**Sunderland General Practice Quality Premium 2020/21**

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1. **Introduction**

The Quality Premium for 2020/21 will be split into three sections:

**Section One: Pre-conditions for participation in the Quality Premium (70%)**

This will account for 70% of the Quality Premium. Whilst there is no financial penalty associated with this element, it will be monitored to ensure adherence to guidance and data will be collected and shared where possible to support discussion around best practice in these areas.

**Section Two: Key Performance Indicators (30%)**

The remaining 30% of the Quality Premium will be monitored via Key Performance Indicators with overall payment being determined by achievement of the indicator.

**Section Three: QP plus**

The Learning Disability Health Checks and Prostate Cancer elements will be included in a QP plus element of the QP and will continue to be paid at a cost per health check/review.

**Payment**

Payment to practices will be **£10.57** per population head for the 2020/21 Quality Premium.

Practices have been paid the full 100% for the first four months of 2020/21.

1. **70% Areas** 
   1. **Learning disabilities**

As in previous years practices are asked to engage with the CNTW health promotion team, and work with the health facilitators to:

* Maintain and validate the autism register
* Identify learning disabilities patients who have reached end of life and are on the palliative care register, and who are in need of additional support from the learning disabilities team.

Practices will be expected to commence this element of the scheme from August 2020.

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| **Guidance:**  The following Snowmed codes will be used for the Autism register**.**  35919005 autism spectrum disorder  408856003 autistic disorder |

* 1. **Serious Mental Health**

Practices are asked to engage with the CNTW and work with the health facilitators to:

* Reinstate SMI health checks to levels achieved in 2019/20.

Given current circumstances surrounding COVID-19 practices will need to look to conduct remote triage and review of patients where possible.

This element of the QP will be required to commence from October 2020.

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| **Guidance:**  Data will be sent monthly to practices with full guidance – this will be sent directly from Linda Reiling, Commissioning Manager. |

* 1. **End of Life**

**2.3.1 Palliative Care Register and MDT meetings**

It is estimated that approximately 1% of the population die each year. If practices are able to predict people who are in their final year of life and include them on the palliative care register, there is evidence that they are likely to receive well-co-ordinated, high quality care.

Once patients are identified and included on the register, they will receive proactive support, leading to better co-ordinated care that reflects the patient’s preferences. Earlier recognition of possible illness trajectories means needs can be better anticipated and addressed.

Practices are to:

* Proactively identify patients who are appropriate to be placed on the palliative care register. Practices will be provided with guidance on identifying patients who are in the last 12 months of their life.
* Patients who are on the palliative care register should be discussed at the practice palliative care MDT. A recommendation for this process is detailed below:

A palliative care MDT meeting should be held at least once a month for an hour. These meeting can be held virtually.

* There should be a named administrator with IT skills (an end of life admin lead should already be identified) who will prepare for the meeting to ensure it runs smoothly. The lead will work with the GP to maintain the register by recording new patients identified and maintaining the current clinical status.
* Coding and adequate recording of plans agreed at the meeting e.g. decision to commence advance care planning and which professional is responsible for the actions. A template will be provided to practices if they wish to use it, this will structure and standardise meetings.
* Agendas should be set to discuss patients, prioritising their needs – patients coded red first, any other patient that members have concerns about, any new addition to the register, and any death that has occurred since the last meeting, in order to recognise good practice and areas for improvement.

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| **Guidance:**  Practices are to demonstrate an increase in the number of patients on their palliative care register against their baseline position. Practices who are achieving 80% or more should aim to maintain this number.  Patients are approaching end of life when they are likely to die within the next 12 months, this includes people whose death is imminent (expected in a few hours or days) and those with:  • Advanced, progressive, incurable conditions  • General frailty and co-existing conditions that mean they are expected to die within 12 months  • Existing conditions if they are at risk of dying from a sudden acute crisis in their condition  • Life-threatening acute conditions caused by sudden catastrophic events  Please see guidance on how to proactively identify patients in the last 12 month of life:    Snowmed codes required are located in the EPACCS template. |

**2.3.2 Care of Dying Patient Pathway**

Practices are to support the roll out of the “Care of the Dying Patient” documentation which aims to address the following concerns that have been highlighted by NICE guidelines;

* The decision that a patient was dying was not always supported by an experienced clinician and not reliably reviewed, even if the person may have had potential to improve.
* The dying person may have been unduly sedated as a result of inappropriately prescribed medication.
* Concerns that hydration and some essential medicines may have been withheld or withdrawn, resulting in a negative on the dying person.

