NHS
Rotherham
Clinical Commissioning Group

QUALITY CONTRACT

2018/2019

Contents

Overview of Rotherham's Primary Care Quality Contract

The Quality Contract is Rotherham's main vehicle of reinvestment of the PMS review monies into Primary Care. It has been phased over 3 years (as the changes to the PMS funding take place).

It consists of **13** standards. Each standard has a clear set of deliverables and standard 7 has Key Performance Indicators (KPI's).

Implementation of the standards was undertaken follows:

2016/2017

- Demand management (referrals)
- Health Improvement (including increase in health checks)
- Cancer

2017/2018

- Access
- Best Care/ Long term conditions

2018/2019

- Exception reporting
- Screening
- Health Protection
- End Of Life Care (EOLC)
- Patient safety
- Mental Health, Learning Disability and military veterans
- Carers
- Patient experience

Please note that since April 2017 all of the enhanced services in the basket must be being delivered or sub-contracted.

Payments:

The information below shows these per year as a payment per patient (**weighted list size**)

YEAR 1	**2016/17 - £1.68 per patient maximum (with clauses)**
YEAR 2	**2017/18 - £3.36 per patient maximum** Delivery (66% of available funds) Key performance indicator (34% of available funds)
YEAR 3	**2018/19 - £5.04 per patient maximum** Delivery (83% of available funds) Key Performance Indicator (17% of available funds)

1. Introduction

In December 2015, the development of a local Quality Outcomes Framework 'QOF' for equitable services was agreed in principle with the Rotherham Local Medical Committee (LMC). It was accepted that this would be the preferred approach to PMS reinvestment and that it would facilitate the implementation of the CCG strategy of 'equity of funding and provision' across general practices in Rotherham.

The PMS funding reinvestment criteria makes clear that investment above core funding should:

a) Reflect joint strategic plans for primary care that have been agreed with Rotherham CCG.
b) Secure services or outcomes that go beyond what is expected of core general practice and basic QOF.
c) Help reduce health inequalities.
d) Offer equality of opportunity for GP practices in each locality (i.e. if one or more practices in a given locality are offered the opportunity to earn extra funding for providing an extended range of services or meeting enhanced quality requirements, other practices in that locality capable of providing those services or meeting those requirements should have the same opportunity).
e) Support fairer distribution of funding at a locality level.

It has been agreed that historic good practice beyond that determined within the Quality Contract should continue within individual practices as part of these new arrangements.

In essence, the PMS reinvestment monies are 'staffing growth' monies which were invested by the PCT. They came into play as a result of historic opportunities for practices to change from nationally negotiated GMS to locally negotiated PMS contracts. As a result of this change, a wide variation in practice baseline funding developed. Practices were offered financial incentives by the Primary Care Trusts to move to a PMS contract, including various additional services as negotiated on an individual practice basis. In order to facilitate the provision of additional services, practices received growth money from the Primary Care Trust to fund additional clinics and staff. Alongside the initial growth money that practices received, an annual increase in their 'pounds per patient' funding was negotiated. In Rotherham £1.94m was invested in staffing.

2. The Rotherham Local Quality Contract

2.1 In line with other CCGs and the views of our members, we have developed a scheme which sustains the investment which has funded the employment of staff in practices, by developing a clear set of standards for General Practice in Rotherham which is a reasonable expectation from this significant investment. The contract has been developed using learning from Liverpool and Bolton CCGs which are already starting to see measurable improvements in care.

2.2 The local Quality Contract provides clear set of standards for General Practice which has been developed to:

a) Ensure consistency in quality across Rotherham
b) Increase capacity in General Practice to improve the service offered and set a good baseline for the development of more integrated models of care
c) Support the delivery of Rotherham CCG's Strategy for general practice and the GP Forward View

d) Reflect the balanced aims of improved population health, better quality and patient experience of care and value for money
e) Incorporate all local enhanced services with General Practice (except care homes, acupuncture and specialist services offered from the Gate)
f) Provide a consistency of offer to Rotherham patients, no matter which practice they are registered with
g) Meet the commissioning priority for improved access to General Practice

2.3 The intention is for this local 'QOF' to raise quality in General Practice by the delivery of clear standards, whilst maintaining a recurrent level of funding.

2.4 It is also envisaged that these arrangements will go some way to addressing the issues NHS England (2013) highlights in relation to the growing challenges in Primary Care:
a) Ageing population – epidemic of long term conditions, increasing co-morbidity, large growth in consultations for older people
b) Rising costs, constrained financial resources, efficiency savings
c) Growing dissatisfaction with access to services
d) Inequalities in health – access and quality of Primary Care
e) Risk factors – unhealthy lifestyles, wider determinants of health

2.5 The CCG aims to provide a framework of support for Practices, which will underpin the implementation of the Quality Contract. As a minimum Practices can expect:
a) Quarterly activity/performance reports
b) Meetings to discuss progress
c) Data quality support
d) Development of templates and appropriate reports
e) Prescribing support
f) Education/CCG events

3. Aims of the Quality Contract

The main aims are:

3.1 Improved access to General Practice

3.2 Improved health outcomes for the population

3.3 Reduced health inequalities:

a) Improved support and better care for carers and people with mental health needs

3.4 Reduced variation:

a) Every Practice will be expected to deliver on all Standards

3.5 Support for the CCGs Quality, Innovation, Productivity & Prevention Challenge (QIPP):
a) Reducing demand on Secondary Care services
b) Eliminating waste in prescribing

4. Contracting basis

4.1 The Rotherham local Quality Contract is an independent contract in addition to the core GMS/PMS/APMS contracts. All GP providers across Rotherham are required to undertake this local Quality contract, there will be no other arrangement for reinvestment or local payment for Local Enhanced Services (LES) identified at 5.2**,** this enables the CCG to provide a consistent income, giving Practices two clear benefits:

a) Investment to sustain or increase staffing capacity. The aim being to meet rising demand and deliver improved access and better outcomes for patient care
b) Clarity of available Practice income

4.2 Direct Enhanced Schemes, Commissioning LIS, Prescribing budgetary management and quality schemes and QoF (decided nationally) will be separate to and, in addition to, this contract. Payment for vaccinations and immunisations will still be directed through NHS England however as health prevention is critical to the CCG agenda there will be a standard within the contract.

4.3 Rotherham CCG are the lead commissioner for this contract however Rotherham Metropolitan Borough Council and NHS England have supported the development of the standards.

4.4 Recognition of the different demands practices are under, due to the age and deprivation of their population, is provided by applying the national weighted payment – the Carr-Hill Formula.

4.5 Practices were required to submit a mobilisation plan consisting of baseline staffing, investment (where baseline staffing is below cluster) and required practice actions to implement the contract via the use of the template document provided. This plan will be updated on an annual basis by practices. In 2016/17/18 these plans were reviewed by the primary care team and the lead GP and a meeting held with each practice. The process for 2018/19 will be a similar meeting with practices. A sample of these will be scrutinised by the Primary Care Committee.

5. Contracting principles – Inclusion / Exclusions

5.1 Our current Local Enhanced Services are important to our population. The intention therefore is to incorporate LESs currently being undertaken by the majority of practices into the scheme. This will therefore include:

a) Case Management
b) Anti-coagulation
c) Shared care (appropriate to general practice) e.g. DMARDs, PSA monitoring, Testosterone etc.
d) Phlebotomy
e) Aural care
f) Suture removal
g) Minor surgery
h) Joint injections
i) Ring pessary changes
j) Transgender

k) Dementia*

* The Dementia LES will be delivered on a hub footprint.

We have agreed with LMC colleagues that for any future LES, acceptance is required by 75% of practices for the LES to be included as a mandated LES.

5.2 The specialist LES for the Gateway, Acupuncture LES and Quality in Care Homes LES are excluded from this contract. Prescribing budgetary management and quality schemes are also excluded from this contract.

6. Contracting principles – Equity

6.1 The investment principle is to provide stability for practice income by identifying the earnings potential that practices can expect to achieve for full achievement of this contract to ensure this is equitable across Rotherham.

6.2 The contract will pay the difference between the core contract payment and LES payments along with the quality payment. The full impact of the ongoing payment will not be seen until Year 4 as Rotherham practices are on a PMS 'pace of change'. It is therefore intended that practices will phase as per their pace of change.

6.2.1 April 2018

PMS phasing concludes on 31 March 2018 and therefore both GMS and PMS practices move to the new quality payment for Rotherham (GMS MPIG phasing will still continue in addition to this).

The new payment will consist of 'core' plus a LES payment, and payment for quality standards. **All practices will receive 83% of the quality standards payment with the remaining 17% performance related.**

Practices will be required to sign up to the whole contract with no separation of elements. Practices will be able to sub-contract to another practice subject to agreement with the commissioner to ensure delivery in accordance with the specification.

7. Payment mechanisms

7.1 RCCG will clearly be honouring the pace of change practices have been advised by NHS England. This therefore means that monies for reinvestment will not be fully released until 2018/19. Payments will therefore be made in accordance with section 6.

8. Payment for 2018/19

8.1 2018/19 will be the first full year of contract delivery. From 1 April 2018 payments will have two components:

8.2 **Payments for Delivery (83% of total) -** Practices are required to have implemented ALL the delivery requirements of the standards to receive 83%

payment. Where the full delivery requirements cannot be evidenced, the Primary Care Committee has discretion to reduce payment by 6% for each standard delivery requirement not met.

