

# **QUALITY CONTRACT**

**2020/2021**

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## **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 was phased over 3 years as the changes to the PMS funding took place and is now fully implemented.

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
- Health Improvement
- 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 delivered or sub-contracted as part of the Quality Contract.

### **Payments:**

The information below shows these per year as a payment per patient (weighted list size, set in January):

**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)

**YEAR 4      2019/20 - £5.04 per patient maximum**  
Delivery (83% of available funds)  
Key Performance Indicator (17% of available funds)

**YEAR 5**      **2020/21 - £5.04 per patient maximum**  
Delivery (83% of available funds)  
Key Performance Indicator (17% of available funds)

## **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:

- Reflect joint strategic plans for primary care that have been agreed with Rotherham CCG.
- Secure services or outcomes that go beyond what is expected of core general practice and basic QOF.
- Help reduce health inequalities.
- 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).
- 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.

### **1. The Rotherham Local Quality Contract**

- 1.1 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.
- 1.2 The local Quality Contract provides clear set of standards for General Practice which has been developed to:
  - Ensure consistency in quality across Rotherham.
  - Increase capacity in General Practice to improve the service offered and set a good baseline for the development of more integrated models of care.
  - Support the delivery of Rotherham CCG's Strategy for general practice and the GP Forward View.

- Reflect the balanced aims of improved population health, better quality and patient experience of care and value for money.
  - Incorporate all local enhanced services with General Practice (except care homes, acupuncture and specialist services offered from the Gate).
  - Provide a consistency of offer to Rotherham patients, no matter which practice they are registered with.
  - Meet the commissioning priority for improved access to General Practice.
- 1.3 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.
- 1.4 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:
- Ageing population – epidemic of long term conditions, increasing co-morbidity, large growth in consultations for older people.
  - Rising costs, constrained financial resources, efficiency savings.
  - Growing dissatisfaction with access to services.
  - Inequalities in health – access and quality of Primary Care.
  - Risk factors – unhealthy lifestyles, wider determinants of health.
- 1.5 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:
- Quarterly activity/performance reports
  - Meetings to discuss progress
  - Data quality support
  - Development of templates and appropriate reports
  - Prescribing support
  - Education/CCG events

## **2. Aims of the Quality Contract**

The main aims are:

- 2.1 Improved access to General Practice.
- 2.2 Improved health outcomes for the population.
- 2.3 Reduced health inequalities; improved support and better care for carers and people with mental health needs.
- 2.4 Reduced variation; every Practice will be expected to deliver on all Standards.
- 2.5 Support for the CCGs Quality, Innovation, Productivity & Prevention Challenge (QIPP); reducing demand on secondary care services and eliminating waste in prescribing

## **3. Contracting Basis**

- 3.1 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:

- Investment to sustain or increase staffing capacity; the aim being to meet rising demand and deliver improved access and better outcomes for patient care.
  - Clarity of available practice income.
- 3.2 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.
- 3.3 Rotherham CCG are the lead commissioner for this contract however Rotherham Metropolitan Borough Council and NHS England have supported the development of the standards.
- 3.4 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.
- 3.5 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 2020/21 will be a similar meeting with practices. A sample of these will be scrutinised by the Primary Care Committee.

#### **4. Contracting Principles: inclusions and exclusions**

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

- Anticoagulation
- Aural Care
- Case Management and over 65 health checks
- CEA Monitoring
- Deep Vein Thrombosis
- Minor Surgery
- Phlebotomy
- PSA Monitoring
- Severe Mental Illness Physical Health Checks
- Shared Care Drugs Monitoring
- Suture Removal
- Transgender

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. IUCD for Menorrhagia and Ring Pessary fitting is still in the basket of services; however, the CCG will be contracting these on a Primary Care Network basis.

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

## **5. Contracting Principles: equity**

- 5.1 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.
- 5.2 The contract pays the difference between the core contract payment and LES payments along with the quality payment.
- 5.3 PMS phasing concluded on 31 March 2018 and therefore both GMS and PMS practices have moved to the new quality payment for Rotherham (GMS MPIG phasing will still continue in addition to this).
- 5.4 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. This includes all enhanced services in the agreed 'basket'.

## **6. Payment Mechanisms**

- 6.1 RCCG has honoured the pace of change practices have been advised by NHS England. This means that monies for reinvestment were fully realised in 2018/19. Payments will therefore be made in accordance with section 7.

## **7. Payment for 2020/21**

- 7.1 Since 1 April 2019 payments have had two components:
- 7.2 **Payment 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.
- 7.3 **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.
- 7.4 KPIs which have been retired will be retained for the purpose of performance monitoring only.
- 7.5 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.
- 7.6 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 in the Quality Contract Information Pack.***



7.7 Where a practice has signed up to deliver the contract and has not met the delivery requirements by the required timescales, 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.

## **8. Principles for payment of the 17%**

8.1 The 17% resource has been allocated to reflect the triple aim of:

- Value for money
- Improved population health
- Better quality and patient experience of care

8.2 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
<b>Overall split</b>		<b>17%</b>			
Best care LTCs		17%		Diabetes COPD Asthma Heart failure (with LVD) Atrial fibrillation	7% 3% 3% 3% 1%

## **9. Monitoring/ Reporting Requirements**

9.2 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.

9.3 Monitoring/activity for 2020/21 will be submitted via electronic survey, where there is any requirement for the practice to provide information.

9.4 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

9.5 Data submissions must be received by the CCG by the 10<sup>th</sup> 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.

9.6 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.*

9.7 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.

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

## **10. Performance**

10.1 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.

10.2 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.

10.3 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.

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

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

10.6 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 Sub-Group and generally provide information as required relating to the Quality contract.

## **11. Disputes**

11.1 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.

11.2 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 has been 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. For clarity and in accordance with the appeals process no new information will be considered after the first appeal (i.e. at Primary Care Committee stage).

