SOMERSET PRACTICE QUALITY SCHEME
SPECIFICATION- 2018/19

1. INTRODUCTION

1.1. As well as responding to urgent needs, GPs play a vital role in secondary prevention and proactive management of patients with long-term conditions. The person-centred care that GPs provide increases the skills, knowledge and confidence of patients to manage their own health, and reduces use of secondary care services.

1.2. The requirements in SPQS for 2018/19 have been developed with the Evidence Based Medicine triad in mind, bringing together clinical evidence, professional judgement and patient preference into one specification.

1.3. Primary Care is being asked to engage in system wide improvements by focusing on the prevention of falls, promoting bone health and management of hypertension which have been identified by analysis and validated by clinicians. The requirement to improve the outcomes in these clinical areas using quality improvement methodology aims to support and promote the clinical evidence element of the triad, delivering better patient outcomes as a health system.

1.4. Through SPQS GPs are being asked to use their clinical judgement to put in place management plans, Treatment Escalation Plans for those patients who in the GPs opinion will benefit from this level of anticipatory care planning. This requirement promotes the professional judgement element of the triad.

1.5. The ethos of SPQS to encourage and promote person centred care will capture the patient preference element. Person centred care will be achieved through the ability of clinicians to treat QOF indicators as advisory and take the time to focus on the needs and preference of the patient.

1.6. In addition, we are asking practices to help us get out of 'special measures'. There are two specific ratings applied to the CCG which rely on QOF data;

- Reviewing the care of patients with a dementia diagnosis
- Completeness of GP Learning Disability registers.

SPQS has compromised the QOF data sources for these two measures, making clinical care appear poor in Somerset.

1.7. The real value to be gained through SPQS in 2018/19 will be the engagement and contribution from primary care to achieve a reduction in clinical variation and improve population health outcomes.

2. SUPPORTING BETTER POPULATION HEALTH OUTCOMES

2.1. SPQS aims to engage primary care in the Somerset health care system to support better population health outcomes and the improvement in the quality of care patients receive.

2.2. The Turnaround programme (a CCG facilitated process to reduce clinical variation and improve patient outcomes) has identified areas where primary care can engage in wider health system activities to deliver better population

health outcomes and the quality of care through improved diagnosis and the tighter management of hypertension and the identification and prevention of falls through person centred care.

2.3. Practices will be supported to achieve better outcomes in these clinical areas through quality improvement methodology following its growing success in 2017/18.

2.4. It is a requirement of SPQS that each practice participates and contributes individually in QI activity and networking.

2.5. The Quality Improvement (QI) Network established in 2016/17 will continue to be supported by the CCG and the South West Academic Health Science Network, to enable services in Somerset to have an arena in which to develop, share and learn both within the GP primary sector and across the whole health and care community in Somerset.

2.6. Practices will participate in the Somerset Quality Improvement Network. This will include:

2.6.1. Nominate a practice QI Lead who is able to influence and manage change within the practice.

2.6.2. If not completed previously, practice leads are required to watch an introductory video or webcast describing the Quality Improvement programme and how practices will participate.

2.6.3. Access to the Quality Improvement tools and techniques disseminated through the Institute for Healthcare Improvement (IHI), the AHSN and the CCG and the Somerset QI Network.

2.6.4. Carry out cycles of change to deliver measurable improvement for the priority areas listed in section 3.

2.6.5. The practice QI Lead will actively contribute to the QI Network community by sharing their quality improvement learning. The CCG will support people to come together to share and learn together through the QI Network events. It is required that practices participate in at least two of these events during the year.

2.6.6. Submitting a narrative each quarter on how clinical engagement in the Quality Improvement activities has been achieved.

2.7. The CCG understands the value of undertaking quality improvement at scale and supports the sharing and collaboration between practices when undertaking the quality improvement cycles, however all practices must undertake quality improvement cycles for all priority areas.

2.8. The CCG wishes to promote an environment within which practices and other local stakeholders can share and learn from each other's quality improvement journey. To enable this to happen, the CCG encourages the use of the AHSN hosted LIFE computer database for internal practice management of quality improvement activities. In addition to creating the sharing of QI activities, it will enable practices to simply reference their QI projects in their quarterly reports,

with little additional reporting required. Support on how to use the tool will be provided through the QI network.

