Llywodraeth Cymru
Welsh Government

Quality Assurance and Improvement Framework

2021/22

Background

The Quality Assurance and Improvement Framework (QAIF) was introduced as part of the contract reform in 2019, it replaced the Quality and Outcome Framework (QOF), which was originally introduced as part of the new GMS contract in 2004.

The QAIF builds on our experience in Wales of QOF, including our approach to incentivise GP practices working together. Welsh Government, NHS Wales and the GP professional representative bodies continue to work together to develop a contractual framework for quality assurance and quality improvement that benefits patients and general practice.

The QAIF rewards contractors for the provision of quality care and helps to embed quality improvement into general practice. It consists of four domains; Quality Assurance, Quality Improvement, Access and GP Collaborative.

Funding

QUALITY ASSURANCE & IMPROVEMENT FRAMEWORK Quality Assurance and Improvement Domains		Points
Quality Assurance	Active Clinical Indicators	**125**
	Practice Quality Assurance	**80**
Quality Improvement	QI projects	**205**
Access	Access to in-hours standards	**125**
GP Collaborative		**100**
Total Points		**635**

Quality Assurance

General information on indicators

Indicators have been prefixed by an abbreviation of the category to which they belong, as per their description under the old QOF scheme. For the purposes of

calculating achievement payments, contractor achievement against QAIF indicators is measured on a cycle of:

- 1st October to 30th September.
- in cases where the contract terminates mid-year, the last day on which the contract subsists.

In the case of a contract that has come to an end before the end of September in any relevant financial year, the reference to periods of time are still calculated on the basis that the period ends on 30th September in the financial year to which the achievement payment relates. The SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the QA and QI achievement year.

Disease Registers are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor. Contractors are required to establish and maintain disease registers for the disease areas of QAIF during 2021/22 and this will be written into the contract regulations. The full list of disease registers can be found at Annex A.

It is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high quality register. Verification may involve asking how the register is constructed and maintained. The health board may also compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

For some QA clinical indicators, there is no disease register, but instead there is a target population group. For example, for FLU001W the target population group is the registered population aged 65 or more.

Indicators in the QI, Access and GP Collaborative domains have neither a disease register nor a target population. These are indicators which require a particular activity to be carried out and points are awarded in full if the activity is carried out. Should the activity not be carried out, no points are awarded.

Verification

For indicators where achievement is not extracted automatically from GP clinical systems the guidance outlines the evidence or type of evidence which the health board requires the contractor to produce for verification purposes. The evidence will not need to be submitted unless requested by the health board. Practices will be responsible for ensuring that any and all required evidence to support the claimed achievement is available on request for examination by the health board.

The Statement of Financial Entitlement Directions set out the reporting requirement for contractors and the rules for the calculation of QAIF payments.

Business Rules

The Dataset and Business Rules that support disease registers and the reporting requirements of the QA clinical indicators of QAIF are based on Read codes (version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS

standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QAIF reporting. Contractors utilising such systems may need to develop strategies to ensure that they are using appropriate Read codes in advance of producing their achievement report. NHS Wales expect to move to SNOMED clinical terms as the NHS standard for coding, in line with the NHS in the rest of the UK.

Exception reporting

Exception reporting applies to those indicators in the clinical domain of QAIF where the achievement is determined by the percentage of patients receiving the specified level of care.

“Exceptions” relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted **and** they have not received the care specified in the indicator wording. If the patient has been excepted, but the care has subsequently been carried out within the relevant time period, the patient will be included in both the denominator and the numerator, i.e. achievement will always override an exception.

Exception Reporting Criteria

Patients may be excepted if they meet the following criteria for exception reporting:

- Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the annual cycle to which the achievement payments relate.
- Disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.
- Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards
- Where a patient does not agree to treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.
- Where the patient has a supervening condition which makes treatment of their condition inappropriate.

Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have ‘excepted’ patients from an indicator and this can be identifiable in the patient record.

Principles

The overriding principles to follow in the decision to except a patient are:

- A duty of care remains for all patients, irrespective of exception reporting arrangements.
- It is good practice for clinicians to review from time to time those patients who are excepted from treatment, e.g. to have continuing knowledge of health status and personal health goals.
- The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record.
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.

Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient's clinical record.

Invitations to attend a review should be made to the individual patient and can be in writing, by telephone or by SMS text messaging. This can also include a note at the foot of the patient's prescription requesting that they attend for review. The three invitations need to have taken place within the QAIF period in question. There should be three separate invitations at three unique periods of time. The telephone call invitation may lead to the application of exception criteria 'informed dissent' if the patient refuses to take up the invitation to attend. The following are examples that are not acceptable as an invitation:

- A generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. influenza immunisation.
- A notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (e.g. influenza immunisation).

Clinical Domain Active Indicators

INFLUENZA (FLU) Indicator	Points	Threshold
FLU001W. The percentage of the registered population aged 65 years or more who have had influenza immunisation in the preceding 1 August to 31 March.	**5**	**55-75%**
FLU002W. The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March.	**15**	**45-65%**

DEMENTIA (DEM) Indicator	Points	Threshold
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in person or if clinically appropriate via telephone or remote video consultation in the preceding 15 months.	**28**	**55-75%**

DIABETES MELLITUS (DM) Indicator	Points	Threshold
DM002. The percentage of patient with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.	**8**	51–91%
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less.	**10**	40-72%
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months.	**17**	40-72%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification; 1) low risk (normal sensation, palpable pulse), 2) increased risk (neuropathy or absent pulse) 3) high risk (neuropathy or absent pulses plus deformity of skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.	**4**	55–90%