# **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
  - Urgent access within **1** working day
  - An appointment for patients within **5** days when their condition is routine.
  - 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).
5. Ensure acutely ill children under the age of 12 are assessed by a clinician on the same day where it is possible for the episode to be concluded by 6:30pm. If this is not possible then referral to out of hours is appropriate.
6. Accept deflections from Yorkshire Ambulance Service (YAS).
7. 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>
8. Improve on patient survey measures; this does not have to be across the board, and could be in one area.
9. 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 hours services and local hubs.

## **CCG Support**

The CCG will 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 GP for Primary Care

## **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 relevant 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 (i.e. partner or salaried) review short term (less than 4 weeks) locum referrals to secondary care. This can be done in a referral meeting.
2. Use local data to improve referral quality and 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, the practice is competent to provide.
4. Comply with the RCGP 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 for Clinical Referral Management Committee

## **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)
4. Promoting physical activity in health and care settings

### **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).

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). In Rotherham in 2015-17 there were 140 deaths due to liver disease in those aged under 75 years (Public Health Profiles).

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 the England averages for the population as a whole for smoking prevalence (**Rotherham 18.9% England 14.4% - 2018 Annual Population Survey**) and **smoking at time of delivery is around 18% (2018/19 Public Health Profiles)**.

Potential Years of Life Lost (PYLL) reflects deaths in people aged under the age of 75. About 6,550 PYLL are lost each year in Rotherham through preventable causes- This is around 1,400 years more than might be expected based on the England average. The CCG will aim to reduce this by 200 years per year over the next 5 years. There has been a good improvement in cardiovascular mortality and liver disease mortality rates with **liver**

disease rates close to target in 2017. Cancer and respiratory disease were off target so may require further exploration.

Potential Years of Life Lost (PYLL) from preventable causes per 100,000 Target shown is National average 2017. Progress for NHS Rotherham CCG based on most recent 2 years 2016 and 2017 (lower is better).

Under 75 mortality rate from cardiovascular disease	Target 69.1	2016 = 86.9 / 2017 = 80.5
Under 75 mortality rate from respiratory disease	Target 33.0	2016 = 48.3 / 2017 = 49.2
Under 75 mortality rate from liver disease	Target 18.0	2016 = 20.2 / 2017 = 18.6
Under 75 mortality rate from cancer	Target 129.4	2016 = 142.8 / 2017 = 156.1

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 under 19s.

The Get Healthy Rotherham service integrates the following public health services into a single service offer:

- NHS Health Checks
- Support to Stop Smoking
- Adult Weight Management and Healthy Eating
- Support to reduce alcohol consumption with Alcohol screening using Audit C and direct referral into the specialist alcohol service as necessary
- Support to get more active

The services listed above 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

### 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 Independent Clinical Services.



## Physical activity in health and care settings

Physical activity can improve health and reduce the risk of developing diseases like type 2 diabetes, cancer and cardiovascular disease. Physical activity can have immediate and long-term health benefits and improve quality of life, yet around 30% of the local population is currently inactive (Public Health England).

People with health conditions are on average, twice as likely to be inactive than people without a condition. Therefore, people who regularly engage with health care professionals are far more likely to be inactive. Increasing physical activity levels, particularly by targeting the least active, contributes to improving population health and wellbeing and can help reduce the strain on health and social systems (Sport England).

Physical activity brief advice in healthcare is considered a 'best buy' for getting a population active and 1 in 4 people would be more active if advised by a GP or nurse (Sport England).

The Public Health England 'Moving Health Care Professionals Programme' provides training and resources to promote physical activity through healthcare and embed into health and care pathways.

### Delivery

Practices will be expected to:

1. Attend the Public Health Improvement Event (PLTC September 2020).
2. Ensure appropriate patients who would benefit from an intervention to address lifestyle issues covered by the service (smoking, alcohol use, weight management) and those eligible for an NHS Health Check are signposted to the Get Healthy Rotherham Service, aiming to achieve 25 patients per 1,000 list size as a target.
3. Offer the National Diabetes Prevention Programme (NDPP) to all patients at risk of diabetes:
  - Aged 18 years and over
  - HbA1c between 42-47 mmol/mol (6.0-6.4%) or
  - Fasting Plasma Glucose between 5.5-6.9 mmols/l within the last 12 months
  - Not pregnant
  - Able to take part in light/moderate physical activity
4. The practice to achieve 4 patients referred by any method per 1000 practice population to the NDPP each year. For clarity, a number for each practice will be provided in the information pack.
5. Use the Public Health England 'Moving Health Care Professionals Programme' to access training for GPs, health professionals and social prescribing link workers to offer brief advice to patients across a range of settings and embed physical activity into pathways where appropriate.

### CCG Support

The CCG Data Quality Team will support practices with queries to extract data.

**Contact:** DESP: [england.sybprimarycare@nhs.net](mailto:england.sybprimarycare@nhs.net) / Public Health: [Nicholas.Leigh-Hunt@rotherham.gov.uk](mailto:Nicholas.Leigh-Hunt@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 1,500 new cases of cancer diagnosed each year (2012/13 – 2016/17 average, National Cancer Registration Service) and currently over 750 die (2013-2017 average, Office for National Statistics). Rotherham currently performs better than average for cervical and breast screening however with the 2ww rate of referral performance is similar to the national average. Coverage is disproportionately lower amongst those with protected characteristics and those within deprived and underserved communities.

**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 NHS Rotherham CCG show 3 year coverage at 75% (2017/18), changing little since 2009/10 (75.6%). This does compare favourably to the England average of 72.1% (2017/18, Fingertips.phe.org.uk) however the uptake is varied across practices.

The NHS Breast Screening Programme offers screening every 3 years to women aged 50 to 70 years. There is also a national age extension pilot, where a randomised group of women aged 47-50 and 71-73 may receive invitations outside of the 50-70 screening age range.