2.9. The CCG would expect practices to undertake quality improvement activity for the priority areas throughout the year, providing updates of the work done in each quarter. Examples of quality improvement activities for each priority area will be provided by the QI Network at the beginning of the 2018/19 contractual year.

3. PRIORITY AREAS

3.1. Priority Area 1

Quality improvement cycle in: Hypertension

Requirement

3.1.1. The management of hypertension takes place almost exclusively in primary care. There is much evidence available to demonstrate that tighter blood pressure control results in reduced cardiovascular disease, strokes and renal failure. NICE guidance offers clear pathways to manage hypertension which includes holistic patient centred care which is an area of focus in the Somerset quality programme.

3.1.2. Practices are required to carry out quality improvement activities that support the reduction in clinical variation and the improvement in diagnosis and management of hypertension in accordance with NICE guidance e.g. patients should have their blood pressure checked at least every 5 years and where drug treatment is required, provide an annual review of care.

3.1.3. A specific area of quality improvement in the management of blood pressure is to improve the detection and management of orthostatic hypotension for patients identified as being severely frail or patients with a history of falls. This may be especially relevant for those practices already achieving high levels of blood pressure within target range. This is linked with priority area 2 to reduce the risk of falls.

Measurement

- Hypertension quality improvement activity identified and recorded
- Established measures to monitor and demonstrate improvement
- Report the progress and outcomes from the quality improvement activity
- Outcomes to include demonstrating:
  - Improved hypertension diagnosis rate (number of BP recorded, recall system)
  - Improved hypertension control rate (borderline BP, not at target)

- Orthostatic hypotension quality improvement activity identified and recorded
- Established measures to monitor and demonstrate improvement
- Report the progress and outcomes from the quality improvement activity
- Outcomes to include demonstrating
  - increased screening for orthostatic hypotension
  - increased number of patients identified with the condition

- number of management plans developed, where in the GP's clinical judgement, the patient would benefit from having a management plan (aligning with the falls prevention and person centred care)

3.2. **Priority Area 2**

Quality improvement cycle in: Falls

Requirement

3.2.1. Falls are a leading cause of morbidity and mortality in particular for Somerset. As a consequence improvements in reducing the risk of falling and the impact of falls in the population will lead to not only better outcomes for people, but more effective resource utilisation in the health and care community, along with supporting the reduction of clinical variation.

3.2.2. Practices will already be following the frailty requirements in the 2017/18 GP contract https://www.england.nhs.uk/publication/supporting-routine-frailty-identification-and-frailty-through-the-gp-contract-20172018/.

3.2.3. Quality improvement activities are to be undertaken to optimise the care of people identified as being severely frail and therefore likely to be at risk of falls. Improvement activity should include supporting patient self-assessment based on the Falls Risk Assessment Tool (FRAT) as a method of demonstrating measurable improvement. An example of a FRAT self-assessment tool can be found on the NHS Choices website and can be sent out/administered by appropriate support staff within the practice.
https://www.nhs.uk/Livewell/healthy-bones/Pages/falls-risk-assessment-tool.aspx

3.2.4. Quality improvement activity will involve working with patients who have been identified as being severely frail, their families and others to improve access to a range of personal and community resources which can reduce the risk of falls (as with dementia care planning).
https://www.ageuk.org.uk/globalassets/age-uk/documents/information-guides/ageukig14_staying_steady_inf.pdf

Measurement

- Falls risk quality improvement activity identified and recorded
- Establish measures to monitor and demonstrate improvement
- Report the progress and outcomes from the quality improvement activity
- Outcomes to include demonstrating
  - Number of patients identified as being severely frail
  - Number of patients given a self-assessment FRAT tool
  - Number of patients completing and returning a self-assessment FRAT tool
  - Number that resulted in action based on clinical evidence and professional judgement (medication review/osteoporosis assessment)

The CCG would expect the number of patients identified as severely frail being equal to the number of patients sent the self-assessment FRAT tool.

3.3. **Priority Area 3**

Quality improvement cycle in: Bone Health

Requirement

3.3.1. The impact of improving bone health in the population will lead to better outcomes for people and more effective resource utilisation in the health and care community.

3.3.2. Quality Improvement activities aimed at improving bone health should be undertaken; including increased use of FRAX scoring (and use of NOGG guidance) and the prescribing of bisphosphonates to appropriately identified patients, based on clinical evidence and professional judgement.

