# Local General Practice Quality Scheme 2016 – 17

North East Lincolnshire CCG has developed a Local Quality Scheme for general practices, with the aim of enhancing quality, effectiveness and consistency across a range of areas. This paper sets out the five areas that have been agreed for inclusion within the scheme for 2016/17, which has been developed in conjunction with representatives from the community membership body (including feedback from PPGs), local Practices, and CCG quality and commissioning teams. All areas will continue to be supported by the CCG's Practice Advisors and the Primary Care Team. The CCG will clearly define the dataset and the target for Practices prior to commencement.

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# Area No 1. – Pre-diabetes Register

**Background to Inclusion**

Locally we have approximately 9,500 patients with diabetes, the majority of which are type 2. A recent report published by the National Cardiovascular Intelligence Network suggests that the average prevalence of non-diabetic hyperglycaemia (pre-diabetes) in England is 10.7% (source). Locally this equates to approximately 15,000 people at risk of diabetes.

Diabetes is a long term condition which can remain undiagnosed for many years and can lead to serious complications, such as lower limb amputation, loss of sight and significantly increased risk of stroke and heart failure. All having major implications for the individual and their families as well as on the NHS budget, utilising an estimated 10% of total NHS spend. Hence, preventing the condition (or at least delaying the onset) is likely to result in significant benefits.

Without intervention (focusing around lifestyle changes), around one third of those who are identified as pre-diabetic are expected to develop diabetes. Whilst an individual is pre-diabetic there is an opportunity to reduce their diabetes risk to either prevent or delay onset. Identifying and supporting these patients to reduce their risk is key to the prevention of diabetes. NELCCG is part of the National Diabetes Prevention Programme (NDPP), which can provide support to the individuals at risk.

**What is required?**

**Creation of Register & On-going Monitoring:**

- Establish & maintain a register for those with non-diabetic hyperglycaemia (Adults with high risk score upon risk assessment and a HbA1c of 42-47 mmol/mol OR FPG between 5.5 and 6.9 mmol/l as defined in PH38 (2012)).
- Establish and operate a recall system to actively monitor* those on the register
- Establish and operate a follow up process for those who DNA recall appointments
- Identify individuals on the register suitable for the National Diabetes Prevention Programme (NDPP)
- Provide information to individuals on the register details of prevention services and refer with individuals' agreement

*Actively monitor includes: (based on NICE Guidance PH38)

- On identification of pre-diabetes, discuss the risks of developing diabetes, provide advice to modify risk factors (increase physical activity, achieve and maintain weight loss where appropriate) and offer appropriate lifestyle change programme.
- Recall patient for review at least yearly and undertake a HbA1c blood test, reassess weight and BMI, assess lifestyle changes, provide advice to modify risk factors (increase physical activity, achieve and maintain weight loss where appropriate) and where not previously attended, offer appropriate lifestyle change programme.

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Codes Requested by the National Diabetes Prevention Programme

Approved codes for
NHS NDPP (Diabetes

**Reporting requirements**

Reporting requirements will commence once the register is established, by October 2016 at the latest.

1.1 Number of individuals on the register - monthly (CCG will compare this to expected prevalence)*

1.2 Number of individuals made aware of the NDPP and offered a referral - monthly

A template for coding individuals at risk is being developed and will be deployed to all practices' clinical systems in the next few weeks.

*As part of being on the first wave of the NDPP, we are required to submit monthly data to NHSE. Initially the dataset was greater, but following negotiations this has been reduced to two requirements.

**Achievement thresholds:**

*15.01-75%* on expected prevalence registers

**Payment**

A total of 49p per patient on practice total register is available for this element. Payment will be made as follows:

Pre-qualification: Practices must submit a copy of the process for their recall system, including follow up for patients who DNA, before any payments are made.

- A total of 25p per patient per year on the total practice list size, for **monthly** reporting of the following, starting at the **end of October 2016 at the latest**:
  - Numbers on register
    **and**
  - Number of individuals offered a referral to the NDPP

  Reports should be submitted by the 5th day of the following month (or the next working day after)

  Practices must report each month in order to claim the payments.

  Payment will be made at the end of the year, subject to confirmation of receipt of all monthly reports.

- 24p per patient on the total practice list size once achievement of register threshold has been achieved:
  - Practices with 15% or less of their expected prevalence on their register = 0p.
  - Practices 75% or more get the full 24p
  - And practices between these corresponding targets get the corresponding percentage of the 24p

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# Area No 2. – Prescribing

Two measures are included.

