NHS
Stoke on Trent

Stoke on Trent CCG Practice Development and Performance

IMPROVING HEALTH OUTCOMES:

Setting aspirational standards in general medical practices in Stoke on Trent

Quality Improvement Framework (QIF) Refresh document 2012 – 13

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This document has been updated by Dr Ruth Chambers and Tracey Cox after consultation with representatives from general practice, public health, health information, practice nursing, CCG localities, LMC. Special thanks to Dr Ian Leese, Dr Max Kalsi, Dr Harald van der Linden, Kellie Johnson, Andrew Harkness, Dr Zafar Iqbal, Jenny Woodfint, and Eunice Foster. This document has also had subsequent approval by NHS Stoke on Trent CCG Executive Group and the Cluster Primary Care Committee.

1. Purpose

This document updates the initial Quality Improvement Framework (QIF) document.[1] Please refer to initial document for details of the scheme for 2012-13 except where sections are updated as below.

2. Context

The Quality Improvement Framework underpins general medical practice in relation to:

- The Clinical Commissioning Group (CCG) culture, priorities and delivery
- Delivery of exemplary primary care which complements core practice, and minimises unwarranted clinical variation and health inequalities
- Revalidation of GPs (from 2012) and other health professionals
- Practice preparation and then registration with the Care Quality Commission (CQC)
- National quality schemes such as quality accounts
- Patient and public involvement and engagement, patient experience
- Strengthening general practice capacity and capability

3. Demonstrating that we are achieving what we set out to do

3.1 Chronic Disease

- Significant improvement in identification of unmet needs through increasing practice prevalence rates which reflects local needs (reduced variation between practices with improved match with predicted prevalence for individual practice populations in selected specific areas i.e. COPD, hypertension, CKD, dementia, asthma, diabetes and heart failure.

- Clear agreement relating to individual practice implementation of best practice for management of long term conditions which include training, appropriate resources allocation by practices e.g. practice nurse time, patient expectations and self care, referral rates and clinical outcomes.

- Specified quantifiable improvement in some long term conditions (see clinical targets)

3.2 Health Promotion

- Significant improvement in health promotion within primary care and a particular focus on smoking, physical activity, obesity and alcohol. Success criteria:

  i) Practice smokers' quit rates

  ii) Brief intervention for alcohol and referrals to specialised services

  iii) Brief interventions offered for physical activity

  iv) Referrals of patients with BMI > 30 in line with Lifestyle Programme strategy and proportion of NHS Health Checks completed for eligible population

3.3 Health Inequalities

a. The CCG as a whole can demonstrate that there has been a significant improvement in the bottom 20% of practices, closing the gap between the 'top'

[1] *Improving Health Outcomes. Setting aspirational standards in general medical practices in Stoke on Trent.* NHS Stoke on Trent. Approved by Trust Board November 2008.

and 'bottom' practices including showing improvement for the middle 60% of practices using a variety of indicators.

b. A clear focus on the extent of support provided to all practices according to their needs.

c. Practices start developing methodologies and approaches to systematically address social issues where it is appropriate for them to do so. This includes recording of social issues (e.g. in work/occupation), pathways to provide interventions for social issues as well as partnership working at a local level with relevant agencies, for instance integrated primary care team pilots.

4. Practice Development and Performance (PD&P) support for learning and development

Figure 1 illustrates the PD&P approach in addressing practices' learning and service needs and the nature of improved outcomes that should result.

Diabetes, chronic heart failure, paediatrics, mental health, atrial fibrillation, cancer, self care, medicines management, telehealthcare and patient experience are the clinical areas prioritised for learning and development support in 2012-13 and a selection of workshops will take place to promote the best practice guidelines that have recently been produced.

We will try to anticipate knowledge, skills and professional behaviour required to deliver Fit for the Future (FfF) pathways and secondary to primary care shift. We will actively interface with CCG localities and their provision of learning & development to ensure that we minimise duplication and optimise a range of learning and development opportunities to match local practitioners' needs.

We will continue to enhance exemplary care in relation to patients with long term conditions (LTCs) – see practice development plan in Appendix 1; example clinical audits in Appendix 2; exemplary standards of care for LTCs in Appendix 3)

We will continue to commission accredited courses and other learning activities to promote effective working for practice managers, practice nurses, GPs and others.

SharePoint will be launched soon in 2012 as a website for hosting clinical and non-clinical templates, policies, protocols and example best practice resources which can be adopted or adapted by practice teams.

Patient and public involvement and engagement

We will build on the contribution of PPGs to planning services in practices in line with the Patient Participation DES by supporting the trial of patient & public involvement in specific clinical areas - COPD, diabetes, hypertension with patient-friendly educational information about quality of care / standards they can expect, so increasing patient expectations and patient engagement.

5. QIF Exemplary standards for long term conditions

The document that accompanied the QIF Refresh document 2011/12 entitled 'QIF Exemplary Standards for long term conditions (LTC) in NHS Stoke on Trent' has been summarised in Appendix 3 to inform practices of the expected standards in relation to the highlighted disease areas and the interventions to include as part of annual reviews for people living with one or more of those long term conditions. For each intervention the document highlights why that intervention is important, how to approach the topic and what to consider to be recorded (although the list provided is not exhaustive).

We will continue to ask practices for evidence that they are seeking to identify patients with previously undiagnosed long term conditions such as COPD, diabetes, hypertension, CKD, dementia, chronic heart failure and asthma, thus increasing their prevalence rates towards predicted levels.

6. QIF standards for tackling significant medical and social problems within NHS Stoke on Trent

The document that accompanied the QIF Refresh document 2011/12 entitled 'QIF standards for tackling significant medical and social problems within NHS Stoke on Trent' illustrated how practices can contribute to the CCG making a positive impact on health inequalities across the health economy. We have summarised the social problem factors as a new focus in the *Summary of indicators with associated points to earn incentives* section (page 7).

7. Assessment format: practice progress

2012-13 assessment: All practices will complete a questionnaire in March 2013 describing progress in practice development plan; with additional CCG/and associated information about practice attainment. A QIF review panel will meet at the end of March 2013 to judge progress for each practice; and if they fulfil the pre-requisites for entry to the next year's QIF.