### **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, NHS Rotherham CCG's bowel screening 2.5yr coverage (persons 60-74 years) for 2017/18 is 60.7% which compares favourably to the England average 59.6% 16/17 (Fingertips.phe.org.uk NHS Cancer Screening Programme data via [fingertips.phe.org.uk](http://fingertips.phe.org.uk)). However, uptake has levelled off recently but varies widely 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

Rotherham's screening 3.5 or 5.5 year coverage for 2017/18 was 76.1%, which compares favourably to the England average 71.7% (Fingertips.phe.org.uk NHS Cancer Screening Programme data via [fingertips.phe.org.uk](http://fingertips.phe.org.uk)). However, uptake is variable across Practices and with the majority below the national targets.

### **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.

Rotherham's screening coverage for 2017/18 was 81.6% and is similar to the England average of 80.8% (Screening Management and Referral Tracking database via [fingertips.phe.org.uk](http://fingertips.phe.org.uk)).

## Delivery

Practices will be expected to:

1. Work with the relevant commissioner, screening provider 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 (preferably telephone but a letter from the practice would be sufficient) 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 all patients **with Protected characteristics**, for example those with learning disabilities and carers of identified individuals are fully informed of the screening programmes and how they can access them in a format that they understand, **and make reasonable adjustments to ensure equity in access.** (<https://www.equalityhumanrights.com/en/equality-act/protected-characteristics> <https://binged.it/2oK4sJE>)
4. **When asked**, support programme providers, relevant commissioner, CRUK and Be Cancer Safe to look at ways to increase awareness and uptake in minority groups and underserved populations (evidence from the patient survey at RFT for breast and bowel indicate limited uptake in groups other than English speaking white population).
5. For Bowel Cancer Screening – practices will sign up to support the GP endorsed invite letters <https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/evidence-on-increasing-bowel-screening-uptake>

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

## CCG Support

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

1. Support Practices with regards to signposting 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](mailto:england.sybprimarycare@nhs.net)

## Standard 5 - Health Protection

1. Influenza (flu) **At risk groups (including pregnant women) and 2- and 3-year olds**
2. **Childhood Immunisation**
3. Pertussis in Pregnancy
4. **Measles**

### **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).

### **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 19/20**). 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. **Ultimately the aim is to achieve at least a 75% uptake in these groups, given their increased risk of morbidity and mortality from flu. Achieving this uptake is associated with statistically significant benefits in terms of reduced morbidity and demand for GP and other frontline services.**

**The aim is to vaccinate** as many individuals as possible early in the season 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.

**Rotherham coverage data is available for three measures (all 2017/18):**

- **Flu (2-3 year3-year olds): Rotherham 43.8%, virtually identical to England 43.5% (ambition 65% or over)**
- **Flu (at-risk individuals): Rotherham 53.6% compared to England 48.9% (ambition 55% or over).**
- **Uptake across 2, 3 year olds and at risk cohorts varies widely across practices, with many falling significantly below the ambition target.**

\*Ambition target is subject to change for the 20-21 flu season.

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

## Childhood Immunisation

Immunisation is one of the most successful and cost-effective public health interventions and cornerstone of public health. High immunisation rates (coverage) are key to preventing the spread of infectious disease, complications and possible early death among individuals. Immunisation also helps protect the population's health through both individual and herd immunity.

All childhood vaccination coverage levels for vaccines protecting against pneumonia are well above England for 2018/2019:

- DTaP/IPV/Hib (1 year old): Rotherham 96.3% England 92.13.1%
- DTaP/IPV/Hib (2 years old): Rotherham 96.6% England 94.295.1%
- PCV (1 year old 1-year-old): Rotherham 96.4%, England 84.893.3%
- PCV booster (2 years old): Rotherham 94.9%, England 90.21.0%
- Hib/ Men C (2 years): Rotherham 94.8% England 90.4%
- Men B (2 years): Rotherham 93.3% England 87.8%
- MMR dose 1 (2 years): Rotherham 94.6% England 90.3%
- DTaP/IPV (5 years old): Rotherham 92.9%, England 84.8%
- MMR Dose 2 (5 years): Rotherham 93%, 86.4%

Whilst comparison to the England average appears positive for Rotherham, the picture is somewhat distorted from when we dive deeper to that seen GP practice level. There is great variance in uptake amongst GP practices, with some showing uptake that is significantly lower than the WHO target of 95%, a requirement for herd immunity.

## 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). **More recently within the Yorkshire and Humber area (May 2019) a baby died where it was established that the baby had confirmed pertussis and the Mother was unvaccinated, again highlighting the need to aim for 100% uptake. Rotherham uptake is around 80% uptake each month, this leaves approx. 30 women each month in Rotherham that are not vaccinated. Annual uptake for 18/19 was 82.5%, which equated to 326 pregnant women having not received vaccination.**

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>

## Measles

Measles is a highly infectious virus and numbers of cases are rising across Europe and the UK. Measles can be severe, particularly in immunosuppressed individuals and young infants. To achieve and maintain elimination, the following is recommended.

- Achieve and sustain  $\geq 95\%$  coverage with two doses of MMR vaccine in the routine childhood programme (<5 years old).
- Achieve  $\geq 95\%$  coverage with two doses of MMR vaccine in older age cohorts through opportunistic and targeted catch-up (>5 years old).

Existing vaccination strategies for Measles and Rubella are highly effective and safe: the vaccine effectiveness of MMR is more than 90% for a single dose and more than 95% for two doses. Performance for the second dose of MMR is currently sub-optimal.

There should be a high clinical suspicion of measles if the patient:

- Is unvaccinated/partially vaccinated.
- Recently travelled to an endemic area or one with an ongoing outbreak.
- Has had contact with a person with measles.
- Belongs to/has contact with communities likely to be unvaccinated.

