

## **Cannock Chase Clinical Commissioning Group**

### **GP Practice Membership Agreement 2019/20**

#### **Aim**

The aim of the GP practice membership agreement is to work with practices to support clinically led commissioning and the delivery of The NHS Long Term Plan to maintain and improve provision of effective, efficient and accessible primary care services.

The CCG has received excellent engagement through the Membership Board and the Membership Agreement and wishes to engage further with member practices to actively participate in commissioning and the implementation of The NHS Long Term Plan, ensuring developments are directly aligned to the transformation of primary care.

#### **Investment and payments**

The total investment in the agreement is £253,831 which will be shared across 2 main components along the same themes as 2018/19:

1. Clinical commissioning and practice engagement – through CCG leads, member meetings and Quality and Engagement visits
2. Quality (Reducing unwarranted variation and supporting CCG and National priorities)

These components assist the organisation in developing and delivering quality services whilst reducing unnecessary spend where possible, supporting the continual work that is required to address the financial challenge. The components also improve the health of the local population and reduce health inequalities, particularly where the CCG falls into the worst performing quartile in The Improvement and Assessment Framework (IAF).

This agreement is covering the period commencing 1st April 2019 to 31st March 2020.

Indicators will either be a flat rate per practice to reflect the equal commitment required to participate in that delivery area or capitated based on registered population as at 1st January 2019.

It is recognised that delivery of the agreement will require considerable effort for each practice and the payments are weighted to reflect this and the new ways of working involved.

The agreement is voluntary, however if practices are to sign up to the agreement, they would be expected to enter into all delivery areas. There will also be a general expectation that:-

- referrals for outpatients will continue to be referred using commissioned pathways and referral templates as detailed on Clinical Decision Support system
- practices submit soft intelligence via DATIX
- local formulary to be followed
- practice will use GRASP tool to support identification and management of population with Long Term Conditions e.g. COPD, AF.

#### **Payment**

Payment will be made at two points within the year: The first payment will be made in September 2019, with the final payment made in May 2020 reconciled to achievement of the individual delivery areas. Those practices wishing to participate will be required to provide evidence of delivery against each area in order to receive final payment. EMIS Enterprise will be the main reporting tool to support practices with evidence of delivery.

Table 1 below provides a summary of the delivery areas and the subsequent guidance describes the requirements and outcomes of each delivery area.

**Data extraction and engagement**

The Practice will receive support from the Data Quality Specialists employed by MLCSU where appropriate to run searches and reports to identify key areas within the membership agreement. By signing this agreement the practice consents to data extractions as follows:-

- Monthly reports being run via EMIS Enterprise searches to determine progress with all membership indicators in order to feedback to practices, inform board meetings and CCG committees.
- Ad hoc data requests via Enterprise at practice aggregated level, for the CCG to support and inform emerging commissioning work streams eg.AF, COPD, diabetes
- Data Quality Specialist running reports /dashboard for CCG on Active Signposting and Workflow documents actioned to support the ongoing rollout and embedding of these work programmes. The reports/dashboard will be developed and shared with practices.
- Full details are listed in **Appendix 2**

**Dispute Resolution Process** – An appeals process has been developed and agreed by the Primary Care Committee (described in **Appendix 1**)