Measurement

- Bone health quality improvement activity identified and recorded
- Establish measures to monitor and demonstrate improvement
- Outcomes to include demonstrating
  - Number of patients screened for osteoporosis using FRAX scoring and use of NOGG guidance
  - Number of patients initiated on bisphosphonates (by either primary care or secondary care)

The CCG would expect an increase in the number of patients appropriately screened using FRAX scoring (and the use of NOGG guidance) and the number of bisphosphonate treatments initiated.

4. CCG ASSURANCE FRAMEWORK

Requirement

4.1. In order to turn around system performance, it is important that all parts of the healthcare system work together to address identified priorities. We are therefore asking GPs to help the CCG get out of 'special measures'.

4.2. There are two specific ratings applied to the CCG which rely on QOF data; reviewing the care of dementia patients and maintaining LD registers.

4.3. SPQS has compromised the QOF data sources for these two measures, making clinical care appear poor in Somerset. Practices can help achieve the assurance framework indicators by doing these two simple actions:

- Create a care plan or undertake an annual care plan review for those patients identified as having dementia as per the national QOF indicator. Appropriate Read (SNOMED) codes should also be used.

- Ensure practice LD registers are up to date by using the appropriate read (SNOMED) codes throughout the year to ensure all those with Learning Disabilities are on the register.

4.4. It is important that practices use the appropriate Read (SNOMED) codes as national achievement against the two assurance indicators are measured using QOF as the data source.

4.5. A simple guide to dementia coding has been produced previously by the CCG and is attached for information. A simple guide to register coding for Learning Disabilities will be issued by the CCG by the start of the 2018/19 contract year.

Measurement

4.6. As per the national assurance framework, the CCG will use national QOF results as the measure to monitor practice achievement against the two requirements. It is expected that there will be progressive improvement in both areas during the year.

5. PERSON CENTRED CARE

5.1. Practices will continue to promote a person centred approach, which includes personalised care planning for patients with long term conditions. Practices should continue to promote patient focused consultations.

Requirement

5.2. As per the requirement in the 2017/18 specification, practices will complete Treatment Escalation Plans (TEP) for those patients who in their GP's clinical judgement would benefit from such anticipatory care planning. The TEP may be contained within a Clinical Communication Document or an existing management plan. There is no need for separate documents that duplicate information. Practices should commence this requirement once the CCG has issued a standard template TEP which practices can use.

5.3. Where practices are already putting in place management plans in the absence of the county wide TEP, an appropriate Read (SNOMED) code should be applied to each patient record to show that care planning is active. The CCG will issue guidance on the appropriate codes at the start of the 2018/19 contract year.

5.4. To be clear, the requirement is not to produce a TEP for all patients but only those patients who would benefit from such anticipatory care planning based on the clinical judgement of the GP.

Measurement

5.5. The number of TEP created or reviewed each quarter. This will enable the panel to understand the level of care planning taking place across the county.

There is no minimum/expected number of TEPs each quarter and the measurement will not impact on the payment process of SPQS. However further discussions may be held with areas where numbers are static/no TEPs are being developed.

6. CLINICAL CODING

6.1. Previous years of SPQS have required practices to continue the delivery of high quality clinical services for their patients on the basis that GPs will treat QOF indicators as advisory, based on individual discussion with patients about their needs and aspirations.

6.2. Practices are also reminded of the importance of coding for disease register maintenance and also for interoperability using the appropriate national Read/SNOMED codes. Currently colleagues accessing EMIS records from

other parts of the health system, such as ED, are only be able to see codes; not free text. It is vital that clinically important information is coded correctly to support joined-up patient care.

6.3. Practices are still required to input the nationally appropriate codes for all patient consultations and under SPQS practices will continue to be asked to treat QOF indicators as advisory.

7. MONITORING OVERVIEW

7.1. All SPQS practices should ensure that they or their federation have submitted the quarterly report at the end of each quarter to the CCG (Sarah.attree@nhs.net). To be clear, the CCG would expect to receive a quarterly return from each federation, providing evidence of individual practice progress where indicated on the template at the end of this document.

7.2. The SPQS assurance panel will monitor progress against the measures set out in sections 2, 3, 4 and 5.

7.3. The SPQS assurance panel would expect to receive sufficient evidence that demonstrates progress from the previous quarter. Evidence will be assessed against the measures within the specification.