Practices are required to;

* Attend training on utilisation of the Care of Dying Patient (CDP) Document. Training will be offered virtually once available at PCN meetings
* Ensure all clinicians feedback to leads on suitability and usability of the new electronic EPACCS templates and pathways; this will be done via Primary Care Network (PCN) meetings.
* Increase the number of patients who have been started on the CDP pathway, practices will be required to use CDP on 70% of eligible palliative patients.

**2.3.3 End of Life Medications – Electronic Prescribing**

Clinical leads across primary care and palliative care specialist have developed an EMIS template for community prescribing (Green Kardex) that enhances the quality of prescribing and also provides the safe and clear prescribing required by community nursing staff. This has been trialled as a pilot to ensure complete safety before rolling out across the city.

The initial findings from the pilot identified the following improvements that can be made if the new community authorisation sheet (Kardex) is rolled out:

* Improve safe prescribing and reduce risk to patients
* Ensure legal requirements of mixing drugs are followed
* Support clinicians in prescribing safely
* Ensure patients at the end of their life are not subjected to multiple infusions and distress when medications can be mixed safely

Once launched in the PCN and training has been undertaken, practices are required to:

* Attend training on utilisation of the electronic kardex
* Ensure all clinicians feedback to leads on suitability and usability of the new electronic templates via PCN meetings
* To fully utilise the new Kardex ( paper or electronic) once training has been provided with an aim of 80% electronic Kardex utilisation. All district nursing and palliative care staff alongside GPs will use the new format. The Kardex is available in paper format and can be printed out and written manually in case of IT failure

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| **Guidance:**   * GPs are to use the Care of the dying patient documentation on 70% of patients recognised to be in their last days or hours of life. * GPs are to use the new process for anticipatory medications on all patients requiring anticipatory medications and syringe drivers on 100% of patients. GPs should aim to use the electronic format on 80% of patients, the paper copy should only be used in exceptional circumstances. * Minimum Prescribing standards must be are adhered to.   Please see following documentation:    Training on the two new processes will be provided during PCN meetings and individual support to practices where required. A training video will be shared with practices and uploaded onto GPTeamNet. The training programme has been developed in partnership with colleagues from primary care and St. Benedict’s Hospice. Details of the training will be confirmed via your PCN Clinical Director. |

* 1. **Personalised Care for Pregnant Women**

Around 4330 babies are born to mothers who are tobacco dependant each year in the North East. Tobacco dependency is the main modifiable risk factor for a range of poor pregnancy outcomes and it is strongly correlated to;

* High neonatal admissions
* Still births
* Sudden infant deaths
* Low birth weight
* Smoking in pregnancy imposes a considerable economic burden on society. Health care costs are imposed on the NHSS, during pregnancy and in the year following birth, as a result of mothers continuing to smoke during pregnancy.

Sunderland is one of the highest areas regionally and nationally of smoking mothers at the time of pregnancy and delivery, currently at 17.8% with the national target being 11% and the regional ambition being 6% in a few years.

Practices are asked to support the following commencing October 2020:

* Identify lifestyle issues which may impact on a mother’s pregnancy – in particular smoking by;
* Signposting to smoking cessation and to midwife when they attend for their first GP appointment – giving them advice and guidance.
* Sharing the patient lists with midwives to ensure appropriate support is provided
* Training for practices – identify a smoking cessation champion and sharing the leadership with the midwives
* Opportunistic discussion when patients present with pregnancy related symptoms.
* Discuss and signpost at six week checks
* Display promotional and communications material in practices and on Jayex screens
* Minimise the risk of Vitamin D insufficiency:Ensure providers discuss vitamins, supplements and nutrition in pregnancy with all women. Women with dark skin or those who always cover their skin when outside may be at particular risk of vitamin D insufficiency and should consider taking a daily supplement of vitamin D all year.

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| **Guidance:**  A Practice EMIS protocol can be developed so that administration staff can develop the health promotion and signpost after telephone appointments to appropriate services. |

* 1. **Prescribing**

**2.5.1 OTC Prescribing**

NHS England carried out a public health consultation on reducing prescribing of over-the –counter medicines for minor, short-term health concerns.

In the year prior to June 2017, the NHS spent approximately £569 million on prescriptions for medicines which can be purchased over the counter from a pharmacy and other outlets such as supermarkets.