The core focus of the assessment will be on:

1. Management of chronic diseases, which includes prevalence as well as providing the right interventions and clinically related QOF data
2. Workforce data
3. Public Health lifestyle interventions for smoking, alcohol, obesity and physical activity
4. Redressing health inequalities and associated social issues
5. Access and the patient perspective
6. Screening such as Cervical Cytology and Vaccinations and Immunisations uptake.
7. Practice Development Plan achievement for the set standards
8. QIF clinical targets
9. QIF / equivalent clinical audits

The indicators below will be used within scope of review of practice progress in QIF end 2013 – which if not met might preclude individual practice's progression into QIF beyond 2013 (providing that the QIF LES is extended beyond March 2013) (unless apparent service gaps can be justified). Indicators are mapped to the NHS Outcomes Framework's domains.

NHS Outcomes Framework 6 domains*:

1) Preventing people from dying prematurely
2) Enhancing quality of care for people with long term conditions
3) Helping people recover from ill health or following injury
4) Ensuring people have a positive experience of care
5) Treating and caring for people in a safe environment and protecting them from avoidable harm
6) Re-dressing health inequalities

(* the sixth domain listed here reflects the Public Health Outcomes Framework)

Indicators	NHS Outcomes Framework domain
Progress with agreed 16 items in Practice development plan- against agreed milestones for core, best practice and exemplary activities and including measuring best practice for long term conditions.	1, 2, 3, 4, 5,6
Progress with core & best practice/exemplary standards: focus on indicative 'criteria' for Care Quality Commission (CQC) domains (revised as CQC domains and associated criteria are refined, higher/tighter 'exemplary' levels as necessary)	1, 2, 3, 4, 5, 6
Progress against clinical targets, clinical audits	2, 3, 6
Staffing levels: extent of GP WTE; nursing WTE, support staff WTE.	1, 2, 3, 4, 5
Prevalence: comparison against indicative levels for specific chronic diseases: (i) predicted prevalence rates and (ii) can demonstrate how practice has attempted to increase prevalence rates for any long term conditions (measured via QOF) where practice is below a required ratio.	1, 2, 6
Public health: quit smoking league tables; interventions for alcohol misuse; numbers NHS Health Checks done; vaccinations/ immunisation rates	1, 2, 6
Efficient and effective use of secondary care resources: first OP referrals, unplanned hospital admissions, A & E frequent attendees.	3, 6
Data re patient experience e.g. patient reported information re access	4, 6
Cervical screening	1, 6

We may utilise the facility for undertaking a SNAP shot survey with Health Intelligence team to determine progress in care of long term conditions by analysing data from practice records in respect to annual reviews etc.

8. Exemplary payments 2013- 4 (if the QIF continues)

Practices eligible for the QIF will continue to receive their fair share of one third of a total £1.3million 'upfront' to allow provision of additional staff time to deliver the QIF standards, providing QIF continues to be commissioned by the CCG/Primary Care. We expect practices to review and audit each of two of the practice's own clinical protocols (selected from COPD, asthma, hypertension, diabetes, CKD, dementia, atrial fibrillation, chronic heart failure). It must be clear that at least one GP and practice nurse has reviewed or written the protocol, that it is based on NICE guidance or equivalent best practice. A clinical audit must have been undertaken including at least 20 patients; with subsequent logged practice discussion, revision of clinical protocol (if needed) and practice action plan – with logged completion of actions.

The exemplary upfront payment for 2013-4 will be reduced by the following amounts if there is inadequate delivery for following areas as assessed end of year 2012-3:

- 10% reduction if clinical protocols not reviewed/audited as above
- 7.5% reduction in upfront payment for actual prevalence is < 70% predicted prevalence for each of COPD, CKD, diabetes, hypertension (according to National Public Health Observatory figures) –unless a practice specific audit is accepted as demonstrating why actual prevalence rates are lower than expected.
- 32% for lack of adherence to Year 4 standards in the 16 items of the practice development plan (2% each item)
- 10% if practice team do not refer at least 2: 1000 FSLS of patients to alcohol support services (who have an AUDIT C score of ≥5) in 2012-3, or can present an audit showing why fewer numbers were justified (e.g. demographics, patients offered referral but refused)

9. Clinical targets for QIF 2012/13

We will maintain the majority of indicators. A number of indicators have been removed to reflect QOF changes and practice achievement. These have been replaced with new areas such as clinical audit of people with diabetes who have an HbA1c >86 mmol/mol and self management plans for children with asthma.

It is an agreed principle that there will be no double-paying in terms of the QIF clinical targets against other National or Local incentivised initiatives and therefore if something is introduced during 2012/13 that indicates there is double-paying, then the original indicator will either need to be deducted or be replaced by an alternative indicator.

Summary of indicators with associated points to earn incentives

Practices achieving clinical aspirational standards in specific clinical fields (as follows) will receive incentives that recognise higher standards of performance than is covered by QoF or LES payments. Please note that we offer 122 points overall (based on weighted list size) in the expectation that some practices will attain the aspirational standards in Year 4; whilst other practices will attain no points or partial points. But individual practices will be capped at a maximum of 110 points each for payment purposes.

Prevalence

If a practice is identified as an outlier in terms of disease prevalence for a particular condition then they may be required to undertake an audit to demonstrate either that their register is robust or that the prevalence is appropriate for the demographics of the population.

Exception reporting

The PD&P team will introduce reasonable restrictions on exception reporting for the clinical aspirational fields in line with best practice and what is realistically attainable for a population such as that in Stoke on Trent.

Blood pressure target standards

Practices will be assessed on the last 2 BP readings in the previous 15 months. BP should be taken regularly for the individual patient, their condition and clinical needs. However if checks undertaken by the CCG reveal that a practice is purposely not coding blood pressures due to them not being in target or purposely not seeing patients to assess blood pressures then the CCG may withhold payment for the standards to which these relate.

Data collection and using CHART

The clinical targets data is collected via MIQUEST queries and CHART. The only exception to this is for diabetes 5 where an audit will be required.

Practices are encouraged to use the CHART software to run searches and view results for the QIF indicators on a regular basis. Training on the CHART software and running QIF queries is available from your Locality Analyst if required. In order to demonstrate that the practice is able to use the CHART software and run QIF queries there will be a requirement to email a summary of results to Tracey Cox in September 2012. Full instructions on how to create the summary will be sent to practices in August.

