NHS
North Cumbria
Clinical Commissioning Group

NHS North Cumbria CCG Primary Care Commissioning Committee	Agenda Item
8 March 2018	6

General Practice Quality Improvement Scheme

Purpose of the Report
To inform the committee on the amendments made to the draft Quality Improvement Scheme presented on 18 January 2018. To seek approval of the final draft of the Quality Improvement Scheme 2018-20

Outcome Required:	Approve	x	Ratify		For Discussion		For Information	

Assurance Framework Reference:
1, Better Health – There is a need to ensure that Cumbria's children and young people (including children looked after) are kept safe and transition into health adulthood.
2, Better Care – Commission services that ensure the delivery if high quality and safe care for patients.
3, Sustainability – Commission services that ensure the delivery of high quality and safe care for patients in a manner that is sustainable for the whole health economy.
4, Leadership – The CCG needs to support its membership (i.e. General Practice) to provide high quality care to patients and support the delivery of safe, high quality financially sustainable health care services. The CCG needs to develop and implement robust governance and management arrangements to operate in a safe and sound manner, including compliance with formal directions from NHSE.

Recommendation(s):

The Primary Care Commissioning committee are asked to:

- Approve the GP Quality Improvement Scheme 2018-20

Executive Summary:
In 2016, Cumbria Clinical Commissioning Group (CCG) introduced a two year Quality Improvement Scheme (QIS) for general practice. The QIS was designed to improve outcomes for patients and to address unwarranted variation in general practice across a wide set of clinical indicators.
A review of the first year results demonstrated improvement, with variation narrowing for 9 of the 11 metrics. Minor changes were made to the indicators for the second year of the scheme to reflect national policy changes and or local service change.

The scheme is due to cease at the end of March 2018. In November 2017, the CCG Clinical Executive committee supported the development of the scheme for a further two years.
In January 2018, the CCG Clinical Executive Committee, the CCG Primary Care Commissioning Committee, the CCG Integrated Care Communities GP leads and the Local Medical Committee received a draft for comment. This paper outlines the recommended changes to the draft QIS as a result of feedback from individuals and the various committees.

Key Issues:
Overall the draft QIS has not changed significantly (Appendix 1).
There was agreement not to include the areas listed in Appendix 2 (highlighted in yellow in earlier draft) as funding had not been agreed.
Changes outlined in Appendix 3 are recommended on the basis of data timeliness, data robustness or the target was considered too high.
The weightings (Appendix 4) assigned to each metric are similar to the previous year

Key Risks:
Timescales are tight to get the scheme ready for 1st April 2018.

Implications/Actions for Public and Patient Engagement:
The Quality Improvement Scheme is designed to improve patient health outcomes.

Financial Impact on the CCG:
Annually, the CCG has invested approximately £2.24 million into the General Practice Quality Improvement Scheme via direct payments into general practice at £7 per registered patient.
In the first year, the payments to practices were split 70% for delivery and 30% on achieving targets. The split changed to 60%/40% in year two.
The split will remain at 60%/40% for 2018-20.

Strategic Objective(s) supported by this paper:	**Please select (X)**
Support quality improvement within existing services including General Practice	**x**
Commission a range of health services appropriate to Cumbria's Needs	x
Develop our system leadership role and our effectiveness as a partner	
Improve our organisation and support our staff to excel	

Impact assessment: (Including Health, Equality, Diversity and Human Rights)	Not yet

Conflicts of Interest Describe any possible conflicts of interest associated with this paper, and how they will be managed	GPs have been involved in the development of the scheme and will benefit from the scheme. The approval process mitigates any conflict of interest.