## Prescribing Measure No.1 - Improved antibiotic prescribing in primary care:

**Background to Inclusion**

Antimicrobial resistant infections impact on patient safety and the quality of patient care. Evidence suggests that antimicrobial resistance (AMR) is driven by over-using antibiotics and prescribing them inappropriately. Reducing the inappropriate use of antibiotics will delay the development of antimicrobial resistance that leads to patient harm from infections that are harder and more costly to treat. Reducing inappropriate antibiotic use will also protect patients from healthcare acquired infections such as Clostridium difficile infections. The Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) published antimicrobial prescribing quality measures in October 2014 and these recommend primary care total antibiotic prescribing to be reduced to 2010 levels.
https://www.gov.uk/government/groups/advisorycommittee-on-antimicrobial-resistance-and-healthcareassociated-infection.

Broad spectrum antibiotics, such as co-amoxiclav, cephalosporins and quinolones should be prescribed in line with prescribing guidelines and local microbiology advice. Reducing inappropriate antibiotic use will protect patients from healthcare acquired infections such as Clostridium difficile infection.

**What is required?**

Practices are expected to engage with the Medicines Optimisation team and action any recommendations that arise. In relation to this section, practices will be required to review their antibiotic prescribing and make changes/improvements where required, working towards achievement of an agreed target.

**Measurement detail:**

All reporting and measurement will be undertaken by the CCG based on the following:

a) Reduction in the number of antibiotics prescribed in primary care:

*Numerator:*

Number of prescription items for antibacterial drugs (BNF 5.1) within the CCG

*Denominator:*

Total number of Oral antibacterials (BNF 5.1 sub-set) ITEM based Specific Therapeutic group AgeSex Related Prescribing Unit (STAR-PUs) http://www.hscic.gov.uk/prescribing/measures

**Target**

It is proposed this will be 3-fold:

1. Practices in the best quartile performance in 15/16

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These practices will be set a target of maintaining the 15/16 best quartile performance in 16/17. Practices in the best quartile in 15/16 will therefore only, in principle, have to maintain their current performance.

2. Practices between best quartile and median performance

   Practices in this group will be set a target of achieving the 15/16 best quartile performance in 16/17.

   The level of improvement required (as a percentage) will therefore increase dependent on their variance from the best quartile. For example, if Practice A's rate of prescribing was very close to best quartile, then the 16/17 target will only be a small percentage reduction, whereas the Practice closest to the median rate will need to show a larger reduction.

3. Practices outside of median performance

   Any practice outside the median will not be required to reduce prescribing rate to the best quartile.

   Instead, all practices in this group will be set a percentage reduction target, based on the same percentage required for the practice closest to the median rate or worst quartile (whichever is lowest). For example, if this practice needed to reduce prescribing rates by 10% to achieve the best quartile rate, then all practices above the median will also have a 10% reduction target.

The overall aim of these targets will be to reduce the variance in prescribing rates, while setting a realistically achievable goal for every practice.
***Further detail, by practice, to follow***

**Payment**

10p per patient on the total practice list for achievement of target.

**Measurement detail:**

b) Number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care:

*Numerator:*

Number of prescription items for BNF 5.1.1.3 (sub-section co-amoxiclav), BNF 5.1.2.1 (cephalosporins) and BNF 5.1.12 (quinolones) within the CCG

*Denominator:*

Number of antibiotic prescription items for BNF 5.1.1; 5.1.2.1; 5.1.3; 5.1.5; 5.1.8; 5.1.11; 5.1.12; 5.1.13 prescribed within the CCG

**Target**

It is proposed this will be 3-fold:

1. Practices in the best quartile performance in 15/16

   These practices will be set a target of maintaining the 15/16 best quartile performance in 16/17. Practices in the best quartile in 15/16 will therefore only, in principle, have to maintain their current performance.

2. Practices between best quartile and median performance

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Practices in this group will be set a target of achieving the 15/16 best quartile performance in 16/17.

The level of improvement required (as a percentage) will therefore increase dependent on their variance from the best quartile. For example, if Practice A's rate of prescribing was very close to best quartile, then the 16/17 target will only be a small percentage reduction, whereas the Practice closest to the median rate will need to show a larger reduction.

3. Practices outside of median performance

   Any practice outside the median will not be required to reduce prescribing rate to the best quartile.

   Instead, all practices in this group will be set a percentage reduction target, based on the same percentage required for the practice closest to the median rate or worst quartile (whichever is lowest). For example, if this practice needed to reduce prescribing rates by 10% to achieve the best quartile rate, then all practices above the median will also have a 10% reduction target.

The overall aim of these targets will be to reduce the variance prescribing rates, while setting a realistically achievable goal for every practice.
***Further detail, by practice, to follow***

**Payment**

10p per patient on the total practice list for achievement of target.

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# Prescribing Measure No. 2 - Cost-effective, quality and safe prescribing

**Background to Inclusion**

There continue to be significant opportunities to improve the cost efficiency, quality and safety of prescribing in NELCCG. It is both the point of initiation and changes in circumstance that offer great opportunities to enhance prescribing. Although various tools are currently used, these require significant time investment, offer limited quality and safety intervention and return diminishing financial benefits over time.

