

Primary Care Local Quality Premium 2018-19 Guidance Document

The following schemes within the Integrated Delivery Framework offer for 2018-19 are now available to apply through HullCCG.Business@nhs.net – please respond by Friday 11 May 2018 – commencement planned 1 June 2018.

Key information

- Eligibility - primary care working at scale with a patient population of 30,000 and over.
- Payments will be based on March 2018 list size.
- Payments will be made quarterly on submission of progress reporting or the appropriate criteria set out in individual schemes.
- Groupings can choose to participate in one, two or all schemes

Reporting

- It is expected that the nominated GP grouping lead will collate information from individual practices to present in quarterly reports and for discussions, for example working groups, grouping PTLs, presentations and other forums in agreement with the Integrated Delivery Support Team.
- GP groupings will need to evidence that all individual practices have agreed to undertake the schemes and provide updates to regular meetings decided upon by the GP grouping leadership team.
- Nominated CCG personnel will support the development and completion of reporting where required in addition to CCG group leads.

Managing Need - Scheme 1 (25p per patient list size)

1. Clinical Peer Review
2. Prescribing
3. Multiple admissions to HEYHT (MH & alcohol)

Chronic Disease -Scheme 2 (25p per patient list size)

1. Cardiovascular – Heart Failure
2. Cardiovascular – Atrial Fibrillation
3. COPD – NICE audits
4. Children's' Asthma

Primary Care Data Quality Scheme 3 (25p per patient list size)

1. Community Frailty Pathway – eFI search and coding
2. Community Infections in Care Homes
3. Data Quality review

Future schemes to be agreed for 2018/19

GP follow up assessment post ICC assessment

Managing Need 2018-19
Primary Care Quality Premium

Scheme 1 – Clinical Peer Review

Overarching aim:

GP NHS e-Referrals / rejections / advice and guidance activity will be monitored monthly to understand any issues that affect patient flow / 18 weeks performance.

1. Clinical Peer Review

ACTION

1. Practices will embed the use of an electronic template which will be provided by the CCG to record clinical peer review.
2. Practices will be asked to supply evidence of activity and any trends and themes to include information on findings through each quarterly period, which should be coordinated by GP group lead.
3. Support and share learning across the CCG through different mediums i.e. provider forum, PTL.

Information required for clinical peer review

1. Referring GP / Practice
2. Date of referral
3. Patient ID
4. Clinical symptom / problem for referral
5. Clinical history / medications
6. Previous treatments or appointments
7. Red flags or issues
8. Clinical Peer review GP/ practice
9. Date of review
10. Clinical decision post clinical peer review and informing the patient of decision
11. Notes for discussion with referring GP

See Portal for further detail

<https://portal.yhcs.org.uk/group/hull-ccg/clinical-peer-review>

Managing Need 2018-19 Primary care Quality Premium

Scheme 1 - Prescribing

Overarching aim:

Prescribing audits - antibiotics / QIPP plan – resource will include Pharmacist leads from each GP group (4 hours protected time per week)

GP Grouping Prescribing Leads will support priority elements of the agreed CCG Medicines Optimisation Work plan 2018/2019 in particular face to face element of patient reviews.

GP grouping lead clinical pharmacists will co-ordinate individual GP practices work in the priority areas below:

1. Analgesia

ACTION

Practices within GP groupings will complete annual review by implementing recommendations of the medicines optimisation team and provide follow up appointments for patients on alternative medication where drug choice indicates a follow-up is required. To maintain a register of all patients on strong opioids via system search and, provide quarterly update to GP group Pharmacist lead for CCG report.

(Buprenorphine, dipipanone, fentanyl, hydromorphone, morphine, oxycodone, pentazocine, pethidine, tapentadol (tapentadol not routinely commissioned by the CCG): plus (excluding injection formulations and buprenorphine preparations prescribed for the management of opioid dependence) to improve safety/quality in prescribing and reduce prescribing costs with an overall aim to reduce volumes of strong opioids in use.

FAQ

Is this duplicated with contractual / extended schemes?