DM0014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 October to 30 September who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	**11**	40–90%

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) **Indicator**	**Points**	**Threshold**
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months.	**9**	50–90%

MENTAL HEALTH (MH) **Indicator**	**Points**	**Threshold**
MH011W. The percentage of patients with Schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI, smoking status and alcohol consumption in the preceding 15 months and in addition to those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months.	**12**	45-85%

PALLIATIVE CARE (PC) **Indicator**	**Points**	**Threshold**
PC002W. The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.	**6**	

Practice Quality Assurance

	Points
Demand and Capacity – to be evidenced in the Collaborative IMTP. The below should be taken into consideration; • A population needs assessment;	**40**

• An analysis of current services available to the collaborative population and identifying any gaps in provision; • A consideration and analysis of current numbers and skills of workforce and its development needs; • An analysis of current performance against the phase 2A primary care measures • Measurement of local health needs as determined by the collaborative.	
Evidence of operating an effective system of clinical governance (quality assurance) in the practice, through engagement in peer review and through discussion of clinical incidents that had occurred within the practice and local services. Contractors will need to evidence completion of CGSAT and IG toolkit.	**40**

Quality Improvement

Overview of QI projects sub domain;

To be able to claim any points for achievement of projects in the QI projects sub domain, the practice must complete the mandatory data and patient safety projects.

Project	Points
Data & Patient Safety QI **Mandatory** Projects; Activity/Appointment Data Patient Safety Clinical Data	 **70** **35**
Legacy 2020-21 QI project. In place for one further QI cycle to allow embedding of learning, governance advantages and collaborative conversations for the Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the collaborative population.	**30**
Practice Choice QI project; The practice has a choice of selecting a 70 point QI basket project not previously undertaken (Reducing stroke, ceilings of care, urinary tract infection) Further detail on these projects can be found at Annex B. **or**	**70**

a collaborative freestyle mini project in agreement with Health Board (35 points) Template can be found at Annex C. **and** Green Inhaler mini project (35 points)	
Total	**205**

Activity/Appointment data QI Project - Mandatory

Background

Activity in General Practice has been traditionally very difficult to accurately capture and reflect. This leaves Welsh Government and LHBs with minimal data or evidence of pressure on GMS contractors and is in stark contrast to source data available freely on WAST utilisation, ED attendance and Hospital admission. Trends cannot be monitored and interventions to increase capacity cannot be assessed for efficacy. There is a gap in understanding real-time activity and pressure on GMS as a result, as well as the experience of the patient, with effectively only the WNWRS and self-reporting of GMS escalation status offering some insight into staffing and pressures.

Methods to capture GMS contractors recorded activity have traditionally relied on data recorded on appointment systems. Whilst these are valuable data, there are significant data quality issues in relying on the appointment books of nearly 400 independent GMS practices, using two different clinical systems. Without significant data quality improvements, including an element of standardisation, an accurate picture of activity, which reflects the breadth and complexity of work undertaken in General Practice cannot be achieved.

This one-year QI project aims to:

1. Improve the validity of appointment book data, which is already collected and analysed for purposes of tracking GMS activity by ‘mapping’ appointment slots to agreed categories, include but not limited to mode of appointment and type of clinician completing the appointment;
2. Undertake regular data collection for those areas of activity not captured by appointment book data collection (telephony, prescriptions, referrals, E-requests, administrative requests) via pre-designed searches and audits if not centrally collected by Audit+, with upload to the Primary Care Information Portal for collation and discussion. This will initially be conducted via practice searches and uploaded, but solutions will be developed to automate the process where possible;
3. Discuss the activity recorded at collaborative level with other GP Collaborative practices and consider collaborative measures for managing demand and standardising good practice and data quality where applicable;
4. Develop an internal and externally facing infographic highlighting activity levels in GMS, specifically for communication to patients for use once the quality of data for presentation is assured.

Requirements of the QI project

Practice Level

- Practices will nominate a GMS activity data quality lead/champion.
- Practices to undertake a one-off exercise to map each slot type it uses to one of the pre-determined national categories (the activity 'map' can be found at below).
- Practices to ensure use of appropriate Read/SNOMED-CT codes to allow central searches to function in line with guidance.
- Practices to undertake monthly activity searches of the categories not collated by the appointment book data or delivered via nationally developed searches, (telephony, prescriptions, referrals, E-requests, administrative requests) Parameters will be developed nationally but performed locally and will be uploaded monthly to the Primary Care Information Portal (categories and codes to be collected can be found below)
- Practices/Champions to encourage all staff to accurately record each clinical contact in an 'appointment slot' and undertake practice-wide training/engagement exercises on data quality topics relevant to this project at regular intervals.
- Practices to review data at least quarterly or prior to discussion with collaborative.
- Practices will aim to publish their activity data via nationally developed infographics to their patient population towards the conclusion of the QI project, once activity data quality has been improved/assured by the QI process and agreed infographics have been developed.
- Practices will complete a brief standardised QI report at the conclusion of the project for assurance. –a national template will be provided.

Collaborative Level

- Practices to share aggregate practice-level activity data with collaborative and LHB.
- Practices to discuss accuracy and content of PCIP appointment book data. This will allow development and RFCs for the data platform.
- Discuss management of patient demand levels, share best practice and adaptation of systems if applicable across collaborative.
- Discuss notable trends and patterns with Pan Cluster Planning Group

DHCW Level

1. Develop a process for mapping centrally agreed appointment definitions to GP systems to be completed within the Primary Care Information Portal
2. Collation of global appointment book data to monitor trends in GP activity in conjunction with GPCW.
3. Develop infographic within the Primary Care Information Portal to present data in a user-friendly way which practices can capture and publish locally.