These prescriptions include items for a condition:

* That is considered to be self-limiting and so does nor need treatment as it will heal of its own accord;
* Which lends itself to self-care, i.e. that the person suffering does not normally need to seek medical care but may decide to seek help with symptom relief from a local pharmacy and use an over the counter medication.

Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs aims to provide a consistent, national framework for CCGs to use.

Commencing October practices are asked to;

* Adopt and implement the NHS England Guidance on ‘Conditions for which over the counter items should not routinely prescribed’.

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| **Guidance:**  The full guidance can be accessed via the following link.  [**https://www.england.nhs.uk/medicines/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed/**](https://www.england.nhs.uk/medicines/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed/) |

**2.5.2 Opiate Reduction**

Sunderland CCG adopted a position statement in 2019 regarding the prescribing of high dose opiates in non-malignant pain. This was based upon the CCGs position as a high outlier nationally for prescribing of these dangerous and dependence inducing drugs.

In late 2019 Sunderland CCG also launched a high profile and successful media PR campaign called ‘#PainkillersDontExist’. This work is supplemented by the development of a bespoke workshop for prescribers entitled ‘Person Centred Approaches – Supporting Discussions about Opioid Use’.

Practices will be required to;

* Work with the PCN Pharmacists on their opiate reduction plan.
* Have at least one GP attend a CPPE workshop on ‘Person Centred Approaches – Supporting Discussions about Opioid Use’.

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| **Guidance:**  At least one GP is to attend the CPPE workshop (only if this can be provided safely/virtually) details of this will be circulated when/if available.    For resources and more information please visit the following links:    [**https://painkillersdontexist.com/**](https://painkillersdontexist.com/)  [**https://www.sunderlandccg.nhs.uk/wp-content/uploads/2019/07/20190327-SCCG-and-STCCG-Opioid-resource-pack-Final-Approved-1.pdf**](https://www.sunderlandccg.nhs.uk/wp-content/uploads/2019/07/20190327-SCCG-and-STCCG-Opioid-resource-pack-Final-Approved-1.pdf)  [**https://www.sunderlandccg.nhs.uk/wp-content/uploads/2019/09/FINAL-SCCG-Position-Statement-on-Opioid-Prescribing-V5.pdf**](https://www.sunderlandccg.nhs.uk/wp-content/uploads/2019/09/FINAL-SCCG-Position-Statement-on-Opioid-Prescribing-V5.pdf) |

**2.6 Timely Triage of GP Same Day Home Visits**

The GP into Recovery at Home Operational Group has overseen the implementation of a GP working into the recovery at home service, providing a home visiting service**.**

The Group is aware that activity surges take place which result in two peaks of home visit requests to Recovery at Home, ambulance call outs to patients’ homes, referral into the emergency department, and into the emergency assessment unit. These surges take place at the end of both the morning and afternoon GP surgeries. These surges all contribute to longer system waiting times as all calls require a response. Patient care is affected as there is a delay in appropriate triage and treatment.

The aim of the indicator is to flatten the peaks by redistribution of the activity across the working day. This will ensure patients are seen in a timelier manner, improving quality in care and patient experience.

Practices are asked to;

* Review internal processes to ensure;
  + all home visits are triaged within 30 minutes of receipt of patient requests
  + the request is documented in EMIS.
* For those who already achieve this baseline, they are encouraged to share good practice with others via PCN meetings and TITO events etc.

**3. 30% Indicators Summary**

This element constitutes 30% of the overall QP and is made up of indicators across five clinical domains. Each clinical domain will be weighted equally and payment will be made to practices who hit targets within a predefined achievement threshold.

**3.1 CVD**

The population of Sunderland has a high prevalence of Cardiovascular Disease (CVD). This makes a significant contribution to reduced life expectancy and below average health outcomes. However CVD is largely preventable and early detection and treatment can help patients live longer. Secondary prevention can help reduce further CVD events such as strokes or heart attacks.

There is a strong evidence base for the use of atorvastatin in both primary and secondary prevention of CVD in line with NICE guidelines and the South of Tyne Lipid Modification Strategy (SLiMS).

Practices requirements are;

* Atorvastatin 80mg to be offered to at least 80% of eligible patients (<80 years) for secondary prevention
* Where Atorvastatin is documented and coded as intolerant, contraindicated or declined, Rosuvastatin 10-40mg is an appropriate alternative to be offered.