Although there is no evidence that health care workers have lower MMR uptake than the general population, the fact that they are in close contact with patients means that they are at increased risk of both catching measles and spreading it to patients and colleagues, so they should all be fully immunised.

Population vaccination coverage for MMR in Rotherham was higher than England average in 2018/197/18:

- MMR for one dose (2 years old): Rotherham 94.6%3.7%, England 90.3%91.2%
- MMR for one dose (5 years old): Rotherham 97.4%, England 94.59%
- MMR for two doses (5 years old): Rotherham 93.1%, England 86.47.2%

The WHO target level for the above is 95%.

Recorded uptake of vaccination reduces in older children, with 10-16 year olds showing the lowest uptake, and whilst this in part may be contributed to incomplete/ inaccurate records rather than missing immunisations, a dedicated focus in improving uptake in older children is imperative.

## Delivery

Practices will be expected to:

1. Ensure vaccination status is established and accurately recorded for all newly registering patients.
2. Promote and pro-actively run targeted promotions of the vaccinations to all eligible groups as per Department of Health National Guidance/National Immunisation Programme. This should include the use of leaflets in the most appropriate language for patients of the practice.



3. 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.
4. Promote the use of the Rotherham App for checking vaccination status to parents and carers and booking appointments.
5. Ensure all childhood immunisations and newly registered patients (Aged 0-19 years) are reported promptly to Rotherham Child health Information Service.
6. 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.
7. Ensure all notified vaccinations given by alternative provider notified to GP practice are recorded correctly on the system within 5 working days of receipt.
8. 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.
9. For patients not in midwifery only led care (i.e. without GP input) see 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>
10. 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**

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. Provide agreed data and information to the CCG for the practice dashboard.

**NHSE Contact:** [england.sybprimarycare@nhs.net](mailto:england.sybprimarycare@nhs.net)



## **Standard 6 - Cancer Referral**

### **Rationale**

Rotherham has a worse early stage of cancer diagnosis record than most local areas (47%) and the national average (52%) and a similarly low 1 year survival from cancer in South Yorkshire and Bassetlaw, with 70.7% compared with the National Average of 72.3%

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.

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) recommends urgent referral within 2 weeks for a 'suspected cancer'.

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.

### **Delivery**

Practices will be expected to:

1. Use the most up to date referral proforma (available on top tips) – <http://www.rotherhamccg.nhs.uk/therapeutic-guidelines.htm>
2. 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 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 hospital's 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).
3. Review all cancer diagnoses made outside the two week wait referral process using the agreed SEA template available on the quality contract section of the intranet.

Cancer Research UK has confirmed that they can come in and support practices in how they reflect on the learning from these reviews.

4. Contact the patients within 3 months of diagnosis (using existing QoF template) and **record a cancer care review using the approved Macmillan template** available for both EMIS and SystmOne (*this does not need to be a face to face consultation it is about contacting the patient to identify any need for support*).
5. **Agree to a visit from the Macmillan GP for Rotherham where early diagnosis and cancer care reviews will be discussed. Any visits taking place from October 2019 will be counted towards the 20-21 contract.**
6. Participate in the National Cancer Diagnosis Audit - <https://www.cancerresearchuk.org/health-professional/diagnosis/national-cancer-diagnosis-audit>.

### **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 and GP Members.
2. Make available the new Macmillan Cancer Care Review Template.
3. Encourage feedback to the Cancer Lead via the generic CCG email address.

**CCG Contact:** SCE GP for Cancer

## **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**
- Heart Failure (with LVD) – 7 indicators
- COPD – 6 indicators
- Asthma – 6 indicators
- Atrial Fibrillation – 3 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.

- **Diabetes (QOF prevalence – age 17+): Rotherham 7.4% (15,509 patients), England 6.8% (2017/18)**
- **People with Type 1 diabetes who received a cholesterol check: Rotherham 83.8%, England 81.1% (National Diabetes Audit) (2017/18)**
- **People with Type 2 diabetes who received a cholesterol check: Rotherham 93.2%, England 82.9% (National Diabetes Audit) (2017/18)**

- Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check (2014/15 – 2018/19): Rotherham 81.5%, England 90.0%
- Cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check (2014/15 – 2018/19): Rotherham 38.1%, England 43.3%

#### 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:

##### Delivery

1. A patient-centred care plan written with and for the patient - reviewed annually.
2. Encouraging the use of technology to encourage patients, where appropriate, to manage their condition better **via telehealth**.
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, **DESMOND**.
4. Ensure that the relevant processes are in place for detection and management as per the management requirements:
  - 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 '19 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.
  - It is a requirement that practices will manage diabetes patients in the community with assistance from secondary care.
5. **Where appropriate**, referral for active lifestyle interventions, using the electronic referral process for the Get Healthy Rotherham service, and including referrals to third sector services **using the services of the Social Prescribing Link Workers**.

## 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.

- Heart failure (QOF prevalence – all ages): Rotherham 0.9% (2,259 patients), England 0.8%(2017/18)
- Heart failure admissions (Directly Standardised Rate per 100,000): Rotherham 121.6 (309 admissions), significantly lower than England 161.7 (2017/18)

### Delivery

1. Ensure all HF discharges / diagnosis are acted upon and the Patient has a management plan e.g. HF management plans produced by the HF Specialist Nurse are acted upon. Ensure patients have 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 to be offered a 6 monthly review of their:
  - Medication
  - Symptom Control
  - Renal Function
4. ACE/ARBs/betablocker medication has been titrated to the recommended therapeutic dosage.

## 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.

- COPD (QOF prevalence – all ages): Rotherham 2.9% (7,741 patients), England 1.9%(2017/18)
- Smoking prevalence in adults (18+) – current smokers: Rotherham 18.9%, England 14.4% (2018, Annual Population Survey)
- Smoking prevalence in adults in routine and manual occupations (18-64 years) – current smokers: Rotherham 29.9%, England 25.4% (2018, Annual Population Survey)
- Emergency hospital admissions for COPD (standardised admission ratio): Rotherham 168.1 (5,239 admissions), England 100 (2013/14 – 2017/18, 5 years)

### 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 a 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.
2. Undertake an annual review of medication needs.