8.3 **Payment for achievement of Key Performance Indicators KPIs (17% of total) -** KPIs are not 'all or nothing' payments. For each KPI, payment will be made for an achievement of each standard's KPI. Each Standard is weighted. Where KPIs have been fully met, this will attract an additional payment.

8.4 **KPIs which have been retired will be retained for the purpose of performance monitoring only**

8.5 Practices will not be routinely asked for evidence of delivery - they will be required to self-certify and may be asked as part of the audit process to show evidence.

8.6 Where a practice can demonstrate evidence that they have implemented the **full delivery requirements** of the standard, but the KPI has not been achieved, the Primary Care Lead Officers have discretion to authorise payment. If however, there are discrepancies in relation to the availability of evidence, it will be for the Primary Care Committee to determine if the KPI payment should be made as per the agreed CCG appeal process. *Examples of evidence of delivery are included on the self-declarations pro-formas.*

8.7 Where a practice has signed up to deliver the contract and has not met the delivery requirements by the required timescales i.e. all in place by the end of March 2018, the Co-commissioning monitoring and review process will be instigated to support the practice to achieve. Ultimately where a practice is not evidencing achievement of the delivery requirements, practice participation in the Quality Contract will be reviewed.

9. Principles for payment of the 17%

9.1 The 17% resource has been allocated to reflect the Triple Aim of:

1) Value for money
2) Improved population health
3) Better quality and patient experience of care

9.2 The CCG is committed to continuous improvement in Primary Care. The setting of KPIs is important for measuring progress. To determine individual Practice KPIs, a Rotherham average methodology has been used.

Table 1: Potential percentage achievement payments

	VFM	Health Improvement	Quality	Underlying KPI	Further split
Overall split		**17%**			
Best care LTCs		17%		Diabetes COPD Asthma Heart failure (with LVD) Atrial fibrillation	5% 3% 3% 3% 3%

10. Monitoring/ Reporting Requirements

10.1 It has been agreed that due to the nature of complexity of the contract that as much data as possible will be extracted automatically using existing processes.

10.2 Monitoring/activity for 2018-19 will be submitted via electronic survey.

10.3 During 2016-17 the CCG developed a comprehensive data pack for each practice so that practices are clear about what information is being measured and what they are being benchmarked against. During this year, systems will be finalised so that it is clear how future data will be submitted - the optimum is that this is 'pulled' from the systems rather than having to be submitted.

10.4 Practices will be expected to ensure that the relevant data is ready for upload/ submission for the following periods:

April - June
July - September
October - December
January - March

10.5 Data submissions must be received by the CCG by the 10th of the month (or the next working day after this date if it falls on a weekend.) Submissions will be sense checked for completeness but if there are omissions the responsibility will lie with the practice to correct and re-submit the data.

10.6 These consequences apply to the late submission of Enhanced Service data as part of existing contracting arrangements:

1 – 7 days: 5% reduction in payment
8 – 14 days: 10% reduction in payment and payment won't be released until the next payment run
15 – 21 days: 50% reduction in payment and payment won't be released until the next payment run
Submissions received after 21 days (3 weeks) will receive no payment.

*In the event of unforeseen **exceptional** circumstances e.g. unplanned admission to hospital, there is scope for the CCG to process a payment without precedent. It is however a practice responsibility to put in place sufficient contingency arrangements to ensure activity is submitted by the date specified.*

10.7 The CCG will monitor and analyse the quarterly data submitted by Practices. Reports will be produced by the CCG and sent out to Practices as soon as practically possible. The CCG will need to take into account the availability of data from sources other than Practices, after quarter end.

10.8 Practices will be required to keep accurate records for all aspects of this Contract, for post payment verification (PPV) purposes.

11. Performance

11.1 Review of practice performance against the indicators will be carried out by the CCG, in line with the Contract Review Process laid out in the NHS Standard Contract.

11.2 Similarly, the Contract Management Process will follow the stages outlined in the NHS Standard Contract, with regular reference to the Primary Care Committee. This process recognises the interface between the CCG and NHSE, in terms of the commissioning of Primary Care, and its development and improvement.

11.3 The CCG will be required to present regular updates to the Primary Care Committee and to evidence the quality, health improvement and value for money from the investment.

11.4 The CCG will be required to provide updates to other stakeholders as requested e.g. NHSE, Health Scrutiny, PHE, Public Health (RMBC).

11.5 Six monthly meetings will be held with localities to discuss locality performance related to the quality contract, to share good practice and support practices who are not achieving.

11.6 A member of the primary care team will regularly attend the Practice Manager Forum to provide feedback from the task and finish group, the business intelligence group and generally provide information as required relating to the Quality contract.

12. Disputes

12.1 Wherever possible, disputes relating to KPIs will be resolved locally. An Appeals Process has been set up. Please refer to Appendix A. The whole process will be overseen by the Primary Care Committee. This is a requirement of Level 3 Co-Commissioning.

12.2 Appeals from Practices will be considered on an individual basis. Practices will be expected to provide comprehensive evidence to back up their reason for appeal. An information pack providing clarity on the examples of evidence required and the formatting of information will be shared with Practice Managers and retained on the Quality contract section of the website. This evidence will be subject to further analysis by the CCG.

Standard 1 - Improving Access to General Practice

Rationale

Practices are required under their standard contract to open 8am – 6.30pm Monday to Friday however there are significant variations in relation to the clinician availability within these times. Rotherham GP survey data, shows 83% of patients were able to get an appointment last time they tried, compared to 85% nationally. 71% of patients described their overall experience of making appointments as good compared to 73% nationally.

Delivery

Practices will be required to deliver the following:

1. Practices are required to be physically open from 8am – 6:30pm, with both reception and clinical staff available. **Non-compliance with this single deliverable will result in non-payment for the whole of standard 1**.
2. Practices will offer sufficient capacity to achieve
    a. Urgent access within **1** working day
    b. An appointment for patients within **5** days when their condition is routine.
    c. Follow-up appointments within a **working week** of when the clinician identified i.e. if a 1 month follow-up, the appointment offered will be no more than 1 month and 5 working days.
3. It is a requirement that there is a minimum of 75 contacts per 1000 patients per week. Contacts may be provided by a qualified practitioner who is able to diagnose and may be face to face or by telephone (triage followed by face to face consultation will be deemed as one episode).
4. Practices are required to have reviewed their capacity and demand and to ensure they are resourcing to meet this demand. This includes:
    - provision of capacity in alternative ways e.g. virtual (telephone) and using alternative roles.
    - 10 bookable sessions (am/pm)
    - offer access to both male and female clinicians.
5. Ensure acutely ill children under 12 are assessed by a clinician on the same day
6. Facilitate 111 bookings into practice systems – 1 booking to be identified daily for practices with less than 7000 patients and 2 bookings for more than 7000 patients.
7. Accept deflections from Yorkshire Ambulance Service (YAS).
8. Provide an in hours home visiting service for those patients presenting with an urgent clinical need requiring a home visit who live within the practice boundary but are registered with a practice outside of Rotherham CCG Boundary in accordance with GP choice requirements with associated payments (currently £60 per home visit). It is not anticipated that demands for such visits will exceed one per month. http://intranet.rotherhamccg.nhs.uk/standards.htm
9. Improve on patient survey measures
10. Access to Primary Care services must be suitably promoted to patients including via practice websites, posters and through other means. This includes the promotion of extended hour's services.

CCG Support

- The CCG will supply and review, in collaboration with the Practice, appropriate data e.g. comparative, A&E attendance, OOHs data, variation data, Patient Survey and other related outcome data

CCG Contact: SCE Member for Primary Care

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 2 - Demand Management & Transfer of Care

Rationale

The NHS is not obliged to provide every treatment that a patient, or group of patients, may demand. It does, however, have a statutory duty to take into account the resources available to it, and the competing demands on those resources. The process for prioritising resource allocation is a matter of judgement. To ensure local resources are used effectively, Rotherham CCG has developed pathways which provide referral guidance for Primary Care. GPs are expected to follow these pathways when considering a referral.

In 2011, The Audit Commission reported outcomes from Primary Care Trusts (PCTS) which had considered the clinical effectiveness of treatments to help them decide what to spend their money on, and importantly, what not to spend their money on. The findings suggest that there is value in making sure that fewer treatments with a low clinical value take place, so that resource can be directed towards the delivery of higher value treatments. Refreshed data packs have also been issued to each CCG (Commissioning for Value: Where to look) to support the right quality and efficiency focus.

There is no single, national list of procedures with limited clinical value (PLCV) to refer to. However, Rotherham CCG has reviewed the available procedures in a number of other CCGs to ensure it is behaving consistently and fairly. Rotherham is still continuing to provide a number of procedures no longer provided in other areas of the country.

RCCG is continuing work with the Clinical Referrals Management Committee. This committee focuses on identifying areas for developing new pathways and service improvement between primary and secondary care.

The main aims of this committee:

- Reduce potential risk to patients (outcome versus risk of procedure)
- Reduce clinical variation between GPs
- Deliver the Government 'referral to treatment' target of 18 weeks, by reducing demand on Secondary Care

This is a quality standard which aims to ensure that patients receive the right treatment at the right time. What can be managed in Primary Care, will be.

In addition to this, there has been an increase in requests from secondary care to Primary Care, to undertake work traditionally carried out in consultant-led units. Unfortunately, this can lead to friction between the Acute Trust and Primary Care, about where responsibility lies. Incidents of this nature have been documented locally. *For example, Secondary Care wants to instigate a drug treatment of their choice. However, before this treatment can be initiated, the patient requires a Dexascan.* Secondary Care issues a request for Primary Care to organise the scan. Learning from incidents, such as this example, has shown that when care of a patient inadvertently falls between 2 services there is a risk that recommended treatment will not be delivered. Rotherham Clinical Commissioning Group (RCCG) aims to minimise such incidents, wherever possible.

