arrangements
 - The practice meets requirements of NHS England (NHSE) for the provision of Core, Additional services and any related Directed Enhanced Service (DES)

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- or National Enhanced Service (NES) that the practice are commissioned to deliver.
 - Practices participating in the Universal Offer will comply with NICE guidance 'Healthcare-associated infections: prevention and control in primary and community care', March 2012 –updated February 2017.
<https://www.nice.org.uk/guidance/CG139>
 - Practices must have an up to date Safeguarding Policy for Adults and Children which clearly outlines their responsibilities in relation to the Mental Capacity Act and how to make a Safeguarding referral.
- Practices are to report all patient safety incidents (including near misses, significant events) to the National Reporting and Learning System (NRLS) through the GP e-form https://report.nrls.nhs.uk/GP_eForm whether they result in harm or not and as soon as they are identified and prior to the investigation commencing. Reporting incidents to a national central system (NRLS) helps protect patients from avoidable harm by increasing opportunities for the NHS to learn when things go wrong.
 - Practices are to report Serious Incidents (SIs), complaints and patient feedback relating to Universal Offer services to the Camden CCG Primary Care Commissioning Team (camdenlcs@nhs.net) and Quality & Safety Team (via secure email gands.camdenccg@nhs.net). SIs must be reported within 24 hours following identification.
 - Please see 'incident reporting' page of the GP website for further information <https://gps.camdenccg.nhs.uk/practice-management/incident-reporting>
 - Providers shall ensure that the workforce delivering the Universal Offer meet the following requirements:
 - All GPs on the Camden Performers List
 - Appropriately trained, qualified and competent staff in place to deliver each service requirement.
 - Where applicable, clinical staff are trained and competent to work under relevant Patient Group Directions (PGDs) or Patient Specific Directions (PSD).
 - Cold chain policies and procedures are in place and adhered to by staff members.
 - Infection Control policies and procedures are in place and adhered to by staff members.
 - Staff members are up to date with mandatory training, including appropriate level of Safeguarding Children and Safeguarding Adults.
 - The CCG reserves the right to audit and require action plans of those providers identified with significant changes in eligible population for a given service, and / or with significant under- or over-delivery of anticipated service activity (with reference to previous years)

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6. Services

6.1 Enhanced Care Planning

Service Aims

The aims of this Enhanced Care Planning service are:

- To improve the health and wellbeing of people living with Long Term Conditions (LTCs), including serious mental illness and those with frailty due to age or other cause.
- Improve the quality and consistency with which people with these LTCs are identified and proactively managed in Camden general practices.
- To improve the quality and coordination of care for patients with complex needs and those at greatest risk of unplanned admission, readmission and A&E attendances.

This enhanced care planning service is part of the CCG's wider commissioning strategy which aims to drive improvements in population health outcomes (through supporting the achievement of neighbourhood clinical outcome targets); and to facilitate neighborhood-based multi-disciplinary working in line with the CCG's objectives for integrated care.

Eligibility and exclusion criteria

The eligible cohort for Enhanced Care Planning are patients with complex needs, who are at higher risk of an unplanned admission, and who would benefit the most from anticipatory care planning and a person-centred approach to care.

This includes people in the following three groups:

1. Serious Mental Illness (SMI) – Patients on the general practice SMI register who are not under the Specialist Mental Health service but are managed in primary care.
2. High Risk Long Term Conditions – As per criteria set out in the table below.

Condition	Criteria
CKD	On practice CKD register with latest eGFR <45 in the last 12 months
COPD	On practice COPD register
	Admission to hospital or seen in ED for COPD in the last 12 months or 3 more exacerbations in the last 12 months
	OR One or more exacerbations in the last 12 months AND current smoker

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Diabetes	On practice diabetes register with latest HbA1c greater or equal to 75 recorded in the last 12 months
Heart Failure	On practice HF register with LVSD

3. Frailty (Moving to the integrated care cohort) – This refers to patients on the general practice frailty register who have been assessed as being at high risk of an adverse event (i.e. A&E attendance or hospital admission) and those who would benefit from multidisciplinary team input.

Service Specification

The service will fund the creation and completion of personalised care plans for eligible patients (using the EMIS template). The creation of a care plan with the patient (and carer) is an annual process and providers will be expected to keep the care plan up to date.

It is the CCG's intention to implement a Camden-wide case finding tool via the North East London Information Exchange (NELIE) or equivalent platform to support the identification of people who would benefit the most from a multidisciplinary/ integrated care approach

NELIE supports clinical decision-making by bringing together primary and secondary data, enabling searches for people on the general practice frailty registers who are admitted to hospital – supporting more focussed, anticipatory care planning to reduce the risk of future hospital admissions.

Pending implementation of a Camden-wide case finding tool, practices are expected to give consideration to the below additional criteria to identify patients on practice frailty registers who would benefit the most from an enhanced care planning approach. This includes:

- Patients who have 2 or more non-elective admissions for ambulatory care sensitive conditions (ACSCs) within the past 12 months. ACSCs are a set of conditions where effective community care and case management can help prevent the need for hospital admission. Even if the ACSC episode itself is managed well, an emergency admission for an ACSC is often a sign of the poor overall quality of primary and community care¹.
- Patients who have attended A&E more than twice in the past 12 months
- Patients who are at risk of hospital admissions for injury related to fall, irrespective of age

Practices are required to code secondary care usage activity (i.e. ACSC admissions, other admissions and readmissions and A&E attendances) for patients on the frailty register following an admission/attendance upon review of patient and the discharge summary.

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/03/red-acsc-em-admissions-2.pdf>

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Enhanced care planning (ECP) process:

- Providers shall invite all eligible patients (and carers) for an ECP appointment using a systematic call and recall system to maximise uptake
- The development of the care plan should be a collaborative process and must take place in conversation with the patient (and carer/family) and other involved members of the primary care and community team
- The care planning process should be person-centred, clearly articulating the goals of the patient (and carer), and integrated team members and specialists where relevant.

This process must include:

- A detailed clinical review, using motivational interviewing techniques
- Agreement of key actions and contact points for escalating care during crisis / exacerbation
- Consideration of the needs of the patient's carers
- Agreement of follow up appointments within 12 months to review patients and monitor their progress against goals and changes in their clinical status
- Consideration of patient activation tools and measures to support and improve self-management
- Completion of EMIS template and creation of care plan. The patient (and carer) should be provided with a paper copy of their care plan at the end of their consultation

N.B. The format of the Enhanced Care Planning template and how it is recorded is being updated in collaboration with other stakeholders under the guidance of the Integrated Care Partnership. This is fundamental to integrated working between primary care and community providers around patient needs. EMIS tools will be updated accordingly. It is expected that care plans will be completed with all the relevant details and will be updated continuously to reflect any changes to the patient's situation or goals (See Quality and Performance Monitoring section below).