10. Clinical domains

CHD

	Indicators	Targets	Points
1.	Percentage of patients with CHD with at least one measured total cholesterol (in previous 15 months) is ≤ 5 mmol/l	≥90% Year 4	2
2.	Percentage of patients with coronary heart disease in whom at least two blood pressure readings (in previous 15 months; at least 4 months apart) are ≤140/90 mmHg	≥50% Year 4	2

Hypertension

	Indicator	Target	Points
1.	Percentage of patients (aged up to 80 years old) on hypertension disease register in whom at least two blood pressure readings (measured in the previous 15 months; at least 4 months apart) are ≤140/90 mmHg	≥ 40% Year 4 ≥ 50% Year 4 ≥ 60% Year 4	5 10 10 i.e. 25 in total

Stroke / TIA

No	Indicators	Targets	Points
1.	Percentage of patients with a history of TIA or stroke in whom at least two blood pressure readings (measured in last 15 months; at least 4 months apart) are ≤ 140/90 mmHg	≥60% Year 4 ≥70% Year 4	2 3

Diabetes

No	Indicators	Targets	Points
1.	Percentage of patients with diabetes in whom HbA_{1c} measurement < 59 mmol/mol in previous 15 months; including those from minority ethnic groups with diabetes	60-80% threshold Year 4	13
2.	Women with gestational diabetes* (diagnosed prior to 1st April 2011) offered lifestyle advice (including weight control, diet and exercise) and fasting plasma glucose measurement undertaken annually	≥90% Year 4	2
3.	Percentage of people with diabetes who have a self management plan updated annually	≥70% Year 4	6
4.	Percentage of patients with type 2 diabetes in whom the last recorded cholesterol, measured in the last 15 months, is ≤4mmol/l	≥ 25% Year 4	2
5.	Provide an audit and re-audit after 6 months of 2 patients per 1000 FSLS with diabetes whose HbA1c is >86 mmol/mol between April – September 2012 (or all patients in this group at end September 2012 if this is fewer than 2/1000 FSLS) (a template will be provided)		4

*Please note that practices can still provide this care annually even if a practice team did not undertake the initial assessment at a postnatal check > 1 year ago

CKD stages 3, 4, 5

	Indicators	Targets	Points
1.	Percentage of patients on the CKD register who have a record of an ACR test in the previous 15 months	≥ 90% Year 4	6
2.	Percentage of patients under 80 years on the CKD register in whom at least two blood pressure readings, measured in the previous 15 months, at least 4 months apart are ≤130/85 mmHg	≥40% Year 4 ≥50% Year 4	4 +2 i.e. 6points in all

COPD

No	Indicators	Targets	Points
3.	Percentage of people with COPD who have a self management plan updated annually.	≥70% Year 4	6

ASTHMA

No	Indicators	Targets	Points
1.	Percentage of people with asthma who have a self management plan updated annually.	≥70% Year 4	6
2.	Percentage of children (aged between 5 – 16 years old) with asthma who have a self management plan updated annually.	≥ 30% Year 4	5

PAD

No	Indicators	Targets	Points
1.	Percentage of patients with peripheral artery disease in whom at least two blood pressure readings (measured in last 15 months; at least 4 months apart) are ≤140/85 mmHg	≥70% Year 4	2

Falls

No	Indicators	Targets	Points
1.	Patients ≥ 75 years old have a record of having been asked about the number of falls they have sustained in the last year	≥ 30% Year 4	2
2.	Screen patients ≥ 75 years old (whether or not have history of falls) for likelihood of falls via agreed CCG Falls assessment tool and pulse rate/rhythm recorded for patients in the last 15 months.	20% ≥ 75 yrs old Year 4 30% ≥ 75 years old Year 4	3 +3 i.e. 6 points in all

