Quality Improvement Scheme 2016-17

Following discussion by the Executives, feedback from the Governing Body, and Member Practices at Locality Meetings, the Clinical Locality Leads worked with Clinical Commissioning Directors to develop detail of the 2016/17 Quality Improvement Scheme (QIS), which can be found below.

Context

Historically this Scheme has previously met critical review from membership; therefore as part of the process for 2016/17, member practices will be consulted on the in the design of the schemes through the locality meetings.

The outcome of our engagement has once again provided two preferred options, which have been used again as a basis for the 2016/17 QIS:

1. **Engagement -** a fixed amount to practices for showing commitment and engagement with the commissioning agenda
2. **Guaranteed payment for project work** - over and above core GMS contract or other payments e.g. QOF, DES, LES, etc.

The Scheme aims to align with CCG priority areas:

1. Prevention – Improving health outcomes for patients with or at risk of developing LTC's by referral to Live Well – Stay Well Lifestyle Services.
2. End of life care
3. Diabetes – optimisation of treatment to prevent diabetic complications
4. Dementia Friendly Surgeries

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 2016/17 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 /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 locality QIPP
- Providing commitment to working on each of the four work streams identified (which are in alignment with the CCG strategic priorities)
- Sign Up to National Diabetes Audit
- Agreement to run GRASP AF audit twice in year (CSU support available)

A fixed payment totalling £6,000 per practice is recommended 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 2017/18

Rewards from the Scheme

Careful consideration has been given to the conditions around which funding should be distributed to practices, with agreement that:

- All of the funding made available to practices (sign-up, engagement and quality payment) can be used at practice 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.

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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
- 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 four work streams identified (which are in alignment with the CCG strategic priorities)
- Continuing participation in Multi-Agency Group (MAG) meetings
- Signing up to the National Diabetes Audit and comply with national IG requirements to enable data submission http://www.hscic.gov.uk/nda by the national deadline (to be confirmed – please check above website for update).
- Agreeing to run GRASP AF audit twice in year and upload/share as required (CSU support available)

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 6 May 2016**

Quality Targets

Target 1: Prevention: Improving health outcomes for patients with or at risk of developing long term conditions (LTC) by referral to Live Well – Stay Well Lifestyle Services

Chiltern CCG has identified ill health prevention as a key clinical priority and has worked with Public Health to jointly commission Live Well Stay Well lifestyle services to support patients seen in Primary Care.

Aim

- To offer the appropriate level of support to help more people make positive lifestyle changes
- To improve the health and social outcomes of people with, or at risk of developing, an existing LTC, supporting positive lifestyle changes
- Reduce the number of people developing LTC's so reducing the health care burden

The Live Well Stay Well service will not be fully launched until 1st July 2016. For Q1 of this QIS Scheme please read the notes under Appendix 2 within the process document below which will explain how the scheme will run during Q1 with the existing Live Well and Get Healthy Bucks Services. Also, during Q1 the QIS 15/16 BMI Obesity QIS will continue to run, this is also detailed in the process document.

Fund

The tiered payment schedule includes:

- £2 per patient referred to Live Well-Stay Well Services (or on presentation of the leaflet)
- £2 per patient who engages with the service
- A supplementary £2 payment if the patient referred is from an identified at risk cohort and accesses Live Well Stay Well Services.
    - psychosis
    - bi polar disorder
    - schizophrenia
    - Pre diabetes Learning Disabilities

Payments capped at 2.5% of practice population (data provided within process)

Patient cohort:

Adult (over 18) patients willing to consider positive lifestyle changes that impact on their health that are happy to be referred or signposted to Live Well Stay Well service.