The CCG also recognises there may be some opportunity for treatment and care to be safely transferred to Primary Care. For example, GPs could undertake prescribing and monitoring, attributable to specialist or Secondary Care follow ups, and have the added benefit of reducing costs.

Discussion on the appropriate transfer of care, will take place at the Clinical Referrals Management Committee to take a view on areas where responsibilities are unclear. Where this involves tasks presently undertaken as part of the secondary care pathway, the Clinical Referrals Management Committee will make a recommendation for onward discussion with the LMC.

Delivery

Practices will be expected to:

1. Reflect on current referral behaviour within the Practice and in particular to have substantive GP sign off of all short term (less than 4 weeks) locum referrals to secondary care. This includes an appropriate administration system signed off by the substantive GP.
2. Use local data to improve referral quality. Identify opportunities to reduce unnecessary hospital attendances
3. Link with other practices to provide robust business continuity for any short or long term staffing issues to ensure continuity of all services provided from the practice e.g. ECGs, phlebotomy, minor injuries the practice is competent to provide.
4. Comply with the RCCG Clinical referral policies.
5. Use CCG intranet to access pathways and supporting information, no referrals will be accepted by secondary care without the relevant checklist (for procedures with clinical thresholds)
6. Use the E-referral system when referring, and offer a choice of providers to patients
7. Accept transfer of care from secondary care at the appropriate point and with all relevant clinical information, to ensure the best patient experience, in the most appropriate clinical setting
8. Ensure that recommendations of the Rotherham Medicines Management Committee are followed and implemented
9. Cascade information about transfer of care to the wider Practice Team at regular team meetings

CCG Support

1. Ensure the intranet is user friendly and includes all the latest pathways and supporting information
2. Provide Practices with data and information
3. Develop and facilitate a peer review event to support practices
4. Work with Secondary Care to ensure services are published on the E-referral system, with availability to book appointments

CCG Contact: SCE GP Lead for Clinical Referral Management Committee

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 3 - Health Improvement

1. Referrals into 'Get Healthy Rotherham' (Parkwood Healthcare Ltd)
2. Screening for Diabetes / At Risk of Diabetes – National Diabetes Prevention Programme (ICS)
3. Making Every Contact Count (MECC)

Rationale

The Secretary of State for Health has prioritised reducing premature mortality from cardiovascular disease (CVD) and diabetes through improving prevention and early diagnosis. There is an economic and social case to act decisively to improve the health of the population. Diabetes costs the UK economy £14 billion per year with CVD costing £30 billion (Kanavos et al, 2012, NICE, 2013). Preventing ill health and supporting people to stay well are key priorities identified in *Rotherham's Health & Wellbeing Strategy 2015-18 and the Rotherham Place Plan.*

NHS Health Checks

In England, over 4 million people are estimated to have cardiovascular disease (CVD). This is recognised as the largest single cause of long-term ill health, disability and death (DH, 2013). A steep rise in unhealthy behaviours – smoking, physical inactivity, eating a poor diet and alcohol misuse - has led to increasing levels of obesity across all sections of the population. This is magnifying the burden of vascular conditions (Murray et al, 2013).

Stroke is a major cause of premature mortality; there were 40,174 deaths in the UK in 2015 and 7,617 of these were premature (BHF, 2017). In Rotherham in 2013/15 there were 450 deaths due to stroke (BHF, 2015). Identifying AF early could prevent 4,500 strokes and 3,000 deaths per year in the UK (Stroke Association, 2014).

Over the last 20 years, the number of people diagnosed with diabetes has increased from 1.4 million to 2.9 million. By 2025, it is estimated that 5 million people will have type 2 diabetes in England (Diabetes UK, 2012).

Over 10.5 million people are drinking at levels which increase their risk of ill-health. Liver disease, linked to alcohol misuse, is fast becoming one of the UK's biggest killers (British Society of Gastroenterology (BSG), 2010).

There are currently 670,000 people in England living with dementia. By 2025, it is estimated this number will have risen to over 1 million. Delaying the onset of dementia by 5 years would reduce deaths directly attributable by 30,000 a year (DH, 2013).

It is estimated that an effective vascular check programme can prevent 1,600 cases of myocardial infarction (MI) and stroke, 650 premature deaths and identify over 4,000 new cases of diabetes each year (PHE, 2013).

One of the main causes of Rotherham's life expectancy gap is smoking. Rotherham is still lagging behind England averages.

Potential Years of Life Lost (PYLL) reflects deaths in people aged under 75. About 6,550 PYLL are lost each year in Rotherham through causes considered amenable to

healthcare. This is around 1,400 years more than might be expected based on the England average. This CCG will aim to reduce this by 200 years per year over the next 5 years. There has been a good improvement in cancer and cardiovascular mortality rates which in 2015/16 were on target. Liver and respiratory disease were off target so may require further exploration.

Potential Years of Life Lost (PYLL) from causes considered amendable to healthcare, per 100,000 Target based on 15/16 trajectory submitted in 2014/15 (Data relates to calendar years so 14/15 actually relates to January to December 2014)

Under 75 mortality rate from cardiovascular disease	Target 63.70	14/15 86.50 (2015 = 76.8)
Under 75 mortality rate from respiratory disease	Target 27.60	14/15 31.20 (2015 = 41.3)
Under 75 mortality rate from liver disease	Target 15.80	14/15 18.90 (2015 = 18.0)
Under 75 mortality rate from cancer	Target 121.40	14/15 143.50 (2015 = 127.3)

Improvements have been made on health-related quality of life for people with long-term conditions, proportion of people feeling supported to manage their condition, unplanned hospitalisation for chronic ambulatory care sensitive conditions, and unplanned hospitalisation for asthma, diabetes and epilepsy in under19s.

Screening – Diabetes & At Risk of Diabetes

Diabetes presents a widely recognised, public health issue. The evidence highlights the need to identify people early. Estimates suggest there are 850,000 people living in the UK who are unaware they have type 2 diabetes (Diabetes UK, 2012). Rotherham's prevalence of diabetes is higher than the national averages along with a higher spend therefore indicating an over reliance on insulin.

The aim of the Diabetic Eye Screening Programme (DESP) is to reduce the risk of sight loss amongst people with diabetes by the prompt identification and effective treatment if necessary of sight threatening diabetic retinopathy, at the appropriate stage during the disease process (NHS England, 2016).

The National Diabetes Prevention Service (NDPP) should be offered to all patients at risk of diabetes. This is being delivered across the South Yorkshire & Bassetlaw footprint by ICS.

Delivery

Practices will be expected to:

1. Attend a Rotherham CCG/Public Health Improvement Event
2. Enable the provision of the Get Healthy Rotherham Service
3. Upload the e- referral template onto IT systems to enable a seamless offer and referral into the Get Healthy Rotherham Service pathway to their patients. The services listed below have been combined with a new model of tiered delivery based on innovative methods of access and delivery form the core offer of the new service which includes access to health and behaviour change advice and support using the three strands of:
    1. Inform me
    2. Enable me
    3. Support me

The new service integrates the following Public Health services into a single service offer:

- NHS Health Checks
- Support to Stop Smoking
- Adult Weight Management
- A Population Alcohol Risk Screening Intervention
- The Health Trainer Service

4. Primary Care to establish Trading Agreements with Parkwood Healthcare Ltd to facilitate electronic transfer of patients results in line with The Local Authorities (Public Health Function and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. NB: This agreement facilitates the upload directly into practice systems and reduces primary care workload.
5. The National Diabetes Prevention Service (NDPP) to be offered to all patients at risk of diabetes. This is being delivered across the South Yorkshire & Bassetlaw footprint by Independent Clinical Services.

CCG Support

The CCG Data Quality Team will:

1. Support Practices with queries to extract data

Contact: DESP: england.sybprimarycare@nhs.net

Public Health: Sally.Jenks@rotherham.gov.uk

Standard 4 - Screening

1. Breast
2. Bowel
3. Cervical
4. Abdominal Aortic Aneurysm (AAA)

Rationale

In 2011, the Government announced its intention to focus the NHS on improving health outcomes for patients with cancer. Cancer Research UK (CRUK) (2014) highlights the importance of local screening programmes, which are proven to increase the chances of spotting cancers early, saving thousands of lives every year.

Whilst screening programmes are effective at targeting and inviting the right people, there are large numbers of patients who decline the opportunity to be screened. Rotherham's Health and Wellbeing strategy focuses on cancer as one of the key contributors to years of life lost.

On a local level, there are approximately 1,300 new cases of cancer diagnosed each year and currently over 700 die. Rotherham currently performs better than average for cervical and breast screening programmes however the 2ww rate of referral performance is worse than the national average.

The focus of this standard is to increase the uptake of screening to improve early detection rate and access to early treatment.

Breast Screening

Breast screening aims to detect cancer at a very early stage, when any changes in the breast would be too small to feel. For women diagnosed early in England, the chance of surviving for 3 years is better than 99%. However, for those diagnosed at a late stage, this drops to just 27.9% (Cancer Research, 2014). The latest figures for Rotherham show 72.9% coverage, a reduction from 81.5% in 2012/13(Health & Social Care Information Centre (HSCIC), 2014).

The NHS Breast Screening Programme offers screening every 3 years to women aged 50 to 70 years.