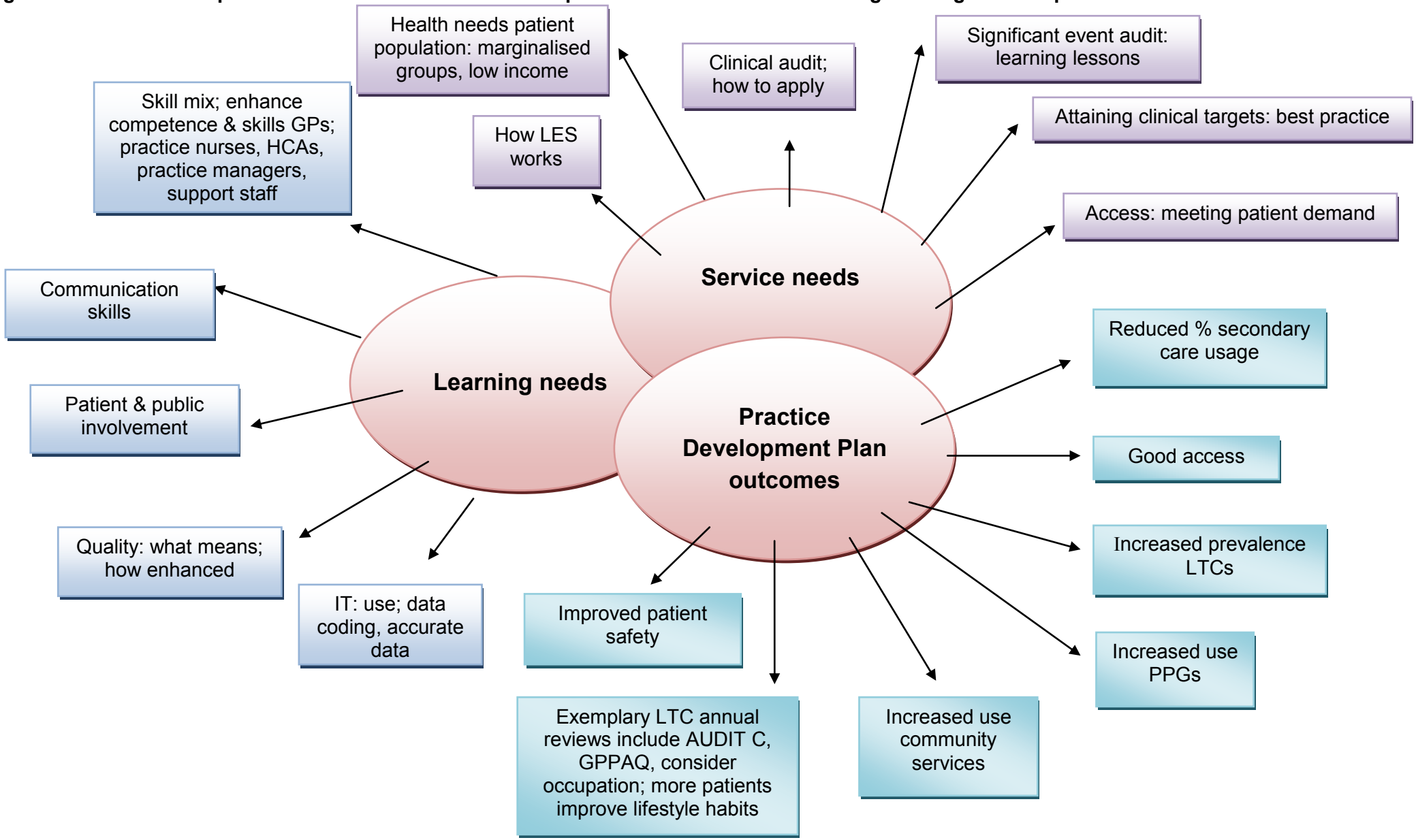
Obesity: 18-39 year olds

	Indicators	Targets	Points
1.	Proportion of patients who have a BMI>30 who have physical activity levels assessed using GPPAQ, AUDIT C, plasma glucose and BP recorded in last three years	≥40% Year 4	8
2.	Percentage of Asian patients ≥ BMI 27 who have physical activity levels assessed using GPPAQ, AUDIT C, plasma glucose and blood pressure recorded in last three years	40% Year 4	4

Alcohol

	Indicators	Targets	Points
1.	Alcohol status assessed at annual reviews of patients with CHD, diabetes and hypertension using the AUDIT C tool on adults≥ 18 years	≥70% Year 4 ≥85% Year 4	5 +5 i.e. 10 points in all

Figure 1 Practice Development and Performance role and responsibilities for 2012-13: meeting learning & development needs



Appendix 1- Practice Development Plan 2012/13 onwards

#	Class-ification[1]	Standards	1. Achieved 2. Partially 3. Not	Year 1 2009/10	Year 2 2010/11	Year 3 2011/12	Year 4 2012/13	Final Target
Workforce and workload								
1	A	The practice employs the appropriate numbers of GPs and practice nurses, and the overall balance (excluding Registrars and student nurses etc) in appropriate				Staffing to be provided by practices in February 2012 as part of the QIF end of year assessment questionnaire.	Staffing to be provided by practices in February 2013 as part of the QIF end of year assessment questionnaire.	Weighted list size* per WTE GP plus one third WTE Practice Nurse is under 2000
2	A	The practice employs the appropriate numbers of managers, administrators and receptionists				Staffing to be provided by practices in February 2012 as part of the QIF end of year assessment questionnaire.	Staffing to be provided by practices in February 2012 as part of the QIF end of year assessment questionnaire.	Weighted list size* per WTE support staff is under 900
3	B	Clinical staff (GPs, Nurses and HCAs) in the practice have been trained in and deliver brief interventions for smoking, obesity, alcohol and physical activity; or local referral services are used appropriately				80% of clinical staff in the practice are trained Either brief intervention PCT approved training OR alternative equivalent	100% of all clinical staff in the practice are trained Either brief intervention CCG approved training OR alternative equivalent	Brief interventions for smoking, alcohol and physical activity and offered and delivered

[1] A = Basic GMS; B = Good Practice; C = Exemplary practice

#	Class-ification[1]	Standards	1. Achieved 2. Partially 3. Not	Year 1 2009/10	Year 2 2010/11	Year 3 2011/12	Year 4 2012/13	Final Target
4	B	The ethnicity of at least 80% of the practice's patients is recorded						80% recording of ethnicity
Access and availability								
5	A	The practice conducts an appropriate number of GP appointments in surgery				Consultation figures to be provided for February 2012 as part of the QIF end of year assessment questionnaire	Consultation figures to be provided by February 2013 as part of the QIF end of year assessment questionnaire	At least 270 appointments (face to face) with either GP or nurse per 1000 weighted patient* list size per month
6	A	The practice conducts an appropriate number of all face-to-face patient contacts (surgery, visits etc)				Consultation figures to be provided for February 2012 as part of the QIF end of year assessment questionnaire	Consultation figures to be provided for February 2013 as part of the QIF end of year assessment questionnaire	At least 350 appointments (face to face, home visits, telephone, telehealth consultations, e-mail consultations) with either GP or Nurse per 1000 weighted patient* list size per month
Clinical								
7	B	The practice has a policy for the follow up of patients after hospital discharge; and it follows this policy		Agree and write a practice policy for patients discharged		Implement and audit the implementation of the policy	Audit the implementation of the policy	On discharge from hospital, patients are followed up appropriately
8	C	The practice's prevalences for diabetes, CHD, asthma, heart failure, Stroke/TIA, hypertension, COPD, hypothyroidism, obesity and smoking are appropriate to its population characteristics. Indicative prevalence targets will be set by the CCG based on local epidemiology and what can realistically be achieved by best practice.		Year 1 minimum prevalence target is met or can justify why the target is inappropriate. Audit to demonstrate % correct coding	Year 2 minimum prevalence target is met or can justify why the target is inappropriate Audit to demonstrate % correct coding	Year 3 minimum prevalence target is met or can justify why the target is inappropriate Audit to demonstrate % correct coding	Year 4 minimum prevalence target is met or can justify why the target is inappropriate Audit to demonstrate % correct coding	The practice achieves the year 4 minimum prevalence targets or can justify why the target is inappropriate Audit to demonstrate % correct coding and register validation