Lead Director	Caroline Rea, Director of Primary Care
Presented By	Andrea Loudon, Primary Care Development/Medicines Lead
Contact Details	Andrea.loudon@northcumbriaccg.nhs.uk
Date Report Written	23.2.18

Quality Improvement Standards

- A rationale for each standard and why North Cumbria CCG has included this within the Quality Improvement Scheme
- How the standard should be delivered, and what practices will be expected to do
- How achievement will be measured with Metrics and targets

Standard 1 -ensure a proactive approach to health improvement and early detection
Standard 2 - improving outcomes for people with long term conditions
Standard 3 - embed a culture of medicines optimisation
Standard 4 - improving cancer survival rates and earlier diagnosis
Standard 5 - improving health outcomes for patients with a mental health condition
Standard 6 - improving access to primary care services
Standard 7 -improving planned care
Standard 8 - pro-active care management to improve outcomes
Standard 9 - improving end-of-life care

1.0	Ensure a pro-active approach to health improvement and early detection
Rationale	Improving prevention and early diagnosis are key factors to help reduce premature mortality.
CCG Priorities	Right Care Heart disease and stroke pathways identified opportunities to - • Reduce number of deaths <75 years from coronary heart disease and stroke • Increase recording of prevalence of hypertension • Increase recording of prevalence of Atrial fibrillation
Aim	The practice works actively with its population to prevent heart disease and stroke by detecting hypertension and atrial fibrillation at its earliest stage.
Delivery	Offer NHS Health Checks to eligible individuals aged 40-75 every 5 years – achieve 66% of eligible population every year (achieve target over 5years) Identify patients at high risk of diabetes (RAIDR – Primary care dashboard) and ensure the relevant individuals receive an invite to the NHS Diabetes Prevention Programme (NHS DPP) Patients over 65yrs who attend the practice to have their pulse rhythm checked annually to screen for AF diagnosis. Practice to undertake 12 lead ECGs on adult patients who require this diagnostic Practice to undertake Ambulatory blood pressure monitoring where clinically indicated Run the GRASP AF tool – available on RAIDR – to monitor the number of undiagnosed AF patients
Metrics	% patients with AF practice disease registers; 2 point ≥ - 0.5 S.D of North Cumbria practice mean at Q3 2017/18
	% patients recorded with hypertension on practice disease register; 2 point ≥ - 0.5 S.D of North Cumbria practice mean at Q3 2017/18
	% patients recorded with COPD, Heart failure, asthma, CHD, stroke and diabetes; 1 point ≥ - 0.5 S.D of North Cumbria practice mean at Q3 2017/18

2.0	**Improving outcomes for people with Long Term Conditions**
Rationale	A growing body of evidence underscores the importance of effective self-management of long-term conditions. People who are more 'activated' (that is, who recognise that they have an important role in self-managing their condition and have the skills and confidence to do so) experience better health outcomes. High blood pressure, atrial fibrillation and high cholesterol are major causes of heart attack and stroke (CVD events). In 'high risk' patients preventative treatment is very effective.
CCG priorities	Right Care Heart disease, stroke, and diabetes pathways identified opportunities to increase number of patients - • with diabetes achieving cholesterol < 5mmol • with diabetes achieving all three NICE targets (HbA1c, cholesterol and BP) (IAF indicator) • with CHD and/or stroke achieving cholesterol < 5mmol Right Care COPD pathway identified higher mortality rates < 75yrs and opportunity to increase the recording of FEV1. (QP target). Right Care Asthma pathway identified higher emergency admission rates for children with asthma.
Aim	Practices are expected to provide care for people with LTCs that is proactive, holistic, preventive and patient-centred. There should be an active role for patients, with collaborative personalised care planning and shared decision making. Patient care must be based on the latest evidence-based practice.
Delivery	Use of the Long Term Condition Care bundles to identify areas for improvement and ensure actions plans (PDSA cycles) are in place to improve Achievement of all Nine Care process for patients with diabetes All patients diagnosed with CHD should be treated in accordance with NICE guidelines CG181 All patients diagnosed with AF and having a CHA2DS2-VASc SCORE ≥ 2 but who are not receiving an anticoagulant should have a face to face consultation using a patient decision aid All patients diagnosed with COPD to have a self-management plan (locally agreed plan) All patients diagnosed with asthma to have a self-management plan (locally agreed plan)
Metric	Long Term Condition composite scores (AF, CHD, HF, stroke, diabetes, asthma and COPD) - % patients achieving all three of the LTC indicators - 1 point ≥ - 0.5 S.D of North Cumbria practice mean at Q3 2017/18 for asthma, stroke, HF and AF - 2 points ≥ - 0.5 S.D of North Cumbria practice mean at Q3 2017/18 for CHD, diabetes and COPD