Bowel Screening

The Bowel Cancer Screening Programme (BCSP) aims to reduce bowel cancer mortality by detecting and treating bowel cancer, or pre-cancerous growths early. More than 90% of people will live for at least 5 years when it is detected early. However, when found late, less than 7% survive for the same period (Cancer Research, 2014). It is estimated that the BCSP will save more than 2,000 lives each year by 2025 (NHSE, 2014).

Currently, Rotherham's screening uptake rate is 60.6%, which compares favourably to the England average of 52%. However, uptake is reducing and variable across

Practices.

The NHS Bowel Cancer Screening Programme offers screening every 2 years to all men and women aged 60 to 74 years.

Cervical Screening

This programme aims to reduce the incidence, and associated mortality, of invasive cervical cancer. If an overall coverage of 80% can be achieved, a reduction in death rates of around 95% is possible in the long term (HSCIC, 2010). Screening is currently offered at different intervals depending on age, allowing the process to be targeted effectively (Sasieni et al, 2003).

The NHS Cervical Cancer Screening Programme offers screening to all women aged 25 to 64 years. Screening intervals are:

- Aged 25 – 49 (every 3 years)
- Aged 50 – 64 (every 5 years)
- 65+ only those who have not been screened since age 50 or who have had recent abnormal tests.

AAA Screening

Ruptured AAA deaths account for around 2.1% of all deaths in men aged 65 and over. This compares with 0.8% in women of the same age group. The mortality from rupture is high, with nearly a third dying in the community before reaching hospital. Of those who undergo AAA emergency surgery, the post-operative mortality rate is around 50%, making the case fatality after rupture around 80%. This compares with a post-operative mortality rate in high quality vascular services of around 2% following planned surgery (NHS England 2016).

The cost effectiveness of AAA Screening is at the margin of acceptability according to current NHS thresholds. Over a longer period, the cost effectiveness will improve substantially (HSCIC, 2014).

Men should be offered screening during the year – 1st April to 31st March – in which they turn 65 years. Men over the age of 65 can self-refer to the screening programme and have their information added manually to the screening management system.

Delivery

Practices will be expected to:

1. Work with the relevant commissioner and CRUK to support the programme by following CRUK best practice (if available for the specific cancer) to increase the uptake of screening in the Practice target population (bowel cancer screening best practice can be found here http://intranet.rotherhamccg.nhs.uk/standards.htm)
2. Follow up DNAs and those currently not participating in the screening programme(s) by personalised contact with individual patients to encourage uptake, with particular focus on women in the 25-49 age group for the cervical cancer screening programme (this does not include letters from the screening service).

3. Ensure that those patients with learning disabilities are fully informed of the screening programmes and how they can access them in a format that they understand.
4. Feedback learning to the CCG

Monitoring of these will be done by the screening and immunisation team.

CCG Support

Support to practices will be provided by the NHS England screening and immunisation team:

1. Support Practices with regards to their education and training
2. Liaise with the practices to support improvements in programme delivery when queries arise
3. Participate and engage in peer review processes
4. Provide agreed data and information to the CCG for the practice dashboard.

NHSE Contact: england.sybprimarycare@nhs.net

Standard 5 - Health Protection

1. Influenza (flu)
2. Pneumonia
3. Shingles
4. Pertussis in Pregnancy

Rationale

The *Public Health Outcomes Framework* highlights health protection as one of 3 main pillars for improving and protecting the nation's health (PHE, 2014).

Annual immunisation programmes are a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year. This can help to reduce unplanned hospital admissions and pressure on Accident & Emergency Departments (A&E) (DH, 2014). Immunisation is also the most important way of protecting people from vaccine preventable diseases (DH, 2014).

1. Flu

Influenza (often referred to as flu) is an acute viral infection of the respiratory tract (nose, mouth, throat, bronchial tubes and lungs) characterised by a fever, chills, headache, muscle and joint pain, and fatigue. For otherwise healthy individuals, flu is an unpleasant but usually self-limiting disease with recovery within two to seven days. Flu is easily transmitted and even people with mild or no symptoms can still infect others. The risk of serious illness from influenza is higher among children under six months of age, older people and those with underlying health conditions such as respiratory disease, cardiac disease or immunosuppression, as well as pregnant women. These groups are at greater risk of complications from flu such as bronchitis or pneumonia or in some rare cases, cardiac problems, meningitis and/or encephalitis. (Flu Plan DOH 16-17). The aim of the national flu immunisation programme is to offer protection against the effects of flu to as many eligible people as possible, particularly those most at risk.

As much vaccination as possible, should take place before the flu virus circulates. Protection can be achieved directly through individual immunisation, or indirectly through herd immunity, which is one of the major benefits of the childhood flu immunisation programme. Improving and extending the child flu immunisation programme is a key focus in protecting the population from flu.

https://www.gov.uk/government/collections/annual-flu-programme

2. Pneumonia

Pneumococcal disease is caused by the bacterium Streptococcus Pneumoniae (pneumococcus). It is a major cause of disease and death globally, and in the UK. There are more than 90 different pneumococcal types (serotypes) that can cause disease in humans. More than 5,000 cases are diagnosed each year in England, with the number of cases peaking in December and January (DH, 2014). The programme covers adults aged 65 and over, and adults and children (aged over 2) in clinical risk groups. Please refer to the green book online for current recommendations and at clinical risk groups, along with dosage guidance.

3. Shingles

The shingles vaccination reduces the number of cases of shingles and its associated sequelae including post herpetic neuralgia (PHN). PHN can last up to six months or in some cases years and in the most severe cases is only partially treatable even with strong painkillers. About a quarter of adults will get shingles at some point in their life and in some severe cases people may die from complications arising from shingles. In the UK the number of Shingles cases is estimated to be around 790 to 880 cases per 100,000 people per year for people aged 70-79. (NHS England, 2016) Refer to the online green book for Shingles eligibility for the national programme

4. Pertussis in Pregnancy

The pertussis in pregnancy programme was introduced in 2012 as the UK reported the largest increase in pertussis activity in over two decades. At that time, the greatest numbers of cases were in adolescents and young adults but the highest rates of morbidity and mortality occurred in infants too young to be protected through routine vaccination. In England and Wales, a total of 14 infant deaths were reported in 2012. (PHE 2016)

Although the numbers of deaths in babies born in the three and a half years since the maternal vaccination programme was introduced has fallen, in England, there have been a further 16 deaths in babies aged ten weeks or younger with confirmed pertussis during this time. Only two of these babies had mothers who were vaccinated during pregnancy and in both cases, vaccination was too close to delivery to confer optimal passive protection to the infant. (PHE 2016)

https://www.gov.uk/government/publications/vaccination-against-pertussis-whooping-cough-for-pregnant-women

Delivery

Practices will be expected to:

1. Promote and pro-actively run targeted promotions of the vaccinations to all eligible groups as per Department of Health National Guidance/National Immunisation Programme
2. Have processes in place to invite all eligible patients for the vaccines above and evidence this has taken place, including pro-actively checking patient vaccinations status at every GP/Nurse Contact and offer in each setting including care homes for flu, pneumococcal and shingles
3. Antenatal pertussis and flu - liaise and work with local maternity providers to ensure the estimated date of delivery (EDD) is recorded on the patient's records and ensure all pregnant women have been offered and given or declined vaccinations recorded
4. Ensure all vaccinations given by alternative provider notified to GP practice are recorded correctly on the system within 5 working days of receipt
5. Record any active declines on the patient record this will then be included on the automated data uploads through immform. If possible try to identify reasons for non-engagement.
6. Use the online green book and PGD to check eligibility and updates for all programmes

https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

7. Have and maintain a practice NHS.net email address into which providers of flu vaccinations can submit notifications in a timely manner.

https://www.gov.uk/government/collections/annual-flu-programme

CCG Support

The Primary Care Team will provide Practices with peer clustered data and information

Further support will be provided by the NHS England Screening and Immunisation Team:

1. Support Practices/sign post with regards to their education and training
2. Liaise with the practices to support improvements in programme delivery when queries arise
3. Ask Practice to participate and engage in practice visits as/where required
4. Provide agreed data and information to the CCG for the practice dashboard.

NHSE Contact: england.sybprimarycare@nhs.net

Standard 6 - Cancer Referral

Rationale

In 2011, the Government outlined a framework to focus on improving health outcomes for cancer; recommending that England should achieve comparable outcomes with the best in the world (DH, 2011). Whilst recent trends show survival rates are improving, international comparisons show that England is worse than many other countries including Canada and Australia (Coleman et al, 2010). To address improved survival, evidence strongly advocates for earlier diagnosis, and timely access to treatment (Foot and Harrison, 2011). GPs have been suggested as pivotal in this arena, and survival rates have been highlighted as a key index of the effectiveness of Primary Care in cancer management locally (Abdel-Rahman et al, 2009).

GPs are expected to be familiar with typical presenting features of cancers, and also alert to the possibility of cancer, when confronted by unusual symptom patterns. Following a systematic review of a patient's history and then examination, the National Institute for Health and Care Excellence (NICE),(2007) recommends urgent referral within 2 weeks for a 'suspected cancer'. Since the introduction of this guidance, survival rates for some cancers have greatly improved (Cancer Research, 2014).