4. Share centrally collated appointment book data with collaboratives and practices via PCIP for local discussion via the agreed access rights.
5. Offer training support and develop 'How to…' modules to drive standardisation of data quality. 'How to…' modules to be provided by end of March 2022
6. Develop a series of automated searches to collect coded data on prescriptions issued/referrals made/Med3's issued/administrative letters issued using agreed codes to replace manual upload where possible. – add in received and results

Health Board Level

- Health Boards to ensure practice completion is accurately monitored and verified against the agreed indicators

Measurement of the implementation of the project

This data project is an important step in quantifying more accurately the volume and diversity of activity undertaken in GMS practices and collaboratives. It is expected that this data quality exercise will embed the accurate collection, discussion and publication of activity data in primary care and that automated data collection methods will be developed and utilised at the fruition of this data quality project.

The outcomes we expect are:

Ability to ensure that the Welsh NHS is better placed to assess the activity undertaken and support the needs of GMS and Primary Care in the coming year and extending into the future.

A dashboard to be created within the PCIP that gives users at various levels the ability to see relevant metrics of activity, such of proportions of appointments that are face-to-face, video or telephone, as well as other administrative activity

Verification and achievement:

Practices:

Practices will need to demonstrate achievement of the project by 30th September 2022, by completion of the standardised reporting template and confirming that required actions have been undertaken and achieved.

- Practices to submit reporting template outlining actions undertaken to improve data quality to the LHB Primary Care Team, as well as declaration of completion of the QI project by 30 September 2022

LHB:

LHBs will be required to verify that practices have undertaken all actions set out in the indicator to confirm achievement and award payment. This will be done by:

- Reviewing individual practice reporting templates and verification of actions and achievement as set out for completion by 30 September 2022.

A standard data set has been agreed and guidance on data extraction and associated queries codes is being compiled by a group including practice managers, WG, DHCW and GPC. This will be finalised and will be made available to practices in March. The PCIP portal is being adapted to hold practice data and will be available for practices to start populating in April.

Clinical Data Quality Improvement (QI) Project – Mandatory

Background

There is a wealth of data held in GP clinical systems that could be analysed to improve planning and patient care. Work is progressing to put the appropriate safeguards in place that will allow clinical system data to be extracted and analysed by NHS Wales. To maximise the benefit of this work, there are some preparatory steps required within general practice to improve the quality of coded data.

The range of READ codes (excluding SNOMED CT) that have existed for so long have led to variable practice in clinical coding. This is exacerbated by variability in approaches by system suppliers to clinical data capture and coding. GP practices may have gone through a series of clinical system supplier migrations during the past 20 years, each migration introducing a potential risk to coding integrity. A standardised approach to coding will improve the ability to complete effective searches and audits of clinical encounters, and ensure that temporary staff (including locums) are able to record their encounters in a consistent way.

The potential magnitude of an exercise to tidy up and improve clinical coding is huge. To extract the maximum benefit from the QI project and limit the practical practice workload to an appropriate level, it is proposed that this QI project focuses on three specific clinical areas to provide a proof of concept for more standardisation in the future.

The clinical areas of focus for this QI project are:

1. Sick Child
2. Suspected Deep Vein Thrombosis
3. Acute Mental Distress

The aim of this one-year QI project is to:

1. Standardise clinical coding within GP clinical systems.
2. Ensure properly coded consultation data is available to be shared across WGPR
3. Highlight the importance of accuracy and completeness in clinical recording.
4. Drive improvement in clinician adherence to standardised coding as best practice, promoting the avoidance of free text where suitable coding exists.
5. Promote an understanding of the whole system patient safety benefit of standardised coding for clinical data.

These elements of work are underway and will be completed in the next 4 weeks. Guidance will then be made available to practices.

Requirements of the QI project

National Level

- Agree the core clinical data that ought to be captured and consistently recorded in the management of each of the clinical scenarios
- Develop templates and 'hot-keys' to be used for the chosen clinical areas for EMIS and VISION systems to be uploaded individually by practices

Health Board Level

- Produce 'How to' guidance for the upload of templates to local systems be end of March
- Ensure practice completion is accurately monitored and verified against the agreed indicators

DCHW Level

- Extract the relevant codes from GP systems and present back to practices, collaboratives, LHBs and Welsh Government via the Primary Care Information Portal

Practice Level

- Practices to upload new templates to GP systems
- Practices to ensure that templates are used for each patient presenting with the agreed conditions
- Practices to review data at least quarterly or prior to discussion with collaborative.
- Practices to encourage all staff to record relevant clinical encounter as per guidance from health board/DHCW

Collaborative Level

- Practices to share aggregate practice-level data with collaborative and LHB.
- Practices to discuss accuracy and reasons for variation of data reported in the Primary Care Information Portal

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Measurement of the implementation of the project

Standardisation of inputs will ensure that there is consistent coding for the selected conditions. Success of the project will be measured through the number of practices uploading the standard templates and the utilisation rate of templates when patients present with the selected conditions. A secondary benefit will be the ability to use the data for comparisons across areas.

The outcomes we expect from the practice are:

Improved visibility and comparability of prevalence of these conditions in practices/geographical regions, as well as providing proof of concept of the value of standardising data capture

Verification and Reporting

Practices:

Practices will need to demonstrate achievement of the project by 30th September 2022, by completion of the standardised reporting template and confirming that required actions have been undertaken and achieved.