#	Class-ification[1]	Standards	1. Achieved 2. Partially 3. Not	Year 1 2009/10	Year 2 2010/11	Year 3 2011/12	Year 4 2012/13	Final Target
				and register validation	and register validation	and register validation	and register validation	
9		The practice are meeting exemplary standards for clinical management of LTCs , supporting lifestyle change interventions and personalised plans (see QIF Refresh document)				Practice provides an audit around a chosen LTC standard with at least 20 patients reviewed – further guidance to be provided.	Audit to be provided. Further guidance to be provided for the Year 4 requirements	
10		The practice has a coherent approach to addressing lifestyle issues to all groups (other than those with LTCs and health check populations)				Practice has a plan to address lifestyle issues (including breast feeding) in general	Further guidance to be provided for the Year 4 requirements	
11	B	The practice can show that its use of exception codes in QIF is appropriate and does not exceed the minimum set by Primary Care or can justify why the rate is higher than the minimum for the QIF areas		Practice exception reporting is at the baseline PCT means	Practice exception reporting meets year 2 targets	Practice exception reporting is less than the national mean for all QOF areas.	Further guidance to be provided regarding the year 4 target in due course.	The use of exception codes is clinically appropriate and is less than the national mean for all QOF areas.
12	C	The practice has a comprehensive plan that includes measuring smoking prevalence, conducting and monitoring brief interventions, accessing referral pathway training run by PH, routinely referring smokers who wish to quit to the hub.		Practice Development and Performance team will measure number of patients entering service then quitting, then set a target.	Practice Development and Performance team will measure number of patients entering service then quitting, then set a target	Practice Development and Performance team to monitor smoking prevalence and number of brief interventions and PH will monitor referrals to hub, quit dates set	Practice Development and Performance team to monitor smoking prevalence and number of brief interventions and PH will monitor referrals to hub, quit dates set	Practices have a comprehensive plan that includes measuring smoking prevalence, conducting and monitoring brief interventions, accessing referral pathway training run by PH, routinely referring smokers who wish to quit to the hub.

#	Class-ification[1]	Standards	1. Achieved 2. Partially 3. Not	Year 1 2009/10	Year 2 2010/11	Year 3 2011/12	Year 4 2012/13	Final Target
13	C	The practice should act to reduce inequalities.		Practice Development and Performance team will produce guidance on best practice to reduce inequalities and provide services for hard to reach groups. E.g. winter warmth initiative, citizen's advice bureau referrals etc. The practice has a plan to address inequalities and provide services for hard to reach groups.			See QIF Refresh document	The practice achieves improved outcomes for vulnerable groups with complex medical and social problems.
14	B	Emergency hospital admission rates are appropriate				Peer practices agree work plan completed satisfactorily for QP indicators 8-10 for unplanned admissions	Practice demonstrates at least 5% fewer unplanned admissions for the clinical fields selected for QP indicators 8-10 in 2011-2 or can justify why not	Levels of non-elective admissions are appropriate
Patient information and involvement								

#	Class-ification[1]	Standards	1. Achieved 2. Partially 3. Not	Year 1 2009/10	Year 2 2010/11	Year 3 2011/12	Year 4 2012/13	Final Target
15	B	The practice has a policy for supporting and developing self-care; including use of self-management plans, information prescriptions and links with the Expert Patient Programme		Agree a practice policy on self care		Implement and monitor that policy	Monitor that policy Practices also introduce measures to raise expectations of LTC condition reviews	Patients are given information, education and support to take appropriate responsibility for their own care
16	B	The practice undertakes patient surveys; collates suggestions from patients; and considers/acts on the findings		The practice agrees a plan for surveying patients (including patient surveys by the GPs to meet the requirements of revalidation)	The plan on surveys is implemented and the results discussed and acted on	The plan on surveys is implemented and the results discussed and acted on	The plan on surveys is implemented and the results discussed and acted on	The practice uses patient views and feedback to improve its services and care

Appendix 2 Example clinical audits

Examples that practices may undertake in association with review of clinical protocols

1. Clinical Audit of CKD in general practice

Undertake a clinical audit to check whether you are delivering consistently good care for people with, or suspected of having, CKD – matched against the quality standards for CKD[1] that are relevant to general practice care. These include:

- People with risk factors for CKD are offered testing; and people with CKD correctly identified.
- People with CKD who may benefit from specialist care are referred for specialist assessment in accordance with NICE guidance.
- People with CKD have a current care plan appropriate to the stage and rate of progression of CKD.
- People with CKD are assessed for cardiovascular risk.
- People with higher levels of proteinuria, and people with diabetes and microalbuminuria are enabled to safely maintain their systolic blood pressure within a target range 120-129 mmHg and their diastolic blood pressure below 80mmHg.
- People with CKD are assessed for disease progression.
- People with CKD who become acutely unwell have their medication reviewed, and receive an assessment of volume status and renal function.
- People with anaemia of CKD have access to and receive anaemia treatment in accordance with NICE guidance.
- People with progressive CKD whose eGFR is less than 20 ml/min/1.73m2, and/or who are likely to progress to established kidney failure within 12 months, receive unbiased personalized information on established kidney failure and renal replacement therapy options.
- People with established renal failure have access to psychosocial support (which may include support with personal, family, financial, employment and/or social needs) appropriate to their circumstances.

Aim

To improve the management of patients diagnosed with CKD stages 3A and 3B in general practice.

Standards

Stated best practice in control of blood pressure and minimising deterioration of CKD for people with correctly classified atages 3A or 3B CKD[2,3]

Criteria[3]

1. Controlled blood pressure – systolic < 140 mmHg and diastolic < 90 mmHg (at least)
2. Controlled blood pressure – sustained systolic < 130 mmHg and diastolic < 80 mmHg (best practice)
3. ACE Inhibitors / ARB prescribed to patients with CKD stages 3 – 5 and an ACR reading > 30mg/mmols
4. UACR checked every 12 months
5. Patients with an ACR of >70mg/mmol referred for specialist treatment

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[2] NICE. *Early identification and management of chronic kidney disease in adults in primary and secondary care*. NICE guidance CG73, 2008. http://guidance.nice.org.uk/CG73

[3] Please see Table 1 for brief summary of best practice guidance.

6. Patients' eGFR measured every 6 months

Method

All patients (18 years old and over) with a diagnosis of CKD (stages 3A, 3B) will be identified from the practice CKD register (n=x). Should your practice population be ≥ 5000 patients, a random sample of 30 patients should be selected for inclusion in the audit and should your practice population be <5000 patients, a random sample of 20 patients should be selected for inclusion in the audit.