Looking to the future, the overall picture for cancer survival is positive. However, in the short term, inequalities still exist. Evidence suggests that some groups are not taking full advantage of the opportunities to improve their health; for whatever reason. Variation, linked to health inequalities, can be seen across Rotherham's Practices. This is in relation to emergency first presentations for cancer and DNAs for appointments under the 2 week rule. The baseline data shows the following variation:

1. Emergency first presentations for cancer: 0.0 – 1.9 (per 1,000 practice population) awaiting data
    - DNA for 2 week waits: 0.0 – 4.6 (per 1,000 practice population) awaiting data Potential Years of Life Lost (PYLL) from causes considered amendable to healthcare, per 100,000
    - Under 75 mortality rate from cancer (CCG) **121.40 Target** – **14/15 143.50** (Target = England Average)

Reducing this variation will present challenges for both patients and clinicians alike. Urgent referral can be particularly difficult for some patients because of personal circumstances, such as age, family, work responsibilities, cultural and social issues. Primary Care may need to change established working practices and processes to meet these challenges (Cancer Research, 2014).

Primary Care has a vital role to play in the early diagnosis of cancer (Gordon-Dseagu, 2008). The aim of this standard is to demonstrate progress and impact in Rotherham, by reducing cancer incidence, ensuring patients have timely access to treatment and services, and reducing cancer inequalities.

Delivery

Practices will be expected to:

1. Identify a Practice Cancer Lead who attends an annual cancer update and shares learning with the practice. A cancer PLT would constitute this update.
2. Use the most up to date referral proforma (available on top tips) – http://www.rotherhamccg.nhs.uk/therapeutic-guidelines.htm

3. Develop a system to prevent DNA of 2 week waits (2ww)
    a) Process referrals within 24 hours (i.e. the hospital has received your referral letter within 24 hours of decision to refer)
    b) Advise the importance of attendance – the patient's ability to attend within the next two weeks needs to be confirmed and if not available for contact to arrange an appointment, a discussion regarding referral needs to take place, please note this means that if a patient chooses that they are not available for contact for the full 2 week period or longer you will inform the hospital when referring to hold notification of the appointment until the patient returns.
    c) Provide written information http://intranet.rotherhamccg.nhs.uk/GP%20Area/Quality%20Contract/Urgent%20referral%20leaflet.pdf
    d) Referrals are to be made electronically through the e-referral system to ensure a robust process for ensuring the patient has received an appointment (please be aware when you have booked the virtual appointment on the e-referral system, remember not to give the patient this appointment as it is not real, it becomes the hospitals responsibility to arrange appointment and chase the patient) note within new GP contract it is stated that practices will aim to have at least 80% of referrals done electronically by March 2017)
4. Review all cancer diagnoses made outside the two week wait referral process using the agreed template. Cancer Research UK has confirmed that they can come in and support practices in how they reflect on the learning from these reviews.
5. Contact the patients within 3 months of diagnosis (using existing QoF template) *(no this does not need to be a face to face consultation it is about contacting the patient to identify any need for support)*

CCG Support

The Primary Care Team will:

1. Share the learning from the Practice reviews at the annual Quality Planning meeting and with Primary Care Committee & GP Members
2. Develop a new diagnosis Cancer Review Template
3. Develop a template to enable feedback to the CCG

CCG Contact: SCE Member for Cancer

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 7 - Best Care: Long Term Conditions (LTCs)

This standard specifically relates to the following:

- Diabetes
- Heart Failure (with Left Ventricular Dysfunction)
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Atrial Fibrillation (AF)

Rationale

Best Care Registers for long term conditions

Treatment and care of people with long term conditions (LTCs) accounts for 70% of the total health and social care spend in England (DH, 2010). It is estimated that by 2025 there will be 42% more people in England aged 65 years and over. This will mean that the number of people with at least one LTC will rise to 18 million (DH, 2010).

Management of care for people with LTCs should be proactive, holistic, preventive and patient-centred. There should be an active role for patients, with collaborative personalised care planning and shared decision making. (The Kings Fund, 2013).

Prevalence of LTCs is higher in Rotherham than national averages. Case Management has been in place since 2012 and is proving effective in identifying and supporting patients to manage their conditions. This work will complement the work done in case management.

A range of indicators have been developed which will provide clarity and information on the care received by patients on the following registers:

- Diabetes – 9 indicators
- Heart Failure (with LVD) – 7 indicators
- COPD – 6 indicators
- Asthma – 6 indicators
- Atrial Fibrillation – 8 indicators

Delivery and Performance Indicators for each area

Diabetes

Preventing diabetes is a key aim of these arrangements. Practices are therefore required to support the National Diabetes Prevention Programme (NDPP) as it is rolled out by identifying patients and referring onto the programme. The Health Check programme is a key strand of the referral pathway into the NDPP; Primary Care actively supporting and referring into the service are also supporting the identification of eligible patients.

To improve detection:

- Holistic assessment for people with diabetes to check for the existence and/ or risk of associated co-morbidities. *NB Referral to diabetic retinopathy screening should be made as soon as possible after diagnosis and not more than 3 months from diagnosis.*
- Increased identification of hypertension and high cholesterol through annual Health Checks and LTC checks, and the prescribing of medication to control both conditions.
- Opportunistic case finding, for example, when patients attend for LTC management, flu clinics etc.

To improve management

- Identify patients and add to the appropriate practice disease register.
- Early referral to lifestyle services, e.g. smoking cessation, weight management and self-management programmes.
- Greater acknowledgement of the impact of a long term condition(s) on a person's mental health. Access to mental health services is available via the Integrated Locality Team (ILT) or a mental health referral.
- Sharing best practice, including Diabetes Specialist Nurse (DSN) input to practices.
- Utilising the (ILT) via multidisciplinary team (MDT) meetings.
- Nominating a key-worker for patients.
- Workforce education.
- Systematic delivery of the '[1]9 Key Care Processes for Diabetes' and Nice Standards for Type 2 Diabetes in Adults (July 2016) to bring the CCG's QOF average in line with national targets.

Delivery

1. A patient-centred care plan written with and for the patient - reviewed annually
2. Encouraging the use of technology to encourage patients to manage their condition better e.g. BMI apps
3. People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to on-going education. e.g. X-Pert patient, DAPHNE.
4. Ensure that the relevant processes are in place for detection and management (see above)
5. Increased referral for active lifestyle interventions, using the electronic referral process for the Get Healthy Rotherham service including referrals to third sector services
6. NHS Health Checks programme – enhanced requirements including coding patients with non-diabetic hyperglycaemia and referring to the National Diabetes Prevention Programme or referral of patients via Health Checks by the Get Healthy Rotherham service.
7. Supporting patients back into work
8. Self-administration of medication, e.g. insulin
9. Self-monitoring of blood-glucose levels
10. Women with diabetes who are planning a pregnancy are provided with knowledge and support to prepare them for pregnancy.

11. Participation in the diabetes national audit: Practices are required to participate in the diabetes national audit to enable review and continual improvement in diabetes care.

Delivering combined clinics in primary care

General practices should be offered mentorship and support for annual reviews, case finding, personalised care planning and patients with difficult to manage disease via combined clinics with diabetes specialists, e.g. DSNs and secondary care consultants. A focus within these clinics should also be on identifying problems earlier to reduce the onset of complications. GPs and practice nurses should be supported in their holistic assessment approach. It is a requirement that practices will manage diabetes patients in the community with assistance from secondary care.

Heart Failure (HF)

Aim

The aim of this standard is to reduce the number of HF non-elective admissions by better management within primary care.

Delivery

1. Practice has a named clinician responsible for
   - Ensuring all HF discharges / diagnosis are acted upon & the Patient has a management plan
   - Ensuring HF management plans produced by the HF Specialist Nurse are acted upon
   - Patients have easy access to advice when HF symptoms worsen / become un-controlled (decompensation)
2. The Practice has a standard operating procedure to ensure newly diagnosed HF Patients have their medication titrated to the recommended therapeutic dose or maximum tolerated dose.
3. All HF Patients have a 6 monthly review of their:
   - Medication
   - Symptom Control
   - Renal Function
4. ACE/ARBs/betablocker medication has been titrated to the recommended therapeutic dosage.
5. The practice is reducing the number of HF non-elective admissions by better management within primary care.

COPD

COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing, primarily due to the narrowing of their airways, this is called airflow obstruction. Most cases of COPD are caused by inhaling pollutants; that includes smoking (cigarettes, pipes, cigars, etc.), and second-hand smoke. Fumes, chemicals and dust found in many work environments are contributing factors for many individuals who develop COPD. As a former mining and industrial area, Rotherham has increased incidence of COPD.

Aim

The primary aim is to improve the COPD specific quality of life which will be measured via audit.

Delivery

1. A comprehensive self-management programme as an adjunct to usual care. Consisting of :
    a. A minimum of one (maximum of 4) tailored sessions with ongoing support (telephone satisfactory) by a practice nurse
    b. Practice to have an appropriate process in place for reviewing all discharge letters and contact patients (telephone satisfactory) identified as an exacerbation by the hospital within 72 working hours of receipt of discharge (unless the patient was already seen in the practice for this condition in the last 4 weeks) and within 4 weeks for a structured follow-up consultation.
    c. Improve management of rescue prescription packs

Asthma

Asthma is a long-term condition that affects the airways in the lungs in children, young people and adults. Classic symptoms include breathlessness, tightness in the chest, coughing and wheezing. The goal of management is for people to be free from symptoms and able to lead a normal, active life. Occupational factors account for about 1 in 6 cases of asthma in adults of working age. (NICE February 2016)

NB Currently the diagnosis & monitoring guidance published by NICE is in development when new NICE guidance is approved for use for the guidance and monitoring of asthma in primary care then this area of chronic disease management for the quality contract will be updated.