- Practices to submit reporting template with a checklist of deliverable actions to the LHB Primary Care Team, as well as declaration of completion of the QI project by 30 September 2022

LHB:

LHBs will be required to verify that practices have undertaken all actions set out in the indicator to confirm achievement and award payment. This will be done by:

- Reviewing and verify achievement of individual practice declarations confirming completion of the QI project and all required actions
- Verify practice implementation via reporting in the Primary Care Information Portal

Green Inhaler QI Project

Background

Pharmaceuticals are the second highest contributing factor towards the NHS carbon footprint, and the largest contributor in general practice. There are a range of options that pharmaceutical companies should develop to help reduce the impact of pharmaceuticals on the environment. [1]

Inhalers account for 3-4% of the whole NHS carbon footprint. Metered dose inhalers (MDIs) use hydrofluoroalkanes (HFA) propellants which are potent greenhouse gases, 1000 – 3000 times more potent than carbon dioxide. In the UK approximately 70% of inhalers used are MDIs which is much higher than many other European countries.[2]

[1] https://www.bma.org.uk/media/2570/bma-sustainable-and-environmentally-friendly-general-practice-report-june-2020.pdf

[2] https://greeninhaler.org/more-environmentally-friendly-inhalers/

To reduce the carbon footprint of inhaler prescribing we recommend that health professionals:

1. Optimise asthma and COPD care
2. Use dry powder inhalers or soft mist inhalers as first-line treatment options where clinically appropriate
3. If metered dose inhalers are needed then chose a brand and dosage regime with care to minimise carbon footprint

Requirements of the QI project

Practice Level

a) Reduce use of inhalers with high Global Warming Potential (GWP) and instead use inhalers with a lower GWP.

Some inhalers have a greater carbon footprint than others. In general, MDIs have a higher carbon footprint than DPIs. Where an MDI is indicated for a specific clinical reason (rather than a DPI) select the most appropriate MDI with the lowest GWP.

NOTE: the AWTTC Decarbonisation dashboard provides information about the carbon footprint associated with different inhaler devices.

b) When prescribing inhaled corticosteroids select the most appropriate strength inhaler to minimise the number of puffs required for the same dose

For example prescribe 1 puff of 200mcg Clenil twice a day rather than 2 puffs of 100mcg Clenil twice a day. This can effectively halve the carbon footprint of treatment.

c) Ask patients to return all used inhalers to pharmacies for disposal.

All medicines should be return to pharmacies for safe disposal. It is particularly important that inhalers, especially MDIs, are returned to pharmacies due to the HFA gases that are contained in the canisters. Inhalers that are discarded into domestic waste will end up in landfill and even ‘empty’ MDIs will release global warming gases into the atmosphere. Returning inhalers to pharmacies means that inhalers can be disposed of responsibly.

Selecting the appropriate inhaler device for your patient

Inhalers should always be selected in discussion with individual patients (or parents/guardians). The NICE Patient Decision Aid may be useful for this. Local prescribing guidance and formularies vary across the country and costs for different brands vary with time. It is recommended that the links below are used to identify

options and then a selection is made informed by local guidance. For patients using multiple inhalers it is best to try to use the same type of device where possible.

The following are All Wales prescribing guidelines have been ratified and endorsed by AWMSG and should be considered when making decisions with patients;

- All Wales adult asthma management and prescribing guideline
- All Wales COPD management and prescribing guideline

The contractor will need to complete a QI template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended and discussed the QI project in a GP collaborative meeting, unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. In these circumstances' contractors are expected to make efforts to ensure alternative participation in peer review.

Health Board Level

Verification – Health Boards may require contractors to provide a copy of the QI template as written evidence that the quality improvement activity has been undertaken. The AWTTC Decarbonisation Dashboard can be used to gather prescribing data and evidence a change in practice to reduce the carbon footprint associated with inhaler prescribing.

Health Boards may require the GP collaborative clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances, then they will need to demonstrate other active engagement in network peer learning and review.

Measurement of the implementation of the project

The outcomes expected from practices are;

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues outside the practice, where practicable, for example local Community respiratory nurses, network pharmacist, patient support groups.

- The outcome measures should be discussed at a Practice meeting.
- Education of Practice clinicians re green impact of inhaler devices.
- QI project shared with the GP collaborative.
- Attend GP collaborative meeting to share learning.

Access

The Access to In-Hours GMS Services Standards were introduced by the Minister for Health and Social Services on 20 March 2019. The Standards set clear requirements on practices in terms of minimum expectations relating to access, including an increased digital offering.

Achievement for the Access domain is measured at the 31 March, with contractors having to evidence achievement for at least one month prior to this date. Contractors are required to report quarterly their achievement position in order to monitor progress through the year.

Details of the 125 points available in the Access domain, the standards, reporting and evidence are set out in more detailed access guidance.

The guidance can be found at https://gov.wales/sites/default/files/publications/2021-12/access-to-in-hours-gms-services-standards-amended-supplementary-guidance.pdf

With agreement reached for an Access Commitment from April 2022, new guidance will be developed and will be provided to all practices ahead of 1 April 2022.

Collaborative Working

Clusters were established in 2010 to encourage the testing of new models of care to more effectively meet local needs.

Whilst significant progress has been made, there is variation between clusters in relation to the maturity of collaborative working and the impact for patients and communities. Mainstreaming of successful projects and evidence of influence on wider strategic planning has been limited and a step change is now needed to realise the full potential of this approach.

For 2022 the Strategic Programme for Primary care has introduced an *Accelerated Cluster Development (ACD) Programme*. This has meant a change to the GP cluster domain within QAIF.

Details of the 100 points available in the Collaborative Working domain and evidence required are set out in the more detailed guidance.