## 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)

- Asthma (QOF prevalence – all ages): Rotherham 6.5% (17,044 patients), England 5.9%) (2017/18)
- Smoking recorded in last 12 months (14-19 years with asthma, QOF AST004): Rotherham 86.6%, England 83.5% (2017/18)
- Hospital admissions for asthma (under 19 years) (crude rate per 100,000): Rotherham 138.9, England 184.8 (81 admissions) (2017/18)

## 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 (delivery is expected but no evidence will be required).

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. 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.
5. With regards to children; 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.
6. 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 in to 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 one 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 be offered at least an annual review of ongoing Anti-coagulation needs including DOAC Patients.
3. To ensure practice 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:

### Diabetes

Rotherham has the highest drug treatment costs/diabetes patient in the Yorkshire & Humber region. Despite the high treatment costs Rotherham has the weakest performance in blood glucose management (HbA1c). This has been the situation for at least 10 years and previous incentives have failed to have any impact on practice. To match the performance of neighbouring CCGs Rotherham needs to improve blood glucose management in between 400 – 2000 patients (HbA1c). Audit data demonstrates that there is a considerable variation in the number of patient's achieving the QoF HbA1c targets across Rotherham's practices.

There are 13,724 patients receiving active drug treatment to manage their blood glucose. This equates to approximately £7.27/patient of funding via the quality contract (subject to weighted list changes).

There are 5 regimens for blood glucose management:

- Regimen 1 - Type 2 diabetes receiving a single drug
- Regimen 2 - Type 2 diabetes receiving a two drugs
- Regimen 3 - Type 2 diabetes receiving a three drugs
- Regimen 4 - Type 2 patient receiving insulin
- Regimen 5 - Type 1 patient receiving insulin

Performance will be assessed against the middle QoF HbA1c indicator (DM008 = HbA1c is 64 mmol / mol or less in the preceding 12 months). Practices will receive 2/3rds of the patient payment if they are within 5% of the Rotherham average. Practices will receive full payment if they are at or exceed the Rotherham average. Averages will be set in April 2020 and will not be recalculated until April 2021.

For the remaining indicators, practices will need to achieve within 5% of the Rotherham average (set using the previous year's data) to achieve the Key Performance Indicators as outlined in the Best care dashboard (below):

### Heart Failure

- HF1 - Practice has a named clinician responsible for HF
- HF2 - Practice has SOP to ensure newly diagnosed HF pts have meds titrated to recommended therapeutic dose or max tolerated dose
- HF3 - % Ace/ARB's medication titrated to recommended titrated dose
- HF4 - % Beta Blocker medication titrated to recommended titrated dose
- HF5 - % Pts with HF on Doxazosin
- HF6 - % Pts with HF on Oral Nsaid
- HF7 - % Pts on both an Ace & Beta Blocker

### Atrial Fibrillation

- AF1 – All practices to use the GRASP AF tool
- AF2 – All AF patients to have an annual review of ongoing anticoagulation needs
- AF3 - % of patients on an Anticoagulant
- AF4 to 8 - Retired



**COPD**

- CO1 - % Non-smoking
- CO2 - % Management plan
- CO3 - % Percent predicted FEV1
- CO4 - % Inhaler technique good
- CO5 - % Depression screening
- CO6 - % Pulse O2

**Asthma**

- AS1 - % Non-smoking
- AS2 - % Management plan
- AS3 - % Peak flow or Percent predicted FEV1
- AS4 - % Inhaler technique good
- AS5 - % The practice has a disease register of viral wheezing children
- AS6 - % The practice reviews all patients after an exacerbation

**Best Care Scores:****Diabetes delivery of indicators**

Practices will receive 2/3rds of the patient payment if they are within 5% of the Rotherham average. Practices will receive full payment if they are at or exceed the Rotherham average.

**Heart failure delivery of indicators**

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

**AF delivery of indicators**

- 0 no payment
- 1 30%
- 2 60%
- 3 100%

**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 / Head of Medicines Management

## **Standard 8 – Personalised Care Adjustment**

### **Rationale**

The Quality and Outcomes Framework (QOF) allows Practices to make **personalised care adjustments** in order to exclude specific patients from data collected, to calculate achievement scores. Patients can be removed 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.

**Personalised care adjustments** apply 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.

### **Delivery**

Practices will be expected to:

1. Ensure the Practice has a policy in place for **personalised care adjustments** and is adhering to the policy
2. Where a practice is reported as having 'unusual' <sup>1</sup> activity, a report will be provided on request to the CCG to provide clarity on the circumstances

### **CCG Support**

The Primary Care Team will:

1. Supply relevant data.
2. Share local learning to support the Practice to achieve the deliverable.

**CCG Contact:** SCE GP for Primary Care

**<sup>1</sup> 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 an end of life care Lead who will take responsibility for ensuring their knowledge is current, and for sharing learning with the practice.
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. Undertake a quarterly review of the appropriateness of EOL patients dying in hospital.
5. Undertake bi-annual communications and DNACPR training.

### **CCG Support**

The CCG will:

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

**CCG Contact:** SCE GP for End of Life Care

## **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 on and maintain a culture of safety and ensure compliance with statutory safeguarding requirements for Primary Care in Rotherham.

### **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 GP Practices have a responsibility to ensure there are systematic measures in place for safeguarding people and the NHS reputation (NHSE, 2013). 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).

### **Safeguarding**

Safeguarding means the protection of health, wellbeing and human rights, and enabling people to live free from harm, abuse and/or 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 Nursing (RCN) 2019) and Adult Safeguarding: Roles and Competencies for Health Care Staff (RCN 2018). 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’.

