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.

For 2015– 2016, RCCG is continuing work with the clinical referrals committee. This committee focuses on identifying areas for developing new pathways and service improvement between primary and secondary care.

The main aims of this committee:

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

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

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

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

Delivery

Practices will be expected to:

1. Reflect on current referral behaviour within the Practice and in particular to have substantive GP sign off of all short term (less than 4 weeks) locum referrals to secondary care. This includes an appropriate administration system signed off by the substantive GP.
2. Use local data to improve referral quality. Identify opportunities to reduce unnecessary hospital attendances
3. Link with other practices to provide robust business continuity for any short or long term staffing issues to ensure continuity of all services provided from the practice e.g. ECGs, phlebotomy, minor injuries the practice is competent to provide.
3. Comply with the RCCG Clinical referral polices
4. 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)
5. Use the E-referral system when referring, and offer a choice of providers to patients
6. Accept transfer of care from secondary care at the appropriate point and with all relevant clinicial information, to ensure the best patient experience, in the most appropriate clinical setting
7. Ensure that recommendations of the Rotherham Medicines Management Group are followed and implemented
8. 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

Key performance indicators

1. Reduce first outpatient appointments by ensuring practices are compliant with the 8 point delivery plan described above to cluster average or by 1%

2. Reduce follow-up appointments by ensuring practices are compliant with the 8 point delivery plan described above to cluster average or by 1%

CCG CONTACT – ANAND BARMADE

Standard 3 – Health improvement

1. NHS Health Checks
2. Screening for Diabetes/At Risk of Diabetes
3. Pulse Checks
4. Alcohol

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.* There is no intention to amend the current payment systems for health improvement and therefore RMBC will continue to remain responsible for payment and this will not be incorporated into the quality contract.

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).

In 2012, 80,000 deaths were due to coronary heart disease (CHD). It is estimated that 46,000 of these were premature, and could possibly have been avoided (British Heart Foundation (BHF), 2014).

Stroke is a major cause of premature mortality, with more than 12,500 per year being attributable to Atrial Fibrillation (AF). Identifying AF early could prevent 4,500 strokes and 3,000 deaths per year in the UK (Stroke Association, 2014).

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

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

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

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

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

Potential Years of Life Lost (PYLL) from causes considered amendable to healthcare, per 100,000 Target based on 15/16 trajectory submitted in 2014/15

Under 75 mortality rate from cardiovascular disease	**Target 63.70**	**14/15 86.50**
Under 75 mortality rate from respiratory disease	**Target 27.60**	**14/15 31.20**
Under 75 mortality rate from liver disease	**Target 15.80**	**14/15 18.90**
Under 75 mortality rate from cancer	**Target 121.40**	**14/15 143.50**

Health-related quality of life for people with long-term conditions	**Target 0.74**	**14/15 0.71**
Proportion of people feeling supported to manage their condition	**Target 67.31**	**14/15 69.14**
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	**Target 937**	**14/15 1,073**
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	**Target 305.80**	**14/15 362.20**
Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence	**Target 71.50**	**14/15 68.54**

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)

Pulse Checks (aged 65 years and over)

Atrial Fibrillation (AF) is the most common sustained dysrhythmia, affecting at least 600,000 people in England. It is a major cause of stroke. Every year there are approximately 152,000 strokes in the UK. Most people affected are over 65 (Stroke Association, 2014).

Alcohol – AUDIT C, AUDIT 10 & Brief Intervention

Alcohol misuse creates a huge burden on health, in terms of treating alcohol related disease and premature mortality. About 26% of all adults in England, equating to 10.5 million people, are drinking at hazardous and harmful levels (British Society of Gastroenterology (BSG), 2010). Patients can, quite often, be treated for health problems such as hypertension, depression and anxiety, without ever having the contributing factor of alcohol addressed (Anderson et al, 2009). Alcohol misuse is associated with a wide range of health problems, including cancer, heart disease and mental problems. It is also associated with a wide range of social problems, such as offending, domestic violence, suicide, deliberate self-harm, child abuse, neglect and homelessness. (All-Party Parliamentary Hepatology Group (APPHG), 2014).

In terms of healthcare provision, alcohol-related ill health is as costly to the NHS as smoking (Anderson et al, 2009). The Institute of Alcohol Studies (2014) estimates the direct costs of alcohol-related harm in England to be £12.6 billion.

Rotherham is above the national average for the prevalence of problem drinking. The *Government's Alcohol Strategy for England 2012* refers to 'capture points' for the opportunity to intervene with hazardous and harmful drinkers. Primary Care is viewed as the single most important capture point from the social care system as a whole.