% of morphine of all strong opioids is in the GP practice extended scheme. This is not included in QOF. Including this in the groupings scheme is seen as a way to review all strong opioids including the historical patients and also existing morphine patients who would not necessarily be reviewed as per the GP practice extended scheme indicator. It is felt this is a go further element around individual reviews of opioids.

How many had an annual review versus number on the register?

All patients on both would be an expectation

What about onward referral

This would be part of normal treatment if needed after GP practice review.

Can the process be done non-face to face?

There would be a significant amount of face to face reviews by the practices hence the go further element and inclusion in the groupings incentive scheme.

How does this interface with pain clinic or RENEW?

As above would be part of normal treatment if needed after GP practice review.

2. Low priority medicines consultation reviews to support implementation

ACTION

Practices in groupings to complete reviews by implementing recommendations of the medicines optimisation team and providing follow up appointment for patients on alternative medication where drug choice indicates a follow-up is required. To maintain a register of all relevant patients via system search and provide quarterly update to the CCG.

<https://www.england.nhs.uk/wp-content/uploads/2017/11/items-which-should-not-be-routinely-prescribed-in-pc-ccg-guidance.pdf>

Items of relatively low clinical effectiveness or which are unsafe:

- I. Co-proxamol
- II. Omega 3 Fatty Acid Compounds
- III. Lidocaine Plasters
- IV. Rubefacients (excluding topical NSAIDs)
- V. Dosulepin
- VI. Glucosamine and Chondroitin
- VII. Lutein and antioxidants
- VIII. Oxycodone and Naloxone Combination Product
- IX. Homeopathy items
- X. Herbal medicines

Items which are clinically effective but where more cost-effective items are available in most cases (this includes items that have been subject to excessive price inflation):

- I. Liothyronine
- II. Prolonged Release Doxazosin
- III. Perindopril Arginine
- IV. Immediate Release Fentanyl
- V. Once Daily Tadalafil
- VI. Trimipramine
- VII. Paracetamol and Tramadol Combination product*

Items which are clinically effective but, due to the nature of the item, are deemed a low priority for NHS funding:

Some travel vaccines already not permitted on the NHS.

FAQ

What do you expect practices to check in link?

[Review the individual drugs listed in the document and decide to stop/use alternative/continue if justified after identified by the medicines optimisation team.](#)

Can we supply a template to practices?

[The Medicine Optimisation \(practice team\) will develop a review template](#)

3. Self-care – Over the counter medicines consultation outcomes.

ACTION

Each practice within groupings will complete reviews to support implementation - achieved via participation in education of patients and staff and provide quarterly update to GP group Pharmacist lead for CCG report.

<https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed/>.

FAQ

Can practices identify 1 or 2 medications to be targeted rather than full list?

This should be all included in the consultation.

Is this for acute prescriptions?

This will include both

4. Antibiotics

ACTION

Practices in groupings to produce an action plan by the end of Q1 2018/2019 to reduce inappropriate antibiotic prescribing volume based on the 2017-18 medicines optimisation antibiotic audit findings. To provide quarterly update to the CCG of the changes made to practice as a result of the action plan.

<https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/qual-prem/>

- Quality Premium area re: 10% reduction or greater in the number of trimethoprim items prescribed to patients 70 years or over.

FAQ

Is this scheme a duplication with the extended service?

The quality premium is a challenge to achieve and high priority for the CCG hence why included to get a GP grouping approach to affect behavioural change.

Managing Need 2018-19
Multiple admissions (frequent)

Scheme 1 – Non- elective multiple admissions

Overarching aim:

Practices will monitor and review patients that are recorded as having multiple admissions with a secondary care diagnosis coding for mental health and/or alcohol.