Summary

Practices will opportunistically and strategically identify adult patients and carers who would benefit from making lifestyle changes. Practitioners will discuss the benefits of making positive lifestyle changes with their patients and signpost or refer them, via a single point of access, to the countywide Live Well Stay Well service. Specific READ codes are indicated within the process. Referral forms and patient leaflets are available via DXS. Practices will receive feedback on patient engagement and progress. Payment will be made for referral or presentation of the leaflet and

increased when patients contact the service. An additional payment will be made if these patients are from the following groups and engage with the service:

- Patients with psychosis
- bi polar disorder
- schizophrenia
- Pre diabetes
- Learning Disabilities

Live Well Stay Well QIS Process:

Live Well Stay Well QIS Process

Target 2: End of Life

Shared care plans for patients at the end stages of life have been shown to reduce unplanned admissions in their final year, and increase the percentage of patients who die in their preferred place of death. In the last 12 months of life, patients average 3.5 emergency admissions, and it is estimated that up to 20% of all hospital beds are occupied by those who are dying. Effective advanced care planning can help to avoid these unnecessary admissions and extended hospital stays, and improve end of life experience for patients and their carers and family.

Transfer from BCCR to SCRAI

Currently BCCR hosted on Adastra is used to share Advanced Care Plans (ACPs) with SCAS, A&E and End of Life (EoL) providers. The method of sharing clinical information will be transferred in 2016/17 from BCCR to the national Summary Care Record Additional (SCRAI). This will remove the need for double entry. By using the clinical templates provided this will ensure all information is correctly coded, allowing this information to be visible on the SCRAI, without any further input from the practice. It is recommended that practices continue to double-enter information into both Adastra and their clinical system until advised that the BCCR has been turned off; in order that End of Life providers can continue to see the data. We expect that the BCCR will be switched off by end of Quarter 1 2016.

Aim

To increase identification of patients expected to die within the next year, and put in place appropriate care and support to ensure that the patient and carers have time to deal with the news, that patients are less likely to be subject to treatments of limited clinical value, that appropriate care management plans can be put in place, and that appropriate community support can be organised around the patient to increase the likelihood that they can die in their preferred place of death.

Funding

The payment will be £80 per **newly created** ACP record within the clinical system during the period 9th May 2016 to 31st March 2017 inclusive using (and completing the agreed fields within) the provided clinical templates, and *excluding* those eligible for backfill payment as part of the BCCR transfer process[1]. Payment will be based on the number of End of Life ACPs completed, with practices required to achieve at least 10% of their individual target (0.1% of total practice population) before receiving a payment in Quarter 1 of 2017/18.

Patient cohort

1% of practice population expected to die within the next year (2016/17), with patients aged 80+ priority (in 2008, 62.6% of women who died and 43.2% of men who died were aged 80+)

Summary

- Practice identifies 1% of their practice population most at risk of dying within the next year and adds these to practice End of Life Register.

[1] Information on Transfer payment process from CSCSU: 'The Wire Special Edition – BCCR Transition' or for further details contact cscsu.ipp-bucks@nhs.net

- Practices are expected to maintain their 1% practice End of Life population. As individuals die the practice will be expected to identify additional patients to maintain the figure.
- Advance Care Plans are created for all of the 1% patients on the End of Life Register using the CCG provided clinical templates and by completing the relevant fields within them.
- Completion of an ACP denotes that a **face-to-face** discussion has been held with the patient by an appropriate clinician.

Scheme Detail

END OF LIFE Final v4.0.docx

Target 3: Diabetes: Optimisation of treatment to prevent diabetic complications

Type 2 diabetes can cause both macrovascular and microvascular complications and there is a good evidence base showing that decreasing the HbA1c level can reduce the risk of developing these complications. It is also known that good control in the early years of type 2 diabetes can delay long-term vascular complications. NICE guidance recommends that people treated with lifestyle measures alone or who are taking metformin the usual target HbA1c value is 48mmol/mol and for those taking two or more anti-diabetic drugs the target HbA1c is less than 59mmol/mol. These targets are based on the evidence that there is a balance between benefit and harm with treatment intensification

Aim

80% of type 2 diabetes patients (excluding those with eGFR<30) will have a latest recorded HbA1C within the last 12 months of:

- ≤58mmol/mol if on dual therapy

Patients with an HbA1c ≤48mmol/mol on diet only or ≤ 53mmol/mol if on metformin only will continue to be monitored and practices will be expected to maintain current position and aspire to improve.