GP Practice Membership Agreement 2019/20		
£1.90 available per head of CCG population		Total value: £253,821
Maintaining engagement, development and improving quality in Primary Care		
Deliverables/Practice Requirements	Practice payment	Payment method
<b>A. Clinical commissioning and practice engagement</b>		
<b>1. Membership Attendance</b> Attendance at 12 Membership Board meetings (attendance required at full duration of meeting) by a GP and/or Practice Manager or Allied Health Professional.	£3025.00	<b>Practice</b>
<b>2. Quality Visit Participation</b> Practice participation in a quality improvement and engagement visit (including preparation and any follow up work).	£750	<b>Practice</b>
<b>B. Quality (Reducing un-warranted variation and supporting CCG priorities)</b>		
<b>1. Peer review</b> Practice to participate in peer review at PLT events on two outpatient specialties and complete peer review templates.	16p	<b>Capitated</b>
<b>2. Learning Disabilities (LD)</b> 2.1 Practice to increase proportion of people with a learning disability on the GP register (aged over 14 years) receiving an annual health check.	19p Sliding scale: >50% 4p, >55% 5p, >60% 5p and >65% 5p	<b>Capitated</b>
<b>3. End of Life</b> 3.1 Practice to increase Palliative Care register prevalence rate. 3.2 >40% of Palliative Care Register patients to have recorded decision on DNAR and/or CPR.	15p Sliding Scale: >0.4%, >0.6%, >0.7% 5p per increment 10p (>40%)	<b>Capitated</b>
<b>4. Sepsis:</b> <ul style="list-style-type: none"> <li>Practice has a named sepsis lead (practice to submit name of Sepsis Lead and demonstrate how they have fulfilled their role (as detailed below):</li> </ul> <b>And</b> <ul style="list-style-type: none"> <li>Clinician Attendance at PLT event</li> </ul>	7p	<b>Capitated</b>
<b>5. Improving Flu Immunisation Rates</b> Practice to increase flu vaccination uptake rates for at risk groups aged <u>under</u> 65 years.	10p (>48% 5p, >53% additional 5p)	<b>Capitated</b>
<b>6. Diabetes</b> <b>6.1 Newly diagnosed patients referred to structured education to have a coded outcome of attendance</b> Practice to code newly diagnosed patient's outcome of attendance at DESMOND structured education course with view to improve CCG attendance rates in National Diabetes Audit (NDA) and IAF	5p (>=70% of newly diagnosed patients to have a coded outcome	<b>Capitated</b>

<p>figures.</p> <p><b>6.2 Increase Management of diabetes patients with BP 140/80 – New QOF DM019 (expressed as % of eligible register).</b>  Percentage of patients with diabetes without moderate or severe frailty on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less – practice to achieve &gt;78%. The practice should not exceed overall exception reporting rates greater than 10%. New personalised care adjustment rates should be on sound clinical grounds and not significantly anomalous with peers.</p>	<p>20p (&gt;78%)  (Exception rates &lt;=10%)</p>	<p><b>Capitated</b></p>
<p><b>7. GP Online Services</b></p> <p><b>Practice to improve % of Patients with access to their Detailed Coded Record (DCR):</b></p>	<p>18p Sliding Scale: &gt;5% 5p, &gt;10% 5p and &gt;15% an additional 8p</p>	<p><b>Capitated</b></p>
<p><b>8. Engagement with CCG annual Digital Maturity Survey</b></p> <p><b>Practice to engage with audit and action plan for improvements.</b></p>	<p>5p</p>	<p><b>Capitated</b></p>

15/4/19

**Signature Sheet for CCG Membership Agreement 2019/20**

**Signature of this document constitutes agreement by the practice to the CCG Membership Agreement for 2019/20.**

Practice gives consent to use EMIS Enterprise search and reporting to allow MLCSU employed data quality specialists (DQS) and/or Medicines Management team to support practices with delivery and reporting of the Membership Agreement to the CCG (as detailed in Appendix 2)

Please select:

**Yes**    ☐

**No**    ☐ Practice will need to do their own search and submit quarterly data to assist for reporting to the CCG, delay in reporting will lead to delay in payments.

Practice Name: \_\_\_\_\_

Practice Code: \_\_\_\_\_

Signature on behalf of practice: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this signature/agreement sheet to  
swprimarycare@staffordsurroundsccg.nhs.uk**

## A. Clinical commissioning and engagement

**Rationale** - This membership agreement builds upon the good relationships with practices that continue to evolve since the CCGs inception.

The development of Primary Care is a key priority for the CCG. The agreement has been developed with the Membership Board with the aim of maintaining and improving quality and creating capacity and capability in the primary care setting. The Membership Board is also an essential forum for developing clinical models of care that improve outcomes for patients. It is important therefore that practices are fully engaged in the delivery of the agreement through the Membership Board.

### 1. Attendance at 12 Membership Board meetings (full duration of meeting attendance) by a GP and/or Practice Manager or Allied Health Professional. (4 of which meetings for locality board meetings).

Practices will be expected to provide consistent, full attendance by a GP and/or Practice Manager or Allied Health Professional who will be expected to represent the views of the practice and disseminate key messages and issues to colleagues.

All member practices must keep up to date declarations of conflict of interests and notify any changes at each meeting.

#### Outcomes

- To develop a culture of clinically led, patient focussed commissioning
- To ensure GP and practice manager attendance at Membership Board
- To ensure members are actively engaged in the implementation and monitoring of the agreement
- Conflicts of Interest Register maintained to protect the Membership practices from external scrutiny

### 2. Practice participation in a quality improvement visit (including preparation and any follow up work)

A rolling programme of quality improvement visits will be put into place. This will provide an opportunity for a 2-way discussion regarding practice level data, communication and engagement. Visits will be offered over a 12 month period and will be approximately 1.5 hours duration. Preparation and any follow up work have been included to ensure a continuous approach. If a practice does not receive a visit within the year they will be required to submit a reflection on the data and agenda used within the visit before end of March 2020.