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) 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).

Doctors and other practice staff often see patients at times of distress and difficulty. It is likely that staff may come into contact with someone who is at-risk or suffering from abuse or neglect. It is important to be able to identify these patients and provide appropriate help and support (GMC, 2018).

Safeguarding adults requires as much vigilance as safeguarding children. According to the Adult Safeguarding Roles and Competencies for Health Care Staff adult safeguarding means working with individuals to protect their right to live in safety, free from abuse, harm and/or neglect.

Whilst everything is not currently statutory, the GMC/NMC/HPCPC may guide professional duties. Each case may differ but what is required is general practice engagement in supporting their patients identified needs. Support and guidance is available from CCG colleagues but the learning is for Practices to embed.

For Child Protection Safeguarding Case Conferences and other safeguarding requests for information a model template can be found in the RCGP/NSPCC guidance “Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice” available via the Rotherham CCG Safeguarding webpage.  
<http://intranet.rotherhamccg.nhs.uk/safeguarding.htm>

## **Delivery**

Practices will be expected to:

### **Incident reporting**

1. Evidence the process they use when conducting SEAs, as well as minutes of meetings where they were discussed, SMART action plans and evidence of the completion of these action plans.
2. 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 Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff / Adult Safeguarding:

Roles and Competencies for Health Care Staff often referred to as the 'intercollegiate documents' (RCN 2019) and provide assurance to the CCG that staff are trained appropriately for their role.

2. Identify a Safeguarding Lead who will attend as a minimum one out of the 'three stage approach events'. These are outside of the PLTC offer, providing access to expert safeguarding supervision for relevant staff. This individual will also disseminate information within the Practice, share learning with colleagues developed by contribution to learning events and reviews e.g. child death overview panel, and encourage all practice staff to do the same.
3. Produce reports as requested by statutory safeguarding partners, for both initial and review case conference meetings, and/or related to safeguarding concerns e.g. Looked After Children (LAC) reviews, Multi-agency Risk Assessment Conference (MARAC), Safeguarding Adult Reviews, Learning Lessons, Serious Case Review's (SCR's), Reports for Child Death Overview Panel (CDOP), LeDeR reports, Domestic Homicide Reviews (DHR's). Except where payment is derived from collaborative arrangements.
4. Whilst everything is not currently statutory, the GMC/NMC/HCPC may guide professional duties. Each case may differ, but what is required is general practice engagement in supporting their patient/clients identified needs. Whilst support and guidance is available from CCG colleagues, the learning is for practices to embed.
5. As and when requested by the CCG Safeguarding Team, be able to provide assurance of improved outcomes based on implementation of recommendations from serious case review, safeguarding adult reviews, and domestic homicide reviews.
6. Ensure the practice has a safeguarding policy, which includes details of managing risk and flagging patient records appropriately.
7. Deliver on national safeguarding standards and best practice in relation to looked-after children and individuals at risk of exploitation, abuse and neglect i.e. intercollegiate guidance for looked after children "Looked after children: Knowledge, skills and competences of health care staff: Intercollegiate role framework, March 2015 (RCGP/RCN/RCPCH).
8. When the Mental Capacity Act (MCA) is replaced by the Liberty Protection Standards (LPS), ensure that all staff are trained and aware of their responsibilities.
9. Complete and publish annual safeguarding self-assessment, to meet the needs of section 11 of the Children Act (1989; 2004) and Safeguarding Children, Young People and Adults in the NHS – Accountability and Assurance Framework (2019), in a format determined as agreed by the CCG.
10. Meet any mandatory or recommended requirements for safeguarding, as stipulated by NHS England e.g. submission of data via enhanced data sets to NHS digital including FGM enhanced dataset.

### **Information Sharing**

1. Sign up to, and make effective use of, the Rotherham Care Record to ensure timely sharing of information.

### **CCG Support**

The CCG will:

Support the arrangement of a biennial Safeguarding Training Event

**CCG Contact:** Head of Safeguarding/Deputy Chief Nurse

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

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

### **Rationale**

#### **Mental Health**

We know that people with poor mental health are more likely to have poor physical health outcomes. People with mental illness are at increased risk of the top 5 killers: heart disease, stroke, liver disease, respiratory disease and some cancers. Those with severe mental health illness (SMI) are more at risk. For example people with SMI:

- Die on average 15 to 20 years earlier than the general population
- Have 3.7 times higher death rate for ages under 75 than the general population
- Experience a widening gap in death rates over time

The disparity in these health outcomes is partly due to this cohort of patients not being offered appropriate or timely physical health assessments.

The national policy context recognises that the NHS needs to move towards a culture where mental health and physical health are valued equally. This is known as parity of esteem (NHS England (NHSE 2014). "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.

To achieve this ambition a fundamental change to the culture of healthcare is required, and in the way services are commissioned and provided. This will require a holistic approach; tackling poor physical health at the same time as addressing mental health disorders.

#### **Suicide Prevention**

Suicide Prevention is a high priority in the Borough with established partnership groups and support from the Chair of the Health and Wellbeing Board. National research shows that a quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within month before their death. (NHS: The Five Year Forward View for Mental Health).

Locally we know that:

- Rotherham is significantly higher than England (Red RAG-status on the PHOF and Suicide Prevention, September 2019) and ranks as 2nd highest compared to 15 CIPFA nearest neighbour local authorities.