Retrospective data will be collected from the practice computer system by a member of the practice team and recorded onto a data collection form (see attached). You might undertake the initial search for all patients with CKD stages 3A or 3B by computer search; identify 20 or 30 patients by random selection via use of Excel spreadsheet; or other means – then complete a form per patient in manual way as the data collection is complicated with so many different features per patient.

A practice might prefer to undertake a series of computer searches and include **all** patients on the CKD disease register with CKD Stages 3A or 3B to collect data over a specific time period:

1. All patients (with CKD Stages 3A, 3B): blood pressure
    a. when last done; whether <140/90 mmHg
    b. further search on patients with ACR ≥ 70 mg/mmol to see what proportion of patients have BP < 130/80 mmHg

2. All patients (with CKD Stages 3A, 3B) : eGFR
    a. when last done; whether within range 30-60
    b. further search to determine if correct coding of CKD Stage

3. All patients (with CKD Stages 3A, 3B): ACR
    a. when last done; whether < 30; ≥ 30; ≥ 70
    b. further search for sub section of patients who also have diabetes and microalbuminuria to determine if on ACE/ARB medication
    c. further search of sub section of patients with ACR ≥ 30 mg/mmol to determine if on ACE/ARB medication

4. All patients (with CKD Stages 3A, 3B): AUDIT C tool done in last three years?

Prevalence

Identify prevalence of CKD in the practice and compare it with your PCT average which is 3.5% for 2009 / 2010. (Undertake additional audit as appropriate to check that patients classified as having stages 3A or 3B are correctly coded according to best practice guidance.[1,2])

Analysis Plan

1. How does practice CKD prevalence compare with PCT prevalence? Any further action needed to check that patients correctly coded; identify other currently undiagnosed patients with CKD Stages 3A or 3B?

2. Was the blood pressure checked in the last 6 months for all patients with CKD Stages 3A, 3B?

3. What percentage of the last two (or you might select last one) blood pressure readings were < 140/90 mmHg?

4. What percentage of patients with diabetes or with ACR ≥ 70 mg/mmol had last blood pressure reading < 130/80 mmHg?

5. In what proportion of cases where patient had diabetes (and microalbuminuria) or patient has ≥ ACR of 30 mg/mmol was the patient prescribed ACE inhibitors or ARB?

6. In what proportion of patients was the ACR checked in the last 6 months?

7. In what proportion of patients was their eGFR checked in the last 6 months?

8. What proportion of patients had an Audit C check in the last 6 months?

9. Were there any patients incorrectly classified as having Stages 3A or 3B who actually had CKD stage 4 or 5 and had not already been referred to/under a renal specialist?

Review and Action Planning
Present the results at a practice meeting and devise an action plan after discussion (template attached). One of the actions should include the necessity to carry out a re-audit, set time for re-audit to complete the audit cycle.

Individual Care Plan

People with CKD should have a current agreed care plan appropriate to the stage and rate of progression of CKD. A care plan incorporates the provision of information on diagnosis and prognosis, multidisciplinary support, education for self care and how future care will be provided. It places emphasis on person-centred care and shared decision-making. A care plan is a process and may take a written, verbal or electronic form to include the following:

- People should feel informed about what CKD is and how it affects them, what they need to do and why it is important for them to do this.
- Treatments available for CKD, and their advantages and disadvantages.
- Complications or side effects that may occur as a result of treatment or medication.
- What people can do to manage and influence their own condition.
- Information about the ways in which CKD and the treatment may affect people's daily life, social activities, work opportunities and financial situation, including benefits and allowances available.
- Information about how to cope with and adjust to CKD and sources of psychological support.
- Drugs that should be used with caution or at reduced dose in people with CKD.

A care plan is current and agreed when it relates to the most recent care delivered as well as forthcoming care that is planned, and when it reflects ongoing shared decision-making between healthcare professionals and the person with CKD.

Annual Review

People with CKD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes the appropriate tests/checks described in the analysis plan above and comorbidities. It is the responsibility of the practice to ensure that the member of staff undertaking the annual review and agreeing the individual care plan is competent and appropriately trained.

Table 1
Standards in best practice guidance for CKD with which to compare your practice's audit findings

Stage CKD on practice disease register	**Prevalence** **PCT average =**	**Blood pressure check in last 6 months?**	**Was it < 140/90?** **Was it < 130/80?**	**On ACE/ARB**	**Urine ACR check in the last 12 months?**	**ACR** **reading**	**eGFR check** **in last 6 months?**	**eGFR level fit how Stage classified on disease register?**	**Audit C check done**	**Referred to/under renal specialist?**
Stage 3A	Your latest QOF prevalence	√	Aim for < 130/80 mmHg	Yes if ACR≥ 30 mg/mmol or has diabetes	Annual test if no proteinuria last time	Aim low ie < 30 mg/mmol	6 monthly	45-59	√	
Stage 3B		√					6 monthly	30-44		
Stage 4		√					3 monthly	15-29		√
Stage 5		√					6 weekly	<15		√
Total that conform to standards	Add comments- are you low or okay?	What % of patients had BP checked in practice or hospital?	Do % <140/90 and % <130/80	What % are on ACE/ARB Rx with ACR ≥ 30 mg/mmol	What % had at least annual check ACR?	How many have ACR ≥ 30 mg/mmol?	What % had eGFR in last 6 months?	How many patients with CKD are classified correctly as to Stage?	How many has AUDIT C check done in last year?	Any patients with Stages 4 or 5 CKD not referred to or under care renal specialist?

2. Audit of use of spirometry and clinical management of people with COPD

Number of patients on COPD register –
Practice prevalence: How does practice prevalence compare with PCT average?

Aim

To ensure that spirometry is being interpreted in the diagnosis of COPD, and that clinical management matches best practice.[7]

Standards

1. Spirometry should match quality assured practice as in national guidance[4] (see www.brit- thoracic.org.uk).
2. Clinical management of COPD matches local/national guidance.

Criteria

1. Patients are classified as having COPD and graded as to severity on the basis of history, examination and confirmation by spirometry of airflow obstruction.
2. Patients who need it are referred for pulmonary rehabilitation.
3. The likelihood of exacerbations is reduced by the appropriate use of inhaled corticosteroids and bronchodilators, and vaccinations so that hospital admissions are minimised.
4. Practice is within 10% of expected prevalence predicted by the PCT for practice population.