Improved Detection

Diagnosis of asthma should ideally follow the BTS/SIGN guidance for asthma – Revised 2016. Confirmation of diagnosis with spirometry would be expected, although a high quality record of serial peak flow measure would be acceptable where spirometry is not able to be completed.

In children the BTS/SIGN guidance as of 2016 – states that the diagnosis of asthma is primary based on clinical assessment via spirometry and trials of inhaler treatments with the consideration of lung functions tests in appropriate age groups. Until further guidance is published by NICE this will be the expected way of diagnosis. However it is recognised in younger age children (under 5s) diagnosis is complicated by viral wheezes which may be managed in a similar way without a formal diagnosis.

Each practice is required to keep a disease register of viral-wheezing children to help ensure these children are followed up to reduce exacerbations.

Delivery

1. A patient-centred care plan written with and for the patient based on symptoms and or peak flow measurement for both children and adults. For children a symptoms based plan is usually preferable for the patient.

2. Sign-posting to internet resources or information leaflets from organisations such as Asthma UK.
3. A clinical review for patients following flare up of symptoms requiring an emergency assessment whether in primary and secondary care should lead to a review ideally in primary care by a specialist asthma nurse. In children it is acceptable for this review to be done by the children's asthma nurse service.
4. Provision and monitoring the use of rescue packs of antibiotics and steroids if clinically appropriate for educated patient when symptoms flare up to enable self-management when immediate access to a clinician may be difficult.
5. Influenza vaccination as per current NICE / QOF guidance.
6. Clinical management with regards to asthma to follow current BTS / SIGN guidance which is obviously changeable as clinical practice is updated. Aiding patients to step-up or down their medications depending on their symptoms.
7. With regards to children – following a recent death in a child with asthma when in school the review panel specifically recommended actions to try reduce the risk of this recurring; an asthma school plan will be created and refreshed annually, at the request of the school (or school nurse) and asthma review/plan will be undertaken.
8. Early referral to lifestyle services, e.g. smoking cessation, weight management and self-management programmes.

Primary Care Review

As is current routine practice annual face to face review with a specialist nurse is the preferred way to assess asthma control and compliance with medication as per current BTS/SIGN guidance. However well controlled asthmatics can be a difficult group to get into attend practice.

In difficult to reach groups an initial telephone review of symptoms or skype consultation would be acceptable, with the organisation of a face to face review if 1 of the three routine asthma monitoring question shows poor control.

In children under the age of 12 an annual face to face review is required either in the child's primary care practice or by the community based asthma team.

Atrial Fibrillation (AF)

Delivery

1. All practices to use the GRASP AF tool to identify & treat AF
2. All AF patients to have at least an annual review of ongoing Anti-coagulation needs including DOAC Patients
3. To ensure compliance in relation to DOAC/warfarin usage

Overall Best Care Delivery

Practices will be expected to:

1. Provide patient-centred care plans for diabetes, COPD and asthma
2. Provide comprehensive annual reviews, and other review sessions as necessary for patients on the 5 Best Care registers
3. Improve the care of patients on the 5 Best Care registers
4. Use the Best Care templates developed by the Data Quality Team
5. Allow access to the Practice System for the Data Quality Team and Primary Care Team
6. Submit data to Rotherham CCG quarterly

CCG Support

The CCG will provide support to the practices for the following:

1. Appropriate read codes and reports to identify and monitor the relevant patients.
2. Support Practices to identify the total eligible practice population

Key Performance Indicators

The practice will be required to:

Reduce to Rotherham average to achieve the Key Performance Indicators as outlined in the Best care dashboard

Best Care Scores:

Diabetes delivery of indicators:

0-3	no payment
4	16%
5	32%
6	48%
7	65%
8	82%
9	100%

Heart failure delivery of indicators:

0-3	no payment
4	25%
5	50%
6	75%
7	100%

AF delivery of indicators:

0-3	no payment
4	20%
5	40%
6	60%
7	80%
8	100%

COPD and Asthma delivery of indicators:

0-2	no payment
3	25%
4	50%
5	75%
6	100%

CCG Contacts: SCE GP for Primary Care

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 8 - Exception Reporting

Rationale

The Quality and Outcomes Framework (QOF) allows Practices to exception report (exclude) specific patients from data collected, to calculate achievement scores. Patients can be exception reported from individual indicators for various reasons e.g. newly diagnosed, newly registered with a Practice, if they do not attend appointments or where treatment is judged to be inappropriate i.e. medication cannot be prescribed due to contraindication. The General Medical Services (GMS) contract sets out the criteria which allow Practices to participate in QOF, but not to be penalised where exception reporting occurs (Health & Social Care Information Centre (HSCIC), 2011).

Patient exception reporting applies to QOF indicators where the level of achievement is determined by the proportion of patients receiving the designated level of care. The maximum achievement threshold is not constant across all clinical indicators, but varies between 50% and 90%.

The condition with the highest percentage of exceptions is Cardiovascular Disease at 31.3 per cent overall. The measure with the lowest percentage of exceptions is Blood Pressure at 0.5 per cent overall. The average exception rate across all relevant indicators is **5.7 per cent.**
(Source http://www.content.digital.nhs.uk/catalogue/PUB22266/qof-1516-rep-v2.pdf)
Current Rotherham average is 4.76

Delivery

Practices will be expected to:

1. Ensure the Practice has a policy in place for exception reporting and is adhering to the policy
2. Where a practice is reported as having 'unusual' [1] activity, a report will be provided on request to the CCG to provide clarity on the circumstances

CCG Support

The Primary Care Team will:

- Supply peer clustered data
- Share local learning to support the Practice to achieve the KPI

CCG Contact: SCE Member for Primary Care

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

[1] Unusual in this instance is determined as an outlier, either significantly above or below the Rotherham average.

Standard 9 - End of Life Care

Rationale

"You matter because you are you, and you matter to the end of your life" (Dame Cicely Saunders cited in NHSE 2014).

Current evidence suggests there is going to be an inexorable rise in the numbers of people with chronic disease. A 17% increase in the actual number of deaths in England is forecast by 2030 (Leadership Alliance for the Care of Dying People (LACDP), 2014).

The Quality Standard for End of Life Care (NICE, 2011) provides a comprehensive picture of what high quality end of life care should look like. Taking into account the current needs of the population and the changing health and social care landscape, NHS England (2014) has developed a 5 year vision for end of life care beyond 2015. This strategy focuses on 'dying well', wherever it occurs, with Primary Care being identified as a key stakeholder.

Delivery

Practices will be expected to:

1. Identify a Practice End of Life (EOL) Lead who attends annual training
2. Hold a monthly end of life meeting. This meeting should be led by the EOL Lead who may wish to invite relevant stakeholders e.g. the District Nurse (This can be part of the case management MDT).
3. Complete the case management/palliative care template for patients identified by the practice
4. Review patients on the EOL register who die in hospital
5. Bi-annual communications and DNACPR training
6.

CCG Support

The Primary Care Team will:

1. Facilitate education sessions around EOL care and communication training at PLTC
2. Continue to improve the palliative care template

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CCG Contact: SCE Member for End of Life Care

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 10 - Patient Safety

1. Significant Event Reporting
2. Safeguarding

Rationale

Improving patient safety in the UK will require a cultural change within the healthcare system. A true safety culture is one in which every person in the organisation recognises their responsibility towards patient safety, and works to improve the care that they deliver. This is the essence of clinical governance (NHS National Patient Safety Agency, (NPSA), 2014). This standard aims to build a culture of safety for Primary Care in Rotherham.

1. Significant Event Reporting

It is widely recognised that mistakes and incidents will happen, and that healthcare is not without its risks. Evidence shows that if the culture of an organisation is safety conscious, and people are encouraged to speak up about mistakes and incidents, then patient safety and care can be improved (Vincent, 2001). NHS incidents are defined as any unintended or unexpected episode which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare (NHSE, 2013).

Incidents in Primary Care are uncommon, but when they do occur GPs have a responsibility to ensure there are systematic measures in place for safeguarding people and NHS reputation (NHSE, 2013). Recent research has highlighted 4 main areas of concern - diagnosis, prescribing, communication and administration (NHS National Patient Safety Agency, (NPSA), 2014). Whilst this research has given some insight into the breadth of incidents, it acknowledges the need for more accurate assessment of the number and severity of patient safety incidents (Sanders & Esmail, 2001). The cause of incidents cannot simply be linked to the actions of individual people. Adoption of a framework, using a system wide perspective for notification, management and learning from serious incidents, will support openness, trust and continuous learning and service improvement. (NPSA 2010). On-going increases in the number of reported safety incidents, especially near misses or no harm incidents, reflect an improving safety culture. However, under-reporting continues to be a major obstacle, particularly in Primary Care (The King's Fund, 2014).

2. Safeguarding

Safeguarding means the protection of health, wellbeing and human rights, and enabling people to live free from harm, abuse and neglect. This is a key part of high quality, health and social care (The King's Fund, 2014). Mandatory training on safeguarding, of both children and adults, should be provided for all NHS staff, to enable them to evidence core competences, key knowledge, skills, attitudes and values (Royal College of Paediatrics & Child Health (RCPCH), 2014). GP Practices are required to be compliant with Care Quality Commission (CQC) requirements on safeguarding and all staff must have had training, appropriate to their role (British Medical Association (BMA), 2013). The General Medical Council (GMC), (2012 pg.10) states that 'Doctors must be

competent and work within their competence to deal with child protection issues. They must keep up-to-date with practice through training that is appropriate to their role'.

