

# Sheffield Primary Care Quality Contract

1 October 2018 to 31  
March 2020

## Sheffield Primary Care Quality Contract 2018/2020

### 1. OVERVIEW, BACKGROUND and AIMS

Investment in General Practice is needed to meet NHS Sheffield Clinical Commissioning Group's (Sheffield CCG/the CCG) commissioning plan and strategy for Primary Care linked to both the [Sheffield Place Plan](#) and the [Health and Wellbeing Strategy](#) for the city.

Prior to 1st October 2018 Sheffield CCG's investment in local services delivered in primary care settings over and above core contracts (General Medical Services, Personal Medical Services and Alternative Provider Medical Services contracts) is in the form of the [NHS Standard Contract](#) and are referred to as Locally Commissioned Services (LCS). These LCS' have increased over the years in both financial value and scope.

To support investment in capacity and quality in General Practice by providing guaranteed income per patient and incentives for the delivery of city-wide consistent high quality standards; Sheffield CCGs intention is to terminate some of the Locally Commissioned Service and replace with this Quality Contract as a Local Incentive Scheme in the NHS Standard Contract.

The aim of this Quality Contract is to provide a clear set of **Standards** for General Practice in Sheffield which supports:

- increased capacity in General Practice to improve access and the service offered to Sheffield people and set a good baseline for the development of more integrated models of care;
- provision of a more consistent offer to the people of Sheffield irrespective of which practice they are registered with; and
- improved quality of service provision and health outcomes across Sheffield.

The CCG will provide an increasing framework of support for practices to deliver the Quality Contract which will include:

- prescribing support;
- specialist nurse support;
- neighbourhood coordination and liaison support;
- education/CCG events as appropriate;
- development of templates as required;
- visits to discuss progress; and
- publicity and materials about all the **Standards**.

This Quality Contract will continually be developed and reviewed to better support the outcomes noted above and also, where appropriate, expand its scope.

Given this Quality Contract is the first of its kind in Sheffield issued on the 1<sup>st</sup> October 2018 it includes a step change requirement in quality over the initial 18 month period. This step change will potentially include the introduction of further **Standards** within the Quality Contract or the transfer of more current LCS service specifications into the Quality Contract. This will be done over a transition period to support the aims above by 1<sup>st</sup> April 2020.

By April 2020 practices will be expected to offer the full range of services contracted for in the Sheffield Quality Contract - any practice declining will only be allowed to offer core services, remaining individual LCSs and any compulsory enhanced schemes offered nationally.

## 2) SHEFFIELD QUALITY CONTRACT

This Quality Contract is intended to be a rolling arrangement, thus there is no official end date. However, it will be reviewed on at least an annual basis in line with the NHS Standard Contract under which this Quality Contract sits. These reviews may include amending the **Standards**, adding in additional **Standards**, or **Key Performance Indicators** (KPIs) or how achievement of payment against these KPIs is assessed.

Either party may terminate this Quality Contract by giving the relevant notice required under the NHS Standard Contract.

### 2019/20

For the first four **Standards** there is a payment of £4 per patient for a full year based on weighted list size as at 1<sup>st</sup> April 2019.

### Payment Schedule

60% of the contract value will be paid to practices for fulfilling all of the **GP Achievement Criteria** in every section. Please note where a practice does not engage in the **GP Achievement Criteria** in any section the full payment for the Quality Contract will be withheld or recouped where payment has already been made.

The remaining 40% of the payment will be linked to the achievement of the **KPI's**, equating to 10% of the fund per **standard**.

Where a practice achieves:

0-50% of the KPI's achieved in a **standard** they will receive 0% of the payment for the KPIs in that **standard**.

51-74% of the KPI's achieved in a **standard** they will receive 50% of the payment for the KPI's in that **standard**.

75-99% of the KPI's achieved in a **standard** they will receive 75% of the payment for the KPI's in that **standard**.

100% of the KPI's achieved in a **standard** they will receive 100% of the payment for the KPI's in that **standard**.