Delivery

Practices will be expected to:

1. Attend a Rotherham CCG/Public Health Improvement Event
2. Offer a Rotherham NHS Health Check to everyone aged 40-74 years, without existing cardiovascular disease or diabetes
3. Review and return Diabetic Eye Screening (DESP) validation lists to the DESP service via secure email within a two week turnaround, ensuring the DESP service is notified of all existing diabetics, mover's out, deaths and new patients

2015 Rotherham NHS Health Check criteria:

- **Age**
- **Gender**
- **Ethnicity**
- **Family history of CHD (first degree relative)**
- **BP** – record systolic and diastolic measurement
- **Height** – actual measurement, not patient report
- **Weight** – actual measurement, not patient report
- **Body Mass Index (BMI)**
- **Smoking** – record status
- **Bloods** – lipids, HbA1c, U&Es, LFTs, (as a minimum)
- **Alcohol – AUDIT C.** If a patients scores ≥5, complete AUDIT 10 at the same time
- **Pulse** – check rate and rhythm – to detect AF
- **Physical Activity** – record current levels
- **Dementia** – over 65s – use the screening question on the template

Elements or metrics may be added, to or removed from, the above list, as per guidance from the Department of Health (DH).

Practices must ensure:

- All staff undertaking health checks are competent to deliver in line with guidance issued by PHE.
- They Submit data to Rotherham CCG/RMBC quarterly
- Offer a diabetes screen (HbA1c) to everyone aged 40 years and over, without diabetes
- Practices who have patients from a South Asian background should offer screening to patients aged 30 years and over

The percentage of those offered screening for diabetic eye screening who attend a digital screening event:

- Achievable => 80%
- Increase on practice uptake in comparison to the previous year
- Submit data to Rotherham CCG annually

Offer opportunistic pulse checks to patients aged 65 years and over

- Submit data to Rotherham CCG annually

Undertake AUDIT C on any patient who is 16 years or over, who has not been screened in the last 2 years

- Offer AUDIT 10 to any patient in accordance with the latest public health requirement
- Offer a brief intervention to all patients who score positive on AUDIT C, at the same time as undertaking AUDIT 10
- Signpost patients scoring 8 onwards on AUDIT 10 to Rotherham's Integrated Drug & Alcohol Service and offer the opportunity to make the appointment from the Surgery
- Submit data to Rotherham CCG/RMBC annually

CCG support

The Primary Care Team will:
1. Support Practices with queries to extract data

Key performance indicators

1. NHS Health Checks completed (aged 40-74 years)
   Achieve Cluster average/1%/10% dependent on review of actions taken by the practice to encourage patient take up.

Standard 6 – Cancer referral

Rationale

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

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

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

1. Emergency first presentations for cancer: 0.0 – 1.9 (per 1,000 practice population) awaiting data
2. DNA for 2 week waits: 0.0 – 4.6 (per 1,000 practice population) awaiting data

- Potential Years of Life Lost (PYLL) from causes considered amendable to healthcare, per 100,000
- Under 75 mortality rate from cancer (CCG) **121.40 Target – 14/15 143.50** (Target = England Average)

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

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

Delivery

Practices will be expected to:

1. Identify a Practice Cancer Lead who attends an annual cancer update and shares learning with the practice
2. Use the most up to date referral proforma(available on top tips)

3. Develop a system to prevent DNA of 2 week waits (2ww)

    a. Process referrals within 24 hours (ie the hospital has received your referral letter within 24 hours of decision to refer)
    b. Advise the importance of attendance – the patient's ability to attend within the next two weeks needs to be confirmed and if not available for contact to arrange an appointment, a discussion regarding referral needs to take place, please note this means that if a patient chooses that they are not available for contact for the full 2 week period or longer you will hold the referral until the patient is available to attend
    c. Provide written information (THE HOSPITAL PROVIDES A BOOKLET)enclosed for further printing
    d. Referrals are to be made electronically through the e-referral system to ensure a robust process for ensuring the patient has received an appointment (please be aware when you have booked the virtual appointment on the e-referral system, remember not to give the patient this appointment as it is not real, it becomes the hospitals responsibility to arrange appointment and chase the patient) note within new gp contract it is stated that practices will aim to have at least 80% of referrals done electronically by March 2017)

4. Review all cancer diagnoses made outside the two week wait referral process using the agreed template. Cancer research uk have confirmed that they can come in and support practices in how they reflect on the learning from these reviews.

5. Contact the patients within 3 months of diagnosis (using existing qof template) this does not need to be a face to face consultation it is about contacting the patient to identify any need for support.

CCG support

The Primary Care Team will:
1. Share the learning from the Practice reviews
2. Develop a new diagnosis Cancer Review Template
3. Develop a template to enable feedback to the CCG

Key Performance Indicators

<u>Reduce DNA - 2 week waits</u>

- Reduce DNA for 2 week waits

CCG CONTACT – RICHARD CULLEN