To Note:

- The target for Enhanced Care Planning completion is set at 95%, based on the eligible population to be defined at month preceding the start of the 2021/22 financial year. This is with the exception of SMI. The target for completion of care planning activity for this cohort is set lower at 85% given the recognised complexity of care planning for this population.
- Enhanced Care planning activity will be paid in quarterly instalments in advance from Month 1. The final reconciliation payment will be made at the end of the year as per the below table.

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For High Risk LTCs and Frailty/IC:	For SMI only:
<ul style="list-style-type: none"> - The quarterly instalments will cover the cost of 95% completion of enhanced care planning reviews - Payment will be based on the eligible population for each practice - There will be an end of year reconciliation of practice delivery against the 95% target which is the maximum payment based on the budget available; <ul style="list-style-type: none"> • 90%-95% No change in payments • 50%-89% Payments recouped proportionally to activity not delivered • <49% recoup 100% 	<ul style="list-style-type: none"> - The quarterly instalments will cover the cost of 85% completion of enhanced care planning reviews - Payment will be based on the eligible population for each practice - There will be an end of year reconciliation of practice delivery against the 85% target which is the maximum payment based on the budget available; <ul style="list-style-type: none"> • 80%-85% No change in payments • 50%-79% Payments recouped proportionally to activity not delivered • <49% recoup 100%

- Care planning and clinical reviews are to be initiated by a GP, Specialist Nurse, or appropriately trained and competent healthcare professional (e.g. Practice Pharmacist or Practice Nurse) with the knowledge and skills in the relevant long term condition/s.
- Providers will use the care plan to support the coordination of patient care including referral and signposting to the Neighbourhood MDT, the Hub MDT or other relevant services/ health and care professionals (e.g. care navigation, social prescribing, allied health professionals etc.).
- Providers will take part in Neighbourhood or Hub multidisciplinary team meetings (MDTs) and utilise the care plan to facilitate communication and the delivery of patient care between MDT members.
- Providers are required to record summary details of the MDT meeting (template available on GP website).
- The CCG reserves that right to undertake an audit to ensure the quality of care planning activity commissioned under this service. For example, the audit will assess the care plan in terms of person-centeredness and for evidence that the care planning process is aligned to wider MDT processes and ways of working.

Quality and Performance Monitoring

- For further details of monitoring please see document, 'Universal Offer Monitoring & Payment Schedule'

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- Additional information on enhanced care planning, SMI & list reviews is available on the Planned Care page of the GP website.
- Providers can choose to use the 'Year of Care' (YOC) Care Planning approach for patients with high risk diabetes and/or COPD. For these patients the following additional activities can be delivered:
 - Invite patients prior to the ECP appointment to a preparation meeting to undertake tests and open discussion about the patient's personal goals
 - Record as part of the consultation disease surveillance information as indicated by the relevant clinical template
 - Send the patient prior to their ECP appointment a letter that includes the results of tests and prompts for personal goals
- Information is available on the YOC planning approach on the Care Planning section of the Camden CCG website; <http://camdenccg.nhs.uk/gps/ltc-care-planning-project.htm>

6.2 Neighbourhood Outcomes

The approach for Neighbourhood Outcomes will be developed in consultation with primary care stakeholders, drawing learning from 2020/22 and with consideration to Covid recovery priorities. It is envisaged that an agreed approach to Neighbourhood Outcomes will be finalised in Q1 (2021/22).

6.3 End of Life Care

Service Aims

The aims of this End of Life Care (EoLC) service are:

1. To ensure that patients are treated in the most appropriate environment, according to their end of life wishes where practical.
2. To reduce, across Camden as a whole, the number of avoidable hospital admissions for patients nearing the end of life and thus reducing secondary care spend.

Service Specification

The service will fund:

- Completion of After Death Analysis (ADA) leading to the completion of a practice action plan that is reviewed annually.
- Attendance at annual neighbourhood meeting to review the ADAs and action plans. The meeting will be facilitated by the Last years of Life Clinical Lead.

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- Creating Co-ordinate My Care (CMC) records for those patients at each practice with documented End of Life Care wishes/Urgent care plans, and updating those records with the patient's preferred place of death as well as when a patient dies.

To note:

The service applies to all patients who are nearing the End of Life whether they are on the palliative care register or not.

The Provider will undertake the following:

- Conduct ADA of deaths over a three-month period, between October and December, accompanied by an action plan – see action plan template on [GP Website – Universal offer page](#).

To Note:

- Deaths that could not reasonably be anticipated would be excluded, including suicide, trauma, and still births.
- There is no limit to the number of deaths that can be subjected to an ADA over the 3-month period reviewed; however, where this is less than five then the numbers can be made up to five by extending the period up to, but not more than, one year.
- Nominate a practice EoLC Lead and send their name and details to camdenlcs@nhs.net. It will be necessary to update the CCG if/when this lead changes.
- Complete Co-ordinate my Care (CMC) in Camden form, having had and recorded the conversation with the patient regarding EoLC wishes;
 - Individual GPs/Clinicians/admin staff will have obtained authorisation to use the CMC register (username and password) after attendance of CMC training. Training can be updated in-house by contacting cmc_training@nhs.net.
 - To publish a CMC personalised urgent care plan so that other services can see there is a minimum set of essential information.
- Meet with the Last Years of Life Clinical Lead. Each practice is to ensure a clinical representative attends the annual event to review the ADA and action plans (in neighbourhood groupings) facilitated by the Last Years of Life Clinical Lead.

To Note:

- In advance of the meeting, practices will: carry out their ADA, review previous year's action plan, propose an action plan for the coming year and forward to the Last Years of Life Clinical Lead.

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Quality and Safety

An annual dashboard will be produced by the CCG IT Team prior to the Neighbourhood peer review meetings. Key findings from the dashboard will be reported annually to the group overseeing the performance and delivery of the Universal Offer. This annual dashboard will draw on data available from various sources including:

- EMIS Data
- CMC data
- The IT and systems team, the Last years of Life Clinical Lead, will also liaise with Public Health to incorporate relevant information from national sources.

Quality and Performance Monitoring

For details of all monitoring please see document 'Universal Offer Monitoring & Payment Schedule'

6.4 Post-Operative Wound Care

Service Aims

The aims of the Post-Operative Wound Care service are:

1. To ensure that ambulatory patients requiring post-operative wound care have access to services within primary care, enabling continuity of care and consistent review.
2. To ensure that patients are not attending urgent and emergency care centres in order to have their wounds managed.

Service Specification

The service will fund:

- Removal of sutures and general wound care management for ambulatory patients who have been discharged from secondary care, following a hospital day case or inpatient procedure.