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| **Guidance:**  Please use the following snowmed codes;  Atorvastatin 80mg: 134489001  Atorvastatin allergy: 13221000122100  Rosuvastatin 10mg,20mg,40mg: 408036003,408037007, 408024009 |

**3.2 Reduction in prescribing of Gabapentin and Pregabalin**

Sunderland is rapidly becoming one of the highest gabapentanoid prescribing areas in the country. Gabapentinoids are not licensed for non-neuropathic pain, nor is there any evidence to support their use.

As with all medicines for the treatment of chronic pain, gabapentinoids should be used only as part of a wider management plan. Patients should be aware that non-pharmaceutical options or those offered along with prescribed medicines, may result in better achievement of goals and result in less harm than medicines alone

Practices are required to reduce pregabalin and gabapentin prescribing (as measured by ADQ/1000 starPU) by 5% if over the CCG average as of September, or 0% growth if under the CCG average as of September.

Baseline data will be provided to practices.

Some available resources that would help primary care in developing internal safety nets and protocols:

<https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/11/Gabapentinoid-Quick-Reference-Guide-23112018-Final-v1.0.pdf>

**3.3 Cancer**

**3.3.1 National Cancer Diagnosis Audit Outcomes and reducing emergency admissions of cancer**

Early diagnosis of cancer is a priority nationally and locally in Sunderland. Data is showing an increase in cancers diagnosed as emergency presentations and the number diagnosed through 2ww has decreased.

The NCDA looks at all cancer diagnoses over the course of 12 months and the route to the diagnosis. The NCDA will help understand the reasons for the emergency diagnosis.

Practices are required to;

* Complete the NCDA for all patients who are newly diagnosed with cancer within a set timeframe. On completion of the audit practices will receive a personalised report, which can be used for quality improvement projects, evidence for CQC and appraisals.

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* Work with the Cancer Facilitator to develop an action plan, identifying three objectives to help reduce the number of cancers diagnosed as an emergency.
* Submit the action plan detailing changes that have been made as a result of the action planning.

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| **Guidance:**  The NCDA runs from April 2020 to March 2020.  Please see attached document for an overview of the NCDA    Practices are required to sign up to the following audit via the following link;  <https://nww.canceraudit.phe.nhs.uk>  Practices are then to complete the audit for patients that are shown for review on the platform. The audit period is from 1st April 2020 to 31st March 2021, practices are required to do retrospective audits on 90% of cancer diagnosis from this date. The audit should be complete by March 2021 for those patients diagnosed with Cancer from 1st April to August 2020.    Practices are also asked to display a patient information poster in the practice, please see link below;    For further information and guidance please see the document below for useful hints and tips.    Once the NCDA is completed;   * Practices are to work with the Cancer Facilitator to develop an action plan, based on the report received from last year’s NCDA (from 1st April 2019 to 31st March 2020). Due to COVID19 the timeframe has now been extended to 31st August 2020. * Implement and monitor the action plan from 1st November 2020 to 31st February 2021. * Produce a report which outlines the learning of the audit e.g. what worked well and what did not work as well. * Attend a PCN meeting in February 2021 to share the findings of the action plan. * Practices will then be required to submit an action plan detailing chages that have been made as a result of the action planning to [Vivienne.gray1@nhs.net](mailto:Vivienne.gray1@nhs.net)   *Please note that if practices do not complete last year’s audit by 31st August then they will not have a report to discuss and will not be able to achieve the 30% of the QP target.* |

**2 WW Referrals**

During the COVID 19 pandemic NHS England provided guidance and expectations to manage 2ww referrals. Referrals may have been managed differently during this time, depending on local pressures and with reference to patient and staff safety. Primary care were expected to refer patients as per the normal 2ww process, however secondary care were able to plan or defer investigations if clinically appropriate.

Practices are required to:

* Audit to be completed on ALL 2ww referrals made during the three month period (March to June 2020)
* Complete the attached template which includes;
  + The number of referrals made
  + The number of referrals that were downgraded or deferred and why
  + The results of referrals seen in secondary care e.g. investigations, discharged back to primary care
  + Of those who were downgraded, number who have since had appointments in secondary care and the outcome.