QAIF Queries Process

Queries can be divided into three main categories:

- those which can be resolved by referring to the guidance and/or FAQs
- those which require interpretation of the guidance or Business Rules
- those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

QAIF queries should be directed as follows:

- Queries relating to QAIF Business Rules/coding should be sent to: NHS Wales Informatics Service via PrimaryCare.ServiceDesk@wales.nhs.uk
- All other queries relating to QAIF should in the first instance be sent to: Welsh Government; HSS-PrimaryCareMailbox@gov.wales

Annex A – Disease Registers

The disease registers are:

- **Atrial Fibrillation**
- **Asthma** – excluding patients who have been prescribed no asthma-related drugs in the preceding 12 months
- **Cancer** – defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'
- **Secondary prevention of Chronic Heart Disease**
- **Chronic Obstructive Pulmonary Disease**
- **Dementia**
- **Diabetes Mellitus** – all patients aged 17 or over, which specifies the type of diabetes where a diagnosis has been confirmed
- **Epilepsy –** patients aged 18 or over receiving drug treatment for epilepsy
- **Heart Failure**
- **Hypertension**
- **Learning Disabilities**
- **Mental Health** - patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy
- **Obesity –** patients aged 16 or over with a BMI of 30 in the preceding 15 months.
- **Osteoporosis –** 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and Aged 75 or over with a record of a fragility fracture on or after 1 April 2012
- **Palliative Care –** all patients in need of palliative care/support irrespective of age
- **Rheumatoid Arthritis –** aged 16 or over with rheumatoid arthritis
- **Stoke and Transient Ischaemic Attack**

Annex B – QAIF QI Projects

The Quality Improvement domain is based on the basket of projects that were introduced in 2019-20, to be delivered at collaborative level:

a. Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the collaborative population.

b. Reducing stroke risk through improved management of Atrial Fibrillation in for the collaborative population.

c. Ceilings of care / Advanced Care planning.

d. Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20

A detailed specification for each project is set out below;

Patient Safety Programme

Introduction

This Quality Improvement project aims to incentivise GMS contractors to collaborate at GP Collaborative level to take action to reduce the prevalence of risk factors associated with avoidable medicines related harm through the implementation of a multifaceted intervention shown to reduce a range of medication errors in general practice.

Medicines related harm

The prescribing of a medication is the most common intervention in healthcare.[3] In Wales, over 80 million prescriptions were dispensed in the community in 2017 and medication use has increased significantly over time.[4,5]

Demographic changes, including an ageing population and the increasing prevalence of co-morbidities, have driven increases in the concurrent use of multiple medicines (so called “poly-pharmacy”)[6] with patients on multiple medicines more likely to suffer side effects from medicines.[7]

Whilst prescribing a medicine has the potential to improve health, it may also be associated with harm which may arise from unintended consequences of therapeutic use (i.e. adverse drug reaction), or medication error (i.e. through inappropriate prescribing, dispensing, administering, monitoring or use).

Interventions to minimise harm

[3] National Institute for Health and Clinical Excellence. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NG5. 2015
[4] Welsh Government. Prescriptions dispensed in the community. 2018
[5] Gao L et al. Medication usage change in older people (65+) in England over 20 years: findings from CFAS I and CFAS II. *Age and Ageing* 2018; 47(2): 220-225
[6] Payne RA et al. Prevalence of polypharmacy in a Scottish primary care population. *Eur J Clin Pharmacol* 2014; 70: 575-581
[7] Pirmohamed M et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. *BMJ* 2004; 329(7456):15-19

In general, evidence for reducing medication errors is strongest for educational outreach[8] and pharmacist-led interventions.[9]

Most preventable adverse drug events in primary care are attributable to errors in prescription and medication monitoring,[10] and changes in practice enabled by information technology have substantial potential to reduce the frequency of these errors.[11]

The pharmacist-led information technology intervention for medication errors (PINCER) study demonstrated how a multifaceted intervention comprising feedback, educational outreach, dedicated pharmacist support and use of information technology can improve quality through improvements in prescription safety and medication monitoring in general practices, at a low cost per error avoided.[12]

Requirements of the QI project

The information below provides details of the responsibilities of the practice, collaborative and health board to implement the project. The details are as follows:-

At Practice Level

Each general practice will have access to an online prescribing safety dashboard and would meet at the start of each QAIF cycle to discuss the information provided by the dashboard.

General practices will identify a prescribing safety lead, who will be expected to use a range of techniques to help correct the medication errors and prevent future ones. This could include (but not be limited to)-

- Inviting patients to surgery for review;
- Ensuring patients have appropriate tests for known side effects;
- Making arrangements for ongoing review; and
- Educational meetings with prescribers.

At GP Collaborative Level

The intervention will be overseen (with improvements agreed and measured) at the GP Collaborative level. Individual general practice data would be aggregated and reported at the GP Collaborative and health board level only. Individual general practice action plans would be agreed within six months of the start of the each

[8] Royal S et al. Interventions in primary care to reduce medication related adverse events and hospital admissions: systematic review and meta-analysis. *Qual Saf Health Care* 2006; 15: 23–31.
[9] Thomson O'Brien MA et al. Educational outreach visits: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2000; 2: CD000409.
[10] Gurwitz JH, Field TS, Harrold LR, et al. Incidence and preventability of adverse drug events among older persons in the ambulatory setting. *JAMA* 2003; 289: 1107–16.
[11] Schedlbauer A, Prasad V, Mulvaney C, et al. What evidence supports the use of computerized alerts and prompts to improve clinicians' prescribing behavior? *J Am Med Inform Assoc* 2009; 16: 531–38.
[12] Avery A et al. A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. *Lancet* 2012; 379: 1310–1319

financial year with improvements (as measured by GP Collaborative reports) reviewed.