Computerised decision support offers the potential for improved clinical practice (Kawamoto et al, 2005). The Kings Fund report "Polypharmacy and medicines optimisation - Making it safe and sound" (2013) and recent NICE Guideline NG5 "Medicines optimisation: the safe and effective use of medicines to enable the best possible outcome" (2015) recommend that organisations should consider computerised clinical decision support systems to support clinical decision−making and prescribing and keep GPs engaged with local decision-making.

Prescribing Decision support software (PSDS) guides prescribers in making the best decision at the point of prescribing and ensures that quality, cost effective and locally or nationally recommended products are chosen at the point of prescribing. An advantage to point of prescribing systems is that patients are prescribed the right medicine at the outset, reducing the need to switch treatments at a later date, e.g. for cost saving, quality or safety purposes.

**What is required?**

Practices are expected to engage with the Medicines Optimisation team and action any recommendations that arise. Where activated, OptimiseRx is expected to assist the earlier and more complete delivery through installation of software into GP practice systems. This will guide prescribers in making the best decision based on national and local recommendations, on a patient specific basis at the point of prescribing. Practices can adopt other methods of ensuring the most effective prescribing as they see fit.

**Reporting requirements**

All reporting and measurement will be undertaken by the CCG

**Targets**

Each practice will be issued a specific target. Based on best practice.

**Payment**

*28p* per patient on the total practice list for achievement of target.

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# Area No 3. – Addressing variation in outpatient activity

**Background to Inclusion**

Across NELCCG outpatient activity there is two-fold variation between the highest and lowest levels of referrals. This suggests scope to improve the consistency and quality of care provided across North East Lincolnshire, to ensure that patients are cared for within with most appropriate setting; however, understanding why such variation exists is a complex issue. This element requires practices to work together to understand the reasons for variation in outpatient activity and to identify actions that could support improved management within the primary care setting and ensure patients receive care in the most appropriate setting.

The aim of this element is to encourage the process of peer review. This is intended to support sharing of best practice and bring about consistency in the quality of care provided and avoid unnecessary outpatient referrals. It is not in any way intended to prevent referrals to hospital where that is clinically deemed to be the most appropriate course of action, particularly in relation to urgent referrals for suspected cancer.

**What is required?**

In relation to their outpatient first and follow up activity, practices are asked to complete the following:

Review their OP first/FU activity levels – write a plan* as to what areas they will focus on and who they should work with for peer review in year (this is based on identifying those Practices that are comparatively lower / higher) by 31st July 2016. It is expected that the peer review would be undertaken with an external practice; however, if a Practice can demonstrate how completing internal peer review would support improvements, this could be considered by the CCG.

Take part in peer review to understand reasons for variation and opportunities for improvement. Prepare a report on the findings*, including the areas identified for a change in practice. To be submitted to the CCG by the end of October 2016.

As part of the peer review the CCG would expect to see the practice choose areas within which they are an outlier. This will include assurance that the Practice have up to date guidelines to support decision-making (NICE, RCGP, other Royal Colleges) and feedback on what else would help to manage the patient, e.g. advice from a Consultant.

Implement any changes agreed as a result of peer review and monitor activity levels throughout the remainder of 2016/17.

*The CCG will create a standard template for this.

**Reporting requirements**

3.1 Submit a plan* as to what areas they will focus on and who they should work with for peer review in year (this is based on identifying those Practices that are comparatively lower / higher) – **by 31st July 2016**

3.2 Prepare a report on the peer review findings*, including the areas identified for a change in practice. To be submitted to the CCG **– by end of October 2016**

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*The CCG will provide standard templates to support this. The CCG will also help to facilitate peer review, if this is required.

**Targets**

Whilst we would encourage practices to review their outpatient follow up activity and take steps, where clinically appropriate, to proactively transfer patients back to primary care for follow up, the target will be based on outpatient first attendances.

Based on the CCG's outpatient benchmarking report for practices, each practice will produce a figure (total OP 1sts per '000 pop in year) for 15/16, which, together with the best quartile and median rates for 15/16, will be used as the baseline to calculate the 16/17 targets.

It is proposed this will be 3-fold:

1. Practices in the best quartile performance in 15/16

   These practices will be set a target of maintaining the 15/16 best quartile performance in 16/17. Practices in the best quartile in 15/16 will therefore only, in principle, have to maintain their current performance.

2. Practices between best quartile and median performance

   Practices in this group will be set a target of achieving the 15/16 best quartile performance in 16/17.