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| **Guidance:**  Template to be sent to practices via Cancer lead |

**3.4 End of Life**

**3.4.1 Care of Dying Patient Pathway**

Continuing on from the elements included in the 70% section, practices will be require to:

* Carry out an audit in January 2021 to determine utilisation of the CDP document. Feedback from the audit is to be shared with PCNs and the learning to be disseminated.
* Demonstrate an increase in the number of non-COVID patients who die in their preferred place of care.

**3.4.2 End of Life Medications – Electronic Prescribing**

Following on from the requirements from October 2020practices will be required to;

* Carry out an audit at six months and twelve months to ensure practices are achieving safe prescribing and mixing of drugs.
* Feedback form the audits are to be shared with PCNs and the learning disseminated.
* The new Kardex will be in place once training for each PCN is complete. All community authorisation will be on the new Kardex with an aim of >80% to be done electronically ( safer and quicker).

1. **QP Plus Summary**

**4.1 Learning Disabilities**

Practices will be expected to offer all patients over the age of fourteen on their learning disabilities register a health check, as a minimum the health check should include:

* + a collaborative review with the patient and carer (where applicable) of physical and mental health with referral through the usual practice routes if health problems are identified, including:
    - health problems
    - chronic illness and systems enquiry
    - physical examination
    - epilepsy
    - dysphagia
    - behaviour and mental health
    - specific syndrome check
  + A check on the accuracy and appropriateness of prescribed medications
  + A review of coordination arrangements with secondary care
  + A review of transition arrangements where appropriate
  + A discussion of likely reasonable adjustments should secondary care be needed
  + A review of communication needs, including how the person might communicate pain or distress
  + A review of family carer needs
  + Support for the patient to manage their own health and make decisions about their health and healthcare, including through providing information in a format they can understand any support they need to communicate (Health Action Plan)

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| KPI | Indicator | £ per Health Check |
| +LD1 | The percentage of patients on the Learning Disabilities Register who have attended an annual health check in the last 12 months | £140 |

**4.2 Prostate Cancer**

**Practices will continue to be paid for the following modules/injections;**

**Module 1:** Patients aged 75 and over - treatment with LHRH analogue (or degarelix) AND regular monitoring in primary care.

GP responsibilities:

* Administration of LHRH analogue or degarelix
* PSA monitoring – 6 monthly or as directed by specialist
* 6 monthly BP monitoring
* Annual review including FBC, U&E, Ca if metastases

The practice must continue to administer LHRH analogue or degarelix after initiation by the specialist. Frequency of administration is dependent on the drug being used – this may be monthly, three monthly or six monthly.

GP practice will monitor PSA levels as directed by local secondary care consultant (this will usually be 6 monthly)

Patients will also have an annual review at the practice.

**Payment:** The practice will receive payment for administering the injections and an annual fee for monitoring and annual review.

**Module 2:** - Patients (any age) requiring treatment with LHRH analogues or degarelix in primary care – all other aspects of care delivered by secondary care.

Patients remain under consultant review and may have complex treatment regime in addition to the LHRH analogue/degarelix.

Practice will continue LHRH analogue/ degarelix after initiation by the specialist. Frequency of administration is dependent on the drug being used – this may be monthly, three monthly or six monthly.

Payment: The practice will receive payment for administering the injections.

# Module 3: Watchful Waiting

Patients aged 75 yrs and over; and patients under 75 who have been stable for two years of watchful waiting in secondary care. Stable PSA is defined as PSA not rising more than 10% per annum.

GP practice will monitor PSA levels every six months, monitor Ca, U&E and FBC every 12 months and perform an annual review of the patient to review test results and patient’s symptoms.

Payment: The practice will receive an annual fee for PSA monitoring and review.

Activity Payment for each patient

LHRH or degarelix monthly injection £44.13 after each third monthly injection

LHRH three monthly injection £44.13 per injection

LHRH six monthly injection £44.13 per injection

PSA monitoring, annual FBC, U&E and Ca monitoring (if required) and annual review £60.73 per annum

Appendix 1

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| **70% Areas** | **Delivery start date** | **30% Areas** | **Delivery Start date** |
| Learning disabilities | August 2020 | CVD | October 2020 |
| Serious mental illness | October 2020 | Prescribing | October 2020 |
| End of life | August 2020 | Cancer – NCDA & 2ww referrals | August 2020 |
| Personalised care for pregnant women | October 2020 | End of Life | October 2020 |
| Prescribing - OTC | October 2020 |  |  |
| Prescribing – Opiate reduction | January 2021 |  |  |
| Home visit triage | August 2020 |  |  |
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