Eligibility and exclusion criteria:

Under the conditions of this agreement, the provider has the responsibility to ensure that:

- Practitioners undertaking suture removal should have had training in surgical environments or been taught and confirmed as competent by an experienced clinician.

This service does not include:

- Management of dressings required as a consequence of a procedure carried out in primary care either under GMS/PMS/APMS or as part of a locally commissioned

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service (minor surgery or minor injury). In such cases the wound management is included as part of those specifications.

- Complex wound care or wound care for house bound patients
- Treatment of leg ulcers

The Provider will:

1. Offer this service Monday to Friday, for all registered patients.
2. Provide post-operative suture removal for patients. The term *suture* includes: stitches, staples and clips
3. Provide post-operative wound care management to patients that have been referred by the hospital, District Nurses, Urgent Care or A&E.
4. Deliver wound care assessment and treatment using evidence-based wound care management.
5. Support self-management of wounds and provide relevant information to patients to facilitate this.
6. Refer housebound patients to the community service provider.
7. Ensure effective, clear communication and partnership working with practice nurses, GPs, District Nurses (DNs), General Practice Nurses (GPNs) and Tissue Viability Nurses (TVNs).
8. Use wound management products in line with Camden Prescribing Recommendations (CPR) and Camden wound management guidance, including the recommended frequency (usual wear time).

Quality and Safety

Accreditations and Qualifications

The Provider will ensure:

- All staff delivering the post-operative wound care service adhere to infection control best practice, are appropriately trained and competent to assess the wound, to escalate for further treatment, where indicated; and apply appropriate wound dressing where indicated.
- Practitioners undertaking suture removal under this service shall have had training in surgical environments or been taught and assessed as competent by an appropriately experienced clinician.
- Practitioners delivering this services understand and implement infection control processes to reduce the risk of secondary infection.

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- Practitioners have the knowledge and experience to advise patients on signs of wound infection and enable self-care where appropriate.
- Where Healthcare Assistants are carrying out activity for this service, the provider must ensure that HCAs have completed specific wound care training and been assessed as competent in this area. HCAs must also be supervised by, and accountable to a registered nurse.

An annual audit report must be submitted to the CCG. Please see [GP Website – Universal offer page](#) for information.

Under the conditions of this agreement, the Provider has the responsibility to ensure that:

- The service will maintain a safe and suitable environment for patients and staff and comply with all relevant statutory governance requirements, legislation, Department of Health Guidance, Professional Codes of Practice, Standards for Better Health, NICE guidance 'Healthcare-associated infections: prevention and control in primary and community care', March 2012 –updated February 2017.
(<https://www.nice.org.uk/guidance/CG139>) and all Health and Safety regulations

Quality and Performance Monitoring

EMIS Web to be used to record activity related to the provision of this service. Practices will need to manually submit activity and complete a quality workbook at the end of the year.

For details of all monitoring please see document 'Universal Offer Monitoring & Payment schedule'

6.5 Asthma Service for Children and Young People

Service Aims

The aim of the Asthma Service for Children and Young People (C&YP) is:

1. To reduce the number of children and young people with unmanaged asthma by:
 - Improving the asthma diagnosis in under 19-year-old patients
 - Reducing variability in diagnoses of asthma
2. To support children and young people with asthma and their families to manage their condition more effectively by:
 - Increasing the number of children and young people diagnosed with asthma who have an asthma management plan in place
 - Ensuring that asthma reviews and management plans are developed jointly between clinicians and families

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Service specification

The service will fund:

- Case finding as outlined below (case finding to be completed annually)
- Extended asthma review and management planning appointments as outlined below.

The Provider will

1. Run and view searches created by Camden GP IT within EMIS Web. These include:
 - Asthma/COPD Associated codes last 1 year (not on COPD/asthma register)
 - Asthma/COPD Beta2adreno >2 issues 1 year (not on COPD/asthma register)
 - Asthma/COPD Corticosteroid 2+ issues 1 year (not on COPD/asthma register)
 - Asthma/COPD Inhalers 3+ times in 12 months not on COPD/asthma register
 - On inhalers without asthma or COPD code
 - Smokers/ex-smokers with obstructive spirometry without COPD or asthma code
 - Not on asthma or COPD register but taking Prednisolone
2. Review notes of all C&YP that meet one or more of the above search criteria and identify patients where an asthma diagnosis is a possibility.
3. Call in all C&YP identified to either make or refute a diagnosis of asthma.
4. Following the Case Finding and Notes Review process, complete the reporting template (Asthma – CYP Case Finding template) available on the Universal Offer page of the GP website. Templates to be submitted to Camden CCG camdenlcs@nhs.net
5. Schedule under 19 years old patients newly diagnosed with asthma for an extended 20-minute appointment and schedule an asthma review appointment for all children and young people on the practice asthma register. In the appointment:
 - Undertake a structured clinical review using the designated asthma EMIS template. The 9 parameters within the review template are to be completed.
 - 1) BMI (in last 3 months)
 - 2) Exposure to passive smoking
 - 3) RCP/ACT questions
 - 4) Demonstrated/assessed inhaler technique (box on patient record/READ code 6636)
 - 5) Following BTS/SIGN guideline
 - 6) Asthma Medication review
 - 7) Asthma Review (QOF)
 - 8) Email sent to school nurse
 - 9) Written Management Plan

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- Complete the action plan and provide the patient with a paper copy of their care plan at the end of their consultation as well as share this with School Nursing Team (for Camden schools the contact is camdenschoolnurses@nhs.net).
- Schedule a review appointment in line with normal practice policy.
- Assess inhaler technique (tick box on patient record, READ code 6636)

Quality and Performance Monitoring

For details of all monitoring please see document 'Universal Offer Monitoring & Payment Schedule'

6.6 Childhood Immunisation

Service Aims

The focus of this service is to monitor vaccination status as part of a wider assessment of the health of children and young people over the age of six and under the age of 19 and to immunise those who have not been immunised or have only been partially immunised. This service covers the enhanced aspects of care, beyond the requirements set out in the Childhood Immunisations Directed Enhanced Services (DES)

The aim of the Childhood Immunisation service is:

1. To ensure that the highest possible percentage of children aged 6 to 19 years receive the appropriate immunisations, as this represents the most effective means of ensuring that individual children and the wider community (especially those for whom immunisation is contra-indicated) are protected from disease and from the complications associated with those diseases.
2. To provide local GP practices with a framework for immunising, recording, maintaining and transferring accurate information on the vaccination status of children and young people.
3. To ensure health professionals who deliver vaccinations have received training that complies with the 'National minimum standard for immunisation training'.

Service Specification

The service will fund:

- Monitoring vaccination status of children and young people aged 6 to under the age of 19 and immunising those who have not been immunised or have only been partially immunised.