**Outcomes** - To ensure that the CCG and practices are actively engaged in quality improvement work and to support statutory and CQC requirements.

## B. Quality

**Rationale** - To reduce unwarranted variation, support quality improvement in general practice and support commissioning of services.

### 1. Peer Review - Practice to participate in peer review across two outpatient specialties and complete peer review audit templates.

As part of the planned care delivery plan for 19/20 there is an element around peer review that needs to be delivered within primary care. This is not a standalone piece and is supported with other elements as below, some of which are also included in the GP Forward view:

- education/PLT events
- clear care pathways
- referral criteria
- signposting / social prescribing
- self-care
- choice

Practices are to review a number of referrals (to be determined) for two specialties (to be confirmed). An audit template will be supplied by CCG. Practices are to discuss findings at PLT to facilitate shared learning and submit anonymised notes to CCG in advance to be summarised for speaker.

**2. Learning Disabilities Annual Health Checks** - The CCG falls into the worst performing quartile on the CCG Improvement Assessment Framework (IAF) for this indicator. Inclusion of this indicator in the agreement will support achievement of NHSE targets set for 19/20.

**2.1 Annual Health check** - Practice is to increase proportion of people with a learning disability on the GP register (aged over 14 years) receiving an annual health check. The practice will be monitored against a stepped target to work towards The Long Term Plan targets.

**Resources:** **EMIS template** is available in EMIS Library > Primary Care Templates > Learning Disabilities HCAP. To activate the protocol: go into the templates manager and then navigate to EMIS Library > EMIS Protocols > DES Protocols Its in as Health Check Action Plan Launch and Print Protocol. Right click on it, select Status and click activate, it will then be available to add to your F12 **menu** (or ask your DQS for support)

**Don't Miss Out campaign:** <https://www.mencap.org.uk/advice-and-support/health/dont-miss-out/dont-miss-out-annual-health-checks>

**Outcome:** People with a learning disability often have poorer physical and mental health than other people <https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2017-to-2018>.

An annual health check can improve people's health by spotting problems earlier. <https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/>

People with a learning disability can sometimes find it hard to know when they are unwell, or to tell someone about it. A health check once a year gives people time to talk about anything that is worrying them and means they can get used to going to visit the doctor.

### 3. End of Life

**3.1 Practice to increase No. of People on QOF Palliative Care register.** Achievement will be monitored against a sliding scale with 5p per head of population allocated to each increment (>0.4%, >0.6%, >0.7% prevalence).

**3.2. Practice to aim for >40% of people on Palliative Care register to have recorded decision on DNAR and/or CPR.**

**Rationale** - General Practices are asked to increase their palliative care registers to help identify patients care preferences and key details about their care are recorded, and shared with those who are delivering it. This will support the co-ordination of quality care and help to reduce unnecessary hospital admissions.

Locally the Staffordshire Health and Wellbeing Board, through the joint Health and Wellbeing Strategy, 'living well in Staffordshire', have identified End of Life as a key priority.

**Resources:** **The Gold Standards Framework Proactive Identification Guidance (PIG)** – aims to enable the earlier identification of people nearing the end of their life who may need additional supportive care. <http://www.goldstandardsframework.org.uk> for more details

**Outcome:** Staffordshire and Stoke-on-Trent STP's Enhanced Primary and Community Care work stream includes an ambition to improve end of life care. The intention is to develop a seamless end of life care pathway. The key elements to this are:

- Increased identification and prioritisation of patients at end of life
- Improved Care Planning and Recording of Preferred Place of Death

- Co-ordination of care
  - Reduction in Emergency Admissions/rapid response;
  - Rapid discharge from Hospital
- Improving the quality and experience for end of life care

#### 4. Sepsis: Named Lead and attendance at PLT

The practice demonstrates they have a **named sepsis lead**. Practices will be required to submit name of sepsis lead and demonstrate how they have fulfilled their role (as detailed below). Also, practice to have had clinician **attendance at PLT event**.

The role of the GP practice sepsis lead/link:

- Can be fulfilled by a non-clinical person
- Should consider the breadth of infection prevention control (IPC), not just sepsis
- Should ensure that all relevant colleagues in the practice have done the appropriate sepsis learning that the practice or CCG decides
- Should ensure that sepsis/IPC messages are visible in the practice
- Should be involved in encouraging the use of flu vaccinations of staff and vulnerable groups among patients

**Rationale/Outcome:** The awareness raised would be ultimately intended to improve local outcomes from sepsis such as reduced mortality rates. Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented. The proposed CCG IAF is an opportunity to encourage healthcare professionals to consider sepsis as a cause of deterioration in a patient and to follow NHS England Operational definition of sepsis advice: <https://t.co/PuLeBHW9yU>

#### 5. Flu Immunisation Uptake Rates (population aged under 65 years and at Risk)

Practice to increase immunisation rates in the at risk group (aged <65 years). Achievement will be based on immunisation rates as at 31<sup>st</sup> January 2020 and on a sliding scale with 5p per head of population allocated to each increment (>48% and >53%)

**Rationale** - The CCG is benchmarking below the England average rate and WHO ambition target of 55%. Vaccine uptake ambitions for 2018/19 are below previous year rates. The long-term ambition for eligible adults is that a minimum 55% uptake rate is achieved; therefore, there is an opportunity to improve the uptake rates of flu vaccination to this population group. This will also support the STP and CCG's Long Term Condition programme.

**Outcome** - The programme makes a significant contribution to reducing illness and death from flu. Flu is a major cause of harm to individuals and a key factor in NHS winter pressures. Preventing flu infection through vaccination also contributes to preventing secondary bacterial infections such as pneumonia. This can help reduce the need for antibiotics and contribute towards preventing antibiotic resistance.

#### 7. Diabetes

##### 7.1 Newly diagnosed patients referred to structured education to have a coded outcome of attendance.

Practice to audit and code newly diagnosed patient's outcome of attendance at DESMOND structured education course with view to improve CCG attendance rates in National Diabetes Audit (NDA) and national Improvement Assessment Framework (IAF). The practices will be measured on **>=70%** of newly diagnosed patients from Jan-19 to Dec-19 to have a coded outcome by 31st March 2020.

**7.2 Increase Management of diabetes patients with BP 140/80 – New QOF DM019 (expressed as % of eligible register).** Percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months ) is 140/80 mmHg or less – practice to achieve >78%. The practice should not exceed overall exception reporting rates greater than **10%**. New personalised care adjustment rates should be on sound clinical grounds and not significantly anomalous with peers. Ultimately patients need to be treated rather than removed from the indicator, unless on the basis of unsuitability or informed choices.

**Rationale:** Poor management can be associated with higher risk of the microvascular complications of diabetes (eye disease and blindness; kidney disease and kidney failure; foot disease, foot ulceration and amputation) and higher risk of cardiovascular disease (heart attack, angina, heart failure, stroke, and amputation). As such, NICE recommends



that newly diagnosed diabetes patients are attend a structured education course within 12-months of diagnosis in order to improve understanding, empowerment and self-management of diabetes.

**Outcome:** Whilst diabetes care process delivery and treatment target achievement are recommended in order to both monitor for the onset of diabetes complications and to minimise the risk of onset of diabetes complications, structured education is recommended to support self-management in order to achieve the same goals, as well as to achieve better understanding of the disease and better quality of life with diabetes.

#### **8. GP Online Services - Practice to improve % of Patients with access to their Detailed Coded Record (DCR).**

Achievement will be monitored at year end on a stepped target (>5%, >10% and >15%)

**Rationale:** Supports new 5 year GP Contract requirement “all patients will have **online access to their full record**, including the ability to add their own information, as the default position from April 2020, with new registrants having full online access to prospective data from April 2019, subject to existing safeguards for vulnerable groups and third party confidentiality and system functionality”.

**Resources:** [GP online services communications toolkit](#) support GP practices in promoting GP online services to patients and encouraging them to register for this service.

#### **9. Engagement with CCG’s annual Digital Maturity Survey –** Practices will be required to engage with audit and action plan for improvements to support data quality assurance.

Practices will be supplied with a report from MLCSU team that might highlight areas for improved coding, training in specific areas or adopting new ways of working. Also, with the implementation of SNOMED this will ensure practices are supported with potential complex change. Participation in the survey will provide data quality assurance to the CCG.