The Royal College of Paediatrics & Child Health (RCPCH), (2014) recommends that Practices develop a safeguarding plan and identify a child health and safeguarding lead. The role will:

- Act as first point of contact for colleagues with safeguarding concerns
- Act as local champion for safeguarding best practice
- Produce reports as requested Children's Social Care Child Protection Unit
- Disseminate relevant information to the practice

Primary care has a duty to cooperate with current legislation, and this is reinforced within the GMC guidance regarding working jointly with other agencies. This includes participating in child protection procedures and information sharing (with and without consent) (GMC, 2012).

Delivery

Practices will be expected to:

Incident reporting

1. Submit 2 clinical incidents per substantive Clinician (GP, Nurse Practitioner, Practice Nurse (> 0.5WTE,) via the NRLS
2. Incidents should be related to work in Primary Care and 1 from the interface with another health care setting or provider
    - These incidents can be in any of the 4 main areas previously mentioned - diagnosis, prescribing, communication or administration
3. Identify a Safety Champion who will attend an annual Quality and Safety meeting to discuss and disseminate key findings and contribute to action planning and developments within the practice throughout the year

Safeguarding

1. Provide access to and attendance at safeguarding training for all staff at a level appropriate to their role, in keeping with the requirements of the intercollegiate documents (RCPCH, 2014), and provide assurance to the CCG that staff are trained
2. Identify a Safeguarding Lead who will attend a biennial CCG Safeguarding Event, and have responsibility for enabling access to safeguarding supervision for relevant staff and will disseminate information within the Practice
3. Produce reports as requested by statutory safeguarding partners, for both initial and review meetings, related to safeguarding concerns e.g. Child Protection Conferences
4. Contribute to information sharing processes in the event of death or significant harm of a child or adult
5. Provide assurance of improved outcomes based on implementation of recommendations from serious case reviews, safeguarding adult reviews, domestic homicide reviews
6. Share learning with colleagues developed by contribution to learning events and reviews e.g. child death overview panel, safeguarding adult reviews, domestic homicide reviews
7. Ensure the practice has a safeguarding policy, which includes details of managing risk and flagging patient records appropriately
8. Deliver on national safeguarding standards and best practice in relation to looked after children and individuals at risk of child sexual exploitation.

9. All GPs must be aware of the Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS) and able to evidence this.
10. All GP Practices will submit Child Protection Conference reports, if requested, using the required template to provide information to inform the decision making.
11. Practice Safeguarding Lead to attend CCG event and disseminate learning to the Practice team
12. All staff to undertake appropriate training to their role, and be supported to implement requirements from their learning
13. Publish annual safeguarding self-assessment, as agreed by the CCG.

CCG Support

The CCG will:

1. Support the arrangement of a biennial Safeguarding Training Event

CCG Contact: - Head of Safeguarding/Deputy Chief Nurse

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 11 - Mental Health, Dementia, Learning Disability and Military Veterans

1. Mental health
2. Dementia
3. Learning Disability
4. Military Veterans

Rationale

NHS England's document "The Five Year Forward View for Mental Health' published in 2016 aims to ensure:

- A reduction in premature mortality of people living with severe mental illness (SMI);
- 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

Over the last 65 years, the NHS has helped deliver dramatic improvements in the health and wellbeing of the population, but more work is still needed. Improvement in this arena will require a fundamental change to the culture of healthcare, and in the way services are commissioned and provided. This will mean moving towards a culture where mental health and physical health are valued equally. This is known as parity of esteem (NHS England (NHSE 2014). Primary Care will need to adapt quickly to embrace this culture of parity.

People with mental illness are at increased risk of the top 5 killers: heart disease, stroke, liver disease, respiratory disease and some cancers. This will require a holistic approach; tackling poor physical health at the same time as addressing mental health disorders.

Delivery

Practices will be expected to ensure that:

To improve the management of mental health in primary care, practices are required to deliver the following:

1. Offer annual health checks to all patients on SMI and learning disability registers
2. Ensure all staff undertaking health checks are competent to deliver

Dementia

Dementia is now the greatest health concern for people over 55 and the economic cost of dementia is more than cancer, heart disease or stroke. Currently, in Rotherham there are 2,331 people on the GP Dementia register compared with a predicted prevalence of 3082, a gap of 863 people. It is estimated that by 2025 the number of people in Rotherham with Dementia will have risen to 4397 (JSNA 2011).

Dementia is a decline in mental ability which affects memory, thinking, problem-solving, concentration and perception. Some people with dementia develop other problems such as depression, anxiety, disturbed sleep patterns and in the later stages incontinence.

Many people with dementia will also have co-morbidities which will need to be managed in Primary Care.

Delivery:

Practices will be expected to:

1. Ensure all staff are able to attend a Dementia Friends sessions or complete e-learning programme
2. Develop a Practice Dementia Friendly Action Plan which is submitted to the Carers resilience service. This plan must be updated on an annual basis
3. Refer carers of people with Dementia to the Dementia Carers Resilience Service for assessment and support.

Practice Support

The Dementia Carer Resilience service will:

- Provide Dementia Friends sessions for the practice
- Support the practice to develop a Practice Dementia Friendly Action Plan

Learning Disability

People with learning disabilities (LD) have complex health needs. Yet, this group are less likely to receive regular health checks and access routine screening

The interaction of physical, behavioural and mental health issues can be difficult to interpret, causing illness to be over-looked. In 2008, annual health checks for adults with LD were introduced by the Government. However, recent research has shown that less than half of those entitled to a health check get one, and there are concerns around quality and consistency (Heslop et al, 2014).

In Rotherham, the Learning Disability Annual Health check is well-established within primary care across Rotherham. The aim is to standardise annual health checks and to develop a clear pathway between the check and subsequent care plan. Improving the quality of health checks and increasing screening rates for people with LD (aged 14 and above) will:

- Improve health outcomes
- Improve access to prevention
- Develop improved relationships with Primary Care staff

Learning Disabilities Mortality Review (LeDeR) programme

In November 2016 the Learning Disabilities Mortality Review (LeDeR) programme death notification process was launched. This was in response to a number of reports and case studies that since the 1990s have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities. The overall aim of the LeDeR programme is to drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population.

It will do this primarily by supporting local agencies to conduct reviews of the deaths of people with learning disabilities and to take account of the learning that comes from

these reviews in order to improve their service provision as well as contributing to national and international evidence about mortality in people with learning disabilities. The LeDeR Programme will support reviews of deaths in line with the key performance indicator.

Delivery

1. Ensure all staff undertaking health checks are competent to deliver
2. Offer annual health checks to all patients on mental health and learning disability registers
3. To report all deaths of patients with learning disabilities aged 4 – 74 (inclusive) who are registered with the practice via the LeDeR death notification process (http://www.bristol.ac.uk/sps/leder/)
4. Support the local LeDeR Review of any patients with learning disabilities aged 4 – 74 (inclusive) who are registered with the practice
5. Use the locally developed template on the Practice system
6. Offer access to screening initiatives to all eligible patients on mental health and learning disability registers
7. Participate in the Learning Disability Self-Assessment Framework (LDSAF)
8. Practice to allow LDSAF to be run by Data Quality Team

Military Veterans

The Armed Forces Covenant (HM Government, 2011) sets out the relationship between the nation, the government and the Armed Forces. In terms of the NHS this means the Armed Forces community, including Reservists, should enjoy the same standard of, and access to healthcare, as received by any other UK citizen. Veterans and Reservists should receive routine healthcare from their local NHS. However, they should receive priority treatment whenever it relates to a condition resulting from their service in the Armed Forces, subject to clinical need.

To enable Primary Care to adhere to the requirements of The Armed Forces Covenant, the status of 'Military Veteran' or 'Reservist' should be recorded in the Practice system. A Veteran is classed as someone who has served at least one full day in the armed forces (HM Government, 2011).

Delivery

1. Record Armed Forces Veterans & Reservists on the Practice system
2. Comply with the primary care requirements of the Armed Forces Covenant and ensure high quality responsive services for Veterans, Reservists and their families

1.

CCG Contact: SCE Member for Mental Health/Primary Care Team

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 12 - Carers

Rationale

It is widely acknowledged that both informal, and family support, have an important part to play in an effective health care system. There has been a growing emphasis in recent years on the need to provide more comprehensive support to carers, since they often face greater social deprivation, isolation and ill health. Also, they have fewer opportunities to do the things other people may take for granted, such as access to paid employment, learning opportunities or having quality time to spend on their own, or with friends. In terms of young carers, it can often compromise their education and social life, limiting their life chances (Carers UK, 2014).

It is acknowledged that GPs are developing and improving their services for carers. However, the Royal College of General Practitioners (RCGP), (2014) highlights an urgent need to further embed the identification and support of carers within General Practice. This will ensure carers are supported at an earlier stage, enabling real benefits for both carers and patients alike.

The Rotherham Carers strategy has been produced which highlights the key issues and priorities for local carers. This can be found on the CCGs website.
https://www.rotherhamccg.nhs.uk/carers.htm

Delivery

Practices will be expected to:

1. Identify a Carers Lead within the Practice
2. Ensure that all staff, including receptionists, are 'carer aware', and have a basic understanding of support available
3. Have a Carers Register which is maintained and updated, and used to support carers by:
    a. Offering carers a health check
    b. Offering carers a flu vaccination for those on the register
    c. Offering information
4. Display information in the waiting room, to help carers identify themselves, and to highlight available support and information

CCG Support

The relevant Lead for Carers at the CCG will:

1. Arrange appropriate carers training for nominated staff to feel confident to act as Carers Lead
2. Hold regular meetings to share good practice
3. Work with providers to increase carers support e.g. via carers clinic

CCG Contact: SCE Member for Primary Care

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Standard 13 - Patient Experience

Rationale

It is well documented that feedback from patients is vital in order to transform NHS services and support patient choice. The Friends and Family Test (FFT) was introduced in England, in April 2013. This was established in all NHS inpatient and A&E departments. In December 2014, it was rolled out across Primary Care organisations.