7.4. The CCG will advise NHS England which practices have provided evidence in order to validate payments. Should practices be unable to meet the requirements, quarterly payment to practices will be adjusted accordingly.

8. PAYMENT

8.1. Payment will be based on 2012-13 percentage achievement of points, with the calculation corrected to reflect the relevant year's number of available QOF points, prevalence factor and practice list size adjustment.

8.2. 70% will be paid in monthly instalments, as at present, with the remaining 30% divided and paid on a quarterly basis, two months after quarter end, and following CCG confirmation of receipt of a satisfactory quarterly progress report from the federation. Should the requirements not be met the quarterly payment will not be approved.

8.3. Practices must demonstrate they have met the requirements and measures set out in sections 2, 3 and 4 to qualify for payment.

8.4. Reconciliation will be undertaken at year-end and any adjustments will be included in the final quarterly payment. The formula used to calculate payment will replicate that within the GMS Statement of Financial Entitlements, this is described as follows:

Clinical domain total QOF Points x £ per point x clinical domain prevalence factor = subtotal (all clinical domains added together)

Subtotal x list size factor (CPI adjustment) = total

Total x Practice 2012-13 % QOF points achievement = payment

8.5. The number of points per clinical domain is determined by the national QOF agreement. The prevalence factor is calculated by dividing the practice's prevalence (calculated by CQRS) by the national average prevalence (data sourced from CQRS). List size factor is practice list size as at 1 January of the relevant financial year (taken for the Exeter System) divided by the national average practice list size of the 1 January (as detailed in the Statement of Financial Entitlement) of the previous financial year.

9. TERMINATION/MERGERS

9.1. Should a practice wish to withdraw from this enhanced service and revert to QOF, this may be done in exceptional circumstances with the agreement of NHS England and the CCG.

9.2. Should a practice merge during the 2018/19 year, the commissioner and contractors will agree, as part of the merger authorisation, how payments should be made from the point of merger onwards in respect of this participation agreement. The agreement will conform to the Statement of Financial Entitlement.

Appendix A

Somerset Practice Quality Scheme
2018– 19
Quarterly Report

The purpose of this template is to provide Somerset CCG with evidence of your progress against the requirements set out in the SPQS specification for 2018-19. This template must be completed by federations detailing practice development.
It is important the report submission deadline is met to allow for prompt payment in accordance with section 10 of the service specification.
Please direct any queries to the CCG by contacting Sarah Attree on Sarah.attree@nhs.net or 01935 384020.

Nominated Contact Details *(please complete)*
Name1/ 2:
Email 1/ 2:
Contact Number 1/ 2:
Report Details *(please complete)*
Quarter:
Name of Federation or practice:
Practice Code(s):

QUALITY IMPROVEMENT	
Please confirm the practice have met / will meet the requirements detailed in 2.6:	

QUALITY IMPROVEMENT PRIORITY AREAS	
In the table below please provide details of the quality improvement cycle undertaken. If the practice has utilised the LifeSystem please give the name of the cycle. **Please ensure all the requirements and expectations as noted in the monitoring section of the specification are referenced. Please detail how clinical engagement in the Quality Improvement activities have been achieved. Please add rows as required.**	
Practice Name:	**Update:**
	Hypertension:
	Falls:
	Bone Health:
	Hypertension:
	Falls:
	Bone Health:
	Hypertension:
	Falls:
	Bone Health:

	Hypertension:
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	Falls:
	Bone Health:
	Hypertension:
	Falls:
	Bone Health:

PERSON-CENTRED CARE
Please confirm number of TEPs and / or CCDs undertaken in this quarter:

Appendix B

Dementia Care Coding

There are four codes for dementia care plans and two codes for dementia care plan reviews, these are as follows. In order to apply a review code, one of the four care plan codes first needs to be applied to the patient record.
Care plan codes:

- 8CMZ – Dementia Care Plan
- 8CSA – Dementia Advanced Care Plan agreed
- 8CMe0 - Dementia Advanced Care Plan
- 8CMZO – Dementia Care Plan agreed

And then, if you are satisfied that the patient has had their care reviewed, one of the review codes:

- 8CMG2 – Dementia Advanced Care Plan review
- 8CMZ1 – Dementia Care Plan reviewed

These can be batch-coded or individually coded.