Method

Complete the template below for at least 20 patients with COPD taken at random from your COPD disease register.

[4] NICE. Chronic obstructive pulmonary disease. CG101. London: NICE, 2010. www.**nice**.org.uk/*copd guidelines*

Patient ID: ..... Age: ..... ☐ Male ☐ Female

Step 1: Complete table for each patient	
SPIROMETRY	
1) Is there evidence that the patient has ever had spirometry?	☐ Yes ☐ No *(Go to Q6)* ☐ Patient Exempted *(Go to Q6)*
2) When was the last spirometry?	☐ ≤ 6 months ☐ ≤ 1 year ☐ ≤ 2 years ☐ > 2 years Date: ☐ Never
3) Please indicate the most recent readings:	FEV1 % predicted ..... & FVC % predicted ..... & FEV1/FVC ..... OR FEV1/FVC% ..... OR FEV1%..... ..... OR FEV1/FVC Base *(reading off graph)* ..... FEV1 ..... FVC ..... ☐ No readings found
4) Has the COPD been recorded as[1]?	☐ Mild ☐ Moderate ☐ Severe ☐ Not recorded *(Go to Q5)*
5) Do the graph curves suggest there may be a problem with the spirometry technique?	☐ Yes ☐ No ☐ No graph *(Go to Q6)*
a) Do the records contain a graph which allows detailed verification of readings?	☐ Yes ☐ No *(Go to Q6)*
b) If Yes to Q6a, are there 3 consistent graph readings?	☐ Yes ☐ No
c) If Yes to Q6b, are there 2 readings within 5%?	☐ Yes ☐ No
6) Has a reversibility test been undertaken?	☐ Yes ☐ No
EXACERBATIONS	

7) How many exacerbations in last 12 months:	State: .....
a) How many exacerbations in last 12 months were managed by GP / PN without admission?	State: .....
8) How many respiratory related admissions/COPD exacerbations in last 12 months?	State: .....
9) How many respiratory related admissions/COPD exacerbations in the last 12 – 24 months?	State: .....
OXYGEN	
10) Has the patient been assessed using pulse oximetry?	☐ Yes ☐ No
a) If Yes, state result:	☐ ≤ 92% ☐ > 92%
PULMONARY REHABILITATION	
11) Has the patient been referred for pulmonary rehabilitation?	☐ Yes ☐ No
a) If Yes, describe outcome (if known)	
ACTION NEEDED	
12) Any changes required to clinical management?	☐ Yes ☐ No
a) If Yes, what?	

Step 2 Collate summary & add comments	
1.In how many patients was there evidence that the patient has ever had spirometry?	
2. How many have had spirometry in last 15 months?	
3. In how many were you content with the spirometry tracings?	
4. In how many patients has COPD been recorded as (i) mild, (ii) moderate, (iii) severe[1]?	(i) (ii) (iii)
5. In how many patients do graph curves suggest there may be a problem with the spirometry technique?	
6. In how many patients was a reversibility test been undertaken?	
7. In how many patients were COPD exacerbations in last 12 months managed by GP / PN without admission?	
8. How many patients had respiratory related admissions/COPD exacerbations in (i) last 12 months; last 12 – 24 months?	
9a. How many patients have been assessed using pulse oximetry? 9b. How many of these ever had oxygen saturation ≤ 92%?	a. b.
10. How many patients were referred for pulmonary rehabilitation?	

Individual Care Plan

People with COPD have a current individualised comprehensive management plan, which includes high-quality information and educational material about the condition and its management, relevant to the stage of disease.

This might include:

- disease education (anatomy, physiology, pathology and pharmacology, including oxygen therapy and vaccination)
- dyspnoea/symptom management, including chest clearance techniques
- smoking cessation
- energy conservation/pacing
- nutritional advice
- managing travel
- benefits system and disabled parking badges
- advance directives (living wills)
- making a change plan
- anxiety management
- goal setting and rewards
- identifying and changing beliefs about exercise and health-related behaviours
- exacerbation management (including when to seek help, self-management and decision making, coping with setbacks and relapses)
- home care support
- support groups - such as the British Lung Foundation Breathe Easy groups, which operate throughout the UK

People with COPD should have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness,

frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and comorbidities.

People with very severe COPD reviewed in primary care should be reviewed at least twice a year.

A comprehensive clinical and psychosocial assessment should include:

- body mass index
- degree of breathlessness (using for example, MRC dyspnoea score)
- frequency and severity of exacerbations
- health status (using for example, the COPD assessment tool [CAT] or St George's respiratory questionnaire [SGRQ])
- prognosis (using for example, the BODE index, DOSE or ADO index)
- presence of hypoxaemia and possible need for oxygen therapy
- presence of comorbidities
- psychological assessment for anxiety and depression (using for example the Hospital Anxiety and Depression Score [HADS])
- need for pulmonary rehabilitation
- need for referral to specialist and therapy services
- inhaler technique
- smoking status and desire to quit
- post-bronchodilator spirometry.

It is the responsibility of the practice to ensure that the member of staff undertaking spirometry, annual review and agreeing the care plan is competent and appropriately trained.

Appendix 3 Exemplary standards for care of patients with a long term condition (LTC)

Andrew Harkness (Public Health Specialty Registrar), Dr Zafar Iqbal, Dr Max Kalsi

The standards for QIF are in addition and distinct to those stated in the national QOF. These are expected to be considered within all clinical consultations in general practice, tailored to the needs of the individual to provide high standards of care:

- The level of training of the personnel who undertake an annual review (or equivalent) needs to be appropriate for the tasks/interventions, for example, spirometry, BP monitoring, blood tests. It is expected that individual GP practices ensure that relevant training standards are met and courses are attended, including obtaining relevant certification (where necessary) by participating staff. Training may include in-practice training, online resources, local or national guidelines.
  This should be demonstrated through accurate recording in patient's notes of interventions undertaken and by whom, which may be subject to peer review.