3.0	**Embed a culture of Medicines Optimisation**
Rationale	Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety.
CCG priorities	Quality Premium - improve antibiotic prescribing rates in primary care (IAF indicator) & improve appropriateness of trimethoprim and nitrofurantoin prescribing. Right Care Respiratory pathway identified prescribing spend as an outlier. Right Care Heart disease & Stroke pathways identified opportunities to improve biometric markers especially cholesterol (see Standard 2) and above average use of symptomatic treatment compared to preventative treatment. Right care Stroke pathway identified opportunities to improve the number of patients with high risk AF who are prescribed an anticoagulant. Right care MSK and Trauma & Injury pathways identified higher opioid prescribing and higher hip fracture admissions than peer group. Right Care renal pathway identified acute renal failure as the cause of emergency admissions more than peer group. Primary care prescribing spend per weighted patient is above the England average. Use of electronic repeat dispensing is well below the England average.
Aim	To support the use of medicine optimisation to achieve improvements in outcomes for patients with long term conditions. To reduce the waste resulting from ineffective prescribing and support improvements in prescribing systems and processes.
Delivery	Engage with Medicines Optimisation Pharmacist (NECS) Support delivery of Medicines Optimisation Quality Framework (workplan for 2018/19 includes priority areas) Attend Prescribing leads and Practice Medicines managers meetings Follow Prescribing guidelines - NECS Medicines Optimisation website Access RAIDR Prescribing Safety dashboard Use Scriptswitch – accepted switches > 10% Ensure patients are enabled for Electronic Prescription service (EPS) Ensure appropriate patients are enabled for electronic repeat dispensing (ERD)
Metric	Replace with new indicators to reflect CCG priority areas - Cumbria or national quartile ranking to calculate scores

4.0	**Improving cancer survival rates and earlier diagnosis**
Rationale	To address improved survival, evidence strongly advocates for earlier diagnosis, and timely access to treatment.
CCG priorities	Right Care Commissioning for Value pack - opportunity to improve the mortality rates from all cancers. Quality Premium – improve proportion of cancers diagnosed at stages 1 and 2 (IAF indicator)
Aim	To 'Find Cancer Early' – by systematic application of safety netting processes and changing of clinical thresholds for 2 week referral in line with NICE guidelines. To actively support the national screening programmes – for example, communication with a healthcare professional can influence compliance with bowel cancer screening and improve uptake by 6-10%
Delivery	<u>Early diagnosis</u> Practice process for 2ww referral includes patient informed of importance to attend within timeframe Robust practice process for safety netting Monitor the number of confirmed diagnosis that is not a 2ww referral Undertake significant event review (SEA) of any confirmed cancer diagnosis that is not a 2ww referral Practice process for shared learning <u>Cancer screening</u> Code and flag up non-responders to the cancer screening programmes Ensure cancer screening outcome is coded appropriately eg did not respond, abnormal result, normal result Actively promote cancer screening programmes Ensure uptake for cervical screening for eligible patients ≥ 80% Ensure uptake for bowel screening for eligible patients ≥ 65%
Metric	Cancer Prevalence - % practice population on practice cancer register - achievement of the lower of mean (3.6%) or 0.25% improvement on March 2017