GP Collaborative will be expected to drive improvement in individual practice outcome measures.

At Health Board Level

The NHS Wales Informatics Service have developed and will deploy a Prescribing Safety Dashboard available to individual general practices which produces aggregated health board and national reports.

Individual general practice data will be aggregated and reported at the GP Collaborative and health board level only. HBs would be responsible for overseeing process measures and using GP Collaborative data to assure improvements in outcome measures with collaborative level peer reviewing individual practices to drive performance improvement at GP Collaborative level.

The intervention could be supported by materials (such as prescribing indicator reports) developed by the All Wales Medicines Strategy Group.

Measurement of the implementation of the project

Each GP practice has a GP or Pharmacist nominated as its medication safety lead.

The GP practice has a plan to improve prescribing safety indicators.

The GP practice has participated in a GP Collaborative meeting to discuss prescribing safety measures.

The GP Collaborative has had a meeting to discuss prescribing safety measures.

Number of medication reviews for patients meeting one or more criteria in the prescribing safety measures.

The outcome we expect from the project are as follows:-

Improvements in the prescribing safety indicators (reduction in numbers at risk).

Reducing stroke risk through improved management of Atrial Fibrillation in primary care collaboratives

Introduction

This Quality Improvement project aims to incentivise GP Collaborative to take action to reduce the stroke risk associated with suboptimal prescribing of anticoagulant and antiplatelet therapy in primary care.

The intervention would be carried out at each practice but would be overseen (with improvements agreed and measured) at the GP Collaborative level

Atrial Fibrillation

Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia and its prevalence is increasing. A patient with atrial fibrillation has a 5-fold increase in the risk of stroke and 20–30% of all strokes are attributed to this arrhythmia. Not only is AF a major risk factor for stroke, but when strokes occur in association with AF, patients suffer increased levels of mortality, morbidity and disability with longer hospital stays compared with stroke patients without AF.

The aim of AF treatment is to prevent complications, principally stroke, and alleviate symptoms.

Pharmacological therapy recommended to reduce the risk of stroke in AF now only comprises of anticoagulants, with clear evidence to support the fact that anticoagulation with vitamin K antagonists (e.g. warfarin) or direct oral anticoagulants (DOACs) reduce stroke and mortality in patients with AF.

Recommended pharmacological therapy to reduce stroke risk

The National Institute for Health and Care Excellence (NICE) clinical guideline 180 entitled *Atrial Fribrillation: Management*, recommends the use of anticoagulant therapy to prevent stroke in specified circumstances (figure one) with potentially clinically significant reductions in stroke incidence.

Requirements of the QI project

The information below provide details of the responsibilities of the practice, GP Collaborative and health board to implement the project. The details are as follows:-

Practice level

Each practice will have access to an online AF dashboard providing computerised feedback on patients identified to be at risk from inappropriate prescribing of antiplatelet therapy or suboptimal use (including no use) of anticoagulant therapy. Individual practices would be able to see their report alongside anonymised reports for other practices.

Each practice to meet annually to discuss the information provided by the dashboard. All doctors, pharmacists and nurses working at the practice should attend this meeting along with the practice manager and at least one member of the reception staff. Where a member of staff is unable to attend, opportunity will be given

for them to see the data, and an opportunity to input views and receive outcomes of the meeting. Local community pharmacists could also be invited to attend.

Individual practices will identify a lead who will be a doctor, pharmacist or nurse working at the practice, to develop and progress actions in the plan.

Following the initial meeting, the practice will be expected to identify AF patients at risk of stroke and undertake structured and documented reviews with a view to improving prescribing and reducing risk.

GP Collaborative

Individual general practice data will be aggregated and reported at the primary care GP Collaborative and health board level only.

Individualised practice data will only be available to the relevant general practice.

Health Board level

Individual general practice data will be aggregated and reported at the GP Collaborative and health board level only.

Brief written educational materials explaining AF, stroke risk and different approaches to treatment and risk reduction will be provided to general practices to inform structured reviews to arrive at shared decisions on treatment and which are consistently documented.

Measurement of the implementation of the project

Each GP practice will lead the implementing a stroke reduction action plan.

The practice has had a meeting to discuss the AF dashboard measures.

Number of structured reviews for patients with AF.

The outcomes we expect from the project are:-

% of patients with AF on anticoagulant or with documented shared decision making declined anticoagulant.

Ceilings of Care/Advanced Care Planning

Introduction

This Quality Improvement project has the aim of increasing the number of patients with long-term conditions, nearing the end of life, who have had an offer to express their wishes and preferences in a most patient-centric way with advance care plans

and to ensure these patients receive continuing and acute care in their preferred places of care.

Background

There is ample evidence to suggest that Advance Future Care Plan (AFCP) discussions are not routinely happening when people are living with multiple long-term and life limiting conditions. Even after losing capacity to make their own healthcare decisions, people may retain control over decisions through an Advance Decision (to refuse treatment).