**Membership Agreement dispute resolution process****APPENDIX 1**

A dispute resolution process has been developed and the process is described below (approved by Primary Care Committee)

Step 1 - Practices should raise any issues at their earliest opportunity with the Primary Care/Medicines Optimisation team. This could be via email to a member of the Primary Care/Medicines Optimisation team, Locality/Membership Board or through a Quality visit. The Primary Care/Medicines Optimisation team will collate any themes and trends of any potential disputes.

Step 2 - The Primary Care/Medicines Optimisation team will look at whether any support e.g. additional training, further information can be given in order to rectify the issue. Where support is available this should be acted upon by the practice unless the practice can demonstrate/evidence that this is not possible and provide reasons for this.

Step 3 – The primary care/Medicines Optimisation team will raise any issues with the Primary Care Committee to make them aware of potential issues at the earliest opportunity.

Step 4 – At year end the Primary Care/Medicines Optimisation team will produce a report of achievement and this will be issued to practices. Practices will be given 14 days to submit any appeal/dispute. Practices will be given details and a template to complete to outline their appeal and provide supporting information.

Step 5 - A panel will be held outside of PCC committee to consider individual practice appeals and will make final recommendations for PCC sign off. This should include a recommendation and rationale to: 1) Pay in full, 2) Part pay, 3) Not to pay. The panel will consist of a clinician, lay member, a member of primary care team and meds optimisation team (if applicable).

Step 6 - A year-end report of practice achievement and any recommendation/rationale following the appeal panel will be presented to the committee. The Primary Care Committee will review the panel's recommendation and rationale. A decision will then be made to 1) Pay the indicator in full, 2) part pay for that indicator or 3) not pay that indicator based on the information provided.

Step 7 – A member of the Primary Care/Medicines Optimisation team will communicate directly with the practice(s) the decision of the Committee. This should be undertaken within 1 week of the decision being made and be provided in writing to the Practice. The decision of the Committee will be final.

NB – Only payment for the disputed indicator will be withheld until a decision has been made. Payment for all other achieved indicators will be made as expected.

## DATA EXTRACTS

## Appendix 2

Indicator	Data required to support	CC CCG	Data Source
Learning Disability Completeness of Register	LD QOF Register	CCG Aggregated	EMIS
Learning Disability Health Check	LD QOF Register Number of Health Checks Completes (Aged 14+)	Practice Level	EMIS
End of Life - Palliative Care Reg	Palliative Care QOF Register	Practice Level	EMIS
End of Life - DNAR/CRP	Palliative Care QOF Register Number of patient records coded with DNAR/CPR decision	Practice Level	EMIS
End of Life - GSF	GSF Grading's	CCG Aggregated	EMIS
Dementia Face to Face Reviews	Dementia QOF Register DEM001 Number of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months - DEM004	CCG Aggregated	EMIS
Diabetes - Structured Education	DM017 - Diabetes Register Patients Eligible (Newly Diagnosed Jan 2019 to Dec 2019) Patients Referred Coding Breakdown for no outcome/attended or completed /declined - Based on patients newly diagnosed Jan 19 to Dec 19	Practice Level	EMIS
Diabetes - BP 140/80	DM017 - Diabetes Register Patients eligible for DM003 BP Checks DM019 Diabetes BP 140/80 (replaces DM003) Exception reporting numbers/rates Diabetes overall and DM019	Practice Level	EMIS
COPD	Prevalence	Practice Level	EMIS
AF	Prevalence	Practice Level	EMIS
HF	Prevalence	Practice Level	EMIS
Patient Online Management - Detailed Coded Records	NHSD Publications	Practice Level	NHS D
Flu Vaccination - At Risk (under 65 age group)	ImmForm Vaccination Uptake Rates	Practice Level	ImmForm
Active Signposting	Active Signposting (Report is in development with practices)	Practice Level	EMIS
Workflow	Workflow (Report is in development with practices)	Practice Level	EMIS
PPV	Vaccination Rate	Practice Level	EMIS
<b>Indicators with no Data</b>	<b>Achievement Measure</b>		
Membership Attendance	Attendance Log		
Quality Visit	Completed Visit		
Peer Review x 2 and attendance at PLT	Participation on Review and PLT Attendance Log		
Sepsis Lead & Attendance at PLT	Named Lead and Attendance Log		
Engagement with Digital Maturity Survey	Initial engagement /action plan		
<b>Key</b>			
	Membership Agreement Indicator with payment incentive		
	Support data to other indicators or previous indicators/prevalence monitoring or ongoing work areas.		