- The time required for a thorough annual review (or equivalent) will vary by condition, level of complexity (including presence/absence of other co-morbidities) and level of experience of member of staff. A specific mechanism of measuring consultation time is not appropriate for the reasons outlined above. However, GP practices are required to ensure that all appropriate interventions are accurately recorded for the particular LTC(s) in line with requirements of local (for example, best practice guidelines) or national guidance (for example, NICE). This ensures that sufficient consultation time has occurred for the individual patient over the preceding 12 month period.
  Audits of the percentage of patients with full records of interventions over the preceding 12 months can demonstrate adherence.

- Every patient living with one or more of LTC needs to have a care plan in place. This needs to clearly state what actions both the patient and GP practice intend to implement over the forthcoming 12 month period (dates need to be clearly defined) and be mutually agreed. Each practice should have a 'practice charter' for patients with a long term condition and publicise it to the practice population. The charter could be developed through the patient group attached to the GPCC in Stoke and implemented by GP practices.
  This may be measured through the percentage of people with a particular LTC having a current care plan in place. This can be audited through reviewing patients with one of the LTCs and the percentage of patients with a care plan in place and assessment of the quality of the care plan itself.

Listed below are public health interventions that are applicable to include in annual reviews (or equivalent) for people living with one of the LTCs stated. Not all interventions are appropriate for all conditions or all people with a specific condition (professional knowledge should direct the most appropriate course of action). An indication for each intervention of why it is important, how to approach the topic and what to consider to be recorded (not exhaustive). The information stated below should be recorded within the last 12 months to ensure that it is recent and relevant (where appropriate).

1. **Nutrition intake & diet**

How Question patients regarding their diet and eating habits. Assess the level of motivation of patients who have an unhealthy diet to want to change.

What Record discussion in patient's notes, diet motivation score, referral to the Lifestyle Programme, appropriate/available referral to dietician/specialist services.

2. **Smoking status**

How Question patients regarding their smoking status. Provide health risk advice to smokers and non-smokers to encourage smokers to quit and non-smokers to prevent initiation.

What Record in patient's notes, tobacco consumption, quit date, pack years, smoking cessation motivation score, referral to smoking cessation service (may be in-house or external).

3. **Alcohol consumption**

How Question patients regarding their alcohol consumption. Provide advice and support regarding the nationally recommended safe levels of consumption in terms of volume and frequency.

What Record in patient's notes, alcohol consumption screen, brief/extended intervention completed, Audit C questionnaire, referral to specialist alcohol treatment services.

4. **Exercise**

How Question patients regarding their level of physical activity, for example, through use of GPAQ. Explain what is meant by physical activity and the level of physical activity they should be aiming to achieve (considering factors such as age, health status and ability)

What Record in patient's notes, advised re-exercise, exercise motivational score, referral to the Lifestyle Programme if the referral criteria are met.

5. **BMI & weight**

How Provide information to patients regarding their body weight and BMI. Discuss concerns relating the weight and/or BMI for people presenting with low or high outcomes against ideal/recommended values.

What In-line with the lifestyle support programme record in patient's notes, ideal weight, patient's motivation to lose/gain weight/BMI to recommended level,

referral to the Lifestyle Programme if the referral criteria are met.

6. Sexual health

How Use professional judgement to consider questioning patients in an appropriate manner to allow problems or concerns to be presented. When accredited ensure that DASH criteria are used appropriately.

What Record in patient's notes, undertake appropriate tests, referral to specialist services and support. *(Sexual dysfunction associated with diabetes, for example. Opportunistic testing of people in risk groups, for example age or lifestyle factors)*. NB. Ensure prescribing of erectile dysfunction medication is in accordance with NHS guidance (see BNF) and not contraindicated.

7. Mental Health

How Question patients who present with symptoms/signs of mental health problems for potential underlying factors. Consider the wider determinants of health as driving factors (including housing, financial affairs, local environment)

What Record in patient's notes, depression screening questionnaire, referral to specialist services (for example the Healthy Minds Network).

8. Dementia

How Ascertain the individuals needs and support available to them. Proactive approach to identifying people with early onset dementia and sustained reduction in vascular risks

What Annual checks including, for example, vascular risks, safety of individual, falls risk/assessment and alcohol intake. Engage with patient's family and/or carer support as appropriate.

9. Learning disabilities

How Ascertain the individuals needs and support available to them. Encourage healthy lifestyle habits and actively manage co-morbidity.

What Appropriate targets the same as for people living without a learning disability. Ensure that patient's family and/or carer support is consulted and/or informed where appropriate to help manage the individual's condition.

10. Falls

How Assess individual patients for factors that may increase the risk of falls. This can include medication prescribed, the LTC itself, the physical health and age of the individual. Practices need to ensure that they implement the

local falls strategy.

What Record in patient's notes, medication review, number of falls in last year, falls risk assessment, referral to specialist services (mobility specialists, physiotherapists).

11. Preconception, pregnancy & breast feeding

How Preconception advice to include proactive promotion of folic acid. Consider the risk factors associated with LTC to both child and mother. The prescribed medication may be unsuitable for use during pregnancy and/or breast feeding (for example, diabetes and epilepsy).

What Record in patient's notes, medication review, refer to specialist support when required for care.

12 Lifestyle issues summarised

1. Smoking
2. BMI & Weight – proportion of practice population with a record in the last 12 months.
3. Exercise - proportion of practice population with a record in the last 12 months.
4. Alcohol - proportion of practice population with a record in the last 12 months. Use of Audit C questionnaire to be used as marker?
5. Nutrition intake & diet – proportion of practice population with a record in the last 12 months.
6. Sexual health – There are several areas that practices can focus efforts to improve the local sexual health. Examples include: proportion of 15-24 year olds offered Chlamydia screening tests and the subsequent uptake of tests (received at lab for testing),
7. Breast feeding – proportion of pregnant women/new mothers in practice population over the last 12 months offered and/or attending breast feeding training.
8. Screening – proportion of eligible population invited and attending appointments for screening e.g. breast, bowel and cervical cancer.

Conclusion:
All of the standards listed above are important and should be considered for all patients with a LTC. The points for each standard are not comprehensive but highlight why the standard is important, how practices may approach achieving the standard and what is expected as a minimum for audit purposes.

Patients and the NHS will both benefit from implementing these standards through reduced morbidity and mortality, fewer complications, less need for health and health care and thereby reducing associated costs.