Definitions

Where possible, the term **Advance Future Care Planning** can encompass both all aspects of Advance Care Planning for people with decisional capacity ***and*** also those with decisional mental capacity as defined by the Mental Capacity Act 2005. For further information visit the Welsh repository for AFCP projects: http://advancecareplan.org.uk/for-professionals/

Requirements of the QI project

The information below provides details of the responsibilities of the practice, GP Collaborative and health board to implement the project. The details are as follows:-

Practice

- Improve ownership and understanding of *Advance Future Care Plans* by patients, relatives and care providers.
- Measure whether for those patients on a practice's palliative care register a discussion of preferences for treatment, resuscitation, and hospitalisation has occurred **or** has been declined by the patient or care giver near admission (in which case document that it was declined). (Note: such discussions must never be forced onto those who do not wish to have them).
- Provide information on Advance Future Care Planning but also discuss patients' and families' views on future investigations and interventions openly and ascertain any strong views.
- Reduce avoidable and unwanted hospital admissions, including by provision of medication at home to reduce symptom burden, such as injectable anti-sickness medicines, pain medications and other common reasons for admission.
- Improve patient centred care in the patients preferred places of care and place of death.
- Ensure active capture of the patients care preferences in the GP electronic record.
  Suggested Read Codes: 8CME - Has end of life advance future care plan
  8IAe – Personal Care Plan declined
- Ensure active communication of patient's care preferences to other parties who are or may be involved in the patients care e.g. 111/OOH.

There is evidence to support improved efficacy of AFCP if it is made available on electronic record sharing systems that work for all e-patient record systems. An example is Co-ordinate My Care in London, which is being adopted in NHS England.[13]

GP Collaborative

Support care staff (community practitioners, care and nursing home staff) to respect and take account of what matters to patients and be familiar with AFCPs. Use resources such as http://talkcpr.wales videos and video media pads to spread good quality information about ceilings of treatment/intervention.

Deliverables might also include delivering standards as required by NICE Quality Standards, e.g. an SBAR* (Situation Background Assessment Recommendation) report to ensure carer and nursing teams in care homes and community have reviewed the care plan prior to calling OOH, 111 or 999. Include GP Collaborative delivered education sessions to nursing home staff and audit of adherence to SBAR.[14]

Health Board

Ensure sharing ownership and auditing of adherence to care plans and existing AFCPs across the health system (e.g. community teams, secondary care).

Establish alignment with new medical examiner mortality review processes and model appropriate 'community MDT review' of place of death and quality of care including auditing place of death consistent with patient's option preference(s) expressed in AFCPs.

Measurement of the implementation of the project

Development of a frailty register by recording frailty score on all nursing home patients and all on active caseload of district nursing to complement existing palliative care registers.

Audit on quarterly cycle with an audit standard that 95% of those on the frailty or palliative care registers have had an offer of AFCP discussion with the patient themselves or their deputy, with clearly defined ceilings of intervention/treatment that have been set out or agreed by the patient, proxy, carers and relatives.

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[13] *Smith C, Hough L, Cheung C, et al Coordinate My Care: a clinical service that coordinates care, giving patients choice and improving quality of life BMJ Supportive & Palliative Care 2012;2:301-307[13].*

[14] *https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf*

The audit would encompass the capture of whether a discussion on AFCP has been offered and been agreed to, or declined. It would capture the documentation of whether the individual had mental capacity to make such decisions, or not. If patient/deputy in agreement with such a discussion, whether an AFCP is then subsequently added to GP electronic record with agreed Read Codes, the active communication of the existence of this AFCP to other relevant parties e.g. 111/OOH, and the concordance of the patient's actual place of death with their expressed preference(s), i.e. patients may express several preferred options for instance home or hospice. Such an audit may also enquire whether anticipatory injectable medications for symptoms like pain or nausea were made available at home, if this was the patients preferred place of care at the end of life.

Use of SBAR to ensure the AFCP is reviewed prior to calling 999/111/00H

The outcomes we expect from the project are as follows:-

- More recording of patient/deputy care preferences in advance
- Reduction in unwanted OOH admissions where a patient/deputy has declined this
- Improved sharing of AFCPs across relative parties currently involved in the patients care or who might be in the future and:
- where this is not achieved, feedback to relevant NHS Wales IT providers to request and embed a system that allows access to all key clinicians, esp input ability for GPs, hospital doctors and senior nurses with read-only access to HCPs like paramedics and 111/999 provider services.
- Feedback on completed projects and examples of practice and outcomes to AFCP Strategy Group for Wales.
- Improved concordance of actual place of death with the location preference(s) expressed in AFCP.

Multidisciplinary Antimicrobial Stewardship Urinary Tract Infection (UTI)

Introduction

This Quality Improvement project aims to incentivise GP Collaboratives to review the diagnosis and management of adults with suspected Urinary Tract Infection.

This supports multidisciplinary collaboration to promote a consistent approach to the management of UTI based on prioritised NICE Quality Standards (QS 90 Urinary Tract Infection in adults, QS 121 Antimicrobial Stewardship).

Antimicrobial resistance

Antimicrobial resistance is a significant threat to health, as outlined in WHC[15] 2018:

> *Antimicrobial resistance already imposes a significant burden of morbidity and mortality on the population of Wales through the failure of empiric antibiotic treatment of infections, and the spread of difficult-to-treat multi-drug resistant*

[15] https://gov.wales/docs/dhss/publications/whc2018-020en.pdf

organisms. Key drivers of AMR Antimicrobial resistance are antimicrobial usage, burden of disease and transmission of resistance.

Urinary Tract Infections and variation

There is particular concern[16] regarding the increasing resistance to common treatments used in managing Urinary Tract infections:
Treatment for most infections is started empirically before antimicrobial susceptibilities are known. A particular problem with the spread of antimicrobial resistance is that it becomes more difficult to select empirical therapy that will have reliable activity. In Primary Care, the effects are most clearly seen in increasing resistance to empirical therapy in urinary pathogens. There is also on-going concern about Clostridium difficile associated disease arising in the community. The main driver for the spread of both resistance and C. difficile is antimicrobial use; certain antibacterial agents have been particularly implicated in the spread of C. difficile… There is however, significant variability between Health Boards and GP Clusters in both the amount and types of antibacterial used, which suggests that there remains room for improvement.