- Males account for around three-quarters of suicide deaths with the trend in death rates matching the total trend. After reaching its highest in 2015-17 (in the period since 2001-03) the rate decreased in 2016-18 from 24.0 to 20.3 deaths per 100,000 population.
- After increasing every period since 2010-12 the female rate decreased from 8.4 to 6.4 deaths per 100,000 populations between 2015-17 and 2016-18 and is now statistically similar to England again (was significantly higher/worse in 2015-17). Rotherham's female rate ranks as highest among CIPFA nearest neighbours

## Problem Gambling

Problem Gambling is a major cause of debt and people suffering with mental health issues are at a higher risk of becoming addicted. It has been estimated that 4.6% of the Yorkshire & Humber population is affected by problem gambling, with Rotherham having an estimated 3,716 problem gamblers (Leeds Beckett University, Kenyon at al. 2016). Currently the number of suicides where problem gambling was a key issue is unknown, but it has been highlighted as a risk factor as a result of debts incurred. Frontline healthcare staff including those working in primary care is in a position to spot the signs of problem gambling and signpost on to sources of help. Help is available through the National Gambling Helpline (0808 8020 133) through whom direct referral to counselling services or regional clinics can be made.

### Delivery:

Practices will be expected to:

1. Identify a mental health lead who will take responsibility for ensuring their knowledge is current, attending training (including that for problem gambling) where applicable, and for sharing learning with the practice.

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

### Severe Mental Illness (SMI) Registers

1. All practices will ensure their SMI register is up to date by sharing and receiving information (in the form of an SMI register) from and to the secondary care mental health provider (RDASH) on an annual basis. The SMI register must include those patients, as defined by the SMI guidelines within QOF. In addition, practices are required to include those individuals with a diagnosis of personality disorders.
2. All practices will promote the Rotherham 5 ways to wellbeing messages to all individuals on the SMI register as well as make early
3. Where appropriate, referral to lifestyle services, e.g. smoking cessation, weight management and self-management programmes.

### Suicide-prevention

1. All non-clinical staff will be required to complete the e-learning training 'Suicide – Let's talk'. Clinical staff should attend a subject specific PLTC event.
2. All practices will work with Public Health to promote Rotherham's 'Be the One Suicide' Prevention campaign <https://www.be-the-one.co.uk/>, with a link to it on practice websites.

3. The mental health lead should attend training on problem gambling, known to be a key risk associated with suicide

#### Problem gambling and associated risks

1. All mental health leads will need to attend the Public Health PLTc Problem Gambling and associated risks workshop

#### CCG Support:

The CCG will provide the following support to practices:

- An information sheet on how to access the e-learning training 'Suicide – let's talk' training, Safe Talk App and the recommended training for practice leads. In addition, the 'NHS Rotherham Guidance on Suicide Prevention for GP Practices will be made available on the CCG intranet Top Tips webpage.
- Information on the 5 ways to wellbeing can be obtained by contacting Ruth Fletcher-Brown, Public Health Specialist, 01709 255867 or [Ruth.Fletcher-Brown@rotherham.gov.uk](mailto:Ruth.Fletcher-Brown@rotherham.gov.uk)
- Information on the Be the one campaign can be found at <https://www.be-the-one.co.uk/>
- Problem gambling training will be delivered as part of the Public Health PLTC event in September 2020

#### 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 2,648 people on the GP Dementia register compared with a predicted prevalence of 3121, a gap of 473 people. Currently, Rotherham has a diagnostic rate of 84.8%, which is 19.09% above the national standard of 67%

Health inequalities have become an increasingly important consideration as we learn more about the potential for risk-reduction in dementia. Many of which will need to be managed in Primary Care. An individual's risk of developing dementia can be significantly determined by a number of factors. Some of these factors are fixed, such as ethnicity, learning disability, gender and others are caused by social or geographical factors.

Nationally, the publication of the Prime Ministers Challenge in 2015 set out the government's ambition to make England the best country in the world for dementia care and support and for people with dementia, their carers and families to live. Since its publication in 2015, there has been a series of other national (Mental Health Forward View, Dementia NICE Guidance and Long-Term Plan) and local (Dementia Local Enhanced Service (LES)) policies and guidance all of which have reinforced the need to improve services for people with dementia and build on the ambitions of the 'Prime Minister Challenge 2020'.

Dementia Carers Resilience service works with all practices across Rotherham to provide

- Assessment for current and future needs
- Access to information and advice
- Short-term home based support
- Access to a range of local support

## Delivery:

Practices will be expected to:

1. All practices will refer people for a dementia diagnosis in line with the dementia pathway (subject to final approval).
2. All practices will be required to ensure all staff are able to attend Dementia Friends sessions or complete e-learning programme at least once every 3 years.
3. All practices ensure that those caring for someone with dementia are registered on the practice carers register.
4. All practices will develop a Practice Dementia Friendly Action Plan which is submitted to the Carers resilience service. This plan must be updated on an annual basis.
5. Work with the Dementia Carers Resilience Service to support those caring for people with dementia

## 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
- The CCG will provide appropriate training for the practice dementia lead

This service can be contacted on 01709 464574 or alternatively, at [www.crossroadsrotherham.co.uk](http://www.crossroadsrotherham.co.uk)

## 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

All practices will be required to become a Veteran's Friendly GP practice Accreditation Scheme by the end of 2020, to ensure they comply with the Primary Care Armed Forces Covenant. This will require practices to:

1. The mental health lead to take responsibility for the practice working towards accreditation.

2. Record and flag Armed Forces Veterans & Reservists on the Practice system.
3. Ensure all the requirements of Veteran's Friendly GP practice Accreditation Scheme are implemented

**CCG Support:**

The CCG will provide the following support to practices:

- Provide details of the Veteran Practice Friendly Accreditation Scheme Criteria
- Guidance on Mental Health Services for those leaving the armed forces and veterans

**CCG Contact:** SCE GP for Mental Health

## **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. Take a proactive role in supporting carers, including sign posting, sharing learning within primary care networks, and improving the experience of carers at the practice and **using the services of the Social Prescribing Link Workers.**
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 well-being check
  - b. Offering carers a flu vaccination for those on the register
  - c. Offering information and signposting as appropriate.
4. Display information for patients including via practice websites, posters and through other means, to help carers identify themselves, and to highlight available support and information.