Eligibility criteria

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In order to be eligible to provide the Childhood Immunisation Service, providers will need to:

- Be commissioned to provide the Vaccinations and Immunisations additional service.
- Be signed up to the Childhood Immunisations Directed Enhanced Services (DES) with NHS England.
- Have a named lead clinician for the service.
- Ensure vaccine supplies are appropriately stored in compliance with manufacturer's instruction and that the cold chain is maintained.
- Ensure all staff delivering immunisation services have current clinical registration, are appropriately trained, competent, and attend immunisation update training, including:
 - Contraindications and common side effects
 - Administration of the vaccine
 - Recognition and initial treatment of anaphylaxis
 - Trained and assessed as competent to work under relevant Patient Group Directions (PGDs), where applicable (non-prescribing registered nurses).

The Provider will:

1. Develop and maintain a register ("*Childhood Immunisation Scheme Register*", which may comprise electronically tagged entries in a wider computer database) of all the children for whom the Provider has a contractual duty to provide childhood immunisation and pre-school booster services (who may already have been immunised, by the Provider or otherwise, or to whom the Provider has offered or needs to offer immunisations).
2. Develop a strategy for liaising with and informing parents or guardians of children on its Childhood Immunisation Scheme Register about its immunisation programme, with the aim of improving uptake.
3. Undertake to offer the recommended immunisations referred to in https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/523044/PHE_Routine_Childhood_Immunisation_Schedule_SPRING16.pdf to the children on its Childhood Immunisation Scheme Register (with the aim of maximising uptake the interests of patients, both individually and collectively).
4. Record the information that it has in Childhood Immunisation Scheme Register using the relevant Read Codes.
5. Keep the child's medical record up-to-date with regard to the child's immunisation status, and shall include the following:
 - Any refusal of an offer of vaccination.
 - All information and advice given to the parent or guardian involved, including discussion about any special needs the child may have or any concerns regarding the vaccination expressed by the child, parent or guardian.

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- Where an offer of vaccination was accepted:
 - Details of the consent to the vaccination or immunisation (where a person has consented on a child's behalf, that person's relationship to the child must also be recorded)
 - The batch number, expiry date and title of the vaccine
 - The date of administration of the vaccine
 - The route of administration
 - Injection site NB. Where injections given in same arm to record in more
 - Any contraindications to the vaccination or immunisation
 - Any adverse reactions to the vaccination or immunisation

To Note:

- Vaccination information shall also be entered into the personal child health record (PCHR, also known as the 'Red Book'). If the relevant red book is 'flimsy' or, if not available, a fax back form (*Records of immunisations given or refused*) must be forwarded to the relevant NHSE Immunisation Team within two weeks of immunisation taking place.
6. Report to the Child Health Department all childhood immunisations given, either by returning the relevant copy of the immunisation page of the child's Red Book or using the attached "*Record of Immunisation Given or Refused*" within two weeks of the immunisation being given.

Quality and Performance Monitoring

For details of all monitoring please see document 'Universal Offer Monitoring & Payment Schedule'

6.7 High-Risk Drug Monitoring

Service Aims

The aims of the High-Risk Drug Monitoring service are:

1. To ensure relevant monitoring in primary care of selected high risk drugs is undertaken in line with national and local guidance.
2. To ensure the safe prescribing in primary care of selected high-risk drugs in order reduce potential harm to patients.
3. To ensure patient education and counselling on the selected high-risk drugs is provided throughout the patient's treatment.

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Service Specification

The service shall fund:

- The safe and appropriate monitoring and prescribing of the specified list of high risk drugs to patients in primary care. Payment to practices will be made quarterly as per the Universal Offer Payment and Monitoring Schedule. Payment for Quarter 4 will be contingent on each practice achieving 50% of the quality markers set out in the Payment and Monitoring Schedule.

The service shall provide:

A shared care drug monitoring and prescribing service in respect of the following drugs for agreed indications for adult patients, for which there is an agreed and formally approved shared care arrangement in place.

- | | |
|------------------|-------------------|
| a) methotrexate | b) azathioprine |
| c) sulfasalazine | d) leflunomide |
| e) mycophenolate | f) mercaptopurine |

For methotrexate, this will be under a Shared Care Guideline (SCG) Agreement and azathioprine, sulfasalazine, leflunomide, mycophenolate and mercaptopurine under the Camden DMARDs monitoring guideline.

Patients will have been initiated and stabilised in secondary care first in line with the SCG/DMARD monitoring guideline before the responsibility for the monitoring and prescribing is taken on in primary care.

To Note:

- The specification of this service is designed to cover the enhanced aspects of patient clinical care that is beyond the scope of essential services.
- The CCG may add to or remove medications from the above list from time to time subject to negotiation with the LMC and Practices and depending on recommendations from Camden Medicines Management Committee. Any changes to this list will be notified to GP practices.

Eligibility Criteria

In order to be eligible to provide the High-Risk Drug Monitoring Service, providers must ensure the following:

- The practice GP agrees and is competent to take on the responsibility for the prescribing and monitoring as specified within the SCG/DMARD monitoring guidelines.

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- Have in place a streamlined service to benefit patients by improving the primary/secondary care interface
- Have in a place a systematic call and recall process for patients on the relevant medication register
- Have clear systems in place for patients for whom they are prescribing AND undertaking monitoring. There should be separate systems in place for patients for whom the practice is only prescribing when secondary care is undertaking monitoring or for whom the hospital both prescribes and monitors. This is to ensure that National Patient Safety Agency (NPSA) recommendations are met.

To Note:

- The High-Risk Drug Monitoring Service is commissioned only for patients for whom the practice is responsible for the prescribing AND monitoring. Patients for whom the practice prescribes the selected high-risk drug but where responsibility of monitoring is retained in secondary care are excluded from this service.
- The service is for patients in whom the monitoring frequency is at least 3 monthly. Where patients have been established on treatment and have stable bloods and the frequency of monitoring is > 3months, then this service is not commissioned.

The Provider shall

1. Provide a shared care drug monitoring and prescribing service in respect of:
 - a. Methotrexate
 - b. Azathioprine
 - c. Sulfasalazine
 - d. Leflunomide
 - e. Mycophenolate
 - f. Mercaptopurine
2. Ensure that it is in receipt of the shared care guideline (SCG) for methotrexate or DMARD monitoring guidelines for azathioprine, sulfasalazine, leflunomide, mycophenolate or mercaptopurine (<https://gps.camdenccg.nhs.uk/shared-care>).
3. Record the indication, dose, details of monitoring and areas of responsibility in the patient notes. If unlicensed indication patient consent should be sought and documented. Prescribers should follow the GMC guidance on unlicensed medicines (<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines>) and MHRA (<https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers-responsibilities>)
4. For methotrexate, there are locally-approved unlicensed indications where there is an established evidence base for use. It is not recommended that the GP takes on the

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shared care for any other unlicensed indication for methotrexate. In the cases, the prescribing and monitoring responsibility to remain with secondary care.