1. Multiple emergency admissions to Hull & East Yorkshire Hospitals

ACTION

1. Each GP grouping will identify a clinical lead to participate within this project
2. Each Clinical Lead will be invited to join a CCG project group where there will be an opportunity to network with professionals (4 meetings estimated).
3. Each Clinical Lead will liaise with their GP practices to feedback suggestions and project initiatives to support the work plan and understand existing activity. This may include reviewing patient activity, themes and trends, reasons for highest volume, and reviewing actions taken to support patients such as MDTs, care planning, care coordinator, social care, etc. There will also be a need to provide information to the project group and other forums such as Provider Forum as required.
4. The Clinical lead will implement best clinical practice and develop and agree approach with their practices, to include regular review and monitoring of those patients identified and recorded as having frequent non-elective multiple admission (5 or more in a rolling 12 months).
5. Each GP practice will support the Clinical Lead in delivering the project and provide soft intelligence to the Clinical Lead for example summary of any gap in service that necessitated an admission, access to appointments in primary care, community services, waiting times, pathways. (This will support the quarterly report to the CCG)
5. Practices will be required to add the appropriate READ Code/SNOMED to monitor emergency admissions - see data quality section.

Monitoring

A template will be provided for data collection on a quarterly basis for 2018-19

Chronic Disease 2018-19 Primary care Quality Premium

Scheme 2 – Chronic Disease

Overarching aim:

Early diagnosis and management of patients with chronic disease remains a priority for the City and focus for Hull CCG 2018-19 is as follows:

1. Heart Failure

Heart Failure prevalence rates are below expected rates based on epidemiological models. Evidence from audit work undertaken by the local academic department of Cardiology suggests a number of patients in the community who are being prescribed long term loop diuretics will have heart failure but have not been given a firm diagnosis of heart failure or indeed coded in the clinical record.

ACTION

1. Practice to identify all patients being prescribed a loop diuretic and without a HF diagnosis
2. Review identified patients and undertake NT-pro-BNP test where indicated and then act on results as per local guidance. There will be some patients for which further investigation may not be appropriate, these patients should either be diagnosed and coded based on their clinical presentation or a clear reason for non-investigation recorded.
3. Patients in whom a diagnosis of heart failure is made following specialist assessment should be coded in the practice system using appropriate READ code/SNOMED.
4. Annual review* of all patients on HF register to ensure optimal treatment in line with NICE Quality Standard 9: *Chronic heart failure in adults* (June 2011, updated February 2016).

*Read code to be used for annual review and practice/gp grouping recall system to be established. The annual review may be delivered as part of a broader review where patients have co-morbidities.

Monitoring – data will be required at 6 monthly intervals

- Number of reviews
- Number of patients prescribed a loop diuretic without a HF diagnosis
- Number of BNP test completed in reporting period
- Number of patients referred to a specialist
- Number of confirmed HF diagnosis
- Number of patients added to the HF register

Evidence of prevalence increase by **April 2019**

2. Atrial Fibrillation (AF)

Data from the Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) has identified Hull as having high levels of stroke mortality. AF strokes are the most devastating in terms of both mortality and long term disability so optimising treatment, including anticoagulation, is key to reducing stroke mortality and improving outcomes.

ACTION

1. Practices to identify all patients with a diagnosis of Atrial Fibrillation or Paroxysmal Atrial Fibrillation and a CHA2DS2-VASc of 2 or more who are not prescribed anticoagulation. (QoF)
2. Practice to review patients not receiving anticoagulation therapy; where anticoagulation contraindicated the reason should be recorded/coded within the practice clinical record.

3. External clinical review* by a clinician from another practice within the grouping undertaken on all contraindicated patients and recommendations made for changes to treatment
4. Outcome of external review and any change in treatment recorded within the patient record
5. Advice and Guidance with Cardiology and any other appropriate specialty to be used where required

* Data sharing agreements to be in place

Monitoring – data will be required at 6 monthly intervals

- Number of reviews
- Number of patients moved to anti coagulation following a review
- Number of patients not receiving anti coagulation with a CHA2DS2-VASc of 2 or more
- Number of patients not receiving anticoagulation therapy; where anticoagulation contraindicated the reason should be recorded/coded

3. COPD NICE Audits

All healthcare professionals involved in assessing, caring for and treating people with COPD should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Standard 10: *COPD in adults* (July 2011, updated February 2016).