The FFT is an important feedback tool that supports the principle that, people who use NHS services should have the opportunity to provide feedback on their experience. Practices are already contracted to ensure that patients provide feedback using the Friends and Family Test. In addition practices have to publish the results.

Patient participation in Primary Care can be a powerful partnership between patients, GPs and their Practice staff. Contractually Practices are already required to establish and maintain a 'Patient participation group'. It should also regularly review its membership and gain feedback from this group. The benefits of patient forums include:

- Helping patients to take more responsibility for their health
- Contributing to continuous improvement of services and quality of care
- Fostering improved communication between Practice staff and patients
- Providing practical support to help implement change

Evidence shows that successful Practices, and effective Patient Forums, go hand in hand (NAPP, 2014).

Delivery

Practices will be expected to:

1. Utilise MJOG for FFT (and other mechanisms for those without mobile telephones) to gain feedback. Ensure that there is evidence that feedback has been responded to i.e. discussion at PPG, shown in the PPG notes on the website, and/or a 'you said, we did' section on the website.
2. Keep their practice website up to date with regard to PPG information, including minutes from meetings (within 1 month of meeting), future meeting dates, and information on the ways people can get involved.
3. Encourage a representative from the PPG to go to the local PPG network meetings.
4. Undertake a local patient survey via MJOG where National GP patient survey results have been in the bottom 10%, and produce an action plan.
5. The practice website address must be clearly communicated to all patients, be easily accessible, include messages for patients on appropriate use of health services, with sign posting supporting care navigation, online services, and details of any information sharing agreements.
6. Practices must promote local health and social care campaigns in line with the Rotherham Place Plan.

CCG Support

The Primary Care Team will:

1. Provide Practices with national updates on the FFT, as and when they are produced
2. Keep Practices up to date on CCG priorities

3. Monitor patient survey results, and feedback to Practices on progress and peer comparisons via the primary care dashboard.
4. The Patient and Public Engagement Manager will provide additional guidance and support.

CCG Contact: Patient and Public Engagement Manager

Please refer to the SCE/RCCG Lead Contact List: SCE CCG Contact List.doc

Appendix A – Appeal Process

Quality Contract & Local Enhanced Services Appeal Process

This process will be used for any practices who wish to appeal NHS Rotherham CCG's decision to withhold funding for any elements of the Quality Contract and Local Enhanced Services.

Appeal Process

If an officer of the CCG decides to withhold funding and a practice wish to appeal against this decision, they must do so in writing to the Primary Care Team using the attached template within 30 calendar days of notification of payment being withheld. The template should detail the grounds of the appeal and include all available supporting evidence. Further evidence will not be accepted later in the process.

The first appeal will be considered by the next available Sub-Group of the Primary Care Committee and the officer who made the original decision will be excluded. The decision will be communicated to the practice within 5 working days of the meeting – if the appeal is accepted the monies will be paid in the next available payment run. If the appeal is rejected the practice can choose to pursue a second appeal.

The second appeal will be heard by a panel of the Primary Care Committee at the next available meeting, chaired by a lay member. None of the original decision makers will be on the panel, and no new evidence can be submitted – the purpose of the panel is to reconsider the decision made on the evidence previously submitted. A practice representative can attend the panel if they wish. The decision will be communicated to the practice within 5 working days of the meeting – if the appeal is accepted the monies will be paid in the next available payment run. If the appeal is rejected this decision is final.

Example evidence

Quality Contract Standard 7 – Better Care (Heart Failure):

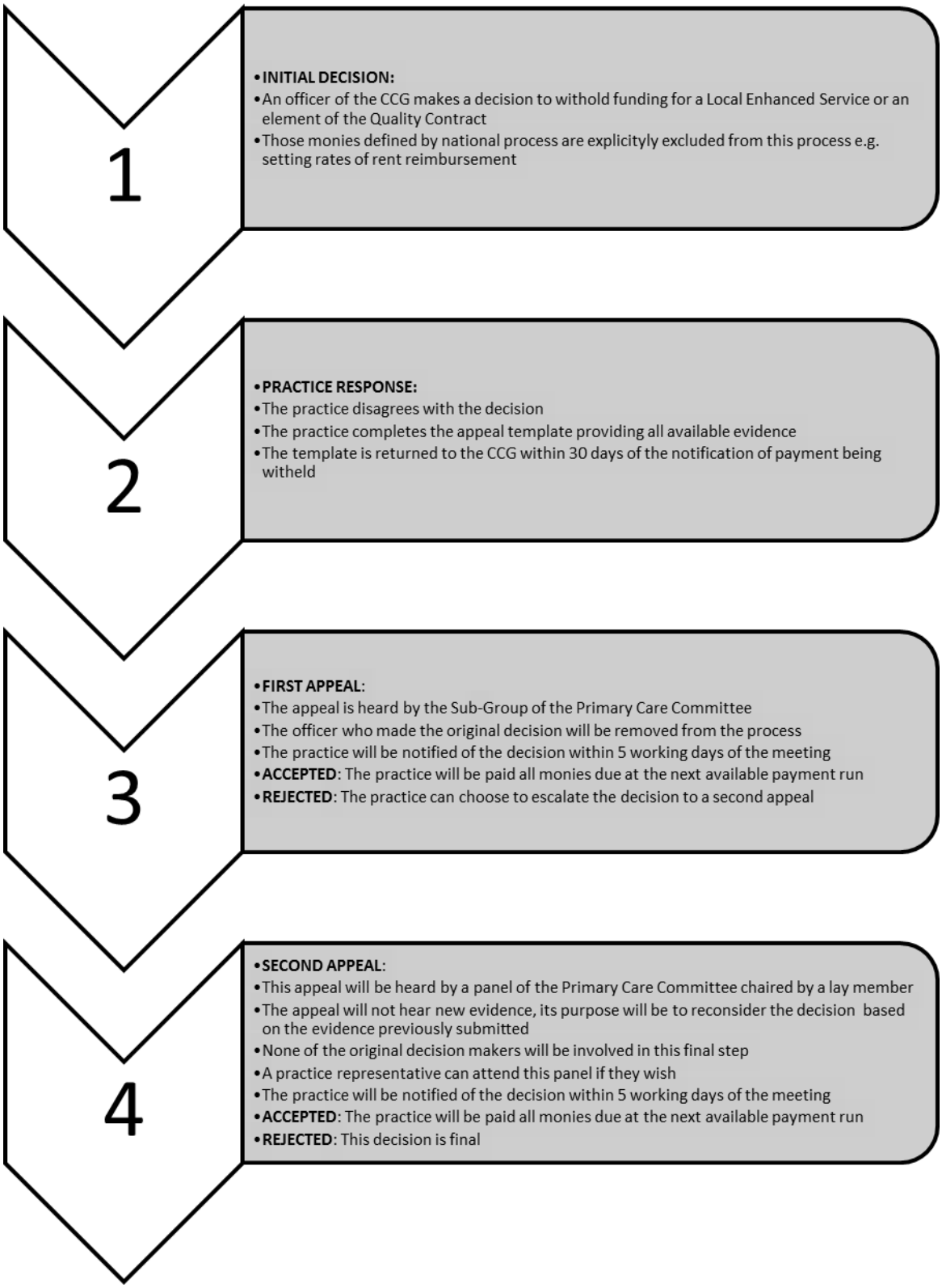
Delivery (3) - All HF patients to have a 6 monthly review of their medication, symptom control, and renal function.

6. The practice would need to evidence that all the deliverables for heart failure are being met.
    1. Providing the name of the clinician responsible with anonymised example of actions taken
    2. Anonymised example of patients having easy access to advice when HF symptoms worsen / become un-controlled (decompensation)
    3. A copy of the standard operating procedure to ensure newly diagnosed HF Patients have their medication titrated

to the recommended therapeutic dose or maximum tolerated dose.

4. Evidence that all HF Patients have a 6 monthly review from the clinical system
5. Example evidence that ACE/ARBs/betablocker medication has been titrated to the recommended therapeutic dosage.
6. The practice is reducing the number of HF non-elective admissions by better management within primary care – report via RCCG

Appeals



Please note: this process involves both the Sub-Group of the Primary Care Committee, and the Primary Care Committee itself, and so each level of appeal will be heard at the first available meeting. We will endeavour to come to a resolution as quickly as possible within the constraints of pre-set meeting dates.

Appeal Template

Practice Name:		**Lead GP:**	
Today's Date:		**Quarter to which the payment applies:**	
LES or Standard of the Quality Contract to which the appeal applies:			
Amount of money withheld: (£)			
Details of the appeal:	*(please give details of why you believe you have an appeal)*		
Evidence:	*(give details of any evidence you have here to support your case, attach files if necessary, but please don't include patient identifiable information)*		
Name:			
Signed:			

Please return this completed form to primarycare@rotherhamccg.nhs.uk or to the Primary Care Team, Rotherham CCG, Oak House, Bramley, Rotherham S66 1YY.