5. Read code indication for each medication and maintain a register. Each register should include all patient on the register, including the following details:
 - a. patient name
 - b. date of birth
 - c. the indication and duration of treatment
 - d. last hospital appointment
6. Undertake monitoring as per the SCG arrangement/DMARD guideline, and act on the results of the monitoring promptly.
7. Contact the specialist in line with the prescribing guidance where monitoring results are outside of range for advice on management.
8. Review regularly and record the need for continuation of therapy under a shared care arrangement between the GP and specialist consultant.
9. Discontinue the therapy when appropriate.
10. Prescribe oral methotrexate/azathioprine/sulfasalazine/leflunomide, mycophenolate and mercaptopurine in accordance with the SCG arrangement /DMARD guideline and ensure patient understanding.
11. Ensure compatibility with other medication taken by the patient and seek advice from consultant if concerned.

To Note:

- The provider shall only prescribe on the receipt of timely monitoring results. If these are not available, the clinician must actively obtain them
- The provider shall:
 - Record blood results, dates of next tests, doses and dose changes on the EMIS system (using the EMIS template) and for methotrexate also record in the patient's methotrexate monitoring booklet has been provided to the patient by secondary care.
 - Ensure a robust process for the repeat prescribing of high-risk drugs, i.e. ensure repeat prescriptions are retained separately for prescribers to review prior to authorising.
 - Reinforce education and advice on the risks and benefits of the drug including side-effects and what to do if experienced and also management of and prevention of secondary complications of their condition. For methotrexate, patients should be given a copy of the NPSA patient information leaflet which is combined with the handheld recording booklet, if one has not already been received from secondary care. Confirmation of the patient's understanding of the risks and benefits of treatment should be regularly (not just on a one-off situation) sought and documented. Consent should be documented.

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- Be aware of symptoms of toxicity or intolerance and to take appropriate action.
- Ensure the implementation of a robust system to target patients that do not attend for blood test monitoring (call and recall system) and hence may not be able to be safely prescribed the drug.
- As per the CCG arrangement/DMARD guidelines, refer the patient back to secondary care, other support agencies or discuss any issues with the consultant as required.
- Maintain adequate records of the service provided, incorporating all known information relating to any significant events, for example, hospital admissions or death, of which the practice has been notified.
- Assist the CCG in monitoring their records by completing quarterly audits and, in the case of methotrexate, an additional annual audit on Citizen Space
- Work with other professionals when appropriate.
- Ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so.
- Ensure that the practice has updated prescribing software to the required specification stated in the NPSA alert.
- METHOTREXATE – the provider shall ensure:
 - Prescriptions for methotrexate state the appropriate dose in milligrams, the number of tablets and frequency (NOT “when required” or “as directed”).
 - 2.5 mg tablets only to be prescribed. There is a local agreement that 10 mg tablets are NOT to be prescribed to minimise dosing errors.
 - The service is provided in accordance with NPSA recommendations:
 - The NPSA website:
 - <http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts/oral-methotrexate/> contains details of the following:
 - NPSA Patient Safety Alert 13 – Improving compliance with oral methotrexate guidelines.
 - Patient briefing – Making sure you take oral methotrexate safely.
 - Oral methotrexate pre-treatment patient information leaflet.
 - Patient-held blood monitoring and dosage record booklet.
 - Oral methotrexate pre-treatment patient information leaflet and Patient-held blood monitoring and dosage record booklet.
 - IT requirement specification.
 - Practices can obtain supplies of the Methotrexate Patient information leaflet and the hand-held record booklet from: 3M Security Print and System Limited, Gorse Street, Chadderton, Oldham, OL9 9QH

To Note:

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- This service is only commissioned for patients on oral methotrexate and not injectable methotrexate. Methotrexate injections have not been locally approved for prescribing or monitoring in primary care under shared care arrangements.

Quality and Safety

Therapy shall only be prescribed for recognised and approved indications for specified lengths of time under shared care arrangements with secondary care specialists.

It is a condition of participation in this service that practitioners will give notification, in addition to their statutory obligations, within 72 hours of the information becoming known to him/her, to the Camden CCG clinical governance lead of all emergency admissions or deaths of any patient covered under this service, where such admission or death is or may be due to usage of the drug(s) in question or attributable to the relevant underlying medical condition.

Report any adverse drug event reported by the patient to the Consultant and the Medicines Health Regulatory Authority (MHRA) <https://yellowcard.mhra.gov.uk/> where appropriate.

Quality and Performance Monitoring

For details of all monitoring please see document 'Universal Offer Monitoring & Payment Schedule'

6.8 Direct Oral Anticoagulants (DOACs) Initiation in Atrial Fibrillation

Service Aims

The aims of the DOACs Initiation service are to:

- Improve patient access to safe and effective anticoagulation initiation through collaboration between the patient's GP and a Consultant anticoagulation specialist
- Offer a cost-effective, standardised and clinically-effective service for Camden patients requiring a DOAC for prevention of stroke in non-valvular atrial fibrillation (AF).
- Support innovation in anticoagulation therapy, utilising evidence-based therapies, where appropriate, in line with local and national guidance, and develop existing anticoagulation services in the community, improving outcomes and patient experience, and reducing costs and inequality of anticoagulation service provision.
- Improve continuity of care for patients

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To Note:

This service is only commissioned for the initiation of DOACs for the prevention of strokes in patients with non-valvular atrial fibrillation (AF). The service is not commissioned for DOAC treatment in patients for any other indication.

The service includes:

- Patient access to initiation of DOACs, as appropriate for each individual patient for stroke prevention in non-valvular AF.

Important Patient Safety Check:

There has been an important patient safety issue that has been escalated nationally during the pandemic where patients who have been switched from Warfarin to DOACs and/or who have then not tolerated and switched back to Warfarin were subsequently inadvertently prescribed both anticoagulants in error due to Warfarin/DOACs being left on current repeat prescription lists. Kindly check this is not the case for your patients.

Service Specification

The service shall fund:

- The initiation of DOACs for stroke prevention in non-valvular AF to appropriate patients in primary care. Payment to practices will be made quarterly for initiation completed within the period. Payment will be linked to 75% achievement against the below quality markers which will be reported via the designated EMIS template.
 - a) Checklist completed for DOAC initiation (as per NCL guidance)
 - b) Shared decision making undertaken with patient on anticoagulation treatment and choice of agent
 - c) Patients initiated on a DOAC have received appropriate counselling (as per NCL checklist) and given a DOAC card.