5.0	Improving health outcomes for patients with a mental health condition or learning disability
Rationale	For people with mental ill health average life expectancy is reduced further compared to general population. Primary care has a key role to play in achieving parity of esteem for physical health and mental health. This should support improved health outcomes, through annual health checks and screening, enhanced patient and carer experience, and a reduction in health inequalities.
CCG priorities	IAF – to increase the proportion of people with a learning disability on the GP register receiving an annual health check IAF – completeness of the GP learning disability register National priority to ensure patients with learning disabilities are only prescribed MH medicines for an appropriate diagnosis (STOMP initiative) IAF – to improve the estimated diagnosis rate for people with dementia
Aim	Improve physical health and mental health in patients with learning disabilities. People with dementia are enabled with the involvement of their carers to access services that help maintain their physical and mental health & wellbeing. Improve the premature morbidity and mortality from cardiovascular disease, diabetes and obesity in all patients with Severe Mental illness
Delivery	<u>Learning disabilities</u> Offer annual health checks to all patients on the learning disability register (aged 14yrs and above) Ensure all staff undertaking health checks are competent to deliver Work with the LD team to ensure register is accurate Use the national LD Health check template which is available on EMIS Work with the LD team where appropriate to offer & facilitate cancer screening/flu immunisation and signposting to ophthalmology services Details of reasonable adjustments to be made available to other health professionals via the Summary Care Record eg person requires quiet waiting area Work with the LD team and MO team to review MH medicine prescribing

	<u>Dementia</u> Undertake opportunistic dementia screening, using recognised screening tool Conduct a case-finding audit to identify any potential patients in relation to the perceived practice diagnosis gap Work with the Memory Link workers to ensure register is accurate Ensure patients coded with Mild Cognitive impairment are regularly reviewed Undertake a comprehensive annual review of all patients on the dementia register <u>Physical Health of adults with severe and enduring mental illness</u> All patients on the SMI register receive a comprehensive annual health check. The health check will focus on physical health problems such as cardiovascular disease, diabetes, obesity and respiratory disease and should include; - Cardiovascular status; pulse and blood pressure - Metabolic status; glycosylated haemoglobin (HbA1c) and blood lipid profile - Weight or BMI, diet, and level of physical activity - Smoking, alcohol and use of recreational drugs - Liver function - Calcium, renal and thyroid function for people taking long term lithium Follow NICE guidance on hypertension, lipid modification, prevention of cardiovascular disease, obesity, physical activity and diabetes. Follow Lester UK adaptation: cardio-metabolic health resource A care plan should be made available to other health professionals via the Summary Care Record.
Metrics	% people with learning disability on the GP register receiving an annual health check ≥ 75%
	% diagnosis rate for dementia ≥ 75%
	% Patients on the practice mental health register who have had all 5 physical health checks (blood pressure, HbA1c, cholesterol, lifestyle advice, BMI) annually ≥ 75%

6.0	Improving Access to Primary Care services
Rationale	A patient's ease of access to their practice, and preferred GP, can affect their quality of care and health outcomes (King's Fund, 2012). Recent evidence highlights that inadequate capacity in general practice can lead to unmet health needs, and also to an increase in demand for A&E and other emergency and hospital services.
CCG priorities	Implementation of Extended Access (GPFV) – an additional 160hrs per week evenings and weekends Bookable 111 appointments (Urgent care workstream priority) Quality Premium – improve % of patients with a good experience of making a GP appointment (CCG target 85%) Implementation of On-line consultations (GPFV) Implementation of online access (eg online bookable appointments, electronic prescriptions) GP streaming
Aim	To improve the overall access to General practice to ensure that patients with primary care problems are consulted with during core hours thus ensuring effective use of resources and better outcomes for patients. Delivering continuity of care for patients, especially those with complex needs, by ensuring that whenever appropriate and possible, patients feel that their clinicians know about and understand them and the context that they live in.
Delivery	Provide 85 clinical contacts per 1000 population/week with a registered health professional (eg GP, nurse or pharmacist) - can include face to face, telephone, video consultation Provide minimum of 10 bookable sessions per week with a prescribing clinician Offer pre-bookable appointments 1 month in advance Ensure children under 12 who are considered as having an urgent clinical need have same day access Ensure continuity of practice for patients attending services outside core hours by enabling shared access to their medical records (in line with IG protocols) Review A/E & MIU attendances if identified as outlier (practices 1 S.D from North Cumbria mean) ensure actions are identified to reduce Ensure > 20% patients are enabled to access on-line services eg bookable appointments, repeat prescriptions, SCR Ensure NHS 111 has direct access to bookable appointments (a minimum of 2 per 1000 population)
Metric	A/E & MIU attendances - practices to be below or within 1 S.D of North Cumbria mean (still to be determined)