The financial quarters are as follows:

- **Quarter 1:** April, May, June;
- **Quarter 2:** July, August, September;
- **Quarter 3:** October, November, December; and
- **Quarter 4:** January, February, March.

Payment will be made on a quarterly basis in arrears following notification of achievement in line with current LCS payments.

Wherever possible the CCG will use data that can be extracted automatically using existing processes to assess whether the **KPIs** have been achieved. The CCG will monitor and analyse the quarterly data submitted and the **CCG Lead Contact** for each **Standard** will agree whether the data fulfils the **KPI** requirement for payment. A **pragmatic approach** will be taken to data quality information which may impact on the achievement of Key Performance Indicators. (Note an appeals process is outlined in section 3 (*DISPUTES*) below).

### 3) DISPUTES

Wherever possible, disputes relating to KPIs will be resolved locally by the **CCG Lead Contact, CCG Primary Care Locally Commissioned Service Contract Manager** and the **Provider**.

If this is not possible an appeals process will be available for the Provider to be utilised on an individual practice basis. An appeals template is available on which the Provider will be expected to provide comprehensive evidence to back up their reason for appeal.

Appeals will be considered in the first instance by the **Quality Contract Sub-group** and thereafter, if a solution is not reached, by a sub-group of the **Primary Care Commissioning Committee**.

### 4) THE STANDARDS

#### **STANDARD 1 - TRANSFORMING ELECTIVE CARE**

##### **a) Rationale**

The sustainability of both NHS primary and secondary care providers in Sheffield is under pressure due to an ever increasing demand for services from an aging population, increasing complexity of patient morbidities and a decreasing availability of a skilled and qualified clinical workforce. Patients have not historically been provided with seamless interface between primary to secondary care with the sharing of the patient's care being fragmented between what happens in the GP practice and what happens in the hospital. This **Standard** is designed to transform this for elective care.

##### **b) GP Delivery Criteria**

GPs and practices will be expected to:

- utilise clinical pathways in the care of the patient, ensuring that localised versions are used where these exist;
- utilise locally developed clinical referral templates to support referral letters wherever these exist, ensuring agreed minimum levels of information are provided with the referral;
- send referrals to the Clinical assessment services, education and support (CASES) peer review service wherever the opportunity exists to do so;
- review and act as appropriate to the responses received from the CASES peer review service;
- advise patients, for referrals sent via CASES GPs, that due to new joint working arrangements with the hospital their referral may not result in the need to attend a hospital outpatient appointment, but an alternative path to the same clinical outcome could be provided;

- utilise the Electronic Referral System (eRS) for referrals to the most clinically appropriate service whenever the ability to do so exists;
- familiarise themselves with the range of community services as these are developed and implemented and to direct appropriate referrals to such services;
- input into the development of the community service model for Sheffield via engagement on Locality and Neighbourhood levels;
- actively engage in opportunities to access clinical upskilling and training opportunities, ensuring at least one clinician per practice is able to undertake training via the use of CASES instructional resources; and
- actively signpost patients to appropriate support services in order to assist them in the management of their own healthcare.
- continually change and develop patient care and learn about conditions and their management, alternative pathways, pre-referral investigation or awareness of 2 week wait criteria.
- ensure that all referrals are sent via eRS where there is an opportunity to do so as is nationally mandated.

### **c) CCG Support**

Through PCS the CCG will enable referrals to CASES. There are currently available in 10 specialties (as of September 2018). Sending referrals via the CASES service will support practices by:

- identifying and following the appropriate clinical pathway for the patient;
- providing GPs with clinical information/knowledge based on the GP Peer Reviewer/Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) Consultant Mentor relationship inherent within the CASES referral model;
- onwardly referring patients to the most appropriate secondary care clinic based on information gained from collaborative working with STHFT clinicians;
- directing relevant referrals to appropriate community services;
- providing data and information based on referrals sent to the CASES services in order for practices to engage in the development of new community services;
- providing online and other clinical upskilling and education opportunities based on learning from referrals and the GP Reviewer/Consultant Mentor relationships; and
- identifying patient support signposting opportunities.