Fund

This is not an all or nothing target: baseline data will be taken, and progress from this towards the 80% target will attract sliding scale payments. Practices achieving 80% will receive 100% of the practice allocation.

The fund will be divided by patient diabetic population. Practices will be entitled to a percentage of the diabetes fund based on the percentage movement from baseline to 80% of dual therapy patients. The total fund available is £60,000 across the CCG. *E.G. if a Practice has £5000 fund, current position = 60% end position = 70% Movement is 50% of total therefore entitled to £2500.*

Patient cohort

In order to be eligible patients will have a current diagnosis of diabetes and:

- Receiving dual oral therapy treatment,
- All patients with a diagnosis of Type 1 diabetes **only** and those with an eGFR <30 are excluded from this cohort.

Summary

Searches have been developed for the monitoring of these target areas and are based on high level coding and prescribed items in the current record. The Medicines Management Team (MMT) endeavours to ensure that searches are accurate, but if uncommon read coding is used these will not be identified in the search.

- Any anomalies in coding identified by the MMT will be communicated to the practices concerned so that action can be taken if necessary.
- Practice will review the records of individual patients who meet the search criteria and optimise treatment as appropriate for the individual patient.
- Treatment optimisation or step 2 will include
    - Initiation of first line second oral therapy as per local guidelines when patient is not to target on maximum tolerated monotherapy

- Titration to maximum tolerated dose to meet HbA1c target
- Consideration of alternative dual therapy where first line is contraindicated or not tolerated as per local guideline
- optimisation of dual therapy

Scheme Detail

QIS 2016.17
Diabetes

Target 4: Dementia Friendly Surgeries

Timely identification of patients with dementia is also important. It will enable patients to access to proactive care and post diagnostic services; empowering these patients to live well with dementia.

Aim

- Practices to nominate a clinical Dementia Lead/Champion
- Practices to develop a Dementia Friendly Action Plan to include evidence of;
  1. Dementia Awareness training for 80% of their staff; e.g. Dementia Friends, Tier one Dementia training (Thames Valley Strategic Networks); National Skills for Health on line training.
  2. Practices working proactively in improving early identification of dementia

Fund

- Practices will each be remunerated £1000 for producing an action plan and sharing the plan with practice team, nominating a Dementia Lead and Practice Champion; by 1st July 2016
- A further £50K to be available to practices on a fair shares calculation according to their predicted dementia prevalence. This would be paid on production of an End of Year report and outcomes from their action plan; with evidence of;
  1. improvement in diagnostic rates from baseline if was below 67% target and maintaining them if already at target,
  2. dementia awareness training for staff
  3. evidence that the SPACE principles have been applied

Patient cohort

- Patients on the dementia registers
- Carers of patients with dementia
- All those patients who are at risk of dementia and not yet diagnosed; For example
  1. Patients over 75
  2. Housebound patients
  3. Patients with vascular long term condition, e.g. heart disease, stroke disease, Parkinson's, neurological disease.
  4. Patients with memory loss

  NB. This list is not exhaustive

Summary

- Practices to become "dementia friendly" and identify patients with a dementia to a target of 67% of the expected prevalence, and therefore enable this cohort of patients to access post diagnostic management and support.
- To Become a Dementia Friendly Surgery using the SPACE Principles
- To increase early identification and prevalence of patients with dementia
- To support patients with dementia by;
  1. Improving quality of life
  2. Promoting dignity
  3. Enabling improved privacy

4. Encouraging independence
5. Enabling dementia care providers to be more responsive to the needs of all people using their services
6. Improving the dementia care provider's ability to meet multiple complex needs
7. Offering non-pharmacological aids to use to reduce anxiety and aggression.
8. Reducing stress and anxiety for patients and carers
9. Reducing aggressive and disturbed behaviour
10. Encouraging care planning; Power of Attorney, Advanced care Plans etc.
11. Enabling people to be cared for in a comfortable and safe environment of their choosing
12. Supporting cultural diversity
13. Reduce inequalities

Scheme Detail

Dementia Friendly Surgeries Spec.docx