7.0	Improving planned care
Rationale	NHS resources come under ever greater pressures each year. Ensuring that treatment and care is focused where it can make the biggest difference is a key part of making best use of these resources. Care provided closer to home makes best use of local NHS resources.
CCG priorities	Right Care identified circulation, musculoskeletal, gastroenterology and genito- urinary as areas where elective procedures were consuming more resources compared with top 5 similar CCGs. Unwarranted variation is an indicator of lower-value healthcare. If unwarranted variation is addressed, it could release resources to fund higher-value healthcare. Care, wherever possible, to be provided closer to home.
Aim	To ensure that practices utilise NHS resources for its patients in evidence –based manner in-line with agreed local and national clinical pathways and guidelines.
Delivery	Adherence to local protocols and procedures - Map of Medicine (to be replaced by STRATA) - Prior Approval process for procedures listed in North Cumbria Value Based Commissioning Policy - Advice & Guidance - Shared Decision Making Tools - eReferral system - Right Care pathways eg MSK, gastro Internal Peer Review - review all referrals if identified as outlier (practices 1 S.D from North Cumbria mean) ensure actions are identified to reduce. Practice process for peer review of referrals for new doctors and locums.
Metrics	Procedures of Limited Clinical Value (listed in CCG Value Based Clinical Commissioning Policy) rates per 1000 weighted population - below or within 0.25 S.D of North Cumbria CCG mean
	Out-patient first attendance: gynaecology, rheumatology, orthopaedics, urology, gastroenterology, cardiology and vascular surgery (GP referral) rates per 1000 weighted population - below or within 0.25 S.D of locality median

8.0	**Pro-active care management to improve outcomes**
Rationale	Pro-active care planning as a method of planning personalised support is promoted as a key enabler in a number of national programmes; Putting People First, Valuing People Now and Capable communities and Active citizens.
CCG priorities	Integrated Care Communities are a key WNE STP priority for delivering person centred care in people's homes and communities. Safeguarding children and vulnerable adults is a key CCG priority.
Aim	To provide person-centred and co-ordinated care, understanding the interaction between physical, psychological and social issues
Delivery	Provide care and support planning to patients identified requiring more support to improve their health and wellbeing Proactively identify cohorts of patients who at risk of admission & ensure they have a care & support plan Where appropriate a care & support plan should be made available to other health professionals via the Summary Care record Safeguarding GPs, when requested, to attend and/or provide a report for multiagency child protection conference Monitor the number of case reports & meetings requests (including notice period) for child protection conferences & number submitted/number attended
Metrics	Emergency admissions rates - practices to be below or within 1 S.D of North Cumbria practice mean

9.0	End-of-Life care
Rationale	The NICE Quality Standard for End of Life Care for adults (2011) http://www.nice.org.uk/guidance/qs13 provides a comprehensive picture of what high quality end of life care should look like. Delivered collectively, this should contribute to improving the effectiveness, safety and experience of care for adults approaching the end of life and the experience of their families and carers. Advanced Care Planning discussions with patients and their families or carers will support delivery of those quality standards.
CCG priorities	IAF indicator - % deaths with three or more emergency admissions in the last three months of life
Aim	To ensure that patients receive the appropriate, co-ordinated care at the end of their life.
Delivery	Identification of patients for the extended palliative register. Ensure that advanced care planning is offered to all patients identified as approaching the end of life ie likely to die within next 12 months. Include discussions regarding Advance Decision to Refuse Treatment (ADRT)/Emergency Health Care Plan where it is considered an appropriate time to discuss Ensure advanced care plans are revisited annually Use of Special Patient notes to notify CHOC and 111 Use of EPACCS – enter key information onto the template to enable sharing Care plan should be made available to other health professionals via the Summary Care record
Metric	% patients who died between 1st April 2018 - 31st March 2019 who had an advanced care plan discussion or Deciding Right form in place ≥ 70%