In addition the Elective Care Portfolio of Sheffield CCG will:

- publish clinical pathways on the PRESS portal and advise practices via the GP Bulletin when new pathways are available;
- work collaboratively with clinicians and colleagues to continuously develop and implement referral templates to be accessed directly from with the GP practice system (EMIS and SystemOne) and other sources, e.g. PRESS portal;
- provide access to eRS training and support;
- advise practices of opportunities to access upskilling and education based on CASES joint clinical working and across-portfolio working.

### **d) Key Performance Indicators**

- (i) 90% of suitable referrals to be sent via the CASES service (consultant to consultant referrals excluded).  
**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.  
**Method of Measurement:** To be remotely gathered by the CCG's Business Intelligence team
- (ii) 100% of all elective referrals sent via eRS where the opportunity exists to do so.  
**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.  
**Method of Measurement:** To be remotely gathered by the CCG's Business Intelligence team
- (iii) Document three examples where the process of CASES peer review, PLI training or education has resulted in a change to patient care.  
**Timing of measurement:** Minimum of three cases entered onto proforma by the end of Q4.  
**Method of measurement:** Data entered onto Sheffield CCG LCS database via online proforma.

**e) CCG Lead Contact**

Linda Cutter  
Email: Linda.Cutter@nhs.net  
*Elective Care Portfolio*

**STANDARD 2 - PRESCRIBING QUALITY**

**a) Rationale**

The utilisation of medicines is one of the key interventions that Primary Care can make and Sheffield CCG supports high-quality prescribing by local GPs which meets the clinical needs of individual patients. However, the CCG also acknowledges the need to change prescribing behaviour, evidenced by local and national guidelines and facilitate the most cost-effective use of the budget including the reduction of waste.

**b) GP Delivery Criteria**

GPs and practices will be expected to:

- engage with prescribing quality initiatives and participate in the prescribing quality forum
- actively work with the CCG Medicines Management team on areas of quality, Innovation, Productivity and Prevention (QIPP); and
- engage with the polypharmacy and de-prescribing agenda;

**c) CCG Support**

The CCG Medicines Management Team will support practices and prescribers to:

- review trends in prescribing to facilitate improvement and change including reductions in non-adherence and waste;
- review current processes and advise of potential efficiencies which can be made; and
- supply the Practice with appropriate prescribing data and help interpret data

#### d) Key Performance Indicators

- (i) Acknowledge at least 80% of posts within the Prescribing Quality forum per year.  
**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.  
**Method of Measurement:** To be collected remotely by the Medicines Management team following online acknowledgement through the tick-box system.
- (ii) Engagement with a minimum of 3 key Medicines Management Team safety initiatives per year.  
**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.  
**Method of Measurement:** To be collected remotely by the Medicines Management team.
- (iii) Be registered with PQIS by 31<sup>st</sup> March each year.  
**Timing of Measurement:** Annually by the 3<sup>rd</sup> April for approval by the 15<sup>th</sup>.  
**Method of Measurement:** By request of the CCG's Medicines Management team.
- (iv) 50% Percent of Medicines Management Team identified QIPP savings achieved.  
**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.  
**Method of Measurement:** To be collected remotely by the Medicines Management team.

#### e) CCG Lead Contact

Gary Barnfield (Head of Medicines Management)  
 Email: GaryBarnfield@nhs.net  
 Medicines Management Team

### **STANDARD 3 - NEIGHBOURHOOD ENGAGEMENT/PARTICIPATION**

#### a) Rationale

Sheffield CCG is a membership organisation incorporating 80 GP practices (correct as of October 2018) and it is important that there is ongoing engagement with practices around the wider Primary Care at scale neighbourhood developments with other key stakeholders including statutory and voluntary services linked into the priority groups within the local area network.