Requirements of the QI project

The information below provide details of the responsibilities of the practice, GP Collaborative and health board to implement the project. The details are as follows:-

Practice level

As part of the project each general practice will identify an 'antibiotic lead'. The practice will participate in at least one antimicrobial stewardship quality improvement activity with at least 2 data collections, relating to the diagnosis & management of UTI.

4 audits are available[17] :

- Healthcare professional do not use dipstick testing to diagnose UTI in adults with urinary catheters [NICE QS 90[18] , PHW UTI standards 3&5[19]]
  See Wales QI UTI Catheter

[16] Antibacterial Usage in Primary Care In Wales 2013/14 - 2017/18 Report from Public Health Wales Healthcare Associated infection, Antimicrobial Resistance & Prescribing Programme (HARP team)

[17] https://phw.nhs.wales/services-and-teams/harp/urinary-tract-infection-uti-resources-and-tools/ see audit and quality improvement tools
[18] NICE QS90 Urinary Tract Infections: https://www.nice.org.uk/guidance/qs90
[19] PHW UTI 9 ' Key Standards for UTI Prevention, Treatment and Management Standard 3&5

- People prescribed an antimicrobial for UTI, have the clinical indication documented in their clinical record. [NICE QS121[20],WHC 18/20[21], UK plan[22]]
  See Wales QI UTI Indication
- Review of urinary prophylaxis [PHW UTI standards, NICE NG112]
  See Wales QI UTI Prophylaxis 3a and Wales QI UTI Prophylaxis 3b
- Adults with a UTI not responding to initial antibiotic treatment have a urine culture [NICE QS 90] (this audit should be undertaken with one of the remaining 3 UTI audits) *see Wales QI UTI MSU after treatment failure*

Practices will need to meet with allied professionals to discuss the findings where appropriate, such as district nurses, pharmacists or care homes.

All practices will continue to participate in Healthcare Associated Infection reviews as requested by the Health Board, such as Clostridium Difficile investigations

GP Collaborative level

Through this project, the GP Collaborative will prioritise the audit(s) to be undertaken, it is assumed most practices in the collaborative would undertake the same audit(s).
Initial measures and action plan will be discussed at GP Collaborative level.

Some data collection may be supported by health boards or antimicrobial stewardship pharmacists, particularly for the urinary prophylaxis topic.

Final practice measures and report will be discussed in the final quarter of the financial year and the aggregated GP collaborative report shared with the health board by an agreed date.

Health Board level

The health board will support the QI project and audit selection with appropriate data provision, data collection where possible and educational activities relating to the multidisciplinary management of UTI.

The health board will identify, and share with GP Collaboratives, key members and committees within the organisation who have responsibility for supporting and ensuring safe and effective care for people within this Quality Improvement project. The final GP collaborative reports will be shared with these stakeholders and with Medical Directors.

The health board will, where possible, provide aggregated GP Collaborative and health board reports to the practice to support benchmarking.

Measurement of the implementation of the project

All participating GP Collaboratives will be required to collate evidence of peer discussions and reflective practice involving the multidisciplinary team (such as, where possible, district nurses, care home, community pharmacy), practice report, GP collaborative report. Audit specific measures include:

- Proportion of episodes of suspected urinary tract infection in adults with urinary catheters that are investigated using dipstick testing.
- Proportion of episodes of a urinary tract infection not responding to initial antibiotic treatment investigated with a urine culture.
- Proportion of prescriptions for UTI antimicrobials with a coded clinical indication for treatment documented.
- Proportion of people prescribed urinary prophylactic antibiotics for more than 6 months who have had a documented prophylaxis review in the last 6 months

The outcomes we expect from the project are as follows:-

Reduction in usage of antibacterials that may be prescribed for urinary tract infections.

Contribute to overarching NHS Wales Delivery Framework, “I am safe and protected from harm through high quality care, treatment and support” and NHS Delivery measures including the national prescribing indicators for antibacterial items and national reduction expectations for E.coli, Klebsiella sp., bacteraemia cases and for cases of C.difficile disease[23].

Annex C – Collaborative Freestyle QI Project Template

To enable GP practices to develop their approach to quality improvement, the health board will also act in a supportive role, with a focus on quality improvement and development.

The Bronze IQT packages are available for all GPs, and can be accessed through Public Health Wales and the ‘1000 Lives Improvement’ initiative, which supports the development of programme for primary care by providing guidance, training and advice for local, regional and national health teams across Wales. Further information on how to access the IQT programme is available from a designated IQT facilitator within each health board.

http://www.1000livesplus.wales.nhs.uk/primary-care

https://learning.wales.nhs.uk

The Royal College of General Practitioners (RCGP) also offers the innovative online tool QI Ready. QI Ready prepares and supports GPs and practice staff to carry out QI activities in their practice. The tool is comprised of an online learning network,

[23] https://gov.wales/healthcare-associated-infections-and-antimicrobial-resistance-improvement-goals-whc2019019-0

which contains complex case studies, a self-accreditation system and QI e-learning modules.

RCGP Wales has three faculties that host educational courses and networking events throughout the regions and North, South West and South East Wales. Many of these events contribute to CPD and professional development. Each health board has an RCGP advocate to promote the values of professional GP practice, and to highlight the resources available through the UK College.

Name of the Collaborative:
Name of the QI project:
Aim of the QI project:
Outline of requirements: Practice Collaborative Health Board
Measurement of the implementation of the project:

Outcome expected from the project: