Quality Improvement Scheme 2015-16

Following discussion at the January and March Executives, feedback from the Governing Body, and Member Practices at Locality Meetings and PLT, the Clinical Locality Leads worked with Clinical Commissioning Directors to develop detail of the 2015/16 Quality Improvement Scheme (QIS), which can be found below.

Context

The Quality Improvement Scheme has been key for engagement and a success for the CCG in achieving quality and efficiency savings.

The Scheme for 2014/15 met critical review from membership, therefore a poll was conducted with members to influence the design of the 2015/16 Quality Scheme model. The outcome of the poll gave two preferred options, which have been used as a basis for the QIS:

1. Engagement: a fixed amount to practices for showing commitment and engagement with the commissioning agenda (similar to that in 2014/15)
2. Guaranteed payment for project work over and above core GMS contract or other payments e.g. QOF, DES, LES, etc.

The Scheme will align with CCG priority areas, as identified in the operational plan:

1. Prevention
2. Diabetes
3. End of Life Care

General Principles for any Quality Scheme

1. Projects should align with the CCG's clinical priorities
2. Projects should be evidence-based to improve quality
3. Projects should have clear patient outcomes
4. Projects should be SMART – Specific, Measurable, Achievable, Realistic and Timely
5. Projects should have baseline data from which progress can be measured and commensurable
6. Data collected to measure project outcomes should be simple to collect and report
7. Project work should be appropriately costed and funded

The 2015/16 Scheme

Sign-Up and Engagement

All practices will be asked to indicate their commitment to the scheme by signing up to all the agreed set of criteria:

- GP attendance at CCG meetings (at least 66% each of all locality, prescribing and urgent care meetings)
- Cascading and embedding learning from the meetings back to practices
- Working with the locality and portfolio teams to share and embed best practice
- Supporting prescribing, urgent and planned care portfolios to develop and implement plans and interventions
- Supporting the locality to remain within budget through the locality QIPP programme (Quality, Innovation, Productivity and Prevention)
- Providing commitment to working on each of the three work streams identified (which are in alignment with the CCG strategic priorities)
- Continuing participation in Multi-Agency Group (MAG) meetings
- Signing up to 2014/15 National Diabetes Audit and comply with national IG requirements to enable data submission http://www.hscic.gov.uk/nda by the national deadline of 14th August 2015.
- Agreeing to run GRASP AF audit twice in year and upload/share as required (CSU support available)

A fixed payment totalling £6,000 per practice will be available as payment to each practice for signing up to the above QIS obligations and principles. This total payment will be guaranteed where the above criteria have been met, with payment made in Q1 2016/17.

NHS Chiltern Clinical Commissioning Group – Quality Improvement Scheme 2015/16

In signing up to the Quality Improvement Scheme, the practice commits to the criteria listed below.

Practice K Code:

Practice Name:

- GP attendance at CCG meetings (at least 66% each of all locality, prescribing and urgent care meetings)
- Cascading and embedding learning from the meetings back to practices
- Working with the locality and portfolio teams to share and embed best practice
- Supporting prescribing, urgent and planned care portfolios to develop and implement plans and interventions
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Signed: ……..
(Senior Partner or representative)

Date: ……....

Email to chilternccg.gis@nhs.net or post to NHS Chiltern Clinical Commissioning Group, Chiltern District Council Offices, Ground Floor, King George V Road, Amersham HP6 5AW by **Friday 31st July 2015**.

Quality Targets

Target 1: Diabetes

Optimisation of treatment in diabetic patients will prevent diabetic complications

Aim

80% of type 2 diabetes patients will have a latest recorded HbA1C within the last 12 months of:

- ≤48mmol/mol if diet only **and**
- ≤ 53mmol/mol if on metformin only

Funding

A total fund of £330,000 will be available, to be divided between practices on a fair shares principle based on practice population. The target will be on a sliding scale, so for example if a practice achieves 50% movement in one target they will be entitled to 50% of the payment. This will reward those practices showing movement from baseline and thus improvement in quality, as well as those already reaching the targets and demonstrating best practice.

Summary

Building on practice work and investment in 2014/15, a continuation of optimisation of diabetic patient treatment. It is judged that this investment could show in-year savings by improving glycaemic control, e.g. reduced A&E attendances, reduced infections, and reduced unplanned admissions. Further significant benefits are seen in the longer term; reduced diabetic complications; cardiovascular disease, strokes, amputations, eye disease and renal disease, etc.

Continued support and education will be provided by the Medicines Management Team.

Scheme Detail

QIS 2015-16
Diabetes v1.0

Target 2: End of Life

Shared care plans for End of Life (EoL) patients will reduce unplanned admissions in their final year, and increase the percentage of patients dying in their preferred place of death. It is expected that 1% of the practice population will die within a year.

Aim

- Identification of patients in last year of life (estimated 1% of practice population) **and**
- For each patient identified, for an End of Life care plan to be created and uploaded to the BCCR

Funding

A total fund of £265,760 will be available, based on a payment of £80 per completed EoL plan. This will be capped at 1% of the practice population. This funding is based on the CCCG practice population size in January 2015, with 1% of the population at 3,322.

Summary

Completion of care plans will be expected to include:

- a face to face discussion with patients at end of life
- DNR status
- preferred place of death
- any advanced directives

The BCCR is the current platform for sharing care plans with other health professionals (Ambulance, Out of Hours etc.) therefore the End of Life Care plan is to be added to the BCCR to enable sharing of the plan.

Please note that once the Medical Interoperability Gateway (MIG) is operational, practices will be required to read code the *subsequent* EoL care plans onto their own practice systems (rather than BCCR) in order to benefit from the sharing of the plans with relevant stakeholders.

Scheme Detail

QIS 2015-16 EoLC Plans Apr15 v1.0.doc

Target 3: Prevention

Identifying adults at risk of developing obesity-related diseases, and providing a healthy lifestyle leaflet to those patients at risk, aiming to prevent the onset of obesity-related disease.

Aim

The identification of adults with BMI ≥30 (BMI ≥27.5 for BME patients), and the provision of a healthy lifestyle leaflet to these patients.

Fund

A total fund of £83,250 will be available, with payment based on £2.50 per case identified with a BMI ≥30 (or BMI ≥27.5 for BME patients[1]), capped to 10% of practice population. Payment takes into consideration that BMI recording is included in some existing funded work schemes.

Summary

Identifying adults at risk of developing obesity-related diseases, intervening and offering healthy lifestyle advice to those patients in order to reduce their risk and empower them to make healthier choices. Through the opportunistic screening, the aim is to identify 10% of the adult population who are obese, offering them a leaflet summarizing the appropriate advice and interventions, including exercise, healthy eating and weight loss programmes.

Scheme Detail

QIS 2015-16 Weight Management v1.0.do

[1] From NICE Obesity Guidelines November 2014, lower threshold recommended for Black African, African-Caribbean, and Asian (South Asian and Chinese) Groups

Reporting

Where possible, existing management information systems will be used to report on these quality targets. Further detail is provided in the scheme outline documents.

Funding available to practices

The maximum total fund available by practice, subject to meeting all criteria and targets, is shown in the table below.

QIS 2015-16 Funding Available

Rewards from the scheme

Careful consideration has been given to how funding should be distributed to practices. It has been agreed that the Engagement and the Quality Target funding will be direct awards and therefore used at practices' discretion. This takes into account the clinical and non-clinical time investment taken out from the practice for the sign up and engagement elements of the Scheme, as well as appropriate compensation for work done towards achieving the quality targets.

Questions and Answers

We have produced a summary of questions and answers raised following discussions with practices on the QIS.

QIS 2015-16 Q&A v1.0