Eligibility Criteria

In order to be eligible to provide this service, providers must ensure:

- Clinicians delivering the service must be appropriately qualified and trained (and able to demonstrate competency)
- Have a system in place for patients to receive urgent medical advice relating to their treatment

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- A competent GP named as the service lead for the DOACs initiation and monitoring service. The service lead will have overall responsibility for ensuring the safe and effective delivery of anticoagulation services.
- Maintain written records of all staff involved with the delivery of the service, including training undertaken, level of responsibility and assessment of competence as part of the annual audit cycle.
- Have a systematic call and recall process in place for patients on the relevant anticoagulation medication register.
- Have service continuity plans in place to cover periods of absence for annual leave, study leave, sickness, equipment failure, epidemics and unforeseen events.
- Have an accurate, up-to-date electronic register of all patients requiring anticoagulation monitoring, including patient name, date of birth, NHS number, the indication for and length of treatment and choice of DOAC agent.
- Meet the needs of the patients and cater for patients with special needs and those without English as a first language.

Clinical Governance Requirements

General

The Provider shall:

- Have a clinical governance lead in place, who shall ensure that all prescribing is within National Institute for Health and Care Excellence (NICE) guidance and local Prescribing Recommendations (The Safe and Secure Handling of Medicines' report [2005], Medicines Act [1968], NICE, Health Service Circular 2000/026 and Misuse of Drugs Act [1971] and Regulations [and subsequent amendments] and locally [CCG and North Central London Joint Formulary Committee] agreed prescribing recommendations, guidelines and treatment pathways²;
- Record in the patient's medical record, the relevant assessment information considered in the decision making process for the initiation of DOAC for the prevention of stroke for non-valvular AF. An EMIS clinical template has been developed to support the facilitation of this.
- Manage the repeat prescribing process.
- Ensure that systematic call and recall of patients on this register is taking place
- Work together with other professionals when appropriate.
- Ensure that all staff involved in providing any aspect of care under this scheme are appropriately trained and have the required skills to deliver the service
- Refer patients promptly to other necessary services, when clinically indicated

² <http://www.ncl-jfc.org.uk/prescribing-guidelines.html>

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- Ensure that the management of the patient follows local anticoagulation treatment pathways and prescribing guidance including the initiation of DOACs, first follow-up (within one month) and regular review of anticoagulation.
- Ensure that all newly-initiated patients on DOACs (and/or their carers and support staff when appropriate) have been adequately counselled and receive appropriate verbal and written information, management of, and prevention of, secondary complications of their condition including the provision of a DOAC alert card.
- Ensure patients on DOACs have an appropriate review at a frequency in line with local guidance. More frequent review to take place where clinical need and to include a review of the patient's health including checks for potential complications
- Maintain adequate records of the performance and result of the service provided, incorporating appropriate known information, as appropriate. This shall include the number of bleeding episodes and deaths caused by anti-coagulants
- Review the risks and benefits for DOAC therapy on a regular basis as patients get older and develop other diseases
- Liaise with Royal Free Hospital Anticoagulation Team with regards to incidents, which will also require reporting into the Anticoagulation Steering Group Meeting (notify via camdenlcs@nhs.net).

Specification for the DOAC Initiation Anticoagulation Service

The provider shall:

- Provide therapeutic anticoagulation management with DOACs for patients with Atrial Fibrillation (AF patients stable on DOAC therapy)
- Initiate a DOAC, where appropriate, and manage DOACs in line with local guidance ((NCL DOAC Resource Supporting Documents (these are available on the Camden GP website, <http://ncl-jfc.org.uk/doac-prescribing.html>)) and national guidance.
- Ensure patients on DOACs are monitored and reviewed at a frequency in line with local guidance. More frequent review to take place where clinical need.
- Ensure that patients initiated on DOACs have received appropriate counselling and been provided with written information, including the DOAC Alert Card, and that this has been documented in the patient's notes.

To Note

- If guidance is required regarding the patient's anticoagulation management, the GP can access advice and guidance via ERS
- If a decision cannot be made between the anticoagulation specialist Consultant and GP, as other specialist review is required, the necessary referral should be made and actioned prior to initiating therapy for the patient (as long as this is clinically safe).

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- Practices providing minor surgery under the Directed Enhanced Service (DES) shall follow the guidelines attached to the minor surgery DES, regarding how to manage patients on DOAC.
- Consider referral to the community pharmacy New Medicines Service (NMS) to provide further support and advice to patients regarding their new DOAC medication.

Incident Reporting & Near-Misses

All patient safety ³incidents and near-misses must be dealt with according to the primary care provider's procedures and guidelines as required by the Care Quality Commission (CQC) and therefore in accordance with (i) the practice's incident management policies and (ii) the incident reporting pages on the Camden GP website

<https://gps.camdenccg.nhs.uk/practice-management/incident-reporting> .

- Providers are required to report all incidents/near-misses to the National Reporting and Learning System (NRLS) via the GP e-form https://report.nrls.nhs.uk/GP_eForm
- Consultant at RFH (so that this may be reported into the Anticoagulation Steering Group)
- All patient safety incidents/near-misses must be reported within 48 hours of identification;
- The primary care provider's named service lead for anticoagulation must also be notified.
- Report any adverse drug event reported by the patient to the
 - Consultant at RFH (so that this may be reported into the Anticoagulation Steering Group)
 - CCG via completion of the anticoagulation incident form available on the Universal Offer Page of the GP website
 - Medicines Health Regulatory Authority (MHRA) <https://yellowcard.mhra.gov.uk/> where appropriate.
- Patient safety incidents could include (although this is not an exhaustive list):
 - Any clinical event which is, or may be due to usage of oral anticoagulants, or attributable to the underlying condition
 - Adverse incidents or near misses involving patients having surgery, dental treatment or other procedures whilst on anticoagulation therapy.
 - Death of a patient on anticoagulation therapy, whatever the cause.

Possible triggers for reporting could be:

Clinical:

³ Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare.

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- Any clinical event which is, or may be due to usage of anticoagulation therapy, or attributable to the underlying condition, including:
 - Bleed or thromboembolism;
 - Apparent drug reaction or interaction;
 - Emergency hospital admission which is, or may be, due to anticoagulation therapy usage or attributable to the underlying condition;
 - Unconsidered other medicine interactions.
- Adverse incidents or near misses involving patients having surgery, dental treatment or other procedures whilst on anticoagulation therapy.
- Death of a patient on anticoagulation therapy, whatever the cause.

Organisational:

- Communication failure, e.g., Between the secondary and primary care providers or between a patient and provider;
- Failure to follow the Did Not Attend pathway/referral of a patient back to secondary care as a result of non-communication with a patient for 28 days following a missed appointment.

Record Keeping:

- Incorrect interpretation and/or dosage;
- Inadequate safety checks at repeat prescribing;
- Failure to discontinue anticoagulation where indicated;
- Failure to fully document, poor quality documentation.
- The service provided must meet the needs of the patients and be reflective of patients with special needs and those without English as a first language.

Quality and Safety

- Primary Care Providers are required to familiarise themselves with their clinical governance requirements under this specification and to comply with them.
- Quality reporting will be viewed by the Anticoagulation Steering Group where representatives from the CCG's Primary Care Commissioning and the Quality team attends.
- All primary care providers must be aware of their clinical and service limitations and refer back to secondary care if the management of any patient is outside his/her sphere of competence.

Quality and Performance Monitoring

Please note that the QCE team will receive and monitor NRLS submissions to verify that these are submitted within the required timeframe of 48 hours and may raise this with practices if the incident appears to be outside of this timeframe or no incidents are submitted by a practice for a full financial year.

For details of all other monitoring please see document 'Universal Offer Monitoring & Payment Schedule'

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6.9 Homelessness

Service Aims:

The aim of the Enhanced Homelessness service is:

- To improve access, reduce inequalities and provide flexible person-centred healthcare arrangements that meet the primary health needs of homeless adult patients in Camden
- To support mainstream general practice to proactively engage with homeless patients to support increased uptake to screening, medical review and health checks.

This service, which is aimed at mainstream general practice is part of a wider Homeless Health pathway. The service provider is expected to work in partnership with the local health and social care services to ensure a seamless patient service provision. This includes the specialist homeless practice (which provides outreach services as well as core primary medical services to homeless people); and homeless agencies where locally commissioned.

To Note:

- This enhanced service is intended for homeless adult patients who do not readily access mainstream services and/or who require more complex interventions; including people who have chaotic lifestyles and/or highly complex needs, often with comorbidity of mental health, drugs and alcohol problems and who often require rapid response.
 - This includes rough sleepers; hostel and night shelter residents; squatters; people who do not have a permanent address (e.g. staying temporarily with friends and relatives for less than 3 months); people who have been housed temporarily for less than 3 months, who are waiting to be assessed and either evicted or moved to permanent housing.
- People who are in temporary accommodation (i.e. by local authority or settled in mainstream housing with family/friends) for more than 3 months are not eligible for this service. These patients are likely to be the most stable, whose needs can be met through the GP core contract unless their circumstances change. GP Practices can contact the CCG Primary Care Team for any exceptions to patients in this group.

Eligibility Criteria

In order to be eligible to provide the Homelessness service, providers must ensure the following:

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- Have a named lead clinician for the service
- Have staff and clinicians with experience, knowledge and understanding of homelessness
- Have up-to-date knowledge and understanding of local statutory services and homelessness agencies
- Be able to demonstrate partnership working with local (to LES provider) homelessness agencies and hostels to proactively support access and provision of primary care
- Provide flexibility in appointments - consideration should be given to the offer of same day/walk-in appointments and longer appointment times for people with multiple needs and learning disabilities.
- Development and maintenance of patient registers
- Maintain an open list, to ensure registration of patients at all times.

Service Specification

The service will fund:

- Comprehensive annual review appointments including physical health checks, clinical assessments and the development of personalised care plans to take into account the holistic needs of the patient. The minimum data set required for the payment of annual reviews is set out below – all fields must be completed on the relevant EMIS template to enable payment:
 - a) BMI
 - b) Blood pressure
 - c) Smoking status
 - d) Alcohol risk status
 - e) Drug misuse screening
 - f) Mental health status discussed
 - g) Sexual health risk assessment completed
 - h) Completion of risk assessment for TB, HIV, Hepatitis B and C
 - i) Completion of personalised care plan
- Extended review payments for the provision of individual screening and immunisation procedures for high risk patients. Individual payments for extended review will be made to providers based on any of the following activities:
 - a) Blood-borne Virus screening (any) bloods completed
 - b) Pneumococcal Vaccination (Given)
 - c) Flu Vaccination (Given)

To Note:

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- Providers will be enabled to complete and code the above activities and minimum data linked to annual and extended reviews via the Homelessness EMIS template.

The Provider shall:

General

- Record and update the housing status for all people accessing services at first contact and at significant review points
- Develop an electronic register or other system for identifying homeless adults using the agreed code. The enhanced service provider will review their register on a regular basis.
- Offer homeless patients permanent registration in line with national patient registration guidance from NHS England. To address barriers to access, it may be necessary to assist/enable registration by simplifying the process, using limited personnel.

To Note:

The CCG will monitor the homeless register on a quarterly basis. In the event of any significant shifts in register size, the CCG reserves the right to request an audit to be undertaken by an appropriate professional to develop a shared understanding of causal factors. The service provider shall comply with commissioner requests for audit, where required.

Comprehensive annual reviews and health checks

- Carry out health checks and reviews for new and existing homeless patients
- Offer a full health check upon registration with the practice. The designated EMIS clinical template must be completed as part of these health checks
- Provide comprehensive annual reviews and extended reviews to include clinically-informed assessment and appropriate screening for the following;
 - Alcohol and substance misuse
 - Blood borne virus (e.g. Hepatitis B and C and HIV)
 - Sexually transmittable infections
 - Physical health checks (BMI, blood pressure, cardiovascular risk check)
 - Cervical screening for eligible women
 - Smoking status and advice (if appropriate)
 - Tuberculosis (TB) in line with national guidance for high-risk groups
 - Mental illness using at least four recognised screening questions concerning mood and interest (e.g. PHQ4)
 - Blood glucose level and cholesterol measurement, as necessary.
- Offer influenza and pneumococcal immunisations
- Support the development of personalised care plans for homeless patients

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- Ensure referral as clinically appropriate to specialist services to meet the needs of patients
- Provide signposting (i.e. via care navigation/advocacy service) for advice and support around housing, financial, legal issues, immigration, educational and employment support etc.

Home address

- Offer the address of the registered practice as the home address to patients who require this to access other health related services and who are entitled to access other services where their registered address may result in the loss of mail.

Education and development

- Review training needs as part of this role to continuously update skills and techniques relevant to their clinical work. Consideration should also be given to support and training for GP Receptionists to enable them to become champions of fair access to healthcare
- Attend annual educational event for homeless health. This is a mandatory requirement for GP practices who have 15 or more registered homeless patients. Backfill funding is available for one GP and practice nurse.

Quality and Performance Monitoring

For details of all monitoring please see document 'Universal Offer Monitoring & Payment Schedule'

6.10 Prostate Cancer Service

Service Aims

The aim of the Prostate Cancer service is:

- To provide enhanced support for prostate cancer patients in the community including an annual holistic needs assessment (HNA) and PSA monitoring.

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- To improve the quality of care delivered to patients and patient experience through annual personalised care planning reviews closer to home.
- To provide rigorous and safe follow-up care for patients with stable prostate cancer.
- To review and revise information given to patients about their follow-up care in order to enhance knowledge of prostate cancer, consequences of treatment and to promote self-management where possible.
- To support the identification of patients whose disease has progressed and ensure rapid referral back into secondary care for review.
- To ensure PSA monitoring at least six monthly or more as indicated in the treatment summary or discharge letter for suitable patients.
- To provide training and development for primary care professionals on (a) prostate cancer and (b) the needs of patients living with and beyond cancer.
- To enable timely identification and management of consequences of treatment by the primary care team.

Service Specification:

(Note that all appendices referred to are available on and can be downloaded through the Camden GP website page for this service)

- The development and maintenance of a Prostate Cancer follow-up register that includes an active recall system of all prostate cancer patients with Read Codes identified in Appendices 5 and 7
- Holistic 'welcome' appointment (Appendix 4) for all newly transferred patients within four weeks of notification of transfer from secondary care into primary care.
- The provision of PSA testing to ensure that PSA levels are checked against patient specific "normal ranges"/parameters twice per year.
- GPs to proactively search and follow up prostate cancer patients already in primary care or lost to follow up. See Appendix 7 for guidance.

To Note:

The Urology Departments at UCLH, Royal Free, Whittington Hospital and North Middlesex Hospital will take responsibility for ensuring that the patient has been transferred, pending agreement from the consultant.

GPs/Practice Nurses will undertake the following:

- Develop and maintain a prostate cancer follow-up register which includes an active recall system and includes all prostate cancer patients with the Read Code B46 or B834 and are not under secondary care.
- Offer a 'welcome appointment' with the primary care nurse or GP to all newly transferred patients within four weeks of notification of transfer from secondary care. This is an opportunity for the practice to start a holistic care plan for long term management of patients. See **Appendix 2** for sample Treatment Summary and **Appendix 4** for sample letter to patient and patient held holistic care plan which should be reviewed at subsequent follow-up consultations.

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- Nominate a named clinical lead (GP or Nurse) to complete the online training session accredited by BMJ Learning and disseminate training material to other staff within the practice.
- Ensure PSA levels are checked against patient specific “normal ranges”/parameters as per their treatment summary. Lab normal ranges may not reflect patient specific thresholds.
- Inform the patients of their PSA results in a timely manner
- Signpost patients to resources for promoting self-management of symptoms such as fatigue and incontinence.
- Ensure that patients are referred into secondary care urgently and ensure they are seen within 14 days (using a specific prostate form (Appendix 8) and not the standard 2ww form) and then send electronically using 2ww email address or e-referral.
- Follow-up patients that fail to attend the review consultation.
- Document in the patient’s record if they decline a follow-up and re-invite the patient at least annually.
- Refer patients to additional services to meet their needs as appropriate.

To Note:

- The responsibility for managing the care of the patient on the prostate cancer register will be deemed to be the registered GP. However, the service may be delivered by another clinician in the practice or local arrangements can be made for the service to be provided by another nominated GP practice.
- It is expected that the service is offered to all patients unless patients choose to opt out.
- The GP provider is responsible for ensuring that the protocols used reflect the most up to date version
- The GP EMIS Clinical Template is available for download on the GP Website.

Eligibility Criteria

Acceptable criteria:

- Medically stable prostate cancer patients discharged from secondary care management.

Exclusion criteria:

This service is not suitable for the following: -

- Patients on active surveillance
- Patients being treated with brachytherapy
- Patients at high risk and who have had radical radiotherapy or surgery
- Patients being treated with focal therapy
- For individuals participating in clinical trials, follow-up will be determined by the clinical trial protocols. All individuals taking part in trials will still access and benefit from the end of treatment clinical OPA (outpatient appointment) and health and wellbeing events.

Definitions of stable prostate cancer patients are:-

- 1. Localised Prostate Cancer – Watchful Waiting:** All patients after 1 year of diagnosis who are willing and able are to be considered for self-management.

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- 2. Patients who have had curative radical prostatectomy:** All patients 1 year after treatment and those who have undetectable PSA.
- 3. Patients who have radical radiotherapy:** All patients 2 years after treatment and PSA is less than 2 ng/ml above nadir. This is within the context of normal testosterone levels.
- 4. Patients being treated with hormonal treatment only for locally advanced disease:** All patients 1 year after treatment whose PSA is less than 2 ng/ml.

Transfer of Patients: -

The responsibility for transfer of the patients sits with secondary care. The GP will be informed when this has been completed and will receive a HNA and Treatment Summary and discharge letter (Appendix 2). Treatment summaries will include patient-specific protocol for PSA monitoring, any consequences of treatment (medical, physical and psychosocial) and instructions for onward management.

GPs able to proactively identify eligible patients on their patient lists, can send this list to secondary care for review. If the consultants agree they can then transfer the patients to primary care. See **Appendix 7** for a guide to proactively identify suitable patients. The Urology Departments at UCLH, Royal Free, Whittington Hospital and North Middlesex Hospital will take responsibility for ensuring that the patient has been transferred, pending agreement from the consultant.

Quality and Safety

The CCG will monitor the service on a quarterly basis.

- Practices must use appropriate escalation procedures to ensure any matters arising are recorded and appropriately managed.
- Where necessary and appropriate, timely escalation of concerns should be made to the CCG.
- Practices must use the EMIS clinical template to code any activities carried out under the contract. This includes activities such as the offer of welcome appointments and provision of PSA tests on a monthly basis.
- Practices must code if the patient declined the offer for an HNA/ Holistic Care Review
- Brief intervention advice should be offered as and when appropriate and significant events managed in line with practice protocol and in line with Section 5 (Quality and Safety)

Quality and Performance Monitoring

For details of all monitoring please see document 'Universal Offer Monitoring & Payment Schedule'.

7. Monitoring and Payment Schedule

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For details of monitoring & payment arrangements please see separate document: 'Universal Offer Monitoring & Payment Schedule'.

8. Exit and Termination

- Payments under the scheme will be suspended if, at any time, the practice is unable to provide services in-line with the service specification, or fail to meet Provider eligibility criteria. Before any suspension, the practice and Camden CCG will meet to discuss the reason for the suspension, identifying any possible resolution. If the matter is not resolved, the CCG will issue a suspension notice to the practice within seven days.
- The CCG may then terminate the scheme within 28 days if, following suspension of payments the contractor fails to re-establish services according to the service specification or take appropriate action to address deficiencies within eligibility criteria. Before termination, the parties will meet to discuss the reason for the proposed termination. If after this meeting the reason for terminating is not resolved, then the CCG will issue a termination notice.
- Primary care providers or the CCG can exit this agreement by providing a minimum of six months' written notice.

9. Supporting Information

Supporting information, including forms, templates and IT tools related information, is available on the GP website – Universal Offer page.

For queries, please email: camdenlcs@nhs.net