Potential QIS activity -

1. **Standard 7 - Improving Planned Care**

Delivery -
Provision of phlebotomy, ECGs and post-op wound care as requested by secondary care clinicians (if numbers increase significantly beyond the baseline audit this element of the contract will be reviewed)

Funding - £1/head money

2. **Standard 8 - Pro-active care management to improve outcomes**

Aim – joint working with key partners of the ICCs such as the community and social care teams and out-reach secondary care specialists

Delivery -

Integrated Care communities joint working

- Attendance at MDT and/or secondary care specialist meetings
- Undertaking any identified activities to support MDT agreed patient actions
- Undertake any required GP visits throughout the GP working day (8-6.30pm) to the cohort of patient previously treated as inpatients
- Support enhanced care and support planning
- Participate in ICC development activities

Engage in delivering the discharge to assess model.
Share information with the coordination Hub to support population intelligence and pro-active MDT working.
Sign data sharing agreement with approved health and social care organisations so that at the point of contact patients can choose to share their data with the health or social care professional that is looking after them at the time.

Metrics –
Reduced readmission rate
Number of care plans xx/1000 patients
Number of MDTs undertaken xx/1000 patients

Additional funding required

3. **Standard 10 – Engagement- supporting a culture of continuous improvement (new standard)**

Rationale - People need to be supported and to feel valued in order to do their work well. Time spent developing quality improvement must be recognised as integral to service delivery.

CCG priorities - Being committed to a journey of continuous improvement, utilising Quality Improvement (QI) tools and the available evidence and reviewing service delivery to ensure this is sustainable, cost-effective and meets the changing needs of patients.

Aim - Leading and participating in systematic and evidence-informed approaches to improving patient care and health services.
Understanding the needs of their communities and populations and working closely with those involved in planning the delivery and evaluation of local health and social care services and the voluntary sector to ensure co-ordinated and cost-effective care delivery.

Delivery - The practice will identify a Quality Improvement Lead
The ICC will identify a Quality Improvement Lead
Relevant staff will attend clinician-led learning groups. The aim of the learning group is to focus on the delivery of improved clinical care.
The clinical areas will be influenced by the Quality Improvement Scheme standards
Local priorities; public health needs; capacity and capabilities of constituent practices will inform the peer group discussions.
The meetings will take place during the six dedicated ICC Protected Learning Time sessions

Metrics – to be decided. Could include attendance at meetings and production of a report with two examples to demonstrate the above.

Additional funding required.

Standard		Recommended change
1. Ensure a pro-active approach to health improvement and early detection	COPD, heart failure, asthma, CHD, stroke and diabetes 1 point ≥ - 0.5 S.D of North Cumbria practice mean at Q3 2017/18	Added to metrics
4. Improving cancer survival rates and earlier diagnosis	Ensure uptake for cervical screening for eligible patients ≥ 80% Ensure uptake for bowel screening for eligible patients ≥ 65%	Add to delivery section
	Ensure uptake for cervical screening for eligible patients ≥ 80%	Remove from metric section as data not timely enough to be used a target
5. Improving health outcomes for patients with a mental health condition	% patients on the practice MH register who have had an annual physical health check	Lower target from 80% to 75% as current target at 48%; stretch was considered too big. Also in-line with the other MH targets.
6. Improving Access to Primary Care services	85 clinical contacts per 1000 population/week (Mon-Fri) with registered health professional	Remove as target due to data integrity. Include in delivery section for monitoring this year. Reconsider as target for 19/20.
	A/E and MIU attendances rate	Undertaking review of data as MIU attendances may skew the mean. May only use A/E attendances as seek to identify the fairest indicator.
8. Pro-active care management to improve outcomes	Safeguarding GPs, when requested, to attend and/or provide a report for multiagency child protection conference Monitor the number of case reports & meetings requested for child protection conferences & number submitted/number attended	Include in delivery section rather than metric/target section.
9. Improving End of Life	% patients who died between 1st April 2018 - 31st March 2019 who had an advanced care plan discussion or Deciding Right form in place ≥ 80%	Lower target from 80% to 70% to account for unexpected deaths. Current target 56%.