   The level of improvement required (as a percentage) will therefore increase dependent on their variance from the best quartile. For example, if Practice A's rate of OP appointments was very close to best quartile, then the 16/17 target will only be a small percentage reduction, whereas the Practice closest to the median rate will need to show a larger reduction.

3. Practices outside of median performance

   Any practice outside the median will not be required to reduce their OP 1st appointments rate to the best quartile.

   Instead, all practices in this group will be set a percentage reduction target, based on the same percentage required for the practice closest to the median rate or worst quartile (whichever is lowest). For example, if this practice needed to reduce OP 1st appointment rates by 10% to achieve the best quartile rate, then all practices above the median will also have a 10% reduction target.

The overall aim of these targets will be to reduce the variance in OP activity rates, while setting a realistically achievable goal for every practice.

**Payment**

Up to 47p per patient on the total practice list. The overall payment will be split into two areas:

Pre-qualification - Submit a plan as outlined in 3.2

- 27p per patient on the total practice list size list for peer review and submission of report to CCG of findings and action plan as set out at 3.2 above – **by end of October 2016**
- Up to 20p per patient on the total practice list size for demonstration of achievement of targets as issued to individual practices.

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# Area No 4. – Improving Patient Experience

**Background to Inclusion**

Results from the National GP Survey, the local Quality survey, and feedback from the local PPGs suggests that there is scope for improving patient experience in some areas, particularly in terms of keeping patients fully informed regarding their waiting time when they have arrived for an appointment, and the consideration of accessibility issues for patients. This element is aimed at gaining a better understanding of these issues and how they can be improved both for the practice and the patients. There is a strong body of evidence about the links between patient experience and clinical safety and effectiveness.

**What is required?**

The CCG will oversee the completion of surveys, working with the CCG's engagement team, Accord and local PPGs. This will include an initial, baseline survey in June 2016 and a follow up survey in February 2017.

Practices will be encouraged to help by publicising the survey and supporting the Accord members and PPG members to undertake surveys within the waiting area.

Following initial baseline survey results, the Practice will be required to work with their PPG to interpret the results and agree actions for improvement, or areas where the practice and PPG need to work together to more clearly articulate / agree the expectations with patients. In the event that the baseline survey results do not provide sufficient information for the PPG to identify areas for improvement, the Practice should work with their PPG to identify areas that could be included for improvement actions during 2016/17.

The Practice will be required to submit a report at the end of the year, following the end of year survey, which sets out improvements and/or further action required for improvement. This may include work with the PPG on agreeing and setting out expectations for patients.

**Reporting requirements**

4.1 The Practice will be required to submit a report* at the end of the year, following the end of year survey, which sets out improvements achieved and/or further action required for improvement – **by 31st March 2017**

*A standard report template will be provided by the CCG

**Payment**

A total of 20p per patient on the total practice list size is available for this element. This will be paid in full following successful completion and submission of the end of year report as set out at 4.1 above.

The response report doesn't expect the practice to necessarily solve all the issues straight away. This area of the scheme is about working through potential solutions with the PPG.

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# Area No. 5 – Quality Improvement: Practice Audit/Survey

**Background to Inclusion**

The use of audits and surveys can help to improve the quality of a service. Without the use of a structured tool it is very difficult to assess the quality of a service against a set of predefined standards. In order to achieve improvement it is key to understand the services current position. This enables the identification of areas for improvement and also contributes to ensure improvement or regression can be measured when the audit/survey is repeated after a set period of time.

This area also helps to support the GP appraisal process.

**What is required?**

For this element of the quality scheme, the CCG is asking Practices to complete one full cycle quality improvement audit / survey, and submit a report to the CCG at the end of the project which sets out the improvement and/or further action required for improvement. The technical guidance below sets out a range of topic areas that could be selected.

**Technical guidance**

Dependent on the audit/survey chosen guidance will be shared with the Practice, please refer to appendix two for further detail.

Appendix 2- Quality Improvement.docx

**Reporting requirements**

5.1 Submit standard letter* to CCG setting out selected topic area from the 4 project options set out in the embedded document (Appendix 2- Quality Improvement, 'Getting Ready' stage) – **by 31st July 2016**

5.2 Submit standard letter* to CCG providing assurance that the practice has reached stage 3 ('Analysis') – **by 30th September 2016**

5.3 Submit report* evidencing improvements and/or further action required for improvement ('Measuring Success') – **by 30th April 2017**

*The CCG will share the standard letters and report template with Practices to support these submissions.

**Payment**

A total of 42p per patient on list is available for this area. This will be broken down into two equal payments, linked to submission of documentation to the CCG.

- First payment: 10p per patient on list on submission of a standard letter as set out at 5.2 above (Analysis) – **by 30th September 2016**
- Second payment: 32p per patient on list on submission of a report as set out at 5.3 above evidencing improvements/further action – **by 30th April 2017**

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