ACTION

1. Each GP group Nurse Lead will work with practices to understand any training requirements and competency level of nursing workforce
2. Will work within nurse network to feedback any gaps in training requirements and look to support improvement of COPD care
3. Will look to work collaboratively across the group and link with pharmacists to provide evidence of written clinical protocols to ensure that people with COPD who are prescribed an inhaler have their inhaler technique assessed when starting treatment and then regularly during treatment. (An audit summary of numbers completed will be required in the year-end report).
4. Coordinate evidence of local written clinical protocols to ensure that healthcare professionals in primary care are trained and competent in teaching inhaler technique.

4. Asthma in Children

Increase the number of children with an asthma management plan including treatment which complies with NICE guidance

ACTION

1. Each practice will identify a nurse lead to undertake an audit of the practice register to identify all children and young people aged under 17 with an asthma diagnosis.
2. Each GP grouping Nurse Lead will agree an approach with practices to review all children and young people identified to ensure treatment compliance against NICE (NG80), recommendations and amend prescribed medicines accordingly.
3. Each Practice Lead will ensure all children and young people identified have a care plan with supportive information for both the child and parents to manage the child's asthma condition, which should be completed by **March 2019**.

Data Quality 2018-19 Primary care Quality Premium

Scheme 3 – Improving Data Quality

Overarching aim:

Each GP grouping will provide a Business Intelligence lead name who will support project work in 2018-19 working with CCG personnel on the following areas.

1. Community Frailty Pathway – Jean Bishop Integrated Care Centre

ACTION

1. Each BI group lead will implement a process for identifying severe and moderate frail patients based on eFI score for referral to comprehensive Geriatric Assessment (guidance will support this)
2. Practices within each group will aim to reach 15% (of all patients) recorded with an enhanced summary care record by **December 2018**
3. Practices will reduce variation of coding by targeting patients as ‘living in a care home’ and refresh their residential institution status (as this impacts weighted payments), report monthly to provide the CCG with eFI scores of severe and moderate patients by strategic ID, report monthly the number of those patients living in care homes by care home name.
4. Run ad hoc reports as required to support the ICC planning and evaluation project
5. Each BI GP Group Lead will implement a process for managing eFI frailty coding during frailty assessment (based on agreed protocols/templates) for all practices within their group (this is linked to initiative 3 (coding in practices).

2. Community Infections in Care Homes

Hull CCG has been working with local care homes to implement best practice to ensure residents who have a suspected UTI, receive treatment when the first symptoms are recognised. This will require the care home to contact the registered GP practice quickly with the aim of preventing a hospital admission.

ACTION

1. GP practices will respond to requests for an assessment from care homes when contacted by telephone or email in a timely manner.
2. Each GP practice will monitor the number of requests from care homes each quarter and add the appropriate READ code / SNOMED code so that activity may be obtained quarterly to support the UTI project. Each GP Group BI Lead will collate the information to support the quarterly report to Hull CCG.
3. Provide data to the CCG quarterly to inform trends and themes

Monitoring

- Number of patients that require an assessment
- Number of patients dehydrated in reporting period (using the coloured rating scale)
- Number of antibiotics prescribed and number of patients that responded to initial antibiotic treatments i.e. require no further treatment.

3. Coding in Practices

To improve the consistency of data quality across GP groupings and Hull CCG and, support practice staff by providing guidelines for future working protocols.

ACTION

1. Each GP grouping will identify a Business Intelligence lead to participate in quarterly data workshops with CCG reps and other stakeholders to support and implement data quality solutions within GP practices.
2. Each BI Lead will work across their practices to implement consistent processes and share best practice (with the support of CCG personnel), including templates and protocols, guidance for coding etc. (TOR to be issued when group established).
3. Work streams will be established to prioritise coding for key areas for example Frailty, care homes, emergency admissions, disease diagnosis review, co-morbidities, respiratory, asthma, but not exhaustive.