### **CCG Support**

The CCG will:

- Work with providers to increase carers support.

**CCG Contact:** SCE GP for Primary Care

## **Standard 13 - Patient Experience and Engagement**

### **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.

For April 2020 new guidance will come into force <https://www.england.nhs.uk/wp-content/uploads/2019/09/using-the-fft-to-improve-patient-experience-guidance-v2.pdf> . This guidance updates the questions, and removes the timescale of 48 hours; with the aim that patients should be able to use FFT at any point to feedback on services.

As a principle, practices should promote local health and social care campaigns in line with the Rotherham Place Plan. And as the new Primary Care Networks (PCNs) develop, work with other practices and patients within PCNs to promote engagement and to take part in PCN/community level engagement activity as appropriate.

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 text messaging or other means for FFT as contractually required (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 (**available within the quarter**), 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 text messaging or other means 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.

### **CCG Support**

The CCG 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

## **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**

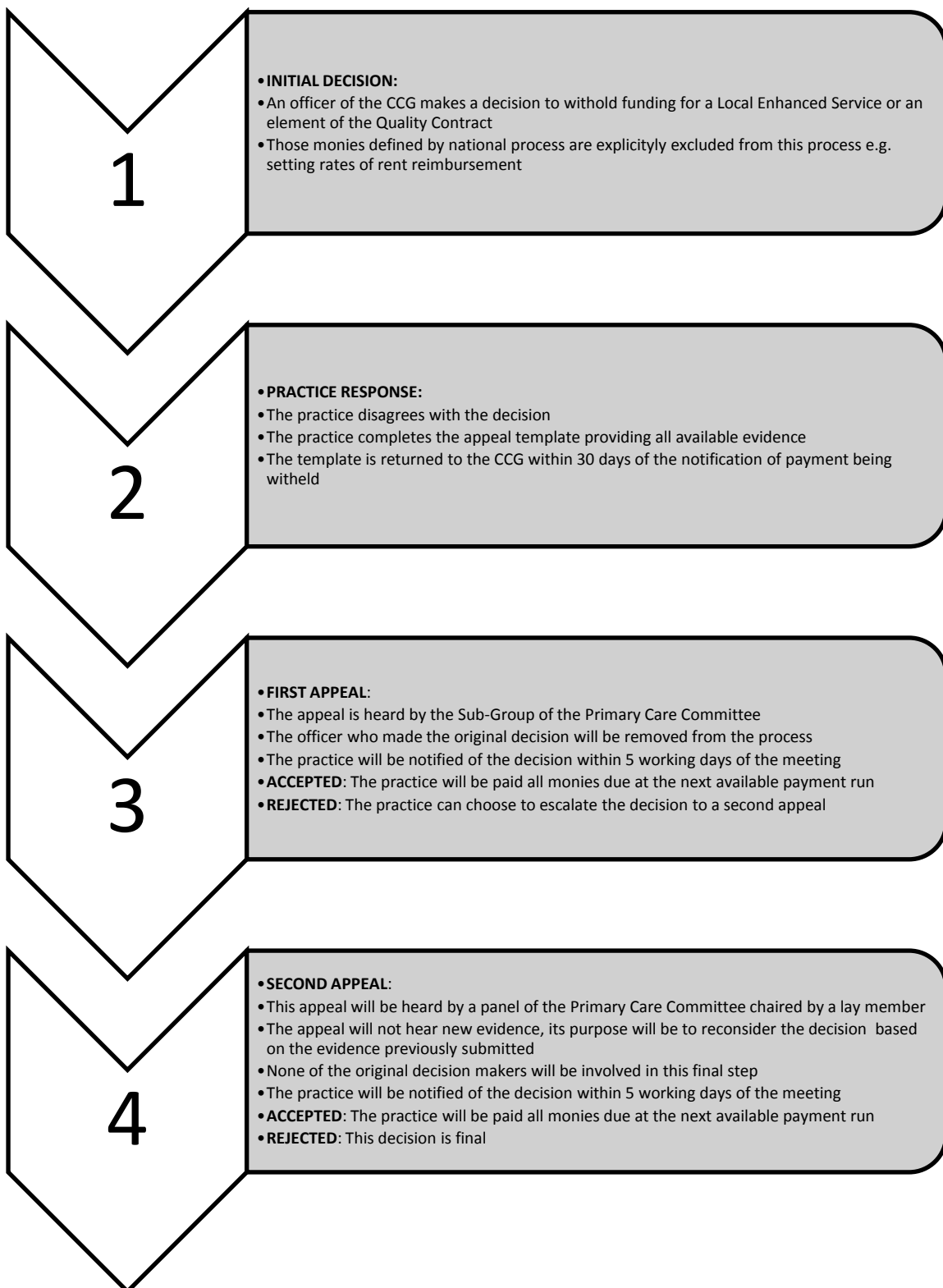
If an officer of the CCG decides to withhold funding and a practice wish to appeal against this decision, they must do so in writing to the Primary Care Team using the attached template within 30 calendar days of notification of payment being withheld. The template should detail the grounds of the appeal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

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 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.



## 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

<b>Practice Name:</b>		<b>Lead GP:</b>	
<b>Date appeal submitted:</b>		<b>Quarter to which the payment applies:</b>	
<b>LES or Standard of the Quality Contract to which the appeal applies:</b>			
<b>Amount of money withheld: (£)</b>			
<b>Details of the appeal:</b>	<i>(please give details of why you believe you have reason to appeal)</i>		
<b>Evidence:</b>	<i>(give details of any evidence you have here to support your case, attach files if necessary, but please don't include patient identifiable information)</i>		
<b>Name and role of person making appeal:</b>			

Please return this completed form to [roccg.primarycare@nhs.net](mailto:roccg.primarycare@nhs.net) or to the Primary Care Team, Rotherham CCG, Oak House, Bramley, Rotherham S66 1YY.