#### b) GP Delivery Criteria

Practices are required to:

- work with others in the neighbourhood to develop integrated services that will provide improved care and reduce avoidable admissions, particularly for patients with multiple co-morbidities and at higher risk of admission or escalation of care needs;
- work collaboratively with other services and organisations, including the voluntary sector, who work in the same Neighbourhood;
- meet within their neighbourhood and agree their Multi-Disciplinary Team (MDT) patient group establishing priority areas to address, with reference to any particular needs of the population being served. A range of data will be made available to help identify the Neighbourhood priorities;
- hold core MDT per practice meetings to review their agreed patient group and review through shared case studies how care may be delivered better;
- share MDT work/learning at Neighbourhood Steering Groups;
- with other services, review information at a Neighbourhood level regarding health needs, activity and patient outcome measures as these become available; and
- share learning with other Neighbourhoods and participating in events designed to achieve this (each Neighbourhood will be asked to identify a senior managerial and clinical lead for this purpose and to participate in Neighbourhood Learning Network events).

#### c) CCG Support

The CCG Neighbourhoods team will support practices and neighbourhoods by:

- actively assisting in the running and administration of neighbourhood events and meetings.
- sharing best practice with other neighbourhoods and sharing updated guidance when required.

#### d) Key Performance Indicators

- (i) Neighbourhood development tool to be submitted twice yearly identifying priority patient groups and maturity levels.  
**Timing of Measurement:** Biannually with returns by 31<sup>st</sup> August and 28<sup>th</sup> February for confirmation by the 15<sup>th</sup> of October and April respectively.  
**Method of Measurement:** To be returned to the Project Support Officer-Neighbourhoods
- (ii) Neighbourhood representatives to attend 75% of their monthly Neighbourhood Steering Group meetings.  
**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.  
**Method of Measurement:** CCG Neighbourhoods team to monitor attendance register.

#### e) CCG Lead Contact

Sarah Chance (Project Support Officer Neighbourhoods)  
Tel: 0114 3051575  
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*Active Support and Recovery Team*

### **STANDARD 4 – END OF LIFE CARE**

### a) Rationale

The NHS has given a commitment that every person nearing the end of their life should expect a good death which means: attentive, dignified and compassionate care.

Five Year Forward View- NHS England (2014) has developed a 5 year vision for end of life care beyond 2015. This strategy focuses on 'dying well', wherever it occurs, with Primary Care being identified as a key stakeholder.

For people being cared for in community settings, the NHS England Standard Core Contract requires a named accountable GP to take responsibility for the co-ordination of all appropriate services and ensure they are delivered where required to each of their patients.

### b) GP Delivery Criteria

GPs and practices will be expected to:

- identify a Practice End of Life (EOL) Lead who receives annual training / updates; and
- complete the case management palliative care plan / templates for patients identified by the practice as being on the Palliative Care Register.

### c) CCG Support

The CCG will develop and facilitate education sessions around EOL care and communication training. The CCG will use the case studies to feed into the strategic vision for future services and it will identify where there may be unmet needs or where services need to link more closely.

### d) Key Performance Indicators

- (i) Provide access to records of preferred place of care and preferred place of death discussions.

**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.

**Method of Measurement:** Practices to provide number of end of life care discussions as recorded on the end of life care template.

- (ii) Please note for this KPI there are three options for achievement of which only one needs to be met.

*Option 1-* Provide copy of minutes of all the practices MDT End of Life Care meetings for the previous quarter.

**Timing of Measurement:** Quarterly by the 3<sup>rd</sup> of July, October, January and April for approval by the 15<sup>th</sup> of each respective month.

**Method of Measurement:** As requested by the Long Term Conditions Team.

*Option 2-* Provide two case studies per practice to be provided describing the end of life care received by two anonymised patients including the impact of MDT review meetings.

**Timing of Measurement:** Biannually with returns by 31<sup>st</sup> August and 28<sup>th</sup> February for confirmation by the 15<sup>th</sup> of October and April respectively.

**Method of Measurement:** Template to follow to return to the CCG Long Term Conditions Team.

*Option 3-* Complete End of Life Care audit for a calendar year.

**Timing of Measurement:** Annually with returns by 28<sup>th</sup> February for confirmation by 15<sup>th</sup> April.

**Method of Measurement:** Audit template to follow to return to the CCG Long Terms Conditions Team.

**e) CCG Lead Contact**

Karen Danvers (Commissioning Manager End of Life Care)  
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Long Term Conditions Team